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NHS
St George's University Hospitals
NHS Foundation Trust

2024-25

St George's University Hospitals NHS Foundation Trust

Annual Report and Accounts

St George's University Hospitals NHS Foundation Trust

Annual Reports and Accounts 2024-25

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

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Chair and Chief Executive's foreword

Welcome to our 2024-25 Annual Report and Accounts.

It's been another incredibly busy year, with financial pressures and increasing demand for our services.

As ever, our staff have delivered in their professionalism and desire to find solutions, while providing safe and compassionate care.

We know this is not always in ideal conditions, with longer waits and 'corridor care' continuing to present challenges for many hospitals across the NHS.

It is important to acknowledge that this is not how we want to be caring for patients, but we must also celebrate our successes, such as tackling our waiting lists for surgical procedures.

We have made good progress in delivering our vision of providing outstanding care, together – and throughout this report you will see how we are doing this.

A focus on quality and safety

We launched a new Quality and Safety Strategy this year, which outlines our plans for the next four years to strengthen quality and safety, improve patient flow through our services, and foster a culture of psychological safety and continuous improvement.

Where we have made mistakes, we continue to be open about them and to learn and improve.

Our performance

As with many NHS Trusts, the pressures on our front door and the management of patients in our hospitals through to discharge remains a challenge.

Despite this, we continue to meet national standards in keeping those waiting in our emergency department under four hours, which is testament to the dedication and commitment of our teams across the Trust.

Waiting times remain a priority and there is a continuing focus on reducing patients waiting over 52 weeks.

We have seen improvements in faster cancer referrals, with 86% of patients diagnosed within 28 days of referral, and are meeting national targets for treatment.

The financial challenges

The financial pressures at St George's and the wider NHS are considerable, and we are working to reduce our current overspend while maintaining patient safety and meeting performance standards.

We need to ensure we live within our means as an organisation, while continuing to meet the needs of our local communities.

We are working hard to become more productive, reduce waste, duplication and unwarranted variation, increase efficiency and spend the NHS pound wisely on behalf of our patients.

We are also innovating in the way we improve quality, while reducing costs and treating more patients. For example, our red cell team at St George's has halved the time it takes to administer transfusions thanks to using ultrasound technology. In the last year, we have taken part in a trial to use ambient listening technology in our emergency department, freeing up our clinicians to spend more time with their patients.

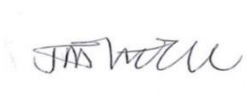
Our new Green Strategy is helping us move towards more environmentally-friendly approaches to how we provide services, such as the introduction of "smart" theatres.

Recognising our staff

Our staff work tirelessly for our local communities and it's important to us that they feel valued at work. That's why we renewed our efforts to do this over the last year by introducing events as part of a new, more consistent approach to reward and recognition across the Trust and the St George's, Epsom and St Helier Hospital Group (gesh). These included gesh25, which sees staff with 25 years or more of continuous NHS service invited to a series of afternoon tea events. Our gesh CARE awards, held in December 2024, meant any member of staff could be nominated for an award, whether delivering life-changing care, pioneering new treatments, or ensuring our hospitals remain safe and welcoming places for all.

Thanks should go to our staff, our Board, Governors, members, and St George's Hospital Charity for their dedication in caring for and improving the lives of our local communities. We would also like to pay tribute to Gillian Norton, whose tenure as Chairman ended in March 2025, having served for eight years. She played a pivotal role in steering the Trust through the unprecedented challenges of the COVID-19 pandemic and overseeing the formation of our Group. She leaves a legacy of dedication to public service and we wish her well in her next chapter.

Jacqueline Totterdell



Group Chief Executive Officer

26 June 2025

Sir Mark Lowcock

Chair

About us

Since the opening of the original St George's Hospital on Hyde Park Corner in 1733, St George's has built an international reputation for quality of care, education, research and medical advances.

We share our main hospital site in Tooting with City St George's, University of London, and together we train future generations of the NHS workforce.

Our organisation is large – with more than 10,000 staff – but retains a strong sense of community. We have strong links with the local populations we serve, but are also recognised nationally and internationally for being a leader in research and innovation. This enables us to attract staff from all over the world.

In February 2015, St George's became an NHS Foundation Trust. In January 2022, St George's became part of a Group with neighbouring Epsom and St Helier University Hospitals NHS Trust to form the St George's, Epsom and St Helier University Hospitals and Health Group (gesh). While continuing to operate as separate, sovereign trusts, the organisations and our teams work increasingly closely with shared goals – there are no Group financial accounts, therefore for the purpose of this annual report there is no consolidation of accounts.

As an individual Trust, and the largest healthcare provider in south west London, our two hospital sites at St George's Hospital and Queen Mary's Hospital in Roehampton serve a population of 1.3 million across south west London. As a provider of many tertiary services, such as neurosciences and paediatric medicine, we also offer care for significant populations in Surrey, Sussex, Hampshire and beyond, totalling around 3.5 million people. Even further afield, we provide care for patients from across the south west of England in specialties such as complex pelvic trauma. Other services are even more specialist, and our family HIV care service and expertise in bone marrow transplantation for non-cancer diseases mean we treat people from across the country.

St George's is one of the four major trauma centres for London, and home to a hyper acute stroke and heart attack centre. We operate one of London's four helipads, which means we treat some of the most unwell and severely injured patients from across the south of England.

We are a major centre for cancer services: St George's Hospital is one of only two designated children's cancer centres in London, and the seventh largest centre for cancer surgery/chemotherapy in London. We are one of London's largest children's hospitals, with one of only four paediatric trauma units in London, and our children's services are rated Outstanding by the CQC. St George's Hospital also hosts the only paediatric intensive care unit in south west London. We are one of the top three centres for specialist paediatric surgery in London, and a centre of excellence in foetal medicine.

St George's is a major centre for neurosciences, and is the third largest provider in London for neurosurgery. We also offer many innovative treatments for patients – for example, we were the first centre in the country to provide a 24/7 mechanical

thrombectomy service, which involves surgically removing blood clots from the brain for patients who have had a stroke. Many of our services are also part of established clinical networks, which bring together clinicians and support staff from a range of healthcare providers to improve the quality of services for patients.

A year in numbers

Our care in numbers

From 1 April 2024 to 31 March 2025, we saw:

- Over 152,000 people come to our emergency department for treatment
- Over 64,000 inpatient admissions
- Over 55,000 day case admissions
- Over 27,000 surgical operations
- Over 891,000 outpatient attendances
- Approximately 4,000 babies born with us

Our people in numbers

- Over 10,000 staff work for us

Our community – and their feedback – in numbers

- 866 formal Complaints received from 1 April 2024 to 31 March 2025
- 511 Compliments received from 1 April 2024 to 31 March 2025

Performance report

In this section, we set out progress against our strategic objectives and an overview of the key risks to delivering them.

Performance overview

Our Strategic Ambitions and Priorities for 2024/25

Our Group Strategy, *Outstanding Care, Together 2023-28,* sets out our strategic ambitions, vision and priorities: collaborating and working in partnership to meet the needs of our patients; making our services affordable and fit for the future; offering the right care, in the right place, at the right time; and engaging and empowering our staff.

Our approach to delivering our strategy

Our strategy describes how we will achieve our vision through the delivery of:

1. **Local improvements**: against a framework of annual priorities aligned to our CARE objectives.
2. **Corporate enablers**: corporate departments, working with clinical teams developing and implementing enabling strategies.
3. **Strategic initiatives**: nine large, complex, long-term, Board-led, transformational programmes of work.

Local improvements are driven by teams across the Group, against our CARE framework. In May 2024, the Board agreed 2024/25 ‘board to ward priorities’ to support this. The Board receives regular updates against these priorities through the Integrated Quality & Performance Report (IQPR). The IQPR can be viewed in our Board papers.

Corporate Enablers are actions led by corporate teams, against a set of strategies. The Board agreed 2024/25 objectives for corporate teams, and has also approved a People Strategy, Quality and Safety Strategy, and a Green Plan during the year – each of these are supported by an Implementation Plan. Progress on delivery of the Implementation Plans are reported by executive Senior Responsible Owners to Board Committees a minimum of three times per year. Corporate enabling strategies for Estates, Digital, and Research and Innovation are in development and will be approved by the Board in 2025/26.

There are nine **strategic initiatives** – complex, multi-year, Board-led programmes of work. Each of our nine strategic initiatives have been set up as programmes of work, led by an Executive Senior Responsible Owner. These initiatives report to the

relevant Board committee, and the Board receives a progress report on these initiatives on a 6-monthly cycle.

In addition, each year our Board agrees a set of annual objectives to help us deliver our strategy. In 2024/25 these were:

- **Collaboration and Partnerships:** Work with other teams to reduce delays in patient journeys through our services;
- **Affordable Healthcare, Fit for the Future:** Live within our means: innovating, working more efficiently and cutting costs;
- **Right Care, Right Place, Right Time:** Keep our patients safe, including those waiting for our care;
- **Empowered, Engaged Staff:** Make our team a great and inclusive one to work in.

The group Programme Manager Office has worked with teams to standardise programme management practices and develop key programme documentation and tools to enable delivery, risk management, stakeholder engagement, monitoring and assurance reporting of programmes.

Risk management practices ensure early identification and management of any threats to the delivery of planned objectives.

Performance analysis

As an NHS Foundation Trust, our principal purpose, defined in legislation, is the provision of goods and services for the purposes of the health service in England.

In practice, that means providing care and treatment for patients across south west London, Surrey, Sussex and beyond.

The Trust is led by the Board of Directors which is accountable, through the Chair, to NHS England and to our Council of Governors. It has a site leadership team, responsible for the day-to-day running and operational decision making of its clinical services.

St George's is structured into three clinical divisions, each led by a Clinical Chair, supported by a Divisional Director of Operations and Divisional Director of Nursing and Governance:

- Medicines and Cardiovascular Division
- Surgery, Neurosciences, Cancer and Theatres Division
- Children, Women's, Diagnostics and Therapies Division.

Alongside these, the Corporate Division comprises key corporate services including finance, human resources, estates and facilities, IT, communications, strategy, continuous improvement, performance and programme management, and corporate affairs.

The Trust employs more than 10,000 staff across our sites. St George's is part of a hospital group with Epsom and St Helier University Hospitals NHS Trust, and is part of the South West London Integrated Care System and the South West London Acute Provider Collaborative.

The national and regional context

Nationally, the NHS is undergoing significant change including the architecture of the NHS at a national, regional and local level. The Government plans to publish its 10 Year Plan in summer 2025, in which it intends to set out how we achieve the transformational change our health system needs. This is expected to focus on the three key shifts already announced by the Government: hospital to community, analogue to digital and sickness to prevention.

From Spring 2025, the delegation of many specialised services from NHS England (NHSE) to Integrated Care Systems (ICSs) will take place. The South London Office of Specialised Services has begun a review of specialised services, which could prompt system level opportunities to re-configure specialised services.

Our Progress

Despite a very challenging financial context, we have made progress in delivering the objectives set by the Board for 2024/25 and have worked to embed these objectives across the organisation.

- Individual teams are continuing to articulate their priorities using the CARE framework.
- The CARE strategy is presented as part of the gesh Senior Leadership Programme, supporting leaders to align individual team objectives to CARE.
- Through our High-Performing Teams strategic initiative, we continue to train staff in improvement methodologies, explicitly linked to the CARE strategy.
- Our CARE Awards took place on 10 December 2024, recognising the achievements, commitment and contribution of our colleagues across our Group in both hospital and community services. Staff were recognised across 12 awards linked to the ambitions of our CARE strategy. This was the first staff awards ceremony held since the pandemic and was supported by the St George's Hospital Charity and other partners.
- The 2024/25 'Board to Ward priorities', linked to the CARE framework, are now regularly reported to Board via the Integrated Quality and Performance

Report (IQPR). We will continue to embed them our in ways of working across the Group in 2025/26.

Corporate enablers The Board agreed that six corporate enabling strategies should be developed	
Strategy	**Progress**
People Strategy	Approved by the Board in May 2024.
Quality & Safety Strategy	Approved by the Board in July 2024.
Green Plan	Approved by the Board in July 2024.
Estates Strategy	Developing this strategy began in late 2024 and will be submitted to the Board in Autumn 2025.
Digital Strategy	This is in development and will be informed by the national 10 Year Plan, which is expected to have a significant focus on shifting the NHS from analogue to digital and will also integrate with the Estates Strategy (above). It will be submitted to the Board in Autumn 2025.
Research & Innovation Strategy	This is in development and planned for board approval in Summer 2025. The group is exploring how its strategic partnership with the newly merged City St George's, University of London might impact on our research and innovation strategy.

Strategic Initiatives

Building Your Future Hospitals programme	The UK government has agreed a funding approach for the New Hospital Programme, with three waves of investment. The Specialist Emergency Care Hospital in Sutton will begin construction in 2032. The Board is reviewing the implications of the delay, mitigating potential infrastructure failures, and working with NHS England to source funding for improvements at Epsom and St Helier hospitals. A £60 million investment has already been made over the last five years on improving our estates.
Supporting a continuous improvement approach throughout our organisations, through high-performing teams and leaders	Progress has been made: • supporting teams throughout our organisation to have a shared set of objectives, linked to our CARE framework • training staff in continuous improvement approaches, so they can make positive change against those objectives • ensuring that the way we monitor and improve performance throughout the organisation reinforces this local team-led improvement.
Implementing a shared system for electronic patient records across our Group	This was implemented across Epsom and St Helier in May 2025 to bring it in line with St George's. We delivered a robust suite of training to support the successful implementation.
Transforming our outpatient services	There is now a regular and more structured interface with primary care colleagues. These meetings have helped to boost relationships and improve the advice and guidance utilisation rate. The Senior Responsible Owner of the Transforming Outpatients Strategic Initiative is chairing the Tackling Health Inequalities meeting, fostering the cross- fertilisation of ideas. There is ongoing collaboration with South west London partners to identify best practice in reducing the impact of health inequalities for patients on waiting lists. An options appraisal and a framework for using automation have been drafted – focusing on the benefits and Group alignment. We are exploring

	the use of artificial intelligence (AI) and the benefits it can bring, including helping to deliver both efficiencies and our Cost Improvement Plans (CIPs).
Collaborating with other hospitals across south west London	We continue to collaborate with other hospitals in south west London through the Acute Provider Collaborative. We have strengthened existing collaborations (such as the SWLEOC, SWL Procurement, SWL Pathology), and developed new joint projects – such as creating a single point of access for Ear Nose and Throat referrals, to enable patients to be seen in the right place as quickly as possible, making best use of capacity in our region. We hold multidisciplinary team meetings to support holistic care planning. Urgent care response services are also being enhanced, providing rapid assessments and care in people's homes within two hours of referrals. Virtual wards in Surrey Downs and Sutton offer hospital-level care at home for patients who would otherwise require admission or extended hospital stays. Partnerships through the Sutton Health and Care Alliance and Surrey Downs Health and Care are key to delivering these integrated services.
Transforming our culture, and making our workplaces more diverse and inclusive	Our Gender Pay Gap, Workforce Race Equality Statement (WRES) and Workforce Disability Equality Statement (WDES) reporting, alongside the Equality Diversity and Inclusion Plan agreed by the Board in February 2025, sets out the progress we have made and the actions we are taking to improve diversity and inclusion. We have implemented training on neurodiversity in the workplace and reviewed the workplace adjustment process, including Group-wide advice and guidance for managers. The gesh Culture Forum was launched in 2024, with events for recognising and celebrating awareness. Chaired by the Chief Executive, the Forum brings together our work in strengthening culture across the Group. During 2024/25, we launched a Group-wide Freedom to Speak Up service, implemented a new Speak Up policy, and embedded the work of our Executive-led Raising Concerns Oversight

	and Triangulation Group, to ensure concerns raised by staff are dealt with promptly and effectively and fosters a culture of psychological safety in speaking up. We launched the Sexual Safety Charter. Led by the Group CEO, a review of our Managing Violence and Aggression policies and resources was completed. The revised toolkit set out a clear violence prevention, reduction and response process. We are developing a positive action pathway to proactively prepare colleagues from ethnic minority backgrounds for leadership – including a shadow board that will recruit in 2025/26.
Pursuing collaboration across our gesh Group	We have made good progress in strengthening collaboration across our Group. We have integrated corporate services including Corporate Nursing, Strategy and Project Management, and Corporate Affairs, providing quality benefits and cost savings. The structural integration of Corporate Medicine, Pharmacy, Human Resources and Estates is on track to be completed in early 2025/26. The integration timeline for finance is behind the original timeline and a revised plan is being explored. IT integration is in the early stages of planning and will be linked with the priorities of the 10 Year Plan. Integration strategies for Surgery and Paediatrics began in 2024/25 and will progress in 2025/26. The new Government's review of the New Hospital Programme means the renal integration programme has been delayed.
Collaborating with local partners in Surrey Downs, Sutton, Merton and Wandsworth	At gesh, we are actively working with partners and local communities to shift care closer to home, supporting more people in the community and reducing reliance on hospital services. This includes developing 10 neighbourhood teams in partnership with local partners across Sutton and Surrey Downs, bringing together GPs, nurses,

	and other health and care professionals to deliver coordinated, local care. These teams provide both reactive care for immediate health needs and proactive support for people at risk of deterioration. Population health tools are used to identify and support people early, and neighbourhood multidisciplinary team meetings are held to support holistic care planning.
Strengthening our specialised services	Following a review, the programme has been re-scoped with a focus on strengthening Neurosciences, Major Trauma, Renal, Cardiac surgery, and Children's Services. Highlights include: • Strengthening Cardiac surgery, including increased theatre capacity, enhanced care capacity, and focus on recruitment/retention of surgical and anaesthetic workforce • 'Model of care' for Major Trauma is under development, to strengthen our approach to delivering the service • Discussions with NHSE on how to strengthen paediatric services, particularly in the context of NHSE's decision to move paediatric cancer to the Evelina in Autumn 2026.

Our Green Plan and commitment to sustainability

In July 2023, the Board approved the gesh Group Green Plan Strategy. As part of the launch, the Green Plan team delivered training at the Board Development session in December 2024, and this training is now being rolled out to staff across the Trusts.

The new strategy is now one of the Group's core enabling strategies and has been refined to provide more tangible targets and milestones to meet our net zero targets. In addition, the new Green Plan clarifies our governance and reporting arrangements. The Green Plan team provides regular updates to the Site Leadership Teams, has regular meetings with the Managing Directors and submits quarterly

updates to the gesh Group joint Infrastructure Committee in common, which is a sub-committee to the gesh Group Board. From 2025, a Green Plan Steering Group will oversee progress on all key workstreams in the Green Plan.

The Green Plan is supported by an action tracker, which identifies detailed actions to achieve our commitments, while aligning with those of the SWL ICB Green Plan and NHS targets. Alongside the action tracker we have developed a set of Key Performance Indicators that are reported to senior management and staff via the Green Plan Dashboard.

As part of our ongoing commitment to improving climate-change risk reporting and raising the challenges to deliver Net Zero Carbon by 2040, we are developing an overarching Group-wide risk assessment with our Emergency Planning teams. As part of this, there will be further work for workstreams and divisions to prepare specific risk assessments against their areas of responsibility, which will feed into the governance framework.

Key areas of focus for the coming year:

1. Support our clinical teams to embed environmental sustainability in their areas of work. We will be running training workshops to identify key actions and projects to improve our clinical sustainability performance, using a Sustainable Quality Improvement model.

2. Ensure all projects aim to increase improvements in Care, Cost and Carbon

3. Review progress of the decarbonisation plans in line with the gesh Group clinical strategy and enabling strategies.

Achievements

- The Trust is in the process of closing the Nitrous Oxide manifolds across the Group, saving approximately 1200 tonnes of CO2e. This will be completed across all of our hospitals in 2025.
- Maternity has installed a Central Destruction Unit which removes harmful nitrous oxide from the delivery room, providing an environmental benefit while reducing exposure for staff and patients.
- We have upgraded to SMART theatres, optimising heating, lighting and environmental sensors to save over £350k in energy costs annually and associated carbon, while improving patient flow and care.
- The Group was awarded £3.14m in January 2025 from the NEEF fund to switch to high efficiency LED lighting. This could save up to £1m per annum in energy costs across the Group.
- The catering team was awarded ‘Exemplar status’ by NHS England, in part for their work on reducing food waste and the low carbon menu.
- In March 2025, a £468k bid to install solar panels was successful. They will save around 60 tonnes of carbon emissions each year for 20 years, equivalent to the carbon emissions of 10 average houses each year. This will

save approximately £85k in electricity costs each year.

Working to reduce health inequalities

Equitable access, reducing health inequalities

National policy follows the ‘Core20PLUS5’ approach to tackling Health Inequalities. This approach encourages systems to focus on:

- The most deprived 20% of the national population
- Five nationally-identified areas of health inequalities (maternity, severe mental illness, chronic respiratory disease, cancer diagnosis, hypertension)
- ICS-identified groups who receive lower access, experience and/or outcomes

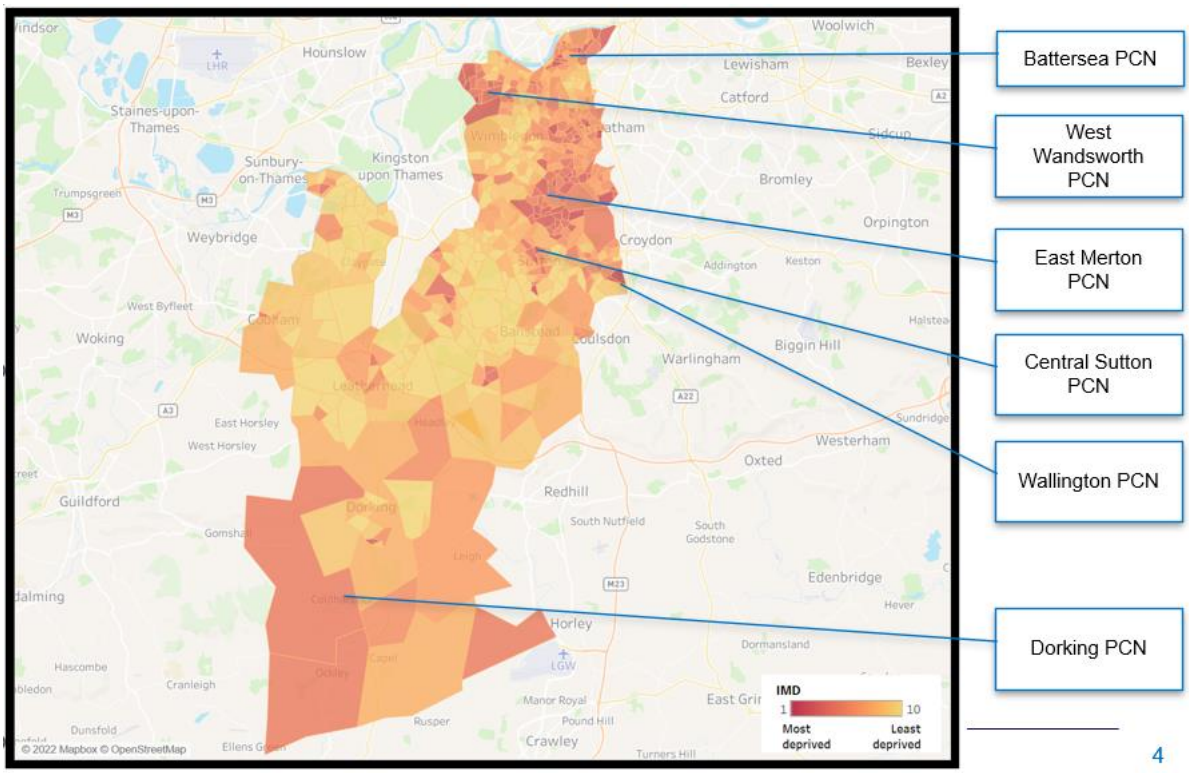
One of the areas that national policy encourages local systems to focus on is ‘the Core20’, the 20% of the population living in the most deprived areas.

In our catchment area, more deprived groups are more likely to have a mental health, diabetes and respiratory COPD diagnosis.

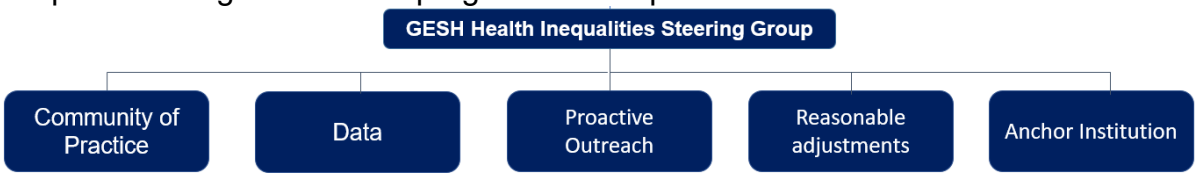
We know that in SWL, these populations:

- are more likely to have an illness, or comorbidity, and are frailer
- have a healthy life expectancy 6 years less than the rest of the population
- access our services differently. For instance, men in the most deprived decile are twice as likely to miss appointments as those in the least deprived.

Our catchment area has pockets of deprivation which could be areas of focus as shown on this map.



In response this challenge, our Group Chief Medical Officer leads a Health Inequalities Programme. The programme comprises:



So far, the work has focused on developing communities of practice; understand and improve our patient demographic data capture; and reasonable adjustments.

Communities of practice

A new Group Communities of Practice for Health Inequalities, comprised of clinical and operational leaders whose services are innovative in Health Inequalities, has been established. A clinical health inequalities lead for St George's has been recruited, with one to be appointed for Epsom and St Helier this coming year. The forum aims to build a culture of tackling health inequalities across the gesh Group.

An area of focus has been a focus on bridging gaps for all women who use SGH maternity services to ensure inequalities and inequities are minimalised. We use a live video translating service to maximise every opportunity for non-English speaking women to be supported. The service was also successfully assessed as achieving in the Equality Delivery System EDI. In the EDI there are eleven outcomes, against which NHS organisations measure their successes and challenges with protected characteristic and vulnerable community groups using evidence and insight.

We formed a Maternity Cultural Transformation Group, following observation of disproportionately higher maternal morbidity among Black, Asian and minority ethnic groups (BAME) booked for maternity care compared to white British mothers. The group:

- coordinates the strategy in developing services which reduces the health inequalities in BAME (Black, Asian, Ethnic Minority) women
- understands global, national and local priorities which inform the disparities in health care and seeks to close this gap
- facilitates cultural understanding of the women by our staff and enables women to express their views and needs, so their voices are heard, understood and responded to
- involves women to co-design services, to improve their experience and health outcomes
- seeks to close links with the Trust REACH network, MVP, local LMNS, infant feeding support groups, community support groups and other services.

In doing so, the programme has improved access to education for both women and maternity staff through:

- developing apps aimed at improving communication between women and staff
- improving access to translational services
- developing an educational film as a teaching resource for healthcare staff, with examples of inappropriate behaviour, racism, micro-aggressions and how the culture can affect team behaviour
- advancing Health Equity through partnership with Primary Care/Neighbourhoods through a Paediatric 'Together Service'. This approach consists of joint clinics with local GPs and paediatric consultants in the same primary care consultation room. This has improved access to secondary care services for children and young people by reducing waiting times from approximately 6 months to 1 month.

Data

Analysis of ethnicity recording in our datasets shows that while data completeness is good, there is significant over-recording of the codes *"any other ethnic group"*, *"not stated"*, and *"not known"*.

We are working with services with the poorest data accuracy to improve accurate data capture, and with the SWL ICS to integrate primary care datasets with our systems to improve patient demographic data.

Reasonable adjustments

As a group we are participating in some early development work with Deep Medical and its Artificial Intelligence tools in focusing specifically on those patients living with

frailty.

The programme is exploring whether it is possible to identify those over 75 being offered appointments across a number of specialities (poly appointments) and to intervene to offer an MDT assessment and comprehensive geriatric assessment. This would improve coordinated patient care and reduce outpatient appointments for high intensity users of our services.

South West London Acute Provider Collaborative: Annual Report Summary 2024–25

In 2024–25, under refreshed leadership, the South West London Acute Provider Collaborative (SWL APC) redefined its role, focusing on high-impact programmes designed to reduce variation, improve outcomes, and deliver greater value for patients and the public.

Key achievements this year include the launch of the Ear, Nose and Throat (ENT) Single Point of Referral pilot, which is streamlining referrals and helping patients access treatment faster and more equitably. Although early days in evaluation, patients and partners have responded well to the new way of working and we are seeing a shift in referral flows across the geography. This past year has seen a strong collective performance in elective recovery: although it remains a very challenging position, SWL has the lowest number of 52-week waiters in London, and capped theatre utilisation consistently exceeds 80%. The operational performance targets for 25/26 continue to challenge all organisations, but performance against the national average on 18-week Referral to Treatment times for SWL acute providers remains strong.

Improvements have also been made through collaborating in Diagnostic activity. Through the Community Diagnostics Centre (CDC) programme, we now deliver 46% of all London CDC activity and over 726,000 tests have been completed since 2021: with over 95% of MRI, CT, and 86% of ultrasound patients seen within six weeks.

Alongside supporting operational improvements, the APC has been driving forward the use of technology to improve patient experience and efficiency. The patient portal now has nearly 500,000 users – one third of the 1.5M population of SWL - and a range of functionality in use, and new digital tools like the GetUBetter app and the use of Ambient Voice Technology are being tested to support prevention and clinical efficiency.

Looking ahead to 2025–26, we will continue to work across our acute providers to improve elective performance, and work with system partners to deliver the changes required to ensure financial and operational sustainability for the SWL system.

Operational performance

Indicator	Target 2024-25	**Performance** St George's **2024-25**
A&E 4 Hour performance (all types)	>78%	79.6%
18 Weeks Referral to Treatment (RTT) - Incomplete Pathways	>92%	61.6%
Cancer - 28 day Faster Diagnosis	>77%	86.5%
31 Day Decision to Treat to Treatment	>96%	96%
62 Day Referral to Treatment	>70%	81%
Diagnostic Waiting Times	>95%	95.3
Operations not rebooked within 28 days	0	38
Infection Control - Number of Clostridium Difficile - Hospital & Community	43	60
Infection Control - Number of MRSA	0	1

Better Payment Practice Code

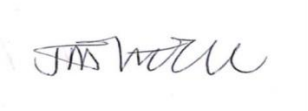
The Better Payment Practice Code (BPPC) requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Non NHS Payables	2024-25 Number	2024-25 £000s	2023-24 Number	2023-24 £000s

Total non-NHS trade invoices paid in the year	118,654	492,008	119,983	477,658
Total non-NHS trade invoices paid within target	106,906	443,620	88,804	377,703
Percentage of non-NHS trade invoices paid within target	**90.10%**	**90.17%**	**74.01%**	**79.07%**

NHS Payables	**2024-25 Number**	**2024-25 £000s**	**2023-24 Number**	**2023-24 £000s**
Total NHS trade invoices paid in the year	3,772	54,231	3,556	61,167
Total NHS trade invoices paid within target	2,265	37,817	2,055	45,950
Percentage of NHS trade invoices paid within target	**60.05%**	**69.73%**	**57.79%**	**75.12%**

Total				
Total bills paid in the year	122,426	546,239	123,539	538,825
Total bills paid within target	109,171	481,437	90,859	423,653
	89.17%	**88.14%**	**73.55%**	**78.63%**



Jacqueline Totterdell
Group Chief Executive

26 June 2025

Our workforce 2024-25 disclosures

Range of staff remuneration for 2024-25 (audited)

In 2024-25, the lowest annualised salary was £31.24 (2023-24 was £31.80). The highest paid was £439,884 (2023-24 £498,559). This is as per the payroll report and is distorted by bank staff and several variables such as prior year arrears payment including clinical excellence award paid in FY24-25. The lowest paid salary of £29,029 compared to FY23-24 £27,516.74 (Band 1).

A statement on how pay and conditions of service are determined by the Remuneration and Nomination Committee is set out in the very senior managers' pay principles section of the Remuneration Report.

Fair Pay Disclosures (audited)

Table 1: Percentage change in remuneration of highest paid director and average employee 24/25

	Highest Paid Director		Average employee pay	
Year	Salary and allowances £ 000	Performance pay and bonuses £ '000	Salary and allowances £ '000	Performance pay and bonuses £ '000
FY 2024-25	216	0	46	1
FY 2023-24	205	0	43	1
% Increase/decrease	5%	0%	9%	-13%

Percentage increases or decreases are calculated based on unrounded figures in table 1

Table 2: Percentage change in remuneration of highest paid Director and average employee 23/24

	Highest Paid Director		Average employee pay	
Year	Salary and allowances £ 000	Performance pay and bonuses £ '000	Salary and allowances £ '000	Performance pay and bonuses £ '000
FY 2023-24	205	0	43	1
FY 2022-23	154	0	40	4
% Increase/decrease	33%	0%	6%	-74%

Percentage increases or decreases are calculated based on unrounded figures in table 2

Notes:

1. In FY24-25 and FY23-24, the highest-paid board member was Managing Director. There is a 5% increase in the highest paid in FY24-25 compared to FY23-24.

2. In FY24-25, 50% salary of the Chief Executive Officer ,Chief Finance Officer, Chief Corporate Affairs Officer, Chief Medical Officer and Chief People Officer were recharged to Epsom and St Helier Hospital NHS Trust (EPSH).
3. The highest-paid Managing Director received no performance pay and bonuses in FY24-25.
4. 9% Increase in average pay for employees in FY24-25 compared to FY23-24. This excludes the highest-paid Managing Director.
5. 13% decrease in performance pay and bonuses (Local Clinical Excellence Awards) in FY24-25 compared to FY 23-24.

Table 3 (audited)

The banded remuneration of the highest paid Director in the financial year 2024-25 was £216k (2023-24 £205k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

Multiple table	2024/25	2023/24
Payroll costs (£000)	827,506	746,160
Whole time equivalent	10,653	10,552
25th Percentile	29	27
Median (£000)	41	37
75th Percentile	60	55
Highest paid director (£000)	216	205
25th percentile pay ratio	7.4	7.7
Median will fit into highest	5.3	5.5
75th percentile pay ratio	3.6	3.7

Table 4: Pay ratio disclosure (audited)

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
FY 2024-25	7.4	5.3	3.6
FY 2023-24	7.7	5.5	3.7

Table 5: Pay ratio information table (audited)

FY 2024-25	25th percentile	Median	75th percentile
Total remuneration (£ '000)	29	41	60
Salary component of total remuneration (£ '000)	29	41	60
Pay ratio information	7.4	5.3	3.6

FY 2023-24	25th percentile	Median	75th percentile
Total remuneration (£ '000)	27	37	55
Salary component of total remuneration (£ '000)	27	37	55

Pay ratio information	7.7	5.5	3.7

Notes:

- Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the 25th, 50th (median) and 75th percentile remuneration of the organisation's workforce.
- The remuneration of the highest paid director compared to the lower quartile, median and upper quartile remuneration of the workforce
- Lower quartile, Median, and upper quartile – The median remuneration of the reporting entity's staff is the total remuneration of the staff member(s) lying in the middle of the linear distribution of the total staff, excluding the highest paid director. Similarly, lower quartile remuneration is the total remuneration of the staff members(s) on the 25th percentile of the linear distribution and the upper quartile on the 75th percentile of the linear distribution; for both, excluding the highest paid director. This is based on annualised, full-time equivalent remuneration as at the reporting period date 31st March 2025
- In 2024-25, the lowest annualised salary was £3.24 (2023-24 was £31.80). The highest paid was £439,884 (2023-24 £498,559). This is as per the payroll report and is distorted by bank staff and several variables such as prior year arrears payment including clinical excellence award paid in FY24-25. The lowest paid salary of £29,029 compared to FY23-24 £27,516.74 (Band 1).
- The calculation is based on full-time equivalent staff working for the Trust on 31 March 2025. Where staff are part time, their salaries have been annualised for the purposes of the pay ratio calculation and highest & lowest paid staff in the Trust.

- Non-exective directors are also included in the calculation.
- The mid point of banded remuneration of the highest paid Director within St Georges's University Hospitals NHS Foundation Trust in the financial year 2024-25 was £217.5k (2023-24: £205k)
- This was 5.3 times (2023/24: 5.5 times) the median remuneration of the workforce, which was £41k (2023-24: £37k).
- This was 7.4 times (2023-24: 7.7 times) the lower quartile remuneration of the workforce, which was £29k (2023-24: £27k).
- This was 3.6 times (2023/24: 3.7 times) the upper quartile remuneration of the workforce, which was £60k (2023-24: £55k).
- There has been an decreased in Lower, Median and Upper quartile between FY24-25 and FY23-24, this is due to a consolidated pay award of 5.5% for agenda for change in FY24-25.
- Total remuneration includes salary, benefits-in-kind, golden hellos and compensation for loss of office. It does not include employer pension contributions, termination payments and the cash equivalent transfer value of pensions
- There are 33 Staff member being paid more than the highest paid director this is due to Arrears, Additional Duties, Extra Sessions, Bank and Clinical Exellence Awards which have been paid in M12.
- The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.

Major risks to Trust's objectives

Successful delivery of our Group strategy means understanding and taking steps to manage and mitigate key strategic and operational risks. The Trust maintains both a Board Assurance Framework and a Corporate Risk Register, informed by risk assessments across the organisation, and supported by our risk management policy.

The purpose of the Board Assurance Framework (BAF) is to provide the Board with assurance regarding the risks to delivering the strategic objectives, when considered alongside the Trust's risk management processes, the Annual Governance Statement and the programme of internal audit. As our strategy is Group-wide, so too is our BAF.

The BAF sets out risk scores, assurance ratings and targets for each of the identified strategic risks, alongside key controls in place to manage our risks and key sources of assurance. The BAF is reviewed regularly by the Board Committees and by the Board, bi-annually. In 2024-25, the Board discussed the BAF in public sessions in July 2024 and January 2025, and at Board Committees at regular intervals throughout the year.

Against each priority, we monitor a set of lead indicators, review progress against these, and assign an assurance rating against the overall corporate priority and a RAG-rating against each lead indictor. We also monitor the linkages between the risks to the delivery of each corporate objective with the corresponding risks on the Corporate Risk Register. The key risks on the Corporate Risk Register are set out in the Corporate Governance Report.

Grouped by corporate objectives, the 14 strategic risks on the BAF in 2024-25 were:

Group Board Assurance Framework 2024-25	
Strategic objectives	**Strategic Risks (SR)**
Collaboration and Partnership	**SR1: Working across our local systems:** If we do not act as an effective, collaborative partner across the whole patient pathway and wider health and care system, we will not build effective integrated models of care across primary, community, mental health, acute and specialist care, resulting in unsustainable demand for acute services, patients not receiving care in the most appropriate setting, and lower health outcomes. **SR2: Working with other hospitals through our Acute Provider Collaborative:** If we do not foster strong, collaborative relationships with other providers through the Acute Provider Collaborative and focus on where we can add the most value in terms of the quality and sustainability of services, we will not deliver effective, efficient and sustainable services for the benefit of patients across South West London and Surrey, resulting in

	longer waiting lists, unwarranted variation in and less responsive care, and less efficient use of resources across our system. **SR3: Working together across our group:** If we do not harness the full benefits of collaboration and integration across our group and capitalise on our strengths, we will be less than the sum of our parts, fail to keep pace with improving standards and face challenges in retaining the breadth of services for the benefit of our local communities, resulting in unwarranted variation in care and poorer outcomes for patients.
Affordable Services, Fit for the Future	**SR4: Achieving financial sustainability:** If we do not manage costs effectively, optimise productivity, and ensure our activities are effective, we will not return to financial balance, resulting in the poor use of public funds and unsustainable services for patients. **SR5: Modernising our estate:** If we do not secure capital funds necessary to address areas of material risk across our estates and deliver our green plans, we will be unable to maintain a safe estate, reduce our carbon footprint, and transform services for patients, resulting in increased risk to patient and staff safety and to the safe and sustainable delivery of clinical services **SR6: Adopting digital technology:** If we do not build a robust digital infrastructure and adopt transformational digital solutions, we will not deliver new and innovative models of care or support staff to work more flexibly and efficiently, resulting in poorer patient outcomes, less efficient services and staff disengagement. **SR7: Developing new treatments through innovation and research:** If we do not create the right culture, infrastructure and partnerships, we will not become a thriving centre for research and innovation and not attract sufficient research funding, resulting in poorer health outcomes for patients, and challenges in attracting and retaining high-calibre staff.
Right Care, Right Place, Right Time	**SR8: Reducing Waiting Times:** If we do not foster and support continuous improvement to improve the efficiency and effectiveness of our services, we will not improve flow through our hospitals, resulting in patients waiting too long for treatment, poorer clinical outcomes and risk of harm, and staff disengagement. **SR9: Improving Patient Safety and Reducing Avoidable Harm:** If we do not develop robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning, we will not deliver safe, effective and responsive care to our patients, resulting in

	increases in avoidable and harm and mortality, and poorer clinical outcomes. **SR10: Improving Patient Experience:** If we do not equip our staff to make improvements in their services and build effective relationships with patient groups, we will not deliver improvements in the quality, effectiveness and efficiency of our services, resulting in lower quality of care, increased risk of harm, and less efficient services. **Strategic Risk 11: Tackling Health Inequalities:** If we do not pursue a more strategic and systematic approach to tackling health inequalities in collaboration with our local partners and act as an anchor institution, we will fail to play our part in improving the health of our local population, resulting in less equitable access to care and poorer outcomes.
Empowered, Engaged Staff	**SR12: Putting Staff Experience and Wellbeing at the Heart of What We Do:** If we do not give our staff the tools and support they need or develop high performing teams and outstanding leaders and managers at every level, our staff will be unable to perform to their best and may not feel fairly treated, resulting in services that are less efficient, poorer quality of care for patients, and difficulties in recruiting and retaining high calibre staff. **SR13: Fostering an Inclusive Culture that Celebrates Diversity:** If we do not develop our organisational culture to make the Group a more inclusive place to work that celebrates our diversity and tackle discrimination, our staff will not feel valued, empowered or psychologically secure, resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients. **SR14: Developing Tomorrow's Workforce:** If we do not retain, train and transform our workforce for the future, we will not be able to support the delivery of new models of care, encounter shortages in our workforce, and increase our reliance on agency staff, resulting in lower quality and less efficient services for patients, and higher staffing costs.

Strategic risks on the Group BAF are assigned to Committees of the Board which provide oversight of the risks and actions being taken to mitigate them. The Group Board receives assurance on the Committee oversight via their reports to the Group Board. The three risks on the BAF which relate to the strategic objective of collaboration (SR1, SR2 and SR3) are reserved to the Group Board and are not delegated to Committees.

Further information about risk, and the Trust's approach to managing and mitigating these are set out in the Annual Governance Statement.

Accountability report

Corporate governance report

This section of the Annual Report focuses on our governance, providing information about the legal status of our Trust, and the processes and structures by which we maintain our commitment to, and deliver, good governance.

Directors' Report

The Trust is governed by the National Health Service Act 2006, the Health and Social Care Act 2012, and by secondary legislation made under these Acts.

The statutory functions of the Trust are set out in the NHS Act 2006 (Schedule 4) and in Establishment Order 1999 No. 848.

The Governance Framework

Our Board of Directors oversees the running of our hospitals. The Board has three principal roles:

- Formulating strategy
- Shaping a positive culture for the Board and the organisation
- Ensuring accountability by holding the organisation to account for the delivery of strategy, and through seeking assurance that systems of control are robust and reliable.

The Board is also responsible for ensuring that there are effective systems of governance, risk management and internal controls in place.

The Board provides a framework of governance, within which we deliver high quality healthcare services across south west London and Surrey.

The Board recognises that effective corporate governance underpins good leadership and accountability, and the Board continually seeks to improve governance arrangements within the Trust.

To achieve its purpose, the Board has delegated some of its powers to its Board Committees. The non-executive directors and executive directors bring a wide range of skills and experience to the Trust, such that the Board achieves balance and completeness.

The Trust Board of Directors

The Trust is led by our Board of Directors, comprising six voting Non-Executive directors, one non-voting associate Non-Executive Director, four voting executive directors and six non-voting Directors. Executive Directors are full-time employees of the Trust, with a notice period of three months. Non-Executive Directors are appointed by the NHS England on behalf of the Secretary of State for Health and Social Care.

In 2021-22, the Boards of Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust formed a hospital Group and in April 2023 established a Group Board to provide collective leadership. The Group Board comprises the non-executives from both Trusts and the Executive Directors, and met bi-monthly in public on six occasions in 2024-25. Following each Group Board meeting in public, the Group Board also met in private. Group Board development sessions were also held on a bi-monthly basis. The agenda, minutes and papers for the Group Board meetings held in public are available on the Trust website. Our annual public meeting for the year ending 31 March 2024 was held on 24 September 2024. We shared some of our achievements during the year in relation to our finances, quality and safety, and performance. We also shared our focus for 2024-25 and future objectives.

Following the formation and development of our Group with St George's University Hospitals NHS Foundation Trust, in 2023-24 we developed a strategy for the Group as a whole, and for its constituent Trusts. Our Group strategy, launched in May 2023, set out our shared vision for the next five years – providing outstanding care, together.

During 2024-25, we agreed new corporate enabling strategies for quality and safety, and people – agreeing a Group-wide green plan. We also progressed our corporate enabling strategies for IT, estates, and research and innovation, and we expect each of these to be launched during 2025-26.

While we have ambitious plans and are supporting staff across our organisation to pursue improvements against our new CARE framework, we are operating within an increasingly complex, challenging and changing landscape. As in 2024-25, there will be difficult decisions in the year ahead when we will need to balance the demands for additional capacity and investment against the cost savings that all NHS organisations have been asked to meet. Our priority remains to provide outstanding care for our patients, staff and the communities we serve, and part of this is ensuring our services are affordable and sustainable for the future.

The Trust Board is confident that all Directors are appropriately qualified to discharge their functions effectively, including monitoring and managing performance, and ensuring management capacity and capability. Both the Board selection process and a Board development programme are in place to ensure that the Executive Directors and Non-Executive Directors have the skills and experience necessary to deliver our vision and strategic objectives.

Our regulatory position

Across all of our services, we work closely with the Care Quality Commission (CQC) to ensure safe and effective care for our patients and to build upon the outcomes of the CQC's last full inspection report for St George's, published on 18 December 2019 following its unannounced inspection in July 2019 and its Well-Led review in September 2019. In that inspection, the Trust maintained its CQC rating of 'Requires Improvement', but the CQC recommended that St George's be taken out of quality special measures, which was endorsed by NHS England and NHS Improvement in March 2020. The Trust also exited financial special measures in December 2020. You can access the CQC's report here: www.cqc.org.uk/location/RJ701#accordion-1.

During 2024-25, the CQC undertook both a Well-Led inspection at St George's and a number of inspections of our core services. A three-day Well-Led inspection was undertaken by the CQC at the end of February 2025 and we await the inspection report.

The Trust has continued to focus on delivery improvements to its maternity services following the issue of a Section 29A Warning Notice under the Health and Social Care Act 2008, arising from an unannounced CQC inspection of its maternity services in March 2023. A further Section 29A Warning Notice was received in December 2024 in relation to an inspection of maternity services in October 2024 and the emergency department in November 2024. The Trust put in place a number of immediate actions to address the matters set out by the CQC and submitted a detailed plan to them in February 2025.

Following the March 2023 Section 29A Warning Notice, an independent external review of quality governance across the group was commissioned. Phase 1 focused on the effectiveness of quality governance in the service and upwards from the maternity service to the Board, considering quality governance structures, processes, systems and controls. Phase 2 considered the wider effectiveness of quality governance from individual service level to Divisional, Site, Executive and Board level across the group as whole. The outcomes and actions to be taken following these reviews receive oversight from the Quality Committee.

In February 2024, the CQC published the results of its Maternity Survey for 2024 within which St George's was rated joint second-best in the capital for its maternity care and treatment, maintaining its position from 2023. The Quality Committee and the Group Board, at its meeting in public, continue to receive regular assurance reports on our maternity services and compliance with the Perinatal Quality Surveillance Measures.

Patient and public engagement

With increasing demand and ever tighter budgets, we are under pressure to improve health outcomes, deliver quality services, and make good use of resources. Patient and public engagement is key to helping us ensure we deliver services to best meet the needs and preferences of the populations we serve.

Our Patient Partnership and Experience Group has continued to help us focus on the principles and benefits of patients working as partners with the Trust. Examples of patient engagement during 2024-25 include:

- A series of events open to all unpaid carers, to listen to their insights to co-design a Carers Charter for the St Georges, Epsom and St Helier University Hospitals and Health Group.
- Our Carers Steering Group, made up of multi-disciplinary members of staff, carers, patients, carer agencies and Integrated Care Board (ICB) staff to implement the Carers and Hospital Discharge toolkit to identify, capture and support unpaid carers.

- Our Veterans Awareness and Engagement group made up of staff who are members of the Armed Forces and volunteer veterans, to raise awareness of the importance of recognising members of the Armed Forces to improve the care and support we can provide.
- Welcoming new volunteers into St George's to improve patient experience as well as supporting our long-standing volunteers with their role.
- Publishing a quarterly Patient Experience newsletter to raise awareness of events, updates, training and workstreams in progress, across the organisation.

Our members

Being an NHS Foundation Trust means we can also draw on the views of our members. The St George's membership community includes more than 12,000 patients and members of the public, who play an important role in ensuring the Trust meets the needs of the people it serves, as well as over 10,000 staff members.

Organisational structure and governance

Our governance framework comprises our membership, the Council of Governors and our Board of Directors. The Trust's members are drawn from our patients, staff and individuals from the communities we serve. Our Council of Governors is elected by the members and also has appointed Governors, in accordance with our Constitution. The Council of Governors is responsible for representing the views of members and the public and holding the Non-Executive Directors to account individually and collectively for the performance of the Board. Led by the Chair, the Board of Directors sets the strategy for the Trust, determines objectives and priorities, oversees quality, operational and financial performance and shapes the culture of the organisation. The Board is responsible for ensuring that there are effective systems of governance and internal control in place. The Board is supported in its work by a number of Board Committees.

Our Council of Governors

Our Council of Governors, led by the Trust Chair, forms an integral part of our governance framework. Our Council of Governors represents our membership body, and during the reporting period its activities contributed to the Trust's work on providing high quality services and care to its patients.

Members of the Council of Governors are elected from the Trust's membership body – which includes members of the public and our staff – and appointed local authority, university and Healthwatch stakeholder representatives. Governors were appointed from the constituencies set out in the Trust's Constitution, and the size of the Council was sufficient to enable governors to give effect to their key duties.

The names and terms of the members of the Council of Governors, along with the record of their attendance at Council meetings, can be found in table 1 below.

Table 1: Constituency terms of Governors and attendance at Council meetings

Governor	Constituency/Office	Term	Elected/Re-elected/ Appointed	Period in Office	Meetings Attended (Actual/Eligible Attendance)
Gillian Norton	Trust Chairman	N/A	N/A	N/A	5/5
ELECTED PUBLIC GOVERNORS					
Afzal Ashraf	Wandsworth	Second	1 February 2023	1 February 2023 - 31 January 2026	4/5
John Hallmark	Wandsworth	Third	1 February 2024	1 February 2024 - 31 January 2027	5/5
Lucy Mowatt	Wandsworth	First	1 February 2023	1 February 2023 – 31 January 2026	4/5
Augustine Odiadi	Wandsworth	First	1 February 2024	1 February 2024 – 31 January 2027	5/5
Jackie Parker	Wandsworth	First	1 February 2024	1 February 2024 – 31 January 2027	4/5
Ataul Qadir Tahir	Wandsworth	Second	1 February 2023	1 February 2023 – 31 January 2026	3/5
Nasir Akhtar	Merton	Second	1 February 2023	1 February 2023 - 31 January 2026	4/5
Patrick Burns	Merton	First	1 February 2023	1 February 2023 – 14 August 2024	½
Chelliah Lohendran	Merton	First	1 February 2024	1 February 2024 - 31 January 2027	5/5
Khaled Simmons	Merton	Third	1 February 2024	1 February 2024 – 4 December 2024	2/4
Luisa Brown	Merton	First	1 February 2025	1 February 2025 – 31 January 2027	1/1
Hann Latuff	Merton	First	1 February 2025	1 February 2025 – 31 January 2027	1/1
Padraig Belton	Rest of England	Second	1 February 2024	1 February 2024 – 18 September 2024	2/3

James Bourlet	Rest of England	First	1 February 2024	1 February 2024– 31 January 2027	4/5
Sandhya Drew	Rest of England	Second	1 February 2023	1 February 2023 - 31 January 2026	3/5
James Giles	Rest of England	First	1 February 2024	1 February 2024 –4 September 2024	1/2
Ashok Bhat	Rest of England	First	1 February 2025	1 February 2025 – 31 January 2027	1/1
Marie Grant	Rest of England	First	1 February 2025	1 February 2025 – 28 March 2025	0/1
ELECTED STAFF GOVERNORS					
Dympna Foran	Nursing & Midwifery	First	1 February 2024	1 February 2024 - 31 January 2027	5/5
Atif Mian	Allied Health Professionals	First	1 February 2024	1 February 2024 - 31 January 2027	1/5
Abul Siddiky	Medical & Dental	First	1 February 2024	1 February 2024 - 31 January 2027	4/5
Huon Snelgrove	Non-Clinical	First	1 February 2023	1 February 2023 – 31 January 2026	5/5
APPOINTED STAKEHOLDER GOVERNORS					
Julian Ma	City St. George's, University of London	First	1 February 2023	1 February 2023 – 31 January 2026	2/5
Alfredo Benedicto	Healthwatch Merton	Third	1 February 2024	1 February 2021 - 31 January 2027	5/5
Sarah Forester	Healthwatch Wandsworth	Second	1 February 2024	1 February 2021 - 31 January 2027	4/5
Stephen Worrall	Wandsworth Council	First	1 September 2022	1 September 2023 – 17 February 2024	2/4
Judith Gasser	Wandsworth Council	First	18 February 2022	18 February 2024 – 17 February 2027	1/1
APPOINTED BY THE COUNCIL OF GOVERNORS					
Sophia Agha	Council of Governors	First	12 March 2025	12 March 2025 – 11 March 2027	0/0

During 2024-25, the following Governors stood down from the Council of Governors:

- Patrick Burns, Public Governor, Merton
- Khaled Simmons, Public Governor, Merton
- Padraig Belton, Public Governor, Rest of England

- James Giles, Public Governor, Rest of England
- Marie Grant, Public Governor, Rest of England
- Stephen Worrall, Appointed Governor, Wandsworth Council

Elections to the Council of Governors were held in January 2025 and the following Governors were elected to serve on the Council for two-year terms of office from 1 February 2025:

- Luisa Brown, Public Governor, Merton
- Han Latuff, Public Governor, Merton
- Ashok Bhat, Public Governor, Rest of England
- Marie Grant, Public Governor, Rest of England

In addition, an appointment process was held for an Associate Governor (Young Members). Sophia Agha was appointed on 12 March 2025.

Council of Governors: role and duties

Our Council of Governors works with the Board of Directors and benefits from sharing the same leadership in the Trust Chair, but there is clear distinction between the role of the Board and the Council. The overriding role of the Council of Governors is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and to represent the interests of Trust members and the public. The schedule of matters reserved for the Board and the Council of Governors is set out in the Trust's Constitution and is reflected in the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Council of Governors has additional key decision-making responsibilities including:

- appointing Non-Executive Directors, setting their terms and conditions, and, where appropriate, removing of Non-Executive Directors
- appointing the external auditors and setting their terms and conditions
- approving the appointment of the Chief Executive by the Non-Executive Directors.
- approving any proposals which significantly change the services the Trust offers, including significant transactions and proposals such as mergers, acquisitions and de-mergers
- approving any proposals to increase the income from non-NHS activities by more than 5% of the total Trust income
- approving changes to the Trust's Constitution.

During 2024-25, the Council of Governors exercised some of these functions, specifically:

Chair Appointment

The Council approved and oversaw the process for the appointment of a new Trust Chair. It was agreed with NHS England that the role would, as had been the case with Gillian Norton, continue to be a Group role and would also Chair the Epsom and St Helier University Hospitals Board. The appointments process was supported by an external consultancy, Alumni Global. Alongside colleagues from NHS England, in relation to Epsom and St Helier University Hospitals, an independent Chair from another NHS Trust and the St George's Senior Independent Director, and representatives of the Council of Governors formed the final interview panel. Representatives of the Council of Governors were also members of the focus groups that fed into the interview panel discussions. Sir Mark Lowcock KCB was appointed Chair, taking up his post on 1 April 2025.

Board appointments

The Council approved and oversaw the process for the appointment of two new Non-Executive Directors and two Associate Non-Executive Directors. Gatenby Sanderson, an external consultancy, were engaged to support the process. Chiew Yin Jones was appointed to the substantive role on 5 September 2024, having been an Associate Non-Executive Director from March 2023 and a Non-Executive Director on an interim basis from October 2023. Pankaj Davé commenced his term of office on 1 February 2025. Claire Sunderland Hay was appointed to the Board as an Associate Non-Executive Director, with her term of office commencing on 18 October 2024. In March 2025, the Council of Governors approved the appointment of a second Associate Non-Executive Director. Khadir Meer commenced his term on 24 April 2025.

The Council approved the appointment of Grant Thornton as a common external auditor, with Epsom and St Helier University Hospitals NHS Trust having undertaken a joint tender process.

The Council also continued to input into the Trust's strategies and annual forward plan, supported the development of the annual quality priorities, and received the annual report and accounts. In reviewing the Trust's strategy and forward plans, governors ensure the views and feedback of members are represented and appointed governors feed in the views of the organisation they represent.

As well as the regular report from the Chief Executive, updates from the Committees of the Council of Governors and regular questions to Non-Executive Directors, some of the key matters considered by the Council included:

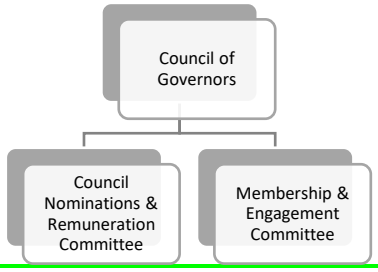
Date	Matters considered by the Council of Governors
22 May 2024	Group Strategy Quality Priorities Patient Safety Incident Response Framework

	NHS Staff Survey Results 2023 Non-Executive Director Appraisals*
18 July 2024	Financial Update Quality & Performance Report Independent Maternity Services Review Emergency Department Pressures Annual Report from External Auditor on Annual Accounts
25 September 2024	Quality and Performance Report Financial Performance Update Maternity Services Update Annual Members Meeting 2024 Plan Strategy Update People Strategy Update Green Plan Strategy Update Estates Report Fit and Proper Persons Test Compliance Report 2023/24 Non-Executive Director and Chair appointment process* External Auditor Tender Process Update*
12 December 2024	Maternity Services Update Integrated Quality and Performance Report Operational Performance People Strategy Update Green Plan and Estates Strategy Update Financial Performance Update Governor Elections Update Learning From Complaints Report Appointment of an External Auditor* Appointment of the Trust Chair*

	Appointment of a Non-Executive Director*
20 March 2025	Strategy Update Financial Update Quality Performance Report on Never Events CQC Section 29A Warning Notice Response and Action Plan* Appointment of Associate Non-Executive Director and Associate Governor*

*Council of Governors meeting in private session.

In addition to its formal meetings, the Council of Governors has established two sub-committees to support it in fulfilling its role.



The Council Nominations and Remuneration Committee is responsible for supporting the Council of Governors in ensuring that the Board of Directors has sufficient skills and knowledge, for supporting the Council in overseeing the appointments process for new Non-Executive Directors, and for overseeing the remuneration paid to the Chair and other NEDs. The Committee met four times during the period. With the support of this Committee the Council was able to:

- receive the appraisal of the Chair and other non-executive directors
- receive the objectives of the Chair and other non-executive directors
- support the Council in appointing a new Chair
- support the Council in appointing two Non-Executive Directors
- support the Council in appointing two Associate Non-Executive Directors.

The Committee is led by the Trust Chair and the other members are Governors. During 2024-25 the following Governors were members of the Committee:

Members	
Gillian Norton	Trust Chairman (Committee Chair)
Afzal Ashraf	Public Governor, Wandsworth
Alfredo Benedicto	Appointed Governor, Healthwatch Merton

John Hallmark	Public Governor, Wandsworth
Chelliah Lohendran	Public Governor, Merton
Lucy Mowatt	Public Governor, Wandsworth
Jackie Parker	Public Governor, Wandsworth
Abul Siddiky	Staff Governor, Medical and Dental
Khaled Simmons	Public Governor, Merton (until 4 December 2024)

The Council's Membership and Engagement Committee is responsible for supporting and delivering the Trust Membership Strategy. The Committee met on two occasions during the year with Sandhya Drew, Public Governor (Rest of England) as Chair until 14 October 2024.

With the support of this Committee the Council was able to:

- Recommend to the Council the approval of a 1 year membership engagement strategy
- Recommend to the Council the appointment of an Associate Governor (Young Members).

There are clear processes and procedures for the Council to engage with the Trust Board to raise any issues, with the Senior Independent Director and Lead Governor acting as key conduits to ensure that these are appropriate and effective.

Governors are able to question the Non-Executive Directors at Council meetings, and also have the opportunity to attend Board meetings and ask questions.

The Trust's Constitution sets out the procedures for resolving any disputes between the Board and Governors. Information on the constitution can be found on our website at https://www.stgeorges.nhs.uk/about/living-our-values/nhs-constitution/. The Council of Governors did not make use of these procedures during 2024-25.

Non-Executive Directors are invited to attend all meetings of the Council of Governors, both to assist the Council in their role of holding the Non-Executives to account for the performance of the Board and to ensure Non-Executive Directors understand the views of Governors. Executive Directors are also invited to attend meetings of the Council on matters related to their portfolio.

Governor development

Governors are afforded the opportunity to attend NHS Providers' training courses and networking events and we seek to match these opportunities to identified

training needs of our Governors. The Trust continues to provide a range of training and development opportunities for Governors to support them in their roles. In 2024-25, Governors were invited to a range of visits to clinical and non-clinical areas across the Trust as well as observing meetings of the Trust Board. In May 2024, an induction session was held with Governors elected in the December 2023 and January 2024 elections. This was delivered by the Trust Chair and Chief Executive, supported by the Chief Finance Officer and Chief Corporate Affairs Officer. The Trust also delivered a training session for governors on the Trust's implementation of the Patient Safety Incident Response Framework.

Our membership

The Trust is committed to involving patients, families and carers, as well as members of the Trust, in the delivery and development of our services. Our Governors and members ensure that we are accountable to, and listen to the needs and views of, our patients and the communities we serve. We have a combined membership of over 22,000 members:

Membership constituency	**2023-24**	**2024-25**
Total Public Members	12,836	**12,863**
Lambeth	539	539
Merton	3,364	3,376
Wandsworth	4,069	4,082
Rest of England	4,861	4,860
Out of Trust Area		6
Total Staff Members	9,753	**8725**

Our public members include patients, friends and family of patients, volunteers and members of the public who reside in one of four geographical constituencies: Wandsworth, Merton, South West Lambeth and Regional (Rest of England). To become a public member, no special skills or experience are required, as long as the individual is over 14 years old.

Any member of staff employed by the Trust on permanent contracts, fixed term contracts of 12 months or longer, or employed through one of our service partners (including transport, catering and cleaning staff) is eligible to become staff members.

While permanent and fixed-term contract staff automatically become members, all other categories of staff must apply to become a member.

The St George's membership strategy is designed to encourage more local people to have a voice in the shaping of the services the Trust provides. Our aim is to increase our engagement with members to create an active and vibrant membership community that is representative of the diverse populations we serve and of the staff who work here. In September 2024, the Council of Governors approved our membership strategy which sets out three overarching aims:

- To improve the quality of engagement and communication with members
- To work to ensure the membership is representative of the diverse communities the Trust serves
- To maintain, and where possible, increase the overall size of the Trust's membership.

The Council of Governors is responsible for the delivery of the membership strategy, and through its Membership Engagement Committee it monitors the implementation and delivery of milestones. The Council as a whole and the Committee receive regular reports on the extent to which the membership of the Trust is representative of the communities we serve. In 2024-25 the Council of Governors agreed a one-year membership engagement strategy to set the foundations for a longer-term strategy, which is due for approval in autumn 2025.

We continue to welcome the views and opinions of our members. Our Board and Council of Governors meetings are held in public and there are opportunities at the end of each meeting to raise questions in person or via email. Our members can contact our Council of Governors by email via members@stgeorges.nhs.uk and can submit questions to the Board by email via gesh.corporategovernance@stgeorges.nhs.uk.

More information on our membership can be found on the Trust's website here: https://www.stgeorges.nhs.uk/about/foundation-trust/members/

The Trust is open and transparent through our public Council of Governors meetings, Board meetings held in public, the various events held during the year, the Trust's Freedom of Information service, and the large amount of information available on our website.

The Trust Board of Directors

The Trust is led by our Board of Directors. Executive members of the Trust Board are full-time employees of the Trust, with a notice period of three months. Non-Executive Directors are appointed by the Council of Governors for three-year terms of office (or two years in the case of Associate Non-Executive Directors).

Trust Board Membership

Sir Mark Lowcock, KCB, Chair (from 1 April 2025)

Sir Mark Lowcock was appointed as Chair in April 2025. Mark previously served as Permanent Secretary of the Department for International Development between 2011 and 2017, and at the United Nations as the Under Secretary General for Humanitarian Affairs and Emergency Relief Coordinator between 2017 and 2021. Sir Mark brings a wealth of experience in government as well as international experience to the NHS, which includes supporting dramatic improvements in life expectancy in Africa and South Asia and coordinating UN humanitarian assistance in countries across the world affected by natural disaster and conflict.

Gillian Norton OBE DL, Chairman (until 31 March 2025)

Gillian Norton OBE served as Chairman from April 2017 until 31 March 2025, having been a Non-Executive Director since June 2016. She spent her executive career in local government, serving as Chief Executive for a total of 23 years, the last 17 of which were in London Borough of Richmond. She has been Representative Deputy Lieutenant for Richmond since 2016, and in 2017 was awarded OBE for services to local government. In October 2019, Gillian also became Chairman of Epsom and St Helier University Hospitals NHS Trust.

Non-Executive Directors

Ann Beasley CBE, Non-Executive Director (Deputy Chair)

Ann Beasley joined St George's in October 2016 and serves as Vice Chair and Senior Independent Director. She has a background in finance, her most recent role being Director General for the Finance, Assurance and Commercial Group at the Ministry of Justice. Ann has also been Chair of Trustees for the Alzheimer's Society. Ann was awarded a CBE in 2010 and in September 2018 was appointed as Chair of South West London and St George's Mental Health NHS Trust. From June 2021, Ann has been a non-executive director at Epsom and St Helier University Hospitals NHS Trust and was appointed Vice Chair in February 2025. Ann chairs the Finance and Performance Committees for both St George's and Epsom and St Helier.

Professor Natalie Armstrong

Professor Natalie Armstrong is the Executive Dean for the School of Health and Medical Sciences at City St George's, University of London. She is the University-appointed Non-Executive Director on the Board. Prior to joining City St George's in January 2025, Natalie spent 17 years at the University of Leicester, where she held various senior leadership roles, including as University-appointed Non-Executive Director to the University Hospitals of Northamptonshire Group.

Pankaj Davé

Pankaj Davé is a qualified accountant who has worked globally as a senior executive, leading teams in finance, strategy, commercial, business transformation, planning, performance management and oilfield operations. He recently completed his term as a Non-Executive Director for University Hospitals Dorset, chairing the Transformation and the People and Culture Committees. Pankaj serves on the Board of Trustees at the Royal College of Surgeons of England, where he chairs the Audit and Risk Committee.

Chiew Yin Jones, Non-Executive Director

Chiew Yin is a lawyer with over 25 years' experience in criminal justice and is an experienced advocate with a substantial casework and litigation background. She chairs disciplinary hearings in several jurisdictions, including Fitness to Practise Committees at the General Pharmaceutical Council. She also acts as a Legally Qualified Advisor for the Police Misconduct Panel in London and the South-East region. In January 2025, Chiew Yin also became a non-executive director at Epsom and St Helier University Hospitals NHS Trust and chairs the People Committee at both Trusts. In addition, Chiew Yin is a non-executive director at West London NHS Trust.

Claire Sunderland Hay

Claire Sunderland Hay has been an Associate Non-Executive Director at St George's since October 2024. She's a qualified accountant with senior experience in the public and private sector, including at the Bank of England, FSA, and globally significant financial services groups. Beyond her role at St George's, Claire is a senior executive in financial services. She has extensive experience in technology, innovation, and governance in highly regulated sectors, as well as working with Boards as both a non-executive and executive. Claire is a trustee and the Chair of the Risk Committee for UKSA and was an Independent Governance Advisor to the Royal College of General Practitioners. She was also previously a Non-Executive Director for Reliance Bank where she chaired their Board Conduct and Risk Committee.

Dr Peter Kane, Non-Executive Director

Dr Peter Kane has a doctorate in economics from the London School of Economics and is a qualified accountant. Throughout his career he has worked in public services, including in the Treasury, Cabinet Office and Home Office. He was also the Chamberlain of the City of London Corporation. Peter brings a wealth of experience in finance, risk, and performance. He is also a Non-Executive Director of the Institute of Fiscal Studies and Crown Prosecution Service. Peter joined the St George's Board in October 2021 and is Chair of the Audit Committee and holds the same role at Epsom and St Helier University Hospitals NHS Trust.

Dr Andrew Murray, Non-Executive Director

Dr Andrew Murray joined St George's as a Non-Executive Director in January 2023. A highly experienced GP, healthcare leader and consultant, he specialises in clinical strategy, service transformation, and population health. He has held senior roles across primary care and integrated care systems, leading major service redesigns, strategic programmes, and organisational change.

Andrew is a practising GP at the Nelson Medical Practice in Merton, and formerly served as Medical Director for the South West London ICS and Chair of the CCG. He has acted as SRO for SWL and worked with the King's Fund on Population Health Management, and contributed to the London data strategy. He led development of the SWL Whole School approach to children and young people's mental health and helped establish a community health worker programme in Myanmar. He regularly advises NHS bodies on future models of care and system integration.

He is also a Non-Executive Director at Epsom and St Helier University Hospitals NHS Trust and chairs the Quality Committee at both Trusts.

Executive Directors (voting)

Jacqueline Totterdell, Group Chief Executive

Jacqueline was appointed Group Chief Executive of St George's and Epsom and St Helier University Hospitals and Health Group in August 2021, after joining St George's University Hospitals NHS Foundation Trust as Chief Executive in May 2017. Jacqueline is also the CEO Lead for the South West London Acute Provider Collaborative. A Paediatric Intensive Care Nurse by background, Jacqueline started her general management career at Leeds General Infirmary, moving to Birmingham Children's Hospital, after which she spent two years working for the Modernisation Agency. After two Executive Director posts at Barnet and Chase Farm Hospitals NHS Trust, and then Hillingdon Hospitals NHS Foundation Trust, Jacqueline held Chief Executive positions at Southend University Hospital NHS Foundation Trust and West Middlesex University Hospital where she oversaw the merger of the Trust with Chelsea and Westminster NHS Foundation Trust. Before taking up her role at St George's, Jacqueline spent 18 months as part of the Executive Team supporting Barts Health NHS Trust out of special measures. Jacqueline also nationally Chairs the Future NHS Workforce Solutions Board, Chairs the South London Clinical Research Network, and co-Chairs the SE Genomics Board.

Professor Arlene Wellman MBE, Group Chief Nursing Officer

Arlene qualified as a general registered nurse in Trinidad and migrated to the UK with the intention of training as a midwife. However, she fell in love instantly with elderly care nursing and has more than 20 years' experience in this specialty. Arlene holds a first degree in Health and Social Care for Older People and a Master's degree in Clinical Healthcare Practice. She has held various senior nursing roles across acute trusts, including Matron, Senior Matron and Divisional Nurse at Oxford University Hospitals NHS Trust. Arlene was appointed Chief Nurse at Epsom and St

Helier University Hospitals NHS Trust in February 2018, a role she served in until her appointment as Group Chief Nursing Officer as part of the St George's, Epsom and St Helier University Hospitals and Health Group in February 2022.

Andrew Grimshaw, Group Chief Financial Officer

Andrew has over 30 years' experience in NHS finance and has worked in a wide range of organisations from district general hospitals, tertiary, teaching and ambulance trusts. He joined St George's as Chief Financial Officer in 2017 and also held the post of Deputy Chief Executive at St George's from 2019 to January 2022. He became Group Chief Finance Officer for the St George's, Epsom and St Helier University Hospitals and Health Group in February 2022.

Dr Richard Jennings, Group Chief Medical Officer

Dr Richard Jennings joined St George's in December 2018 as Chief Medical Officer, having previously been Executive Medical Director at Whittington Health NHS Trust. Dr Jennings specialises in infectious diseases and acute medicine and underwent his training at the London School of Hygiene and Tropical Medicine. Before becoming Executive Medical Director at the Whittington, he held the posts of Clinical Director for medicine and then Deputy Medical Director. He became Group Chief Medical Officer for St George's, Epsom and St Helier University Hospitals and Health Group in February 2022.

Non-voting Board members

Mark Bagnall, Group Chief Officer, Facilities, Infrastructure and Estates

Mark joined St George's, Epsom and St Helier University Hospitals and Health Group in August 2024. He is a chartered building services engineer with many years' experience in designing, building and operating buildings in healthcare, higher education, historic buildings and Ministry of Defence premises.

Mark previously worked at Barts Health as their Group Estates, Facilities and Capital Development Director and prior to that he was in a similar role at University Hospital Southampton.

Dr Stephen Jones, Group Chief Corporate Affairs Officer

Stephen Jones joined the Trust in March 2018. Stephen was previously Chief of Staff and executive lead for corporate governance at the General Medical Council. Prior to this, Stephen worked as Stakeholder Engagement Director on Co-operation and Competition policy at Monitor (which became NHS Improvement). He also held a number of senior policy roles within the Department of Health, including on provider policy, the NHS Constitution and legislative reform, and served as Senior Private Secretary to the Minister for Quality. Prior to joining the Department of Health, Stephen was an adviser and inquiry manager to the House of Commons Defence Committee and a senior clerk in the House of Commons Research Service.

Kate Slemeck, Managing Director for St George's Hospital

Kate previously worked at Royal Free Hospital as Director of Operations in 2011 before being appointed Chief Operating Officer in 2012 following the Trust Acquisition of Barnet and Chase Farm Hospitals. Following the Royal Free London NHS Trust forming a group model Kate was appointed to the site Chief Executive of the Royal Free in 2018. Kate originally trained as an Occupational Therapist. Her previous roles also include Director of Operations and Chief Operating Officer, having over 30 years' NHS management experience, 17 of which as a Board Director mainly in acute Trusts (including Royal Free London NHS Trust, Whittington Health).

Victoria Smith, Group Chief People Officer

Victoria joined St Georges, Epsom and St Helier University Hospitals and Health Group in July 2024 as Group Chief People Officer. Victoria has a wide variety of experience, most recently as Human Resources Director for the Ministry of Defence. She started her career in the private sector, working as a management consultant with many well-known multinational organisations.

Other Directors who served on the Board during 2024-25

During 2024-25, three Non-Executive Directors and three Executive Directors also served on the Trust Board and left the Trust during the course of the year:

Professor Jenny Higham, Non-Executive Director

Professor Jenny Higham was Vice Chancellor at St George's, University of London. She previously held senior roles at Imperial College and the Lee Kong Chian School of Medicine in Singapore and served as president of the UK's Medical Schools Council. In addition to managerial roles, she continues clinical practice. She has been named Mentor of the Year at the Women of the Future Awards, been awarded a President and Rector's Award for Outstanding Contribution to Teaching Excellence and the Imperial College Medal for outstanding leadership. Professor Higham stood down from the Board in July 2024.

Professor Philippa Tostevin, Interim Non-Executive Director

Professor Philippa Tostevin is Professor of Practice - Surgical Education and Head of the Centre of Clinical Education, Institute of Medical and Biomedical Education at City St George's, University of London. She was the interim appointed Non-Executive Director for City, St George's following the departure of Professor Jenny Higham and prior to Professor Natalie Armstrong taking up the post substantively. Professor Tostevin stood down from the Board in December 2024.

Tim Wright, Non-Executive Director

Tim Wright is a Chartered Mechanical Engineer and Fellow of the British Computer Society. He worked for 20 years in the oil and gas industry on major engineering and

construction projects, undertaking global consulting and senior IT leadership roles at BP, Halliburton and Amec before joining the Department for Education as Chief Information Officer in 2007. In the public sector, Tim led technology programmes across government, with local authorities, the Cabinet Office and the Government Digital Service. He was a non-executive director at the Trust from September 2017 until the end of his term of office in January 2025. During his appointment on the Board, Tim also served as the Board-nominated Trustee of St George's Hospital Charity, a position he held from January 2018 until he stood down from the Trust Board.

James Marsh, Group Deputy Chief Executive Officer
James has been at Epsom, Sutton and St Helier hospitals for more than 20 years, joining as a renal (kidney) consultant in 2003, before becoming lead consultant for transplantation and, subsequently, Clinical Director for renal services. He was appointed Deputy Medical Director in 2011. He graduated with first class honours from the University of Oxford in the mid-1980s, continuing his clinical training at Guy's Hospital where he earned a Distinction in pathology, surgery, pharmacology and therapeutics. James became Group Deputy Chief Executive Officer St George's, Epsom and St Helier University Hospitals and Health Group in February 2022 and stood down from the Board in March 2025.

Angela Paradise, Interim Group Chief People Officer

Angela joined St George's, Epsom and St Helier University Hospitals Health Group on an interim basis in January 2024. Angela has a Masters in Law from Cambridge University and after graduating joined the Metropolitan Police as a serving Woman Police Constable, based at Kensington in London.

After several years, Angela moved into Human Resources and over the years has worked as HR Director in both the private, public and charity sectors. She has a wealth of experience in banking, legal, retail, telecoms, PR and higher education, as well as in healthcare at the Parliamentary Ombudsman, Medical Research Council, General Healthcare Group and on the NHS Covid Vaccination Programme. Angela stood down from the Board in July 2024 following the appointment of Victoria Smith as the substantive Group Chief People Officer.

Trust Board Attendance Register 2024-25

In 2023-24, the Board of Directors established a Group Board with the Board of Directors of St George's University Hospitals NHS Foundation Trust. The two Trust Boards have delegated extensive authority to the Group Board by amending the Scheme of Delegation and Reservation of Powers. With the exception of private Trust Board meetings held to approve the Annual Report and Accounts for 2023-24 for the Trust and the Epsom and St Helier Hospitals Charity, all Board meetings in 2024-25 were held as Group Board meetings. Meeting as a Group Board enables a Group-wide perspective on areas of common challenge, and to provide leadership and oversight of the Group strategy and Group-wide risks and issues.

Table 2 Board attendance

Board of Directors	Appointed Role	Eligible Period	Actual/Eligible Attendance
Voting Non-Executive Directors			
Gillian Norton	Chairman	1 April 2024 – 31 March 2025	6/6
Natalie Armstrong	Non-Executive Director	1 January 2025 – 31 March 2025	1/2
Ann Beasley	Non-Executive Director	1 April 2024 – 31 March 2025	5/6
Pankaj Dave	Non-Executive Director	1 February 2025 – 31 March 2025	1/1
Prof. Jenny Higham	Non-Executive Director	1 April 2024 – 31 July 2024	2/2
Chiew Yin Jones	Non-Executive Director	1 April 2024 – 31 March 2025	4/6
Dr Peter Kane	Non-Executive Director	1 April 2025 – 31 March 2025	6/6
Dr Andrew Murray	Non-Executive Director	1 April 2024 – 31 March 2025	6/6
Prof. Philippa Tostevin	Interim Non-Executive Director	1 August 2024 - 31 December 2024	2/2
Tim Wright	Non-Executive Director	1 April 2024 – 31 January 2025	5/5
Voting Executive Directors			
Jacqueline Totterdell	Group Chief Executive Officer	1 April 2024 – 31 March 2025	5/6
Andrew Grimshaw	Group Chief Financial Officer	1 April 2024 – 31 March 2025	5/6
Arlene Wellman	Group Chief Nursing Officer	1 April 2024 – 31 March 2025	5/6
Dr Richard Jennings	Group Chief Medical Officer	1 April 2024 – 31 March 2025	6/6
Non-Voting Non-Executive Directors			

Claire Sunderland Hay	Associate Non-Executive Director	18 October 2024 – 31 March 2025	3/3
Non-Voting Executive Directors			
Mark Bagnall	Group Chief Officer – Facilities, Infrastructure and Estates	27 August 2024 – 31 March 2025	4/4
Stephen Jones	Group Chief Corporate Affairs Officer	1 April 2024 – 31 March 2025	6/6
James Marsh	Deputy Group Chief Executive Office	1 April 2024 – 7 March 2025	5/6
Angela Paradise	Interim Group Chief People Officer	1 April 2024 – 26 July 2024	2/2
Kate Slemeck	Managing Director	1 April 2023 – 31 March 2025	5/6
Victoria Smith	Group Chief People Officer	1 July 2024 – 31 March 2025	4/4

** Natalie Armstrong serves as a non-executive director on the Trust Board of Directors for the duration of her term of office as Vice Chancellor of City St George's University of London.*

A new *Code of Governance for NHS Provider Trusts* was published by NHS England in 2023 and for the first time applies to NHS Trusts. The Code requires the Trust's Annual Report to set out each Non-Executive Director it considers to be independent. The Board must determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, their judgement. The Board is required to state its reasons if it determines that a Director is independent despite the existence of relationships or circumstances which may appear relevant to its determination.

The Board considers the following Non-Executives to have been independent for the purposes of this report for the year 2024-25: Gillian Norton, Natalie Armstrong, Ann Beasley, Chiew Yin Jones, Andrew Murray and Phil Wilbraham. Gillian Norton, Ann Beasley, Chiew Yin Jones, Peter Kane and Andrew Murray served on the Board of St George's University Hospitals NHS Foundation Trust during 2024-25. The Board was formally notified of the existence of a conflict of interest in relation to posts across St George's, Epsom and St Helier University Hospitals and Health Group and notes this at each Board meeting, but recognises the benefits to the communities of both Trusts that result from working as a hospital Group. Ann Beasley also chairs the Board of South West London and St George's Mental Health NHS Trust. Natalie Armstrong is an appointed representative as Executive Dean of the School of Health and Medical

Sciences at City St George's, University of London.

Non-executive Directors are appointed for terms of office of three years. In the case of the Associate Non-Executive Directors, the term is two years. The terms of office of our current Non-Executive Directors are set out below and their attendance can be seen in table 2 above.

Name	Current term of office	Term length	Previous term of office (if relevant)
Mark Lowcock	1 April 2025 – 31 March 2028	3 years	n/a
Natalie Armstrong	1 January 2025 (open ended)*	3 years	N/A
Ann Beasley	13 Oct 2022 – 12 Oct 2025	3 years	13 Oct 2019 – 12 Oct 2022 13 Oct 2016 – 12 Oct 2019
Pankaj Davé	1 February 2025 – 31 January 2028	3 years	n/a
Chiew Yin Jones	5 September 2024 – 4 September 2027	3 years	2 March 2023 – 12 October 2023 (as Associate NED) 13 October 2023 – 4 September 2024 (Acting NED)
Dr Peter Kane	1 October 2024 – 30 Sept 2025	1 year	1 October 2021 – 30 September 2024
Andrew Murray	22 Jan 2023 – 21 Jan 2026	3 years	N/A
Claire Sunderland Hay	18 October 2024 – 17 October 2026	2 years	N/A

** Professor Armstrong's appointment as NED is for the duration of her appointment as Executive Dean of the School of Health and Medical Sciences at City St George's.*

Board Committee structure

During 2024-25, the Trust Board had in place six Board committees, as shown in the diagram below:

All Committees met as Committees-in-Common with the equivalent Committees of the Board of Epsom and St Helier University Hospital NHS Trust and ensured that the assurance needs of both Trusts were appropriately met. The Finance Committee and Infrastructure Committees met on a monthly basis throughout 2024-25 with the Quality Committee and the Quality Committee meeting on 6 occasions. In the months when the Quality and People Committees did not meet formally, the Chairs of the respective Committees met with the Executive Leads or held focus sessions. The Nominations and Remuneration Committee met on 5 occasions during this period. The Audit Committee met 5 times during this period.

Under the Committees-in-Common arrangements, each Committee of the St George's Board retained its own Chair, its own separate terms of reference, and each needed to be quorate, reflecting the fact that the two Trusts within the group remain separate legal entities. The advantage of these in-common arrangements were that it facilitated a Group-wide perspective on issues of shared focus, provided an opportunity to identify and share learning and good practice, and support closer collaborative working within a robust governance framework.

Each Board Committee produced reports following each meeting to summarise the key areas of focus, assurance and risk considered, and these were considered at the Group Board meetings held in public. The Committees also conducted annual effectiveness reviews to assess their performance and produce annual reports including proposed revisions to their terms of reference for the Board to consider each year.

Audit Committee

The Audit Committee has been established to ensure that the Trust has effective mechanisms and systems of internal control. It provides the Board of Directors with an independent review of the Trust's financial, corporate governance and risk management processes. It uses the functions of independent internal and external auditors to provide assurance that these systems are sound and adhered to across all areas of the Trust.

The Committee comprises four independent Non-Executive Director members (including one associate Non-Executive Director). The Group Chief Corporate Affairs Officer and Group Chief Finance Officer, as the relevant executive leads, attend each meeting of the Committee.

During 2024-25 the Committee held five meetings and attendance is recorded below:

Member/Attendees	Title	Meetings Attended/ Eligible to Attend
Peter Kane	Non-Executive Director, Committee Chair	5/5

Ann Beasley	Non-Executive Director	4/5
Tim Wright	Non-Executive Director	4/4
Chiew Yin Jones	Non-Executive Director	2/5
Claire Sunderland Hay	Associate Non-Executive Director	2/2

During the period, the Committee:

- reviewed the 2023-24 draft Annual Report and Accounts, including the Quality Account, and recommended that the Board approve and adopt these as a true and fair record, and considered the plan for the 2024-25 Annual Report
- reviewed any significant issues relating to the financial statements
- monitored the programme of internal audit based on which the Trust received a reasonable assurance rating of its systems and internal controls from its independent internal auditor, RSM UK Ltd
- received regular updates from the Trust's counter-fraud specialist
- reviewed the Trust's cybersecurity arrangements
- provided oversight of the management of losses and special payments
- agreed a Group-wide Policy Framework
- reviewed and recommended to the Board a Group-wide risk assurance framework
- received updates on external tender for external audit services jointly with Epsom and St Helier University Hospitals NHS Trust following the expiry of its current contract with Grant Thornton Ltd at the end of 2024/25.

Finance Committee

The Finance Committee operated as a Committee-in-Common with the Finance Committee of Epsom and St Helier University Hospitals NHS trust throughout 2024-25.

The Committee assists the Trust to maximise its healthcare provision subject to its financial constraints, while considering patient safety. It achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensure detailed consideration is given to the Trust's financial position, that the Trust uses public funds wisely, and also provides assurance in relation to operational performance.

The Committee membership comprises non-executive and executive directors. The Trust Chair, Group Chief Executive Officer, Group Chief People Officer, and Group

Chief Corporate Affairs Officer regularly attended the meetings of the Committee. During 2024-25 the Committee held 14 meetings and attendance is recorded below:

Members		Meetings Attended/ Eligible to Attend
Ann Beasley	Non-Executive Director, Chair	14/14
Pankaj Davé	Non-Executive Director	3/3
Peter Kane	Non-Executive Director	13/14
Claire Sunderland Hay	Associate Non-Executive Director	5/7
Tim Wright	Non-Executive Director	10/12
Andrew Grimshaw	Group Chief Finance Officer	14/14
Kate Slemeck	Managing Director, SGUH	11/13
Dr Richard Jennings	Group Chief Medical Officer	11/14
Arlene Wellman	Group Chief Nursing Officer	9/14

During the period, the Committee:

- reviewed the delivery of the Trust's financial plan in 2024-25 and the risks associated with delivery
- reviewed the delivery of the Trust's Cost Improvement Programmes (CIPs)
- reviewed the development of the Trust's financial plans for 2025-26
- closely monitored operational performance, including against the emergency care operating standard, elective performance, productivity and activity levels
- considered the Trust's capital position and reviewed business cases for investment in the Trust's services and infrastructure.

Infrastructure Committee

The Infrastructure Committee operated as a Committee-in-Common with the Infrastructure Committee of Epsom and St Helier University Hospitals NHS trust throughout 2024-25. The Committee considers assurance across estates and facilities issues, including maintenance, facilities management, patient transport, and environmental sustainability. Health and Safety is also within the remit of the

Committee. In addition, the Committee is responsible for information, digital and technology (IDT), including information management and data quality assurance. The Committee alternates the focus of its meetings each month between estates and facilities one month and IT and digital the next.

The Committee membership comprises Non-Executive and Executive Director members.

During 2024-25, the Committee held 11 meetings and attendance is recorded below:

Member/Attendees	Title	Meetings Attended/ Eligible to Attend
Ann Beasley	Non-Executive Director, Committee Chair	9/11
Pankaj Davé	Non-Executive Director	1/1
Peter Kane	Non-Executive Director	10/11
Andrew Murray	Non-Executive Director	8/11
Claire Sunderland Hay	Associate Non-Executive Director	3/3
Tim Wright	Non-Executive Director	6/6
Andrew Grimshaw	Group Chief Finance Officer	11/11
Arlene Wellman	Group Chief Nursing Officer	8/11
Kate Slemeck	Managing Director – St George's	9/11
Mark Bagnall	Group Chief Officer Facilities, Infrastructure and Estates	5/7

During the period, the Committee:

- Received estates reports on Trust performance in responding to operational and maintenance issues and incidents
- Received facilities assurance reports including Trust compliance with cleaning standards, security issues, health and safety training, and patient transport
- Received deep dives across a range of estates and facilities issues
- Reviewed the Trust's Premises Assurance Model to receive assurance on the safety and effectiveness of the Trust's estates and facilities
- Received updates on the Group Green Plan and how the Trust is delivering against its priorities in relation to environmental sustainability and achieving NHS Net Zero Carbon targets
- Reviewed the Board Assurance Framework risks and mitigations in relation to estates and digital
- Received updates on key critical IDT infrastructure projects including the implementation of the South West London Picture Archiving Communication systems (PACS) & Radiology Information Systems (RIS) and the Electronic Patient Record (EPR) at Epsom and St Helier on a shared domain with St George's
- Considered the priorities and requirements for the Group Digital Strategy.

Quality Committee

The Quality Committee operated as a Committee-in-Common with the Quality Committee of Epsom and St Helier University Hospitals NHS trust throughout 2024-25.

The Committee is responsible for examining and providing assurances on the level of risk to which patients are exposed, and the extent to which clinical outcomes requirements are being met.

The Committee membership comprises Non-Executive and Executive Directors. The Trust Chair, Group Chief Executive, Group Deputy Chief Executive Officer, and Group Chief Corporate Affairs Officer regularly attended the meetings of the Committee. During 2024-25 the Committee held 6 formal meetings and attendance is recorded below. In addition, the Committee held four informal focus sessions to explore topics in greater depth.

Members		**Meetings Attended/ Eligible to Attend**
Andrew Murray	Non-Executive Director, Chair	5/6

Prof. Jenny Higham	Non-Executive Director	2/3
Peter Kane	Non-Executive Director	6/6
Chiew Yin Jones	Non-Executive Director	6/6
Dr Richard Jennings	Group Chief Medical Officer	6/6
Arlene Wellman	Group Chief Nursing Officer	5/6
Kate Slemeck	Managing Director, SGUH	5/6

As part of its annual work programme, the Committee:

- contributed to the development of the new Group Quality and Safety Strategy and monitoring of its ongoing implementation
- monitored risks on the Board Assurance Framework and the Corporate Risk Register relating to patient safety and quality, as well as reviewing the quality and safety dimensions of risks relating to operational performance
- continued a specific focus on the Trust's maternity services, particularly in the context of both the national focus on quality of maternity services, the August 2023 CQC inspection of maternity services at ESTH, and in relation to the safety actions in the Maternity Incentive Scheme
- focused on quality concerns within the emergency department as a result of the continued pressure this service is under. This included monitoring the work being undertaken with system partners relating the increase in numbers of patients presenting to the EDs with concerns relating to mental health issues
- monitored Serious Incidents and Never Events and undertook deep dives into Never Events and Learning From Deaths
- reviewed implementation locally of the new national Patient Safety Incident Response Framework. This included a particular focus on training of staff and ensuring engagement
- monitored the Trust's arrangements for and performance in relation to infection prevention and control
- Focused on safeguarding, medicines management, mortality monitoring.

People Committee

The People Committee operated as a Committee-in-Common with the People Committee of Epsom and St Helier University Hospitals NHS Trust throughout 2024-25.

The Committee considers the development and delivery the of the Group's People Strategy and oversees and monitors workforce planning and performance and delivery of the Trust's strategic aims in relation to workforce, staff wellbeing and compliance with regulatory requirements in relation to workforce, It also oversees the Trust's culture, equality, diversity and inclusion programme, seeking assurance on progress and that management has taken corrective action where appropriate.

The Committee membership comprises Non-Executive and Executive Directors. The Group Chief Executive, Group Deputy Chief Executive and Group Chief Corporate Affairs Officer also regularly attend the meetings of the Committee. During 2024-25 the Committee held 6 meetings and attendance is recorded below:

Members		**Meetings Attended/ Eligible to Attend**
Chiew Yin Jones	Non-Executive Director Chair	6/6
Andrew Murray	Non-Executive Director	5/6
Tim Wright (until 31 January 2025)	Non-Executive Director	5/5
Dr Richard Jennings	Group Chief Medical Officer	3/6
Angela Paradise (until July 2024)	Interim Group Chief People Officer	1/2
Arlene Wellman	Group Chief Nursing Officer	5/6
Kate Slemeck	Managing Director, SGUH	6/6
Andrew Grimshaw	Group Chief Finance Officer	3/6
Victoria Smith (from July 2024)	Group Chief People Officer	4/4

During the year the Committee:

- reviewed key workforce performance indicators, including turnover rates, stability, sickness absence and training, as well as receiving regular updates on the impact of industrial action taken by various groups of staff during the year
- conducted deep dives into areas where the Committee felt that further assurance was required
- considered and monitored progress against the culture change programme, staff engagement plan, diversity and inclusion plans, and in relation to the Trust's Workforce Race Equality Standard and Workforce Disability Standard position
- received reports on staff health and wellbeing, as well as staff support counselling and mediation
- reviewed the Trust's plans for and results from the annual NHS Staff Survey
- received reports on the results from the General Medical Council National Training survey
- received reports from the Trust's Freedom to Speak Up Guardian, Guardian of Safe Working, and the Medical Revalidation Responsible Officer
- reviewed the new strategic risks assigned to the Committee on the Group Board.

Declaration of interests

St George's is committed to openness, transparency and public accountability in its work and decision making. As part of that commitment, we maintain a register of interests declared (including gifts and hospitality) by members of the Board of Directors, Council of Governors and senior decision-making staff across the Trust. The Trust's declarations can be found on the Trust's website here: https://stgeorges.mydeclarations.co.uk/declarations.

Performance evaluation of the Board

The Trust has in place established processes for undertaking performance evaluations of all Board members. A policy has been agreed by the Council of Governors, which governs the appraisal process for the Chair and other Non-Executive Directors. This was last reviewed and updated in May 2022. Annual objectives are agreed at the start of year and reported to the Council of Governors' Nominations and Remuneration Committee for information. The Chair's appraisal is undertaken by the Senior Independent Director and the other Non-Executives' appraisals are undertaken by the Chair. The annual appraisals of the Chair and Non-Executive Director involves seeking multi-source feedback from other Non-Executives, Executive Directors and Governors. This is then shared with the relevant Non-Executive Director on a non-attributable basis and helps inform the appraisal discussion.

In May 2024 and March 2025, the Council of Governors Nominations and Remuneration Committee considered the outcomes of the appraisals of the

Chairman and non-executive directors in 2023-24 and 2024-25 respectively. The outcome of appraisals are presented to the Council of Governors in private session.

The Council of Governors has the power to appoint Non-Executives and also has the authority, subject to the provisions of the Trust's Constitution and the Code of Governance for NHS provider Trusts, to remove Non-Executives in certain circumstances.

The process for the appraisal of Executive Directors is broadly similar and involves multi-source feedback from other Executives, their direct reports, and from Non-Executive Directors. The 2024-25 appraisal process for Executive Directors began in March 2025 and the outcomes will be reported to the Board's Nominations and Remuneration Committee.

The Board of Directors considers that there is an appropriate balance of skills and experience on the Board, and that it is constituted in a way that appropriately meets the requirements of the Trust. The skills mix among the Non-Executives is reviewed by the Council of Governors' Nominations and Remuneration Committee and the skills mix among executive Directors by the Board's Nominations and Remuneration Committee.

NHS System Oversight Framework

NHS England's NHS System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

- additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS Foundation Trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

St George's University Hospitals NHS Foundation Trust has been placed in segment 2. This segmentation information is the Trust's position at the time of writing this report. Current segmentation information for NHS trusts and foundation trusts is

published on the NHS England and NHS Improvement website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

CQC Well-Led Framework

The CQC Well Led guidance published in April 2024 replaces the eight previous Well Led Key Lines of Enquiry (KLOEs) in the 2017 Well-Led Framework, with a new set of eight quality statements. The Board is ultimately responsible for all aspects of leadership in the organisation and oversees the Trust's compliance with the CQC's well-led framework.

A summary of the Trust's self assessment of its position in relation to the Quality Statements is set out below:

CQC Quality Statement	Trust position
We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.	• A group Strategy was approved in May 2023 with 'board to ward priorities' agreed by the Board each year. • The Executive, relevant Board subcommittees and the Board monitor progress delivering our strategic initiatives. • Risks to delivering the CARE strategy and actions to mitigate them are reflected in the Board Assurance Framework. The Board also receives regular updates on changes in the external environment. • 2,000+ people (staff, patients, partners) were involved in engagement events to help develop our CARE strategy. • We have a clear set of values which have been in place for some years: Excellent, Kind, Responsible, Respectful.
We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.	• Advancing the leadership skills of all our people managers is included in the People Strategy 2024-26. A wide range of leadership and management development programmes for staff aimed at different levels of seniority are available, with compassionate and inclusive leadership an area of focus. • Equity of access to our leadership and management programmes is monitored to ensure all staff groups are given the opportunity to participate. • A number of actions have been implemented to ensure our recruitment processes is inclusive and fair, including through the use of Recruitment Inclusion Specialists at interview panels. • A culture of honestly is promoted throughout the Trust so that staff are encouraged to

	speak up if they have any concerns, knowing that these will be taken seriously and acted upon appropriately.
We foster a positive culture where people feel that they can speak up and that their voice will be heard.	• We have significantly strengthened the Freedom to Speak Up Service (FTSU) and its visibility, with the presence at Queen Mary's Hospital particularly improved. • We have a FTSU Vision and Strategy and the Board has approved a new Freedom to Speak Up Policy incorporating national guidance. • There is reporting to the Quality Committee on safety concerns raised by staff to give greater Board-level oversight. • We have established an innovative new Executive-led Raising Concerns Oversight and Triangulation Group to provide better oversight, identify learning and emerging areas of concern. • FTSU is integrated into all staff induction – the FTSU service attends all staff induction events.
We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.	• EDI is a part of our overarching People Strategy and is monitored by the Board. • New policies on disability in the workplace; menopause; supporting trans and non-binary staff; and EDI in employment have been progressed. • There are mandatory earning modules, including disability in the workplace; essential workplace adjustments; LGBTQ+; Oliver McGowan. • Staff network leadership presence in our Culture Forum and CEI Programme Board ensures our staff network leaders are integrated in trust leadership and part of core change. • We have launched a new monthly series (DIVE IN to EDI) to develop line managers and aspiring leaders in their knowledge of EDI related topics.
We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.	• Responsibilities across the Board, Executive team, Sites and Divisions are clearly defined and codified in a new Group Accountability Framework. The risks on our Board Assurance Framework are aligned our Corporate Risk Register. • The Trust has a group wide Risk Management Policy and Framework. This provides for enhanced oversight of risk through an Executive-led gesh Risk and Assurance Group to oversee the integrity of risk management systems and processes.

	• Through our Integrated Quality and Performance Report (IQPR) aligned to our CARE strategy, we are able to monitor and improve.
We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.	• Collaboration is one of the four pillars of our CARE strategy and central to 4 of our 9 strategic initiatives. • Through the gesh Group, we collaborate with Epsom and St Helier University Hospitals NHS Trust, releasing money for frontline care and improved care for patients through spreading best practice, adopting new treatments and making more collective use resources. • Through our SWL Acute Provider Collaborative we have a range of joint ventures which improve care for patients. • The Trust is an active partner in its local boroughs of Merton and Wandsworth. We provide a range of tertiary, often regional services, and for these services we collaborate with partners across South London and Surrey. • We are a founding partner of the South London Office for Specialised Services.
We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.	• Our strategic initiative of high performing teams encompasses our holistic approach to developing a continuous improvement culture. • We offer a range of training opportunities in improvement skills to different cohorts of staff to provide them the opportunity to develop improvement skills. • We ensure our performance reports are using measurement for improvement principles so that we have data-led discussions and ensure our Board reports role-model this. • We have made significant progress on research and have implemented almost all of the objectives set out in the Trust's Research and Development Strategy 2020-24.
We understand any negative impact of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same	• The Green Plan was approved by the Board in July 2024. The strategy clearly sets out the vision of the Board on environmental issues, linking human health and environmental health. • Board-level training in December 2024 outlined the links between human and environmental health and we are delivering all staff comms and training to communicate the message. • There will be a Green Plan Steering Group providing oversight for delivery of the gesh Green Plan. • A dashboard is being developed with key metrics to track progress and impact such

	as: air quality improvements; carbon emissions; efficiency savings; sustainable procurement. • We are substituting high carbon products for low-carbon alternatives.

The Trust has used the Well-Led framework to inform its overall assessment of the Trust's performance as set out in this annual report. The new Group Board Assurance Framework was developed to ensure that the core aspects of the framework were integrated into its approach. Likewise, each Committee of the Board considers the relevant Well-Led domains within its terms of reference and reports on these through each Committee's annual report to the Board.

The CQC undertook a Well Led inspection at St George's University Hospitals in February 2025. The inspection report is awaited at the time of writing.

Remuneration report

St George's University Hospitals NHS Foundation Trust's remuneration report describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration, as required by the Companies Act 2006, Regulation 11 and Schedule 8 of the Large and Medium Sized Companies and Groups (Accounts and Reports) Regulations 2008 and The Code of governance for NHS provider trusts.

The remuneration report comprises:

- annual statement of remuneration
- very senior managers' pay policy
- annual report on remuneration.

Nominations and Remuneration Committee

The Trust has a Board Nominations and Remuneration Committee and a Council of Governors Nominations and Remuneration Committee. Both work in tandem to ensure that there remains an appropriate balance of skills and experience on the Board. These Committees, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors respectively and gives consideration to both performance and succession planning, supporting the development of a diverse pipeline which takes into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them.

The Committees aim to evaluate annually the balance of skills, knowledge and experience on the Board of Directors and each prepares a description of the role and capabilities required for appointment of Executive (Board) and Non-Executive

Directors, including the Chair (Council). The Board Nominations and Remuneration Committee makes decisions regarding pay for Executive Directors. It is also responsible for determining, on behalf of the Board, the broad policy for remuneration of the Trust's very senior managers (VSMs). In 2024-25, the Board's Nominations and Remuneration Committee has met as a Committee-in-Common with the equivalent Committee at Epsom and St Helier University Hospitals NHS Trust.

Attendance at the Board Nominations and Remuneration Committee is set out below:

Members		**Meetings Attended/ Eligible to Attend**
Gillian Norton	Trust Chairman, Chair	4/5
Ann Beasley	Non-Executive Director (Vice Chair)	5/5
Natalie Armstrong	Non-Executive Director	0/2
Professor Jenny Higham	Non-Executive Director	0/1
Chiew Yin Jones	Non-Executive Director`	4/5
Peter Kane	Non-Executive Director	4/5
Tim Wright	Non-Executive Director	3/3
Andrew Murray	Non-Executive Director	4/5
Claire Sunderland Hay	Associate Non-Executive Director	3/3

The Council of Governors' Nominations and Remuneration Committee determines the remuneration of Non-Executive Directors, oversees the process for the appointment of new Non-Executive Directors, and reviews the outcomes of annual appraisals of Non-Executives. During 2024-25, the Committee increased Non-Executive Director remuneration to £17,000 per annum (previously £14,000). It oversaw the process for the appointment of two new, non-voting, Associate Non-Executive Directors and two voting Non-Executive Directors. The Committee also reviewed the outcomes of the Non-Executive Director appraisals and the objectives for the coming year, based on the policy on Non-Executive Director appraisals which was approved by the Council of Governors in February 2022.

Senior managers' remuneration policy

The Committee reviews the remuneration arrangements of leadership team posts in line with NHS guidance. The Trust has a policy on diversity and inclusion which applies to all staff and the decisions of the Committee are taken in line with this.

Very Senior Managers' pay principles

St George's is committed to the overarching principles of value for money and high performance. The Trust recognises that it must attract and retain a high-calibre senior management team and workforce in order to ensure it maintains its long and short term strategic objectives, excellent standards of clinical outcomes and patient care, functions efficiently, and is well positioned to deliver its business strategy.

Differences between remuneration for executive directors and other employees

The key difference between the remuneration of Executive Directors and other employees is that the fixed salary of Executive Directors is inclusive of a high-cost area supplement, whereas for other employees this is a separate part of their pay. When setting remuneration levels for the Executive Directors, the Committee considers the prevailing market conditions, the competitive environment (in particular through comparison with other NHS trusts of similar size and complexity) and the positioning of pay and employment conditions across the broader Trust workforce.

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of St George's University Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of St George's University Hospitals NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England. NHS England has given Accounts Directions which require St George's University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions.

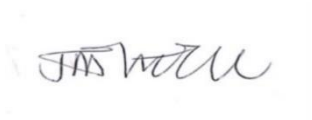
The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of St George's University Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year. In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Jacqueline Totterdell

Group Chief Executive

26 June 2025

Annual Governance Statement

Statement of Compliance with The Code of governance for NHS provider trusts

The Code of Governance for NHS provider trusts replaced the former NHS Foundation Trust code of governance on 1 April 2023 and is modelled on the 2018 version of the UK Corporate Governance Code. St George's University Hospitals NHS Foundation Trust has applied the principles of the Code of Governance for NHS provider Trusts on a comply or explain basis and has met the new requirements related to required disclosures within this report.

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of St George's University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts

Capacity to handle risk

The Trust has an approach to decision making that is informed by a full range of corporate, financial, clinical and quality governance processes, and ensures compliance with the five main principles of the corporate governance code: leadership, effectiveness, accountability, remuneration and relations with stakeholders, including ensuring the views of system and place-based partners are

considered in our decision-making. The Trust undertakes an annual internal audit of its risk management systems and processes, and in 2024/25 the internal auditors found that the Trust could have reasonable assurance these processes.

In February 2025, the Board approved a revised accountability framework. This built on the established governance frameworks which is supported and maintained by a number of committees, which contributes to the delivery of our strategic objectives and oversight of the organisation's future sustainability. The Trust Board has overall responsibility for the effectiveness of the governance framework and as such requires that each of its committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness.

The Board itself has standing orders, reservation and delegation of powers and standing financial instructions in place which are reviewed regularly. As the Accountable Officer, I support the Chair in ensuring the effective performance of the Board and its committees and achieve this in a number of ways, including:

- monitoring attendance
- maintaining an overview of the quality of presented information, including agenda items and supporting evidence
- requesting the attendance of representatives from across the Trust when required
- ensuring that there is an annual declaration of interests by the members of the Board
- ensuring that each of the Board's committees reviews its own performance at least annually.

Senior leadership in corporate governance is provided by the Group Chief Corporate Affairs Officer who also acts as the Trust Secretary. Governance is embedded across the Trust's three clinical divisions which are each led by a divisional chair. These report into the St George's Site Leadership Team, which itself reports into the Executive, ensuring clear responsibility and accountability lines across the Trust.

Each division has an established governance structure which reports into the Trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks. The Trust undertakes regular reviews of its governance structures including reviewing the effectiveness of its committees and groups.

The Trust has robust governance arrangements to support the delivery of key activities. The Trust Management Group is accountable to the Group Executive Committee which, in turn, is accountable to the Board through the Chief Executive. The Group Executive Committee comprises the Chief Executive and Group Executive Directors, including the Managing Director for St George's and is the most

senior management group within the Trust. The Trust Management Group escalates issues to the Group Executive Committee as required within the agreed Accountability Framework. There are two sub-groups of the Trust Management Group to provide leadership and oversight of key areas: Patient Safety and Quality Group and Operations Management Group. Each of these groups reports into the Trust Management Group.

Issues identified by the CQC in its inspection of maternity services in March 2023 led the Board to seek further assurance in terms of the robustness of clinical governance structures, systems and processes. It commissioned an independent quality governance review and appointed, on secondment, an NHS England Improvement Director to undertake this work. Phase 1 of the review was completed in April 2024 and the second phase, which incorporated services at Epsom and St Helier University Hospitals NHS Trust, was expanded to include Integrated Care, Renal Services Division (ESTH), and Surgery, Neurosciences, Cancer, and Theatres Division (SGUH). This second phase was completed in early 2025 and was reported to the Board in May 2025.

From 2023-24 onwards, the Quality, Finance, People, Infrastructure and Nominations and Remuneration Committees have operated as Committees-in-Common with the equivalent Committees at Epsom and St Helier University Hospitals NHS Trust. From 2024-25, the Audit Committee also operated as a Committees-in-Common, and appropriate measures are in place, which have been approved by the Board, to ensure that the Audit Committee, operating as a Committees-in-Common with its Epsom and St Helier equivalent, continued to provide effective assurance to the Board on governance, risk and internal control.

Staff receive training in risk management that is appropriate to their roles and duties. The Trust policy on risk management is made available to all staff in the organisation and this provides both the risk management framework and guidance to staff to handling and managing risk. A new framework was reviewed by the Audit Committee in February 2025 and was approved by the Board in March 2025, which further strengthens the organisation’s approach to risk management. Good practice in risk management is identified in discussions of risk through our governance framework and this captured both informally and formally through updates to our policy and guidance.

Risk and control framework

The Risk Management Framework and supporting procedures set out the key responsibilities for managing risk within the organisation, including ways in which the risk is identified, evaluated and controlled.

A risk management matrix is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and incidents. The Trust’s appetite for risk is articulated through the boundaries within the risk evaluation matrix that have been defined by the Board of Directors. Risks assessed as significant are monitored

to ensure mitigating actions are undertaken to reduce them to an acceptable level. The process for the management and monitoring of risk assessments is defined within the Risk Management Framework and supporting procedures. All serious incidents and serious risks are reported to the Board of Directors via the established governance committee structures.

The Board Assurance Framework sets out the principal risks to delivery of key priorities and the Trust's overarching strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The Board Assurance Framework identifies the assurances available to the Board of Directors in relation to the achievement of the Trust's key objectives. The principal risks to the delivery of these objectives are mapped to key controls.

The Board Assurance Framework supports the process for monitoring ongoing compliance with the requirements for registration set by the Care Quality Commission (CQC), with mapping of the regulations to strategic priorities.

The Board has an agreed scheme of delegation and standing orders, and monitors compliance with these and with Trust policies and procedures. Certain procurement matters are reserved for the Board in the scheme of delegation, and this oversight helps to ensure resources are used efficiently and effectively.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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

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

St George's has undertaken risk assessments on the effects of climate change and severe weather and a Green Plan is being developed 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 is able to assure itself of the validity of its Corporate Governance Statement through reporting via the Trust's Audit Committee. The Committee scrutinises compliance with the Trust's Constitution and provider licence, The Code

of governance for NHS provider trusts and with its Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Risks to the Trust

Strategic Risks on the 2024-25 Group Board Assurance Framework		
Trust objective	**Risk description**	**Mitigation**
Collaboration and Partnerships	Strategic Risk 1: Working across our local systems	We continue to play an active role across our local system and with our Acute Provider Collaborative. Our Chief Executive is the lead CEO of the SWL APC and our Executive team is fully engaged in a number of SWL-wide forums to drive forward collaboration across our system in the interests of our patients. Our Board reviewed progress in relation to system working and our Integrated Care System at Board meetings on a regular basis, which enables the Board to shape our engagement across the system.
	Strategic Risk 2: Working with other hospitals through our Acute Provider Collaborative Strategic Risk 3: Working together across our group	In 2023-24 we integrated our Communications, Corporate Affairs, Strategy, Continuous Improvement, Project Management Office, and Corporate Nursing teams into single Group-wide teams. During 2024-25 we took similar steps to begin the process to bring together our Corporate Medical, People, ICT and Estates teams. We have also defined a programme of collaboration across a number of our clinical services. This is overseen by a Collaboration Group, which reports into our Group Executive.
Affordable Healthcare Fit for the Future	Strategic Risk 4: Achieving financial sustainability	In terms of financial risks, 2024-25 was a particularly challenged year. We rated the financial risk facing St George's as a risk score of 25 on the BAF, the highest possible score, and unchanged from 2023-24. This reflects the fact that we were unable to break even and required deficit support funding to deliver our plan in 2024-25. Capital remained very challenged, but we continued to invest in our estates and ICT infrastructure.
	Strategic Risk 5: Modernising our Estate	The establishment of the Infrastructure Committee, which operates as a Committee-in-Common with its Epsom and St Helier equivalent has strengthened oversight of estates and infrastructure issues. The Infrastructure Committee has reviewed the Premises Assurance Model for the Trust, reports from Authorised Engineers, and updates in relation to soft facilities management. A Group Green Plan has been agreed by the Board.

	Strategic Risk 6: Adopting Digital Technology	On ICT, Board oversight was improved through the establishment of the new Infrastructure Committee. The Trust has continued to ensure there is effective scrutiny at Board level of operational ICT risks facing the Trust, key ICT improvement programmes, and arrangements in relation to cybersecurity. In addition, the Committee, operating as a Committee-in-Common with its Epsom and St Helier equivalent, has overseen the implementation of a new Electronic Patient Records system for ESTH on a shared domain with St George's. However, digital remains a key area of challenge for the Trust and a digital strategy is in development.
	Strategic Risk 7: Developing new treatments through innovation and research	In relation to research and innovation, we continue to have in place an existing research strategy for the Trust, while we develop our new Group-wide research strategy. We also have close working relationships with City St George's, University of London, with whom we share a site. The Translational Clinical Research Institute is now well-established and St George's has been designated as an NIHR Clinical Research Facility. A Group-wide non-medical research leadership post has been established.
Right Care, Right Place, Right Time	Strategic Risk 8: Reducing Waiting Times	In relation to operational performance, our key area of focus has remained promoting effective flow through the hospital to ensure that patients receive the care they need, when they need it and in the right setting. This has included work to promote flow through our emergency department, as well as working with our partners, particularly our local mental health trust and local authorities, in relation to discharge, with both being key areas of challenge. We monitor operational performance carefully at our Group Executive Committee and through our Finance and Performance Committee.

	Strategic Risk 9: Improving patient safety and reducing avoidable harm	Maintaining safe services while managing operational and financial pressures has continued to be a key area of focus. The Board approved a new Quality and Safety Strategy in July 2024. We have in place arrangements to scrutinise the quality impact of cost improvement plans and monitor this through our Executive and Quality Committee. In 2024-25, we have continued our focus in particular on strengthening quality governance in maternity services and more widely by taking actions to address the findings of the CQC in its recent inspection of maternity services. We have used the external review of maternity governance as the basis for this work and the second phase has looked more broadly at quality governance across the Trust and hospitals group and has provided a model for ongoing internal assessment of the robustness of our quality governance. In addition, we have been particularly focused on actions to maintain safety in our emergency department given the operational pressures, the delivery of corridor care, and challenges with discharge. We have also commissioned reviews from the Royal College of Surgeons to examine theatre safety following a number of Never Events and have developed a set of actions to respond to the recommendations.
	Strategic Risk 10: Improving patient experience	In relation to patient experience, we have continued to take actions to strengthen how we engage with our patients, families and carers. This has included steps to improve our complaints processes. Data on complaints is collated and shared with the Board. Patient stories form a part of the Group Board meetings in public.
	Strategic Risk 11: Tackling health inequalities	On health inequalities, we commissioned research to help us understand how best we can contribute as an acute provider to the wider efforts across our local health system to improve health inequalities. From this, we have developed plans to improve how we use our data to understand health inequalities as well as specific steps we can take to play an active role and make every contact count. This work is being overseen by our Group Executive Committee, with assurance overseen by the Quality Committee.
Engaged, Empowered Staff	Strategic Risk 12: Putting staff experience and wellbeing at the heart of what we do	The Board approved a Group-wide People Strategy in May 2024. The Trust has in place a number of support programme for its staff and a Board level Wellbeing Guardian is in place. The Trust has developed action plans in response to key themes from the NHS Staff Survey and the Executive and People Committee oversee the delivery of this. Following a programme of work, we have launched policies to address violence and aggression against staff and a separate programme to address sexual violence in the workplace.

	Strategic Risk 13: Fostering an inclusive culture that celebrates diversity	Strengthening organisational culture has been a key priority over the past year. Action plans for the Workforce Race Equality Standards and Workforce Disability Equality Standards have been developed and are overseen by the People Committee. The Trust has a number of staff networks in place. The Board approved a new Freedom To Speak Up Policy in January 2025. In addition, the Trust established a new Culture Forum, chaired by the Chief Executive in 2024-25, which is helping to steer our activities to develop our organisational culture. The Board has also endorsed the creation of a shadow Board to help with promoting diversity in senior leadership positions, which is expected to launch in 2025/26.
	Strategic Risk 14: Developing tomorrow's workforce	The Trust has a Group-wide People Strategy. We have in place clear workforce recruitment and retention targets and monitor these through our Executive team and People Committee. We are an active partner with our Acute Provider Collaborative colleagues in South West London Recruitment and the Group-wide Staff Bank is in place as is corporate induction for all new starters.

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

Operational and financial performance is monitored monthly, via the monthly integrated quality and performance report, by the Finance and Performance Committee and by the Board. Performance against a range of quality metrics is monitored through the Quality Committee, and performance on workforce metrics by the People Committee. Cost Improvement Plans are subject to a rigorous Quality Impact Assessment process, the outcomes of which are reported to the Executive and assurance provided to the Quality Committee. Our performance is reported through a number of key performance indicators (KPIs) through the appropriate regulatory framework. At the end of this reporting period, March 2025, the Trust was performing positively against a large number of key indicators. However, the outlook for 2025-26 remains extremely challenging and there are particular challenges relating to finance and capital pressures arising from the levels of backlog and estates work combined with a number of large projects, as well as the impact of - potential industrial action and the broader challenges across the health service.

The Board, supported by its committees, oversees the future sustainability of the organisation. One of the key strategic priorities agreed by the Board is affordable healthcare, fit for the future, and through the Board Assurance Framework, the Board regularly monitors the risk to the delivery of this strategic priority

Information governance

The Board is aware of the importance of maintaining high standards of information governance (IG), including protecting the confidentiality of patient and staff information.

The Digital Assurance Group (DAG) oversees the completion of the Data Security and Protection Toolkit (DSPT) on an annual basis, as well as reviewing information governance incidents and all other IG activities. The Group Chief Financial Officer is our Senior Information Risk Officer (SIRO), and a senior consultant is the Caldicott Guardian. The Trust also has an information governance management team which includes our Chief Information Officer, the Data Protection Officer, and Information Governance Manager. We have a range of policies, procedures, and training to ensure that all staff are aware of information governance requirements. The achievement level assessed within the DSPT provides an overall indicator of compliance against the National Data Security Standards.

Our Information Governance Assessment Report

The completion date of the 2024-25 NHS Data Security and Protection Toolkit (DSPT) is 30 June 2025, and the submission is being prepared at the time of writing. It is a mandatory requirement of the DSPT that all staff members complete appropriate Data Security and Awareness/Information Governance training. The DSPT is currently being audited by an independent accredited auditor. In 2023-24, the Trust achieved ‘Standards Met’ status.

The Trust is required to report all Data Security and Protection incidents meeting the reporting criteria to the Data Security and Protection Toolkit and subsequently to Information Commissioner’s Office(ICO), and the Department of Health and Social Care ,NHS England(NHS Digital), the National Cyber Security Centre and other relevant parties within 72 hours. There were six incidents reportable between April 2024 and March 2025.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and the Audit Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control by the Board and Audit Committee are set out below.

On behalf of the Board, our Board Committees regularly review the Integrated Quality and Performance report (IQPR) from the perspective of their remit. The Board also reviews this at each public meeting. The monthly IQPR report details national priority and regulatory indicators including safety, clinical effectiveness and patient experience. The report is supplemented by more detailed briefings on any areas of adverse performance. In addition to this, our divisional directorates hold monthly performance review meetings with their care groups and individual services, and the Trust Management Group provides oversight of Divisional performance.

The Audit Committee provides the Board of Directors with an objective review of financial and corporate governance and internal control within the Trust, thereby providing independent assurance on them to the Board. In addition, it reviews and independently scrutinises the Trust's systems of clinical governance, internal control and risk management thereby ensuring, through proper process and challenge, that integrated governance principles are embedded and practiced across all the Trust's activities and that they support the achievement of the Trust's objectives. It also reviews the integrity of financial statements prepared by the Trust.

Internal audit reports are issued to and followed-up with the responsible Executive Directors and the results are reported to the Audit Committee. Internal audit reports are also made available to our external auditors, who may rely on them in arriving at their annual opinion. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern.

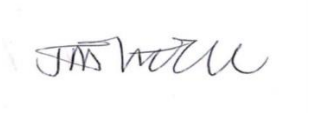
The Executive Directors and managers have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

The Board Assurance Framework provides the Board with evidence that the effectiveness of the controls used to manage the risks to the organisation in achieving its strategic objectives have been regularly reviewed. The Trust's committee structures ensure sound monitoring and review mechanisms to make certain that the systems of internal control are working effectively. Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports and mortality monitoring; and reports from external assessments. I am confident as to the effectiveness of the system described above and that conclusion is informed in a number of ways.

Conclusion

The Head of Internal Audit has provided reasonable assurance that no significant internal control issues have been identified. The opinion is that overall reasonable assurance could be provided, and that the controls are generally sound and

operating effectively. Through review of these assurances, the Board has considered any issues that fall within the definition of ‘significant issue’ according to the requirements of this governance statement.



Jacqueline Totterdell

Group Chief Executive

26 June 2025

Remuneration report (audited)

Name	Job Title	Period	2024/25						2023/24					
			Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
Executive directors			(bands of £5000) £000	Total to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	total to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Ms Jacqueline Totterdell	Group Chief Executive Officer	From 1st May 2017	165-170 *(Note 1)	0	0	0	0 *(Note 15)	**165-170**	155-160 *(Note 1)	0	0	0	0 *(Note 1)	**155-160**
Mr Andrew Grimshaw	Group Chief Finance Officer	(CFO) from 19th June 2017 and (Deputy CEO) from 25th April 2019 to 31st Jan 2022	115-120 *(Note 1)	0	0	0	0 *(Note 15)	**115-120**	110-115 *(Note 1)	0	0	0	0 *(Note 1)	**110-115**
Mr Stephen Jones	Group Chief Corporate Affairs Officer	From 5th March 2018	70-75 *(Note 1)	0	0	0	40-42.5	**115-120**	70-75 *(Note 1)	0	0	0	35-37.5	**105-110**
Dr Richard Jennings	Group Chief Medical Officer	From 19th November 2018	125-130 *(Note 1)	0	0	5-10 *(Note 14)	0	**135-140**	120-125 *(Note 1)	0	0	5-10 *(Note 14)	135-137.5	**265-270**
Kate Slemeck	Managing Director - St George's	From 3rd February 2022 (See note 1)	215-220 *(Note 1)	0	0	0	100-102.5	**315-320**	205-210 *(Note 1)	0	0	0	27.5-30	**230-235**
Vicky Smith	Group Chief People Officer	From 1st July 2024 (See note 2)	55-60 *(Note 1)	0	0	0	17.5-20	**75-80**	0	0	0	0	0	**0**
Arlene Wellman	Group Chief Nursing Officer	From 1st February 2022 (See note 3)	90-95 *(Note 3)	0	0	0	0 *(Note 3)	**90-95**	80-85 *(Note 3)	0	0	0	0 *(Note 3)	**80-85**
Mark Bagnall	Group Chief Facilities, Infrastructure and Environment Officer	From 27th August 2024 (See note 17)	50-55 *(Note 1)	0	0	0	0 *(Note 18)	**50-55**	0	0	0	0	0	**0**

Non-executive Directors														
Ms Gillian Norton	Chairman (Chair Board/Council and Nominations and Remuneration Committee, Trust Board and Council of Governors)	From 1st April 2017 until 31st March 2025 (see note 4)	55-60	0	0	0	0	**55-60**	55-60	0	0	0	0	**55-60**
Ms Ann Beasley	Non-executive Director (Chair of Finance and Investment Committee and Senior Independent Director).	NED from 13th October 2016. Senior Independent Director from 1st April 2021	15-20	0	0	0	0	**15-20**	10-15	0	0	0	0	**10-15**
Pankaj Davé	Non-executive Director	From 1st February 2025 (see note 5)	0-5	0	0	0	0	**0-5**	10-15	0	0	0	0	**10-15**
Peter Kane	Non-Executive Director	From 1st October 2021	15-20	0	0	0	0	**15-20**	10-15	0	0	0	0	**10-15**
Mr Andrew Murray	Non-executive Director (Chair of Quality & Safety Committee)	From 23 January 2023	15-20	0	0	0	0	**15-20**	10-15	0	0	0	0	**10-15**
Chew Yin Jones	Non-Executive Director	Associate Non-Executive Director 1 March 2023 to 12th October 2023 . Non-Executive Director From 13th October 2023 (See note 6)	10-15	0	0	0	0	**10-15**	10-15	0	0	0	0	**10-15**
Claire Sunderland Hay	Associate Non-Executive Director	From 18th October 2024 (see note 7)	5-10	0	0	0	0	**5-10**	0	0	0	0	0	**0**
Professor Natalie Armstrong	Non-executive Director	From 1st January 2025 (see note 8)	0 *(Note 16)	0	0	0	0	**0**	0	0	0	0	0	**0**
Leavers														
Angela Paradise	Group Interim Chief People Officer	From 3 January 2024 to 26th July 2024 (See note 9)	40-45 *(Note 9)	0	0	0	0 *(Note 18)	**40-45**	50-55 *(Note 1)	0	0	0	17.5-20	**120-125**

James Marsh	Group Deputy Chief Executive Officer	From 1st February 2022 (See note 10) to 21th March 2025	140-145 *(Note 10)	0	0	0	0	**140-145**	130-135 *(Note 10)	0	0	0	0 *(Note 10)	**125-130**
Mr Timothy Wright	Non-executive Director	From 25th September 2017 to 31st January 2025 (see note 11)	10-15 *(Note 11)	0	0	0	0	**10-15**	10-15	0	0	0	0	**10-15**
Professor Jennifer Higham	Non-executive Director	From 1st November 2015 to 31st July 2024(see note 12)	0 *(Note 16)	0	0	0	0	**0**	0	0	0	0	0	**0**
Philippa Tostevin	Non-executive Director	From 5th September 2024 to 31st December 2024 (see note 13)	0 *(Note 16)	0	0	0	0	**0**	0	0	0	0	0	**0**

Note 1. 50% of salary recharged to Epsom and St Helier for Jacqueline Totterdell, Andrew Grimshaw, Vicky Smith, Stephen Jones Richard Jennings and Mark Bagnall for FY 2024/25. Kate Slemeck is St. George's managing director; therefore, there are no recharges for Kate.

Note 2. Vicky Smith joined the Trust on 1st of July 2024 as Group Chief People Officer, therefore no comparative information for 2023/24

Note 3. Arlene Wellman has been recharged from Epsom and St Helier Hospital NHS Trust from 1st February 2022 as part of group management. Also, her pension related benefit will be disclosed by Epsom and St Helier Hospital NHS Trust.

Note 4. Gillian Norton finished her role as Chairman on 31st March 2025

Note 5. Pankaj Davé joined the Trust board on 1st February 2025 to replace Mr Timothy Wright

Note 6. Yin Jones position changed from Associate Non-Executive Director on the 12th October 2023 to Non Executive Director on the 13th October 2023

Note 7. Claire Sunderland Hay joined the Trust board on 18th October 2024 as Associate Non-Executive Director

Note 8. Professor Natalie Armstrongn joined the Trust board on 1st Janunary 2025 to replace Philippa Tostevin

Note 9. Angela Paradise left the Trust board Group Interim Chief People Officer on 26th July 2024

Note 10. James Marsh has been recharged from Epsom and St Helier Hospital NHS Trust from 1st February 2022 until he left the Trust board on 21st March 2025 as part of group management. Also, his pension related benefit will be disclosed by Epsom and St Helier Hospital NHS Trust.

Note 11. Timothy Wright finished his role as Non-executive Director on 31sth January 2025

Note 12. Professor Jennifer Higham finished her role as Non-executive Director on 31sth July 2024

Note 13. Philippa Tostevin joined the Trust board on 5th September 2024 to replace Professor Jennifer Higham and left the Trust board on 31sth December 2024

Note 14. The long term performance pay and bonuses for Dr Richard Jenning's is from a Clinical Excellence Award

Note 15. Ms Jacqueline Totterdell and Mr Andrew Grimshaw- For FY24-25 the valuation from NHS Pensions Agency resulted in a net reduction during the year which under the guidelines is reported as a zero value pension related benefit as there is no pension contribution this year because they are over the Normal Pension Age (NPA).

Note 16. Professor Natalie Armstrong, Professor Jennifer Higham and Philippa Tostevin are the City St George's University of London Medical School representative on the Trust Board. They are not remunerated by the Trust for the role on the Board.

Note 17. Mark Bagnall joined the Trust on 27th of August 2024 as Group Chief Facilities, Infrastructure and Environment Officer, therefore no comparative information for 2023/24

Note 18. There are no pensions figures disclosed for Mark Bagnall and Angela Paradise because they have opted out of the NHS pension scheme

Pensions report (audited)

		2024/25								2023/24							
Name and job title	Period	Real increase in pension at pension age	Real increase in pension and related lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at pension age related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value at 01 April 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's contribution to stakeholder pension	Real increase in pension at pension age	Real increase in pension and related lump sum at pension	Total accrued pension at pension age at 31 March 2024	Lump sum at pension age related to accrued pension at 31 March 2024	Cash Equivalent Transfer Value at 01 April 2024	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employer's contribution to stakeholder pension
		(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Ms Jacqueline Totterdell, Chief Executive	from 1st May 2017	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mr Andrew Grimshaw, Chief Financial Officer and Deputy Chief Executive	from 19th June 2017 and from 25th April 2019	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mr Stephen Jones, Chief Corporate Affairs Officer	from 5th March 2018	2.5-5	0	20-25	0	270	27	210	0	2.5-5	0	15-20	0	210	46	132	0
Dr Richard Jennings, Chief Medical Officer	from 19th November 2018	0	0	60-65	155-160	385	0	490	0	5-7.5	27.5-30	85-90	240-245	490	0	1,746	0
Victoria Smith, Group Chief People Officer	from 1st July 2024	0-2.5	0	0-5	0	27	6	0	0	0	0	0	0	0	0	0	0
Kate Slemeck	from 3rd February 2022	5-7.5	5-7.5	70-75	170-175	1721	117	1478	0	0	57.5-60	60-65	155-160	1,478	278	1,065	0
Mark Bagnall, Group Chief Facilities, Infrastructure and Environment Officer	from 27th August 2024	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Note 19. McCloud judgement: The Court of Appeal ruling on 'protection', known as the McCloud judgement. From 1st April 2022 all active members will be members of the reformed scheme.

All legacy pension schemes will be closed, including the 1995/2008 NHS Pension Scheme

Note 20. The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) Indexation on 08th August 2019.

This will affect the calculation of the real increase in CETV and does not affect the real increase in pension benefits. This is more likely to affect the 1995 section and the 2008 section.

Note 21. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of non-executive directors.

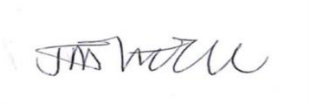
Note 22. The above disclosures is audited by Trust's external auditor.

Pension scheme

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

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

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or an arrangement which the individual has transferred to the NHS pension scheme) and uses common market valuation factors for the start and end of the period.



Jacqueline Totterdell
Group Chief Executive

26 June 2025

Financial performance

Financially 2024/25 was a very challenging year. The Trust faced considerable financial pressures that are not immediately evident from the headline deficit position reported, and these pressures will remain as the trust moves into 2025/26 and beyond.

At the close of the year, the trust the Trust reported a deficit of £4.3m which was in line with plan. This was only possible due to security additional non-recurrent monies of £13.2m from SWL ICB. The adverse position was driven by increased staffing costs in the emergency department and ward areas, as well as non-pay inflationary pressures above planning assumptions.

However, the underlying challenge in the financial position was much higher than the reported deficit of £4.3m. The reason for the change was driven by two factors: deficit support funding and non-recurrent actions.

The reported deficit includes £45.8m of deficit support funding. This was received from NHSE via SWL ICB to support the deficit and ensure the Trust had sufficient cash across the year. This funding is exceptional and should not be seen as part of the Trust's normal operating income. If this funding is included from the reported position, the Trust would have reported a deficit of £50.1m. The Trust planned to have a deficit of £50.1m as it had material pressures that it could not fully address, even after a large Cost Improvement Plan (see below). The pressures driving the planned deficit are productivity challenges post-Covid and structural estates issues. The drivers of the adverse variance from the plan remain the same as the items listed above.

Non-recurrent benefits within the plan and actual positions: the Trust included a range of non-recurrent benefits within its plan, and actual positions with a value of £67.4m. These benefits provided one-off improvements to the position in 24/25 and will not be repeated in 25/26. This means the challenge in 25/26 will be greater than that indicated in 24/25 accounts.

Cost Improvement Programme 2024/25

The Trust identified a plan to deliver £68.5m of CIPs in 24/25, representing 5.5% of operational expenditure. This target should be seen as very high; it was set to help address the challenging financial position faced by the Trust. Delivery of this was always seen as challenging.

The full £68.5m of CIP was achieved at year-end. Key areas of delivery included clinical productivity in elective care, cost out across clinical and corporate services and additional commissioner income support. Of the CIP delivered, £32.3m was non-recurrent.

CIPs are subject to the governance of Quality Impact Assessments signed off by the Group Chief Medical and Group Chief Nursing Officers for all schemes that deliver a financial improvement.

St George's delivered a CIP of £60.1m in the previous year, 2023/24. The total achieved in year represents the sixth year of high CIP delivery by the Trust.

Contractual payments

The Trust instead received block contract funding from its main commissioners in the financial year, in line with 2023/24. Since block contracts began being used in 2020/21, they have reduced in value (after inflation adjustment), to reflect the need for the NHS to make further savings. However, the Trust received significant non-recurrent income in 2024/25 to mitigate this challenge.

Performance against plan

The 2024/25 financial plan was challenged by staffing pressures in the emergency department and ward areas, as well as excess non-pay inflation compared to planning assumptions.

Capital expenditure

The Trust spent £47.28 million of capital in 2024/25. This was funded from internally generated funds, and additional one-off PDC funding. The capital funds available to us were used to support ongoing investment in IT, our estate and medical equipment. This level of funds meant that the Trust was able to address a full investment programme.

As in previous years, the demands for capital materially exceeded the funds available to the Trust. There is a robust prioritisation process to ensure we continually balance multiple demands, including:

- the urgent need for stabilising and upgrading IT infrastructure, estates infrastructure, and theatres
- increasing diagnostic capacity and upgrades
- maintaining our infrastructure to ensure we provide safe, compliant services
- the need to invest capital and revenue in service transformation that will drive change and more efficient ways of working both internally and with partners (e.g. as part of the South West London Health and Care Partnership)
- investment in digital transformation and analytical capacity.

IFRS16 (Right of use assets - ROU)

As part of IFRS16 lease standard, £495k medical equipment, £28k transport and £4.26m of building operating leases have been classified as IFRS 16 ROU assets (Right of Use asset) in 24/25

We used leasing to supplement capital investment in medical equipment, where appropriate, taking account of implicit rates of interest, the expected useful economic life of the equipment, the residual value of the equipment at the end of the lease term and the expected rate of technological change to ensure value for money.

Cash flow

The Trust began the financial year with £48.5m of cash and cash equivalents. During the year, cash balances increased to £80.4m. The cash balance at the end of the year reflects the deficit support funding received in year. The cash is required to pay capital and other creditors in 25/26.

Financial performance against plan

	2024/25 Actual	2024/25 Plan	Variance
	£ millions	£ millions	£ millions
Operating Income	1,328.2	1,293.4	34.8
Operating Expenditure	- 1,321.4	- 1,273.5	- 47.9
Operating Surplus / Deficit	**6.8**	**19.9**	**- 13.1**
Non-Operating costs	- 21.0	- 26.1	5.1
Accounting Surplus / Deficit	**- 14.2**	**- 6.2**	**- 8.0**
AFP impairment adjustments	7.9	-	7.9
Remove capital donation income and depreciation	0.6	1.7	- 1.0
Remove impact of PFI liability measurement	1.4	0.2	1.1
Adjusted financial performance	**- 4.3**	**- 4.3**	**0.0**

Financial performance comparison

	2024/25 Actual	2023/24 Actual	Change
	£ millions	£ millions	£ millions
Operating Income	1,328.2	1,221.8	106.4
Operating Expenditure	- 1,321.4	- 1,317.6	- 3.8
Operating Surplus / Deficit	**6.8**	**- 95.8**	**102.5**
Non-Operating costs	- 21.0	- 25.1	4.1
Accounting Surplus / Deficit	**- 14.2**	**- 120.8**	**106.6**
Add back AME I&E impairments	7.9	115.9	- 108.0
Remove capital donation income and depreciation	0.6	1.1	- 0.4
Remove impact of PFI liability measurement	1.4	0.3	1.1
Adjusted financial performance	**- 4.3**	**- 3.6**	**- 0.7**

Cash flow

	2024/25	2023/24
	£ million	£ million
Operating surplus/deficit before finance and other costs	6.8	- 95.8
Add back non-cash and expense	52.2	166.3
Increase/decrease in operating activities	35.4	- 43.4
Net cash generated from operating activities	94.4	27.2
Net cash generated from investing activities	- 39.9	- 38.7
Net cash generated from financing activities	- 22.7	1.5
Net increase / decrease in cash	**31.8**	**- 10.0**
Opening Cash and equivalents	**48.5**	**58.5**
Closing Cash and equivalents	**80.4**	**48.5**

Charitable funding

We received £1.09m from charitable sources during the year, principally from St George's Hospital Charity. However, the Trust also received £0 of donated equipment from the Department of Health.

Private Finance Initiative

We entered into a Private Finance Initiative (PFI) contract in March 2000 for the exclusive use of Atkinson Morley wing on the St George's Hospital site over a 35 year term. The capital value of the building is approximately £50.5 million. All of these loans are included within borrowings in the statement of financial position within the accounts, included separately in this annual report.

Revaluation of land and buildings

As part of preparing the annual accounts, we are required to assess the value of our land and buildings. This exercise is carried out at the end of each financial year. The annual revaluation has led to a £5.87m (£17.9million 23/24) reduction in value of some buildings and £69k (£2.28m 23/24) reduction in value of land. However, there is a £13.34m (£2.4m 23/24) increase in building and £1.32m (£170k 23/24) increase in land to revaluation reserve. This is a reflection of changes in the basis of the valuation.

The reason for the decrease in the value of some buildings mainly relates to impairments in capital spend on the estate, as the cost of improvement works to existing building will not cause corresponding equal increases to the building's value. The valuer has to assess the operational properties by reference to the cost of providing a 'modern equivalent asset'; this by definition creates a 'ceiling' value beyond which it would not be possible to go, no matter how much might be expended on an asset. The valuer also assessed that land values had fallen this year. This decrease was not included in the plan and represents a technical accounting adjustment.

This year, the Trust undertook valuations for some of its leasehold assets and this resulted in a decrease in the valuations of these compared to the previous year's value, which had been derived from the cost model. The leases that were valued were those where it was determined that the annual payments were not regularly adjusted in line with the market. Following the RICS guidance, the valuers estimated the market rent, which in general was lower than the annual payments which often included other non-rental charges. The valuers also adopted market derived yields which were above the prescribed HM Treasury discount rate. Both these reasons caused the valuations to be lower than the previous year's ROU asset values.

This valuation of ROU assets has resulted in an impairment of £4.9m (£115.9m 23/24) charged to operating expenses, as there was insufficient balance in the revaluation reserve for these asset in 2024/25. The adjustments are in line with IFRS16 requirements.

External audit services

Grant Thornton received £361,780 in audit fees in relation to the statutory audit of the Trust to 31 March 2025.

Events since the end of the financial year

There have been no events since the end of the financial year that have a bearing on the analysis of our performance.

Contracts with commissioners

The financial performance regime for 2025-26 from NHS England is that Trusts will still be funded through block contracts, although more elements will now be subject to cost and volume adjustments. The Trust will lose a significant portion of non-recurrent income which has been a major cause of the Trust declaring an unbalanced position for the new financial year.

Processes to manage cash and working capital

The Trust has accurate and clear cash forecasting and collection processes, an achievable aged debt recovery plan, clear payments processes for creditors, and ensuring we manage stock holdings to agreed levels.

Political and charitable donations

We have not made any political or charitable donations during 2023/24.

Countering fraud and corruption

We have a counter fraud and corruption policy. Counter fraud arrangements are reviewed during the year by the Local Counter Fraud Service (LCFS). The LCFS undertakes an ongoing programme of work to raise the profile of counter fraud measures and carries out ad hoc audits and specific investigations of any reported alleged frauds. This includes the use of fraud awareness presentations and fraud awareness surveys. The Audit Committee receives and approves the Counter Fraud Annual Report, monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

Transactions with related parties

Transactions with third parties are presented in the accounts. For the other Board members, the Foundation Trust’s governors, or parties related to them, none of them have undertaken material transactions with the Trust.

Remuneration of senior managers

Details of senior employees' remuneration can be found in the Remuneration Report.

Anti-bribery and fraud policies and issues

One of the fundamental objectives of public sector organisations is the appropriate use of public funds. The vast majority of people who work in the NHS are honest and professional; they believe that fraud and bribery are wholly unacceptable. Besides the impact on professional morale, bribery and fraud ultimately leads to a reduction in the resources available for patient care.

NHS Counter Fraud Authority (NHSCFA) and St George's are committed to taking all necessary steps to prevent fraud, bribery and corruption or, failing that principal objective, detect it early to minimise the consequences. To meet its objectives, the Trust adheres to the Government Function Standard 013: Counter Fraud, as well as a four-stage approach developed by NHSCFA to tackle fraud and bribery

Statement of going concern

2.12 Going concern disclosure

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. The Trust incurred a £4.3m deficit financial position for the year ended 31 March 2025 (after adjusting for excluded items against the control total).

The draft financial plan for 25/26 has estimated as a deficit of £13.0m, having taken account of the underlying financial position going into 2025/26 and the Block contract arrangements.

After making enquiries, although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the NHS Foundation Trust Annual Reporting Manual 2024/25, the Directors have

prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Staff report

This year, we employed 10,552 staff, clinical and non-clinical, all of whom contribute to providing quality patient care in our hospitals and in the local community. The majority of the Trust's staff are permanently employed clinical staff directly involved in delivering patient care. We also employ a significant number of scientific, technical, and administrative staff who provide vital expertise and support. The table below provides a breakdown of our workforce.

Male and female

Staff group	WTE		%	
	Female	Male	Female	Male
Directors	11	8	58%	42%
Senior Manager (AFC 8c+)	117	71	62%	38%
All staff	7,197	3,062	70%	30%

Average number of employees (audited)

	2024/25			2023/24
TYPE	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,691	93	1,784	1,803
Administration and estates	2,242	122	2,364	2,298
Healthcare assistants and other support staff	2,015	238	2,253	2,262
Nursing, midwifery and health visiting staff	2,860	393	3,253	3,191
Scientific, therapeutic and technical staff	882	117	999	998
Total average numbers	9,690	963	10,653	10,552

Number of employees (WTE) engaged on capital projects	22	21	43	45

Sickness absence data

Sickness absence data is published by NHS Digital and can be found here: **NHS Sickness Absence Rates - NHS England Digital**

Staff turnover

Information on staff turnover is published by NHS Digital, and can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Gender pay gap

Information on the gender pay gap can be found on the Cabinet Office website at: http://gender-pay-gap.service.gov.uk

Disclosures required by Health and Social Care Act

Total Employee Expenses (audited)

Cost	2024/25			2023/24
	Permanently employed	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	617,385	13,430	630,815	570,374
Social security costs	67,770	0	67,770	63,671
Apprenticeship Levy	3,583	0	3,583	2,422
Employer's contributions to NHS pensions	69,813	0	69,813	63,205
Pension Cost - employer contribution paid by NHSE on provider's behalf (6.3%)	45,611	0	45,611	27,577
Pension cost - other - (Restated heading for 2023/24)	28	0	28	49
Temporary staff	0	12,783	12,783	18,862
Total gross staff costs	**804,190**	**26,213**	**830,403**	**746,160**

The 2023/24 pension cost - employee contribution and pension cost - other figures have been restated and now reported on separate lines with no impact on the total reported. The 2023/24 pension cost is restated and now showing on the correct heading.

Expenditure on consultancy

Expenditure on consultancy	2024/25	2023/24
Consultancy costs (£k)	2,695	934

Staff exit packages (audited)

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	1	1
£10,001 – £25,000	1	3	4
£25,001 – £50,000	0	0	0
£50,001 – £100,000	0	1	1
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	**1**	**5**	**6**

Total resource cost (£k)	**£22**	**£119**	**£141**

Exit packages: non-compulsory departure payments (audited)

Other (non-compulsory) departure payment	Agreements Number	Total Value of Agreements £0
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	3	42
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	2	77
Total	**5**	**119**

Off-payroll engagements

Table 1: For all off-payroll engagements as of 31 March 2022 for more than £245 per day and that last for longer than six months	**2024/25** **Number of engagements**	**2023/24** **Number of engagements**
Number of existing engagements as of 31 March 2021	0	16
Of which…	0	0
No. that have existed for less than one year at time of reporting	0	14
No. that have existed for between one and two years at time of reporting	0	2
No. that have existed for between two and three years at time of reporting	0	0
No. that have existed for between three and four years at time of reporting	0	0
No. that have existed for more than four years at time of reporting	0	0

	2024/25	**2023/24**

Table 2: For all new off-payroll engagements, or those that reached six months duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last for longer than six months	Number of engagements	Number of engagements
Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	14	8
Of which:	0	0
Number assessed as within the scope of IR35	0	0
Number assessed as not within the scope of IR35	0	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0	0
Number of engagements reassessed for consistency/assurance purposes during the year	0	0
Number of engagements that saw a change to IR35 status following the consistency review	0	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	2024/25 Number of engagements	2023/24 Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	0	0

All Foundation Trusts must disclose the number of individuals in the capacity of a board member or senior manager having significant financial responsibility in the year. This includes both on-payroll and off-payroll engagements.

In any cases where individuals are included within the first row of this table, please set out:	Checks	Checks
Details of the exceptional circumstances that led to each of these engagements.	0	0

Details of the length of time each of these exceptional engagements lasted.	0	0

Equality, diversity and inclusion

As the largest healthcare provider in south west London, it is vital that our workforce reflects the rich diversity of the communities we serve. In the last year, we've taken important steps toward building a more inclusive culture at St George's, introducing new process, policy and training to upskill and protect our workforce.

Our recently launched gesh 2025-27 EDI Action Plan, which aligns with the NHS England Equality, Diversity, and Inclusion Improvement Plan, provides a clear plan to support achieving our EDI objectives – there is still a lot more work to be done to ensure every member of our team feels valued and supported. We are committed to continuing this journey and making meaningful progress together.

Developing a culturally intelligent workforce which delivers outstanding care to all

To enable us to deliver the best possible healthcare services to our diverse communities, it is crucial that we have a culturally intelligent and diverse workforce which directly reflects the communities we serve.

Since 2019, we worked to cement our commitment to building a workforce in which each employee can enjoy a strong sense of belonging and where diversity is truly valued. As well as being well-represented across all levels, we recognised that we must ensure that people from marginalised groups, including people with disabilities, are actively included, and that this inclusion is felt authentically at a personal level across our organisation.

We are confident that working towards a truly inclusive culture across gesh not only improves the experience of our workforce but also offers significant benefits to our patients and service users.

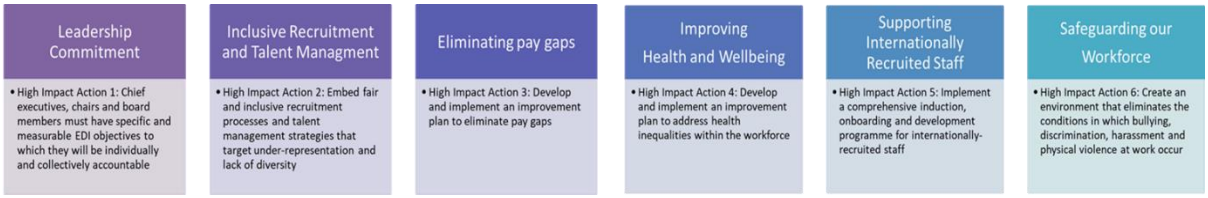
These benefits include:

- staff who feel included, engaged and supported have greater personal resources and resilience to offer thorough and compassionate care
- a reduction in bullying, harassment, discrimination and other forms of exclusion by building greater understanding, appreciation and respect
- improved staff retention and reduced sickness absence supports better continuity of care
- diverse lived experiences and views can offer enhanced empathy and support to patients
- stronger team performance by maximising our blend of skills, talents, knowledge and professional experiences.

Aligning with NHSE EDI Improvement Plan

Our first Culture and D&I Action Plans, which were introduced in late 2020, have driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities. Whilst many of the actions and projects set out in these action plans have now been successfully delivered, there are still a number to be implemented, particularly as we move to closer group working and sharing best practice across both St George's and Epsom and St Helier.

These open actions or live projects have been mapped across to NHSE's EDI Improvement Plan and aligned with our People Strategy 2024-2026. This mapping exercise has identified six gesh EDI workstreams:



Following this initial review and mapping exercise, we began shaping our draft 2024-2026 action plan via a series of in-depth discussions and collaborative sessions with a range of stakeholders.

This process has involved our Executive and Non-Executive Directors, Site Management Teams and Heads of Services. This has provided several points of review and challenge to ensure that our plans are achievable and contribute to the successful delivery of our wider strategic plans.

We have also engaged and consulted with key stakeholders across a range of services, including our staff networks, ensuring their perspectives are reflected in our planning.

Furthermore, we have drawn on workforce data and key performance metrics to inform our decisions and actions. By reviewing data and other relevant indicators, we have ensured that our plan is evidence-based and responsive to the needs of our workforce.

Culture, Equity and Inclusion (CEI) Forum

To ensure continued momentum and engagement, the St George's Culture Forum will be provided with regular updates and oversee delivery of our culture and leadership programme, and the diversity and inclusion action plan. A separate group

level Culture Forum provides group level oversight. The St George's Culture Forum is chaired by our Managing Director Kate Slemeck, includes representatives from each of our staff networks, and has divisional representation, to make sure we have a range of views and voices from across the organisation on these matters.

Staff networks

Our four networks launched in 2019 and continue to work with our diversity and inclusion workforce team, to deliver several events and initiatives to support our staff and patients. Our networks are:

- Black, Asian, and Minority Ethnic (BAME) Network
- Disability and Wellbeing (DaWN) Network
- LGBTQ+ Network
- Women's Network.

Workforce Race and Equality Standard (WRES)

Since 2017, all healthcare providers have been required to publish their workforce data regarding ethnicity. This data helps organisations to understand and respond to the experience of Black, Asian and Minority Ethnic staff. In line with national requirements, our WRES report for 2023-24 was published in October 2024 and is available on the Trust's website. This WRES report is based on a snapshot of data from 31 March 2024 and our 2023 NHS Staff Survey results.

Workforce Disability Equality Standard (WDES)

The WDES was introduced in 2019 and is designed to improve the experiences of people with disabilities working in, or seeking employment within, the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its staff. These findings inform the organisation's WDES Action Plan, which aims to directly address inequalities faced by disabled members of staff. In line with national requirements, our WDES report for 2023-24 was published in October 2024 and is available on the Trust's website. This WDES report is based on a snapshot of data from 31 March 2024 and our 2023 NHS Staff Survey results.

If you would like to read more on our progress in relation to Equality, Diversity and Inclusion and steps taken in 2024, please see our Public Sector Equality Duty (PSED) Report which is available on the Trust website.

Freedom to Speak Up Guardians

Staff are encouraged and supported to speak up about any concerns or suggestions they have about any aspect of their work and have various ways of doing so. The

Trust has in place a clear policy that sets out how staff can raise concerns which reflects relevant national guidance from NHS England and the National Guardian's Office for Freedom to Speak Up.

Staff are encouraged in the first instance to raise issues with their line manager, as often concerns can be resolved at this level. However, it is recognised that some staff may not feel comfortable in taking this route, especially if the concern being raised pertains to their line manager.

Staff can raise concerns with:

- any manager/ leader within their department
- Group Freedom to Speak up Guardian/ Champion
- their Human Resource Adviser/ Manager.
- Executive and Non-Executive leads for Freedom to Speak Up
- any other Executive and non- executive
- Chair.

Staff can raise concerns face to face, by letter or email or telephone.

Staff are also advised how they can raise concerns externally if they are unhappy with using any of the internal routes for raising concerns or if they indicate that after raising a concern they do not feel the concern was investigated in line with the Trust policy. These external routes include the Care Quality Commission and recognised professional or union body.

Staff with concerns about potential fraud are encouraged to raise concerns with NHS Counter Fraud. Staff who speak up are advised to report incidents where they feel speaking up has been to their detriment. If it is found that this is the case, the Trust will take appropriate action to mitigate the risk to the staff member concerned and, if necessary, appropriate action taken under the Trust's disciplinary procedure.

Staff are also regularly referred for additional support after raising concerns to our staff support team and or Occupational Health by agreement with the staff member. Once an outcome is received, the feedback is given to the person raising the concern either in writing or verbally, depending upon the issue raised, how it was resolved (i.e. formally or informally) and the preference of the person raising the concern.

Anonymous concerns cannot be fed back; however, the outcome is logged by the Trust. Themes and trends in the concerns raised by staff that come to the FTSU Service are reported to the Trust Board and to the People Committee. A Group-wide FTSU team is in place which supports staff across the St George's, Epsom and St Helier University Hospitals and Health Group, which gives a wider reach and more flexibility when supporting teams and groups of staff members. The team currently comprises one Group FTSU Guardian and three Group Deputy FTSU Guardians covering all of the sites and services across the Group.

Trade union facility time

Number of trade union representatives	30
Total FTE of trade union representatives	27.77

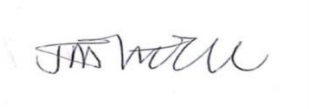
Number who spend between 1 – 50% of their time on Trade Union activities	30
Number who spend 100% of their time on trade union activities	1
Total Trust pay bill	£781,993,000.00
Total cost of facility time	£22,203.65
Percentage of total pay spent on facility time	0.003%
Hours spent on paid facility time	4,012.13
Hours spent on paid trade union activities	3,050.36
Percentage of total paid facility time hours spent on paid TU activities	76.03%

Modern Slavery Act 2015

Like all public sector organisations, we are committed to upholding the provisions of the Modern Slavery Act 2015.

We take very seriously our commitment towards ensuring that no modern slavery or human trafficking takes place in our supply chains or in any part of our organisations, or across the many services we run out of St George's, Queen Mary's, as well as in the community.

Our internal policies reflect our commitment to acting ethically and with integrity in all our interactions – with staff, patients and suppliers of goods and services. We have also developed a Modern Slavery and Human Trafficking Statement in line with the Modern Slavery Act 2015. This statement outlines our due diligence on modern slavery in respect of our supply chain; details of relevant policies and processes in place to ensure we are conducting our business in an ethical and transparent manner; details of the relevant training which facilitates staff awareness of the signs of modern slavery and the process for raising safeguarding concerns; and assurance in respect of our pre-employment checks. This statement can be found on the Trust's website here https://www.stgeorges.nhs.uk/about/st-georges-and-the-modern-slavery-act, and is reviewed, updated and approved by the Board of Directors on an annual basis.



Jacqueline Totterdell
Group Chief Executive

26 June 2025

Annual Accounts for the year ended 31 March 2025

St George's University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2025

St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by St George's University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Jacqueline Totterdale**
Job title **Chief Executive**
Date **26 June 2025**

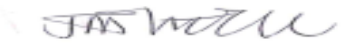
Statement of Comprehensive Income

			2024/25	2023/24
		Note	£000	£000
Operating income from patient care activities		3	1,156,133	1,064,052
Other operating income		4	172,037	161,369
Operating expenses		6,8	(1,321,411)	(1,321,181)
Operating surplus/(deficit) from continuing operations			**6,759**	**(95,760)**
Finance income	10		3,496	1,947
Finance expenses	11		(17,553)	(16,706)
PDC dividends payable			(6,357)	(9,519)
Net finance costs			**(20,414)**	**(24,278)**
Other gains / (losses)	12		(559)	(796)
Surplus / (deficit) for the year			**(14,214)**	**(120,834)**
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Impairments		7	(5,257)	(13,920)
Revaluations		16	10,165	2,830
Total comprehensive income / (expense) for the period			**(9,306)**	**(131,924)**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	13	26,653	32,199
Property, plant and equipment	14	452,439	447,670
Right of use assets	17	40,980	46,149
Receivables	19	11,678	11,843
Total non-current assets		**531,750**	**537,860**
Current assets			
Inventories	18	15,045	18,417
Receivables	19	70,401	68,649
Cash and cash equivalents	20	80,397	48,550
Total current assets		**165,843**	**135,616**
Current liabilities			
Trade and other payables	21	(155,326)	(129,773)
Borrowings	23	(18,671)	(18,271)
Provisions	24	(594)	(397)
Other liabilities	22	(19,187)	(15,159)
Total current liabilities		**(193,778)**	**(163,600)**
Total assets less current liabilities		**503,815**	**509,876**
Non-current liabilities			
Borrowings	23	(217,451)	(228,999)
Provisions	24	(4,681)	(4,565)
Total non-current liabilities		**(222,132)**	**(233,564)**
Total assets employed		**281,683**	**276,312**
Financed by			
Public dividend capital		647,750	633,073
Revaluation reserve		80,792	75,884
Other reserves		1,150	1,150
Income and expenditure reserve		(448,010)	(433,795)
Total taxpayers' equity		**281,683**	**276,312**

The notes on pages 8 to 52 form part of these accounts.



Name **Jacqueline Totterdale**
Position **Chief Executive**
Date **26 June 2025**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**633,073**	**75,884**	**1,150**	**(433,795)**	**276,312**
Deficit for the year	-	-	-	(14,214)	**(14,214)**
Impairments	-	(5,257)	-	-	**(5,257)**
Revaluations	-	10,165	-	-	**10,165**
Public dividend capital received	14,677	-	-	-	**14,677**
Taxpayers' and others' equity at 31 March 2025	**647,750**	**80,792**	**1,150**	**(448,010)**	**281,683**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**585,984**	**86,974**	**1,150**	**(265,083)**	**409,026**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	-	(47,879)	**(47,879)**
Deficit for the year	-	-	-	(120,834)	**(120,834)**
Impairments	-	(13,920)	-	-	**(13,920)**
Revaluations	-	2,830	-	-	**2,830**
Public dividend capital received	47,089	-	-	-	**47,089**
Taxpayers' and others' equity at 31 March 2024	**633,073**	**75,884**	**1,150**	**(433,795)**	**276,312**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserves

This reserve of £1.15m was created in March 2003 to recognise the portion of land at St George's Grove that had been omitted from the land valuation used to establish the St George's opening PDC capital balance when it became a NHS Trust on 1st April 1993. The associated land has since been sold but this reserve remains as an adjustment to the originating PDC Capital balance.

Income and expenditure reserve

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

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		6,759	(95,760)
Non-cash income and expense:			
Depreciation and amortisation	6.1	43,065	50,979
Net impairments	7	10,254	115,859
Income recognised in respect of capital donations	4	(1,088)	(504)
(Increase) / decrease in receivables and other assets		(3,926)	16,057
(Increase) / decrease in inventories		3,372	2,214
Increase / (decrease) in payables and other liabilities		35,746	(61,208)
Increase / (decrease) in provisions		232	(448)
Net cash flows from / (used in) operating activities		**94,414**	**27,189**
Cash flows from investing activities			
Interest received		3,496	1,947
Purchase of intangible assets		(445)	(323)
Sales of intangible assets		-	1,112
Purchase of PPE and investment property		(48,222)	(41,965)
Sales of PPE and investment property		4,214	-
Receipt of cash donations to purchase assets		1,088	504
Net cash flows from / (used in) investing activities		**(39,869)**	**(38,725)**
Cash flows from financing activities			
Public dividend capital received		14,677	47,089
Public dividend capital repaid		-	-
Movement on loans from DHSC		(602)	(602)
Movement on other loans		(739)	(1,478)
Capital element of lease rental payments		(14,946)	(14,671)
Capital element of PFI, LIFT and other service concession payments		(2,855)	(2,488)
Interest on loans		(211)	(250)
Other interest		(2)	-
Interest paid on lease liability repayments		(5,046)	(5,335)
Interest paid on PFI, LIFT and other service concession obligations		(8,955)	(8,889)
PDC dividend (paid) / refunded		(4,019)	(11,836)
Net cash flows from / (used in) financing activities		**(22,698)**	**1,540**
Increase / (decrease) in cash and cash equivalents		**31,847**	**(9,996)**
Cash and cash equivalents at 1 April - brought forward		**48,550**	**58,546**
Cash and cash equivalents at 31 March	20.1	**80,397**	**48,550**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England 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, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust incurred a £4.3m deficit for the year ended 31 March 2025 (after adjusting for excluded items against the control total). The final financial plan for 25/26 remains to be finalised, with the Trust aspiring to achieve a £13m deficit, having taken account of the underlying financial position going into 2025/26. Currently the Trust is exploring the funding streams confirmed for the new financial year, in order to decide if any risk or opportunities to this position exist. After making enquiries the directors, have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the NHS Foundation Trust Annual Reporting Manual 2024/25, the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Note 1.3 Interests in other entities

From 1 April 2015, the Trust has participated in South West London Pathology, a partnership with Kingston NHS Foundation Trust and Croydon University Hospitals NHS Trust to provide pathology services for all three organisations, The partnership was expanded on 1st May 2021 to include Epsom & St Helier University Hospitals NHS Trust. The partnership is hosted by St George's NHS Trust and accountable through a consortia agreement to the SWL Acute Provider Collaborative

Ownership is divided based on full year Activity with percentages to be updated at year end.

• Croydon University Hospitals NHS Trust	19.60%
• Kingston NHS Foundation Trust	20.50%
• Epsom & St Helier NHS Foundation Trust	32.40%
• St George's University Hospitals NHS Foundation Trust	27.50%

South West London Pathology is not a separate vehicle for the three trusts, making this a joint operation as defined by IFRS11. As a joint operation the Trust accounts for its share of the income and expenditure for South West London Pathology.

South West London Pathology is hosted by St Georges NHS Foundation Trust. In addition to this participates in:

South West London Procurement Partnership (hosted by St Georges NHS Foundation Trust)
South West London Recruitment Hub (hosted by Kingston and Richmond NHS Foundation Trust)
South West London Acute Provider Collaborative (hosted by Kingston and Richmond NHS Foundation trust)

In addition to South West London collaborations, the St Georges NHS Foundation Trust hosts corporate services on behalf of Epsom & St Helier University Hospitals NHS Trust:

Group Corporate Affairs' services.
Group Communications' services.
Group Corporate Nursing services.
Group Corporate Medical services.
Group Deputy CEO services.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

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

In reviewing income recognised in the annual accounts in accordance with IFRS15, the Trust has reviewed contractual challenges and penalties, CQUIN delivery and education and training income as all are material elements of the Trust's income performance.

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

The Trust receives income from Health Education England for Education and training of medical and non medical trainees. Revenue is in respect of training provided and is recognised when performance obligations are satisfied when training has been performed. All performance obligation are undertaken within the financial year and is as agreed and invoiced to HEE.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants 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.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment
Recognition

Property, plant and equipment is capitalised where:
• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control. Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

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

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie 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 and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. 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 and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

Impairments

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

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

De-recognition

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

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

Donated and grant funded assets

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

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) 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 and LIFT liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other 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.

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	**Max life**
	Years	**Years**
Buildings, excluding dwellings	1	115
Dwellings	15	80
Plant & machinery	5	25
Transport equipment	10	10
Information technology	3	16
Furniture & fittings	7	15

Note 1.9 Intangible assets

Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

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

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Information technology	5	16
Software licences	3	10

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method

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

Note 1.11 Cash and cash equivalents

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

Note 1.12 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, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

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

Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial assets at amortised cost

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

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

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

Impairment of financial assets

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

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

Doubtful debt is assessed monthly. The main factors in determining whether there will be a full realisation of the invoiced debt or not is

1. statute barred
2. information from External Debt Collection agencies (including SBS)
3. local knowledge.

The exception is for Overseas Visitors debt where experience of non-payment is recognised throughout the NHS, we provide 100% after 12 months. We will continue to pursue the debt using EDR and the debt is also registered with Border Agency, until such time as it is statute barred or we have knowledge giving cause for us to cease activity.

Private Patients debt, if not covered by health insurers is paid directly in advance. With the introduction of Healthcode and other similar processes for invoicing insurers, the risk of incorrect billing has been significantly reduced.

Where all avenues have been exhausted the uncollectable debt is presented to the Audit Committee for authorisation to write off.

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.

Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 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.

The Trust as a lessee

Recognition and initial 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 or other systematic basis [explain if relevant]. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

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

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

The Trust as a lessor

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

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

Finance leases

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

Note 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%).

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 24.1 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.16 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

Note 1.17 Value added tax

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

Note 1.18 Climate change levy

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

Note 1.19 Losses and special payments

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

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

Note 1.20 Gifts

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

Note 1.21 Early adoption of standards, amendments and interpretations

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

Note 1.22 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. These Standards are still subject to HM Treasury FReM adoption.

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM which is expected to be from the 1 April 2025. Early adoption is not permitted. when adopted It is not expected to result in a material impact to the Trust.

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.

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. [Where it is practicable, provide an assessment of the impact of Standards that have not yet been adopted.

Note 1.23 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

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

Impairment

Renal Building Project

The Trust has judged that an impairment review is required for the Renal Building Project. The trigger for the impairment is change in government policy i,e, the NHP review and the overall affordability of the scheme. The impairment is based on a fair value assessment of work help on the balance sheet and whether a reasonable prospect exists of the asset being brought into use within a reasonable timeframe. The Trust does not currently have line of sight to funding for the whole capital cost of the build project. Revenue affordability in a financial challenged health economy will be significant.

Note 1.24 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:

The total balance of intangible, tangible fixed assets and right of use assets as at 31 March 2025 is £520.07m (2023/24 £526.02m) of which £342.83m (2023/24 £365.85m) relates to revalued owned assets and £28.49m (2023/24 £25.27m) relates to revalued leasehold properties.

Where non-estate assets are of low value and/or have short useful economic lives, such as operational equipment, they are carried at depreciated historical cost (cost less any accumulated depreciation) as this is not considered to be materially different from fair value. The lives of equipment assets are estimated using historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Intangible software licences are depreciated over the shorter of the term of the licence and the useful economic life. These are types of estimation, but they are less likely than the valuation of estate assets to present a significant risk of causing material misstatement.

The value and remaining useful lives of estate assets are estimated by the Trust's valuer, Gerald Eve LLP. Valuations are carried out annually and are performed in accordance with the Royal Institute of Chartered Surveyors' RICS Valuation – Global Standards ('Red Book Global Standards') and other relevant RICS guidance notes, primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. In particular, land and building assets at each site are valued as a single combined hospital facility ('single alternative site model'), as described in the previous section. The composition of this alternative replacement model requires the operation of significant levels of professional estimation by the valuer.

This methodology assumes a modern asset equivalent (MEA) approach to valuation of Trust's specialised assets, with replacement buildings being of the same service potential. Inherent within the MEA valuation approach, using the depreciated replacement cost, is the Build Cost Information Service Indices (BCIS) input, A 2 - 3% change in BCIS build costs during the year would generate changes of circa 2 - 3% in the asset valuation

Because the Trust undertakes annual revaluations of estate assets, estimation uncertainty relating to asset lives and depreciation does not present significant risk of causing material adjustments.

However, as in previous years, the Trust’s reliance on valuation methods does present a risk of causing a material adjustment to the carrying amount of non-current assets.

Note 2 Operating Segments

This note is not applicable to St George's University NHS Foundation Trust as the organisation does not consider itself to have more than one operating segment that accounts for at least 10% of total revenue.

Income from ICBs account for 49% (2023/24 - 60%) of the Trust revenue with a further 40% (2023/24 - 26%) from NHS England. No customer external to the NHS accounts for more than 10% of the Trust's revenue hence there are no other segments

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2024/25	Restated 2023/24
	£000	£000
Income from commissioners under API contracts - variable	242,576	225,205
element* Income from commissioners under API contracts -	739,677	707,400
fixed element* High cost drugs income from commissioners	102,378	86,175
Other NHS clinical income	5,018	3,620
Private patient income	1,265	1,386
National pay award central funding***	2,684	551
Additional pension contribution central funding**	45,611	27,577
Other clinical income	16,924	12,138
Total income from activities	**1,156,133**	**1,064,052**

23/24 figures have been adjusted to be consistent with classifications in the 24/25 accounts. Changes between the original and restated 23/24 reflect the full cost of variable and high cost drug elements from all commissioners rather than overperformance against baseline. This is a change in the classification and does not reflect a change to the overall income recognised in 23/24.

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

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available 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-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2024/25	2023/24
Income from patient care activities received from:	**£000**	**£000**
NHS England	485,042	447,182
Integrated care boards	655,219	603,627
Other NHS providers	5,018	3,620
NHS other	272	306
Non-NHS: private patients	1,265	1,386
Non-NHS: overseas patients (chargeable to patient)	4,112	3,769
Injury cost recovery scheme	4,326	2,575
Non NHS: other	878	1,587
Total income from activities	**1,156,133**	**1,064,052**
Of which:		
Related to continuing operations	1,156,133	1,064,052
Related to discontinued operations	-	-

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

	2024/25	2023/24
	£000	£000
Income recognised this year	4,112	3,769
Cash payments received in-year	1,065	336
Amounts added to provision for impairment of receivables	1	3,034
Amounts written off in-year	4,780	0

Note 4 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	10,315	-	**10,315**	8,011	-	**8,011**
Education and training	42,177	-	**42,177**	39,505	-	**39,505**
Non-patient care services to other bodies	102,525		**102,525**	96,919		**96,919**
Income in respect of employee benefits accounted on a gross basis	12,627		**12,627**	12,692		**12,692**
Receipt of capital grants and donations and peppercorn leases		1,088	**1,088**		504	**504**
Charitable and other contributions to expenditure		-	**-**		177	**177**
Other income	3,304	-	**3,304**	3,562	-	**3,562**
Total other operating income	**170,949**	**1,088**	**172,037**	**160,688**	**681**	**161,369**
Of which:						
Related to continuing operations			172,037			161,369
Related to discontinued operations			-			-

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	1,149,877	1,057,310
Income from services not designated as commissioner requested services	178,293	168,111
Total	**1,328,170**	**1,225,421**

The 2023/24 figure has been restated with an increase of £1.6k on revision.

Note 6.1 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,373	1,797
Purchase of healthcare from non-NHS and non-DHSC bodies	4,563	1,911
Staff and executive directors costs	827,506	746,160
Remuneration of non-executive directors	107	80
Supplies and services - clinical (excluding drugs costs)	145,211	132,357
Supplies and services - general	60,081	58,203
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	112,986	100,839
Consultancy costs	2,695	934
Establishment	10,128	12,481
Premises	46,833	30,155
Transport (including patient travel)	12,779	11,053
Depreciation on property, plant and equipment	36,908	44,645
Amortisation on intangible assets	6,157	6,334
Net impairments	10,254	115,859
Movement in credit loss allowance: contract receivables / contract assets	4,266	2,688
Increase/(decrease) in other provisions	311	132
audit services- statutory audit	361	215
Internal audit costs	217	170
Clinical negligence	25,955	25,274
Legal fees	1,289	613
Insurance	160	137
Education and training	2,947	3,236
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,333	1,159
Car parking & security	270	594
Losses, ex gratia & special payments	145	119
Other services, eg external payroll	312	1,275
Other	6,263	22,761
Total	**1,321,411**	**1,321,181**
Of which:		
Related to continuing operations	1,321,411	1,321,181
Related to discontinued operations	-	-

Audit Fees

The fees reconciles to the Financial statement as follows		
Statutory Audit Fee	300,650	179,355
VAT	60,130	35,871
Total Audit fee 2023/24	**360,780**	**215,226**

Statutory Audit fees is inclusive of VAT

Note 6.2 Other auditor remuneration

	2024/25	2023/24
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
Total		

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2,000k (2023/24: £2,000k).

Note 7 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	5	-
Abandonment of assets in course of construction	11,581	-
Changes in market price	(1,312)	114,137
Other	(20)	1,722
Total net impairments charged to operating surplus / deficit	**10,254**	**115,859**
Impairments charged to the revaluation reserve	5,257	13,920
Total net impairments	**15,511**	**129,779**

The Trust has judged that an impairment review is required for the Renal Building Project The trigger for the impairment is change in government policy i,e, the NHP review and the overall affordability of the scheme. • The impairment is based on a fair value assessment of work help on the balance sheet and whether a reasonable prospect exists of the asset being brought into use within a reasonable timeframe. • The Trust does not currently have line of sight to funding for the whole capital cost of the build project. • Revenue affordability in a financial challenged health economy will be significant.

Note 8 Employee benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	630,815	570,374
Social security costs	67,770	63,671
Apprenticeship levy	3,583	2,422
Employer's contributions to NHS pensions	115,424	90,782
Pension cost – other	28	49
Temporary staff (including agency)	12,783	18,862
Total gross staff costs	**830,403**	**746,160**
Recoveries in respect of seconded staff	-	-
Total staff costs	**830,403**	**746,160**
Of which		
Costs capitalised as part of assets	2,897	-

Note 8.1 Retirements due to ill-health

During 2024/25 there were 7 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £570k (£248k in 2023/24).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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.

C) National Employment Savings Scheme (NEST)

The Trust offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), for those members of staff who do not qualify for the NHS pension scheme.

Note 10 Finance income

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	3,496	1,947
Total finance income	**3,496**	**1,947**

Note 11.1 Finance expenditure

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	203	217
Interest on other loans	3	27
Interest on lease obligations	5,046	5,335
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	8,955	8,889
Remeasurement of the liability resulting from change in index or rate	3,239	2,135
Total interest expense	**17,448**	**16,603**
Unwinding of discount on provisions	105	103
Total finance costs	**17,553**	**16,706**

Note 11.2 The late payment of commercial debts (interest) Act 1998

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

Note 12 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	19	160
Losses on disposal of assets	(578)	(956)
Total gains / (losses) on disposal of assets	**(559)**	**(796)**
Total other gains / (losses)	**(559)**	**(796)**

The Trust dispose £4.8m (£1.9m 23/24) of old plant and equipment in 2024/25 There were expired leases of £.01m (£5.9m in 23/24) with 0 net book value.

Note 13.1 Intangible assets - 2024/25

		Software licences	Internally generated information technology	Total
		£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward		**2,790**	**63,312**	**66,102**
Additions		91	354	**445**
Reclassifications		(41)	207	**166**
Disposals / derecognition		(828)	(385)	**(1,213)**
Valuation / gross cost at 31 March 2025		**2,012**	**63,488**	**65,500**
Amortisation at 1 April 2024 - brought forward		**1,535**	**32,368**	**33,903**
Provided during the year		342	5,815	**6,157**
Disposals / derecognition		(828)	(385)	**(1,213)**
Amortisation at 31 March 2025		**1,049**	**37,798**	**38,847**
Net book value at 31 March 2025	**963**		**25,690**	**26,653**
Net book value at 1 April 2024	**1,255**		**30,944**	**32,199**

Note 13.2 Intangible assets - 2023/24

		Software licences	Internally generated information technology	Total
		£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated		**2,474**	**63,311**	**65,785**
Additions		318	5	**323**
Impairments		11	(11)	**-**
Reclassifications		284	7	**291**
Disposals / derecognition		(297)	-	**(297)**
Valuation / gross cost at 31 March 2024		**2,790**	**63,312**	**66,102**
Amortisation at 1 April 2023 - as previously stated		**1,474**	**26,392**	**27,866**
Provided during the year		351	5,983	**6,334**
Impairments		7	(7)	**-**
Disposals / derecognition		(297)	-	**(297)**
Amortisation at 31 March 2024		**1,535**	**32,368**	**33,903**
Net book value at 31 March 2024	**1,255**		**30,944**	**32,199**
Net book value at 1 April 2023	**1,000**		**36,919**	**37,919**

Note 14.1 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	**47,907**	**286,839**	**113**	**59,970**	**75,488**	**6,588**	**32,451**	**7,595**	**516,950**
Additions	-	9,243	-	28,892	1,824	-	2,094	5	**42,058**
Impairments	(2)	(8,182)	-	(9,273)	-	-	-	-	**(17,457)**
Reversals of impairments	17	4,510	-	-	-	-	-	-	**4,527**
Revaluations	1,312	(6,189)	-	-	-	-	-	-	**(4,877)**
Reclassifications	-	7,376	-	(16,731)	3,912	-	5,216	20	**(207)**
Disposals / derecognition	-	-	-	-	(2,990)	(5,223)	(14,479)	(1,618)	**(24,310)**
Valuation/gross cost at 31 March 2025	**49,234**	**293,597**	**113**	**62,858**	**78,234**	**1,365**	**25,282**	**6,002**	**516,684**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**4**	**32**	**-**	**38,514**	**601**	**25,314**	**4,814**	**69,280**
Provided during the year	-	15,038	4	-	9,587	398	4,002	536	**29,565**
Revaluations	-	(15,042)	-	-	-	-	-	-	**(15,042)**
Reclassifications	-	-	-	-	-	-	(41)	-	**(41)**
Disposals / derecognition	-	-	-	-	(2,683)	(737)	(14,479)	(1,618)	**(19,517)**
Accumulated depreciation at 31 March 2025	**-**	**(0)**	**36**	**-**	**45,418**	**262**	**14,796**	**3,732**	**64,245**
Net book value at 31 March 2025	**49,234**	**293,597**	**77**	**62,858**	**32,815**	**1,103**	**10,486**	**2,270**	**452,439**
Net book value at 1 April 2024	**47,907**	**286,835**	**81**	**59,970**	**36,973**	**5,987**	**7,137**	**2,781**	**447,670**

Land valuation:

The Trust has updated the valuation of its land and buildings in these financial statements. The valuation report was prepared by an independent valuer, Gerald Eve LLP, a firm of professionally (RICS) qualified valuers. The valuation was effective from 31 March 2025 .

The Trust changed the basis of the valuation of the land on the St George's Hospital site to an alternative site basis in 2015/16 and has maintained this basis of valuation in 2024/25. This alternative site basis applies the principle of the modern equivalent asset (MEA) valuation methodology which values land and buildings at the cost that would be incurred if they had to be replaced. The valuation methodology allows the use of feasible alternative sites to value the land required to locate the Trust's buildings Including RoU assets buildings, and still serve the same local population. Gerald Eve LLP has identified an alternative site in Merton and has formulated a valuation for the land using relevant valuation metrics. The Trust considers that the Merton site identified by the valuer as the alternative site for valuation purposes is reasonable and consistent with the provision of the services from the current location as it is near the St George's Hospital site in Tooting.

The applicable valuation principles make clear that where specialised buildings e.g., hospital facilities are involved and re-provision of buildings on the existing site would represent a waste of economic resources then a feasible lower cost site may be valued as an alternative. The Trust is satisfied the assumptions underpinning the valuation of the St George's Hospital site including Rou assets buildings, on the alternative site basis in these financial statements is reasonable and consistent with the principles of the alternative site valuation method.

Note 14.2 Property, plant and equipment - 2023/24

	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 2023 - as previously stated	**50,090**	**291,211**	**113**	**61,339**	**73,752**	**-**	**31,388**	**7,595**	**515,487**
Additions	-	9,065	-	21,521	921	1,718	680	-	**33,905**
Impairments	(2,353)	(19,697)	-	-	-	-	-	-	**(22,050)**
Revaluations	170	(8,256)	-	-	-	-	-	-	**(8,086)**
Reclassifications	-	14,516	-	(22,890)	5,447	4,870	1,281	-	**3,224**
Disposals / derecognition	-	-	-	-	(4,632)	-	(898)	-	**(5,530)**
Valuation/gross cost at 31 March 2024	**47,907**	**286,839**	**113**	**59,970**	**75,488**	**6,588**	**32,451**	**7,595**	**516,950**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**(0)**	**28**	**-**	**28,309**	**-**	**20,773**	**4,233**	**53,344**
Provided during the year	-	10,916	4	-	9,414	601	5,439	581	**26,955**
Impairments	-	4	-	-	-	-	-	-	**4**
Revaluations	-	(10,916)	-	-	-	-	-	-	**(10,916)**
Reclassifications	-	-	-	-	3,515	-	-	-	**3,515**
Disposals / derecognition	-	-	-	-	(2,724)	-	(898)	-	**(3,622)**
Accumulated depreciation at 31 March 2024	**-**	**4**	**32**	**-**	**38,514**	**601**	**25,314**	**4,814**	**69,280**
Net book value at 31 March 2024	**47,907**	**286,835**	**81**	**59,970**	**36,973**	**5,987**	**7,137**	**2,781**	**447,670**
Net book value at 1 April 2023	**50,090**	**291,211**	**85**	**61,339**	**45,442**	**-**	**10,615**	**3,362**	**462,143**

Note 14.3 Property, plant and equipment financing - 31 March 2025

	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
Owned - purchased	48,011	235,448	77	62,858	29,677	1,103	10,486	2,242	**389,901**
On-SoFP PFI contracts and other service concession arrangements	-	46,426	-	-	-	-	-	-	**46,426**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - donated/granted	1,223	11,723	-	-	3,138	-	-	28	**16,112**
Total net book value at 31 March 2025	**49,234**	**293,597**	**77**	**62,858**	**32,815**	**1,103**	**10,486**	**2,270**	**452,439**

Note 14.4 Property, plant and equipment financing - 31 March 2024

	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
Owned - purchased	46,732	227,147	81	59,970	33,346	5,987	7,137	2,742	**383,141**
On-SoFP PFI contracts and other service concession arrangements	-	47,294	-	-	-	-	-	-	**47,294**
Owned - donated/granted	1,175	12,394	-	-	3,627	-	-	39	**17,235**
Total net book value at 31 March 2024	**47,907**	**286,835**	**81**	**59,970**	**36,973**	**5,987**	**7,137**	**2,781**	**447,670**

Note 15 Donations of property, plant and equipment

The Trust has recognised capital donations receivable towards the cost of various items of medical equipment. These donations are receivable from the St George's Hospital Charity and other various charitable organisations.

Note 16 Revaluations of property, plant and equipment

In 2024/25 the Trust commissioned a valuation of its land and buildings by an independent valuer, Gerald Eve LLP, a firm of professionally (RICS) qualified valuers. The effective date of the revaluation was 31 March 2025 and the results of the valuation are included in these accounts. The valuations were prepared on the modern equivalent asset (MEA) basis applicable to NHS Trusts.

The Trust changed the basis of the valuation of the land on the St George's Hospital site to an alternative site basis in 2015/16 and has maintained this basis of valuation in 2024/25. This alternative site basis applies the principle of the modern equivalent asset (MEA) valuation methodology which values land and buildings at the cost that would be incurred if they had to be replaced. The valuation methodology allows the use of feasible alternative sites to value the land required to locate the modern equivalent replacement of the Trust's buildings and still serve the same local population. Gerald Eve LLP has identified an alternative site in Merton and has formulated a valuation for the land using relevant valuation metrics. The Trust considers that the Merton site identified by the valuer as the alternative site for valuation purposes is reasonable and consistent with the provision of the services from the current location as it is near the St George's Hospital site in Tooting. Gerald Eve LLP have valued the existing buildings as they stand using Gross Internal Floor areas provided by the Trust by reference to the cost of providing a modern equivalent asset capable of delivering the required service provision. In instances where buildings or parts of buildings would not form part of the MEA, then this has been reflected in the valuation.

The applicable valuation principles make clear that where specialised buildings e.g. hospital facilities are involved and re-provision of buildings on the existing site would represent a waste of economic resources then a feasible lower cost site may be valued as an alternative. The Trust is satisfied the assumptions underpinning the valuation of the St George's Hospital site on the alternative site basis in these financial statements is reasonable and consistent with the principles of the alternative site valuation method.

In 2016/17 the Trust changed the basis of valuation for Atkinson Morley wing to exclude VAT on the grounds that this building is financed by a PFI scheme for which the VAT on the unitary charges payable by the Trust is recoverable. This treatment is permitted under a change in the applicable valuation techniques effective from 2016/17 onwards.

Buildings are subject to composite depreciation rates according to their elemental breakdown eg substructure 80 years, internal wall 25 years etc.

Plant and Machinery: 5-25 years
Building : 1-115 years
Fixtures & Fittings: 7-15 years
Information technology: 3-16 years
Transport equipment: 10 years
Dwellings: 15-80 years

There is no compensation from third parties for assets impaired, lost or given up that is included in the Trust's deficit for the year.

The Trust's external valuers, Gerald Eve LLP, provided a valuation for land and buildings in 24/25. Market trends and forecasts are a prediction based on current data and historic trends and have the potential to change with consumer behaviour. The net book value of land and buildings at the 31 March 2025 is £343m (2024 £335m)

This year the Trust undertook valuations for some of its leasehold assets and this resulted in a decrease in the valuations of these compared to the previous year's value which had been derived from the cost model. The leases that were valued were those where it was determined that the annual payments were not regularly adjusted in line with the market. Following the RICS guidance the valuers estimated the market rent, which in general was lower than the annual payments which often included other non-rental charges. The valuers also adopted market derived yields which were above the prescribed HM Treasury discount rate. Both these reasons caused the valuations to be lower than the previous year's ROU asset values.

In 2024/25the Trust had an net impairment of £15.5m (2023/24 129.8m). There was a decrease in the value of land of £2k (2022/23 £2.3m decrease) and a decrease in buildings of £5.9m (2023/24 17.8m decrease). In relation to decrease in the buildings £5.2m (2023/24 £11.64m decrease) was charged to the revaluation reserve and £10.3m (2023/24 £115.9m) which was made up of PPE £7.7m and IFRS16 £2.6m (2023/24 PPE £8.1m and IFRS16 £107.7m) was charged to operating expenses as there was insufficient balance in the revaluation reserve for the asset.

Note Leases - St George's University Hospitals NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust has a number of leases for high value capital medical equipment including MRI scanners, CT scanners and ultrasound equipment and building.

Note 17.1 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**38,466**	**24,691**	**138**	**63,295**	**36,247**
Additions	-	495	28	**523**	-
Remeasurements of the lease liability	4,258	-	-	**4,258**	4,750
Movements in provisions for restoration / removal costs	(24)	-	-	**(24)**	(24)
Impairments	(4,914)	-	-	**(4,914)**	(4,914)
Reversal of impairments	2,335	-	-	**2,335**	1,716
Revaluations	(3,314)	-	-	**(3,314)**	(3,314)
Disposals / derecognition	(5)	-	-	**(5)**	(5)
Valuation/gross cost at 31 March 2025	**36,802**	**25,186**	**166**	**62,154**	**34,384**
Accumulated depreciation at 1 April 2024 - brought forward	**1,884**	**15,131**	**131**	**17,146**	**1,340**
Transfers by absorption	-	-	-	**-**	-
Provided during the year	4,549	2,763	31	**7,343**	4,191
Impairments	2	-	-	**2**	2
Revaluations	(3,314)	-	-	**(3,314)**	(3,314)
Disposals / derecognition	(3)	-	-	**(3)**	(3)
Accumulated depreciation at 31 March 2025	**3,118**	**17,894**	**162**	**21,174**	**2,216**
Net book value at 31 March 2025	**33,684**	**7,292**	**4**	**40,980**	**32,168**
Net book value at 1 April 2024	**36,582**	**9,560**	**7**	**46,149**	**34,907**

Net book value of right of use assets leased from other NHS providers	2,496
Net book value of right of use assets leased from other DHSC group bodies	29,672

Note 17.2 Right of use assets - 2023/24

		Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
		£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward		**167,429**	**21,502**	**74**	**189,005**	**164,670**
Additions		654	3,189	64	**3,907**	381
Remeasurements of the lease liability		1,279	-	-	**1,279**	995
Movements in provisions for restoration / removal costs		2,513	-	-	**2,513**	2,156
Impairments		(107,725)	-	-	**(107,725)**	(106,823)
Revaluations		(25,684)	-	-	**(25,684)**	(25,132)
Valuation/gross cost at 31 March 2024		**38,466**	**24,691**	**138**	**63,295**	**36,247**
Accumulated depreciation at 1 April 2023 - brought forward		13,010	12,090	40	**25,140**	12,555
Provided during the year		14,558	3,041	91	**17,690**	13,917
Revaluations		(25,684)	-	-	**(25,684)**	(25,132)
Accumulated depreciation at 31 March 2024		**1,884**	**15,131**	**131**	**17,146**	**1,340**
Net book value at 31 March 2024	**36,582**		**9,560**	**7**	**46,149**	**34,907**
Net book value at 1 April 2023	**154,419**		**9,412**	**34**	**163,865**	**152,115**

Net book value of right of use assets leased from other NHS providers	2,937
Net book value of right of use assets leased from other DHSC group bodies	31,970

Note 17.3 Revaluations of right of use assets

The Trust RoU assets were revalued as part of the revaluation of assets in 2024/25

Note 17.4 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 23.1.

	2024/25 £000	2023/24 £000
Carrying value at 1 April	**151,733**	**161,218**
Carrying value at 1 April - restated	**151,733**	**161,218**
Transfers by absorption	-	-
Lease additions	523	3,907
Lease liability remeasurements	4,258	1,279
Interest charge arising in year	5,046	5,335
Early terminations	(21)	-
Lease payments (cash outflows)	(19,992)	(20,006)
Carrying value at 31 March	**141,547**	**151,733**

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

Note 17.5 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:		16,964	14,104	11,784
- not later than one year;	19,409	66,508	57,140	50,181
- later than one year and not later than five years;	71,856	74,097	80,489	79,469
- later than five years.	74,446	**157,569**	**151,733**	**141,434**
Total gross future lease payments	**165,711**	(23,553)	-	-
Finance charges allocated to future periods	(24,164)	**134,016**	**151,733**	**141,434**
Net lease liabilities at 31 March 2025	**141,547**			
Of which:		1,638		1,904
Leased from other NHS providers		132,378		139,530
Leased from other DHSC group bodies				

Note 18 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	4,746	5,876
Consumables	10,299	12,541
Total inventories	**15,045**	**18,417**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £181,463k (2023/24: £154,909k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £0k).

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 £177k 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.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 19.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	60,305	66,507
Allowance for impaired contract receivables / assets	(13,331)	(14,328)
Prepayments (non-PFI)	14,509	6,675
PDC dividend receivable	1,143	3,481
VAT receivable	5,415	1,619
Other receivables	2,361	4,695
Total current receivables	**70,401**	**68,649**
Non-current		
Contract receivables	10,426	10,635
Other receivables	1,252	1,208
Total non-current receivables	**11,678**	**11,843**

Of which receivable from NHS and DHSC group bodies:		
Current	32,551	37,858
Non-current	1,252	1,208

Note 19.2 Allowances for credit losses

	2024/25	2023/24
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**14,328**	**11,996**
Allowances as at 1 April - restated	**14,328**	**11,996**
New allowances arising	4,266	2,688
Utilisation of allowances (write offs)	(5,263)	(356)
Allowances as at 31 Mar 2025	**13,331**	**14,328**

Note 19.3 Exposure to credit risk

The Trust has carried out a review of 24/25 receivables and there is no material exposure to credit risks.

Note 20.1 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	**48,550**	**58,546**
At 1 April (restated)	**48,550**	**58,546**
Net change in year	31,847	(9,996)
At 31 March	**80,397**	**48,550**
Broken down into:		
Cash at commercial banks and in hand	43	167
Cash with the Government Banking Service	80,354	48,383
Total cash and cash equivalents as in SoFP	**80,397**	**48,550**
Total cash and cash equivalents as in SoCF	**80,397**	**48,550**

Note 21.1 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	44,715	26,038
Capital payables	7,345	13,509
Accruals	75,138	63,658
Social security costs	8,126	8,364
Other taxes payable	9,725	8,697
Pension contributions payable	10,226	9,496
Other payables	51	11
Total current trade and other payables	**155,326**	**129,773**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	11,779	6,603
Non-current	-	-

Note 22 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	19,187	15,159
Total other current liabilities	**19,187**	**15,159**

Note 23.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from DHSC	674	679
Other loans	-	739
Lease liabilities	14,843	14,104
Obligations under PFI or other service concession contracts	3,154	2,749
Total current borrowings	**18,671**	**18,271**
Non-current		
Loans from DHSC	8,432	9,034
Lease liabilities	126,704	137,629
Obligations under PFI or other service concession contracts	82,315	82,336
Total non-current borrowings	**217,451**	**228,999**

Borrowings from the Department of Health and Social Care

DHSC capital loans

1. The Trust drew down a DHSC capital loan of £14.7m in 2014/15 and 2015/16. This capital loan is repayable over 25 years at a fixed interest rate of 2.2%. The Trust repaid £0.6m of these loans in 2024/25. As at 31/03/25 the balance owed by the Trust on this loan is £9.04m.

London Energy Efficiency Fund

2. The Trust received a loan from the London Energy Efficiency Fund (LEEF) for £13.3m in 2014/15 to finance an energy performance contract capital project with British Gas. The LEEF loan is repayable over 10 years at a fixed interest rate of 0.67% for the period July 2014 to March 2015 inclusive and a fixed interest rate of 1.81% thereafter. The Trust repaid £739k of this loan in 2024/25. As at 31/03/25 the balance owed by the Trust on this loan is £0k.

Note 23.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**9,713**	**739**	**151,733**	**85,085**	**247,270**
Cash movements:					
Financing cash flows - payments and receipts of principal	(602)	(739)	(14,946)	(2,855)	**(19,142)**
Financing cash flows - payments of interest	(208)	(3)	(5,046)	(8,955)	**(14,212)**
Non-cash movements:					
Additions	-	-	523	-	**523**
Lease liability remeasurements	-	-	4,258	-	**4,258**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				3,239	**3,239**
Application of effective interest rate	203	3	5,046	8,955	**14,207**
Early terminations	-	-	(21)	-	**(21)**
Carrying value at 31 March 2025	**9,106**	**-**	**141,547**	**85,469**	**236,122**

	Loans from DHSC	Other loans	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2023	**10,321**	**2,227**	**161,218**	**37,559**	**211,325**
Cash movements:					
Financing cash flows - payments and receipts of principal	(602)	(1,478)	(14,671)	(2,488)	**(19,239)**
Financing cash flows - payments of interest	(223)	(27)	(5,335)	(8,889)	**(14,474)**
Non-cash movements:					
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023				47,879	**47,879**
Additions	-	-	3,907	-	**3,907**
Lease liability remeasurements	-	-	1,279	-	**1,279**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				2,135	**2,135**
Application of effective interest rate	217	27	5,335	8,889	**14,468**
Other changes	-	(10)	-	-	**(10)**
Carrying value at 31 March 2024	**9,713**	**739**	**151,733**	**85,085**	**247,270**

Note 24 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2024	**759**	**233**	**3,970**	**4,962**
Change in the discount rate	1	-	(12)	**(11)**
Arising during the year	120	176	58	**354**
Utilised during the year	(130)	-	(44)	**(174)**
Reversed unused	-	-	(24)	**(24)**
Unwinding of discount	18	-	150	**168**
At 31 March 2025	**768**	**409**	**4,098**	**5,275**
Expected timing of cash flows:				
- not later than one year;	-	409	185	**594**
- later than one year and not later than five years;	767	-	157	**924**
- later than five years.	1	-	3,756	**3,757**
Total	**768**	**409**	**4,098**	**5,275**

The provision for pension costs is calculated using information provided by the NHS Business Services Authority. The provision for legal claims has been calculated using figures and estimated probabilities supplied by the NHS Resolution, the Trust's solicitors and the Trust's Human Resources department.

Note 24.1 Clinical negligence liabilities

At 31 March 2025, £369,919k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2024: £309,644k).

Note 25 Contingent assets and liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	(26)	(41)
Gross value of contingent liabilities	**(26)**	**(41)**
Net value of contingent liabilities	**(26)**	**(41)**
Net value of contingent assets	**-**	**-**

Note 26 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	2,342	21,869
Intangible assets	55	-
Total	**2,397**	**21,869**

Note 27 On-SoFP PFI or other service concession arrangements

Note 27.1 On-SoFP PFI or other service concession arrangement obligations

The following obligations in respect of the PFI or other service concession arrangements are recognised in the statement of financial position:

	31 March 2025 £000	31 March 2024 £000
Gross PFI or other service concession liabilities	**159,436**	**164,967**
Of which liabilities are due		
- not later than one year;	11,810	11,377
- later than one year and not later than five years;	47,240	45,508
- later than five years.	100,386	108,082
Finance charges allocated to future periods	(73,967)	(79,882)
Net PFI or other service concession arrangement obligation	**85,469**	**85,085**
- not later than one year;	3,154	2,749
- later than one year and not later than five years;	16,285	14,200
- later than five years.	66,030	68,136

The Trust signed a private finance initiative (PFI) contract in March 2000 for the exclusive use of the new Atkinson Morley wing on the St George's Hospital site. The new wing was commissioned in August 2003 and the 35 year lease for the wing started from this date. At the end of the 35 year term the Trust has the right to exercise the option to acquire the building at a nominal cost. The contract is with Blackshaw Healthcare Services Ltd, a special purpose vehicle company which is responsible for the maintenance of the building and the availability of the facilities within the building. On the adoption of International Financial Reporting Standards (IFRS) in 2008/09 the Trust accounted for the scheme as an on-statement of financial position PFI scheme and therefore the £50m original capital value of the facility was included within property plant and equipment and the associated finance lease creditor within borrowings. The building is depreciated and revalued on a consistent basis with purchased buildings.

Note 27.2 Total on-SoFP PFI and other service concession arrangement commitments

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

	31 March 2025 £000	31 March 2024 £000
Total future payments committed in respect of the PFI or other service concession arrangements	**176,762**	**181,380**
Of which payments are due:		
- not later than one year;	13,142	12,439
- later than one year and not later than five years;	52,571	50,046
- later than five years.	111,049	118,895

Note 27.3 Analysis of amounts payable to service concession operator

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

	2024/25 £000	2023/24 £000
Unitary payment payable to service concession operator	**13,143**	**12,536**
Consisting of:		
- Interest charge	8,955	8,889
- Repayment of balance sheet obligation	2,855	2,488
- Service element and other charges to operating expenditure	1,333	1,159
Total amount paid to service concession operator	**13,143**	**12,536**

Note 28 Financial instruments

Note 28.1 Financial risk management

IAS 32 defines financial instrument as a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Examples of financial assets are cash or a contractual right to receive cash.

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The Trust is not exposed to the degree of financial risk faced by business entities because of the continuing service provider relationship that the Trust has with intergrated care boards and the way those bodies are financed. 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.

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 minimal overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure subject to affordability as confirmed by the regulator. 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 also borrows from government to finance working capital and to finance operating losses using working capital loans and working capital facilities respectively. These borrowings are at fixed rates of interest. The Trust has a loan with the London Energy Efficiency Fund to finance capital expenditure which is also at a fixed rate of interest. Therefore the Trust has low exposure to interest rate fluctuations.

Credit risk

The Trust has low exposure to credit risk because the majority of the Trust's revenue comes from contracts with other public sector bodies. The maximum exposures as at 31 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 primarily under contracts with integrated care boards which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks in terms of the timing of payments for most of its receivables. The Trust has incurred operating deficits since 2014/15 and this has necessitated borrowing from government to maintain liquidity in previous years, The Trust has not borrowed funds in 23/24 and 24/25

Note 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	54,376	-	**54,376**
Cash and cash equivalents	80,397	-	**80,397**
Total at 31 March 2025	**134,773**	**-**	**134,773**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	67,475	-	**67,475**
Cash and cash equivalents	48,550	-	**48,550**
Total at 31 March 2024	**116,025**	**-**	**116,025**

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025

	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	9,106	**9,106**
Obligations under leases	141,547	**141,547**
Obligations under PFI, LIFT and other service concession contracts	85,469	**85,469**
Trade and other payables excluding non financial liabilities	113,058	**113,058**
Total at 31 March 2025	**349,180**	**349,180**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	9,713	**9,713**
Obligations under leases	151,733	**151,733**
Obligations under PFI, LIFT and other service concession contracts	85,085	**85,085**
Other borrowings	739	**739**
Trade and other payables excluding non financial liabilities	92,043	**92,043**
Total at 31 March 2024	**339,313**	**339,313**

Note 28.4 Maturity of financial liabilities

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

	31 March 2025	31 March 2024
	£000	£000
In one year or less	145,069	119,055
In more than one year but not more than five years	122,134	105,743
In more than five years	181,505	195,996
Total	**448,708**	**420,794**

Note 28.5 Fair values of financial assets and liabilities

The Trust considers that the fair value of financial assets and financial liabilities are the same as book value.

Note 29 Losses and special payments

	2024/25		2023/24	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Bad debts and claims abandoned	1,407	5,377	1,440	5,781
Stores losses and damage to property	20	125	15	122
Total losses	**1,427**	**5,502**	**1,455**	**5,903**
Special payments				
Ex-gratia payments	46	15	31	20
Special severance payments	2	77	-	-
Total special payments	**48**	**92**	**31**	**20**
Total losses and special payments	**1,475**	**5,594**	**1,486**	**5,923**
Compensation payments received				

Note 30 Related parties

St Georges University Hospitals is a Foundation Trust within the Department of Health and Social Care. The Department of Health and Social Care is regarded as a related party.

During the year, St George's University HospitalsNHS Foundation Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department, as listed below:-

NHS Foundation Trusts
NHS Trusts
Department of Health and Social Care
Public Health England
Health Education England
ICB's and NHS England
Special Health Authorities
Non - Department Public Bodies
Other DH bodies

The following Organisations had transactions of more than 1m with the Trust in 2024/25

NHS and DHSC Related Party List

NHS Provider Organisation
Guy's & St Thomas' NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
Croydon Health Services NHS Trust
Epsom and St Helier University Hospitals NHS Trust
Kingston Hospital NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
Royal Free London NHS Foundation Trust

Local Authorities
Wandsworth London Borough Council

Integrated Care Boards
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
NHS Frimley ICB
NHS Hampshire and Isle of Wight ICB
NHS Hertfordshire and West Essex ICB
NHS Kent and Medway ICB
NHS Mid and South Essex ICB
NHS North Central London ICB
NHS North East London ICB
NHS North West London ICB
NHS South East London ICB
NHS South West London ICB
NHS Surrey Heartlands ICB
NHS Sussex ICB

Other
NHS England (including regional offices)
HM Revenue & Customs
NHS Property Services
Department for Work and Pensions
NHS Pensions
NHS Blood and Transplant
NHS Resolution
Community Health Partnerships

	Amounts due from Related Party		Amounts owed to related party	
	2024/25	2023/24	`24/25	23/24
	£000	£000	£000	£000
	3,570	4,808	576	
	284	540		
Non - NHS Related party transactions	**3,854**	**5,348**	**576**	
St George's University of London				-
St George's Hospital Charity				
Total				

	Receipts from Related Party		Payments to Related party		
	2024/25	2023/24	2024/25	0	2023/24
	£000	£000	£000		£000
Non - NHS Related party transactions					
St George's University of London	4,332	6,018	9,508		6,144
St George's Hospital Charity	214	1,920	-		-
Total	**4,546**	**7,938**	**9,508**		**6,144**

Under the Requirements of IAS 24 (Related Party Disclosures), the Trust has disclosed as related parties, St George's Hospital Charity - Joint Director, and for St George's University of London - Share of key management personnel, although are not necessarily related parties in line with IAS 24. Nonetheless, the Trust continues to disclose these for transparency purposes

Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust

Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of St George's University Hospitals NHS Foundation 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 in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

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 its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been 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, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector

bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.
Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer 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 and accounts other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report, accounts and quality report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the 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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024-25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the 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:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of 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.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2024-25, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance**,** but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit and risk committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;

- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the audit and risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, fraudulent revenue and expenditure recognition. We determined that the principal risks were in relation to:
  - Journal entries which met a range of criteria defined as part of our risk assessment;
  - Revenue recognition for material streams of patient care income and other operating revenues; and
  - Fraudulent expenditure recognition to meet externally set targets.
- Our audit procedures involved;
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journals meeting a range of criteria defined as part of our risk assessment to select high risk unusual journals;
  - challenging the Trust's estimates and the judgements in order to arrive at the total income from contract variations
    recorded in the financial statements and other manual accruals/deferrals of healthcare income and other revenues;
  - challenging and evaluating assumptions and judgements made by management in its recognition of expenditure accruals at year-end; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the risk of management override of controls through journal entries, the potential for fraud in revenue and expenditure recognition and the potential for fraud through significant accounting estimates. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:

  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework**.**

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 other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter, except on 18 June 2025 we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This was in relation to:

- the Trust's failure during 2024-25 to develop plans for required efficiency savings for 2025-26 which are intrinsic to addressing its underlying deficit and to maintain financial sustainability; and
- the Trust's failure to develop a credible medium term financial plan.

We recommended the Trust should:

- in conjunction with system partners, as part of the development of the system clinical strategy, develop service plans and initiatives that improve the short and medium term underlying financial position of the Trust;
- look to maximise recurrent cost saving opportunities in 2025-26 and quickly progress the development of savings to minimise risk.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting 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 the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

John Paul Cuttle

John Paul Cuttle, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
London
27 June 2025

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St George's University Hospitals
NHS Foundation Trust

2024-25

St George's University Hospitals NHS Foundation Trust

Annual Report and Accounts