

Annual Report and Accounts

2025 – 2026



St George's University Hospitals NHS Foundation Trust Annual Report and Accounts 2025/26

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(4) (a) of the National Health Service Act 2006

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Chair and Chief Executive's foreword

When we reflect on 2025/26, what stands out most is not a particular performance measure or financial result. It is the dedication of our staff.

Every day, across St George's Hospital and Queen Mary's Hospital, thousands of people come to work knowing they will face pressure, complexity and difficult decisions. They do so because they care deeply about the patients and communities we serve. Throughout the year, our staff continued to demonstrate remarkable professionalism, skill and compassion, often in exceptionally challenging circumstances.

As one of the country's leading teaching hospitals and providers of specialist care, we see some of the most complex patients in the NHS. We provide life-saving care for major trauma patients, specialist treatment for children and adults with highly complex conditions, and everyday care for hundreds of thousands of local people. Behind every statistic in this report are individual patients, families and staff, and it is their experience that matters most.

The year brought both progress and challenge. We reduced the longest elective waits, delivered our financial plan and continued to transform outpatient services and digital care. At the same time, we continued to face the pressures affecting the NHS nationally – growing demand, increasing acuity of the patients we treat, ageing infrastructure and continued financial constraint – and our 2025 NHS Staff Survey shows the progress we need to make in developing the empowering and inclusive culture we seek to create across the Trust and our wider Group.

Perhaps most importantly, 2025/26 was also a year in which we looked beyond the immediate pressures of today and focused on the future.

During the year, the Trust completed a major strategic stocktake, developed a new Medium-Term Plan and established a transformation programme designed to support long-term sustainability and improvement. These are not simply organisational programmes. They are about ensuring that future generations continue to receive the high-quality care that our communities rightly expect.

The year also marked an important milestone in the development of the Group. In March 2026, the Boards of St George's and Epsom and St Helier approved submission of a Strategic Case to NHS England setting out the case for a future merger of the two organisations, which will support the delivery of our strategy, the transformation of our services, and the delivery of high quality care to our patients and the communities we serve. Whatever decisions are taken in the future, our focus remains the same: improving care for patients, strengthening services and creating a more resilient organisation for the years ahead.

As we look ahead, we do so with optimism. The challenges facing the NHS are significant, but so too are the opportunities. We have exceptional staff, strong partnerships, a clearer strategic direction and a shared commitment to improvement.

We would like to thank our staff, volunteers, governors, university partners, commissioners, local authorities and system partners for their support throughout the year. Above all, we would like to thank our patients and communities for the trust they place in us every day.

A handwritten signature in black ink, appearing to read 'Mark Lowcock'.

Sir Mark Lowcock
Group Chair
24 June 2026

A handwritten signature in black ink, appearing to read 'Matthew Shaw'.

Matthew Shaw
Group Chief Executive Officer
24 June 2026

About us

For more than 290 years, St George's has been at the forefront of healthcare, medical education and innovation. From the opening of the original St George's Hospital at Hyde Park Corner in 1733 to today's role as one of the UK's leading teaching hospitals, we have continually evolved to meet the changing needs of our patients and our local communities.

Today, St George's is one of the largest and most complex healthcare providers in the country. Across St George's Hospital in Tooting and Queen Mary's Hospital in Roehampton, we provide acute, community and specialist services to a local population of around 1.3 million people. Through our tertiary and highly specialised services, our reach extends far beyond south west London to patients across Surrey, Sussex, Hampshire, the south west of England and nationally, serving a wider population of approximately 3.5 million people.

As a major university teaching hospital, we combine world-class clinical care with research, education and innovation. In partnership with City St George's, University of London, we help train future generations of NHS professionals while advancing research and new models of care that are shaping the future of healthcare. Our clinicians and researchers are recognised nationally and internationally for pioneering work across neurosciences, stroke care, paediatrics, infection, genomics and transplantation.

St George's is home to some of the country's leading specialist services. We are one of London's four major trauma centres and provide hyper-acute stroke, cardiac and specialist neurosciences services for patients across the region. Our helipad enables us to receive and treat some of the most critically ill and severely injured patients from across the south of England. We are also one of London's leading centres for children's services and cancer care, including one of only two designated children's cancer centres in London and the only paediatric intensive care unit in south west London.

Innovation and continuous improvement are central to our identity. St George's was the first hospital in the UK to provide a 24/7 mechanical thrombectomy service for stroke patients, transforming outcomes for people experiencing life-threatening blood clots in the brain. Across our services, we continue to embrace advances in digital technology, research and clinical practice to improve patient outcomes, safety and experience.

In January 2022, St George's became part of the St George's, Epsom and St Helier University Hospitals and Health Group (gesh), alongside Epsom and St Helier University Hospitals NHS Trust. Together, the Group brings two organisations with complementary strengths into one of the largest healthcare groups in the NHS. While both trusts remain sovereign organisations, we increasingly work together as one family of hospitals — collaborating to improve quality, strengthen specialist services, develop our workforce, advance digital innovation and deliver more integrated care for our communities.

The gesh Group strategy, "Outstanding Care, Together", sets out a shared ambition to provide high-quality, compassionate and sustainable healthcare for future generations. Through collaboration across our hospitals, with local partners and across the wider NHS, we are helping shape a more connected and resilient healthcare system for south west London and beyond.

Our organisation may be large and complex, but we retain a strong sense of community, purpose and compassion. More than 10,000 staff from around the world work at St George's, united by a commitment to compassionate care, inclusion, learning and continuous improvement. Together, we are proud to serve our local communities while delivering specialist care, research and innovation with national and international impact.

Performance Report 2025/26

Performance Overview

2025/26 was a year in which the organisation delivered care under sustained operational and financial pressure while progressing significant organisational transformation and further development of the Group operating model with Epsom and St Helier University Hospitals NHS Trust.

Demand remained high across urgent and emergency care, elective pathways and specialist services, while diagnostics, workforce pressures and operational flow continued to affect performance. The Trust was also required to deliver substantial financial efficiencies.

The Trust continued to focus during the year on operational resilience, patient flow, workforce sustainability, financial recovery and quality governance. Emergency care performance remained comparatively strong relative to many London acute providers despite severe winter pressure and increasing patient acuity. The Trust also made substantial progress in reducing very long waits, successfully exiting national elective tiering arrangements after reducing the 65-week cohort from a projected position of around 400 patients to four by December 2025.

Mortality performance has historically been strong at St George's and this was sustained in 2025/26. Outpatient transformation also accelerated during the second half of the year, including expansion of Patient Initiated Follow Up pathways and continued focus on productivity and pathway redesign.

The Trust delivered its financial plan despite sustained operational challenge, delivered £95.3m of cost improvement and ended the year with cash favourable to plan. However, Referral-to-Treatment Time (RTT) performance remained below national expectations, cancer 62-day performance remained challenged and productivity remained below plan. Several quality indicators, including Venous Thromboembolism (VTE) risk assessment, delirium assessment and pressure ulcer prevention, also required improvement.

The organisation continued to face strategic challenges associated with workforce sustainability, productivity, digital transformation and estate infrastructure. Average non-elective length of stay remained above plan throughout much of the year, reflecting the continuing challenge of delayed discharge, high bed occupancy and increasingly complex patient pathways.

Staff continued to demonstrate significant professionalism, resilience and commitment throughout the year. Staff engagement remained above the national average, although sickness absence, organisational culture and inclusion remained important areas of focus, as highlighted in both our 2025 NHS Staff Survey results and in the CQC's Well Led inspection.

The organisation also continued to strengthen governance maturity, operational oversight and organisational learning during the year. This included further development of the Group operating model, strengthening of quality governance arrangements, enhancement of workforce governance and speaking up arrangements and greater integration of financial, operational, workforce and quality oversight processes.

During 2025/26, the Trust also undertook a major strategy stocktake and commenced development of a new Medium-Term Plan and transformation portfolio in response to the NHS 10-Year Plan and increasing financial pressure. The Board recognised that long-term sustainability will depend on improving productivity, redesigning pathways, strengthening workforce resilience, modernising digital and estates infrastructure and delivering transformation at scale.

This Performance Report summarises the Trust's performance during 2025/26 against the CARE strategic framework and the priorities agreed by the Group Board.



Matthew Shaw
Group Chief Executive Officer
24 June 2026

Performance Analysis

Delivering our CARE strategy in 2025/26

2025/26 demonstrated both the resilience of the organisation and the scale of transformation and operational improvement still required across the Trust and wider health and care system.

Performance during 2025/26 was monitored through a combination of operational, workforce, quality and financial indicators aligned to the CARE strategic framework and reported regularly through the Integrated Quality and Performance Reports.



The Trust continued to operate as part of St George's, Epsom and St Helier University Hospitals and Health Group ("gesh"). The Group's CARE strategy continued to provide the organising framework for performance and improvement during the year. Throughout 2025/26, the Trust continued to strengthen alignment between operational performance, financial recovery, workforce sustainability, quality governance and transformation delivery.

Strategy implementation and organisational transformation

The Group strategy, *Outstanding Care, Together 2023-28*, launched in May 2023, continued to provide the organising framework for operational performance, workforce improvement, financial sustainability and transformation activity across the Trust and wider Group.

A formal strategy stocktake was undertaken during the year to assess whether the strategic direction and assumptions agreed in 2023 remained appropriate. The review concluded that the overall direction of the CARE strategy remained broadly right, but that the environment in which the Trust operates had changed significantly.

The Board recognised that the NHS 10-Year Plan, increasing financial pressure and growing emphasis on neighbourhood health and digital transformation required a sharper focus on sustainability, productivity and organisational transformation.

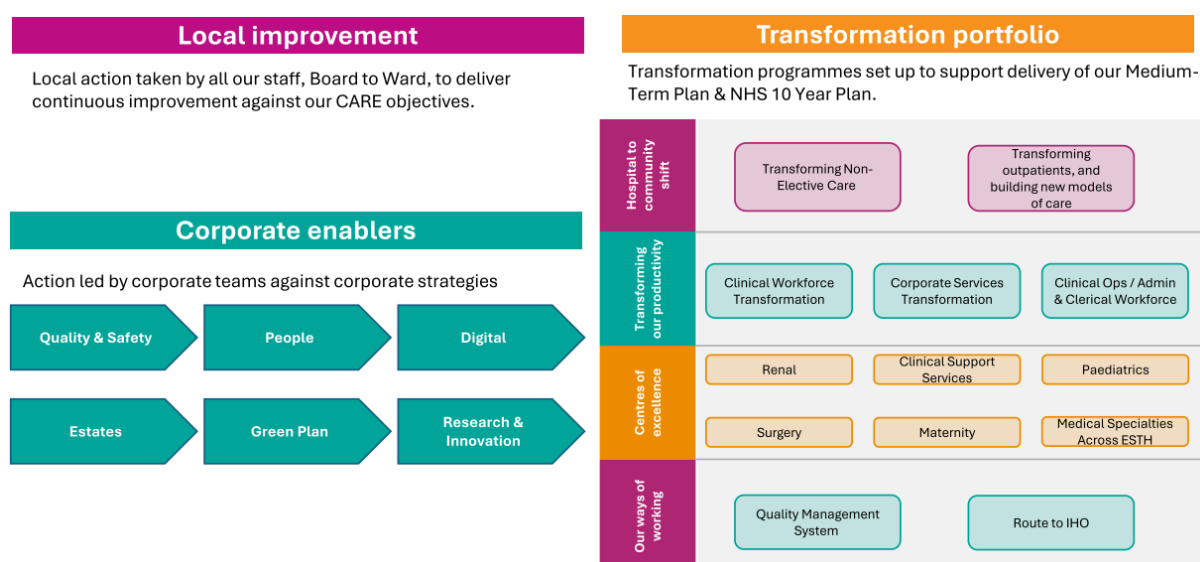
In response, the organisation commenced development of a medium-term plan and transformation programme focused on improving productivity, redesigning outpatient and elective pathways, transforming non-elective care, developing centres of excellence, transforming our workforce both clinical and non-clinical, strengthening digital capability, improving operational flow and supporting longer-term financial sustainability.

A Medium Term Plan was agreed by the Group Board and submitted to NHS England in February 2026, and a narrative five-year plan covering the period 2026/27 to 2030/31 was subsequently endorsed by the Group Board in March 2026. The plan reflected increasing recognition that sustainable improvement will depend on more fundamental redesign of pathways, workforce models, infrastructure and ways of working.

The Board also recognised that long-term transformation would require continued investment in infrastructure resilience, digital capability, workforce development and operational productivity, particularly in the context of estates infrastructure challenges and increasing operational demand across the Trust's services.

To support delivery of the Medium-Term Plan, the Group established a transformation programme comprising 13 major workstreams with quarterly oversight by the Board. The programme was designed to support delivery of the Group's strategic objectives through a coordinated approach to productivity improvement, operational resilience, workforce sustainability, service transformation and long-term financial recovery.

The transformation portfolio brought together a broad range of programmes focused on clinical service transformation, operational flow and urgent care improvement, workforce transformation, corporate services efficiency, digital enablement, infrastructure and estates, research and innovation, quality improvement and future organisational development. During the year, governance arrangements for the programme were strengthened through regular reporting to the Finance and Performance Committee on Medium Term Plan delivery, and to Group Executive Committee and Board on both MTP delivery and delivery of the transformation programme as a whole, together with the development of clear programme accountability and benefits realisation arrangements.



The Board recognised that successful delivery of the Medium-Term Plan would depend on effective implementation of the transformation programme and increasingly viewed transformation delivery as a critical enabler of long-term financial sustainability, operational resilience and service improvement across the Group. As a result, the Group Board agreed to add transformation delivery as a new strategic risk on the Board Assurance Framework as we enter 2026/27.

In March 2026, the Boards of Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust approved submission of a Strategic Case to NHS England setting out the case for a future merger of the two organisations. The Strategic Case reflected the Boards' view that greater organisational integration could support improved patient outcomes, stronger operational resilience, reduced unwarranted variation and enhanced long-term sustainability, supporting the five year vision and our ambitions for transformation. Consideration of the Strategic Case formed part of the wider strategic and transformation planning undertaken during the year.

Collaboration and Partnerships

The objectives of the Collaboration and Partnerships theme within the Group strategy are to work collaboratively across organisational boundaries to deliver more integrated, sustainable and population-focused care for the communities served by the Trust.

In 2025/26, the Trust's priorities under this strategic theme focused on improving patient flow, reducing delayed discharge and strengthening system integration.

Collaboration remained central to the Trust's operational performance during the year. Many of the most significant pressures facing St George's – including urgent and emergency care demand, delayed discharge, elective recovery, diagnostics and cancer pathways – depended heavily on effective partnership working across South West London.

Patient flow remained one of the clearest examples of this interdependency. While St George's maintained performance around the national four-hour emergency care standard for much of the year, sustained pressure on inpatient capacity and discharge continued to affect operational resilience. Average non-elective length of stay remained above plan at 10.2 days in March 2026 against a plan of 8.4 days.

The Trust continued to work with system partners to strengthen discharge pathways, virtual wards, urgent community response and admission avoidance services. Virtual ward occupancy remained above the 80% target during part of the year, supporting patient flow and reducing avoidable admissions.

Collaboration was also increasingly important to elective and cancer recovery. St George's continued to work with Royal Marsden Partners and South West London partners to improve pathway resilience, diagnostic capacity and cancer performance. The Trust also continued to work collaboratively through South West London Pathology, South West London Procurement Partnership, South West London Elective Orthopaedic Centre, and the South West London Recruitment Hub and wider partnerships to improve resilience, productivity and service integration.

During 2025/26, the Trust continued to work closely with NHS South West London Integrated Care Board and system partners in support of urgent and emergency care recovery, discharge improvement, elective recovery, diagnostics, cancer pathways and wider system transformation priorities.

The Board recognised collaboration as central to improving patient flow, access, productivity and long-term sustainability. The Group strategy stocktake, NHS 10-Year Plan and development of the South West London clinical strategy all pointed towards greater integration of services, increased delivery of care outside traditional hospital settings and wider use of digital capability. Our five year vision and transformation programme focus on how we will, as part of the wider system, effect the shift from hospital to community envisaged in the NHS 10 Year Plan.

Affordable Healthcare, Fit for the Future

The objectives of the Affordable Healthcare, Fit for the Future theme within the Group strategy are to deliver financially sustainable healthcare services supported by modern infrastructure, digital transformation and improved productivity.

In 2025/26, the Trust's priorities under this strategic theme focused on financial recovery, productivity improvement and delivery of transformation programmes.

Financial sustainability remained one of the Trust's most significant challenges. At the close of the year, the Trust reported a surplus of £4.9m, which was £4.9m favourable to plan. Delivery of the plan was supported by £95.3m of cost improvement, including a significant non-recurrent element, reflecting the continuing need to improve recurrent productivity and deliver transformation at scale.

Productivity improvement remained a major focus throughout the year. Priorities included outpatient transformation, expansion of Patient Initiated Follow Up pathways, theatre productivity and digital pre-operative assessment. The Trust recognised that long-term sustainability will increasingly depend on redesign of pathways, improved operational flow and greater use of digital capability.

Digital transformation also remained a major enabler of future sustainability. Continued implementation and stabilisation of the shared Electronic Patient Record supported development of common digital processes and greater opportunity for integrated pathways across the Group. The

programme also reinforced the importance of data quality, reporting reliability and operational readiness when delivering major digital change.

Estates and infrastructure remained important constraints on performance. St George's continued to operate from a complex and ageing estate, with limited capital availability. The Trust also continued implementation of its Green Plan, recognising that environmental sustainability, infrastructure resilience and long-term financial sustainability are increasingly interconnected.

Financial performance

The following section should be read alongside the Trust's audited financial statements and accompanying notes.

Financially 2025/26 was a very challenging year. The Trust faced considerable financial pressures that are not immediately evident from the headline position reported, and these pressures will remain as the Trust moves into 2026/27 and beyond.

At the close of the year the Trust reported a surplus of £4.9m which is £4.9m favourable to plan. The favourable position was driven by NHS England redistributing any Deficit Support Funding foregone by systems that did not deliver their plans this year to those providers that did.

However, the underlying challenge in the financial position was much higher than the reported surplus of £4.9m. The reason for the change was driven by two factors, deficit support funding and non-recurrent actions.

The reported deficit includes £40.2m (core) and £4.9m (additional) deficit support funding. The latter drove the year end favourable variance to plan as above. The former was received from NHS England via South West London Integrated Care Board 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 excluded from the reported position the Trust would have reported a deficit of £40.2m. This reflects material pressures that it could not fully address even after a large Cost Improvement Plan (CIP), see below. These include costs associated with productivity challenges, related to the increase in WTE (whole time equivalent staffing) during and shortly post the covid pandemic and structural estates issues.

Non-recurrent benefits within the plan and actual positions also drove the underlying deficit. The Trust included a range of non-recurrent benefits within its plan, and actual positions with a value of £59.9m. These benefits provided one-off improvements to the position in 2025/26 and will not be repeated in 2026/27. This means the challenge in 2026/27 will be greater than that indicated in 2025/26 accounts.

Cost Improvement Programme 2025/26

The Trust identified a plan to deliver £95.3m of CIPs in 25/26, this represented 7.5% of operational expenditure. This target should be seen as very high was set to help address the challenging financial position faced by the Trust. Delivery of this was always seen as challenging.

The full £95.3m of CIP was achieved at year end. Key areas of delivery included clinical productivity in elective care, efficiencies across clinical and corporate services and additional commissioner income support. Of the CIP delivered, £42.8m was non-recurrent.

CIPs are subject to Quality Impact Assessments, for which the Trust has a robust process assessment including review at Divisional, Site and Executive level. Schemes are assessed for their impact on quality and safety and approved where there is assurance that there is no detrimental impact on safety. QIAs for significant CIPs are ultimately signed off by the Group Chief Medical and Group Chief Nursing Officers.

St George's delivered a CIP of £68.5m in the previous year, 2024/25. The total achieved in year represents the seventh year of high CIP delivery by the Trust.

Capital expenditure

The Trust spent £45.25 million of capital in 2025/26. This was funded from internally generated funds, and additional one-off Public Dividend Capital (PDC) funding. The capital funds available to the Trust were used to support ongoing investment in IT, the estate and medical equipment. This level of funding meant that the Trust was able to invest to mitigate key infrastructure risks.

As in previous years, demand 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 services and safe and compliant
- 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)

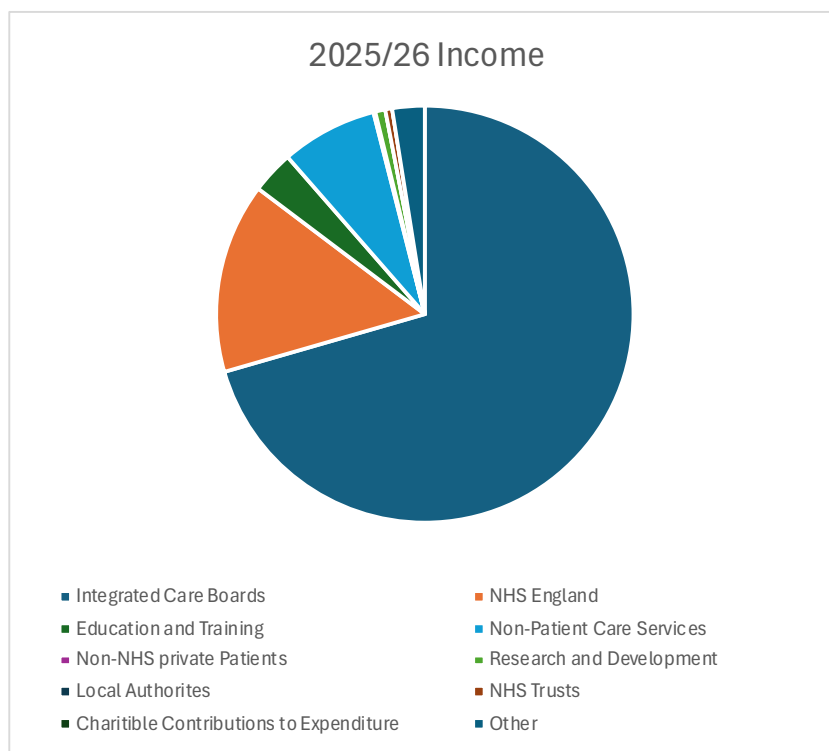
As part of IFRS16 lease standard, £770k medical equipment, £89k transport and £7.88m of building operating leases have been classified as IFRS 16 ROU assets (Right of Use asset) in 2025/26.

The Trust 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.

Contractual payments – where our money comes from

The total income received by the Trust during 2025/26 was £1,386.0m of which £1,199.3m was for clinical services and £186.7m related to income for non-patient care, such as research and development, training and education and facilities income. Income from ICBs and NHS England was £1,182.1m.

Description of Income	2024/25 £'000s	2025/26 £'000s
Integrated Care Boards	655,219	977,643
NHS England	485,042	204,417
Education and Training	42,177	45,721
Non-Patient Care Services	102,525	103,271
Non-NHS private Patients	1,265	2,010
Research and Development	10,315	10,811
Local Authorities	0	0
NHS Trusts	5,018	7,343
Charitable Contributions to Expenditure	0	0
Other	26,608	34,821
Grand Total	1,328,170	1,386,037

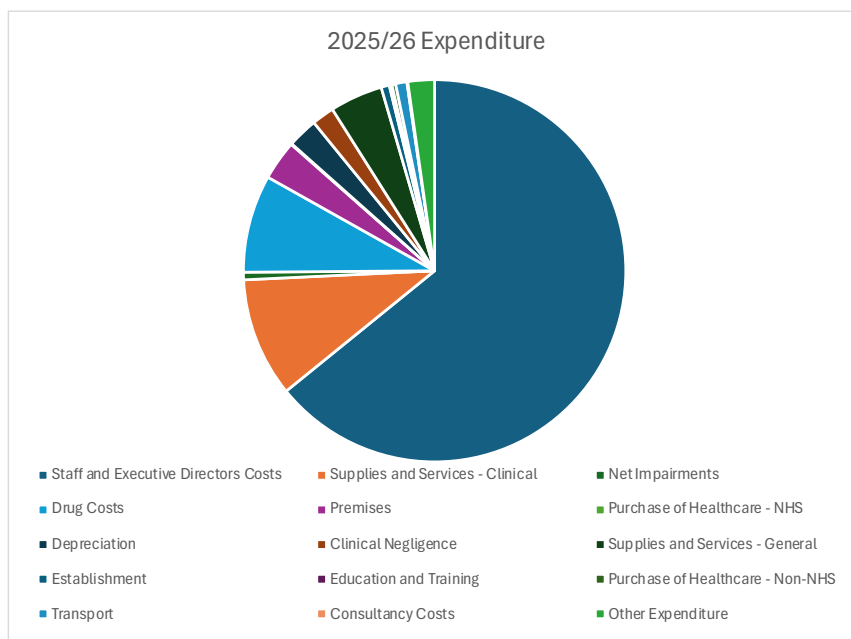


What we spend our money on

The Trust spent £1,369.6m on operating costs during 2025/26, a reported increase of £48.2m from 2024/25. Areas increased in line with inflation offset by delivered cost improvement programmes. The largest area of expenditure was staffing at £878.6m, which accounts for 64.1% of all expenditure, followed by expenditure on clinical supplies and services (excluding drugs) at 10.1%.

The following table and chart shows the breakdown of different types of expenditure incurred by the Trust:

Description of Expenditure	2024/25 £'000s	2025/26 £'000s
Staff and Executive Directors Costs	827,506	878,623
Supplies and Services - Clinical	145,211	138,209
Net Impairments	10,254	8,733
Drug Costs	112,986	113,160
Premises	46,833	46,039
Purchase of Healthcare - NHS	1,373	906
Depreciation	36,908	34,929
Clinical Negligence	25,955	26,038
Supplies and Services - General	60,081	61,221
Establishment	10,128	9,467
Education and Training	2,947	3,089
Purchase of Healthcare - Non-NHS	4,563	4,335
Transport	12,779	13,050
Consultancy Costs	2,695	1,000
Other Expenditure	21,192	30,797
Grand Total	1,321,411	1,369,596



Cash flow

The Trust began the financial year with £80.4m of cash and cash equivalents. During the year, cash balances increased to £103.2m. The increase in cash was driven by additional capital and working capital movements at year end.

Charitable funding

The Trust received £706k from charitable sources during the year, principally from St George's Hospital Charity. The Trust received £0 of donated equipment from the Department of Health and Social Care.

Private Finance Initiative

The Trust 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 the preparation of 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 £8.98m (£5.87m 24/25) reduction in value of some buildings and £2k (£69k 24/25) reduction in value of land. However, there is a £1.66m (£13.34m 24/25) increase in building and £620k (£1.32m 24/25) 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 £3.45m (£4.91m 2024/25) charged to operating expenses as there was insufficient balance in the revaluation reserve for these assets in 2024/25. The adjustments are in line with IFRS16 requirements.

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 the Trust's performance.

Contracts with commissioners

The financial performance regime for 2025/26 from NHS England was that Trusts would be funded through block contracts although more elements would be subject to cost and volume adjustments.

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.

Going concern statement

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 £4.9m surplus financial position for the year ended 31 March 2026 (after adjusting for excluded items against the control total).

The draft financial plan for 26/27 has estimated a breakeven position, having taken account of the underlying financial position going into 2026/27 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 2025/26, 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.

Looking forward to 2026/27

2026/27 will be a very challenging year for the Trust, local systems and the whole of the NHS. The Trust has set a break-even plan for the coming year, which includes deficit support funding of £21.6m. The Board recognises the challenge in delivering this plan as it will require a £90.8m savings programme and further strengthening of financial controls. We are working with the Trust staff, the

wider Group and the South West London system to deliver this. All new expenditure will be subject to review and challenge to appropriately balance quality, delivery and finance.

Environmental sustainability and climate resilience

Environmental sustainability and climate resilience remained important strategic priorities during 2025/26.

The Trust continued implementation of the gesh Green Plan, recognising the close relationship between environmental sustainability, operational resilience and long-term organisational sustainability. Priority areas included estate decarbonisation, sustainable procurement, waste reduction, medicines optimisation, transport and climate adaptation.

Progress during the year included continued estate decarbonisation activity, reduction in anaesthetic gas emissions, expansion of electric vehicle infrastructure, improved waste segregation and further integration of sustainability considerations into procurement, capital planning and service redesign. The Trust also continued to strengthen climate adaptation planning through development of a Climate Change Adaptation and Resilience Risk Assessment aligned to organisational risk management processes. This work recognised the increasing impact that extreme weather events, infrastructure resilience, energy dependency and wider environmental factors may have on healthcare delivery over the short, medium and long term.

Further information on the Trust's approach to climate-related governance, strategy, risk management and performance is set out in the climate-related financial disclosures below.

Climate-related financial disclosures

The Trust has prepared the following climate-related financial disclosures in accordance with Appendix 7 of the NHS Foundation Trust Annual Reporting Manual 2025/26. These disclosures are aligned to the recommendations of the Task Force on Climate-related Financial Disclosures (TCFD) framework and relate specifically to St George's University Hospitals NHS Foundation Trust.

Governance

The Board oversees climate-related issues through the Trust's Green Plan governance arrangements and associated committee reporting structure.

Oversight of environmental sustainability, climate adaptation and climate-related operational risk is provided through the Infrastructure Committee, supported by regular reporting to executive and Board-level committees.

Operational leadership is provided through the Trust's Green Plan governance framework, including oversight of estate decarbonisation, infrastructure resilience, sustainable procurement, waste reduction, medicines optimisation, digital transformation and climate adaptation planning.

During 2025/26, the Trust approved a Climate Change Adaptation and Resilience Risk Assessment to identify climate-related risks affecting operational resilience, estate infrastructure, service delivery and patient demand. Climate-related risks and sustainability priorities are also integrated into wider organisational planning, capital prioritisation and risk management processes.

Strategy

Environmental sustainability and climate resilience are increasingly important strategic considerations for the Trust.

The Trust identified a number of climate-related risks affecting operational resilience, infrastructure and service delivery, including increased demand associated with extreme weather events, disruption

to estate infrastructure, supply chain disruption, workforce disruption and increasing operational pressure associated with heatwaves, flooding and other severe weather events.

The Trust also recognises that climate change may increase demand for healthcare services through worsening cardiovascular and respiratory disease, heat-related illness, infectious disease transmission and increased vulnerability within some patient groups.

Alongside these risks, the Trust identified opportunities associated with environmental sustainability and climate adaptation, including improving energy efficiency, reducing waste and carbon emissions, strengthening estate resilience, redesigning pathways through digital transformation and improving sustainable procurement and clinical models of care.

The Climate Change Adaptation and Resilience Risk Assessment concluded that climate-related operational disruption and infrastructure pressures are likely to increase over the short, medium and long term. Long-term planning and adaptation will therefore become increasingly important to operational resilience and sustainability.

Risk management

Climate-related risks are managed through the Trust's Green Plan governance framework and wider organisational risk management processes.

The Climate Change Adaptation and Resilience Risk Assessment forms the basis of the Trust's climate risk management approach. Risks identified through the assessment are incorporated into Green Plan workstreams, divisional planning processes, business continuity arrangements and wider organisational risk management processes.

Climate-related risks are also integrated into the Trust's risk registers and reviewed through the Trust's governance arrangements alongside wider strategic and operational risks.

Risk mitigation activity during 2025/26 included estate resilience planning, decarbonisation programmes, infrastructure investment, waste reduction initiatives, digital transformation and sustainable procurement activity.

The Trust continues to strengthen links between sustainability planning, infrastructure resilience, capital prioritisation and operational transformation. Climate-related risks and adaptation requirements are expected to become increasingly significant over future planning periods and will continue to form part of the Trust's wider strategic and operational planning framework.

Metrics and targets

The Trust continued implementation of its Green Plan during 2025/26 and monitored progress through a range of sustainability, adaptation and carbon reduction indicators aligned to NHS Net Zero requirements.

The Trust's principal strategic target remains achievement of a 47% reduction in carbon emissions against the 2019/20 baseline by 2032 and achievement of Net Zero by 2040. During 2025/26, St George's reported a 40.52% reduction in carbon emissions against the 2019/20 baseline. Progress during the year included estate decarbonisation activity, reduction in anaesthetic gas emissions, expansion of electric vehicle charging infrastructure, reduction in food waste and continued integration of sustainability considerations into infrastructure planning, procurement and service redesign.

Further progress included expansion of sustainability training and engagement activity, implementation of Green Days across the Trust and continued development of biodiversity and adaptation planning initiatives.

The table below summarises key environmental sustainability metrics reported during 2025/26:

Area	2025/26 performance	Commentary
Carbon emissions reduction	40.52% reduction against 2019/20 baseline	Continued progress towards the NHS Net Zero trajectory and 47% reduction target by 2032.
Clinical waste segregation	15:32:53 ratio against 20:20:60 target	Continued progress towards national clinical waste segregation targets.
Food waste	34 tonnes	Reduction from 85 tonnes in 2024/25 and 150 tonnes in 2023/24 following improved monitoring and waste reduction initiatives.
Digital outpatient appointments	>40% across gesh	Continued expansion of digital outpatient delivery supporting pathway redesign and reduction in travel-related emissions.
Anaesthetic gas emissions	191 tonnes CO ₂ e	Reduction supported by ending desflurane use and implementation of nitrous oxide reduction measures.
Sustainability training and engagement	Monthly sustainability awareness training delivered	Green Plan engagement and sustainability training expanded during the year.
Capital sustainability standards	BREEAM/NZBS compliance programmes continued	Sustainability standards integrated into capital and infrastructure planning.
Travel and transport	EV charging infrastructure programme implemented	Continued transition towards lower carbon transport infrastructure.

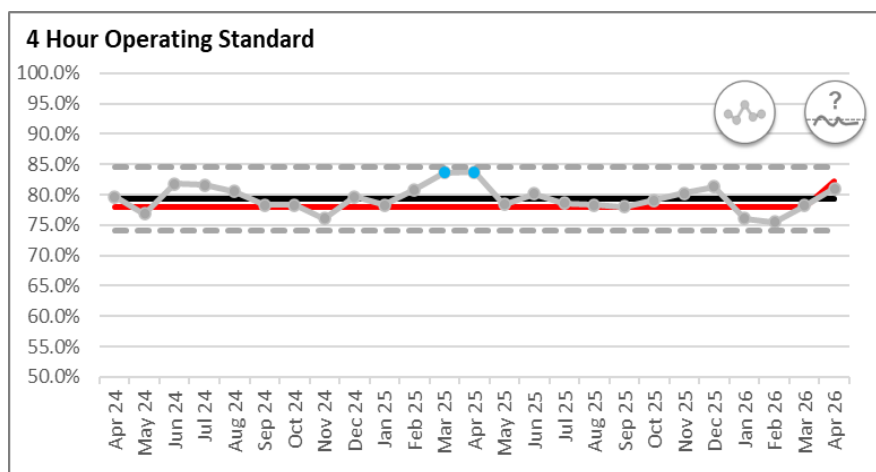
Right Care, Right Place, Right Time

The objectives of the Right Care, Right Place, Right Time theme within the Group strategy are to provide timely, high-quality and safe care in the most appropriate setting, improving both patient outcomes and patient experience.

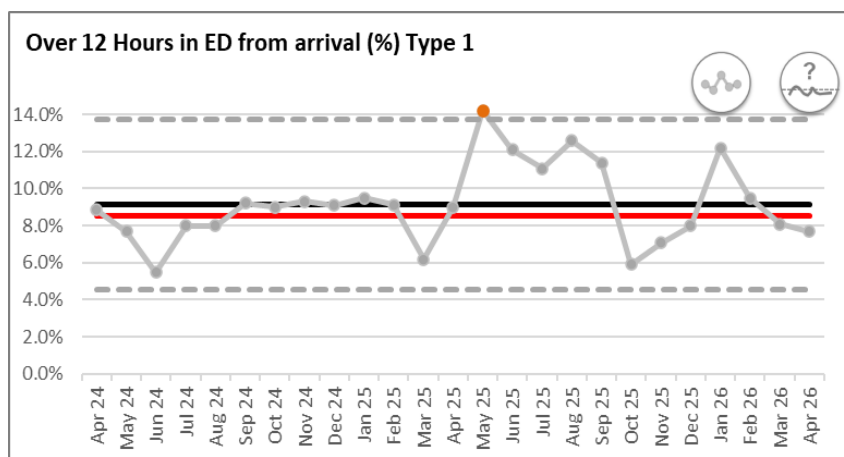
In 2025/26, the Trust's priorities under this strategic theme focused on urgent and emergency care, elective recovery and quality improvement.

Urgent and emergency care

Urgent and emergency care remained one of the Trust's most significant operational challenges during 2025/26. Demand remained high throughout the year and operational performance continued to be affected by delayed discharge, constrained inpatient capacity and wider system flow pressures. Despite this environment, St George's maintained comparatively strong emergency care performance relative to many London acute providers. Performance against the four-hour emergency care standard was 78.1% in September 2025, improved to 80.3% in December 2025 and ended the year at 78.2% in March 2026. Performance reduced to 76.1% in January 2026 during the period of greatest winter pressure before recovering later in the year.



The Trust also continued to experience pressure in relation to 12-hour waits from Emergency Department arrival. However, by March 2026 the proportion of patients waiting more than 12 hours had reduced to 7.5%, substantially better than the plan assumption of 13.5%.



Average non-elective length of stay remained above plan at 10.2 days in March 2026 against a plan of 8.4 days, while delayed discharge continued to constrain operational flow. The average delay between planned and actual discharge was 0.7 days in February 2026.

Improvement work focused increasingly on end-to-end patient flow rather than solely Emergency Department performance. The Trust strengthened Same Day Emergency Care pathways, discharge oversight, operational escalation processes and front-door streaming. Virtual wards and community pathways also supported admission avoidance and earlier discharge throughout the year.

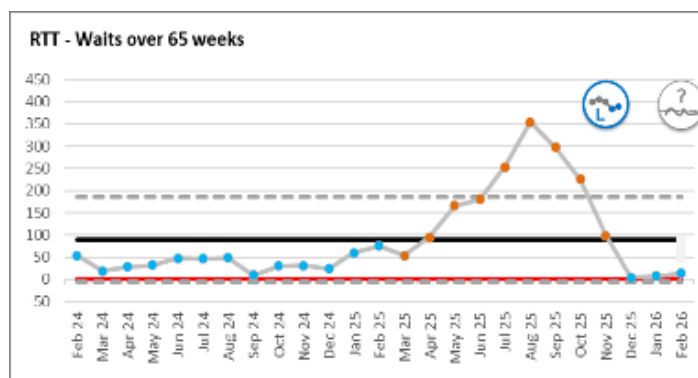
The urgent and emergency care story during 2025/26 was therefore one of operational resilience in the face of sustained system pressure, while recognising that significant flow and capacity challenges remain unresolved.

Elective recovery and RTT

Elective recovery remained one of the Trust's most significant operational priorities throughout 2025/26.

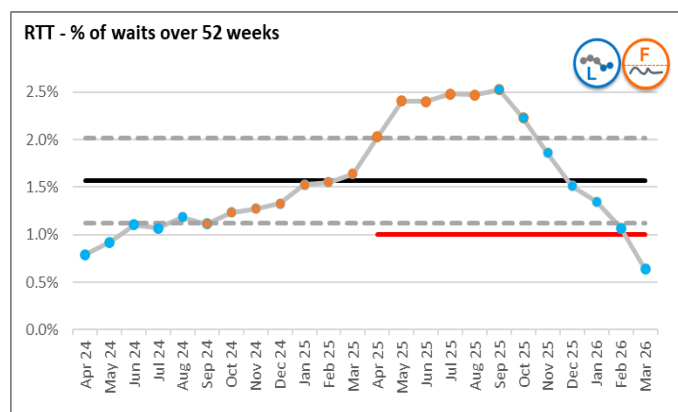
The Trust continued to experience pressure on RTT performance, particularly within Neurosurgery, Gynaecology, General Surgery and Bariatric Surgery. At the start of the year, around 2% of the Patient Tracking List had waited more than 52 weeks against a March 2026 target of 1.6%.

The most significant improvement during the year was the reduction in very long waits. By December 2025, St George's had reduced the 65-week cohort to four patients compared with a projected position of around 400 patients. Those remaining patients were subsequently treated and the Trust exited NHS England elective tiering following substantial improvement in long waits.



The Trust also improved 52-week performance during the second half of the year. By February 2026, the proportion of patients waiting more than 52 weeks had reduced to 1.07%, close to the plan of

1.0%. By March 2026, the Trust had delivered its trajectory for 18-week RTT performance and 52-week waits.



The Trust nevertheless continued to face pressure across elective pathways, workforce capacity and productivity. Improvement work focused on outpatient transformation, Patient Initiated Follow Up pathways, waiting list validation, theatre productivity and pathway redesign.

The elective recovery story during 2025/26 reflected meaningful progress in reducing the longest waits and stabilising performance during the second half of the year, while highlighting the continuing challenge of sustaining RTT recovery in a financially and operationally constrained environment.

Cancer performance

Cancer performance remained one of the Trust's most challenged operational areas during the year. Performance against the Faster Diagnosis Standard deteriorated during summer and autumn 2025, reaching 64.4% in August 2025, before improving significantly during the second half of the year. By March 2026, the Trust exceeded the 77% national Faster Diagnosis Standard.

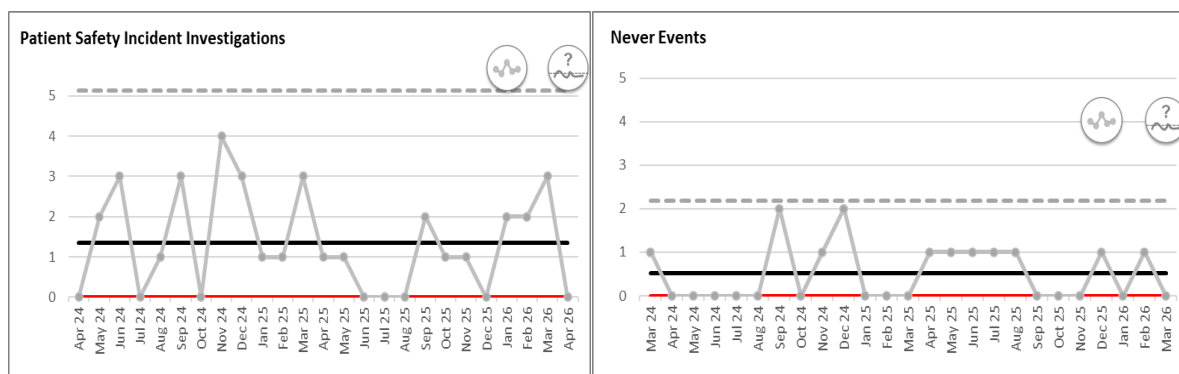
Performance against the 62-day standard also improved during the year, rising from 68.3% in late 2025 to 72.4% in March 2026. However, performance remained below the national standard. The main pressures were within thoracic services and dermatology pathways, where demand, capacity constraints and increased referral volumes affected performance. Recovery actions included additional outpatient and diagnostic capacity, targeted recruitment, Waiting List Initiative activity, mutual aid and continued collaboration through Royal Marsden Partners.

Patient safety

Quality and safety performance in 2025/26 showed areas of improvement alongside areas requiring continued operational focus.

Mortality performance continued to be strong throughout the year, with St George's consistently within the expected range. VTE risk assessment compliance also improved, although performance remained below the national target and continued to receive focused Quality Committee oversight.

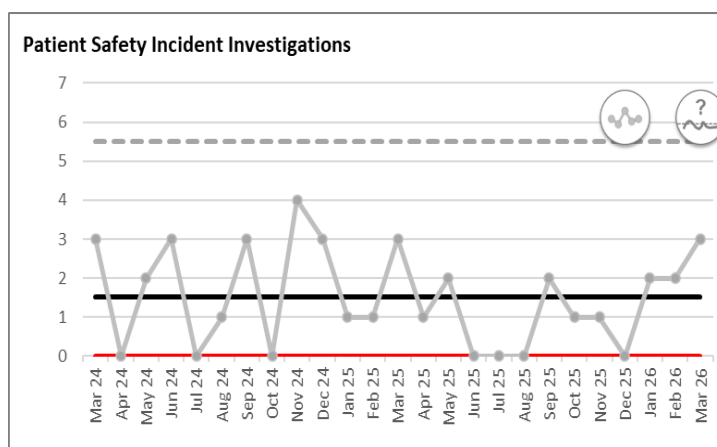
The Trust continued implementation of the Patient Safety Incident Response Framework (PSIRF), strengthening its focus on organisational learning and thematic review of patient safety issues. Patient safety investigations and organisational learning, including from Never Events, remained a major area of Quality Committee and Executive oversight throughout the year.



Pressure ulcer prevention, delirium assessment, infection prevention and control and reduction of avoidable harm remained important quality priorities. Delirium assessment compliance emerged as a particular area of concern and became the subject of targeted improvement activity during the second half of the year.

Maternity services remained under enhanced organisational focus throughout the year. The Trust maintained compliance with all ten safety actions within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme and continued to strengthen maternity governance, safety oversight, workforce capability and organisational learning. Maternity incidents and patient safety investigations continued to receive enhanced executive oversight, reinforcing the importance of escalation, multidisciplinary communication and learning culture within maternity pathways.

A major focus during the year was implementation of the Group Quality and Safety Governance Improvement Plan and continued development of quality governance arrangements. The Trust also continued implementation of PSIRF, moving progressively towards more learning-focused and intelligence-led approaches to patient safety and quality improvement.



Care Quality Commission inspections and wider assurance processes undertaken during the year identified areas of good practice alongside opportunities to strengthen aspects of governance consistency, operational oversight, documentation standards and organisational learning.

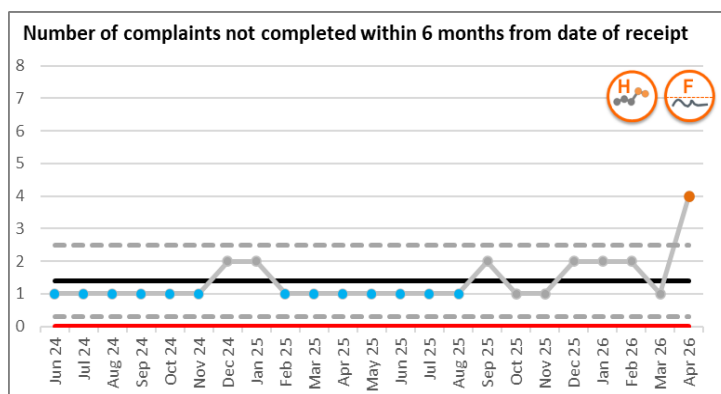
Overall, the quality picture during 2025/26 was one of safe care delivered in the context of sustained operational and financial pressure. The Trust improved mortality performance, strengthened patient safety learning arrangements, maintained CNST compliance within maternity services and continued to develop more mature quality governance arrangements. Further work remains necessary to improve consistency of quality governance, surveillance and operational delivery across services and pathways.

Patient experience

Patient experience performance during 2025/26 reflected both areas of strong patient feedback and areas where operational pressure increasingly affected responsiveness and experience.

Outpatient experience remained one of the strongest areas of patient feedback during the year. Satisfaction within outpatient services remained above 90% throughout 2025/26 despite sustained operational pressure and increasing demand.

Complaints performance was comparatively strong during much of the year. During summer and autumn 2025, St George's achieved high levels of compliance with complaint acknowledgement timescales and maintained strong responsiveness across many services.



Patient feedback nevertheless increasingly reflected the operational pressure experienced across services during the year. Concerns relating to communication, waiting times, responsiveness and continuity of care became more prominent during periods of heightened operational pressure, particularly during winter.

Patient experience and engagement remained recurring areas of Quality Committee oversight throughout the year, including review of patient feedback, complaints, Patient Advice and Liaison Service (PALS) activity and organisational learning.

At the same time, patient feedback continued to highlight the compassion and professionalism of staff despite the intensity of the operational environment. Outpatient feedback remained particularly positive, with many patients reporting that staff were caring, respectful and supportive even where waits and delays affected the wider experience.

The patient experience picture during 2025/26 reflected the wider operational position of the organisation: highly compassionate care delivered by committed staff within an increasingly pressured operational environment. Patients continued to report positive experiences of staff professionalism and outpatient care, although responsiveness, communication and continuity of experience became more difficult to sustain during periods of operational pressure.

Health inequalities and population health

Reducing health inequalities and improving equality of access, experience and outcomes remained an important strategic priority during 2025/26.

The Trust continued to strengthen its approach to health inequalities and population health in response to national policy developments and local priorities across South West London. This included development of a dedicated health inequalities programme, appointment of a St George's Health Equity Lead and closer alignment of health inequalities work with quality improvement, patient safety, research and operational delivery.

The Trust worked closely with South West London Integrated Care Board and local partners to support priorities relating to prevention, healthy ageing, cancer screening, discharge improvement and reducing inequalities in access and outcomes.

A major focus during the year was improving the quality and completeness of patient demographic and ethnicity data to support population health analysis and identification of inequalities in access, experience and outcomes. The Trust also secured a South West London data-sharing agreement intended to strengthen ethnicity data completeness and system-wide population health intelligence.

The Trust established a Health Equity Community of Practice and Health Equity Champions network to support organisational awareness, staff engagement and embedding of health equity principles across clinical and operational services.

The Trust also began embedding health inequalities considerations within Quality Impact Assessment processes, service redesign and operational planning arrangements. The Board recognised that reducing health inequalities will require sustained collaboration with patients, communities, local authorities, primary care, voluntary sector organisations and wider system partners.

Social value and community impact

As a major NHS provider and anchor institution within South West London, the Trust recognises the wider social, economic and community impact of its activities.

During 2025/26, the Trust continued to support local employment, education, training, research, volunteering and partnership activity across the communities it serves. The organisation also continued to contribute to wider system objectives relating to prevention, population health improvement and reducing health inequalities.

The Trust remained committed to promoting equality, inclusion, dignity and respect for patients, staff and communities and to acting in accordance with the Human Rights Act 1998, the Equality Act 2010 and the NHS Constitution.

Social value considerations continued to be integrated within procurement, sustainability and transformation activity, supporting wider community benefit alongside delivery of healthcare services.

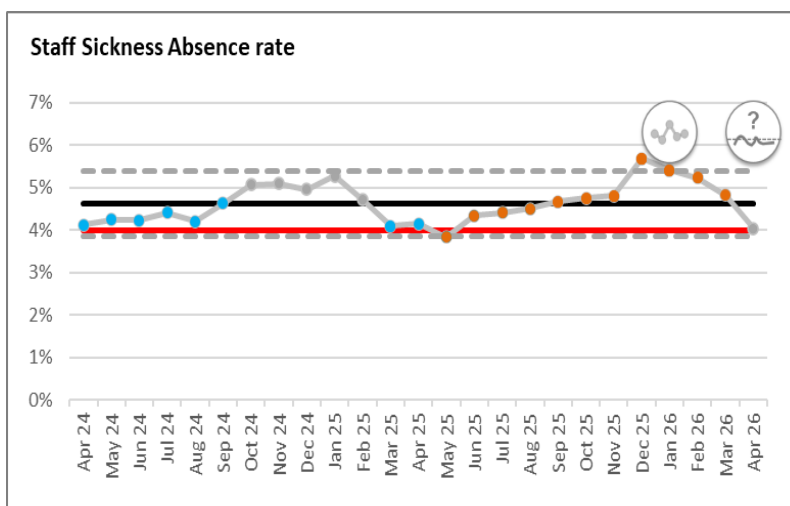
Empowered, Engaged Staff

The objectives of the Empowered, Engaged Staff theme within the Group strategy are to build a skilled, inclusive and engaged workforce supported by strong leadership, positive organisational culture and effective workforce development.

In 2025/26, the Trust's priorities under this strategic theme focused on workforce resilience, staff experience, organisational culture, and equality, diversity and inclusion.

Workforce performance remained one of the most important determinants of organisational performance during the year. The Trust employed an average workforce of more than 10,800 staff across clinical, operational, academic and support services and continued to experience workforce pressures affecting operational resilience, temporary staffing utilisation and service delivery.

Sickness absence remained one of the Trust's most significant workforce challenges and remained above target throughout much of the year. Recruitment and retention pressures also persisted within some specialist workforce groups, particularly theatres, diagnostics and specialist services.



The 2025 NHS Staff Survey, undertaken in autumn 2025 and published in March 2026, demonstrated continued staff commitment to patient care and teamwork across the organisation, with a staff engagement score of 6.81, above the national average of 6.74. However, staff survey findings also highlighted concerns relating to wellbeing, morale, reward and recognition, leadership visibility and aspects of organisational culture, including equality, diversity and inclusion.

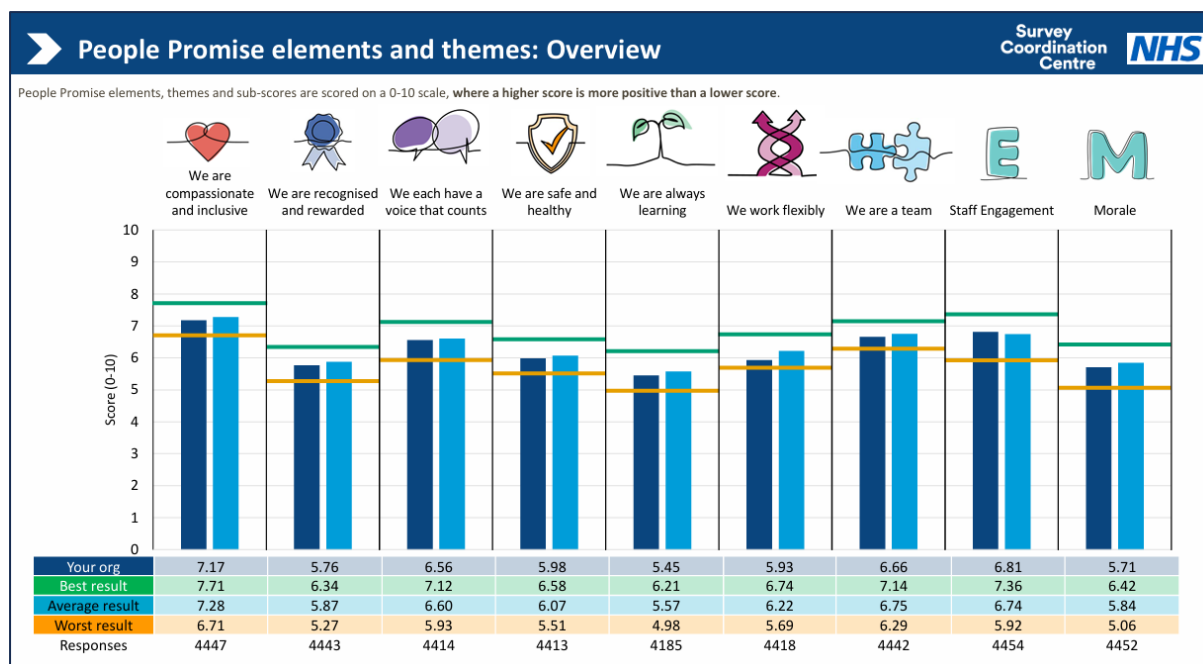
These themes aligned closely with issues identified through Freedom to Speak Up reporting and wider workforce feedback, particularly in relation to leadership behaviours, staff experience, equality, diversity and inclusion and confidence in raising concerns.

People Committee oversight during the year focused on organisational culture, inclusion, workforce equality, staff wellbeing, workforce transformation and talent management. The Trust continued to implement the gesh People Strategy 2024-2026, with priorities including workforce retention, leadership development, staff wellbeing and inclusive culture.

Workforce equality and inclusion remained important areas of focus. Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reporting demonstrated mixed progress during the year, while the Trust continued development of the Inclusive Talent Management Programme and establishment of the new Inclusion Board.

The Trust also strengthened workforce culture and organisational development arrangements during the year through targeted sickness absence improvement work, wellbeing support, leadership development and violence and aggression reduction initiatives.

Overall, the workforce picture during 2025/26 reflected both resilience and strain. Staff engagement and commitment to patient care remained comparatively strong despite sustained operational pressure, although sickness absence, workforce fatigue, organisational culture, diversity and inclusion, retention pressures and wellbeing continued to represent significant organisational risks.



Principal Risks

The Trust ended 2025/26 having delivered important operational improvements while also recognising that many of the underlying drivers of organisational pressure remain.

Throughout the year, the organisation continued to operate within a highly volatile and increasingly interconnected risk environment. Operational performance, workforce resilience, financial sustainability, infrastructure resilience, digital maturity and organisational culture increasingly influenced one another and, in several cases, reinforced one another.

The principal risks facing the organisation continued to be captured through the Group Board Assurance Framework (BAF) and Corporate Risk Register.

During 2025/26, the Group BAF contains 14 strategic risks aligned to the four CARE strategic themes. Eleven of the risks were overseen through the relevant Board Committees, with three risks relating to collaboration and partnerships reserved directly to the Group Board.

During 2025/26, the Board undertook a significant review of the BAF in light of the organisation's evolving strategic context. This review reflected:

- publication of the NHS 10-Year Plan;
- development of the Group medium-term plan and transformation portfolio;
- increasing financial challenge across the NHS;
- major changes in NHS England and Integrated Care Board operating arrangements;
- increasing emphasis on neighbourhood health and system integration;
- and the increasingly interconnected nature of the organisation's strategic risks.

The review concluded that the existing BAF remained broadly appropriate but that the strategic risks required streamlining and refreshing to provide greater clarity, sharper strategic focus and improved alignment with the organisation's medium-term strategic direction. The review also recognised that the organisation's strategic risks had become increasingly long-term and transformational in nature. A revised and more streamlined BAF was therefore developed during late 2025/26 with implementation planned for early 2026/27.

Many of the Trust's principal risks – including workforce sustainability, productivity, operational flow and infrastructure resilience – require long-term transformation rather than short-term operational recovery alone.

The 14 strategic risks on the Group Board Assurance Framework at Q3 2025/26 are summarised below:

Strategic risk	Strategic objective	Principal issues during 2025/26	Key mitigation and organisational response
SR1: Working across our local system	Collaboration and Partnerships	Risk that the Group does not act as an effective system partner across South West London, Surrey Heartlands and local Places, limiting its ability to influence system priorities, improve pathways and support care closer to home.	Continued leadership within system and Place partnerships, development of neighbourhood and integrated care models, discharge and flow improvement work, and engagement with the emerging South West London clinical strategy.
SR2: Working with other hospitals through our Acute Provider Collaborative		Risk that the Group does not maximise opportunities from acute provider collaboration, including clinical networks, mutual aid, pathway improvement and service sustainability.	Continued participation in acute provider collaborative arrangements, clinical network development, shared pathway improvement and collaboration on diagnostics, cancer and specialist services.
SR3: Working across the Group		Risk that the Group does not realise the benefits of working together across St George's, Epsom and St Helier and Integrated Care, including reducing unwarranted variation and improving resilience.	Development of Group operating arrangements, shared leadership, Group-wide strategy and transformation work, common governance frameworks and strengthened cross-site collaboration.
SR4: Achieving Financial Sustainability	Affordable Healthcare, Fit for the Future	Risk that the Group does not achieve financial sustainability, deliver recurrent efficiencies or maintain financial control in a materially challenging NHS financial environment.	Delivery of financial recovery arrangements, Cost Improvement Programmes, productivity improvement, medium-term financial planning and development of the transformation portfolio.
SR5: Modernising our Estates		Risk that ageing estate infrastructure, capital constraints and compliance challenges affect service resilience, patient experience and long-term sustainability.	Estates compliance programmes, capital prioritisation, fire and water safety work, infrastructure risk management, Green Plan implementation and longer-term estate planning.
SR6: Adopting Digital Technology		Risk that the Group does not adopt and embed digital technology at the pace required to improve care, productivity, data quality and operational resilience.	EPR implementation and stabilisation, digital strategy development, cyber security strengthening, PACS programme oversight and digital risk management.
SR7: Developing New Treatments through Research and Innovation		Risk that the Group does not fully realise its potential as a research, innovation and specialist care organisation, limiting improvement in treatments, outcomes and reputation.	Continued support for research, innovation, academic partnerships, specialist service development and alignment of innovation with clinical strategy.
SR8: Reducing Waiting Times	Right Care, Right Place, Right Time	Risk that the Group does not reduce elective waiting times, long waits and access delays, affecting patient outcomes, experience and regulatory performance.	Waiting list validation, long-wait recovery, outpatient transformation, theatre productivity improvement, additional capacity and strengthened operational grip.
SR9: Improving Safety and Reducing Avoidable Harm		Risk that the Group does not improve safety or reduce avoidable harm, including risks relating to patient safety incidents, maternity, VTE, pressure ulcers and infection prevention.	Implementation of PSIRF, Quality and Safety Governance Improvement Plan, maternity improvement work, harm reduction programmes and strengthened quality surveillance.
SR10: Improving Patient Experience		Risk that patient experience does not improve consistently, particularly in areas affected by access delays, communication, complaints and operational pressure.	Patient experience reporting, complaints and PALS learning, outpatient experience improvement, divisional review of themes and strengthened patient feedback mechanisms.
SR11: Tackling Health Inequalities		Risk that the Group does not reduce health inequalities or improve access and outcomes for underserved communities.	Population health work, system partnership activity, pathway redesign, equality impact consideration and alignment with integrated care priorities.

Strategic risk	Strategic objective	Principal issues during 2025/26	Key mitigation and organisational response
SR12: Putting Staff Experience and Wellbeing at the Heart of What We Do	Empowered, Engaged Staff	Risk that staff experience, wellbeing and morale do not improve, affecting retention, attendance, operational delivery and quality of care.	Staff survey response, wellbeing support, sickness absence improvement work, Freedom to Speak Up arrangements and workforce engagement programmes.
SR13: Fostering an Inclusive Culture that Celebrates Diversity		Risk that the Group does not create an inclusive culture or address workforce inequalities, affecting staff experience, leadership, representation and organisational culture.	EDI action plan, WRES and WDES reporting, Inclusion Board, staff networks, inclusive recruitment and leadership accountability.
SR14: Developing Tomorrow's Workforce		Risk that the Group does not develop the workforce capability, leadership pipeline and future skills required to deliver sustainable services.	Inclusive Talent Management Programme, workforce planning, leadership development, education and training, appraisal improvement and career development activity.

The Board recognised throughout the year that many of these risks are closely interconnected. Urgent and emergency care performance is linked directly to workforce resilience, delayed discharge and system capacity. Elective recovery depends on theatre productivity, diagnostics and staffing. Financial sustainability increasingly depends on transformation delivery, digital maturity and recurrent productivity improvement.

The Trust's medium-term plan and transformation portfolio therefore represent a strategic shift from short-term operational recovery towards more fundamental organisational redesign. The Trust enters 2026/27 with a clearer strategic direction and sharper focus on the operational, workforce and transformation priorities required to deliver sustainable improvement.

Looking ahead to 2026/27

Looking ahead, the Trust expects demand growth, workforce pressures, financial constraint, productivity challenge and infrastructure pressures to continue throughout 2026/27 and beyond.

The Board has approved a financial plan for 2026/27 that requires significant efficiency delivery and successful mobilisation of the Group transformation programme. Delivery of sustainable improvement will increasingly depend on operational flow, workforce resilience, infrastructure modernisation, partnership working and successful delivery of transformation at scale.

The Trust also expects further work during 2026/27 to support consideration of the Strategic Case for merger with Epsom and St Helier University Hospitals NHS Trust, recognising the potential opportunities associated with greater organisational integration across the Group.

St George's enters 2026/27 with a clearer strategic direction and sharper focus on the operational, workforce, infrastructure and transformation priorities required to deliver sustainable improvement for the patients and communities it serves.

Accountability Report

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Directors Report 2025/26

This report describes the governance, leadership and accountability arrangements of St George's University Hospitals NHS Foundation Trust during 2025/26, including the operation of the Trust within the wider St George's, Epsom and St Helier University Hospitals and Health Group.

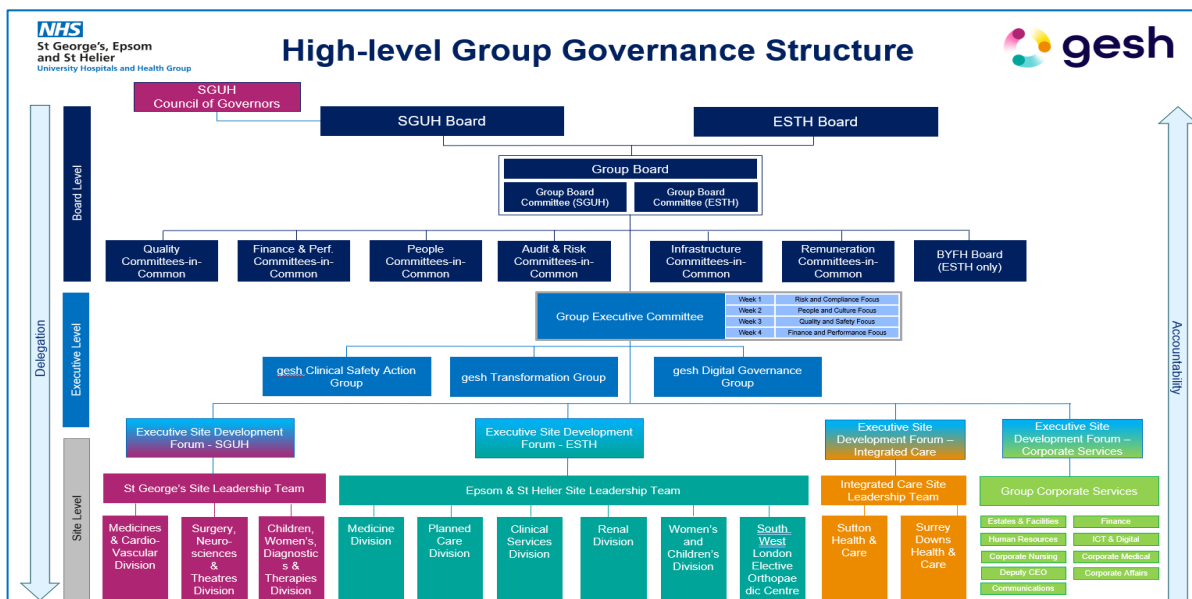
Governance Framework and Group Operating Model

The Group Model

St George's University Hospitals NHS Foundation Trust is an NHS foundation trust established under the National Health Service Act 2006. The Trust provides acute and specialist healthcare services locally, regionally and nationally and is responsible for a wide range of tertiary and specialist services.

The Trust forms part of the St George's, Epsom and St Helier University Hospitals and Health Group alongside Epsom and St Helier University Hospitals NHS Trust. The Group was established to support closer clinical and operational integration, strengthen organisational resilience, reduce unwarranted variation in care and enable the organisations to take strategic decisions affecting the Group with a single mind wherever practicable.

The Group model is intended to support improved outcomes and experience for patients through greater collaboration between clinical teams, stronger clinical networks, more integrated planning of services and infrastructure, improved resilience across services and greater consistency in standards of care across the Group. It is also intended to support staff through broader professional opportunities, strengthened leadership and development pathways, more integrated workforce planning and greater organisational resilience during a period of increasing operational and financial challenge.



St George's remains a sovereign NHS foundation trust led by a Trust Board. However, during 2025/26, governance arrangements continued to operate within the wider Group operating model, intended to support increasingly integrated strategic oversight, organisational collaboration and consistent governance standards across the Group while maintaining clear statutory accountability within each organisation.

Governance arrangements are intended to support collective strategic leadership, shared decision-making and greater organisational integration while maintaining clear accountability and escalation arrangements. The Group operating model is also intended to support subsidiarity, with operational accountability and day-to-day delivery remaining as close as possible to clinical services and Site leadership teams.

Governance framework

In practice, a significant proportion of Board business was conducted through Group governance arrangements operating in common across the two Trust Boards. This included operation of a Group Board arrangement through a Committees-in-Common arrangement, enabling the two Boards to consider shared strategic, operational and governance matters collectively while retaining their respective statutory responsibilities.

Board Committees also operated through Committees-in-Common arrangements with shared agendas, papers and minutes. These included the Quality Committee, Finance and Performance Committee, People Committee, Infrastructure Committee, Remuneration Committee, and Audit and Risk Committees.

A single Group Executive Committee operated as the senior executive management forum across the Group and sovereign organisations. During 2025/26, executive governance arrangements were further developed through refinement of the Group Executive Committee structure, reduction and alignment of supporting executive sub-groups and introduction of Executive Site Development Forums intended to strengthen operational integration, executive oversight and alignment between executive and site leadership teams, and support robust ward to Board escalation.

These changes were intended to support a clearer and more disciplined governance and assurance pathway from operational services through Site leadership, executive governance and Board oversight, while also reducing duplication, improving decision-making and supporting greater organisational alignment across the Group.

Governance arrangements continued to evolve during the year as the organisation sought to develop a more mature, integrated and strategically aligned Group governance model.

Together, these developments reflected the organisation's continued transition towards a more integrated Group operating model and a stronger focus on long-term transformation, organisational sustainability and delivery of strategic priorities.

Role of the Board

The Board of Directors is responsible for the overall leadership, strategy, performance and governance of the Trust. The Board's role is to provide strategic leadership for the organisation, establish its objectives and priorities, oversee delivery of high-quality and sustainable services, and ensure effective stewardship of public resources.

The Board is responsible for promoting the success of the organisation through:

- setting strategic direction and organisational priorities;
- overseeing quality, operational and financial performance;
- ensuring effective governance, risk management and internal control;
- shaping organisational culture and values;
- supporting organisational learning and improvement;
- ensuring effective engagement with patients, staff, governors, partners and wider stakeholders; and
- ensuring the organisation remains sustainable, well-led and responsive to the populations it serves.

The Board seeks to operate through constructive challenge, collective leadership and evidence-based decision-making.

The Board operates within a framework of Standing Orders, Standing Financial Instructions and a Scheme of Reservation and Delegation of Powers which define matters reserved to the Board and those delegated to Committees and executive management.

The Board's principal areas of focus during 2025/26 included:

- quality governance and operational improvement;
- response to the CQC Well-Led review and service inspections;
- operational recovery and urgent care pressures;
- financial sustainability and delivery of the Medium-Term Plan;
- workforce sustainability, organisational culture and inclusion;
- infrastructure resilience and digital maturity; and
- continued evolution of the Group operating model.

The Board increasingly recognised that financial sustainability, operational resilience, workforce sustainability and quality governance were closely interconnected and therefore required integrated strategic oversight.

Board meetings were held in public unless confidential or commercially sensitive matters required discussion in private session.

Table 1: Public Board meeting attendance 2025/26

Public Board meeting attendance, April 2025 – March 2026		
Name	Title	Actual / Possible
Mark Lowcock	Group Chair	6 / 6
Andrew Murray	Non-executive director and Deputy Chair (from January 2026)	5 / 6
Chiew Yin Jones	Non-executive director, Senior Independent Director (from January 2026)	4 / 6
Natalie Armstrong	Non-executive director	4 / 6
Ann Beasley	Non-executive director and Deputy Chair (until 12 October 2025)	3 / 3
Pankaj Davé	Non-executive director	6 / 6
Peter Kane	Non-executive director (until 30 September 2025)	3 / 3
Khadir Meer	Associate non-executive director	6 / 6
Leonie Penna	Non-executive director (from 1 October 2025)	3 / 3
Bidesh Sarkar	Non-executive director (from 13 October 2025)	3 / 3
Claire Sunderland Hay	Associate non-executive director	5 / 6
Jacqueline Totterdell	Group Chief Executive Officer (until 17 September 2025)	3 / 3
James Blythe	Interim Group Chief Executive Officer (from 18 September 2025)	3 / 3
Elizabeth Alabaster	Interim Group Chief Finance Officer (from 1 December 2025)	2 / 2
Mark Bagnall	Group Chief Infrastructure, Facilities, Infrastructure and Environment Officer	6 / 6
Elaine Clancy	Interim Group Chief Nursing Officer (from 15 September 2025)	2 / 3
Andrew Grimshaw	Group Chief Finance Officer (until 30 November 2025)	3 / 4
Richard Jennings	Group Chief Medical Officer	5 / 6
Stephen Jones	Group Chief Corporate Affairs Officer	6 / 6
Ralph Michell	Group Chief Transformation Officer (from 1 April to 31 August 2025)	1 / 2
Michael Pantlin	Group Deputy Chief Executive Officer (from 22 April 2025)	6 / 6
Kate Slemeck	Managing Director – St George's	5 / 6
Victoria Smith	Group Chief People Officer	6 / 6
Arlene Wellman	Group Chief Nursing Officer (until 31 August 2025)	2 / 2

Board Committees and assurance

The Board is supported by a number of Board Committees responsible for providing detailed scrutiny, oversight and assurance within their delegated areas of responsibility. The Committee structure is intended to strengthen Board assurance, support effective governance oversight and enable more detailed scrutiny of key strategic, operational and organisational issues.

Committee arrangements continued to evolve during the year to support increasingly integrated governance and assurance across the Group. Annual Board and Committee effectiveness reviews identified strengths including constructive challenge, strengthened strategic oversight and increasingly mature Group governance arrangements, while also identifying opportunities to improve strategic focus, streamline reporting and strengthen the quality and synthesis of assurance information presented to Committees and the Board.

Table 2: Committee membership 2025/26

Board Committee membership, April 2025 – March 2026		
Committee	Non-executive directors	Executive directors
Group Board Committee	All non-executive directors	All executive directors
Audit & Risk Committee	Pankaj Davé (from 1 October 2025) Peter Kane (until 30 September 2025) Ann Beasley (until 12 October 2025) Chiew Yin Jones Khadir Meer (from 24 April 2025) Claire Sunderland Hay	
Finance & Performance Committee	Bidesh Sarkar (from 13 October 2025) Ann Beasley (until 12 October 2025) Leonie Penna (from 1 October 2025) Peter Kane (until 30 September 2025) Pankaj Davé (until 30 September 2025) Claire Sunderland Hay	Elizabeth Alabaster (from 1 December 2025) Andrew Grimshaw (until 30 November 2025) Michael Pantlin (from 22 April 2025) Elaine Clancy (from 15 September 2025) Richard Jennings Kate Slemeck Arlene Wellman (until 31 August 2025)
Infrastructure Committee	Claire Sunderland Hay Ann Beasley (until 12 October 2025) Andrew Murray Peter Kane (until 30 September 2025) Leonie Penna (from 1 October 2025) Pankaj Davé	Mark Bagnall Ralph Michell (until 31 August 2025) Michael Pantlin (from 10 December 2025) Elizabeth Alabaster (from 1 December 2025) Andrew Grimshaw (until 30 November 2025) Elaine Clancy (from 15 September 2025) Kate Slemeck Arlene Wellman (until 31 August 2025)
People Committee	Chiew Yin Jones Pankaj Davé Andrew Murray	Victoria Smith Elizabeth Alabaster (from 1 December 2025) Elaine Clancy (from 15 September 2025) Andrew Grimshaw (until 30 November 2025) Richard Jennings Kate Slemeck Arlene Wellman (until 31 August 2025)
Remuneration Committee	All non-executive directors	
Quality Committee	Andrew Murray Leonie Penna (from 1 October 2025) Natalie Armstrong Chiew Yin Jones Peter Kane (until 30 September 2025) Khadir Meer (from 1 August 2025)	Elaine Clancy (from 15 September 2025) Richard Jennings Kate Slemeck Arlene Wellman (until 31 August 2025)

Audit and Risk Committee

The Audit and Risk Committee provided assurance regarding governance, risk management, financial governance, internal control and assurance arrangements across the organisation. During 2025/26, the Committee focused particularly on strengthening the Group's approach to risk management and assurance, including refresh of the Board Assurance Framework, alignment between operational and Board-level risks and strengthening consistency of assurance arrangements across the Group.

The Committee also maintained oversight of internal audit, counter fraud, cybersecurity, information governance and financial controls and reviewed the Annual Report, Annual Accounts and Quality Accounts prior to recommendation to the Board for approval.

The Committee also maintained oversight of financial reporting, external audit and annual accounts preparation. During the year, the Committee reviewed external audit planning, auditor independence and effectiveness, and the arrangements supporting preparation of the Trust's annual report and

accounts. Grant Thornton UK LLP has served as the Trust's external auditor since November 2012. The Committee remained satisfied with the independence and effectiveness of the external audit process.

Audit & Risk Committee attendance, April 2025 – March 2026		
Name	Title	Actual / Possible
Pankaj Davé	Non-executive director and Committee Chair (from 1 October 2025)	2 / 2
Peter Kane	Non-executive director and Committee Chair (until 30 September 2025)	4 / 4
Ann Beasley	Non-executive director (until 12 October 2025)	3 / 4
Chiew Yin Jones	Non-executive director	5 / 6
Khadir Meer	Associate non-executive director	2 / 2
Claire Sunderland Hay	Associate non-executive director	5 / 6

Quality Committee

The Quality Committee provided assurance regarding patient safety, clinical governance, clinical effectiveness and patient experience across the Group. During 2025/26, the Committee focused particularly on the effectiveness and consistency of quality governance arrangements, including governance structures, escalation processes, quality reporting and implementation of improvement actions.

The Committee maintained detailed oversight of maternity governance, urgent and emergency care pressures, patient safety and implementation of the Group Quality and Safety Clinical Governance Improvement Plan. The Committee also oversaw operation of the Group-wide Quality Integrated Impact Assessment process for transformation and Cost Improvement Programmes.

Quality Committee attendance, April 2025 – March 2026		
Name	Title	Actual / Possible
Andrew Murray	Non-executive director and Committee Chair	12 / 12
Leonie Penna	Non-executive director and co-Committee Chair (from 1 October 2025)*	5 / 6
Natalie Armstrong	Non-executive director	6 / 12
Chiew Yin Jones	Non-executive director	6 / 12
Peter Kane	Non-executive director (until 30 September 2025)	6 / 6
Khadir Meer	Associate non-executive director (from 24 April 2025)	6 / 8
Elaine Clancy	Interim Group Chief Nursing Officer (from 15 September 2025)	7 / 7
Richard Jennings	Group Chief Medical Officer	12 / 12
Kate Slemeck	Managing Director – St George's	12 / 12
Arlene Wellman	Group Chief Nursing Officer	5 / 5

* Co-Chair from 1 January 2026

Finance and Performance Committee

The Finance and Performance Committee provided assurance regarding financial sustainability, operational performance, productivity, business planning and delivery of the Medium-Term Plan. During 2025/26, the Committee maintained close oversight of delivery of the annual financial plan, Cost Improvement Programmes, productivity improvement and operational performance.

The Committee also focused on alignment between financial, workforce and operational planning arrangements and the interdependencies between operational resilience, workforce sustainability and long-term financial sustainability across the Group.

Finance & Performance Committee attendance, April 2025 – March 2026		
Name	Title	Actual / Possible
Bidesh Sarkar	Non-executive director and Committee Chair (from 13 October 2025)	6 / 6
Ann Beasley	Non-executive director and Committee Chair (until 12 October 2025)	6 / 6
Pankaj Davé	Non-executive director (until 30 September 2025)	6 / 6

Finance & Performance Committee attendance, April 2025 – March 2026		
Name	Title	Actual / Possible
Peter Kane	Non-executive director (until 30 September 2025)	6 / 6
Mark Lowcock	Non-executive director and Group Chair (from 1 October 2025)	5 / 6
Leonie Penna	Non-executive director (from 1 October 2025)	5 / 6
Claire Sunderland Hay	Associate non-executive director	9 / 12
Elizabeth Alabaster	Interim Group Chief Finance Officer (from 1 December 2025)	4 / 4
Elaine Clancy	Interim Group Chief Nursing Officer (from 14 September 2025)	0 / 7
Andrew Grimshaw	Group Chief Finance Officer (until 30 November 2025)	8 / 8
Richard Jennings	Group Chief Medical Officer	11 / 12
Michael Pantlin	Group Deputy Chief Executive Officer	11 / 12
Kate Slemeck	Managing Director – St George's	11 / 12
Arlene Wellman	Group Chief Nursing Officer (until 31 August 2025)	3 / 5

People Committee

The People Committee provided assurance regarding workforce sustainability, organisational culture, staff experience, leadership development, workforce transformation and equality, diversity and inclusion. During 2025/26, the Committee focused particularly on workforce performance and affordability, staff experience and organisational culture, speaking up and psychological safety, leadership development and implementation of the People Strategy.

The Committee also maintained oversight of workforce risks, workforce transformation, staff engagement and inclusive leadership initiatives, including development of the Inclusion Board.

People Committee attendance, April 2025 – March 2026		
Name	Title	Actual / Possible
Chiew Yin Jones	Non-executive director and Committee Chair	5 / 6
Pankaj Davé	Non-executive director	6 / 6
Andrew Murray	Non-executive director	5 / 6
Elizabeth Alabaster	Interim Group Chief Finance Officer	0 / 2
Elaine Clancy	Interim Group Chief Nursing Officer	2 / 3
Andrew Grimshaw	Group Chief Finance Officer	2 / 4
Richard Jennings	Group Chief Medical Officer	5 / 6
Kate Slemeck	Managing Director – St George's	4 / 6
Victoria Smith	Group Chief People Officer	5 / 6
Arlene Wellman	Group Chief Nursing Officer	1 / 3

Infrastructure Committee

The Infrastructure Committee provided assurance regarding estates, facilities, digital infrastructure, statutory compliance and wider infrastructure risks across the organisation. During 2025/26, the Committee maintained oversight of estates and facilities risks, fire and water safety, capital programmes, digital transformation, and implementation of the Shared Electronic Patient Record programme.

The Committee also considered strategic infrastructure risks associated with ageing estate infrastructure, operational resilience and long-term estates infrastructure transformation across the Group.

Infrastructure Committee attendance, April 2025 – March 2026		
Name	Title	Actual / Possible
Claire Sunderland Hay	Associate non-executive director and Committee Chair (from 13 Oct 2025)	10 / 12
Ann Beasley	Non-executive director and Committee Chair (until 12 October 2025)	6 / 6
Peter Kane	Non-executive director (until 30 September 2025)	6 / 6
Pankaj Davé	Non-executive director	12 / 12

Andrew Murray	Non-executive director	9 / 12
Leonie Penna	Non-executive director (from 1 October 2025)	4 / 6
Elizabeth Alabaster	Interim Group Chief Finance Officer (from 1 December 2025)	1 / 4
Mark Bagnall	Group Chief Facilities, Infrastructure and Environment Officer	8 / 12
Elaine Clancy	Interim Group Chief Nursing Officer	2 / 7
Andrew Grimshaw	Group Chief Finance Officer	4 / 7
Michael Pantlin	Group Deputy Chief Executive Officer	3 / 7
Kate Slemeck	Managing Director – St George's	2 / 12
Arlene Wellman	Group Chief Nursing Officer	2 / 5

Remuneration Committee

The Remuneration Committee provided assurance regarding remuneration governance, senior executive appointments and senior leadership remuneration arrangements in line with statutory and regulatory requirements.

During 2025/26, the Committee oversaw a number of significant senior leadership recruitment and appointment processes across the Group, including processes relating to the appointment of a new Group Chief Executive Officer, Group Chief Finance Officer and Group Chief Nursing Officer. The Committee also maintained oversight of wider senior leadership succession considerations and leadership continuity across the Group.

Remuneration Committee attendance, April 2025 – March 2026		
Name	Title	Actual / Possible
Mark Lowcock	Group Chair	5 / 5
Natalie Armstrong	Non-executive director	3 / 5
Ann Beasley	Non-executive director and Deputy Chair (until 12 October 2025)	4 / 4
Pankaj Davé	Non-executive director	5 / 5
Chiew Yin Jones	Non-executive director	2 / 5
Peter Kane	Non-executive director (until 30 September 2025)	3 / 4
Khadir Meer	Associate non-executive director	4 / 4
Andrew Murray	Non-executive director	4 / 5
Leonie Penna	Non-executive director (from 1 October 2025)	3 / 4
Bidesh Sarkar	Non-executive director (from 13 October 2025)	1 / 1
Claire Sunderland Hay	Associate non-executive director	5 / 5

Executive and operational governance

A single Group Executive Committee operated as the senior executive management forum across the Group and sovereign organisations. The Group Executive Committee provides collective executive leadership across the Group and is responsible for strategic delivery, operational oversight, organisational performance, transformation delivery, regulatory compliance and implementation of Group-wide priorities.

During 2025/26, executive governance arrangements were further streamlined through refinement of the Group Executive Committee structure, reduction and alignment of supporting executive sub-groups and introduction of Executive Site Development Forums intended to strengthen operational integration, executive oversight and alignment between executive and site leadership teams.

Executive Site Development Forums were established during the year to bring together Group Executive and Site leadership teams in a single forum focused on operational delivery, improvement, risk escalation and alignment between Group strategy and Site-level priorities.

Operational accountability for day-to-day delivery, quality, workforce and performance remained devolved to Site leadership teams and divisional governance structures operating across the organisation. These governance arrangements are intended to support subsidiarity within the Group model, ensuring that operational decision-making remains as close as possible to clinical services while enabling effective escalation, oversight and organisational assurance where required.

Divisional governance arrangements continued to support oversight of operational performance, quality, workforce, risk management and organisational improvement at service level, with escalation through Site and executive governance structures where appropriate.

Appointments, succession planning and diversity

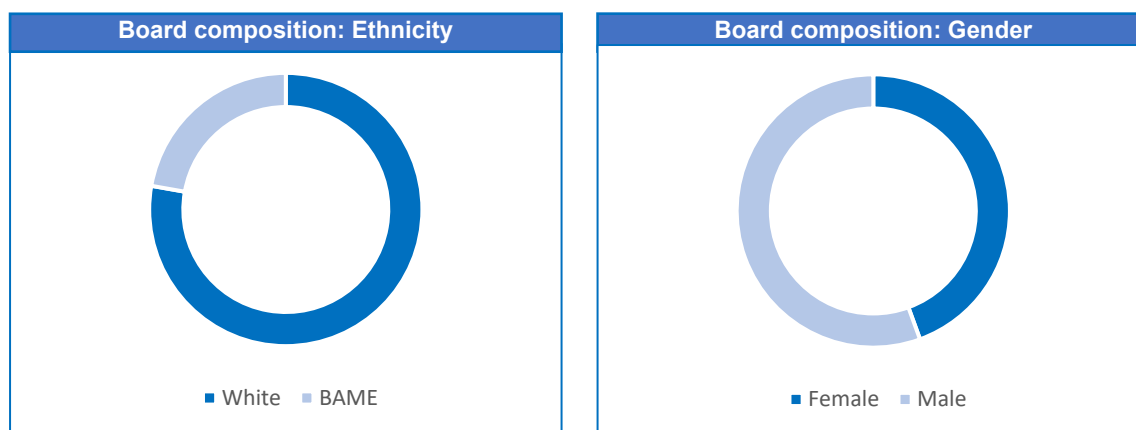
The Remuneration Committee considers executive succession planning, senior leadership appointments and Board composition.

During 2025/26, there were a number of significant changes to Board membership and senior leadership across the Group, including recruitment processes relating to the Group Chief Executive Officer, Group Chief Finance Officer, Group Chief Nursing Officer and Managing Director for Epsom and St Helier roles. The Board and Remuneration Committee maintained oversight of leadership continuity and succession planning throughout the year.

Non-Executive Directors are appointed by the Council of Governors for fixed terms of office in line with the Trust's Constitution and relevant governance requirements. Appointments and reappointments are made having regard to the balance of skills, experience, independence and knowledge required by the Board.

The Board is committed to promoting equality, diversity and inclusion and recognises that diverse leadership supports stronger decision-making, broader perspectives and improved organisational culture. Diversity and inclusion considerations form part of recruitment, succession planning and leadership development arrangements across the Group, supported by initiatives including the Inclusive Talent Management Programme and Inclusion Board.

At 31 March 2026, the Board comprised 18 members, of whom 8 (39%) were female and 10 (61%) were male. The Board also comprised 14 White members (78%) and 4 Black, Asian and Minority Ethnic members (22%), all of whom were Non-Executive Directors. The Board recognises the importance of ensuring that leadership teams increasingly reflect the diversity of the workforce and communities served by the Trust and continues to monitor progress through workforce equality reporting, including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).



The most recent data in relation to the Workforce Race Equality Standard (WRES), which is accurate as at 31 March 2025, shows that the ethnic composition of the Board does not reflect the ethnic composition of the staff as a whole. The percentage difference between the Board voting membership as at 31 March 2025 and the overall BAME workforce is -25%. The percentage difference between the Board executive membership and the overall BAME workforce is -42%.

Further information regarding the composition of the wider workforce, including gender balance across very senior managers, senior managers and the overall workforce, is set out in the Staff Report. Further information regarding workforce equality, diversity and inclusion is also set out in the Staff Report.

Board composition and effectiveness

The Board comprised Executive and Non-Executive Directors with a broad range of clinical, operational, financial, professional and leadership experience. The Board's composition is intended to provide an appropriate balance of skills, experience, independence and knowledge to support effective governance, constructive challenge and strategic leadership across the Group.

Annual Board effectiveness reviews continued to support development of governance arrangements, Board dynamics and assurance processes. During the year, the review identified strengths including constructive challenge, increasingly mature Group governance arrangements and strengthened strategic oversight. Areas identified for further development included improving the clarity and synthesis of information presented to the Board and maintaining a strong focus on strategic priorities.

The Board effectiveness review informed ongoing development of governance arrangements, Board priorities and future succession planning considerations. The Board continued to review its composition to ensure that it retained the skills, experience and diversity required to support delivery of the Trust's strategic objectives and the continued evolution of the Group operating model.

Non-Executive Directors

Non-Executive Director Terms of Office				
Name	Role	Voting member of the Board	Appointed	Current term expires
Sir Mark Lowcock	Group Chair	Yes	1 April 2025	31 March 2028
Prof. Natalie Armstrong	Non-Executive Director	Yes	1 January 2025	31 December 2027
Pankaj Davé	Non-Executive Director, Chair of Audit & Risk Committee	Yes	1 February 2025	31 January 2028
Chiew Yin Jones	Non-Executive Director, Chair of People Committee	Yes	2 March 2023	4 September 2027
Khadir Meer	Associate Non-Executive Director	No	24 April 2025	23 April 2027
Dr Andrew Murray	Non-Executive Director, Co-Chair of Quality Committee	Yes	23 January 2023	22 January 2029
Dr Leonie Penna	Non-Executive Director, Co-Chair of Quality Committee	Yes	1 October 2025	30 September 2028
Bidesh Sarkar	Non-Executive Director, Chair of Finance & Performance Committee	Yes	13 October 2025	12 October 2028
Claire Sunderland Hay	Associate Non-Executive Director, Chair of Infrastructure Committee	No	18 October 2024	17 October 2026



Sir Mark Lowcock KCB, Chair

Sir Mark Lowcock was appointed Chair in April 2025. He previously served as Permanent Secretary of the Department for International Development between 2011 and 2017 and subsequently as United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator between 2017 and 2021. Sir Mark brings extensive experience in public service leadership, international systems leadership, organisational transformation and governance in highly complex and challenging environments.



Professor Natalie Armstrong, Non-Executive Director

Professor Natalie Armstrong is Executive Dean for the School of Health and Medical Sciences at City St George's, University of London and serves as the University-appointed Non-Executive Director on the Board. Prior to joining City St George's, she held a number of senior academic and leadership roles at the University of Leicester and

also served as University-appointed Non-Executive Director to the University Hospitals of Northamptonshire Group. She brings significant expertise in healthcare leadership, academic governance and organisational transformation.



Pankaj Davé, Non-Executive Director

Pankaj Davé is a qualified accountant with extensive international executive experience across finance, strategy, business transformation, operational leadership and performance management. He has previously served as a Non-Executive Director at University Hospitals Dorset, where he chaired the Transformation and People and Culture Committees, and served as a Trustee of the Royal College of Surgeons of England, and Audit and Risk Committee Chair, until August 2025. He brings extensive expertise in transformation, finance, governance and organisational performance.



Chiew Yin Jones, Non-Executive Director

Chiew Yin Jones is a lawyer with more than 25 years' experience in criminal justice, professional regulation and disciplinary proceedings. She chairs disciplinary and professional standards hearings across a number of regulatory jurisdictions and also serves as a Non-Executive Director at West London NHS Trust. During 2025/26, she chaired the People Committee across both Trusts and brought extensive expertise in governance, leadership, organisational culture, equality and inclusion and professional accountability. In January 2026, Yin was appointed Senior Independent Director at St George's.



Khadir Meer, Associate Non-Executive Director

Khadir Meer has held a range of senior leadership roles across the NHS, local government and higher education sectors. His previous roles include Chief Operating Officer and Deputy Chief Executive of the London Ambulance Service and senior operational leadership roles within NHS London. He currently serves as Deputy Vice Chancellor and Clerk to the Board of Trustees at SOAS, University of London. He brings extensive experience in operational leadership, organisational transformation, estates and infrastructure, public sector governance and leadership in highly complex organisations.



Dr Andrew Murray, Non-Executive Director

Dr Andrew Murray joined the Board in January 2023 and chairs the Quality Committee across both Trusts. Since January 2026, he has also served as Deputy Chair of the Trust. A highly experienced GP, healthcare leader and consultant, he specialises in clinical strategy, service transformation and population health. He has held senior leadership roles across primary care and integrated care systems in South West London, including serving as Medical Director for the South West London Integrated Care System and Chair of the Clinical Commissioning Group. He brings extensive expertise in clinical governance, integrated care, population health and system leadership.



Dr Leonie Penna, Non-Executive Director

Dr Leonie Penna joined the Board in October 2025. A consultant in high-risk obstetrics and fetal medicine, she previously served as Chief Medical Officer at King's College Hospital NHS Foundation Trust and has held a range of senior clinical leadership roles across major NHS organisations. She also previously worked at both Epsom and St

Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust. Leonie brings extensive expertise in clinical leadership, maternity services, quality governance and patient safety.



Bidesh Sarkar CBE, Non-Executive Director

Bidesh Sarkar joined the Board in October 2025 and chairs the Finance and Performance Committee across both Trusts. He has more than two decades of Board-level executive experience across government, public services and the private sector, most recently serving as Chief Financial Officer at the Department for Business and Trade. He brings extensive expertise in finance, governance, transformation, corporate services and leadership within highly regulated organisations.



Claire Sunderland Hay, Associate Non-Executive Director

Claire Sunderland Hay has served as an Associate Non-Executive Director since October 2024. A qualified accountant, she has extensive senior leadership experience across financial services and highly regulated sectors, including at the Bank of England and major financial institutions. She brings expertise in governance, technology, innovation, regulation and risk management and has also held a number of governance and trustee roles across healthcare and professional bodies.

Executive Directors

Executive Director Appointment Dates			
Name	Role	Voting member of the Board	Appointed
Matthew Shaw	Group Chief Executive Officer	Yes	April 2026
Elizabeth Alabaster	Interim Group Chief Finance Officer	Yes	December 2025
Mark Bagnall	Group Chief Facilities, Infrastructure and Environment Officer	No	August 2024
Elaine Clancy	Interim Group Chief Nursing Officer	Yes	September 2025
Dr Richard Jennings	Group Chief Medical Officer	Yes	December 2018
Dr Stephen Jones	Group Chief Corporate Affairs Officer	No	March 2018
Michael Pantlin	Group Deputy Chief Executive Officer	No	April 2025
Kate Slemeck	Managing Director – St George's	No	February 2022
Victoria Smith	Group Chief People Officer	No	July 2024



Matthew Shaw, Group Chief Executive Officer

Matthew Shaw was appointed Group Chief Executive Officer on 7 April 2026 following completion of the recruitment process overseen by the Remuneration Committee during 2025/26.

Matthew is a qualified children's spinal surgeon and highly experienced NHS leader with more than 30 years' experience across clinical practice, executive leadership and healthcare transformation. Prior to joining the Group, he served for eight years as Chief Executive of Great Ormond Street Hospital for Children NHS Foundation Trust, having previously also held the role of Medical Director. He has also held senior leadership roles at Whittington Health NHS Trust and the Royal National Orthopaedic Hospital NHS Trust. Trained at St George's Hospital Medical School, Matthew brings extensive experience in clinical leadership, organisational transformation, health inequalities and innovation, including the use of AI and health data to improve patient care and organisational performance.



Lizzie Alabaster, Interim Group Chief Financial Officer

Lizzie Alabaster has served as Interim Group Chief Financial Officer since December 2025, having previously held senior finance leadership roles across the Group and NHS England London Region. Prior to joining the NHS, she trained as an accountant within the financial services sector.

Lizzie brings extensive expertise in NHS finance, operational delivery, financial performance, planning and regulatory oversight, including experience across NHS England, acute providers and the wider financial sector.



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

Mark Bagnall joined the Group in August 2024 and brings extensive experience in estates, infrastructure and capital development across large NHS organisations. He is a chartered building services engineer and has previously held senior estates and infrastructure leadership roles at Barts Health NHS Trust and University Hospital Southampton.

He brings significant expertise in infrastructure resilience, capital programmes, estates transformation and operational infrastructure management.



Elaine Clancy, Interim Group Chief Nursing Officer

Elaine Clancy joined the Group as Interim Group Chief Nursing Officer in September 2025. She also serves as Chief Nursing Officer for South West London and has more than 30 years' NHS experience across acute, community and commissioning settings.

Elaine has held a number of senior nursing and leadership roles across major London NHS organisations and brings extensive experience in quality improvement, nursing leadership, workforce leadership and system-wide service improvement.



Dr Richard Jennings, Group Chief Medical Officer

Dr Richard Jennings has served as Group Chief Medical Officer since February 2022, having joined St George's as Chief Medical Officer in 2018. A consultant in infectious diseases and acute medicine by background, he has previously held executive medical leadership roles at Whittington Health NHS Trust.

He has led a range of quality, clinical governance and transformation initiatives across the Group and brings extensive expertise in patient safety, clinical governance and system leadership.



Dr Stephen Jones, Group Chief Corporate Affairs Officer

Dr Stephen Jones joined the Trust in 2018 and leads corporate governance, Board governance and wider corporate affairs functions across the Group. Prior to joining the Trust, he held senior roles within the General Medical Council, Monitor/NHS Improvement, the Department of Health and the House of Commons.

He brings extensive expertise in governance, public policy, regulatory affairs, organisational transformation and Board governance.



Michael Pantlin, Interim Group Deputy Chief Executive Officer

Michael Pantlin joined the Group as Interim Group Deputy Chief Executive Officer in April 2025. He has held senior leadership roles across acute providers and integrated care systems, including within Barts Health NHS Trust and Surrey Heartlands.

He brings extensive experience in workforce strategy, organisational development, integrated care, transformation and system leadership.



Kate Slemeck, Managing Director – St George's Hospital

Kate Slemeck has extensive NHS operational leadership experience across major acute hospital organisations, including senior executive roles at the Royal Free London NHS Foundation Trust and Whittington Health. Originally trained as an Occupational Therapist, she has more than 30 years' NHS leadership experience.

Kate brings significant expertise in operational performance, hospital management, service transformation and organisational leadership.



Victoria Smith, Group Chief People Officer

Victoria Smith joined the Group in July 2024 as Group Chief People Officer. She has experience across both the NHS and wider public sector, most recently serving as Human Resources Director for the Ministry of Defence.

She brings extensive expertise in workforce strategy, organisational development, leadership, transformation and people management within large and complex organisations.

Directors who served during 2025/26 and left during the year

During 2025/26, a number of Executive and Non-Executive Directors who had made significant contributions to the organisation completed their terms of office or left the Board during the year.

Ann Beasley CBE, Non-Executive Director and Deputy Chair: Ann Beasley served on the Board from October 2016 until October 2025 and held the roles of Deputy Chair, Senior Independent Director and Chair of both the Finance and Performance Committee and Infrastructure Committee. She brought extensive experience in public sector finance, governance and leadership, including service as Chair of South West London and St George's Mental Health NHS Trust.

Dr Peter Kane, Non-Executive Director: Dr Peter Kane served on the Board from October 2021 until September 2025 and chaired the Audit and Risk Committee. He brought extensive expertise in finance, governance, performance and public sector leadership gained through senior roles across central and local government.

Jacqueline Totterdell, Group Chief Executive Officer: Jacqueline Totterdell served as Group Chief Executive Officer from August 2021 until September 2025, having previously served as Chief Executive of St George's University Hospitals NHS Foundation Trust since 2017. She played a central role in the development of the Group operating model, strengthening collaboration across the Group and wider South West London health system, while also contributing to a number of national NHS leadership initiatives.

James Blythe, Interim Group Chief Executive Officer: James Blythe served as Interim Group Chief Executive Officer from 18 September 2025 for the remainder of 2025/26, acting up from his substantive role as Managing Director of Epsom and St Helier University Hospitals NHS Trust. James previously served as Director of Commissioning at Surrey Downs Clinical Commissioning Group and Managing Director of Merton and Wandsworth Clinical Commissioning Groups, and as St George's and Epsom and St Helier Collaboration Programme Director. James was appointed Managing Director of Epsom and St Helier in February 2022.

Professor Arlene Wellman MBE, Group Chief Nursing Officer: Professor Arlene Wellman served as Group Chief Nursing Officer from February 2022 until August 2025, having previously served as Chief Nurse at Epsom and St Helier University Hospitals NHS Trust. She made a significant contribution to nursing leadership, workforce development, quality improvement and clinical governance across the Group.

Andrew Grimshaw, Group Chief Financial Officer: Andrew Grimshaw served as Group Chief Financial Officer from February 2022 until November 2025, having previously served as Chief Financial Officer and Deputy Chief Executive at St George's University Hospitals NHS Foundation Trust. He played an important role in the development of financial governance, financial strategy and organisational integration across the Group.

Ralph Michell, Group Chief Transformation Officer: Ralph Michell served as a Board member between April and August 2025 in his role as Group Chief Transformation Officer. He continues to serve the organisation in this role, which from September 2025 became a direct report to the Group Deputy Chief Executive Officer rather than a Board position.

The Board records its thanks for their contribution to the Board, the organisation and the wider Group.

Non-Executive Director independence

The Board reviewed the independence of the Non-Executive Directors during 2025/26, taking account of the provisions of the Code of Governance for NHS Provider Trusts.

The Board considered Sir Mark Lowcock, Pankaj Davé, Chiew Yin Jones, Dr Andrew Murray, Dr Leonie Penna, Bidesh Sarkar, Claire Sunderland Hay and Khadir Meer to be independent for the purposes of the Code during 2025/26.

A number of Non-Executive Directors and Associate Non-Executive Directors served on the Boards of both St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust as part of the Group operating model. The Board considered that these arrangements supported effective Group governance and integrated oversight and did not of themselves impair the independence of the relevant individuals.

Professor Natalie Armstrong serves as the University-appointed Non-Executive Director in accordance with the Trust's relationship with City St George's, University of London, where she serves as Executive Dean for the School of Health and Medical Sciences. The Board nonetheless considers Professor Armstrong to demonstrate independence of judgement and provide effective constructive challenge and oversight.

Relevant interests and appointments were declared and managed in accordance with the Trust's standards of business conduct and conflicts of interest arrangements.

Performance evaluation of the Board

Performance evaluation processes are intended to support continuous improvement in Board effectiveness, governance and leadership capability. 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. 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 Directors involve 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. The Chief Executive is appraised annually by the Chair. Executive Directors are appraised annually by the Chief Executive. The outcomes of Executive Director appraisals are reported to the Remuneration Committee.

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>.

Council of Governors, Membership and Public Accountability

As an NHS Foundation Trust, St George's University Hospitals NHS Foundation Trust is accountable not only through its Board of Directors and wider governance arrangements, but also through its membership community and Council of Governors. The Council of Governors forms an important part of the Trust's accountability arrangements, representing the interests of patients, staff, members and the public and helping ensure that the organisation remains responsive, transparent and accountable to the communities it serves.

Our members

During 2025/26, the Trust's membership community comprised more than 13,000 public members and more than 8,700 staff members across a range of constituencies including Wandsworth, Merton, Lambeth and the Rest of England.

The Trust continued during the year to strengthen its approach to membership engagement, with a focus on improving engagement with members, strengthening representativeness and supporting greater involvement of members and the public in the development of services and organisational priorities.

The Trust remained committed during 2025/26 to openness, transparency and public accountability through Board meetings held in public, public Council of Governors meetings, member engagement activity, public consultation and availability of information through the Trust website and Freedom of Information arrangements.

St George's Membership			
Membership constituency	2023-24	2024-25	2025-26
South West Lambeth	539	539	541
Merton	3,364	3,376	3,493
Wandsworth	4,069	4,082	4,198
Rest of England	4,861	4,860	4,984
Out of Trust Area	0	6	20
Total Public Members	12,836	12,863	13,236
Total Staff Members	9,753	8,725	8,915
Total Members	22,589	21,588	22,151

The role of the Council of Governors

The Council of Governors forms an important part of the Trust's accountability arrangements and provides a direct link between the Trust, its membership community and the wider public. Governors are elected and appointed in accordance with the Trust's Constitution and play an important role in representing the interests of members, patients, staff and local communities.

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 members and the public.

The Council of Governors also has a number of specific statutory responsibilities, including:

- appointing the Chair and Non-Executive Directors;
- approving the appointment of the Chief Executive;
- appointing the external auditor;
- approving amendments to the Trust's Constitution; and
- approving significant transactions and formal organisational changes such as mergers.

The Council works closely with the Board of Directors while maintaining a clear distinction between the responsibilities of the Board and those of Governors. Governors are supported to discharge their responsibilities through regular reporting, formal meetings, Board engagement, development sessions and opportunities to observe Board and Committee meetings.

St George's Council of Governors 2025/26					
Governor	Constituency / Office	Term	Start Date of Current / Most Recent Term of Office	Current Term of Office	Meetings Attended (Actual / Eligible Attendance)
Mark Lowcock	Chair	N/A	1 April 2025	1 April 2025 – 31 March 2028	5 / 5
Elected Public Governors					
Afzal Ashraf	Wandsworth	Third	1 February 2026	1 February 2026 – 31 January 2029	3 / 5
Jane Curley	Wandsworth	First	1 February 2026	1 February 2026 – 31 January 2029	1 / 1
John Hallmark	Wandsworth	Third	1 February 2024	1 February 2024 – 31 January 2027	5 / 5
Lucy Mowatt	Wandsworth	Second	1 February 2026	1 February 2026 – 31 January 2029	4 / 5
Augustine Odiadi	Wandsworth	First	1 February 2024	1 February 2024 – 31 January 2027	4 / 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	0 / 4
Nasir Akhtar	Merton	Third	1 February 2026	1 February 2026 – 31 January 2029	3 / 5
Luisa Brown	Merton	First	1 February 2025	1 February 2025 – 31 January 2027	5 / 5
Hannibal Latuff	Merton	First	1 February 2025	1 February 2025 – 31 January 2027	5 / 5
Chelliah Lohenhran	Merton	First	1 February 2024	1 February 2024 – 31 January 2026	1 / 4
Ifeanyi Nwike	SW Lambeth	First	1 February 2026	1 February 2026 – 31 January 2029	1 / 1
Ashok Bhat	Rest of England	First	1 February 2025	1 February 2025 – 31 January 2027	5 / 5
James Bourlet	Rest of England	First	1 February 2024	1 February 2024 – 31 January 2027	4 / 5
Munir Dean	Rest of England	First	1 February 2026	1 February 2026 – 31 January 2029	1 / 1
Xavier Fernandes	Rest of England	First	1 February 2026	1 February 2026 – 31 January 2027	0 / 1
Sandhya Drew	Rest of England	Second	1 February 2023	1 February 2023 – 31 January 2026	0 / 4
Elected Staff Governors					
Dympna Foran	Nursing & Midwifery	First	1 February 2024	1 February 2024 – 31 January 2027	4 / 5
Khalid Khan	Non-Clinical	First	1 February 2026	1 February 2026 – 31 January 2029	1 / 1
Atif Mian	AHPs	First	1 February 2024	1 February 2024 – 22 May 2025	0 / 1
Abul Siddiky	Medical & Dental	First	1 February 2024	1 February 2024 – 31 January 2027	3 / 5
Huon Snelgrove	Non-Clinical	First	1 February 2023	1 February 2023 – 31 January 2026	4 / 4
Appointed Stakeholder Governors					
Alfredo Benedicto (Lead Governor)	Healthwatch Merton	Third	1 February 2024	1 February 2024 – 31 January 2027	4 / 5
Sarah Forrester	Healthwatch Wandsworth	Second	1 February 2024	1 February 2024 – 31 January 2027	4 / 5
Judi Gasser	Wandsworth Council	First	18 February 2024	18 February 2024 – 17 February 2027	5 / 5
Julian Ma	City St George's University	First	1 February 2023	1 February 2023 – 31 March 2026	3 / 5
Georgina Sims	Kingston University	First	1 May 2024	1 May 2024 – 30 April 2027	2 / 5
Shuile Syeda	Merton Council	First	1 April 2025	1 April 2025 – 31 March 2028	4 / 5
Associate Governor, appointed by the Council of Governors					
Sophia Agha	Council of Governors	First	12 March 2025	12 March 2025 – 11 March 2027	3 / 5

Council of Governors activity during 2025/26

During 2025/26, the Council of Governors considered a broad range of strategic, operational and governance matters affecting the organisation. Key areas of focus included:

- quality and patient safety;
- operational performance and urgent care pressures;
- maternity services and quality improvement;
- financial sustainability and financial performance;
- development of the Group transformation programme and Medium Term Plan;
- workforce and People Strategy developments;
- estates and infrastructure challenges;
- health inequalities; and
- oversight of Board appointments and governance arrangements.

The Council received regular updates from the Group Chief Executive, Board Committee Chairs and Executive Directors and continued to question and challenge Non-Executive Directors regarding the performance of the Board and the effectiveness of governance and assurance arrangements across the Group.

During the year, Governors also received updates and presentations regarding:

- operational recovery and emergency care pressures;
- implementation of the Group strategy and five-year plan;
- quality priorities and patient safety;
- maternity services;
- implementation of the People Strategy;
- financial recovery and operational performance;
- estates and Green Plan developments;
- Care Quality Commission inspection findings;
- development of the membership engagement strategy; and
- governor elections and governance developments.

The Council also played an important role during the year in relation to leadership appointments and governance continuity. During 2025/26, the Council approved the appointment of a new Group Chief Executive Officer and re-appointed an existing Non-Executive Director to a second term of office.

The appointment process for the new Chair, undertaken in 2024/25, involved engagement with NHS England, external recruitment advisers and Governor representatives, including Governor participation in stakeholder engagement and interview processes. Sir Mark Lowcock KCB commenced in post as Chair on 1 April 2025.

Governor engagement and assurance

A significant component of the Council's work during 2025/26 involved direct engagement with clinical and operational services across the organisation through Governor visits, service engagement sessions and feedback from community engagement activity.

Governors visited a wide range of services and departments across the hospital estate during the year, including inpatient wards, urgent and emergency care services, outpatient services, renal services and support services.

These visits enabled Governors to observe services directly, engage with staff and patients and provide feedback regarding patient experience, operational pressures, workforce culture, infrastructure challenges and service quality. Governors consistently highlighted the commitment, professionalism and compassion of staff across the organisation, while also identifying recurring themes relating to estate infrastructure, patient flow, discharge delays, operational pressures and digital and infrastructure constraints.

Governor visits also provided important opportunities for Governors to understand how strategic and operational issues affected frontline services and patient experience in practice. Feedback arising from visits was routinely discussed at Council meetings and informed wider discussions regarding quality, operational performance, estates and workforce issues across the Group.

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.

Attendance by Non-Executive Directors at Council meetings, Governor visits and member engagement activity also supported Board understanding of the views and experiences of Governors, members and the wider public.

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 2025/26.

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.

Council Committees

The Council of Governors is supported by two formal sub-committees:

- the Council Nominations and Remuneration Committee; and
- the Membership and Engagement Committee.

The Council Nominations and Remuneration Committee supports the Council in relation to appointment, appraisal and remuneration arrangements for the Chair and Non-Executive Directors. During 2025/26, the Committee supported the Council of Governors in the re-appointment of Andrew Murray as Non-Executive Director on the Board and considered the allowances for the role of Senior Independent Director.

The Council of Governors is responsible for appointing the Trust Chair and Non-Executive Directors. The Council is supported in this role by the Council Nominations and Remuneration Committee, which oversees succession planning, reviews the skills, experience, diversity and expertise required on the Board, and makes recommendations to the Council regarding appointments and reappointments. When vacancies arise, the Committee reviews the composition of the Board and agrees the skills and experience required. Recruitment is undertaken through an open and transparent process, supported where appropriate by external recruitment advisers. Governors are involved throughout the process, including the development of role specifications, stakeholder engagement activity, candidate assessment, shortlisting and interview arrangements.

Following consideration of recommendations from the Council Nominations and Remuneration Committee and interview panel feedback, the Council of Governors determines whether to approve the appointment or reappointment of the Chair or Non-Executive Director. Appointments are made on merit against objective criteria and with due regard to equality, diversity and inclusion and the need to maintain an effective balance of skills, knowledge, experience and independence on the Board.

The main role and responsibilities of the Council Nominations and Remuneration Committee are set out in its Terms of Reference. These include responsibility for supporting the Council in relation to succession planning, appointment and reappointment processes, appraisal arrangements and remuneration matters relating to the Chair and Non-Executive Directors.

The Membership and Engagement Committee supports delivery of the membership engagement strategy and oversight of membership development and engagement activity. During the year, the Committee supported development of a refreshed membership engagement strategy and plans for proactive engagement with members and the public.

Governor development and support

The Trust continued during 2025/26 to support Governor development through induction sessions, formal training opportunities, Board development activity, visits to clinical and non-clinical services and opportunities to observe Board and Committee meetings.

Governors also participated in development sessions on quality and patient safety matters, implementation of the Patient Safety Incident Response Framework, operational pressures, governance developments and strategic priorities across the Group.

The Trust recognised the importance of ensuring Governors were appropriately supported to fulfil their statutory responsibilities within an increasingly complex governance and operating environment and therefore continued to develop Governor engagement, development and communication arrangements during the year.

Membership engagement and communication

The Trust remains committed to maintaining effective communication and engagement between members, Governors and Directors. During 2025/26, the Council of Governors continued to oversee an active programme of membership engagement, including member events, public meetings, engagement activities and opportunities for members to contribute feedback and questions relating to the Trust and its services.

The Council of Governors also reviewed and updated the Trust's Membership Engagement Strategy during the year to support stronger member engagement, improve accessibility and ensure that membership arrangements continue to reflect the communities served by the Trust.

Members are able to communicate directly with the Council of Governors and Board of Directors through a range of engagement mechanisms and formal communication channels. The Trust's website includes clear information regarding the role of Governors, how to contact Governors and Directors and how members can raise questions, feedback or matters of interest relating to the Trust and its services. Contact details and information about the Council of Governors, Board of Directors and membership arrangements are available on the Trust's website and through the Trust's membership office. Members can contact the Trust and 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>

Elections and changes during the year

During 2025/26, the following Governors stood down from the Council of Governors:

- Ataul Qadir Tahir, Public Governor – Wandsworth;
- Chellian Lohendran, Public Governor – Merton;
- Huon Snelgrove, Staff Governor – Non-Clinical;
- Atif Mian, Staff Governor – Allied Health Professional and other scientific & technical; and
- Julian Ma, Appointed Governor – City St George's University.

Elections to the Council of Governors were held in November 2025 and the following Governors were elected to serve on the Council from 1 February 2026:

- Jane Curley, Public Governor – Wandsworth;
- Ifeanyi Nwike, Public Governor – South West Lambeth;
- Munir Dean, Public Governor – Rest of England;
- Xavier Fernandes, Public Governor – Rest of England; and
- Khalid Khan, Staff Governor – Non-Clinical.

Conclusion

During 2025/26, governance arrangements across the Trust and wider Group continued to evolve in response to increasing operational complexity, financial challenge and organisational transformation. Across the Board, Committees and Council of Governors, increasing emphasis was placed on assurance quality, strategic alignment, organisational learning and strengthening integrated governance arrangements across the Group.

The Board recognised that continued development of governance maturity, leadership capability and organisational culture remained essential to supporting delivery of safe, sustainable and high-quality care across the organisation. Governance arrangements therefore continued to evolve during the year to support clearer accountability, stronger organisational collaboration and more integrated strategic and operational leadership across the Group.

Corporate Governance and statutory disclosures

Alongside the governance and accountability arrangements described above, the following section sets out additional corporate governance and statutory disclosures relevant to the operation of the Trust during 2025/26.

NHS Provider Licence

The Trust remained compliant during 2025/26 with the NHS Provider Licence issued by NHS England.

The Board maintained oversight of compliance with the conditions of the licence through the Trust's wider governance, risk management and assurance arrangements, including oversight through the Board Assurance Framework, Board Committees and regular performance and regulatory reporting.

During the year, the Trust continued to work closely with NHS England in relation to operational performance, quality and governance matters, including actions arising from Care Quality Commission inspection activity and wider NHS Oversight Framework arrangements. No enforcement action was taken against the Trust in relation to the NHS Provider Licence during 2025/26.

NHS Oversight Framework

NHS England's NHS Oversight Framework provides 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 of capability and capacity.

The Trust continued during 2025/26 to monitor organisational performance and delivery through the NHS Oversight Framework, which forms an important component of the Trust's wider performance, governance and assurance arrangements. The Board and its Committees received regular updates regarding NHS Oversight Framework performance and associated regulatory oversight through the Integrated Quality and Performance Report and wider governance reporting arrangements.

During 2025/26, the Trust was in Segment 3 of the NHS Oversight Framework.

During the year, the Trust continued to face significant operational, workforce and financial pressures affecting a number of national performance standards, particularly urgent and emergency care performance, elective recovery and some areas of quality and operational delivery. However, the Trust also delivered improvement across a number of operational and quality indicators, including cancer performance, elective recovery trajectories and reductions in long waits.

The Board and its Committees maintained close oversight of NHS Oversight Framework metrics and associated improvement actions through regular review of operational, quality, workforce and financial performance reporting. Particular focus during 2025/26 included urgent and emergency care performance, corridor care, elective recovery, diagnostic performance, workforce pressures, productivity improvement, quality governance and delivery of the Medium-Term Plan.

The Board recognised the importance of ensuring that operational, quality, workforce and financial performance were considered in an integrated way through the NHS Oversight Framework and wider governance arrangements. Improvement actions arising from NHS Oversight Framework oversight were therefore aligned with the Trust's wider transformation, operational improvement and governance improvement programmes.

The Care Quality Commission and NHS England Well-Led Framework

During 2025/26, the Board continued to have regard to the Care Quality Commission well-led framework and wider NHS England well-led principles in assessing organisational performance, governance effectiveness, internal control and the operation of the Board Assurance Framework.

The Board recognised the importance of effective leadership, organisational culture, governance, assurance and continuous improvement in supporting delivery of safe, sustainable and high-quality care. During the year, significant focus was placed on strengthening governance maturity, assurance quality, escalation arrangements, organisational learning and consistency of governance processes across the Group.

During 2025/26, the Trust received findings arising from Care Quality Commission inspections and the Well-Led review process, including Section 29A Warning Notices relating to maternity and urgent and emergency care services and findings relating to Regulation 17 concerning aspects of governance, management and assurance arrangements. The Board recognised these findings and prioritised substantial improvement work during the year, including implementation of the Group Quality and Safety Clinical Governance Improvement Plan, strengthened oversight and escalation arrangements, governance and assurance improvements and targeted operational and quality improvement actions across affected services.

The Board considered the findings from regulatory reviews alongside internal assurance processes, Board and Committee oversight, internal audit activity, operational performance reporting and wider governance and assurance information in forming its overall assessment of organisational performance, governance and internal control arrangements.

There were no material inconsistencies identified between the Annual Governance Statement, other sections of the Annual Report and findings arising from Care Quality Commission reviews. Further detail regarding governance, risk management, internal control arrangements and actions taken in response to Care Quality Commission findings is set out in the Annual Governance Statement.

Disclosures

Principal activities of the Trust

Information on the Trust's principal activities, including performance management, financial management and risk is set out in the Performance Report.

Counter fraud, bribery and corruption

The Trust is committed to maintaining high standards of business conduct, integrity and accountability across all aspects of its activities.

The Trust has policies and procedures in place intended to prevent fraud, bribery and corruption and to support compliance with relevant legal and regulatory requirements, including the Bribery Act 2010.

Counter fraud arrangements operate through the Trust's Local Counter Fraud service, supported by policies relating to standards of business conduct, conflicts of interest, gifts and hospitality, raising concerns and fraud response arrangements.

The Audit and Risk Committee receives regular reports relating to counter fraud activity, including proactive and reactive work, fraud risk assessment activity and progress against the counter fraud workplan.

During 2025/26, the Trust continued to promote awareness of fraud, bribery and corruption risks through mandatory training, policy awareness and wider governance and assurance arrangements.

Directors' responsibilities

The directors acknowledge their responsibilities for the preparation of the annual report and annual accounts, and consider that, taken as a whole, these are fair, balanced and understandable, and provide the information necessary for stakeholders to assess the Trust's performance, business model and strategy.

Section 43 income disclosures

The Trust is required under section 43(2A) of the NHS Act 2006 to disclose information relating to income generated from activities other than the provision of goods and services for the purposes of the health service in England. A full breakdown of the Trust's operating income is set out in the Performance Report (Financial Performance).

Cost allocation

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

Better Payment Practice Code

The Trust has not made any political or charitable donations during 2025/26. 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		2025-26 Number	2025-26 £000s	2024-25 Number	2024-25 £000s
Total non-NHS trade invoices paid in the year		120,781	694,256	118,654	492,008
Total non-NHS trade invoices paid within target		105,118	640,904	106,906	443,620
Percentage of non-NHS trade invoices paid within target		87.03%	92.32%	90.10%	90.17%
NHS Payables		2025-26 Number	2025-26 £000s	2024-25 Number	2024-25 £000s
Total NHS trade invoices paid in the year		3,324	55,534	3,772	54,231
Total NHS trade invoices paid within target		2,330	36,277	2,265	37,817
Percentage of NHS trade invoices paid within target		70.10%	65.32%	60.05%	69.73%
Total					
Total bills paid in the year		124,105	749,790	122,426	546,239
Total bills paid within target		107,448	677,181	109,171	481,437
Percentage of bills paid within target		86.58%	90.32%	89.17%	88.14%

Political and charitable donations

The Trust has not made any political or charitable donations during 2025/26.

External audit fees

Grant Thornton received £373,408 in audit fees in relation to the statutory audit of the Trust to 31 March 2026.

Disclosures under the Code of Governance for NHS Provider Trusts

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. The Code of Governance for NHS provider trusts, published in October 2022, has been applicable since 1 April 2023.

Throughout this Annual Report, the Trust describes how it has applied the principles of the Code in relation to Board leadership, governance, accountability, risk management, internal control, quality governance and engagement with members and stakeholders.

The Board considered that the Trust's governance arrangements were consistent with the principles of the Code throughout 2025/26. During the year, governance arrangements continued to evolve in response to development of the Group operating model with Epsom and St Helier University Hospitals NHS Trust, including operation of a number of governance arrangements through Committees-in-Common while maintaining clear statutory accountability within each organisation.

The Board considered these arrangements to be consistent with the principles of effective governance, accountability, Board leadership and assurance set out within the Code.

A summary of where detail can be found on the issues we are required to disclose is given in the following table:

Code of Governance requirements	
Code reference	Section of annual report
A.2.1	Performance Report The Performance Report provides information related to the Trust's operational performance, financial performance, quality of care provided, how the Trust works with partners, an overview of the risks to future sustainability, and information about how the Trust's governance contributes to the delivery of the Trust's strategy.
A.2.3	Staff Report The Staff Report sets out details of how the Trust has sought to implement its People Strategy, the steps it is taking to strength culture , equality, diversity and inclusion, an speaking up.
A.2.8	Performance Report The Performance Report describes how the interests of stakeholders, including system and place-based partners, have been considered the Trust's work and decision-making. The Report also sets out the mechanisms for engaging with stakeholders and how the Trust's governance oversees collaboration with other organisations.
B.2.6	Accountability Report The Accountability Report (Board composition and effectiveness) sets out the non-executive directors the Board considers to be independent. This includes details relevant to the shared non-executive director appointments across the St George's, Epsom and St Helier University Hospitals and Health Group.
B.2.13	Accountability Report Details of the number of times the Board and its Committees have met during 2025/26, and individual director attendance, is set out in the Directors' report, within the Accountability Report.
B.2.16	Accountability Report The Accountability Report sets out the number of times the Board and its committees met during 2025/26 and individual director attendance.
B.2.17	Accountability Report The Accountability Report sets out the roles and responsibilities of the Council of Governors, including providing details about how any disagreements between the Council and the Board would be resolved.
C.2.5	Staff Report The Staff Report sets out the disclosures relating to consultancy spend in 2025/26.
C.2.8	Accountability Report The section of the Directors' report on the Council of Governors sets out details about the process followed by the council of governors to appoint the chair and non-executive directors.
C.4.2	Accountability Report The Accountability Report provides a description of each director's skills, expertise and experience.

Code of Governance requirements	
Code reference	Section of annual report
C.4.7	The Trust had a CQC Well Led inspection in February 2025, the report of which was published in October 2025. As a result, the Trust did not carry out an externally facilitated developmental review of leadership and governance using the Well Led framework in 2025/26. However, the Trust plans to hold an external review of leadership and governance in 2026/27.
C.4.13	Accountability Report The Directors' Report and the Remuneration Report describe the work of the Remuneration Committee. The Directors' Report includes details about the process used in relation to appointments and succession planning, the ethnic and gender composition of the Board, and details about how the Board has been evaluated. Wider information regarding the gender and ethnic composition of the Trust's workforce are set out in the Staff Report.
C.5.15	Accountability Report The Accountability Report sets out how the Trust and Governors have engaged with the Trust's members in 2025/26. While Governors did not personally canvass the opinion of FT members in 2025/26 on the Trust forward plan, Governors did discuss and review the Trust's Medium Term Plan at the Council of Governors meeting in December 2025.
D.2.4	Accountability Report The Directors Report within the Accountability Report includes details about the Audit and Risk Committee's review of financial statements and assurance regarding the independence and effectiveness of the external audit process, and the duration of the external auditor's appointment at the Trust.
D.2.6	Accountability Report The disclosures in the Directors' Report set out the responsibility of the directors for preparing the annual report and accounts, and states that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
D.2.7	Performance Report The Performance Report sets out the details of the principal risks facing the Trust.
D.2.8	Annual Governance Statement The Annual Governance Statement sets out how the Board monitors the Trust's risk management and internal control systems.
D.2.9	Statement of the chief executive's responsibilities as the accounting officer of St George's University Hospitals NHS Foundation Trust
E.2.3	Remuneration Report Details of retention of earnings by directors released during the year are set out in the Remuneration Report.
Appendix B, para 2.3	Accountability Report The Accountability Report identifies the members of the Council of Governors, including details of the constituency they represent, whether they were elected or appointed, and the duration of their appointments. The Lead Governor is also identified. The Accountability Report also sets out the number of meetings of the Council held in 2025/26 and details of attendance by individual governors.
Appendix B, para 2.4	Accountability Report Details on the mechanisms for communications between governors are members, and contact procedures for members who wish to communicate with governors and / or directors are set out on the Trust website and are also included in the Directors' Report section of the Accountability Report.
Appendix B, para 2.15	Accountability Report The Directors' Report section of the Accountability Report sets out how the Board, and non-executives in particular, are supported to develop an understanding of the views of Governors and members.

Remuneration Report 2025/26

This report sets out the remuneration arrangements for senior leaders and Board members of St George's University Hospitals NHS Foundation Trust during 2025/26. It describes the governance arrangements supporting remuneration decisions, the work of the Remuneration Committee during the year and the remuneration disclosures required under the NHS Foundation Trust Annual Reporting Manual.

The Remuneration Committee operated throughout the year as part of the wider Group governance model and through Committees-in-Common arrangements with Epsom and St Helier University Hospitals NHS Trust, while maintaining clear statutory accountability within each organisation. The Committee provided oversight of remuneration governance, senior executive appointments, succession planning and senior leadership remuneration arrangements in line with relevant statutory, regulatory and governance requirements.

The Board recognises the importance of ensuring that remuneration arrangements support effective leadership, accountability, organisational sustainability and delivery of high-quality care, while also remaining transparent, proportionate and aligned with the principles of public service.

Details of the Committee's remit, membership, meeting attendance and governance arrangements are set out within the Directors' Report, alongside the other committees of the Board.

Annual statement from the Chair of the Remuneration Committee

During 2025/26, the Remuneration Committee continued to oversee senior leadership remuneration, executive appointments, succession planning and Very Senior Manager (VSM) arrangements across the Group. The Committee operated through Committees-in-Common arrangements across St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust while maintaining clear statutory accountability within each organisation.

The year was characterised by significant leadership transition, organisational transformation and continued operational and financial challenge across the NHS. Within this context, the Committee placed particular emphasis on leadership continuity, long-term organisational resilience, succession planning and ensuring that remuneration arrangements remained proportionate, transparent and aligned with the long-term strategic priorities of the organisation. Particular importance was also placed on ensuring continuity of leadership and organisational stability during a period of significant operational and organisational change across the Group.

Significant remuneration and leadership changes during the year included implementation of interim executive leadership arrangements following changes to Group executive leadership roles during the year, including interim arrangements relating to the Group Chief Executive Officer, Group Chief Finance Officer, and Group Chief Nursing Officer. The Committee also continued oversight of affordability, organisational continuity and alignment between senior leadership arrangements, organisational transformation and the wider financial position of the organisation.

Major decisions considered by the Committee during 2025/26 included:

- oversight and approval of the recruitment and appointment process for a new Group Chief Executive Officer, including consideration of interim leadership arrangements following the departure of the previous Group Chief Executive Officer;
- consideration and approval of interim and substantive arrangements relating to the Group Chief Finance Officer and Group Chief Nursing Officer roles;
- consideration of executive succession planning, executive objectives and wider executive leadership development arrangements across the Group;

- approval of the Group VSM pay framework and consideration of wider executive and senior leadership workforce structures;
- approval of remuneration arrangements relating to recruitment of a substantive Group Chief Digital Information Officer following an open competitive recruitment process.

In considering these matters, the Committee placed particular emphasis on affordability, long-term organisational resilience, leadership capability and ensuring that remuneration and organisational arrangements remained proportionate within the wider financial and operational context facing the NHS.

Throughout the year, the Committee remained mindful of the importance of equality, diversity and inclusion within senior leadership appointments and succession planning and considered these issues as part of recruitment and workforce discussions. The Committee also continued to have regard throughout the year to NHS England guidance relating to VSM pay, affordability and senior appointment governance arrangements.

The Committee considers that the remuneration arrangements described within this report support effective leadership, accountability, long-term organisational resilience and stewardship of public resources expected within the NHS and wider public sector.



Sir Mark Lowcock
Chair, Remuneration Committee
24 June 2026

Senior Managers' remuneration policy

The Trust's approach to senior managers' remuneration is intended to support effective leadership, financial and organisational sustainability and delivery of high-quality care, while ensuring appropriate stewardship of public resources. Remuneration arrangements are designed to be transparent, proportionate and aligned with relevant national NHS guidance and public sector principles.

The Remuneration Committee is responsible for determining remuneration arrangements for Very Senior Managers (VSMs) and other senior leadership roles within its remit. In doing so, the Committee has regard to relevant NHS England guidance relating to senior pay, VSM pay frameworks, organisational affordability and wider workforce considerations.

During 2025/26, the Committee continued to review senior leadership structures and remuneration arrangements in the context of wider organisational transformation, leadership transition and the continued development of the Group operating model. In doing so, the Committee remained mindful of the importance of balancing organisational affordability, leadership capability and long-term organisational resilience.

The Committee did not make any significant changes during 2025/26 to the overarching principles underpinning the Trust's senior managers' remuneration policy.

During 2025/26, the Trust continued to apply the NHS Very Senior Managers Pay Framework published jointly by the Department of Health and Social Care and NHS England. The Remuneration Committee had regard to relevant national guidance relating to senior pay, affordability, recruitment and retention, organisational performance and governance requirements when considering remuneration arrangements for Executive Directors and other Very Senior Managers.

Components of senior managers' remuneration		
Component	Purpose and approach	Policy operation
Base salary	To support recruitment and retention of high-quality senior leaders capable of delivering the Trust's strategic, operational and transformation priorities.	Salaries of very senior managers are determined by the Remuneration Committee having regard to relevant NHS England guidance, organisational scale and complexity, market conditions, affordability and wider public sector considerations.
Pension and benefits	To provide appropriate retirement and life assurance / in service benefits in line with national NHS arrangements.	Senior managers are eligible to participate in the NHS Pension Scheme, subject to scheme rules and individual eligibility. Life assurance / death in service benefits may be provided as part of an individual's pension arrangements.
Performance-related pay	The Trust does not operate local performance-related bonus or incentive arrangements for Executive Directors or Very Senior Managers.	Annual remuneration arrangements are determined in accordance with relevant NHS England guidance relating to Very Senior Managers and may take account of appraisal outcomes, organisational performance, affordability and wider national pay arrangements where applicable. No annual bonus or long-term incentive arrangements operated during 2025/26.
Severance arrangements	To ensure that contractual arrangements relating to termination of employment are managed fairly, proportionately and in accordance with relevant contractual and statutory requirements.	Any severance arrangements are considered by the Remuneration Committee where appropriate and are managed in accordance with relevant NHS guidance and contractual obligations.
Recruitment and retention arrangements	To support recruitment to particularly challenging or specialist senior leadership roles where appropriate.	The Committee may, where appropriate, consider market conditions, organisational complexity and NHS England VSM guidance when determining remuneration arrangements for specific appointments.
Expenses	To reimburse legitimate business expenses incurred in the course of official duties.	Expenses are reimbursed in accordance with the Trust's policies relating to business expenses and standards of business conduct.

Executive Director service contracts

Executive Directors are employed on permanent contracts of employment unless otherwise stated. Notice periods are intended to support appropriate organisational continuity while remaining proportionate and consistent with relevant NHS guidance and contractual practice.

Executive Director Appointments and Notice Periods ¹				
Executive Director	Post	Date of first appointment as Executive Director	Unexpired term	Notice period
Matthew Shaw	Group Chief Executive Officer	April 2026	Open ended	3 months
Elizabeth Alabaster	Interim Group Chief Finance Officer	December 2025	August 2026	3 months
Mark Bagnall	Group Chief Facilities, Infrastructure and Environment Officer	August 2024	Open ended	3 months
Elaine Clancy	Interim Group Chief Nursing Officer	September 2025	September 2026	3 months
Richard Jennings	Group Chief Medical Officer	December 2018	Open ended	3 months
Stephen Jones	Group Chief Corporate Affairs Officer	March 2018	Open ended	3 months
Michael Pantlin	Group Deputy Chief Executive Officer	April 2025	Open ended	3 months
Kate Slemeck	Managing Director – St George's	February 2022	Open ended	3 months
Victoria Smith	Group Chief People Officer	July 2024	Open ended	3 months

Chair and Non-Executive Director remuneration

The remuneration of the Chair and Non-Executive Directors is determined by the Council of Governors on the recommendation of the Council of Governors' Remuneration Committee.

During 2025/26, the Group Chair received remuneration of £85,000 per annum in respect of the role of Group Chair across St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust. The costs of this arrangement were shared equally between the two organisations.

In 2025/26, the remuneration for Non-Executive Directors and Associate Non-Executive Directors of St George's University Hospitals NHS Foundation Trust was £17,000 per annum. The Senior Independent Director received an additional supplement of £2,000 per annum in recognition of the additional responsibilities associated with the role.

Where Non-Executive Directors served on the Boards of both St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust as part of the Group operating model, combined remuneration was £22,000 per annum, with costs shared equally between the two organisations.

These arrangements were consistent with relevant NHS England guidance and reflected the operation of the wider Group governance model during 2025/26.

¹ Certain Executive Directors entered into revised contractual arrangements following the establishment of the Group Executive arrangements in February 2022.

Statutory Remuneration Disclosures

The following section sets out the statutory remuneration disclosures required under the NHS Foundation Trust Annual Reporting Manual in relation to senior managers' remuneration, pension benefits, fair pay, exit payments and other remuneration-related matters for 2025/26. These disclosures should be read alongside the governance and remuneration policy information set out earlier in this report.

Sections identified as audited have been audited by the Trust's external auditor, Grant Thornton UK LLP.

Fair pay disclosures (audited)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2025/26 was £220,000–£225,000 (2024/25: £215,000–£220,000). This is a change between years of 3%. This was 5.0 times (2024/25: 5.3 times) the median remuneration of the workforce, which was £45,000 (2024/25: £41,000). The highest paid Director received no performance pay or bonuses during 2025/26.

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

For employees of the Trust as a whole, the range of annualised full-time equivalent remuneration in 2025/26 was from £30,074 to £298,982 (2024/25: £29,029 to £439,884). The percentage change in average employee remuneration between years was 5%. Nineteen employees received remuneration in excess of the highest-paid director in 2025/26 (2024/25: 33 employees).

Range of staff remuneration for 2025/26 (audited)

Annualised full-time equivalent remuneration across the Trust's workforce ranged from £30,074 at the lower quartile of the workforce pay distribution to £298,982 for the highest paid employee during 2025/26 (2024/25: £29,029 and £439,884 respectively).

Certain payroll figures within the workforce remuneration disclosures may be affected by factors including arrears payments, clinical excellence awards, additional clinical activity and bank work during the financial year. The Trust also notes that payroll reporting may include anomalous low-value payments associated with bank staff or partial-period payments which do not reflect substantive annualised remuneration levels.

Table 1: Percentage change in remuneration of highest paid director and average employee 2025/26²

Year	Highest Paid Director		Average employee pay	
	Salary and allowances £ 000	Performance pay and bonuses £ 000	Salary and allowances £ 000	Performance pay and bonuses £ 000
FY 2025-26	223	0	49	1
FY 2024-25	216	0	46	1
% increase / decrease	3%	0%	5%	1%

² In FY25-26 and FY24-25, the highest-paid board member was Managing Director. There is a 3% increase in the highest paid in FY25-26 compared with FY24-25.

In FY25-26, 50% salary of the Group Chief Executive Officer, Group Deputy Chief Executive Officer, Group Chief Finance Officer, Group Chief Medical Officer, Group Chief Nursing Officer, Group Chief People Officer, Group Chief Infrastructure, Facilities and Environment Officer and Group Chief Corporate Affairs Officer were recharged to Epsom and St Helier Hospital NHS Trust (ESTH).

The highest-paid Managing Director received no performance pay and bonuses in FY25-26.

5% Increase in average pay for employees in FY25-26 compared to FY24-25. This excludes the highest-paid Managing Director.

1% increase in performance pay and bonuses (Local Clinical Excellence Awards) in FY25-26 compared with FY 24-25.

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 2024/25

Year	Highest Paid Director		Average employee pay	
	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 2

Table 3: Pay multiples

Multiple table	2025/26	2024/25
Payroll costs (£000)	879,623	827,506
Whole time equivalent	10,821	10,653
25 th percentile	30	29
Median (£000)	45	41
75 th percentile	63	60
Highest paid director (£000)	223	216
25 th percentile pay ratio	7.4	7.4
Median pay ratio	5.0	5.3
75 th percentile pay ratio	3.5	3.6

Table 4: Pay ratio disclosure (audited)

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

Year	25 th percentile pay ratio	Median Pay ratio	75 th percentile pay ratio
FY 2025/26	7.4	5.0	3.5
FY 2024/25	7.4	5.3	3.6

Table 5: Pay ratio information table³ (audited)

FY 2025/26	25 th percentile pay ratio	Median Pay ratio	75 th percentile pay ratio
Total remuneration (£000)	30	45	63

³ 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 2026. In 2025-26, the lowest annualised salary was £1.68 (2024-25 was £3.24). The highest paid was £298,982 (Chief Executive) (2024-25 £439,884). 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 FY25-26. The lowest paid salary of £30,074 compared to FY24-25 £29,029 (Band 1).

The calculation is based on full-time equivalent staff working for the Trust on 31 March 2026. 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-executive directors are also included in the calculation.

The mid-point of banded remuneration of the highest paid Director within St George's University Hospitals NHS Foundation Trust in the financial year 2025-26 was £222k (2024-25: £215k)

This was 5.0 times (2024/25: 5.3 times) the median remuneration of the workforce, which was £45k (2024-25: £41k).

This was 7.4 times (2024-25: 7.4 times) the lower quartile remuneration of the workforce, which was £30k (2024-25: £29k).

This was 3.5 times (2024-25: 3.6 times) the upper quartile remuneration of the workforce, which was £63k (2024-25: £60k).

There has been no change in the lower quartile for FY24-25 to FY25-26. There has been a decrease in median and upper quartile between FY25-26 and FY24-25. This is due to a consolidated pay award of 3.6% for Agenda for Change in FY25-26.

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 19 staff members being paid more than the highest paid director. This is due to Arrears, Additional Duties, Extra Sessions, Bank and Clinical Excellence Awards which have been paid in M12.

The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.

FY 2025/26	25 th percentile pay ratio	Median Pay ratio	75 th percentile pay ratio
Salary component of total remuneration (£000)	30	45	63
Pay ratio information	7.4	5.0	3.5

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

The median remuneration of the workforce increased from £41,000 in 2024/25 to £45,000 in 2025/26. Lower quartile remuneration increased from £29,000 to £30,000 and upper quartile remuneration increased from £60,000 to £63,000 over the same period. These changes principally reflected national Agenda for Change pay awards and wider workforce pay pressures across the NHS during the year.

The Trust employed an average workforce of 10,821 whole-time equivalent staff during 2025/26 (2024/25: 10,653). Total payroll costs for the year were £879.6 million (2024/25: £827.5 million).

In 2025/26, a proportion of remuneration costs relating to Group Executive roles, including the Group Chief Executive Officer, Group Chief Finance Officer, Group Chief Medical Officer, Group Chief Nursing Officer, Group Chief People Officer, Group Chief Infrastructure, Facilities and Environment Officer and Group Chief Corporate Affairs Officer, were recharged to Epsom and St Helier University Hospitals NHS Trust in accordance with the Group operating model and associated governance arrangements.

Payments to past directors (audited)

During 2025/26, the Trust funded secondment arrangements for two former Executive Directors following their departure from Board-level roles. These arrangements related to transitional secondments to external organisations and were approved in accordance with relevant contractual and governance arrangements, including approval by the Remuneration Committee. No payments were made to past Non-Executive Directors during 2025/26.

Payments for loss of office

No severance or compensation payments for loss of office were made during 2025/26.



Matthew Shaw
Group Chief Executive and Accounting Officer
24 June 2026

Remuneration Report 2025/26: Salary and benefits of senior managers (audited)

NameJob TitlePeriod			2025/26						2024/25					
			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
James Blythe	Interim Group Chief Executive Officer	From 18th September 2025 (GESH)	70-75 *(Note 9)	0	0	0	0	70-75	0	0	0	0	0	0
Michael Pantlin	Group Deputy Chief Executive Officer	From 1st April 2025 Interim Group Deputy CEO. From 1st Sep 2025 Deputy CEO. (GESH)	100-105 *(Note 16)	0	0	0	22.5-25	125-130	0	0	0	0	0	0
Elizabeth Alabaster	Interim Group Chief Finance Officer	From 1st December 2025 (GESH)	25-30 *(Note 15)	0	0	0	0	25-30	0	0	0	0	0	0
Dr Richard Jennings	Group Chief Medical Officer	From 19th November 2018 (GESH)	130-135 *(Note 1)	0	0	5-10 *(Note 6)	62.5-65	200-205	125-130 *(Note 1)	0	0	5-10	0	135-140
Elaine Clancy	Interim Group Chief Nursing Officer	From 15th September 2025	40-45 *(Note 17)	0	0	0	0	40-45	0	0	0	0	0	0
Mr Stephen Jones	Group Chief Corporate Affairs Officer	From 5th March 2018 (GESH)	75-80 *(Note 1)	0	0	0	42.5-45	120-125	70-75 *(Note 1)	0	0	0	40-42.5	115-120
Victoria Smith	Group Chief People Officer	From 1st July 2024 (GESH)	80-85 *(Note 1)	0	0	0	40-42.5	125-130	55-60 *(Note 1)	0	0	0	17.5-20	75-80
Mark Bagnall	Group Chief Officer, Facilities, Infrastructure and Environment	From August 2024 (GESH)	95-100 *(Note 1)	0	0	0	790-792.5	885-890	50-55 *(Note 1)	0	0	0	0	50-55
Kate Slemeck	Managing Director - St George's	From 3rd February 2022 (STG)	220-225 *(Note 1)	0	0	0	77.5-80	300-305	215-220 *(Note 1)	0	0	0	100-102.5	315-320
Non-executive Directors														
Sir Mark Lowcock	Chairman (Chair Board/Council and Nominations and Remuneration Committee, Trust Board and Council of Governors)	From 1st April 2025	40-45 *(Note 1)	0	0	0	0	40-45	0	0	0	0	0	0
Pankaj Davé	Non-executive Director	From 1st February 2025 (GESH)	15-20 *(Note 3)	0	0	0	0	15-20	0-5	0	0	0	0	0-5
Bidesh Sarkar	Non-executive Director	From 12th Oct 2025 (GESH)	5-10 *(Note 14)	0	0	0	0	5-10	0	0	0	0	0	0
Chiew Yin Jones	Non-Executive Director	Associate Non-Executive Director 1 March 2023 to 12th October 2023 . Non-Executive Director From 13th October 2023 (GESH)	10-15 *(Note 4)	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Mr Andrew Murray	Non-executive Director (Chair of Quality)	From 23 January 2023 (GESH)	15-20 *(Note 11)	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Dr Leonie Penna	Associate Non-Executive Director	From 1st Oct 2025 (GESH)	5-10 *(Note 13)	0	0	0	0	5-10	0	0	0	0	0	0
Claire Sunderland Hay	Associate Non-Executive Director	From 18th October 2024 (STG)	15-20	0	0	0	0	15-20	5-10	0	0	0	0	5-10
Khadir Meer	Associate Non-Executive Director	From 24 April 2025 (STG)	15-20 *(Note 12)	0	0	0	0	15-20	0	0	0	0	0	0
Professor Natalie Armstrong	Non-executive Director	From 1st January 2025 (STG)	0 *(Note 8)	0	0	0	0	0-5	0	0	0	0	0	0
Leavers														
Ms Jacqueline Totterdell	Group Chief Executive Officer	From 1st May 2017 until 18th Sept 2025 (GESH) (Group CFO) from 19th June 2017 and (Deputy CEO) from 25th April 2019 to 31st Jan 2022. Finished his role on 28th November 2025 (GESH)	70-75 *(Note 1)	0	0	0	0 *(Note 7)	70-75	165-170 *(Note 1)	0	0	0	0	165-170
Mr Andrew Grimshaw	Group Chief Finance Officer		70-75 *(Note 1)	0	0	0	0 *(Note 7)	70-75	115-120 *(Note 1)	0	0	0	0	115-120
Arlene Wellman	Group Chief Nursing Officer	From 1st February 2022 - 29th August 2025, new person in post Elaine Clancy (GESH)	35-40 *(Note 2)	0	0	0	0	35-40	90-95	0	0	0	0	90-95
Peter Kane	Non-Executive Director	From 1st October 2021 - 30th September 2025 (STG)	5-10 *(Note 19)	0	0	0	0	5-10	15-20	0	0	0	0	15-20
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 - 11th October 2025 (STG)	5-10 *(Note 18)	0	0	0	0	5-10	15-20	0	0	0	0	15-20
James Marsh	Group Deputy Chief Executive Officer	From 1st February 2022 to 21th March 2025 (GESH)	0-5	0	0	0	0	0-5	140-145	0	0	0	0	140-145
Angela Paradise	Group Interim Chief People Officer	From 3 January 2024 to 26th July 2024 (GESH)	0-5	0	0	0	0	0-5	40-45	0	0	0	0	40-45
Mr Timothy Wright	Non-executive Director	From 25th September 2017 to 31st January 2025 (STG)	0-5	0	0	0	0	0-5	10-15	0	0	0	0	10-15
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 (GESH)	0-5	0	0	0	0	0-5	55-60	0	0	0	0	55-60
Professor Jennifer Higham	Non-executive Director	From 1st November 2015 to 31st July 2024 (GESH)	0	0	0	0	0	0-5	0	0	0	0	0	0
Philippa Tostevin	Non-executive Director	From 5th September 2024 to 31st December 2024 (GESH)	0	0	0	0	0	0-5	0	0	0	0	0	0

Notes to Remuneration Report 2025/26: Salary and benefits of senior managers	
Note No.	Explanatory note
1	50% of salary recharged to Epsom and St Helier for Jacqueline Totterdell, Andrew Grimshaw, Vicky Smith, Stephen Jones, Mark Bagnall, Michael Pantlin, Richard Jennings and Sir Mark Lowcock for FY 2025/26. Kate Slemeck is St. George's managing director; therefore, there are no recharges for Kate.
2	Arlene Wellman has been recharged from Epsom and St Helier Hospital NHS Trust from 1st February 2022 as part of group management. Arelene finished her role on 29th August 2025. Also, her pension related benefit will be disclosed by Epsom and St Helier Hospital NHS Trust.
3	Pankaj Davé joined the Trust board on 1st February 2025 to replace Mr Timothy Wright. First 6 months of the year charged from St George's, and from 01/10/2025 split 50:50 between Epsom and St George's.
4	Professor Natalie Armstrong joined the Trust board on 1 January 2025 to replace Philippa Tostevin.
5	Chiew Yin Jones position changed from Associate Non-Executive Director on the 12th October 2023 to Non-Executive Director on the 13th October 2023. 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.
6	The long term performance pay and bonuses for Dr Richard Jennings is from a Clinical Excellence Award.
7	Ms Jacqueline Totterdell and Mr Andrew Grimshaw- For FY25-26 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).
8	Professor Natalie Armstrong is the City St George's University of London Medical School representative on the Trust Board. Professor Natalie Armstrong is not remunerated by the Trust for her role on the Board.
9	James Blythe was the Managing Director of Epsom and St Helier Hospitals from April 2022 to September 2025. Started as Interim Group Chief Executive Officer 18 September 2025. He is charged 50% to SGH from this date. Also, his pension related benefit will be disclosed by Epsom and St Helier Hospital NHS Trust.
10	Andrew Grimshaw was Group Chief Finance Officer (GCFO) from 19th June 2017 and (Deputy CEO) from 25 April 2019 to 31 January 2022. He finished his role as Group Chief Finance Officer on 28 November 2025, and started with Mid and South Essex FT on 1 December 2025.
11	Andrew Murray is also a Non-Executive Director at Epsom and St Helier University Hospitals NHS Trust and also chairs the Quality Committee at both Trusts. Charged 57% to SGH.
12	Khadir Meer joined the Trust board on 24 April 2025.
13	Dr Leonie Penna is also an Associate Non-Executive Director at Epsom and St Helier University Hospital NHS Trust, and is charged 50% to SGH.
14	Bidesh Sarkar CBE joined the Trust board on 12th October 2025. He is Chair of the Finance and Performance Committee and holds the same role at Epsom and St Helier University Hospitals NHS Trust.
15	Elizabeth Alabaster started as interim GCFO from 1st December, and has moved to the ESTH Board budget. She is charged 50% to SGH from this date. Also, her pension related benefit will be disclosed by Epsom and St Helier Hospital NHS Trust.
16	Michael Pantlin was seconded in April 2025 to the St George's, Epsom and St Helier Hospital as Interim Group Deputy CEO. Permanent from 1st Sep 2025 as Group Deputy CEO. He is charged from Surrey Heartlands for the first 5 months of the year.
17	Elaine Clancy (Interim Group Chief Nursing Officer) joined the Trust board on 15 September 2025. She is charged from South West London at 80%, therefore is on SWL payroll. Split 50:50 between St George's & Epsom.
18	Ann Beasley finished her role as Non-executive Director on 11 October 2025.
19	Peter Kane finished his role as Non-executive Director on 30 September 2025.
20	Jacqueline Totterdell started with the Welsh Government on 1 October 2025, although she finished working with the Trust as of 18 September 2025.
21	Employee's pension information and taxable benefit will be disclosed by the host Trust.
22	The above disclosures have been audited by the Trust's external auditor, Grant Thornton UK LLP.

Pensions Report 2025/26 (audited)

The following table sets out pension benefits relating to Executive Directors during 2025/26:

Name and job title	Period	2025/26								2024/25							
		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 2026	Lump sum at pension age related to accrued pension at 31 March 2026	Cash Equivalent Transfer Value at 31 March 2026	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2025	Employer's contribution to stakeholder pension	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 31 March 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2024	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
Michael Pantlin, Group Deputy Chief Executive Officer	From April 2025 Interim Group Deputy CEO. From 1st Sep 2025 Deputy CEO.	0-2.5	0	40-45	0	622	19	553	0	0	0	0	0	0	0	0	0
Dr Richard Jennings, Group Chief Medical Officer	from 19th November 2018	2.5-5	2.5-5	65-70	160-165	454	41	385	0	0	0	60-65	155-160	385	0	490	0
Mr Stephen Jones, Group Chief Corporate Affairs Officer	from 5th March 2018	2.5-5	0	20-25	0	325	31	270	0	2.5-5	0	20-25	0	270	27	210	0
Victoria Smith, Group Chief People Officer	from 1st July 2024	2.5-5	0	5-10	0	68	19	27	0	0-2.5	0	0-5	0	27	6	0	0
Mark Bagnall, Group Chief Officer, Facilities, Infrastructure and Environment	From 27 Aug 2024	37.5-40	0	35-40	0	738	732	0	0	0	0	0	0	0	0	0	0
Kate Slembeck, Managing Director - St George's	from 3rd February 2022	5-7.5	2.5-5	75-80	175-180	553	0	1,721	0	5-7.5	5-7.5	70-75	170-175	1,721	117	1,478	0

Notes to Pensions Report 2025/26	
Note No.	Explanatory note
22	The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual.
23	The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.
24	This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
25	The pension benefit table provides further information on the pension benefits accruing to the individual.
26	The Court of Appeal ruling on 'protection', known as the McCloud judgement, resulted in all active members joining the reformed NHS Pension Scheme from 1 April 2022.
27	The method used to calculate CETVs changed on 8 August 2019 to remove the adjustment for Guaranteed Minimum Pension (GMP) indexation. This affects the calculation of real increase in CETV but does not affect pension benefits.
28	As Non-Executive Directors do not receive pensionable remuneration, there are no pension entries in respect of Non-Executive Directors.
29	The above pension disclosures have been audited by the Trust's external auditor, Grant Thornton UK LLP.

Staff Report 2025/26

Our people are central to the delivery of safe, effective and compassionate care across St George's University Hospitals NHS Foundation Trust. During 2025/26, staff across the organisation continued to deliver high-quality care in the context of sustained operational pressure, significant organisational transformation, continued financial challenge and wider pressures affecting the NHS workforce nationally.

Throughout the year, the Trust continued to progress delivery of the gesh People Strategy 2024-26, which supports the wider CARE strategy ambition to develop empowered and engaged staff and to position the organisation amongst the leading acute trusts in London for staff engagement. The strategy focuses on improving staff wellbeing, strengthening organisational culture and inclusion, developing the future workforce and supporting new ways of working across the Group.

The Trust continued to place particular emphasis during 2025/26 on workforce stability, leadership capability, staff wellbeing, inclusion, organisational culture and reducing reliance on temporary staffing. Workforce governance and assurance arrangements continued to operate through the People Committees-in-Common arrangements across St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust.

Workforce overview

During 2025/26, the Trust employed an average workforce of more than 10,800 staff across a wide range of clinical, operational, academic and support professions. Workforce performance continued to be monitored closely through the Board and People Committee governance structure, including oversight of workforce establishment, vacancy rates, turnover, sickness absence, appraisal compliance, temporary staffing utilisation and workforce productivity.

At St George's, workforce turnover remained comparatively stable throughout the year, reflecting continued workforce retention despite wider operational and workforce pressures across the NHS. Workforce metrics reported during the year also demonstrated continued reduction in temporary staffing usage and sustained focus on workforce productivity and workforce controls.

The Trust continued to experience challenges relating to sickness absence during 2025/26, with stress, anxiety and respiratory illness remaining among the principal causes of absence. Nursing and administrative staff groups accounted for the highest proportion of sickness absence. In response, the organisation continued to prioritise attendance management, staff wellbeing and targeted support for areas experiencing higher levels of absence.

Reducing reliance on temporary staffing and improving workforce productivity remained key organisational priorities throughout the year. Workforce transformation initiatives focused on improving workforce deployment, reducing premium staffing expenditure, strengthening workforce planning and supporting safer and more sustainable staffing models.

The Trust continued to progress implementation of the gesh People Strategy 2024–2026 during the year. Key strategic priorities included:

- improving staff wellbeing and staff experience;
- strengthening workforce planning and retention;
- improving equality, diversity and inclusion;
- developing leadership and management capability;
- enhancing appraisal, learning and talent management arrangements; and
- supporting integrated and digitally enabled ways of working across the Group.

The Trust also continued to review workforce structures and workforce controls during the year in support of financial sustainability, organisational transformation and long-term workforce resilience.

Staff experience and organisational culture

The Trust continued throughout 2025/26 to place significant emphasis on staff experience, organisational culture, staff wellbeing and workforce inclusion.

The Trust continued during the year to strengthen the way it listens and responds to staff experience and organisational culture feedback through the NHS Staff Survey, staff engagement activity, Freedom to Speak Up arrangements, workforce metrics and the findings of the Care Quality Commission's Well-Led review. T

The CQC's Well-Led review highlighted the importance of continuing to strengthen organisational culture, leadership visibility, staff experience, equality, diversity and inclusion and staff confidence in raising concerns safely. These themes were also reflected within workforce feedback and staff engagement activity during the year.

The Trust also continued throughout the year to support staff recognition, inclusion and engagement activity across the organisation and wider Group. This included the CARE awards, gesh25 long service awards and wider staff recognition initiatives intended to strengthen organisational culture, psychological safety and staff engagement across both hospital and community services.

NHS Staff Survey 2025

The 2025 NHS Staff Survey demonstrated that staff at St George's remained highly committed to patient care and proud of the services they provide, despite continued operational pressure and organisational change during the year. The Trust achieved a staff engagement score of 6.81, above the national average of 6.74.

The survey identified a number of positive themes across the organisation, including strong teamworking, compassion towards patients and colleagues and continued staff commitment to delivering high-quality care. Scores relating to teamwork, inclusion and staff engagement remained comparatively strong and reflected the professionalism and resilience demonstrated by staff throughout the year.

The survey also identified a number of areas requiring continued organisational focus and improvement. In particular, feedback highlighted concerns relating to staff wellbeing and morale, flexible working, learning and development opportunities, reward and recognition and aspects of staff experience relating to digital infrastructure, equipment and working environments. Staff also identified concerns relating to discrimination, bullying and harassment and variability in leadership visibility, management experience and organisational responsiveness.

The Trust recognised that several themes identified through the NHS Staff Survey aligned with areas highlighted through the Care Quality Commission's Well-Led review, particularly in relation to organisational culture, leadership visibility, equality, diversity and inclusion, staff experience and confidence in raising concerns.

The survey findings also reinforced the importance of continuing to strengthen psychological safety, civility and respectful behaviours across the organisation and ensuring staff feel listened to, supported and able to contribute to organisational improvement.

Following consideration of the survey findings and wider workforce feedback, the Trust identified four organisational priorities to guide workforce culture and improvement activity during 2026/27:

Priority	Focus for 2026/27
Leadership and management	Strengthening leadership visibility, management capability, compassionate leadership and organisational responsiveness.
Behaviours and civility	Improving civility, respect, psychological safety, speaking up culture and organisational learning.
Equality, diversity and inclusion	Improving workforce inclusion, representation, reasonable adjustments, staff experience and leadership accountability.
Reward and recognition	Strengthening reward and recognition

NHS Staff Survey 2025 results

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise', retaining two previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2025 survey among trust staff was 42% (2024/25: 47%).

Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community Trusts) are presented below:

Indicators (‘People Promise’ elements and themes)	2025		2024		2023	
	Trust score	Bench-marking group score	Trust score	Bench-marking group score	Trust score	Bench-marking group score
People Promise:						
We are compassionate and inclusive	7.17	7.28	7.20	7.29	7.15	7.31
We are recognised and rewarded	5.76	5.87	5.81	5.92	5.71	5.94
We each have a voice that counts	6.56	6.60	6.62	6.67	6.50	6.70
We are safe and healthy	5.98	6.07	6.00	6.13	5.97	6.11
We are always learning	5.45	5.57	5.55	5.64	5.37	5.62
We work flexibly	5.93	6.22	5.92	6.24	5.83	6.20
We are a team	6.66	6.75	6.67	6.75	6.57	6.75
Staff engagement	6.81	6.74	6.90	6.54	6.82	6.91
Morale	5.71	5.84	5.75	5.93	5.63	5.90

Equality, diversity and inclusion

The Trust remained committed during 2025/26 to promoting equality, diversity and inclusion and to improving workforce equality outcomes across the organisation.

The Trust published its annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports during the year. These reports identified areas of progress alongside areas requiring continued improvement in workforce equality and staff experience.

The proportion of Black and Minority Ethnic staff within the workforce continued to increase during the year and represented approximately 55% of the St George’s workforce. The Trust reported improvements across several WRES indicators, including recruitment outcomes, disciplinary processes and perceptions of career progression. However, the reports also identified continued underrepresentation of Black and Minority Ethnic staff within senior leadership positions, particularly at Very Senior Manager level and within senior non-clinical posts.

The WDES reporting also identified improvements in several workforce indicators, including recruitment outcomes and reductions in formal capability processes involving disabled staff. However, the Trust recognised that disabled staff continued to report higher levels of harassment, bullying and abuse and lower levels of satisfaction relating to workplace adjustments and workplace experience.

The Trust also published its first combined Gender, Ethnicity and Disability Pay Gap Report during 2025/26. The report identified continued workforce inequalities across a number of protected characteristics, while also recognising that much of the reported pay gap reflects workforce composition and the distribution of staff across professional groups and senior grades.

The Trust continued delivery of a wide-ranging Equality, Diversity and Inclusion Action Plan during the year, aligned to the People Strategy and NHS England improvement frameworks. Priority workstreams included:

- inclusive recruitment and talent management;
- improving staff wellbeing;

- leadership and accountability;
- reducing workforce inequalities;
- supporting internationally recruited staff;
- and strengthening workforce inclusion and representation.

During 2025/26, the Trust also continued development of the Inclusive Talent Management Programme, which supports delivery of the People Strategy and wider workforce equality objectives. The programme includes work relating to inclusive recruitment, succession planning, leadership development, appraisal improvement and career conversations, with the aim of improving workforce representation, staff experience and opportunities for career progression.

The Trust also established a new Inclusion Board during the year to support greater staff engagement, inclusion and leadership accountability in relation to workforce equality and organisational culture. The Inclusion Board, which held its first formal meeting on 7 May 2026, forms part of the Trust's wider programme of work to strengthen organisational culture, inclusion and staff experience across the organisation, and helps nurture senior leadership talent for the future.

Freedom to Speak Up

The Trust remained committed during 2025/26 to promoting a culture in which staff feel able to raise concerns safely, confidently and without fear of detriment.

Freedom to Speak Up arrangements continued to operate throughout the year, supported by the Group Freedom to Speak Up (FTSU) Guardian Service. Regular reporting of the themes from FTSU was presented to the People Committee through the year.

During 2025/26, a total of 131 concerns were raised with the Freedom to Speak Up Guardian by staff at St George's University Hospitals NHS Foundation Trust, including 41 concerns during Q1 and Q2 and 90 concerns during Q3 and Q4. Administrative and Clerical staff and Nursing and Midwifery staff accounted for the highest number of concerns raised during the year.

Themes identified through Freedom to Speak Up activity during the year included behavioural culture, communication, staff experience, leadership responsiveness and organisational culture. The principal themes identified through concerns raised at SGUH related to management conduct, HR process concerns, bullying and harassment, patient safety and organisational processes. Feedback from staff reinforced the importance of psychological safety, civility and respectful behaviours across the organisation.

Analysis of concerns raised during the year identified recurring themes relating to management behaviour, communication, organisational change, consistency of policy application and confidence in organisational processes. Staff also raised concerns relating to delays in investigations and formal processes, transparency of decision-making, handling of grievances and concerns regarding fairness and consistency in the application of organisational policies and procedures.

The Trust recognised that some concerns reflected the impact of sustained operational and financial pressures across the organisation, including workforce pressures, organisational change and service transformation. Concerns raised through Freedom to Speak Up also highlighted the importance of leadership visibility, timely communication, management capability and ensuring staff feel listened to and supported during periods of organisational change and operational pressure.

The Trust recognised that themes arising through Freedom to Speak Up arrangements aligned with areas identified through the 2025 NHS Staff Survey and the Care Quality Commission's Well-Led review, particularly in relation to organisational culture, leadership visibility, staff confidence in raising concerns and organisational responsiveness.

The 2025 NHS Staff Survey led to the Trust's overall "raising concerns" score of 6.2. While all Divisions remained broadly aligned to the Trust average, Surgery, Neurosciences, Cancer and Therapies and Medicine and Cardiovascular both demonstrated slight reductions compared with the previous year.

During the year, the Trust continued to strengthen organisational improvement work relating to behavioural expectations, civility and respect, leadership visibility and organisational learning from staff feedback and concerns raised.

The Trust also continued to strengthen governance and oversight arrangements relating to Freedom to Speak Up activity during the year. This included strengthened divisional reporting arrangements and work to improve organisational learning arising from concerns raised through Freedom to Speak Up, HR and workforce governance processes.

The Trust also recognised the importance of continuing to strengthen management capability and confidence in responding to concerns raised by staff. During the year, further work was undertaken to support managers in handling concerns appropriately, consistently and in a timely manner, including continued mandatory Freedom to Speak Up training through the MAST programme.

Freedom to Speak Up themes and organisational learning continued to inform wider workforce culture, wellbeing and equality, diversity and inclusion initiatives throughout 2025/26 and will continue to inform workforce improvement priorities during 2026/27.

Workforce development and future capability

Developing workforce capability and supporting future workforce sustainability remained important strategic priorities during 2025/26.

The Trust continued to invest in workforce education, leadership development and organisational development programmes throughout the year. This included development of leadership and management programmes, appraisal and career development initiatives and talent management arrangements.

The Inclusive Talent Management Programme continued to develop during the year and formed an important part of the Trust's wider workforce development and organisational culture work. The programme supports workforce sustainability, leadership development and succession planning and aims to improve staff experience, career development opportunities and workforce representation within senior leadership roles.

The Trust also continued work to strengthen workforce planning and workforce redesign in response to changing service models, digital transformation and wider NHS workforce challenges.

Apprenticeships, workforce development programmes and integrated workforce initiatives continued to support future workforce development and retention.

The organisation also continued to work collaboratively with higher education institutions and regional partners in support of workforce development, education and training.

Workforce governance and assurance

Workforce governance arrangements continued to operate throughout 2025/26 through the Board and People Committee structure.

The People Committees-in-Common provided oversight and assurance in relation to:

- workforce performance and workforce KPIs;
- staff engagement and organisational culture;
- workforce equality and inclusion;
- staff wellbeing and safety;
- workforce strategy and transformation;
- education and workforce development;
- Freedom to Speak Up arrangements;
- and workforce risks and compliance matters.

Workforce metrics and people-related risks also continued to be reported through the Group Integrated Quality and Performance Report and wider Board assurance arrangements.

Statutory workforce disclosures

The following section sets out the statutory workforce disclosures required under the NHS Foundation Trust Annual Reporting Manual, including workforce composition, staff survey information, sickness absence, equality reporting and other workforce-related disclosures for 2025/26.

Workforce composition and staff numbers (audited)

The average number of persons employed during the year was:

Type	2025/26			2024/25
	Permanently employed (Number)	Other (Number)	Total (Number)	Total (Number)
Medical and dental	1,777	70	1,847	1,784
Administration and estates	2,386	97	2,483	2,364
Healthcare assistant and other support staff	1,996	236	2,232	2,253
Nursing, midwifery and health visiting staff	2,916	328	3,244	3,253
Scientific, therapeutic and technical staff	917	98	1,015	999
Total average numbers	9,992	829	10,821	10,653
Number of employees (WTE) engaged on capital projects	53	2	55	43

The composition of the workforce by gender during the year was:

Staff type	Female WTE	Male WTE	Total Staff	Female %	Male %
Very Senior Manager	15	16	31	48%	52%
Senior Manager (AfC 8C+)	137	76	213	64%	36%
All other staff	7,553	3,071	10,624	71%	29%
Total workforce	7,705	3,163	10,868	71%	29%

Staff turnover rate (audited)

The Trust's staff turnover rate during 2025/26 was 16.35%. The turnover rate has been calculated in accordance with Cabinet Office guidance and represents the proportion of employees who left the organisation during the year as a percentage of the average workforce employed during the period.

The Trust's turnover rate in 2025/26 was higher than the 13% turnover target for the Trust in the same year. The Trust continues to monitor workforce turnover as an important indicator of workforce stability, retention and organisational culture.

Sickness absence disclosures

Average sickness absence during 2025/26 remained above the Trust's internal target, with stress, anxiety and respiratory illness continuing to represent significant causes of absence. The Trust continued to prioritise attendance management, wellbeing support and targeted interventions within areas experiencing higher levels of absence.

Staff sickness absence	2025/26	2024/24
Total days lost	108,571	101,459
Total staff years	10,288	9,170
Average working days lost (per WTE)	11	11

Equality, diversity and inclusion disclosures

The Trust published annual Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Pay Gap reports during 2025/26.

Key findings included:

- continued growth in Black, Asian and Minority Ethnic representation within the workforce;
- improvements across several WRES and WDES indicators;
- continuing underrepresentation of Black, Asian and Minority Ethnic staff within senior leadership positions;
- continued workforce inequalities relating to experiences of harassment, bullying and discrimination;
- and continued focus on improving reasonable adjustments and workplace inclusion for disabled staff.

The Trust's first combined Gender, Ethnicity and Disability Pay Gap Report was also published during the year. A copy of this report can be found at: <https://www.stgeorges.nhs.uk/wp-content/uploads/2026/03/export-2026-03-04-11-26-40.pdf>

Consultancy expenditure

Consultancy expenditure reduced during 2025/26 compared with the previous year:

Expenditure on consultancy	2025/26	2024/25
Consultancy costs (£k)	1,000	2,695

Exit package disclosures

Exit packages during the year principally related to organisational restructuring, mutually agreed departures and contractual arrangements:

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	6	6
£10,001 - £25,000	1	2	3
£25,001 - £50,000	3	2	5
£50,001 - £100,000	1	0	1
Total number of exit packages by type	5	10	15
Total resource cost (£k)	£222	£157	£379

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	8	138
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HM Treasury approval	2	19
Total	10	157

Early retirements due to ill health

Early retirements due to ill health	2025/26		2024/25	
	Number	£0	Number	£0
No. of early retirements on the grounds of ill-health	6		7	
Value of early retirements on the grounds of ill-health		475		570

Off-payroll engagements

Table 1: Off-payroll engagements as of 31 March 2026, earning £245 per day or greater	2025/26 Number of engagements	2024/25 Number of engagements
Number of existing engagements as of 31 March 2026	0	0
Of which, the number that have existed:	0	0
For less than one year at the time of reporting	0	0
For between one and two years at the time of reporting	0	0

For between two and three years at the time of reporting	0	0
For between three and four years at the time of reporting	0	0
For four or more years at the time of reporting	0	0

Table 2: All new off-payroll engagements, or those that reached six months duration between 1 April 2025 and 31 March 2026, for more than £245 per day that last longer than six months	2025/26 Number of engagements	2024/25 Number of engagements
Number of new engagements, or those that reached six months in duration, between 1 April 2025 and 31 March 2026	0	14
Of which, the number:	0	0
Assessed as within the scope of IR35	0	0
Assessed as not within the scope of IR35	0	0
Engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0	0
Of engagement reassessed for consistency / assurance purposes during year	0	0
Of engagements that saw a change to IR35 status following 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 2025 and 31 March 2026	2025/26 Number of engagements	2024/25 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

In any cases where individuals are included within the first row of Table 3 (above), 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

Expenses paid to Directors, Non-Executive Directors and Governors

Executive Directors	Non-Executive Directors	Governors
£0	£0	£0

Staff costs

Cost	2025/26			2024/25
	Permanently employed £000	Other £000	Total £000	Total £000
Salaries and wages	654,075	12,138	666,213	630,815
Social security costs	84,868	0	84,868	67,770
Apprenticeship Levy	3,217	0	3,217	3,583
Employer's contributions to NHS pensions	75,135	0	75,135	69,813
Pension cost – employer contribution paid by NHSE on provider's behalf (6.3%)	49,135	0	49,135	45,611
Pension cost – other	32	0	32	28
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Temporary staff	4,849	0	4,849	12,783
Total gross staff costs	871,311	12,138	883,449	830,403

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.

Conclusion

Throughout 2025/26, staff across St George's University Hospitals NHS Foundation Trust continued to demonstrate professionalism, resilience and commitment in the delivery of patient care during a period of significant operational challenge and organisational change.

The Trust recognises that sustaining high-quality care depends upon maintaining a supported, inclusive and engaged workforce and will continue to prioritise workforce wellbeing, leadership capability, inclusion and workforce sustainability during 2026/27.

Statement of 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 the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS 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.

A handwritten signature in black ink, appearing to be 'MS' followed by a stylized flourish.

Matthew Shaw
Group Chief Executive and Accounting Officer
24 June 2026

Annual Governance Statement 2025/26

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 2026 and up to the date of approval of the annual report and accounts.

During 2025/26, the Trust strengthened governance maturity, assurance arrangements and strategic oversight during a period of significant operational pressure, financial challenge and organisational transformation. The year also highlighted important weaknesses within aspects of quality governance and operational control, particularly within maternity and urgent and emergency care services. The Board identified these issues through internal governance processes, external review and regulatory inspection and prioritised substantial improvement work in response.

The Trust also continued to evolve its governance arrangements within the wider St George's, Epsom and St Helier Group operating model. This included further development of Group governance structures, accountability arrangements and assurance processes intended to support increasingly integrated strategic oversight while maintaining clear statutory accountability within each sovereign organisation.

Capacity to handle risk

The Trust recognises that effective risk management is fundamental to delivery of safe, high-quality and sustainable services and achievement of its strategic objectives. The Board provides leadership for the organisation's approach to risk management through clear governance structures, defined accountability arrangements and regular oversight of strategic and operational risks.

The Board maintains overall responsibility for oversight of the principal strategic risks facing the organisation through the Board Assurance Framework (BAF). During 2025/26, the Board refined its strategic risk framework to reflect the evolving Group operating model, Medium-Term Plan and wider NHS operating environment. The Board also applied its risk appetite framework to support clearer strategic decision-making and understanding of the level of risk the organisation is prepared to tolerate in pursuit of its objectives.

Board Committees support the Board in overseeing specific areas of strategic risk and assurance. The Audit and Risk Committee provides oversight of governance, risk management and internal control arrangements. Other Committees oversee risks within their delegated areas of responsibility, including quality and safety, workforce sustainability, financial sustainability, infrastructure resilience and digital maturity.

Governance and risk management responsibilities are embedded across the organisation through divisional, site and Group governance structures with defined escalation routes and lines of

accountability. These arrangements are intended to provide both clear organisational oversight and strong local ownership of risks and performance.

The Trust continued during the year to strengthen governance capability and organisational learning through Board and Committee effectiveness reviews, leadership development programmes and ongoing support from governance, quality and risk teams. Risk management guidance and training was provided to staff appropriate to their roles and responsibilities, supported through the Group-wide Risk Management Policy and escalation framework implemented during the year.

Learning from internal governance reviews, external inspections, incidents, complaints, claims, Freedom to Speak Up concerns and internal audit activity informed further development of governance and assurance arrangements during the year.

The Trust also responded to findings arising from the CQC Well-Led review, maternity oversight arrangements, independent quality governance reviews and CQC inspections of maternity, urgent and emergency care and surgery services. These reviews identified areas of good practice alongside opportunities to strengthen aspects of operational control, governance consistency, documentation, medicines management, staffing oversight and escalation processes.

Taken together, these reviews demonstrated improving governance maturity but variable operational control effectiveness across services. The Board increasingly focused on strengthening operational control effectiveness, assurance confidence and organisational learning across the Group.

The risk and control framework

The Trust's risk and control framework is designed to support identification, assessment, management and mitigation of risks which may affect achievement of strategic objectives, delivery of services, regulatory compliance and organisational sustainability.

The Trust operates a Board Assurance Framework to identify and oversee the principal strategic risks to delivery of the Group Strategy, Outstanding Care, Together. The BAF distinguishes strategic risks overseen by the Board from operational risks managed through Corporate Risk Registers (CRRs). Operational risks identified through the Corporate Risk Registers provide the detailed operational risk intelligence underpinning the principal strategic risks described within the BAF.

During 2025/26, the Board refreshed the BAF to improve alignment between strategic objectives, principal risks, assurance arrangements and operational risk intelligence. Significant work was also undertaken to strengthen alignment between strategic risks on the BAF and operational risks held on Corporate Risk Registers.

The organisation recognises that many of the risks it faces are interconnected and systemic in nature. Workforce sustainability, operational resilience, financial sustainability, estates constraints, digital maturity and quality risks increasingly influence one another and require integrated oversight and assurance arrangements.

The organisation also strengthened the consistency and maturity of risk management arrangements through further development of the Group-wide Risk Management Policy and escalation framework, clearer articulation of risk ownership and stronger alignment between strategic and operational risk management arrangements.

The Board recognised that visibility of risk improved during the year, although further work remains necessary to strengthen consistency of operational control, mitigation delivery and assurance quality. The Board recognises the importance of maintaining effective governance arrangements to support continued compliance with the NHS provider licence, including effective Board oversight, clear accountability arrangements, reliable reporting processes and timely escalation of risks to compliance.

Principal strategic risks

The Board Assurance Framework identifies the principal strategic risks to delivery of the Group Strategy and organisational objectives. During 2025/26, the principal strategic risks facing the organisation included:

- working effectively across local systems, provider collaboratives and the evolving Group operating model;
- achieving long-term financial sustainability;
- modernising estates and infrastructure;
- digital maturity and cyber resilience;
- reducing waiting times and improving operational flow;
- improving patient safety and reducing avoidable harm;
- improving patient experience and reducing health inequalities; and
- workforce sustainability, staff wellbeing, inclusion and workforce capability.

Particular focus during the year was given to maternity safety, urgent and emergency care pressures, workforce sustainability, estates resilience, financial sustainability and the consistency and effectiveness of quality governance arrangements.

The organisation also identified emerging strategic risks relating to delivery of the Medium-Term Plan and transformation programme, increasing operational demand and complexity, capital constraints, digital dependency and the continued evolution of the Group operating model.

Many of these risks were closely interconnected, particularly workforce sustainability, operational flow, financial sustainability and quality governance. The Board increasingly focused on strengthening alignment between strategic oversight, operational risk management and assurance processes.

Mitigating actions during the year included implementation of the Quality and Safety Clinical Governance Improvement Plan, development of the Medium-Term Financial Plan and transformation programme, workforce initiatives, estates and infrastructure improvement work, strengthening digital and cyber governance, and continued alignment of strategic and operational risk management arrangements.

The effectiveness of mitigating actions and controls is assessed through regular review of the Board Assurance Framework, Integrated Quality and Performance reporting, Committee oversight, internal audit, regulatory review, external inspection and ongoing monitoring of operational, workforce, quality and financial performance indicators.

Quality governance and assurance

The Trust maintains a framework of quality governance arrangements intended to support oversight of patient safety, clinical effectiveness, patient experience and regulatory compliance. Oversight is provided through the Board-level Quality Committee, supported by executive governance structures, divisional governance arrangements, Integrated Quality and Performance reporting, incident management processes and quality improvement programmes.

The Quality Committee receives regular reports relating to patient safety, mortality, incidents, complaints, safeguarding, infection prevention and control, medicines management, quality risks and patient experience. These reports support triangulation of quality information and provide assurance regarding the quality and safety of services.

During 2025/26, the organisation continued work to strengthen the consistency and maturity of quality governance arrangements across the Group. External reviews, including the CQC Well-Led review and independent quality governance reviews undertaken by an NHS England Improvement Director, identified opportunities to strengthen governance consistency, escalation arrangements, access to clinical data and alignment of governance processes across the Group.

The Board recognised that while the organisation had established increasingly mature overarching corporate governance arrangements, aspects of quality governance, operational oversight and assurance consistency required further strengthening.

CQC inspections of maternity, urgent and emergency care and surgery services at St George's Hospital during 2025/26 provided further external insight regarding governance effectiveness and operational control. The inspections identified areas requiring improvement, including documentation, medicines management, staffing oversight, environmental controls, audit follow-through and governance arrangements within some services. Section 29A Warning Notices were issued in relation to maternity and urgent and emergency care services.

The inspections also identified areas of good practice, including multidisciplinary learning, bereavement support, teamwork and aspects of governance and leadership within services. The inspection of surgery services at Queen Mary's Hospital identified a strong safety culture, effective team working and good leadership arrangements.

Taken together, these reviews demonstrated improving governance maturity but variable operational control effectiveness across services. The Board therefore prioritised strengthening governance consistency, operational oversight and organisational learning.

The organisation implemented a refreshed Group Quality and Safety Clinical Governance Improvement Plan focused on standardising governance arrangements, improving quality data and reporting, strengthening multidisciplinary governance and assurance, improving escalation arrangements and further developing the organisation's Quality Management System. The organisation also strengthened assurance regarding compliance with CQC registration requirements through regulatory review, audit activity, quality reporting and oversight through the Quality Committee and executive governance structures.

Patient, staff and stakeholder feedback continued to inform governance, quality improvement and risk management arrangements during the year, including consideration of patient experience data, complaints, Freedom to Speak Up concerns and engagement with governors, patients, carers and system partners.

Financial sustainability

Financial sustainability remained a significant strategic risk during 2025/26. The organisation operated within a highly constrained financial environment characterised by increasing operational demand, workforce pressures, inflationary cost pressures, capital constraints and uncertainty across the wider NHS financial and commissioning landscape.

Oversight of financial performance, productivity and financial recovery is provided through the Finance and Performance Committee, supported by regular Board reporting, Medium-Term Financial Planning processes, transformation governance arrangements and executive oversight through the Group Executive Committee.

During 2025/26, the organisation developed its Medium-Term Financial Plan and associated transformation programme. The Board recognised that delivery of long-term financial sustainability would require significant transformation of clinical services, operational processes, workforce models and corporate services across the Group.

The Board also recognised the importance of balancing financial recovery with operational resilience, workforce sustainability and delivery of safe, effective and equitable patient care. Particular focus during the year was placed on reducing reliance on temporary staffing, improving productivity, strengthening operational flow and supporting more integrated models of care.

The organisation delivered its financial plan during 2025/26, although this remained highly challenging and depended in part on non-recurrent measures and active management intervention. The Board recognised that delivery of recurrent efficiencies and sustainable productivity improvement remained a significant risk area.

The Board and Finance and Performance Committee maintained oversight of financial risks relating to delivery of Cost Improvement Programmes, workforce cost pressures, commissioner and contractual risks, operational pressures affecting financial delivery, transformation delivery risk and the financial implications of estates and infrastructure pressures.

The organisation increasingly aligned financial recovery, workforce transformation and operational improvement programmes through the wider Group transformation portfolio. The Board recognised that long-term financial sustainability depends not only on delivery of efficiencies, but also on operational resilience, workforce sustainability and successful organisational transformation.

The Quality Committee also oversaw the quality and safety implications of financial recovery and Cost Improvement Programmes through the Group-wide Quality Integrated Impact Assessment (QIIA) process. During 2025/26, the QIIA process was strengthened through enhanced executive oversight, earlier assessment of quality and safety risks and clearer arrangements for mitigation and assurance. The Board recognised that significant challenges remain in relation to delivery of recurrent efficiencies, productivity improvement and long-term financial sustainability. The organisation therefore continued during the year to strengthen governance oversight, transformation capability, financial planning and assurance arrangements intended to support the effective, economic and efficient use of resources across the Group.

Workforce

The Trust recognises that safe, sustainable and effective staffing is fundamental to the delivery of safe care, positive patient outcomes and effective organisational performance. Workforce sustainability, staff wellbeing and organisational culture continued to represent significant strategic risks during 2025/26.

Oversight of workforce risks and workforce strategy is provided through the People Committee, which provides assurance to the Board regarding workforce sustainability, workforce performance, organisational culture, equality, diversity and inclusion, staff wellbeing, leadership development and workforce transformation.

The Board and People Committee receive regular workforce assurance through workforce KPI reporting, the Integrated Quality and Performance Report, workforce transformation reporting, staff survey reporting, Freedom to Speak Up reporting and wider workforce governance processes. During 2025/26, workforce pressures continued to affect operational performance, staff wellbeing and organisational sustainability. The organisation recognised increasing risks associated with workforce shortages, sickness absence, workload, burnout, morale and retention.

The 2025 NHS Staff Survey demonstrated that staff remained highly committed to patient care and that staff engagement scores remained above the national average. However, the survey also identified areas requiring improvement, including morale, flexible working, learning and development, staff wellbeing, leadership behaviours and equality of experience for some staff groups.

The survey findings aligned closely with themes identified through Freedom to Speak Up reporting and the CQC Well-Led review, particularly in relation to organisational culture, leadership behaviours, staff voice and equality of experience. The Board increasingly recognised workforce sustainability, organisational culture and operational resilience as interdependent governance challenges.

The organisation continued during the year to strengthen workforce governance, workforce planning and workforce improvement arrangements. This included leadership and management development programmes, inclusive talent management initiatives, wellbeing programmes and inclusion programmes.

The Board and People Committee also maintained oversight of workforce culture and speaking up arrangements. Thematic reporting from the Freedom to Speak Up Guardian highlighted concerns relating to management conduct, bullying and harassment, workforce pressures and staff experience, reinforcing the importance of psychological safety and effective management capability.

The Trust maintained arrangements intended to support compliance with National Quality Board guidance and Developing Workforce Safeguards recommendations. Safe staffing and workforce sustainability were overseen through workforce planning processes, safer staffing governance arrangements, workforce escalation procedures and regular Board and Committee reporting, including specific oversight of nursing, midwifery and neonatal staffing.

The organisation recognised that workforce sustainability and staffing safety remained challenged in some services during the year, particularly within maternity and urgent care services. The Board therefore maintained enhanced oversight of staffing, workforce escalation and safer staffing assurance within these areas.

Information governance, data quality and data security

The Trust recognises the importance of effective information governance, cyber security and data quality arrangements in supporting safe and effective care, operational performance and regulatory compliance. The Board recognises the importance of maintaining high standards of information governance, including protection of patient and staff confidentiality.

During 2025/26, responsibility at Board Committee level for oversight and assurance relating to digital, cyber security, information governance and wider infrastructure risks transferred from the Audit and Risk Committee to the Infrastructure Committee. This reflected the increasing strategic and operational importance of digital, cyber and infrastructure risks and supported a more integrated approach to infrastructure resilience and operational oversight.

Oversight of digital, cyber and infrastructure risks is therefore provided through the Infrastructure Committee, supported by specialist digital, cyber security and information governance teams. The Digital Governance Group provides oversight of the Data Security and Protection Toolkit (DSPT), information governance incidents and wider information governance activity, with formal reporting and escalation to the Infrastructure Committee. The Group Deputy Chief Executive Officer acts as Senior Information Risk Owner, supported by the Trust's Caldicott Guardian.

The organisation maintains policies, controls and governance arrangements relating to information governance, cyber security, data protection and data quality. Data quality and reporting arrangements form part of the wider governance and assurance framework operating across the organisation. Mandatory information governance and data security training supports staff understanding of their responsibilities.

During the year, the Infrastructure Committee increased its focus on digital governance maturity, cyber resilience, infrastructure risk and digital strategy, including the relationship between infrastructure investment, operational resilience and organisational transformation objectives.

The completion date of the 2025/26 NHS Data Security and Protection Toolkit (DSPT) is 30 June 2026 and the submission was in preparation at the time of approval of this statement. In 2024/25, the Trust achieved "Approaching Standards" status due to a long-term outstanding requirement and expects to return to "Standards Met" status.

During 2025/26, two incidents were reported through the DSPT process. Neither incident met the threshold for formal reporting to the Information Commissioner's Office (ICO) and no further regulatory action was required. The Trust also received four contacts from the ICO relating to concerns raised directly by data subjects regarding information requests. These cases remained open at the date of approval of this statement.

The CQC inspection of urgent and emergency care services identified concerns relating to aspects of documentation standards and information security processes. The organisation responded through strengthening governance oversight, reinforcing operational controls and implementing improvement actions within the affected services.

Estates and infrastructure risks

Estates and infrastructure remained a significant strategic risk during 2025/26 and continued to have implications for operational resilience, patient safety, workforce experience, service transformation and financial sustainability.

The organisation faced challenges associated with ageing estate infrastructure, backlog maintenance requirements, digital infrastructure resilience, utilities infrastructure and capital constraints.

Oversight of estates, infrastructure and digital risks is provided through the Infrastructure Committee, supported by executive oversight from the Group Chief Infrastructure, Facilities and Environment Officer and specialist estates, facilities, digital and cyber teams.

The Board recognised that estates and infrastructure risks were increasingly interconnected with operational flow, workforce experience, digital transformation, productivity and quality of care. Infrastructure constraints continued to affect operational efficiency and the organisation's ability to support transformation and service redesign.

Specific areas of oversight during the year included:

- backlog maintenance and ageing estate infrastructure;
- power resilience and utilities infrastructure;
- operational estate pressures affecting patient flow and capacity;
- ITU build and planning for the Renal development
- capital investment prioritisation; and
- infrastructure requirements associated with future service transformation and Group integration.

Particular focus was placed on infrastructure risks following CQC inspections and wider governance reviews. This included oversight of equipment safety checks, environmental controls, infrastructure resilience and operational estate risks.

The organisation also recognised increasing strategic risks associated with capital constraints and the ability to modernise infrastructure at the pace required to support operational recovery, digital transformation and long-term service redesign.

The organisation continued during the year to develop its strategic approach to infrastructure and estate transformation, including consideration of longer-term opportunities associated with the Group operating model and wider system transformation plans.

Group operating model and governance evolution

During the year, the organisation continued to evolve its Group governance and operating arrangements.

The Trust continued its transition from historically separate organisational governance arrangements towards a more mature integrated provider governance model. This required ongoing development of governance structures, accountability arrangements, assurance processes and organisational culture. The Board recognised that substantial progress had been made in developing Group-wide governance arrangements, integrating corporate functions and strengthening collaboration across the Group. However, aspects of the operating model and governance arrangements continued to evolve.

During the year, the organisation further developed Group-wide governance structures, integrated executive oversight arrangements and shared governance processes intended to support clearer strategic alignment, stronger organisational collaboration and more consistent governance standards across the Group. The organisation also refined the relationship between Group-level governance, Site-level governance and sovereign organisational accountability. The Board recognised the importance of maintaining clear accountability, escalation and assurance arrangements while continuing to strengthen integrated strategic oversight across the Group.

Feedback arising from regulatory review and internal governance processes highlighted the need to continue strengthening clarity regarding accountability, decision-making, escalation and assurance within the Group model.

The organisation therefore continued to develop and strengthen the Group Accountability Framework during the year and undertook further work to improve consistency, integration and governance maturity across the Group.

The Board recognised that successful delivery of the Group operating model depended not only on structural integration, but also on organisational culture, leadership behaviours, staff engagement and development of shared approaches to governance and operational management.

The Board recognised that development of a mature integrated provider governance model would continue to require further evolution of governance structures, assurance processes, leadership behaviours and organisational culture during 2026/27 and beyond.

Compliance with CQC Registration

The foundation trust is not fully compliant with the registration requirements of the Care Quality Commission. During 2025/26, CQC inspections identified weaknesses within aspects of operational control and quality governance within maternity and urgent and emergency care services. Section 29A Warning Notices were issued following inspections of these services, and the CQC Well-Led review identified findings relating to Regulation 17 concerning aspects of governance, management and assurance arrangements.

The Board recognised these findings and prioritised improvement work during the year, including strengthened oversight arrangements, targeted service improvement actions and implementation of the refreshed Group Quality and Safety Clinical Governance Improvement Plan.

Register of interests

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

NHS Pension Scheme

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.

Equality, diversity and inclusion

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

The Board recognises that equality, diversity and inclusion were integral to workforce sustainability, organisational culture and leadership effectiveness. During the year, the organisation established an Inclusion Board operating as a shadow board development programme intended to strengthen leadership capability, improve representation within senior leadership pipelines and support development of a more inclusive organisational culture across the Group.

Further details of the organisation's work to improve equality, diversity and inclusion are set out in the Staff Report.

Climate change

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has arrangements in place designed to secure economy, efficiency and effectiveness in the use of resources and to support delivery of safe, sustainable and high-quality services within the resources available.

The Board maintains oversight of the effective use of resources through regular review of financial, operational, workforce and quality performance. Oversight is supported through the Finance and Performance Committee, Audit and Risk Committee, Quality Committee, Infrastructure Committee and People Committee, each of which provides assurance to the Board within its delegated areas of responsibility.

The Finance and Performance Committee has primary responsibility for oversight of financial performance, operational performance, productivity, transformation delivery and financial sustainability. During 2025/26, the Committee received regular reporting relating to financial performance, Cost Improvement Programmes, productivity, workforce performance, operational flow, cash and liquidity, Medium-Term Financial Planning, transformation delivery and key financial and operational risks.

The organisation continued during the year to strengthen integration between financial, operational, workforce and quality governance arrangements. Integrated Quality and Performance Reports were routinely reviewed through the Finance and Performance Committee, Quality Committee and Board, supporting triangulation of financial, workforce, operational and quality information.

The organisation developed and commenced implementation of a Medium-Term Financial Plan and wider transformation programme intended to support sustainable financial recovery, operational improvement and long-term productivity gains.

The Quality Committee also oversaw the quality and safety implications of financial recovery and Cost Improvement Programmes through the Group-wide Quality Integrated Impact Assessment (QIIA) process. During 2025/26, the QIIA process was strengthened through enhanced executive oversight, earlier assessment of quality and safety risks and clearer arrangements for mitigation, monitoring and assurance.

The organisation maintained arrangements for the development, review and approval of business cases and investment decisions, including oversight of major capital investments and transformation programmes through established governance processes and Committee structures.

Internal audit provided independent assurance regarding aspects of governance, risk management and internal control relating to the effective use of resources. The Audit and Risk Committee maintained oversight of internal audit findings, management actions and assurance themes arising from audit work undertaken during the year.

The Board recognised that significant challenges remain in relation to delivery of recurrent efficiencies, productivity improvement and long-term financial sustainability. The organisation therefore continued during the year to strengthen governance oversight, transformation capability, financial planning and assurance arrangements intended to support the effective, economic and efficient use of resources across the Group.

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 performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Following review by the Board and its Committees during 2025/26, I am satisfied that the Trust maintained an appropriate framework of governance, risk management and internal control, although further work remains necessary in a number of areas to continue strengthening governance maturity, quality governance consistency and assurance effectiveness.

The Board maintained oversight of the effectiveness of the system of internal control through regular review of the Board Assurance Framework, principal strategic risks, operational performance, workforce performance, financial performance, quality and safety metrics and wider governance and assurance reporting throughout the year.

The Audit and Risk Committee provided assurance to the Board regarding the adequacy and effectiveness of governance, risk management and internal control arrangements. The Quality Committee focused particularly on the organisation's response to the CQC Well-Led review, maternity and urgent care inspection findings, quality governance improvement work and the quality implications of transformation and Cost Improvement Programmes. The Infrastructure Committee provided assurance regarding estates, infrastructure, digital and cyber risks, while the People Committee provided assurance regarding workforce sustainability, organisational culture, staff wellbeing and workforce transformation.

Clinical audit provided assurance regarding compliance with clinical standards, effectiveness of care, patient safety and clinical governance arrangements. The organisation also received assurance through external review and assurance mechanisms during the year, including Care Quality Commission inspections, NHS England oversight processes, maternity oversight arrangements and external governance reviews.

The Head of Internal Audit Opinion for 2025/26 concluded that the Trust had a reasonable system of governance, risk management and internal control, providing reasonable assurance overall regarding the adequacy and effectiveness of the framework.

The Board also considered the outcomes of annual Board and Committee effectiveness reviews. These identified strengths in governance arrangements, including constructive challenge, strengthened risk oversight and increasingly mature Group governance arrangements, alongside opportunities to improve strategic focus, reduce duplication and improve the quality of information presented to the Board and Committees.

The organisation recognised that important governance, risk and control issues remained during the year, particularly in relation to quality governance and operational control, workforce sustainability and culture, financial sustainability and transformation delivery, operational pressures and the continued evolution of the Group operating model.

Actions taken during the year included implementation of the refreshed Group Quality and Safety Clinical Governance Improvement Plan, further development of the Group Accountability Framework, enhanced oversight of maternity and urgent care services, continued development of workforce governance and speaking up arrangements, and refinement of transformation, risk management and assurance processes across the Group.

The organisation therefore remains committed to continuing to strengthen governance maturity, organisational learning, quality governance, assurance processes and risk management capability during 2026/27.

Conclusion

During 2025/26, the Trust strengthened governance maturity, assurance arrangements and strategic oversight during a period of significant operational pressure, organisational transformation and increasing complexity.

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 considered the governance, risk and control issues identified during the year, particularly in relation to quality governance and operational control, maternity and urgent care pressures, workforce sustainability and culture, financial sustainability and transformation delivery, operational flow and the continued evolution of the Group operating model.

The Board recognised that these issues required substantial management attention and governance oversight during the year. Nevertheless, the Board concluded that they did not represent a material breakdown in the overall framework of governance, risk management and internal control.

The organisation identified these issues through internal governance processes, Board and Committee oversight, regulatory review, internal audit, external review and wider assurance mechanisms.

Actions taken during the year included implementation of the refreshed Group Quality and Safety Clinical Governance Improvement Plan, development of the Group Accountability Framework, enhanced oversight of maternity and urgent care services, continued development of workforce governance and speaking up arrangements, and refinement of transformation, risk management and assurance processes across the Group.

The Board recognised that further work remains necessary during 2026/27 to continue strengthening quality governance consistency, operational oversight, workforce sustainability, transformation delivery and organisational effectiveness.

Overall, based on the sources of assurance available to me, including the opinion of the Head of Internal Audit, I am satisfied that the Trust had in place a generally effective framework of governance, risk management and internal control during 2025/26.



Matthew Shaw
Group Chief Executive and Accounting Officer
24 June 2026

Annual Accounts for the year ended 31 March 2026

St George's University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, 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	Matthew Shaw
Job title	Chief Executive
Date	24 June 2026

Statement of Comprehensive Income

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	1,199,291	1,156,133
Other operating income	4	186,745	172,037
Operating expenses	6,8	<u>(1,369,596)</u>	<u>(1,321,411)</u>
Operating surplus/(deficit) from continuing operations		<u>16,441</u>	<u>6,759</u>
Finance income	10	3,836	3,496
Finance expenses	11	(16,734)	(17,553)
PDC dividends payable		<u>(5,828)</u>	<u>(6,357)</u>
Net finance costs		<u>(18,726)</u>	<u>(20,414)</u>
Other gains / (losses)	12	<u>231</u>	<u>(559)</u>
Surplus / (deficit) for the year		<u>(2,055)</u>	<u>(14,214)</u>
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(5,931)	(5,257)
Revaluations	16	<u>2,281</u>	<u>10,165</u>
Total comprehensive income / (expense) for the period		<u>(5,705)</u>	<u>(9,306)</u>

Statement of Financial Position

		31 March 2026 £000	31 March 2025 £000
	Note		
Non-current assets			
Intangible assets	13	28,068	26,653
Property, plant and equipment	14	443,422	452,439
Right of use assets	17	38,840	40,980
Receivables	19	13,397	11,678
Total non-current assets		523,726	531,750
Current assets			
Inventories	18	16,314	15,045
Receivables	19	64,237	70,401
Cash and cash equivalents	20	103,276	80,397
Total current assets		183,827	165,843
Current liabilities			
Trade and other payables	21	(162,186)	(155,326)
Borrowings	23	(19,609)	(18,671)
Provisions	24	(1,071)	(594)
Other liabilities	22	(22,252)	(19,187)
Total current liabilities		(205,118)	(193,778)
Total assets less current liabilities		502,435	503,815
Non-current liabilities			
Borrowings	23	(208,328)	(217,451)
Provisions	24	(4,462)	(4,681)
Total non-current liabilities		(212,790)	(222,132)
Total assets employed		289,645	281,683
Financed by			
Public dividend capital		661,417	647,750
Revaluation reserve		76,830	80,792
Other reserves		1,150	1,150
Income and expenditure reserve		(449,752)	(448,010)
Total taxpayers' equity		289,645	281,683

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

Signed



Name

Matthew Shaw

Position

Chief Executive

Date

24 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	647,750	80,792	1,150	(448,010)	281,683
Surplus/(deficit) for the year	-	-	-	(2,055)	(2,055)
Impairments	-	(5,931)	-	-	(5,931)
Revaluations	-	2,281	-	-	2,281
Transfer to retained earnings on disposal of assets	-	(312)	-	312	-
Public dividend capital received	13,735	-	-	-	13,735
Public dividend capital repaid	(68)	-	-	-	(68)
Taxpayers' equity at 31 March 2026	661,417	76,830	1,150	(449,752)	289,645

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' equity at 1 April 2024 - brought forward	633,073	75,884	1,150	(433,795)	276,312
Surplus/(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' equity at 31 March 2025	647,750	80,792	1,150	(448,010)	281,683

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.

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.

Statement of Cash Flows

		2025/26	2024/25
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		16,441	6,759
Non-cash income and expense:			
Depreciation and amortisation	6.1	41,562	43,065
Net impairments	7	8,733	10,254
Income recognised in respect of capital donations	4	(706)	(1,088)
(Increase) / decrease in receivables and other assets		4,475	(3,926)
(Increase) / decrease in inventories		(1,269)	3,372
Increase / (decrease) in payables and other liabilities		6,591	35,746
Increase / (decrease) in provisions		281	232
Net cash flows from / (used in) operating activities		76,107	94,414
Cash flows from investing activities			
Interest received		3,836	3,496
Purchase of intangible assets		(1,236)	(445)
Purchase of PPE and investment property		(31,943)	(48,222)
Sales of PPE and investment property		1,150	4,214
Receipt of cash donations to purchase assets		706	1,088
Net cash flows from / (used in) investing activities		(27,487)	(39,869)
Cash flows from financing activities			
Public dividend capital received		13,735	14,677
Public dividend capital repaid		(68)	-
Movement on loans from DHSC		(602)	(602)
Movement on other loans		-	(739)
Capital element of lease rental payments		(15,809)	(14,946)
Capital element of PFI and other service concession payments		(3,255)	(2,855)
Interest on loans		(195)	(211)
Other interest		(9)	(2)
Interest paid on lease liability repayments		(4,747)	(5,046)
Interest paid on PFI and other service concession obligations		(8,934)	(8,955)
PDC dividend (paid) / refunded		(5,857)	(4,019)
Net cash flows from / (used in) financing activities		(25,741)	(22,698)
Increase / (decrease) in cash and cash equivalents		22,879	31,847
Cash and cash equivalents at 1 April - brought forward		80,397	48,550
Cash and cash equivalents at 31 March	20.1	103,276	80,397

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 2025/26 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 £4.9m surplus for the year ended 31 March 2026 (after adjusting for excluded items against the control total). The final financial plan for 26/27 has been submitted, with the Trust aspiring to achieve a breakeven position, having taken account of the underlying financial position going into 2026/27. 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 2025/26 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 and Richmond NHS Foundation Trust and Croydon Health Services 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 Health Services NHS Trust	19.60%
• Kingston and Richmond NHS Foundation Trust	20.50%
• Epsom and St Helier University Hospitals NHS Trust	32.40%
• St George's University Hospitals NHS Foundation Trust	27.50%

South West London Pathology is not a separate vehicle for the four 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 George's University Hospitals 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)
- South West London Elective Orthopaedic Centre (hosted by Epsom and St Helier University Hospitals NHS Trust)
- In addition to South West London collaborations, the St George's University Hospitals 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 Deputy CEO services.
- and supports through group management structures
- Group Corporate Medical services including Research and Innovation.
- Group Human Resources' services
- Group Facilities, Infrastructure and Environment services
- Group Digital 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.

The majority of income received by the Trust is via NHS commissioning organisations and is paid in the month that the activity is undertaken as per the SLA. In the financial year 2025/26, the Trust received the vast majority of income through Block contracts with its main commissioners. This is in recognition of the impact of the COVID-19 pandemic, simplifying financial arrangements to support front line care. The Trust has however been funded on a 'cost and volume' basis for areas such as High Cost Drugs and Devices, Unbundled Diagnostics and Nuclear Medicine, and Chemotherapy delivery.

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.

In 2025/26 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 100% of the tariff price.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such 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 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, 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 value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use 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. 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.

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

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.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	1	115
Dwellings	15	80
Plant & machinery	1	25
Transport equipment	10	10
Information technology	3	16
Furniture & fittings	5	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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve. There is no revaluation reserve for Intangible assets in 2025/26

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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	Max life
	Years	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.

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

Financial assets are classified as subsequently measured at amortised cost, fair value through their comprehensive income.

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 24.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25.

Contingent liabilities are defined as:

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

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 Third party assets

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

Note 1.20 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 1.21 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 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.23 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 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

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

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £362.41m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £362.41m at 31 March 2026. The Trust has not yet been able to reliably quantify the financial impact of this change, as it will depend on future valuation assumptions and market conditions at the date of implementation. However, the removal of the alternative site assumption may result in changes to asset valuations, and the impact could be material.

Note 1.24 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.

Note 1.25 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 2026 is £510.33m (2024/25 £520.07m) of which £336.09m (2024/25 £342.83m) relates to revalued owned assets and £26.32m (2024/25 £28.49m) 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, Newmark. 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 71% (2024/25 - 49%) of the Trust revenue with a further 18% (2024/25 - 40%) 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)	2025/26	2024/25
	£000	£000
Income from commissioners under API contracts - variable element*	250,517	242,576
Income from commissioners under API contracts - fixed element*	776,985	739,677
High cost drugs income from commissioners	96,317	102,378
Other NHS clinical income	7,343	5,018
Private patient income	2,010	1,265
National pay award central funding***	-	2,684
Additional pension contribution central funding**	49,135	45,611
Other clinical income	16,984	16,924
Total income from activities	1,199,291	1,156,133

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 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 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

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

Note 3.2 Income from patient care activities (by source)

	2025/26	2024/25
Income from patient care activities received from:	£000	£000
NHS England	204,417	485,042
Integrated care boards	977,643	655,219
Other NHS providers	7,343	5,018
NHS other	242	272
Non-NHS: private patients	2,010	1,265
Non-NHS: overseas patients (chargeable to patient)	5,611	4,112
Injury cost recovery scheme	1,198	4,326
Non NHS: other	827	878
Total income from activities	1,199,291	1,156,133
Of which:		
Related to continuing operations	1,199,291	1,156,133
Related to discontinued operations	-	-

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

	2025/26	2024/25
	£000	£000
Income recognised this year	5,611	4,112
Cash payments received in-year	602	1,065
Amounts added to provision for impairment of receivables	3,531	1
Amounts written off in-year	898	4,780

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	10,811	-	10,811	10,315	-	10,315
Education and training	45,721	-	45,721	42,177	-	42,177
Non-patient care services to other bodies	103,271		103,271	102,525		102,525
Income in respect of employee benefits accounted on a gross basis	22,837		22,837	12,627		12,627
Receipt of capital grants and donations and peppercorn leases		706	706		1,088	1,088
Other income	3,398	-	3,398	3,304	-	3,304
Total other operating income	186,039	706	186,745	170,949	1,088	172,037
Of which:						
Related to continuing operations			186,745			172,037
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:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	1,190,843	1,149,877
Income from services not designated as commissioner requested services	195,193	178,293
Total	1,386,036	1,328,170

Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	906	1,373
Purchase of healthcare from non-NHS and non-DHSC bodies	4,335	4,563
Staff and executive directors costs	878,623	827,506
Remuneration of non-executive directors	167	107
Supplies and services - clinical (excluding drugs costs)	138,209	145,211
Supplies and services - general	61,221	60,081
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	113,160	112,986
Consultancy costs	1,000	2,695
Establishment	9,467	10,128
Premises	46,039	46,833
Transport (including patient travel)	13,050	12,779
Depreciation on property, plant and equipment	34,929	36,908
Amortisation on intangible assets	6,633	6,157
Net impairments	8,733	10,254
Movement in credit loss allowance: contract receivables / contract assets	5,081	4,266
Increase/(decrease) in other provisions	559	311
Change in provisions discount rate(s)	4	1
Fees payable to the external auditor		
audit services- statutory audit	373	361
Internal audit costs	211	217
Clinical negligence	26,038	25,955
Legal fees	960	1,289
Insurance (as a policy holder)	83	160
Education and training	3,089	2,947
Redundancy	952	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,376	1,333
Car parking & security	-	270
Losses, ex gratia & special payments	167	145
Other services, eg external payroll	449	312
Other	13,782	6,263
Total	1,369,596	1,321,411
Of which:		
Related to continuing operations	1,369,596	1,321,411
Related to discontinued operations	-	-
Audit Fees		
The fees reconciles to the Financial statement as follows		
Statutory Audit Fee	311,173	300,650
VAT	62,235	60,130
Total Audit fee 2024/25	373,408	360,780

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2,000k (2024/25: £2,000k).

Note 7 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	-	5
Abandonment of assets in course of construction	2,234	11,581
Changes in market price	6,499	(1,312)
Other	-	(20)
Total net impairments charged to operating surplus / deficit	8,733	10,254
Impairments charged to the revaluation reserve	5,931	5,257
Total net impairments	14,664	15,511

Note 8 Employee benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	666,268	630,815
Social security costs	84,868	67,770
Apprenticeship levy	3,217	3,583
Employer's contributions to NHS pensions	124,270	115,424
Pension cost - other	32	28
Temporary staff (including agency)	4,849	12,783
Total gross staff costs	883,504	830,403
Of which		
Costs capitalised as part of assets	3,929	2,897

Note 8.1 Retirements due to ill-health

During 2025/26 there were 6 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £475k (£570k in 2024/25).

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2023, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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

C) National Employment Savings Scheme (NEST)

The Trust offers an additional defined contribution workplace pension scheme, the National Employment Savings

Note 10 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	3,834	3,496
Other finance income	2	-
Total finance income	3,836	3,496

Note 11.1 Finance expenditure

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	191	203
Interest on other loans	-	3
Interest on lease obligations	4,747	5,046
Interest on late payment of commercial debt	9	2
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	8,934	8,955
Remeasurement of the liability resulting from change in index or rate	2,746	3,239
Total interest expense	16,627	17,448
Unwinding of discount on provisions	107	105
Total finance costs	16,734	17,553

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

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	9	2

Note 12 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	231	19
Losses on disposal of assets	-	(578)
Total gains / (losses) on disposal of assets	231	(559)
Total other gains / (losses)	231	(559)

The Trust disposes £0.94m of land and building in 2025/26.(£4.8m of old plant and equipment in 24/25)

There were expired leases of £1.76m (£.01m in 24/25) with 0 net book value.

Note 13.1 Intangible assets - 2025/26

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward *	2,012	63,488	-	65,500
Additions	176	-	1,060	1,236
Reclassifications	504	4,932	1,376	6,812
Cost at 31 March 2026	2,692	68,420	2,436	73,548
Amortisation at 1 April 2025 - brought forward	1,049	37,798	-	38,847
Provided during the year	444	6,189	-	6,633
Amortisation at 31 March 2026	1,493	43,987	-	45,480
Net book value at 31 March 2026	1,199	24,433	2,436	28,068
Net book value at 1 April 2025	963	25,690	-	26,653

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 13.2 Intangible assets - 2024/25

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	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 - as previously stated	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 14.1 Property, plant and equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	49,234	293,597	113	62,858	78,234	1,365	25,282	6,002	516,684
Additions	-	11,580	-	16,630	3,559	-	3,506	2	35,277
Impairments	(2)	(8,977)	-	(2,234)	-	-	-	-	(11,213)
Revaluations	620	(8,512)	-	-	-	-	-	-	(7,892)
Reclassifications	-	3,360	-	(18,809)	6,044	-	2,593	-	(6,812)
Disposals / derecognition	(331)	(609)	-	-	-	-	-	-	(940)
Valuation/gross cost at 31 March 2026	49,521	290,439	113	58,445	87,837	1,365	31,381	6,004	525,104
Accumulated depreciation at 1 April 2025 - brought forward	-	-	36	-	45,418	262	14,796	3,732	64,245
Provided during the year	-	13,800	4	-	9,619	136	3,580	490	27,629
Revaluations	-	(10,171)	-	-	-	-	-	-	(10,171)
Disposals / derecognition	-	(21)	-	-	-	-	-	-	(21)
Accumulated depreciation at 31 March 2026	-	3,608	40	-	55,037	398	18,376	4,222	81,682
Net book value at 31 March 2026	49,521	286,831	73	58,445	32,799	967	13,005	1,782	443,422
Net book value at 1 April 2025	49,234	293,597	77	62,858	32,815	1,103	10,486	2,270	452,439

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, Newark, a firm of professionally (RICS) qualified valuers. The valuation was effective from 31 March 2026 .

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. Newmark 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 - 2024/25

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	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 - as previously stated	-	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	-	-	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

Note 14.3 Property, plant and equipment financing - 31 March 2026

	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	48,631	231,127	73	58,445	30,222	967	13,005	1,763	384,232
On-SoFP PFI contracts and other service concession arrangements	-	44,973	-	-	-	-	-	-	44,973
Owned - donated/granted	890	10,731	-	-	2,577	-	-	19	14,217
Total net book value at 31 March 2026	49,521	286,831	73	58,445	32,799	967	13,005	1,782	443,422

Note 14.4 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
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 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 2025/26 the Trust commissioned a valuation of its land and buildings by an independent valuer, Newmark, a firm of professionally (RICS) qualified valuers. The effective date of the revaluation was 31 March 2026 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 2025/26. 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. Newmark 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. Newmark 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: 1-25 years

Building : 1-115 years

Fixtures & Fittings: 5-15 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, Newmark, provided a valuation for land and buildings in 25/26. 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 2026 is £336m (2025 £343m)

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 2025/26 the Trust had a net impairment of £2.2m (2024/25 £15.5m). There was a decrease in the value of land of £2k (2024/25 £2k decrease) and a decrease in buildings of £8.98m (2024/25 £5.9m decrease). In relation to decrease in the buildings £5.9m (2024/25 £5.2m decrease) was charged to the revaluation reserve and £6.5m (2024/25 £10.3m) which was made up of PPE £3.05m and IFRS16 £3.45m (2024/25 PPE £7.7m and IFRS16 £2.6m) was charged to operating expenses as there was insufficient balance in the revaluation reserve for the asset.

Note 17 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 - 2025/26

	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 2025 - brought forward	36,802	25,186	166	62,154	34,384
Additions	2,919	-	-	2,919	-
Remeasurements of the lease liability	4,961	770	89	5,820	4,836
Movements in provisions for restoration / removal costs	(130)	-	-	(130)	(114)
Impairments	(3,454)	-	-	(3,454)	(3,447)
Reversal of impairments	3	-	-	3	3
Revaluations	(3,538)	-	-	(3,538)	(3,445)
Reclassifications	(1)	1	-	-	76
Valuation/gross cost at 31 March 2026	37,562	25,957	255	63,774	32,293
Accumulated depreciation at 1 April 2025 - brought forward	3,118	17,894	162	21,174	2,216
Provided during the year	4,793	2,459	48	7,300	4,341
Revaluations	(3,540)	-	-	(3,540)	(3,447)
Reclassifications	(2)	2	-	-	(1)
Accumulated depreciation at 31 March 2026	4,369	20,355	210	24,934	3,109
Net book value at 31 March 2026	33,193	5,602	45	38,840	29,184
Net book value at 1 April 2025	33,684	7,292	4	40,980	32,168
Net book value of right of use assets leased from other NHS providers					2,100
Net book value of right of use assets leased from other DHSC group bodies					27,084

Note 17.2 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)
Reclassifications	-	-	-	-	(72)
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
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 17.3 Revaluations of right of use assets

The Trust RoU assets were revalued as part of the revaluation of assets in 2025/26

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.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	141,547	151,733
Lease additions	2,919	523
Lease liability remeasurements	5,820	4,258
Interest charge arising in year	4,747	5,046
Early terminations	-	(21)
Lease payments (cash outflows)	(20,556)	(19,992)
Carrying value at 31 March	134,477	141,547

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.

Income generated from subleasing right of use assets is £0k and is included within revenue from operating leases in note 4.

Note 17.5 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	19,703	17,473	19,409	16,964
- later than one year and not later than five years;	73,128	67,393	71,856	66,508
- later than five years.	62,850	60,825	74,446	74,097
Total gross future lease payments	155,681	145,691	165,711	157,569
Finance charges allocated to future periods	(21,204)	(19,925)	(24,164)	(23,553)
Net lease liabilities at 31 March 2026	134,477	125,766	141,547	134,016
Of which:				
Leased from other NHS providers		1,394		1,638
Leased from other DHSC group bodies		124,372		132,378

Note 18 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	4,611	4,746
Consumables	11,703	10,299
Total inventories	16,314	15,045
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £167,915k (2024/25: £181,463k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 19.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	56,680	60,305
Allowance for impaired contract receivables / assets	(16,242)	(13,331)
Prepayments (non-PFI)	15,143	14,509
PDC dividend receivable	1,172	1,143
VAT receivable	5,067	5,415
Other receivables	2,417	2,361
Total current receivables	64,237	70,401
Non-current		
Contract receivables	12,299	10,426
Other receivables	1,098	1,252
Total non-current receivables	13,397	11,678
Of which receivable from NHS and DHSC group bodies:		
Current	32,822	32,551
Non-current	1,098	1,252

Note 19.2 Allowances for credit losses

	2025/26	2024/25
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	13,331	14,328
Prior period adjustments		-
Allowances as at 1 April - restated	13,331	14,328
Transfers by absorption	-	-
New allowances arising	5,081	4,266
Utilisation of allowances (write offs)	(2,170)	(5,263)
Allowances as at 31 Mar 2026	16,242	13,331

Note 19.3 Exposure to credit risk

The Trust has carried out a review of 25/26 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.

	2025/26	2024/25
	£000	£000
At 1 April	80,397	48,550
Net change in year	22,879	31,847
At 31 March	103,276	80,397
Broken down into:		
Cash at commercial banks and in hand	175	43
Cash with the Government Banking Service	103,101	80,354
Total cash and cash equivalents as in SoFP	103,276	80,397
Total cash and cash equivalents as in SoCF	103,276	80,397

Note 21.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	51,418	44,715
Capital payables	10,679	7,345
Accruals	69,355	75,138
Social security costs	9,563	8,126
Other taxes payable	10,205	9,725
PDC dividend payable	-	-
Pension contributions payable	10,949	10,226
Other payables	17	51
Total current trade and other payables	162,186	155,326
Non-current		
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	10,808	11,779
Non-current	-	-

Note 22 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	22,252	19,187
Deferred grants	-	-
Total other current liabilities	22,252	19,187
Non-current		
Total other non-current liabilities	-	-

Note 23.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Loans from DHSC	670	674
Lease liabilities	15,343	14,843
Obligations under PFI, LIFT or other service concession contracts	3,596	3,154
Total current borrowings	19,609	18,671
Non-current		
Loans from DHSC	7,830	8,432
Lease liabilities	119,134	126,704
Obligations under PFI, LIFT or other service concession contracts	81,364	82,315
Total non-current borrowings	208,328	217,451

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 2025/26. As at 31/03/26 the balance owed by the Trust on this loan is £8.43m.

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 31/03/26 the balance owed by the Trust on this loan is £0k.

Note 23.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	9,106	-	141,547	85,469	236,122
Cash movements:					
Financing cash flows - payments and receipts of principal	(602)	-	(15,809)	(3,255)	(19,666)
Financing cash flows - payments of interest	(195)	-	(4,747)	(8,934)	(13,876)
Non-cash movements:					
Additions	-	-	2,919	-	2,919
Lease liability remeasurements	-	-	5,820	-	5,820
Remeasurement of PFI / other service concession liability resulting from change in index or rate				2,746	2,746
Application of effective interest rate	191	-	4,747	8,934	13,872
Carrying value at 31 March 2026	8,500	-	134,477	84,960	227,937

	Loans from DHSC £000	Other loans £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £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

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2025	768	409	4,098	5,275
Change in the discount rate	4	-	(86)	(82)
Arising during the year	73	481	5	559
Utilised during the year	(119)	-	(30)	(149)
Reversed unused	-	-	(249)	(249)
Unwinding of discount	17	-	162	179
At 31 March 2026	743	890	3,900	5,533
Expected timing of cash flows:				
- not later than one year;	-	890	181	1,071
- later than one year and not later than five years;	743	-	1,098	1,841
- later than five years.	0	-	2,621	2,622
Total	743	890	3,900	5,533

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 24.2 Clinical negligence liabilities

At 31 March 2026, £351,790k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2025: £369,919k).

Note 25 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	(26)
Net value of contingent liabilities	-	(26)
Net value of contingent assets	-	-

Note 26 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	2,922	2,342
Intangible assets	-	55
Total	2,922	2,397

Note 27 On-SoFP PFI, LIFT or other service concession arrangements**Note 27.1 On-SoFP PFI, LIFT or other service concession arrangement obligations**

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

	31 March 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	152,369	159,436
Of which liabilities are due		
- not later than one year;	12,190	11,810
- later than one year and not later than five years;	48,758	47,240
- later than five years.	91,421	100,386
Finance charges allocated to future periods	(67,409)	(73,967)
Net PFI, LIFT or other service concession arrangement obligation	84,960	85,469
- not later than one year;	3,596	3,154
- later than one year and not later than five years;	18,570	16,285
- later than five years.	62,794	66,030

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, LIFT and other service concession arrangement commitments

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

	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	169,336	176,762
Of which payments are due:		
- not later than one year;	13,566	13,142
- later than one year and not later than five years;	54,261	52,571
- later than five years.	101,509	111,049

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:

	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	13,565	13,143
Consisting of:		
- Interest charge	8,934	8,955
- Repayment of balance sheet obligation	3,255	2,855
- Service element and other charges to operating expenditure	1,376	1,333
Total amount paid to service concession operator	13,565	13,143

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 integrated 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 2026 are in receivables from customers, as disclosed in the trade and other receivables note.

The Trust does not have any substantiated basis to conclude that the impact of Covid 19 will result in a credit risk.

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 25/26 and 26/27

Note 28.2 Carrying values of financial assets

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2026			
Trade and other receivables excluding non financial assets	55,038	-	55,038
Other investments / financial assets	-	-	-
Cash and cash equivalents	103,276	-	103,276
Total at 31 March 2026	158,314	-	158,314

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

Note 28.3 Carrying values of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2026		
Loans from the Department of Health and Social Care	8,500	8,500
Obligations under leases	134,477	134,477
Obligations under PFI, LIFT and other service concession contracts	84,960	84,960
Trade and other payables excluding non financial liabilities	121,440	121,440
Total at 31 March 2026	349,377	349,377

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025		
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

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 2026 £000	31 March 2025 £000
In one year or less	154,112	145,069
In more than one year but not more than five years	124,871	122,134
In more than five years	160,218	181,505
Total	439,201	448,708

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

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	611	2,188	1,407	5,377
Stores losses and damage to property	16	151	20	125
Total losses	627	2,339	1,427	5,502
Special payments				
Ex-gratia payments	22	15	46	15
Special severance payments	2	19	2	77
Total special payments	24	34	48	92
Total losses and special payments	651	2,374	1,475	5,594
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 2025/26

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 and Richmond NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- Royal Free London NHS Foundation Trust

Local Authorities

- Wandsworth London Borough Council

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

Integrated Care Boards

- NHS Buckinghamshire, Oxfordshire and Berkshire West ICE
- 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

Non - NHS Related party transactions

- St George’s University of London
- St George’s Hospital Charity

Total

Related Party		Related Party	
2025/26	2024/25	2025/26	2024/25
£000	£000	£000	£000
2,796	3,570	135	576
23	284	-	-
2,819	3,854	135	576

Non - NHS Related party transactions

- St George’s University of London
- St George’s Hospital Charity

Total

Related Party		party	
2025/26	2024/25	2025/26	2024/25
£000	£000	£000	£000
5,189	4,332	16,607	9,508
352	214	-	-
5,541	4,546	16,607	9,508

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

2025/26 Related parties

There are no related parties for Directors in 2025/26 and 2024/25

Note 31 Events after the reporting date

There are no known events after reporting date at present.

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 2026, 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 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 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 2025-26; 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 2025-26 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 and accounts. 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 2025/26 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 2025/26; 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 2025/26, 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 2025-26).
- 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 and 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 assumptions and judgements in order to arrive at the total income 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 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 2026.

We have nothing to report in respect of the above matter except on 18 June 2025 we identified a significant weakness in how the Authority plans and manages its resources to ensure it can continue to deliver its services for the year ended 31 March 2025. This was in relation to a failure during 2024/25 to develop plans for required efficiency savings for 2025/26, and a failure to develop a credible Medium Term Plan (MTP). Despite some progress against our prior year key recommendation in year, there remains a significant weakness in arrangements due to the level of risk around savings required to return to financial balance in the medium-term, coupled with the Trust's continuing under-delivery of recurrent savings. If the Trust cannot effectively manage these risks to deliver the savings set out in its MTP, this will prevent it from addressing its underlying deficit and achieving financial sustainability in the medium-term.

We recommended the Trust should:

- strengthen the identification, development and delivery of recurrent savings to ensure ambitious recurrent savings targets included in its MTP can be achieved; and
- accelerate the development of its medium-term transformation portfolio, closely monitoring planned transformational savings to ensure benefits can be delivered as planned.

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 March 2026. 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 2026 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules and 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 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

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
25 June 2026

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

Audit completion

In our auditor's report, issued on 27 June 2025, for St George's University Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2025, we reported an unqualified opinion on the Trust's financial statements.

We explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2025, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had received confirmation from the National Audit Office (NAO) that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. The NAO has confirmed the audit of the NHS group consolidation is complete for the year ended 31 March 2025.

We are therefore satisfied all audit work necessary has been completed.

Report on other legal and regulatory requirements - 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.

In our auditor's report for the year ended 31 March 2025 issued on 27 June 2025 we reported that:

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.

No matters have come to our attention since that date that would have resulted in any additional exception reporting on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

Report on other legal and regulatory requirements – audit certificate

We certify that we have completed the audit of St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

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
30 July 2026