NHS
Guy's and St Thomas'
NHS Foundation Trust

Annual Report and Accounts 2024/25

Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2024/25

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

Guy's and St Thomas' is one of the UK's largest, busiest and most successful NHS Foundation Trusts. We are home to 5 world-famous hospitals: Guy's, St Thomas', Evelina London Children's Hospital, Royal Brompton and Harefield, as well as community services in Lambeth and Southwark – all with long histories of delivering exceptional clinical care, education and research.

Across our 5 hospitals, and in the community, we provide comprehensive lifelong healthcare – caring for patients from pre-conception and birth, through childhood, adulthood and into old age.

St Thomas' provides a wide range of outpatient services and is one of the UK's largest centres for emergency and critical care. It provides an extensive range of surgical and medical specialties, along with one of London's busiest maternity services. The site is also home to Evelina London Children's Hospital, which – together with our children's services at Royal Brompton Hospital – delivers many specialist services as well as general services for local children and young people.

We are the largest provider of cancer care in London, with our state-of-the-art Cancer Centre based at Guy's Hospital. Guy's also serves as a major elective centre for south east London and is home to St John's Institute of Dermatology and the largest dental school in Europe. It is a major research campus, providing clinical research facilities, including the Centre for Translational Medicine.

Royal Brompton is our specialist heart and lung hospital. Together with St Thomas', Evelina London and Harefield hospitals, it forms one of the largest and most advanced specialist heart and lung centres in the world.

Harefield Hospital is internationally renowned for its expertise in heart and lung transplants and serves as the dedicated heart attack centre in north west London.

Our community services care for adults and children across Lambeth and Southwark, working in close partnership with local NHS organisations, GPs, local authorities and the voluntary sector.

We are a diverse and welcoming organisation, and are immensely proud of our 23,700 staff and the dedication they show our patients and each other. As one of the largest employers in central and south London, we strive to reflect the diversity of our local communities and recognise our vital role in improving their health and wellbeing.

We are committed to building strong partnerships with local people, patients, neighbouring NHS organisations, local authorities, GPs and charitable bodies.

As a leading centre of clinical research, with a strong history of innovation and medical firsts, we provide the most advanced and cutting-edge treatments. Together with our partners in King's Health Partners, we form one of the UK's 8 Academic Health Sciences Centres.

We train the healthcare professionals of the future. The GKT School of Medical Education, our medical school, and the Dental faculty are run jointly with King's College London and King's College Hospital NHS Foundation Trust. The Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care is run jointly with King's College London.

Front cover: Amoh Bodje is a registered nurse in our Neighbourhood Nursing Team. She cares for people who are housebound – helping them care for themselves and to be as independent as possible.

Our team at Royal Brompton Hospital successfully completed its first robotic-assisted lung surgery using the da Vinci Xi robotic system in April 2024.

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Staff member Metian Parsanka is featured in a mural at Guy's Hospital which celebrates the contribution of African women in healthcare.

1 Chairman's statement

I would like to take this opportunity to pay tribute to our colleagues working across our 5 hospitals and in the community. Their hard work and dedication have ensured that Guy's and St Thomas' has navigated a challenging year, having met our financial obligations and achieved a strong performance against national standards.

This year, the Board welcomed the launch of our new Trust Strategy to 2030 which sets out our ambition to deliver 'better, faster, fairer healthcare for all', as well as our new values which guide us in everything we do.

The first half of the year was overshadowed by the criminal cyber-attack on our pathology partner Synnovis in June 2024, which had a major impact on the delivery of services. Recovering from this, while also focusing on reducing waiting lists and delivering our operational and financial plans, proved extremely challenging, and the efforts of our staff were exceptional throughout this period.

We are proud of our performance against national standards, although we clearly recognise that some patients are still experiencing unacceptably long waits, particularly those needing certain cancer treatments, and we are committed to addressing this.

We acknowledge the important role our organisation plays in our communities and the influence we have on the health and wellbeing of local people – both as a healthcare provider, and in our wider role in the community.

We are extremely proud of the diversity of both our staff and the communities we serve, but we know there is more we need to do to make our organisation a truly inclusive and welcoming place for all.

We continue to work collaboratively with our partners, particularly in south east London, to address the increasing demand for care and to ensure equitable access to treatment. We work with local Integrated Care Boards, the Acute Provider Collaborative (including King's College Hospital and Lewisham and Greenwich) as well as with South London and Maudsley and King's College London through King's Health Partners. We look forward to developing these relationships further in a joint effort to enhance our patient services and improve population health more broadly.

We are especially grateful to Guy's & St Thomas' Foundation, whose continued support helps fund pioneering research, further innovations in care, and support the wellbeing of our valued staff.

On behalf of the Board, and as Chairman of the Council of Governors, I would like to thank our governors, who provide essential oversight of our efforts to deliver the best possible care for the communities we serve. Thank you to those whose term of office came to an end this year and a warm welcome to our new colleagues on the Council.

I want to thank my fellow Board members for their commitment and leadership. In particular, I extend my appreciation to Baroness Sally Morgan, Professor Reza Razavi, Julie Screaton and Lawrence Tallon, who stepped down this year. We also welcome Jamie Heywood, Professor Graham Lord and Alison Wilcox as new Non-Executive Directors, along with Crystal Akass, our new Chief People Officer and Louise Dark, Chief Executive of our Integrated and Specialist Medicine Clinical Group.

Finally, I am grateful to Professor Ian Abbs for his commitment to a smooth succession process following his decision to stand down as Chief Executive during 2025. I am also delighted that we have appointed Amanda Pritchard as our new Chief Executive and she will take up her new appointment in early September.

Charles Alexander, Chairman
25 June 2025

We care for 1,000 babies a year in our neonatal intensive care unit, with some of the best survival rates in the UK.

2 Performance report

Annual performance statement from the Chief Executive

Throughout 2024/25, staff across the Trust have worked tirelessly to provide safe, compassionate, and high-quality care to as many patients as possible.

The first half of the year was notable for the very significant challenges we faced following a major cyber-attack on Synnovis, our pathology provider, and by further periods of industrial action; while the second half of the year was marked by a relentless focus on restoring activity and delivering our recovery plan.

Through the collective efforts of our staff we have ended the year in a strong position, and performed well against national operational standards. Thanks to careful financial management and the commitment of teams across the Trust, we also closed the year with a financial surplus.

The criminal cyber-attack on Synnovis, the Trust's pathology partner, in June 2024, caused major disruption to clinical and operational services across Guy's and St Thomas' and King's College Hospital NHS Foundation Trusts, as well as mental health, community and primary care services in south east London. In response to the scale of the impact and the need for mutual aid, NHS England declared a regional level 3 critical incident. The National Cyber Security Centre also supported efforts to manage and learn lessons from the attack.

Trust staff worked tirelessly in extremely difficult circumstances to prioritise the most urgent patients and maintain the delivery of safe care. Despite the best efforts of our clinical and administrative staff, a significant number of both inpatient and outpatient appointments were regrettably cancelled.

Thanks to the dedication and resilience of our staff, Synnovis colleagues, and partners across the South East London Integrated Care System, we gradually restored services – with pathology capabilities, including electronic cross-matching of blood, fully restored during October.

The response and recovery reflected an extraordinary collective effort under incredibly challenging circumstances, and I am immensely grateful to everyone whose commitment meant we could continue to care for patients throughout this period.

We do not underestimate the impact that cancellation or delays to diagnostic tests, clinic appointments or treatment have on our patients and their families.

In the first half of the year, we also experienced disruption to planned activity due to further industrial action by a number of professional groups. I thank our clinical and non-clinical staff who ensured that we were able to

Annual performance statement

maintain the delivery of safe patient care during these periods, and the Board has welcomed the pay deals that were agreed.

Despite the continued high demand for emergency care, particularly during the busy winter months, our emergency department exceeded the national 4 hour standard and is among the best performing trusts in the country, including for ambulance handover times.

We continue to focus on tackling the unacceptable delays faced by some patients requiring emergency treatment for serious mental health conditions, and are working with system partners to raise these issues and address the need for timely access to appropriate care.

We have made significant progress in reducing the number of patients waiting for planned (elective) treatment and have reduced our overall waiting list by 20,000, exceeding our target by 11,000 whilst also eliminating the longest waits for all but a handful of patients.

Both our Trust-wide surgical productivity programme, and significant investment in our operating theatres and robotic surgery programme, have been key enablers of our ability to treat more patients and reduce waiting lists.

Our performance against the Faster Diagnostics Standard for cancer patients has remained strong and over 80% of patients receive a diagnosis within 28 days. Despite this, we have continued to struggle to deliver the national standard that for 2024/25 70% of patients should receive their first cancer treatment within 62 days. As a result, we remain in NHS England's tiering programme for our performance against the 62 day standard, and we are working hard to reduce the time that patients wait for treatment to begin, especially where a patient's care pathway initially started at another Trust.

Demand for a wide range of diagnostic tests, including complex imaging, has continued to rise. Whilst this remains a significant challenge, through additional investment and the tireless efforts of staff, we have successfully halved our diagnostic waiting times since their peak at the time we launched Epic, our new electronic health record system. We know that we have more work to do to achieve the national standard, and we remain in NHS England's tiering programme for this too – see page 73 for details.

Our financial performance underpins all that we do, including our ability to invest in service improvements and deliver our Strategy to 2030: 'Better, faster, fairer healthcare for all'. I am pleased to report we ended the 2024/25 financial year with a surplus of £12.7 million before technical adjustments such as capital donations, depreciation on donated assets and valuations.

The financial landscape across the NHS remains extremely challenging, and achieving this financial outcome has taken a huge effort from staff across the Trust, both to deliver savings and to improve operational efficiency. In common with other organisations, we also introduced a number of central controls, and the combination of these efforts means that we have ended the year in a relatively positive position.

Our staff are our most precious asset, and we are determined to create an environment where everyone truly feels welcome and valued. We are committed to tackling discrimination in all its forms. In September 2024, we launched our new values - caring, ambitious, inclusive – and we will ensure that these underpin everything we do.

We also recognise the important role we play in supporting our communities to be healthier and to thrive. As an 'anchor institution', our responsibilities to support local people's health and wellbeing, tackle health inequalities and reduce our impact on the environment are central to our new strategy to 2030.

In January 2025, I announced my intention to step down from my role as Chief Executive of the Trust once a successor was appointed and able to assume the role. It has been an honour to lead this incredible organisation for more than 6 years, and I would like to take this opportunity to pay tribute to all our staff, whose dedication to our patients, and to education, research and innovation, is simply inspirational.

Professor Ian Abbs
Chief Executive Officer

Overview

Across our 5 hospitals, and in the community, Guy's and St Thomas' NHS Foundation Trust provides comprehensive lifelong healthcare – caring for patients from pre-conception and birth, through childhood, adulthood and into old age.

The Trust was formed in 1993 from the merger of Guy's and St Thomas' hospitals, and the current Evelina London Children's Hospital was opened in 2005. In 2011 Lambeth and Southwark community services joined the Trust, and in 2021 the merger with Royal Brompton and Harefield NHS Foundation Trust created one of the largest NHS organisations in the country.

As an NHS foundation trust, we are accountable to Parliament and regulated by NHS England. As part of the NHS we must meet national standards and targets. Our governors and members ensure that we are accountable to and listen to the needs and views of our patients and communities.

St Thomas' provides a wide range of outpatient services and is one of the UK's largest centres for emergency and critical care. It provides an extensive range of surgical and medical specialties, along with one of London's busiest maternity services. The site is also home to Evelina London Children's Hospital, which – together with our children's services at Royal Brompton Hospital – delivers many specialist services as well as general services for local children and young people.

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Royal Brompton is our specialist heart and lung hospital. Together with St Thomas', Evelina London and Harefield hospitals, it forms one of the largest and most advanced specialist heart and lung centres in the world.

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Our community services care for adults and children across Lambeth and Southwark, working in close partnership with local NHS organisations, GPs, local authorities and the voluntary sector. We also provide services at other hospital sites across south London, such as Queen Mary's, Sidcup, and through clinical networks that deliver an extensive range of outpatient care in local hospitals.

As a leading centre of clinical research, we are able to provide the latest and most advanced treatments. Together with our partners, King's College Hospital and South London and Maudsley NHS Foundation Trusts and our shared academic partner King's College London, we form King's Health Partners, one of 8 academic health sciences centres. We also work with Imperial Healthcare Partners in north west London, as well as other academic partners including Imperial College London and London South Bank University

Our famous teaching hospitals train the doctors, dentists, nurses and healthcare professionals of the future. GKT School of Medical Education, our medical school, and the Dental faculty are run jointly with King's College London and King's College Hospital. The Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care is run jointly with King's College London.

Guy's and St Thomas' is organised into 4 large clinical groups, and the Essentia delivery group, all of which are supported by corporate departments, as outlined in Chapter 7 'Our organisational structure.'

In September 2024 we launched our new 'Better, faster, fairer healthcare for all' Trust strategy and new values which provide an

ambitious strategic framework for the whole organisation to ensure we continue to provide the best possible care for patients now and in the future. Our strategy is available on our website at: www.guysandstthomas.nhs.uk/about-us/our-strategy-and-values.

We are committed to working in close collaboration with our partners to deliver the shared strategic priorities of our Integrated Care Board – particularly in south east London, but also in north west London and beyond. Our collective aim is to deliver timely and effective healthcare to the populations we serve, to improve health outcomes and to reduce inequalities.

The Trust also continues to work closely with the Integrated Care Boards to ensure compliance with capital limits, and utilisation of capital funds. The Trust supports the South East London Integrated Care Board in hosting capital funding for the Acute Provider Collaborative with a particular focus on digital diagnostics.

As a major employer and purchaser of goods and services we also recognise the importance of our wider role as good partner in supporting healthy, sustainable communities.

Our quality objectives and priorities, and further detail about our performance, are included in the Quality Report which is published on our Trust website.

Key operational and financial risks

In common with all NHS organisations, we face the continued challenge of delivering high-quality care against the backdrop of rising demand, high patient acuity and the need to increase productivity and efficiency. The Trust's 4 main priorities in 2024/25 were: increasing elective activity and operational productivity; controlling our finances and improving delivery of efficiencies; delivering the benefits of Epic, our new electronic health record system; and supporting our workforce – which together support the delivery of safe, high-quality care. Further details of our key risks for 2024/25 are set out on page 78 and 79 of the Annual Governance Statement.

Following the criminal cyber-attack on Synnovis, our pathology provider, in June 2024, the Trust and its partner organisations in south east London managed the impact of this extremely serious incident as part of a level 3 critical incident led by NHS England, London until October 2024. A comprehensive operational recovery plan followed in the second half of the year.

Successfully embedding and optimising Epic, including the delivery of benefits set out in the Business Case remains a priority, and this is closely monitored by the Board and Trust Executive in a number of forums.

The Trust's financial position and uncertainty around the future funding model has also continued to be closely monitored throughout the year. Whilst the Trust delivered a positive financial outturn, the delivery of an ambitious cost improvement plan combined with the development of a comprehensive productivity programme, remains a key priority in 2025/26. Further details of the principal strategic risks for the organisation in 2025/26 are available on page 79 of the Annual Governance Statement.

The directors have reasonable expectations that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the 'going concern' basis in preparing the accounts.

Events since the end of the financial year

On 30 May 2025, Guy's and St Thomas' Enterprises Limited sold Lexica Health and Life Sciences Consultancy Limited to WSP. From 31 May 2025, Lexica will therefore no longer be consolidated into the results of the Group.

Performance analysis – clinical

Thanks to the hard work and dedication of our staff, the Trust delivered a strong performance by the end of March 2025, performing well against national operating standards and maintaining continuity of care for our patients. This achievement is particularly notable given the severe disruption in the first half of the year, when activity was reduced due to the major cyber-attack on our pathology partner, Synnovis.

The Trust's clinical performance is measured against key national standards which are set by NHS England. These include the 4 hour target for emergency care; the number of patients receiving planned (elective) care; reductions in the longest waits for routine treatment; the number of patients waiting over 62 days for their first cancer treatment; and the number of patients waiting over 6 weeks for a routine diagnostic test or procedure. Delivery is monitored by the Board of Directors and its sub committees.

Throughout the year, we have continued to embed and optimise the use of our new electronic health record system, Epic: continuing to support staff to use the system, and redesigning care pathways to improve quality, efficiency and patient experience.

We have also focused on better capturing quantitative and qualitative information, ensuring accurate recording and reporting of our activities and creating new opportunities to use data and analytics to drive future improvements in care delivery. Our performance against the key standards is described below.

The Board also considers the insights provided by national patient surveys, the Friends and Family Test, local feedback, complaints, and individual patient stories. We routinely participate in surveys spanning emergency, inpatient and maternity care, as well as children's and cancer services.

In 2024/25, areas highlighted as examples of good practice included care in our emergency department, opportunities for cancer patients to engage in clinical trials and the provision of medicines information. Areas for improvement included making it easier for patients to contact the Trust and reschedule appointments, and the need to reduce waiting times for diagnostic tests.

Emergency care

Demand for urgent and emergency care has remained high, with almost 212,000 patients attending our emergency department at St Thomas' in 2024/25. Despite a challenging winter period across the NHS, the Trust was amongst the best performing nationally for emergency care. In March 2025 our performance against the 4 hour standard was 79.1%, exceeding the national standard of 78%.

Teams across the Trust have worked hard to improve the experience of our patients, both for emergency and planned care, with a focus on ensuring patients receive the right care, in the right place and at the right time. This included a 24% increase in patients attending the Same Day Emergency Care service.

The Trust has also performed well on ambulance handovers, reducing delays to admissions and ensuring ambulance staff are free to attend other patients. The focus on improving care for patients attending the emergency department and requiring specialist mental health care remains a challenge and a key priority for the Trust, working closely with system partners.

Increasing activity

We have continued to focus on sustainably treating more patients as part of the NHS-wide effort to return to pre-pandemic levels of activity.

These efforts were interrupted by the cyber-attack on our pathology partner Synnovis in early June 2024. Regrettably, this led to the cancellation of inpatient procedures and outpatient appointments at both Guy's and St Thomas' and King's College Hospital NHS Foundation Trusts over a number of weeks, as well as disruption to primary care and mental health services in south east London.

Staff across both Trusts, Synnovis, and other partner organisations worked relentlessly to maintain safe care for patients and to restore services as quickly as possible. The critical incident was finally stood down in October 2024 when pathology services, including blood transfusion services, were fully back to normal.

As a result of reduced activity during this period, the Trust's total waiting list reached a peak of 142,000 and a recovery plan, with revised operational trajectories to the end of March 2025, was agreed with NHS England.

In addition to the cyber-attack, the Trust also faced periods of industrial action and ongoing pressure on operating theatre capacity, which further affected our ability to deliver the required activity levels.

Despite these significant issues, we have worked extremely hard to deliver our operational plan and to increase the number of patients we were able to treat, for example, through extended working hours and weekend work, as well as targeted investment in our planned theatre refurbishment programme, ahead of longer term plans to substantially increase theatre capacity at Guy's.

We have also continued to expand our robotic surgery programme, including through the installation of a new da Vinci Xi robotic assisted surgical system at Royal Brompton Hospital. The Trust's 11 robotic systems, serving patients across 9 surgical specialties, provide quality benefits as well as efficiencies which enable more patients to be treated.

The Children's Day Surgery Unit at Evelina London Children's Hospital, which opened in July 2023, continues to provide vital additional surgical capacity for patients who do not need to stay overnight, and in its first year, 2,300 children and young people were treated there.

Further information about our service improvements and investment in patient care are available in the Directors' Report on pages 31-32.

Reducing waiting times

The Trust has continued to focus on reducing the longest waits, including to deliver the national requirement that no patient waits more than 65 weeks for routine or planned treatment. Many of these patients waiting for treatment at the Trust have complex healthcare needs, or require specialist services, and we have worked hard to increase capacity in these specialties so that patients are treated as quickly as possible.

Despite this commitment, the Trust was placed into NHS England's regulatory tiering programme for planned (elective) waits in July 2024 due to its relative position in London for the speed with which we were able to treat patients waiting the longest for treatment.

Our ability to provide timely treatment had deteriorated significantly following the cyber-attack on Synnovis, and as a result of industrial action, although we were able to improve our performance in the second half of the year and are pleased to report that we were taken out of the tiering programme for elective waits in January 2025.

The Trust has also continued to make significant progress in reducing waiting lists more broadly, and reduced the total number of patients waiting for elective (planned) treatment by 20,000 in the final months of the year. The total waiting list at the end of March 2025 was around 121,000 patients, 11,000 less than our plan.

We ended the year with a small number of patients waiting over 65 or 78 weeks, 47 and 4 respectively, which was consistent with our recovery plan, and these patients will be treated as soon as possible.

Alongside our work to reduce the time that patients are waiting, we are committed to ensuring patients are 'waiting well' and receive appropriate support and updates about their care.

We continue to develop the MyChart patient portal to give patients greater involvement and control over their care – this includes details about their appointments and information about any test, treatment or procedure. Going forward, it will increasingly enable patients to choose or reschedule appointments at a time of their choice and enable them to communicate directly with their clinical team.

Cancer performance

The Trust has continued to work extremely hard to ensure patients with suspected cancer, or who require cancer treatment, are seen as quickly as possible. While we remain within NHS England's regulatory tiering programme for cancer, we have made significant progress against all the national cancer standards during the year and we have welcomed the support received.

Our performance against the Faster Diagnosis Standard has shown sustained improvement and 80% of patients received their diagnosis within 28 days in March 2025, exceeding the national standard of 77%.

Performance against the national standard for 2024/25 that 70% of patients should begin their cancer treatment within 62 days remains the greatest challenge - particularly for some tumour groups where the Trust is the main provider of specialist care and receives referrals for complex care from across south east London and beyond.

We recognise the impact that waiting for treatment has on patients and their families and it remains a priority to improve the speed with which they can begin their treatment. We have more work to do, particularly for some tumour groups such as lung cancer, where increased demand for complex specialist care exceeds current capacity.

As a result, we remained below plan against the 62-day standard, with an overall performance of 56% (70% for patients referred directly to the Trust) in March 2025. Despite the significant operational challenges which reduced capacity in the first half of the year, the number of urgent suspected cancer patients waiting longer than 62 days for their cancer treatment reduced from a peak of 304 in July 2024, to 187 at the end of the year.

We continue to focus on improving our cancer pathways, both for patients referred directly and for those who are referred by clinical teams at other hospitals for specialist diagnosis or treatment. This includes working closely with our partner hospitals and the South East London Cancer Alliance to deliver

our comprehensive recovery plans for all patients with suspected or diagnosed cancer.

Diagnostic tests

The Trust provides a wide range of diagnostic tests and procedures, including highly specialist services in areas such as imaging and genetics, and these play a central part in the delivery of timely, high-quality care. We have seen a significant increase in referrals over the past year, for example an increase of 30% for diagnostic imaging, and demand exceeded capacity in a number of areas.

This has made it difficult to improve performance and to meet the national standard that less than 5% of patients should wait longer than 6 weeks for their diagnostic test or procedure. As a result, the Trust has been in NHS England's regulatory tiering programme for diagnostics since March 2024.

In response, the Trust established a comprehensive recovery programme with the aim of reducing the number of patients waiting over 6 weeks from 48.5% in March 2024 to 19.5% by March 2025. Significant investment had been made in additional capacity, including 2 additional MRI scanners at St Thomas' which became operational in December 2024.

In common with other areas, following the operational challenges in the first half of the year, performance improved significantly in the second half of 2024/25. By March 2025 we had reduced the number of patients waiting over 6 weeks to 25.4%, our best performance since July 2023.

Community care

Our adult and children's services provide care to people in our local communities of Lambeth and Southwark and some of our teams cover a much wider geography. We deliver care in a range of locations such as patients' homes, outpatient clinics, health centres, specialist rehabilitation centres, GP surgeries and group classes.

In 2024/25 over 692,000 community patient contacts were delivered by multi-disciplinary teams which include pharmacists, nurses, doctors, allied health professionals, social workers and support workers.

Over the past year we have expanded our @Home Service to provide a wider range of care in patients' own homes. This includes care pathways for people with long term health conditions, or urgent care for very unwell people, who would previously have to be admitted to hospital to get the treatment they need. Providing care for patients in the right place for them, leads to better outcomes, helps to keep patients out of hospital and supports them to leave hospital more quickly.

We support many of the most vulnerable individuals and communities, often working in partnership with other agencies, including local authorities and voluntary organisations.

Our community teams are at the heart of the Trust's commitment to improving the health of our local population, and work in the past year to tackle health inequalities is described on page 23-25.

Performance analysis – financial

The Trust's Adjusted Financial Performance at the end of the financial year was a surplus of £12.7 million against a planned target of breakeven. This is the measure used by NHS England to rate the Trust's financial performance. The reported position after making a number of technical adjustments was a deficit of £25.5 million.

The technical adjustments that contributed to the £25.5 million deficit are shown in the table below. The main adjustments relate to impairments of £19.7 million arising from the revaluation of land and buildings, and £18.4 million of income and expenditure from capital donation entries.

Our financial performance

The Trust's plan was to achieve a breakeven position, before technical adjustments such as capital donations, depreciation on donated assets and valuations. Despite the challenging operational and financial environment across the NHS, and the significant impact of the cyber-attack on Synnovis, at the end of the financial year the Trust reported a surplus of £12.7 million before technical adjustments. The adjustments are shown in the table below and include: impairments of £19.7 million arising from revaluation of land and buildings; the impact of income and expenditure associated with capital donations which was £11.7 million above plan, made up of in-year donations of £0.5 million and £18.9 million in depreciation and amortisation of capital donations; and 2 minor technical adjustments.

The key national priorities for the NHS continued to be the delivery of planned (elective) care and for cancer treatment to exceed pre-pandemic activity levels. To support this, planned (elective) activity was paid for by a variable payment mechanism which incentivised trusts to earn extra income and reduce waiting lists, while unplanned (non-elective) and emergency care was funded via fixed payments.

Financial performance against plan	Plan £'000	Actual £'000	Variance £'000
Total surplus (deficit)	(6,696)	**(25,505)**	(18,809)
Less: Impairment movements	0	**(19,718)**	(19,718)
Capital donations (I&E impact)	(6,696)	**(18,419)**	(11,723)
Technical accounting adjustments	0	**(50)**	(50)
Adjusted Financial Performance	0	**12,682**	12,682

The Adjusted Financial Performance is a measure of the financial performance before a number of technical adjustments as shown in the table above. This is the main financial measure against which the Trust's financial performance is viewed by our regulator. Excluding these adjustments, the Trust reported a surplus of £12.7 million

Cost improvement programme

At the start of the year, the Trust set an ambitious cost improvement programme of £93.8 million, which reflected the level of savings required to deliver our financial plan, achieve national efficiency targets and treat an increased number of patients. A number of factors including industrial action and the cyber-attack on our pathology provider, Synnovis, reduced activity during the first part of the year. Despite this we successfully delivered £72.1 million of savings at year end – a significant proportion of the planned cost improvement target we had set ourselves.

Cash flow

The Trust began the financial year with £90 million of cash and cash equivalents. The majority of the cash reserve resulted from surpluses achieved in previous years and is earmarked for the Trust's capital programme.

During the year, cash balances increased by £101 million, to £191 million. For details of the Trust's net cash balances, see note 25 in the annual accounts. These changes during the year are the result of capital support from NHS England, movements in working capital and investment in property and other intangible assets. The operating surplus after adding back non-cash items resulted in £164 million of net cash generated from operating activities. The Trust spent a net £83 million on investments, including £91 million purchasing intangible assets and property, plant and machinery and received £8 million in interest. A net £20 million was received in loans, lease liability repayments, Public Dividend Capital dividends and draw downs. Full details can be found in the statements of cash flows in the annual accounts on page 94.

Charitable funding

The Trust received £9 million from charitable sources during the year, £0.5 million of which consisted of donations towards capital expenditure which principally came from Guy's & St Thomas' Foundation.

Capital expenditure

In 2024/25, the Trust spent £98 million, and £0.3 million of donated assets, on property, plant and equipment (£68 million and £5 million of donated assets in 2023/24). The Trust also spent £5 million on intangible assets, mostly software and other information technology assets (£57 million in 2023/24). The capital programme is funded from a combination of internally generated resources, surpluses generated in previous years, charitable donations and loans from the Department of Health and Social Care.

Capital loans

A significant part of the Trust's capital programme is funded from loans provided by the Department of Health and Social Care. At the beginning of the financial year, the Trust had drawn down loans totalling £315 million, with £193 million left outstanding for these loans in principal and interest. During the year, the Trust made principal repayments of £17 million and interest payments of £5 million, creating a cash outflow of £22 million, and interest of a further £5 million was charged. At the year end, total borrowings equated to £176 million. See note 23.6 in the annual accounts.

Revaluation of land, buildings and other assets

As part of the preparation of the annual accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of each financial year. This year, the full impact of these revaluations on the income statement is a charge of £20 million (£106 million charge in 2023/24). In addition, impairments were charged to the revaluation reserve of £7 million (£49 million in 2023/24). Together, and including assets abandoned in the course of construction, the net impairment charge is £28 million (£159 million in 2023/24). These entries, referred to as impairments, do not reflect any physical damage to our land and buildings or intangible assets; there is no loss of utility or financial loss, and they have no implications for patient care. More details can be found in note 15.2 to the annual accounts.

External audit services

Grant Thornton UK LLP received £337,000 in audit fees (excluding VAT) in relation to the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2025. For more details, see note 7.2 to the annual accounts.

Identifying potential financial risks

In 2025/26, the Trust faces a number of financial risks. These include:

Delivering required efficiency savings – the Trust is required to deliver £102 million efficiency savings. There is a risk that we cannot identify sufficient efficiencies to fully address the financial challenge, or that we cannot deliver these at the required pace. Failure to deliver our planned breakeven position could potentially lead to regulatory intervention under NHS England's NHS Oversight Framework.

Clinical income risk – the Trust is entering into contracts with commissioners which contain significant proportions of 'block' income and this presents a risk where activity levels exceed those which are funded. A reintroduction of centrally-set elective recovery targets with potential funding clawback could also pose a financial risk should our elective performance fall short of funding allocated in contracts and targets set to achieve them. There is also the risk of commissioners imposing unilateral contractual adjustments with the Trust having limited ability to influence the decisions. Changes to the specialised commissioning financial regime could have a significant impact on the Trust.

Excess inflation costs – inflationary cost pressures continue to run at higher levels than those funded through contract income uplifts.

Accurate activity reporting – following the implementation of our new electronic health record system on 5 October 2023, the Trust has been working hard to provide accurate clinical activity data which is still going through cleansing and improvement processes. This has presented a number of challenges, and the focus has been to prioritise activity which triggers a variable payment to enable both the Trust and its commissioners to understand the financial position as accurately as possible. The Trust is working with commissioners to improve reporting and reduce any financial risk to the Trust. Given the Trust's strong history of sound financial management, as and when risks materialise, management action will be taken decisively and rapidly in mitigation.

Capital planning

Since 2023 the Trust has maintained a Medium-Term Capital Plan with an annual refresh covering a rolling 5-year period. This has now been updated to cover the period 2025/26 to 2029/30 and retains a focus on investment in the resilience of existing infrastructure, medical equipment and technology.

The availability of capital funding remains the primary constraint on capital expenditure. The Trust has undertaken a prioritisation of clinical group and corporate priorities as a result of commitments to its major programmes and infrastructure resilience. In addition to resilience and replacement programmes, including those for operating theatre maintenance and catheter laboratory replacement, the plan prioritises allocation for strategic schemes, major programmes and leases, and consists of a 5 year plan totalling £500m.

Procurement

The Trust hosts a procurement shared service which supports Lewisham and Greenwich NHS Trust, as well as Great Ormond Street Hospital for Children, South London and Maudsley, and Oxleas NHS Foundation Trusts. During the last 12 months the procurement team underwent an operating model review, which has resulted in a new structure. The new operating model and relationship with shared service members went live on 1 April 2025. The next phase of the transformation will be to establish a new operating model for the supply chain team, which will include all aspects of materials management, logistics and warehousing.

Trends in activity, income and expenditure

Chart 1: Completed patient spells

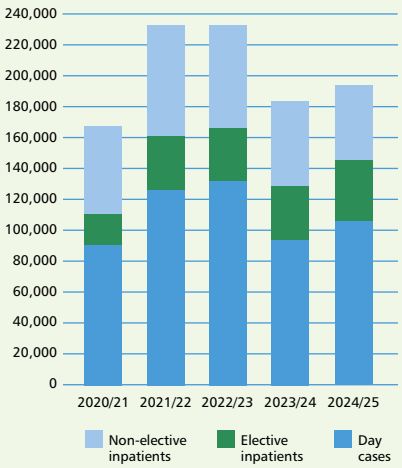


Chart 2: Outpatient attendances

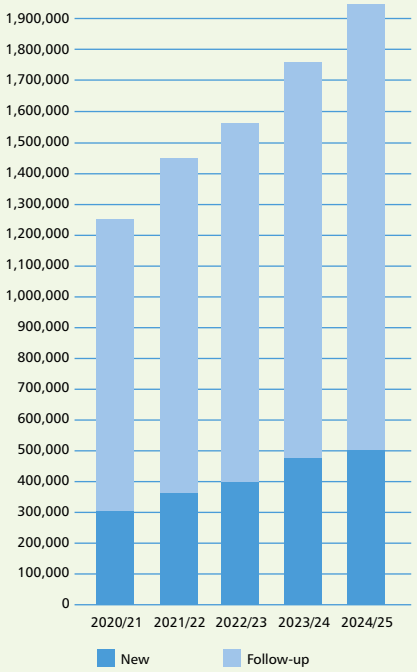
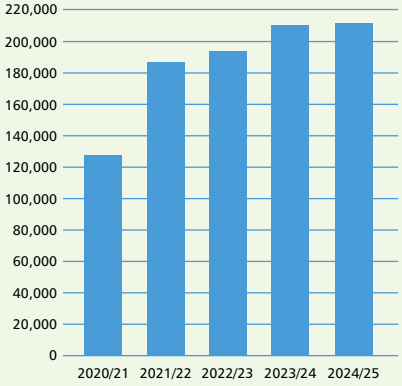


Chart 3: A&E attendances



During 2024/25, we saw 1,952,000 outpatients, 88,000 inpatients, 106,000 day case patients and 212,000 accident and emergency attendances.

We also provided over 692,000 contacts in the community, bringing our total patient contacts to 3.05 million.

Chart 4: Operating income £millions

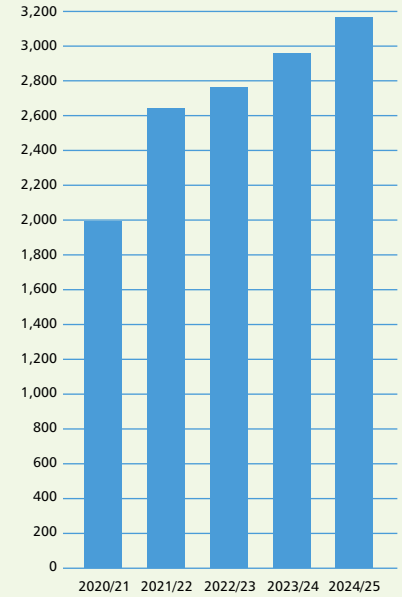
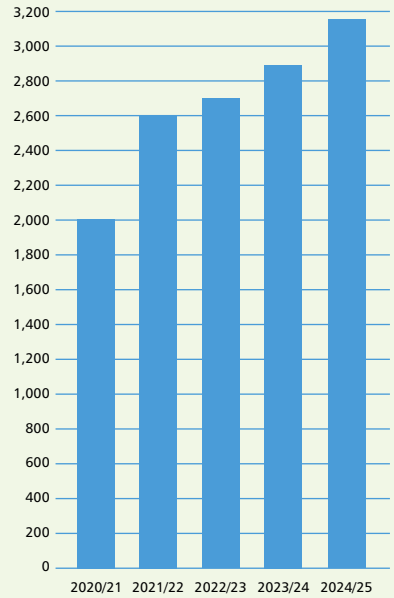


Chart 5: Operating expenditure £millions



The merger with Royal Brompton and Harefield and the implementation of Epic, mean that direct comparisons between years should be made with caution.

Sustainability report

Environmental sustainability

The Trust's 10-year Sustainability Strategy 2021-31 sets out our commitment to providing sustainable healthcare and our plans to comply with the 'Delivering a Net Zero NHS' report. This commitment is also central to our Trust strategy to provide 'better, faster, fairer healthcare for all'.

While we have a long way to go to reach Net Zero we have been able to reduce our NHS Carbon Footprint (the emissions we directly control) by 3% over the year. Our NHS Carbon Footprint Plus (which we can only influence) has increased by 5% which is in line with an increase in non-pay spend across the Trust. We have continued to make positive progress across our 3 strategic themes of carbon zero; connecting with nature; and cycle of resources, and a number of projects across these themes are outlined below:

Reducing emissions

Following the launch of our Green Travel Plan in 2023, we have continued to support our staff, patients and visitors to use more active and sustainable means of transport to reduce our carbon emissions. This includes expanding our 'Dr Bike' initiative to support staff across our hospital and community sites to get their bikes regularly checked by a mechanic.

Since February 2023, we only offer electric vehicles through our staff salary sacrifice scheme, and electric vehicles now make up over 80% of this fleet. We are working towards ensuring all our Trust vehicles, including specialised and patient transport vehicles, are fully electric by 2030. We have also made progress on improving fleet efficiency by disposing of our most underutilised vehicles.

Nitrous oxide is an anaesthetic gas that is responsible for two thirds of our anaesthetic carbon footprint. Where it is still needed for patient care, we are making sure it is used efficiently and this has helped to reduce emissions by 5% in the past year.

Heating our buildings is one of the main contributors to our overall carbon footprint. With funding from the Department for Energy Security and Net Zero we are progressing plans for a low carbon District Energy Network at St Thomas' Hospital which will increase our resilience and efficiency, and would help us achieve a significant reduction in carbon emissions.

Greenspace and air quality

A year after the introduction of our Clean Air Plan, developed thanks to funding from Impact on Urban Health, part of Guy's & St Thomas' Foundation, we are continuing to make progress in reducing air pollution and raising awareness of the issue with our staff, patients and visitors.

Air quality is improving at the majority of our pedestrian entrances and, by monitoring the vehicles on our loading bays, we are able to engage with suppliers whose vehicles most often cause spikes in pollution levels. We have also installed new and more visible anti-idling signage to remind all drivers that vehicle emissions harm health.

At Harefield Hospital we have created a new 4 acre wildflower meadow, and a new greenspace next to the Healing Garden. We also ran a 'Garden for Health and Nature' competition which saw 3 community sites awarded funding to enhance or create new nature-friendly gardens. We will continue to build on our staff's passion for nature in 2025 as we consult on a new Greenspace and Nature Plan for the Trust.

Reducing waste

We are committed to conserving resources in everything we do. Our 'Gloves Off' campaign, which encourages staff to think about when it is appropriate to wear non-sterile gloves, was launched across the Trust in September 2024. We have purchased 1.6 million fewer gloves than the previous year, resulting in 8 tonnes of plastic waste and £200,000 saved.

We also launched our first inhaler recycling scheme in summer 2024 to help avoid inhalers going into landfill. Recycling them correctly means that harmful gases can be repurposed into a coolant and the plastic and aluminium parts can be recycled.

Task force on climate-related disclosures

As set out in NHS England's reporting guidance, we are adopting a phased approach to publishing sustainability disclosures and meeting reporting requirements. We are working hard to ensure that we collect robust data across a wide range of environmental performance indicators, including our carbon

Environmental impact performance indicators 2024/25

Overall carbon footprint	2024/25	2023/24*	% change 24/25 vs 23/24
NHS Carbon Footprint (we can directly control this), tCO2e	64,366	66,054	-3%
NHS Carbon Footprint Plus (including emissions we can only influence), tCO2e	347,323	330,807	5%

Carbon footprint per key area	2024/25	2023/24*	% change 24/25 vs 23/24
Utilities			
Water ($m^{3)}$	736,873	785,640	-6%
Imported Electricity (kWh)**	60,259,718	52,517,598	15%
Gas (kWh)**	200,017,942	222,368,264	-10%
Oil (kWh)	2,102,277	2,877,762	-27%
tCO2e for building energy use	59,898	62,766	-5%

Waste, acute hospitals	2024/25	2023/24*	% change 24/25 vs 23/24
All waste (tonnes)	5,642	6,243	-10%
High temperature disposal (tonnes)	537	548	-2%
Alternative Treatment (tonnes)	1,385	1,376	1%
Offensive Waste (tonnes)	975	892	9%
Landfill waste (tonnes)	-	10	-100%
Recycling by % of total domestic waste	47%	31%	52%
tCO2e all waste	1,005	1,083	-7%

Travel and transport	2024/25	2023/24*	% change 24/25 vs 23/24
Core fleet (cars, vans and minibuses), vehicles	307	269	14%
tCO2e	1,100	1,103	0%
Air pollution - tNOx	2.62	2.84	-8%
Air pollution - tPM2.5	0.12	0.11	12%
Salary sacrifice fleet, vehicles	297	268	11%
tCO2e	287	286	0%
Grey fleet, mileage	288,904	285,052	1%
tCO2e	93	92	1%
Air travel, mileage	1,141,850	632,906	80%
tCO2e	508	247	106%
Public transport, mileage claimed * **	14,909	28,510	-48%
tCO2e	1	3	-52%
Cycling, mileage claimed * **	2,798	4,901	-43%

Anaesthetic gases	2024/25	2023/24*	% change 24/25 vs 23/24
Desflurane tCO2e	0	0	0%
Isoflurane tCO2e	102	108	-6%
Sevoflurane tCO2e	181	188	-4%
Nitrous oxide pure tCO2e	637	670	-5%
Nitrous oxide mixed - Entonox tCO2e	629	593	6%

* Please note that some of these figures vary from those reported in the 2023/24 Annual Report, because more accurate data became available, or to reflect updated guidance, following publication.

** Increased electricity and reduced gas consumption are linked to a temporary outage of the combined heat and power plant at St Thomas' Hospital in 2024.

*** The Trust is in the process of introducing a new expenses system, which has impacted the data availability of mileage claimed for public transport and cycling.

footprint, which we have been able to report across all Trust sites and activity since 2023/24 (please refer to table on page 21.

The phased approach incorporates the disclosure requirements relating to governance; risk management; and the metrics and targets which are set out below:

- **Governance**

The Trust Board, through the Transformation and Major Programmes Committee, has responsibility for oversight, assessment and management of climate-related issues and our commitments relating to environmental sustainability.

Delivery of the Trust Sustainability Strategy is overseen at an executive level by the Sustainability Steering Committee, which has representation from all clinical and delivery groups. It meets every 2 months and reports biannually to the Trust Executive Committee. There is also a nominated Board-level Net Zero lead, whose role is to champion sustainability initiatives and promote sustainability considerations in the Board's decision-making.

A number of sustainability working groups, many of which sit within the clinical groups, lead on the implementation of Trust-wide initiatives in their areas - as well as group or departmental specific pieces of work. All clinical and delivery groups have defined key performance indicators for environmental sustainability which are reviewed regularly and enable the Trust to track progress and escalate any issues. Work is ongoing to ensure environmental sustainability considerations are fully embedded into clinical and delivery group planning and reporting.

- **Risk management**

The Trust recognises both the 'transitional' risk associated with meeting the mandatory Net Zero carbon targets and the 'physical' risk associated with the impacts of climate change on our operations.

Physical risks are managed by our Emergency Preparedness Resilience and Response (EPRR) team and associated governance processes, including the EPRR Steering Group and Trust corporate risk register. Plans to mitigate these risks include the 'severe weather plan', 'heatwave plan' and 'Corporate Business Continuity Plan'.

At the time of writing, we are developing our Trust Climate Change Adaptation Plan and reviewing our risk register to ensure strategic climate risks are recognised and support our preparedness for climate change.

Further information about our approach to managing climate-based risk is set out on page 80 of the Annual Governance Statement.

- **Metrics and targets**

We use a range of metrics and targets to assess and manage climate related issues. The environmental impact performance indicators for 2024/25 are outlined on page 21 and are used to track our progress to Net Zero as well as other sustainability programme targets.

Our Sustainability Strategy 2021-31 sets out the targets and objectives for each of our strategic themes, while our Green Travel Plan 2023-27, and Clean Air Plan 2023-26, use a wide range of data and insights to develop detailed action plans. These are available on the Trust website.

We will be reviewing metrics and targets relating to our 'physical' risks once our Climate Change Adaptation Plan has been published.

Serving our communities

As a Trust we are committed to meeting the needs of our diverse communities by tackling health inequalities, ensuring equity of service delivery and widening participation.

Tackling health inequalities

Our 'Better, faster, fairer healthcare for all' strategy to 2030 sets out our commitment to tackle harmful and avoidable differences in health and healthcare access across our communities. Throughout 2024/25 we have focused on building the capacity and expertise needed to tackle health inequalities and deliver personalised, evidenced-based, high-quality care to the populations we serve.

In 2025 we established a new Population Health Hub, funded by Guy's & St Thomas' Charity, which is part of a portfolio of programmes to improve patient health outcomes. The Hub will support teams to drive improvement by using quality data and evidence to inform decision making and apply a structured approach to co-designing services with patients, carers and staff. For example, the Hub is working with local integrated neighbourhood teams to improve the care pathway for elderly patients who require more intensive support to lead healthier, independent lives.

The Trust delivers local hospital and community services across Lambeth and Southwark, working closely with a wide range of partners, including the South East London Integrated Care Board; Lambeth and Southwark public health teams; King's College London; Lambeth Together; Partnership Southwark and Lewisham and Greenwich NHS Trust.

We also provide specialist heart and lung services at Royal Brompton and Harefield hospitals, and work with partners in north west London including North West London Integrated Care Board. In 2024/25 our health inequalities report is focused on our populations in south east London, where we provide the majority of our services to local communities.

Our local populations

Lambeth and Southwark are densely populated and home to some of the most diverse patient populations in the UK: approximately 50% of residents identify as being from non-white communities, and many identify with multiple ethnic groups.

There is also significant socio-economic variation, with an above average number of people experiencing high levels of deprivation. A quarter of people in Lambeth live in poverty, and more than a third of people in Southwark live in areas with the highest levels of deprivation in England.

These inequalities have a significant impact on health outcomes. The difference in life expectancy between the richest and poorest in Lambeth and Southwark can be up to 12 years, and a 17

year gap in years lived in good health. Both Lambeth and Southwark also have above average preventable mortality rates for major conditions, such as cancer and cardiovascular disease.

Population health data

In 2024/25 we have worked hard to improve the quality and breadth of patient population data available to us, both within the Trust and with our partners on the South East London Integrated Care Board. Through our Population Heath Hub we have made good progress, including in using Epic, our electronic health record system, to ensure our data is as robust as possible.

The Trust has created a new population health dashboard that provides services with an overview of their patients' socio-economic and demographic information, allowing them to better identify and monitor trends to help address inequalities.

The visibility of data such as this is proving particularly important in specialties such as cardiology and vascular surgery, where trends show that we treat significantly more patients living in areas of greater deprivation. This aligns with research which found that cardiovascular disease accounts for one fifth of the life expectancy gap between the least deprived and most deprived communities.

Accurately recording patient ethnicity remains a priority for the Trust, and we completed this for 76% of our patients, against a target of more than 80% in 2024/25.

Our aim is to tackle health inequalities in the diverse populations that we serve, and we are working towards an approach that reflects the national Core20Plus5 focus on the 20% most deprived communities and 5 priority clinical areas for accelerated improvement. For adults these are: maternity; physical health checks for people with severe mental illness; chronic respiratory disease; early cancer diagnosis; and hypertension case-finding. For children and young people, the 5 focus areas are: epilepsy; diabetes; asthma; oral health and mental health.

We recognise we have more to do to encourage patients and staff to declare and record personal information accurately, ensuring they feel confident in doing so and understand why this is important, as it will enable us to improve the care we provide.

Reporting health inequality indicators

For 2024/25 the Trust is able to report against some of the key indicators outlined in NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006), which are outlined below. Work is ongoing to ensure that this data is as accurate and robust as possible, so that we can understand more about the populations we serve and reduce healthcare inequalities.

Tobacco withdrawal management programmes

Smoking remains strongly associated with most indicators of disadvantage, and a person's likelihood of smoking increases in line with the level of deprivation in their neighbourhood. Building on the NHS Long Term plan and the Core20plus5 approach, we offer patients tailored withdrawal programmes to support better health outcomes:

Maternity – our midwives offer tobacco dependency support to all patients at the point of booking-in for their maternity care. Patients requiring further support and advice to manage tobacco withdrawal during their pregnancy are referred to specialist midwives who are trained to provide cessation support alongside maternity care.

Inpatients – safely withdrawing from tobacco dependence before planned treatment such as surgery, has been found to improve both recovery and longer-term outcomes. We

recognise that admission to hospital is an important opportunity to offer our patients access to tailored advice and support.

Our tobacco dependence treatment team delivers a full range of services including staff training and an inpatient screening programme. Our data shows approximately 60% of our patients were screened for tobacco dependence in 2024/25, although it is likely that this figure will be higher as we introduce improved data capture processes within the Epic system.

Children's oral health

An area of focus in the Core20Plus5 approach for children and young people, is oral health, specifically reducing tooth extractions due to decay in patients aged 10 and under. In 2024/25, 54 children and young people underwent tooth extractions due to decay, 17% of whom were aged 5 and under, with the majority (70%) aged between 8 and 10 years old.

22% of these patients were from the most deprived areas using the Index of Multiple Deprivation levels 1 and 2. The largest recorded ethnicity groups among these patients were 'White British' and 'White – Other White Background', although the data for this patient group is poor and we are working hard to address this.

Children's urgent and emergency care

Our urgent and emergency care teams see a higher proportion of children and young people from deprived, rather than more affluent, neighbourhoods which is in line with data from the Office of National Statistics showing that attendance increases with levels of deprivation - and can be up to 1.7 times higher for those living in areas of the highest deprivation.

In 2024/25, there were 2,070 paediatric urgent and emergency care admissions, 22% of which were for children under the age of 1 year. For young people, 17 year olds accounted for 7% of admissions, and 24% of admitted children and young people were recorded as living in areas experiencing the greatest deprivation. Most patients and their families identified as White British (17%), with Black British – African (14%) and Other White (14%) being the second largest groups.

Inclusion health

Throughout the year we have continued to focus on a number of important initiatives that support health inclusion for communities facing stigma, social exclusion and structural inequalities, and therefore experience multiple risk factors for poor health. This includes those experiencing homelessness or substance misuse, or who are vulnerable migrants or sex workers.

The Trust's Addiction Clinical Care Suite is 1 of only 2 inpatient NHS addiction detox units in London and the first dedicated to supporting people experiencing homelessness. We are proud to have secured funding to expand the service with an extra 14 beds to meet the rising demand for its services. Over the year we received 512 referrals and treated 344 patients, 87% of whom achieved a successful treatment outcome.

Those sleeping rough commonly face the greatest risk factors for poor health and the addiction service provides personalised care for drug and alcohol dependence, alongside access to a wide range of medical care.

Recovery from addiction and the wider physical and psychological impact of homelessness and associated trauma requires a compassionate, holistic approach, and this is a guiding principle of the service. Patients are offered peer and group support, smoking cessation, healthy eating advice, mental wellbeing support, essential screening and vaccinations as well as access to psychologists and psychiatrists.

Equity of service delivery

We remain committed to delivering services that are inclusive, accessible and responsive to the diverse needs of our patients, service users, staff and the wider community. In line with the Equality Act 2010 and our Public Sector Equality Duty, we actively work to ensure no one is disadvantaged or excluded based on their age, disability, ethnicity, sex, religion or belief, gender reassignment, sexual orientation, pregnancy and maternity, or marriage and civil partnership.

We work hard to ensure all our processes, practices and outcomes are fair for all and this work is supported and assured by the Trust's equality, diversity and inclusion team. We undertake equality and quality impact assessments to provide assurance that our policies, functions and services are fair and equitable and help drive service level improvements. We continue to:

- design, develop and deliver both new and existing services to meet the needs of all patients, and carers
- analyse responses to the Friends and Family Test, concerns received by our Patient Advice and Liaison Service and complaints and compliments by protected characteristics where possible
- work with patients and their carers to ensure they receive information and communication in their preferred format
- ensure that our environment, facilities and services are accessible to all
- work closely with local schools, colleges voluntary and community organisations to improve social mobility by raising awareness of the 350 different careers within the Trust, as well as education and work experience opportunities.

The Friends and Family Test scores are reported by ethnic group across our inpatient, outpatient, maternity and community services. While there were some variations in how respondents from different ethnic groups rated their experiences, not all chose to state their ethnicity. We recognise the importance of improving our data in this respect so that we can better understand and respond to patient views.

The Trust is committed to safeguarding all our patients, including the most vulnerable such as those with learning difficulties and those who are supported by our 'health inclusion' team. We participate in our local, multi-agency safeguarding boards which aim to safeguard vulnerable people through a partnership approach.

Care and treatment is provided to all patients with their consent, and for patients who cannot consent to treatment, care is provided in their best interests in accordance with the Mental Capacity Act 2005. Our safeguarding service consists of separate teams for adults and children and they work closely with statutory bodies to provide support, guidance and decisions on all safeguarding issues.

The teams also provide training to all staff as part of the Trust's wider training programmes. This includes Barbara's Story, our award-winning training film which raises awareness of dementia and the issues faced by vulnerable patients and their families, as well as specific training to support those with learning disabilities. Our clinical areas have dementia and delirium leads and learning disabilities leads who champion, and work with colleagues to implement best practice in their area.

The Trust provides a comprehensive language and accessible support service to meet the communication needs of our diverse population. Our website has been designed to ensure everyone can access the information they need, regardless of background, ability or needs. We were also the first trust to roll out the 'sunflower' initiative to support patients and staff with hidden disabilities, and the first to install state-of-the-art 'changing places'

facilities – which have now been introduced at all our hospital sites.

We undertake comprehensive accessibility audits in all patient-facing areas and work with AccessAble to provide detailed accessibility information about all our wards, departments and services to help people plan their visit before they arrive.

Widening participation

As an anchor organisation we are committed to widening access to jobs for our local communities. Working with local schools, colleges, community groups and other partners we aim to support local people from all backgrounds to understand the variety of roles and entry routes to employment within the Trust and to provide pathways to employment. This includes initiatives such as:

- Our sector-based work academy programme, in collaboration with Job Centres, Southwark College and Southbank Gateway College, which has supported over 100 local job seekers onto our Staff Bank and into permanent jobs.
- The provision of industry placements for our first cohort of 16 T-Level students from La Retraite School in Lambeth. All the students successfully progressed onto Nursing and Midwifery degree programmes. In the next phase of the programme we are hosting 36 students from La Retraite School, Southbank Technical College, Southwark College and South Bank University Sixth Form.
- Our supported internship programme which continues to provide valuable work placements for young people with autism, learning disabilities or learning difficulties. This year, graduates of the programme were employed into a variety of roles including portering, nursery support workers and community administration.

The Trust is committed to fostering an equal and inclusive environment and collects a range of employment data to monitor and address diversity issues and inequalities, including through the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

The results are published in an annual workforce monitoring report on our website and through reporting to NHS England. To address disparities in people's experience of our recruitment processes, we are reviewing our recruitment processes through an equality, diversity and inclusion lens to ensure fair access to jobs. This includes updating our public website to include easy-read information and guidance on the application process, details of the adjustments that can be requested at interview, and sign-posting to our support programmes and resources to optimise chances of success.

We also have a well-established reverse mentoring programme and we continue to develop and support cultural competence amongst our managers and leaders.

A multi-faith spiritual care team, reflecting the diverse faiths and beliefs of our local communities, is available to support patients and staff. The Trust celebrates its rich diversity through events, conferences and its vibrant staff networks, which provide important platforms to support an inclusive and compassionate culture; ensure that the lived experiences of staff are shared; and that staff can provide challenge, direction and innovation.

Professor Ian Abbs
Chief Executive Officer
25 June 2025

Our Healthy Weight Hub provides free weight loss and exercise programmes for people living in Lambeth, Southwark and Lewisham. Lanceford Brown was supported by nutritionists and physiotherapists to lose 8kg over the 12 week programme.

3 Accountability report

More than 1,000 adults are treated by the sickle cell service at Guy's and St Thomas' each year. Ansella Aaron has been under their care for 60 years.

4 Directors' report

Over the past year we have done everything we can to provide high-quality, timely care to as many people as possible. This objective is set out in our new strategy to 2030 'Better, faster, fairer healthcare for all'.

Our new strategy was published in September 2024 and sets out our shared vision to 'deliver excellent healthcare and improve wellbeing as a local, national and international leader in clinical care, education, research and innovation' and ultimately to deliver better, faster, fairer healthcare for all.

Alongside this, we also published a new set of values for the whole organisation which guide our decisions and behaviours and shape our Trust culture:

- **Caring** – we put patients first
- **Ambitious** – we innovate and strive for excellence
- **Inclusive** – we respect each other and work collaboratively.

Both our strategy and values were developed following extensive engagement with patients, staff, local communities, governors and partners and ensure a clear direction for us as an expanded organisation following our merger with Royal Brompton and Harefield NHS Foundation Trust.

Despite the significant disruption caused by the cyber-attack on Synnovis, and continued periods of industrial action, over the past year we have focused on doing everything possible to deliver our strategic plans, and to adapt and improve our services to enable us to care for more patients.

We pay tribute to the hard work and dedication of our staff, which has been critical in enabling us to manage the challenging operational and financial challenges which have been felt across the NHS.

Following the successful implementation of Epic, our new electronic health record, in October 2023, we have continued to focus on optimising the system to ensure the benefits can be fully realised by patients and colleagues. More than 610,000 patients (from Guy's and St Thomas' and King's College Hospital) now use the MyChart patient app and website which gives them secure and easy access to their information and enables them to be more engaged in their health and care.

We are introducing new artificial intelligence (AI) listening technology in Epic, which provides clinicians with a summary of a patient consultation and supports faster, more accurate documentation and letter creation. This allows them to spend more time in face-to-face patient interactions and leads to an improved patient experience. Epic is also enabling our productivity and sustainability agendas, for example clinical teams are able to avoid unnecessary patient tests through alerts which inform them when tests have already been completed, or are not recommended, for example due to a short timeframe since the last test was carried out.

We have continued to advance our imaging capability to support earlier and faster diagnoses for our patients. In November we unveiled a new positron emission tomography (PET) scanner at St Thomas' Hospital. This total-body scanner produces faster, higher quality images for earlier diagnosis and treatment of illnesses such as cancer and heart conditions. It is one of only 3 in the UK.

A new 'gamma camera' at Royal Brompton Hospital, made possible thanks to Royal Brompton & Harefield Hospitals Charity, is now providing improved 3D imaging for heart and lung patients. It is the first of its kind in an NHS hospital in London and combines 2 different types of imaging to create faster, high-quality 3D scans – reducing the need for additional tests.

We are also working hard to ensure patients can access scans closer to home, and are piloting a new quick and convenient liver scan for people in Lambeth with signs of liver disease. The project is made possible by Guy's & St Thomas' Charity, is being delivered in partnership with the Lambeth GP federation, and enables people to receive their scans more quickly at Akerman Health Centre in Oval.

Innovation to improve care

We continue to work with our partners to deliver new innovative ways of working to provide better, faster, fairer healthcare. We are trialling an initiative to move urgent blood samples, initially between Guy's and St Thomas' hospitals, by electric drone. Transporting the blood by drone between the sites takes less than 2 minutes, compared to around half an hour by road, and reduces carbon emissions by up to 99% compared to non-electric cars.

We have expanded our robotic-assisted surgery programme, and our 11 robotic systems, across 9 surgical specialties and 4 hospital sites, make it the largest robotic programme in the UK. It provides many benefits for patients including reduced length of stay, fewer complications, faster recovery and improved outcomes for cancer. The programme is a central element of our Trust-wide vision for innovation, and our ambition to collaborate with academic and industry partners. It also enables us to attract and retain highly-skilled clinical professionals.

We have continued to build our capability and expertise in genomic medicine, firmly establishing Guy's and St Thomas' as a global leader in this field. For example the Trust has been commissioned by the Office of Life Sciences and NHS England to lead the Respiratory Metagenomics Clinical Service Network – providing a world-first biosecurity surveillance programme which combines infectious diseases management with rapid emerging pathogen detection.

We continue to develop our plans to expand Evelina London Children's Hospital – including as the future location for the Principal Treatment Centre for specialist cancer services for children living in south London and much of south east England. This significant programme of work is preparing clinical and capital plans to deliver these crucial services in our dedicated children's hospital with paediatric services under one roof. This will bring our region into line with children's cancer care delivery in the rest of England.

We remain fully committed to working with patients, their families, staff from the current service and other partners to design the new service with children, young people and staff at its heart, as well as to ensure continuity of care during the transition period and to agree a plan for the transfer of the service.

In March 2025 the Trust received NHS England, Department of Health and HM Treasury approval to proceed with a new elective surgical hub at Guy's Hospital – a new purpose-built building with 6 state-of-the-art theatres. The new hub will consolidate complex, specialist orthopaedic work into a single south east London site. It will address the growing demand for complex and specialist planned surgery, particularly cancer and cardiac surgery, to meet rising demand from a growing, ageing population.

We have continued to work closely with our partners across the south east London and the north west London health systems. Through the South East London Acute Provider Collaborative we are working hard to ensure equitable access to care for patients on the waiting list for high volume specialties such as ophthalmology, dental and orthopaedics.

Standards of care

Under the Care Quality Commission's (CQC) system for regulating health and social care organisations, Guy's and St Thomas' is registered to provide services without conditions or restrictions, having complied with all the essential standards for quality and safety. The Trust's last full inspection and assessment by the CQC was in March and April 2019.

We were pleased to have maintained an overall rating of 'good' and that our community services for adults were rated as 'outstanding'. This was a significant achievement given the size and complexity of the Trust, and reflects the dedication of our staff. The Trust was rated 'outstanding' for caring services and for being well-

led, and 'good' for effective and responsive services.

Our rating for being safe remains as 'requires improvement' as we have not had the opportunity for this to be re-inspected. We continue to focus on a range of activities to improve and assure safety and this includes directorate led quality assessments, risk and governance assurance frameworks, and our ward accreditation programme. Further information about our approach to improving quality and safety is provided in our Quality Report, published on our website.

Royal Brompton and Harefield hospital sites were last assessed by the CQC in October and November 2018, prior to our merger, and remain rated as 'good' overall.

The CQC last carried out a service-specific inspection in September 2022 focused on our maternity service at St Thomas' Hospital. The service was rated 'good' overall with positive findings and there were no changes to the Trust's overall CQC ratings as a result. It is disappointing that our maternity service was rated 'requires improvement' under the 'safe' domain, and a range of improvement actions are underway.

As part of our ongoing 'Good to outstanding' programme, we have increased both midwifery and medical staffing levels in the Maternity Assessment Unit, and continue to improve the environment for women, families and staff. In 2024/25 we met all 10 safety actions in the Maternity and Perinatal Incentive Scheme, demonstrating full compliance with national maternity safety standards ensuring high-quality, safe care for mothers and their babies.

In 2024/25 the Trust's Quality and Performance Board Committee continued to monitor the full range of clinical and non-clinical performance indicators. It received regular updates on our elective recovery and operational performance, as well as the clinical and operational impact of Epic, following its implementation in October 2023.

These indicators and updates are reported monthly through the integrated performance report. This report is published in our public board papers on the Trust website ahead of each public Board meeting, ensuring that we are open and transparent about our performance.

We continue to work hard to reduce our waiting lists for planned (elective) care, with a strong focus on quality, safety and clinical effectiveness. We were an early adopter of the Patient Safety Incident Response Framework and strive to learn from incidents and share good practice across the Trust.

We take complaints very seriously as they form a crucial part of learning from patients, and we are working hard to improve our response to patient feedback and concerns. Increasing access to patient information through our MyChart app and ensuring patients can contact our services remain key areas for improving patient experience in 2025/26.

Ensuring our services are well-led

Although the Trust has not had a full well-led inspection or Trust-wide CQC since 2019, the Board continues to keep the Trust's readiness for a future inspection under close review. In 2024/25 assurance was received from internal audit that changes made to the Trust's governance structure had led to an overall improvement of corporate governance arrangements, particularly in terms of oversight and decision-making.

We continue to focus on a range of actions to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, including through a well-established programme of multidisciplinary quality visits and peer-to-peer reviews. The Trust also runs an internal programme to promote organisational excellence in line with the 8 quality statements under the CQC's well-led domain, which helps ensure its leadership and governance arrangements are fit for purpose and support the delivery of high-quality care to our patients.

The Board has continued to assess its compliance with the principles of the Code of Governance for NHS provider trusts, and has kept the makeup and responsibilities of its Board committees and their terms of reference under review. Further details can be found in the organisational structure chapter on page 59.

The Trust is committed to

carrying out its business fairly, honestly and openly and has a zero-tolerance commitment towards bribery which is set out in a Bribery Act statement on our website and enforced through the Trust Counter Fraud and Bribery Policy.

Engaging patients and the public

The Trust's patient and public governors continue to play an important role in representing the view of patients and the public to the Board. Trust members are engaged directly through initiatives such as Patient-Led Assessment of the Care Environment (PLACE) inspections, national patient surveys, the Friends and Family Test and the Annual Public Meeting.

We maintain a close working relationship with local Healthwatch organisations through regular liaison meetings, keeping them informed about service developments, patient survey results, and progress on quality priorities. We value insights that local Healthwatch organisations provide through their work, including with diverse local communities, and use these to help drive improvements in patient care.

Following Healthwatch Southwark's report on the healthcare access experiences of adults with learning disabilities and autistic adults, we were pleased to work with families and user groups to develop the Trust's autism strategy.

Healthwatch organisations have a statutory power to 'enter and view' healthcare premises to observe the delivery of services and the care environment. They did not undertake any onsite visits during 2024/25.

The Trust was not required to undertake any formal public consultation exercises this year. However, we have continued to provide information to local authority scrutiny committees regarding the delivery and development of our services. This included updates on the opening of our new dialysis facility in Brixton, which was developed in partnership with King's College Hospital NHS Foundation Trust and Diaverum, an independent dialysis provider.

Our women's and children's services continue to involve young patients, their families, and carers as we work with partners to deliver our vision for children's and young people's cancer care, following the outcome of NHS England's consultation in 2023/24 which confirmed Evelina London Children's Hospital as the Principle Treatment Centre.

Parents and carers were also engaged in developing the maternity services strategy, which is being delivered through our 'Maternity good to outstanding programme'.

At Royal Brompton and Harefield hospitals we have focused on building strong relationships with patients and carers through active engagement, including through a review of our day case appointment system for patients undergoing lung function tests, and by reinvigorating our patient and carer advisory group to ensure continuous engagement.

We have also continued to work with patients and carers on projects that support our cancer and surgical strategies, including the development of a digital perioperative care assessment tool which patients and clinicians will use to assess patients before surgery.

This year, sexual and reproductive health services gathered service users' feedback on their experiences of using the service at its new location – Minnie Kidd House in Lambeth. Patients' insights also influenced the design of information to help them decide how their sexual healthcare records will be managed, following legislative changes and the launch of MyChart, our patient app.

Additionally, a steering group of local partners, including patient and public governors and Healthwatch bodies, helped shape the development of our new Patient and Public Engagement Strategy to 2030.

System working and partnerships

Our new strategy to 2030 – 'Better, faster, fairer healthcare for all' outlines the importance of working with a broad range of partners to deliver clinical, research, education and innovation to our local healthcare system and beyond.

Our patients, and the communities we serve, are our most important partners and we are working to ensure each patient is a critical partner in their healthcare. Through understanding their experiences we are adopting tools such as MyChart, part of our new electronic health record system, to support patients to have greater involvement in their care.

During 2024/25 we continued to work in partnership with Great Ormond Street Hospital for Children and South London and Maudsley NHS Foundation Trusts to develop the NHS Children and Young People's Gender Service (London).

The Trust is also committed to being a supportive partner to the many organisations we work with across our local healthcare systems, including in both the south east and north west London integrated care systems.

We also have a number of close relationships with other local NHS providers as part of the South East London Acute Provider Collaborative where we work closely with King's College Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust. We jointly plan, co-ordinate and deliver services to support equity of access to our services.

Within our local communities we are founding partners and active members in the borough-based partnerships of Lambeth Together and Partnership Southwark, which bring together a range of NHS organisations, including primary care, local councils as well as voluntary and community sectors to join up care in these neighbourhoods.

Our partnerships with local primary care colleagues are crucial for supporting a sustainable local health system, delivery of our strategic priority to improve the health of our populations and also our response to the 3 NHS strategic shifts of moving care from: hospital to community; sickness to prevention; and analogue to digital. Together we are identifying how we can transform ambulatory care and further develop the role of our integrated neighbourhood teams.

Our close partnership with Guy's & St Thomas' Foundation is also supporting us to realise these ambitions through the Foundation's wider focus on driving more equitable healthcare through its Impact on Urban Health programmes. We are also working together to align our joint fundraising priorities across our charities: Guy's & St Thomas' Charity, Evelina London Children's Charity, Guy's Cancer Charity and Royal Brompton and Harefield Hospitals Charity, so these support the delivery of our strategic aims.

Guy's and St Thomas' is part of King's Health Partners, one of 8 Academic Health Sciences Centres nationally. King's Health Partners brings together 3 NHS foundation trusts – Guy's and St Thomas', King's College Hospital, and South London and Maudsley – and our shared university partner King's College London. We work together within the wider system to pioneer better health for all and to transform lives in south east London and beyond.

King's Health Partners connects its partners, builds capacity through education and training, and creates opportunities for innovation and research for the benefit of our patients and the communities we serve.

Its new strategy will align with and support the strategic goals of the partners and centres on: personalised health, digital health and population health. It will continue to integrate mental and physical health across these priority areas.

The King's Health Partners Centre for Translational Medicine is a partnership between the Trust and King's Health Partners, with generous funding from Guy's & St Thomas' Charity. It aims to improve the health of people locally, nationally and globally by accelerating research and innovation, with a particular focus on reducing health inequalities in the communities we serve.

King's Health Partners offers a wide range of education and training opportunities, developing future generations of healthcare professionals, including through an online Learning Hub, which hosts a comprehensive series of events and webinars attended by over 6,000 people in 2024. The partnership also recently launched the KHP Digital Health Hub which supports innovators to develop digital health solutions.

Commercial Partnerships

The Trust has a longstanding tradition of innovation and successful business development, consistently exploring commercial opportunities that will generate additional income to support the delivery of NHS services. Over the past year we have progressed several key initiatives, including:

- **ongoing managed service partnerships:** Collaborations with Johnson & Johnson Managed Services, Diaverum and Active Care Group (Remeo) have been instrumental in enhancing service delivery.

- **global network expansion:** Efforts to develop our global networks and partnerships aim to optimise the Trust's prospects to develop its international business. Notably, the Trust has signed a strategic partnership with Cedar Sinai and partnered with King's College London and the Hinduja Foundation to further these efforts.
- **consolidation of expertise:** The Trust is actively consolidating and enhancing the collective commercial expertise across its clinical groups and corporate services. A network of clinical leads has been recruited to bolster consulting, innovation, and private practice endeavours.
- **Expansion of private patients capacity:** The Trust continues to develop its private patients services, including through the expansion of facilities at Wimpole Street, where dedicated facilities for dermatology and women's services will shortly open, complementing existing services for cardiac and respiratory patients.

The Trust also owns Guy's and St Thomas' Enterprises Limited, which independently manages several fully or partially-owned companies:

- **Lexica Health and Life Sciences Consultancy Limited** (until 30 May 2025)**:** which manages a number of estates, life sciences, and infrastructure projects.
- **Synnovis:** A pathology joint venture with King's College Hospital NHS Foundation Trust and Synlab UK & Ireland.
- **KHP Ventures:** A joint venture with King's College London, King's College Hospital NHS Foundation Trust, and now University College London Hospitals, focused on accelerating 'MedTech' initiatives with start-ups and small and medium-sized enterprises.
- **Spin-out Technology Companies:** Including Cydar, SpotOn, Zeus and XRnostics, among others.

For a comprehensive list of subsidiaries and interests in associates and joint ventures, please refer to Note 19 of the Accounts (Subsidiaries and interests in associates and joint ventures).

Board of Directors

The Board of Directors brings a wide range of experience and expertise to its stewardship of the Trust, and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive.

In 2024/25, Board membership comprised the following executive directors: Chief Executive, Ian Abbs; Chief People Officer, Crystal Akass (from August 2024); Chief Nurse, Avey Bhatia; Chief Financial Officer, Steven Davies; Chief Operating Officer, Jon Findlay; Chief People Officer, Julie Screaton (to June 2024); Chief Medical Officer, Simon Steddon; and Deputy Chief Executive, Lawrence Tallon (to March 2025).

In addition, in January 2025 the chief executives of the Trust's 4 clinical groups were formally established as Board members. They are: Gubby Ayida, Women's and Children's Clinical Group; Sarah Clarke, Cancer and Surgery Clinical Group; Louise Dark, Integrated and Specialist Medicine Clinical Group; and Richard Grocott-Mason, Heart, Lung and Critical Care Clinical Group.

The Board also comprised the following non-executive directors: Chairman Charles Alexander; Simon Friend (joint Deputy Chair from January 2025), Felicity Harvey (Senior Independent Director and joint Deputy Chair from January 2025); Miranda Brawn; Nilkunj Dodhia; Jamie Heywood (from January 2025); Shitij Kapur (from

Better payment practice code

Measure of compliance	Year ended 31 March 2025 Number	£000	Year ended 31 March 2024 Number	£000
Total bills paid in the year	**364,044**	**2,132,884**	326,279	1,983,149
Total bills paid within target	**290,094**	**1,598,692**	295,645	1,670,084
Percentage of bills paid within target	**80%**	**75%**	91%	84%

May to August 2024); Deirdre Kelly; Graham Lord (from September 2024); Sally Morgan (Deputy Chair to December 2024); Pauline Philip; Ian Playford; Reza Razavi (to May 2024); and Alison Wilcox (from January 2025).

Biographies of the Board members are set out on pages 68-70 and on the Trust's website.

All of our Board of Directors meet the standards of the 'Fit and proper persons' regulations which require annual self-attestations to be made. There have been no declarations of donations to political parties. A register of directors' interests is published on the Trust's website. Details of external directorships or other positions of authority held by the directors of the Trust where there are related party transactions can be found in Note 29 to the Annual Accounts.

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's external auditor, and members of the Board take all the necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

The Trust has a responsibility to meet the Better Payments Practice Code which requires NHS trusts to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target is to pay 95% of invoices, in terms of value and volume, within 30 days. Both the volume and value of invoices paid in 2024/25 is higher than the previous year which has unfortunately had an impact on our payment performance.

The Trust meets the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for other purposes. For full details see Note 1.3 to the Annual Accounts.

Surpluses from other income that the Trust has received have been used to support the provision of goods and services for the purposes of the health service in England. The Board confirm that the Trust complies with the cost allocation and charging guidance issued by HM Treasury.

The Board also considers the Annual Report and Accounts and the Quality Report, ensuring they are fair, balanced and understandable, and provide the information necessary for patients, regulators and stakeholders to assess our performance, business model and strategy.

Professor Ian Abbs
Chief Executive Officer

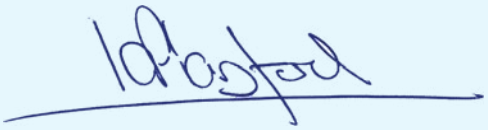
As a leading centre for clinical research, with a strong history of innovation and medical breakthroughs, we are able to offer many new treatments to our patients.

5 Remuneration report

Annual statement

As the Chair of the Senior Leadership Talent, Appointments and Remuneration Committee, I am pleased to present our remuneration report for 2024/25.

The Committee approved a 5% cost of living increase to executive and very senior managerial salaries with effect from 1 April 2024.



Ian Playford
Chair, Senior Leadership Talent, Appointments and Remuneration Committee
25 June 2025

Remuneration policy report 2024/25

Senior managers' remuneration policy

Remuneration for the Trust's most senior managers (executive directors who are members of the Board of Directors) is determined by the Senior Leadership Talent, Appointments and Remuneration Committee, the membership of which consists entirely of non-executive directors, including the Chairman.

The total remuneration for each of the Trust's executive directors comprises the following elements:

Salary + Pension = Total remuneration

The Trust's remuneration policy in respect of each of the above elements is outlined in the following table.

	Salary	Pension and benefits
Purpose and link to strategy	To provide a core reward for the role. Salary is set at a level appropriate to secure and retain the high calibre individuals needed to deliver the Trust's strategic priorities, without paying more than is necessary.	NHS Pension Scheme arrangements provide a competitive level of retirement income. Life assurance/death in service benefits may be provided as part of an individual's pension arrangements.
Operation	When determining salary levels, an individual's role, experience and performance, and independently sourced data for relevant comparator groups are considered. Executive director salaries are inclusive of a high cost area supplement. Salary increases typically take effect from 1 April each year.	Executive directors are eligible to receive pension and benefits in line with the policy for other employees. Pension arrangements are in accordance with the NHS Pension Scheme. There is no cash alternative. The NHS Pension Scheme is made up of the 1995/2008 Section legacy membership and the 2015 Section for all from 01/04/2022. New executive directors are entitled to join the 2015 Section, which is a career average revalued earnings scheme.
Opportunity	There is no formal maximum limit, however salary increases will ordinarily be in line with increases for the wider NHS workforce (not including incremental progression increases) as recommended by the NHS Pay Review Body. Increases may be higher to reflect a change in the scope of an individual's role, responsibilities or experience.	Existing executive directors are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Details of the 2024/25 pension benefits of individual executive directors are available in the single total figure table in the annual report on remuneration. Total pension entitlement for each executive director is available in the total pension entitlement table.

	Salary	Pension and benefits
Opportunity	Where a new executive director has been appointed to the Board on a salary lower than the typical Trust level for such a role, the salary may be reviewed as the executive director becomes established in the role. Salary adjustments may also reflect wider external market conditions. Salary levels for 2024/25 are set out in the single total figure table in the annual report on remuneration.	A new external recruit will be eligible to join the NHS Pension Scheme. The main features of the 2015 Scheme include: ● a career average revalued earnings (CARE) scheme with benefits based on a proportion of pensionable earnings each year during the individual's career ● a build-up rate of 1/54th of each year's pensionable earnings with no limit on the number of years that can be taken into account. This is a higher build-up rate than the 1995/2008 Scheme ● revaluation of active members' benefits in line with inflation, currently the Consumer Price Index (CPI) plus 1.5% per annum ● a normal pension age at which benefits can be claimed without reduction for early payment linked to the state pension age. In accordance with NHS Pension Scheme rules, the employer contribution rate is 20.68%.
Performance measures	The overall performance of the individual is a consideration when reviewing salaries.	None.

Salaries for senior managers are established and maintained taking the following elements into consideration: the individual's role, experience and performance, and independently sourced data for relevant comparable organisations. This includes consideration of salary levels at other members of the Shelford Group (which represents 10 of England's leading academic healthcare organisations). Salaries for senior managers are formally reviewed every 3 years with annual interim reviews.

Senior managers are employed on substantive contracts of employment and are employees of the Trust. Their contracts are open-ended employment contracts which can be terminated by either party with either 3 or 6 months' notice.

The Trust's key workforce policies are held on the Trust intranets. These include equality and diversity and recruitment and selection policies which set out the process for ensuring fair employment, training and career development opportunities for individuals with protected characteristics. As referenced in the equality, diversity and inclusion section on page 53 of this report, the Trust has a comprehensive plan to ensure better and fairer outcomes in access to learning and development, recruitment opportunities and career progression and development.

Disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

Differences between remuneration for executive directors and other employees

The key difference between the remuneration for executive directors and other employees is that the fixed salary of executive directors is considered to be inclusive of a high cost area supplement, whereas for other employees this is a separate pay element.

When setting remuneration levels for the executive directors, the committee considers the prevailing market conditions, the competitive environment (in particular, through comparison with the remuneration of executives at other leading NHS multi-specialty academic healthcare organisations of similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader Trust workforce.

In particular, the committee considers the recommendations of the NHS Pay Review Body and the Review Body on Doctors' and Dentists' Remuneration as reflecting most closely the economic environment encountered by the executive directors. The Trust does not therefore consult more widely with employees on such senior managers' remuneration matters.

Annual report on remuneration 2024/25

The remuneration for the Trust Chairman and non-executive directors is determined by the Council of Governors, taking account of the guidance issued by NHS England. Two non- executive directors were awarded an increase from £20,000 to £25,000 as a result of becoming joint Deputy Chairs with effect from 1 January 2025. There has been no other increase to the non-executive remuneration in 2024/25.

Senior Leadership Talent, Appointments and Remuneration Committee

The Senior Leadership Talent, Appointments and Remuneration Committee is responsible for determining the remuneration, including special payments and acting-up allowances, and other conditions of service of executive directors and very senior managers (VSMs), for identifying and appointing candidates to fill the executive director positions on the Trust Board and for overseeing succession planning across the Trust's senior leadership. The Committee is also responsible for evaluating the balance of skills, knowledge, experience and diversity of the executive directors to help ensure the Board reflects, as far as possible, the ethnic diversity of the Trust's workforce and the communities it serves.

The Committee is chaired by an independent non-executive director and membership comprises 5 additional non-executive directors, including the Trust Chairman. For any decisions relating to the appointment or removal of the executive directors with voting rights, membership of the Committee will expand to include all non-executive directors.

Membership of the Committee is restricted to non-executive directors except when there are decisions relating to the appointment or removal of executive directors with voting rights, when membership of the Committee will include the Trust Chief Executive, as required under Schedule 7 of the NHS Act 2006. However, the Chief Executive, Chief People Officer and Trust Secretary (or their nominated deputy) also attend the Senior Leadership Talent, Appointments and Remuneration Committee either regularly or as required.

Other individuals may also be invited to attend Senior Leadership Talent, Appointments and Remuneration Committee meetings during the year. Executive directors and other Committee attendees are not involved in any decisions, and are not present at any discussions regarding their own remuneration.

Attendance details for the Committee and an overview of its activities during 2024/25 are shown on page 66.

Fair pay disclosures

NHS Foundation Trusts are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in 2024/25 was £335,000-£340,000 (£300,000-£305,000 in 2023/24). Based on the mid-point of the banded remuneration, this represents an increase of 11.6% between 2023/24 and 2024/25.

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £22,369 to £337,050 (£17,050 to £301,739 in 2023/24). The percentage change in average employee remuneration between 2023/24 and 2024/25 was an increase of 6.5%. The calculation is based on the total for all employees, on an annualised basis, divided by full time equivalent number of employees. Remuneration includes overtime, additional hours worked and selling of annual leave. The general increase in remuneration results from the national pay uplift across Agenda for Change bands.

No employees received remuneration in excess of the highest-paid director in 2024/25 or 2023/24.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out in the table below. The pay ratio shows the relationship between the total remuneration of the highest-paid director and each point in the remuneration range for the organisation's workforce. The calculation is based on full-time equivalent staff working for the Trust on 31 March 2025. Where staff are part time, their salaries have been annualised for the purposes of the ratio calculation.

Fair pay disclosures

2024/25	25th percentile	Median	75th percentile
Total remuneration (£)	41,284	54,393	62,112
Pay ratio	8.18	6.20	5.43
2023/24			
Total remuneration (£)	39,132	52,576	63,578
Pay ratio	7.73	5.75	4.76

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

Service contracts

The following table contains details of the service contacts in place during 2024/25 for executive directors:

Service contracts

Executive director	Date of service contract	Unexpired term	Notice period
Ian Abbs	Jan 2011	Open ended	6 months
Crystal Akass	Aug 2024	Open ended	3 months
Gubby Ayida	Jan 2025	Open ended	3 months
Avey Bhatia	Nov 2020	Open ended	3 months
Sarah Clarke	Jan 2025	Open ended	3 months
Louise Dark	Jan 2025	Open ended	3 months
Steven Davies	Jan 2022	Open ended	3 months
Jon Findlay	Dec 2016	Open ended	3 months
Richard Grocott-Mason	Jan 2025	Open ended	3 months
Julie Screaton	Jun 2017	Aug 2024	3 months
Simon Steddon	Jul 2019	Open ended	6 months
Lawrence Tallon	Mar 2020	March 2025	3 months

Note: the differential in notice periods is as a result of a policy change by the Trust and not any agreements made on a personal basis with the postholder.

Salaries of senior staff

The Trust is a large and complex organisation, when compared with other leading NHS multi-specialty academic healthcare organisations. The Trust recognises that it will be necessary to pay at the upper quartile of NHS salaries, when compared with similar organisations such as members of the Shelford Group and similar private sector organisations. This will enable the Trust to attract and retain individuals with the appropriate experience to fulfil the Trust's senior managerial roles.

The Trust acknowledges that meeting these principles is likely to lead to a number of senior staff being paid more than £150,000. It is satisfied that this is justified.

Salary and benefits of senior managers

The following tables contain details of the salary and benefits of the Trust's senior managers in 2024/25 and 2023/24.

Single total figure 2024/25

Name	Title	Salaries and fees (bands of £5k) £000	Taxable benefits (to nearest £100)	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
I.Abbs	Chief Executive	335-340	11,100	-	345-350
C.Akass	Chief People Officer (from 5 August 2024)	130-135		30-32.5	160-165
G.Ayida	Chief Executive, Women's and Children's (from 6 Jan 2025)	65-70		-	65-70
A.Bhatia	Chief Nurse	195-200		20-22.5	220-225
S.Clarke	Chief Executive, Cancer and Surgery (from 6 Jan 2025)	60-65		-	60-65
L.Dark	Chief Executive, Integrated and Specialist Medicine (from 6 Jan 2025)	55-60		5-7.5	60-65
S.Davies	Chief Financial Officer	210-215		147.5-150	360-365
J.Findlay	Chief Operating Officer	215-220		-	215-220
R.Grocott-Mason	Chief Executive, Heart, Lung and Critical Care (from 6 Jan 2025)	60-65		-	60-65
J.Screaton	Chief People Officer (until 28 June 2024)	50-55		-	50-55
S.Steddon	Chief Medical Officer	270-275		107.5-110	380-385
L.Tallon	Deputy Chief Executive (until 31 March 2025)	225-230		-	225-230
C.Alexander	Chairman	70-75			70-75
M.Brawn	Non-Executive Director	20-25			20-25
N.Dodhia	Non-Executive Director	20-25			20-25
S.Friend	Non-Executive Director and Joint Deputy Chair	20-25			20-25
F.Harvey	Non-Executive Director, Joint Deputy Chair and Senior Independent Director	20-25			20-25
J.Heywood	Non-Executive Director (from 6 January 2025)	0-5			0-5
S.Kapur	Non-Executive Director (from 6 May 2024 to 31 August 2024)	5-10			5-10
D.Kelly	Non-Executive Director	20-25			20-25
G.Lord	Non-Executive Director (from 1 September 2024)	10-15			10-15
S.Morgan	Non-Executive Director (until 31 December 2024)	45-50			45-50
P.Philip	Non-Executive Director	20-25			20-25
I.Playford	Non-Executive Director	20-25			20-25
R.Razavi	Non-Executive Director (until 5 May 2024)	0-5			0-5
A.Wilcox	Non-Executive Director (from 6 January 2025)	0-5			0-5

Salaries and fees

Salaries and fees includes payment for sold annual leave for J.Findlay and L.Tallon.

No senior manager received any annual or long-term performance bonuses in 2024/25.

Professor Graham Lord is a Non Executive Director at King's College Hospital NHS Foundation Trust and Simon Friend was Non Executive Director at King's College Hospital NHS Foundation Trust until 31 March 2025. Salaries and wages disclosed for these individuals in the table above relate purely to their roles on the Guy's and St Thomas' Board.

Taxable benefits relate to rental of Trust accommodation.

Pension related benefits

I.Abbs, J Findlay, S.Clarke and G.Ayida were not members of the NHS Pension scheme for the year 2024/25.

L.Tallon opted back into the NHS Pension Scheme on 1 September 2024. There are no in-year reportable pension related benefits.

J.Screaton opted out of the NHS Pension Scheme from 1 April 2024. There are therefore no pension disclosures for 2024/25 relating to J. Screaton

R.Grocott-Mason is opted into the NHS Pension scheme, but had no reportable pension related benefits for 2024/25

S.Davies, A.Bhatia, S.Steddon, C.Akass and L.Dark are all opted into the NHS Pension scheme.

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual. Pension related benefits may vary for each individual depending on which specific pension scheme they are in and whether there have been any changes to the pension scheme itself.

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

Single total figure 2023/24

Name	Title	Salaries and fees (bands of £5k) £000	Taxable benefits (to nearest £100)	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
I.Abbs*	Chief Executive	300-305	11,100	-	310-315
A.Bhatia	Chief Nurse	215-220		-	215-220
S.Davies**	Chief Financial Officer	200-205		-	200-205
J.Findlay*	Chief Operating Officer (Joint Deputy Chief Executive until January 2024)	205-210		-	205-210
J.Screaton	Chief People Officer	185-190		-	185-190
S.Steddon	Chief Medical Officer	250-255		182.5-185	435-440
L.Tallon***	Deputy Chief Executive	210-215		97.5-100	310-315
C.Alexander	Chairman	55-60		-	55-60
M.Brawn	Non-Executive Director	20-25		-	20-25
N.Dodhia	Non-Executive Director (from 1 July 2023)	15-20		-	15-20
S.Friend	Non-Executive Director	20-25		-	20-25
F.Harvey	Non-Executive Director and Senior Independent Director	20-25		-	20-25
D.Kelly	Non-Executive Director (from 1 July 2023)	15-20			15-20
J.Khan	Non-Executive Director (until 31 March 2024)	20-25		-	20-25
S.Morgan	Non-Executive Director and Deputy Chair	60-65		-	60-65
J.Pelly	Non-Executive Director (until 30 June 2023)	5-10		-	5-10
P.Philip	Non-Executive Director (from 1 July 2023)	15-20		-	15-20
I.Playford	Non-Executive Director	20-25		-	20-25
R.Razavi	Non-Executive Director	20-25		-	20-25
S.Shribman	Non-Executive Director (until 12 June 2023)	0-5		-	0-5
P.Singh	Non-Executive Director and Deputy Chair (to 31 October 2023)	15-20		-	15-20
S.Weiner	Non-Executive Director (until 22 July 2023)	5-10		-	5-10

Salaries and fees

Salaries and fees includes payment for sold annual leave for J.Findlay and L.Tallon.

No senior manager received any annual or long-term performance bonuses in 2023/24.

A.Bhatia received a one-off additional responsibility allowance of £30k recognising her leadership of the Apollo programme.

A number of senior staff held joint posts with King's College Hospital NHS Foundation Trust during 2023/24: C.Alexander was Joint Chairman for both organisations between December 2022 and January 2024; S.Weiner was a non-executive director on both boards until July 2023, and S.Friend also became a non-executive director at King's College Hospital in September 2023. Salaries and wages disclosed for these individuals in the table above relate purely to their roles on the Guy's and St Thomas' Board.

Taxable benefits relate to rental of Trust accommodation.

The Trust has not paid any of the directors compensation on early retirement.

Pension related benefits

* I.Abbs and J Findlay were not members of the NHS Pension scheme for the year 2023/24.

** S.Davies re-joined NHS Pension Scheme on 1 February 2024. The Pension related benefits for the 2 months is nil effect.

*** L.Tallon opted out of NHS Pension Scheme on 1 January 2024.

J. Screaton and A.Bhatia were members of the NHS Pension scheme for the full year. They have no in-year reportable pension related benefits.

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

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

Salary and pension entitlements of senior managers

2024/25 Salary and pension entitlements of senior managers

Name/Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2024 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2025 £000
S.Davies Chief Financial Officer	7.5-10	20-22.5	50-55	130-135	833	150	1,065
S.Steddon Chief Medical Officer	5-7.5	5-7.5	100-105	260-265	2,069	125	2,366
L.Tallon* Deputy Chief Executive	0	0	25-30	0	347	0	374
A.Bhatia Chief Nurse	2.5-5	0	85-90	230-235	1,910	35	2,097
C.Akass Chief People Officer	0-2.5	0	10-15	0	80	14	132
L.Dark Chief Executive, Integrated and Specialist Medicine	0-2.5	0	50-55	125-130	965	5	1,072
R.Grocott Mason Chief Executive, Heart, Lung and Critical Care	0	0	65-70	185-190	55	8	112

* L.Tallon opted back into the NHS Pension Scheme on 1 September 2024.

J.Screaton opted out of the NHS Pension Scheme from 1 April 2024. There are therefore no pension disclosures for 2024/25 relating to J.Screaton. I.Abbs, J.Findlay, G.Ayida and S.Clarke were not NHS Pension Scheme members for the year 2024/25.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

Professor Ian Abbs
Chief Executive Officer
25 June 2025

Edward Thawe, who has worked at Royal Brompton Hospital since 2006, was named Porter of The Year at the National MyPorter Awards.

6 Staff report

We employ around 23,700 staff, all of whom contribute to providing high quality patient care across our 5 hospitals and in the community. The majority are permanently employed clinical staff who are directly involved in delivering patient care. We also employ a significant number of people in non-clinical roles including in our scientific, technical, Essentia and administrative teams who provide vital expertise and support. The table below provides a breakdown of our workforce.

Staff group	Permanently employed	Agency, bank and seconded staff	Total 2024/25
Administration and estates	5,640	339	**5,979**
Healthcare assistants and other support staff	1,011	515	**1,526**
Medical and dental	3,127	386	**3,513**
Nursing, midwifery and health visiting staff	6,774	543	**7,317**
Nursing, midwifery and health visiting learners	1,443	258	**1,701**
Scientific, therapeutic and technical staff	3,530	129	**3,659**
Social care staff	5	–	**5**
Total average numbers	**21,530**	**2,170**	**23,700**

The numbers above show the average number of staff (Whole Time Equivalent) employed at the Trust. The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.

Communicating with staff

We remain committed to keeping our staff informed of changes across the organisation, involving them in decision-making and engaging them in the Trust's performance. We work hard to ensure that our staff are aware of both internal and external developments that may affect the organisation and the wider NHS. We place great importance on staff engagement as there is a positive correlation with the quality of patient care. In the 2024 NHS Staff Survey we significantly improved our score for the 'staff engagement' theme and achieved significantly higher results than in the previous year – see overleaf for details.

Our range of well-established communication channels include regular online briefings from the Chief Executive and senior leaders; topic or audience specific newsletters; daily computer desktop messages; and extensive intranets where staff can find policies, guidance and online tools.

Our annual internal communications survey enables us to understand how effective our communications are and adjust our strategy accordingly. In the last 12 months we have responded to staff feedback by improving the accessibility and design of our 3-times-a-week Staff Bulletin, monthly written Team Briefings and other regular Trust-wide newsletters – reducing the amount of communication we send out by streamlining our Trust-wide messages and using updated software to improve the user-experience of our virtual briefings. Following some unavoidable delays, we are pleased to be moving forward with our work to deliver a single, accessible, Trust-wide intranet.

In September 2024, we launched our new Trust strategy and values. Around 1,500 colleagues took part in locally-led 'big conversations' about what these mean to them, both as individuals and as teams. We are proud that our new strategy and values were well received across the organisation, largely due to

the extensive period of staff engagement that was built into their development. Our work to embed these continues, including within important internal messaging on our financial and operational performance.

We produce a popular magazine, the GiST, and a monthly e-newsletter, the e-GiST for staff, patients and our Foundation Trust members. We work closely with the chair of staff side, our staff networks and other staff representatives to ensure the voices of employees are listened to and taken into account.

The Trust Joint Staff Committee meets quarterly, acting as a valuable consultative forum for key developments affecting staff, with sub-groups looking at policy and pay issues.

The Trust has 8 staff governors from clinical, non-clinical and community teams who contribute to the development of the organisation and represent colleagues' views at Board level.

NHS Staff survey

The NHS Staff Survey is the largest annual workforce survey in the world and has been conducted every year since 2003. The 2024 survey asked 123 questions which were aligned to the NHS People Promises and themes.

The results are benchmarked against our comparator group which is made up of 122 'acute and combined acute and community trusts'.

We carried out an extensive communication and engagement plan to encourage and support as many colleagues as possible to complete the 2024 survey. This resulted in a completion rate of 57%, with 13,190 responses received. We were pleased to report that this was significantly above the national average of 49% and 19% higher than the Trust's 2023 response rate of 37%.

In 2024, our scores improved in all 9 of the NHS People Promise elements and themes and our results were identified as 'statistically significantly higher' than 2023 by the NHS Staff Survey Coordination Centre. We scored above the national average in all NHS People Promise elements and themes.

The Trust also achieved its best scores in 4 years (2021-2024) for a number of People Promise elements: we are recognised and rewarded, we are safe and healthy, we are always learning, we work flexibly, and we are a team; as well as the morale theme. At sub-score level the results were above national average in all areas except diversity and equality, burnout, negative experiences, motivation and thinking about leaving.

The engagement theme questions provide insight into people's levels of motivation, involvement and advocacy and our engagement scores in the 2024 survey remain well above national average as shown by the table below.

These positive scores are reinforced by one of the local questions reporting that 91% of our staff said that they were proud to work at the Trust.

The results also indicate that best practice exists within our clinical and delivery groups with some scores exceeding the best score nationally. We are committed to sharing best practices and promoting continuous improvement in all areas of the organisation.

The response rate for our bank staff was 23% with 647 responses, an increase from 15% in 2023. Compared to the Trust average, bank staff scored higher across all areas except for in the 'We each have a voice that counts' People Promise. This group also responded more favourably than substantive staff on the 3 core engagement questions demonstrating that our bank staff have strong levels of engagement and satisfaction working for the Trust.

Engagement theme question	National average	Trust score	Trust ranking
Staff agreeing that the care of patients/service users is the organisation's top priority	74%	84%	7th nationally and 4th in London.
Staff recommending the Trust to a friend or relative as a place to receive care or treatment	62%	82%	4th nationally and 2nd in London.
Staff recommending the Trust as a place to work	61%	73%	7th nationally and 2nd in London.

NHS Staff Survey Results

Comparison of NHS Staff Survey Results for 2021-24 against national average (acute, acute and community Trusts)

	National Average 2021	Trust Score 2021	National Average 2022	Trust Score 2022	National Average 2023	Trust Score 2023	National Average 2024	Trust Score 2024
Response rate	46%	47%	44%	41%	45%	38%	49%	**57%**
People Promise Elements								
We are compassionate and inclusive	7.19	7.37	7.18	7.29	7.24	7.23	7.21	**7.35**
We are recognised and rewarded	5.81	5.96	5.72	5.80	5.94	5.82	5.92	**5.99**
We each have a voice that counts	6.67	6.98	6.65	6.84	6.70	6.76	6.67	**6.89**
We are safe and healthy	5.88	6.04	5.88	5.95	6.08	5.99	6.09	**6.1**
We are always learning	5.24	5.74	5.35	5.63	5.62	5.58	5.64	**5.86**
We work flexibly	5.95	6.17	6.00	6.06	6.20	6.06	6.24	**6.25**
We are a team	6.58	6.74	6.64	6.68	6.75	6.68	6.74	**6.81**
Theme								
Staff engagement	6.84	7.24	6.80	7.11	6.91	7.04	6.84	**7.15**
Morale	5.73	5.96	5.68	5.79	5.90	5.82	5.93	**6.01**

Please note: There are a number of small adjustments in figures reported for 2021 to 2023 in previous annual reports. This is because the NHS Staff Survey benchmark reports are weighted based on the occupational group profile of each organisation to enable comparison with other organisations. Historical trend data are re-weighted according to the 2024 benchmark group proportions.

Areas for improvement

While the 2024 survey highlights a notable improvement in overall employee experience compared to recent years, several key challenges persist – with certain areas still falling below the national average.

Our top priority is to enhance the experience of all staff, with a particular emphasis on supporting disabled colleagues and those from global majority backgrounds, especially in relation to career progression, bullying, harassment, and burnout. The Trust has seen some year-on-year progress across these areas and we remain committed to driving meaningful and lasting improvements.

To support this commitment, over the past year, we have introduced a number of initiatives to address these challenges including:

- Equality and diversity – thanks to generous funding from Guy's & St Thomas' Charity, we have created a dedicated Equality, Diversity and Inclusion Improvement Programme, with an initial focus on anti-racism. This remains a core priority as we continue to actively challenge racism and promote racial equity across the Trust. We have now expanded our work to focus on LGBT+ inclusion, which included initiatives such as the launch of our Progress Pride badges.

As part of our commitment to creating a truly inclusive environment, we also introduced our first Trust-wide transgender equality policy, along with supporting guidance for staff. These aim to ensure a safe, respectful and inclusive workplace for everyone, regardless of gender identity or expression and will be updated following the Supreme Court ruling and awaited guidance for NHS organisations.

We are now progressing the programme further by making disability inclusion a key focus. In particular, we are working to improve our workplace adjustment process and other related initiatives, ensuring colleagues can access the support they need to thrive and perform at their best. Further details are available on pages 53-54.

- Improving overall staff experience – we launched our new 'Making working lives better' programme, to enhance the day to day experience of our staff. It focuses on providing better access to

nutritious, high-quality and out of hours food; upgrading changing and toilet facilities; and ensuring safe storage for personal belongings. We are also working to ensure that all staff receive their rotas in a timely manner, helping them to balance their work and personal lives more effectively.

- Improving career opportunities – we launched a new Careers Hub on our online learning platform to provide a one-stop resource for workshops, training, and tools to support career development. As part of our commitment to addressing underrepresentation in senior roles, we successfully recruited 3 full cohorts for our new Positive Action Programmes, designed to support staff from global majority backgrounds.

We also introduced a Coaching and Mentoring Hub to increase access to developmental support. Our People Manager Programme continues to equip managers to have effective career conversations, and these conversation are now embedded in our new Performance and Development Review process.

- Health and wellbeing – we continue to deliver our 'Showing we care about you' programme, funded by Guy's & St Thomas' Charity, to support a happier and healthier workforce. Our network of around 500 wellbeing champions help promote and raise awareness of the wide range of health and wellbeing resources available.

Next steps

We are working closely with internal stakeholders to respond to the staff survey results by developing both Trust-wide and local action plans aimed at driving improvements across the organisation. The survey insights will be reviewed alongside other staff feedback gathered throughout the year to build a more complete picture of what we're doing well and where we need to improve.

We are committed to keeping staff updated on progress through regular Trust-wide Team Briefings and local forums, reinforcing that their feedback is not only heard but actively shaping our decisions.

Improving the working lives of all our people remains a key priority. We continue to embed equality, diversity, and inclusion in everything we do – from enhancing career pathways to strengthening our wellbeing support.

Managers play a vital role in shaping staff experience and the quality of service delivery. With this in mind, we are continuing to roll out the People Manager Programme, prioritising areas identified through survey data and local plans. This programme equips managers with the skills and tools to lead compassionately, foster inclusive teams, and support career development across all roles and bands.

As part of our ongoing commitment to becoming a truly anti-racism organisation, we are taking deliberate steps to challenge racism at every level and create a fairer, more inclusive workplace. Our ambition is to make Guy's and St Thomas' one of the best places to work and to receive care – driven by a culture of compassion, respect, and equity.

Freedom to Speak Up Guardian

We are dedicated to creating a culture where everyone feels able and confident to voice opinions, suggest improvements, share ideas and raise concerns. Our 'Quality matters' newsletter provides a regular focus on quality and safety messages, and our 'Safety signals' emails share good practice, including learning from serious incidents.

The Trust's 'Showing we care by speaking up' initiative encourages all staff to speak up about concerns they may have about patient safety, the way the Trust is run or anything that affects their working life. The initiative is led by the Lead Freedom to Speak Up Guardian, who is now supported by 2 full-time deputy guardians, 2 part time guardians and a network of around 180 Speaking up champions across the Trust.

The guardians and champions work together with local inclusion agents and wellbeing champions to provide an integrated and inclusive staff support network.

The guardians play an active and visible role in raising awareness, developing staff and dealing with concerns, while ensuring that our governance processes for raising concerns are robust and effective. The Trust continues to achieve an above average score in the freedom to speak up metrics in the Model Hospital benchmarking.

The number and type of speak up contacts are shared on a quarterly basis with the National Guardian's Office and published on the Model Health System website.

Employee costs (including executive directors)

	Permanently employed £000	Agency, bank and seconded staff £000	Year ended 31 March 2025 Total £000	Year ended 31 March 2024 Total £000
Salaries and wages	**1,279,250**	**97,204**	**1,376,454**	1,269,715
Social security costs	**149,934**	**6,275**	**156,209**	148,414
Apprenticeship levy	**6,420**	**374**	**6,794**	6,513
Pension cost: employer's contributions to NHS pensions	**149,444**	**3,440**	**152,884**	142,129
Pension cost: employer contributions paid by NHSE on provider's behalf (6.3%)	**97,695**	**2,275**	**99,970**	62,315
Termination benefits	**1,936**	**–**	**1,936**	8,374
Temporary staff – agency / contract staff	**–**	**24,926**	**24,926**	31,633
Total gross staff costs	**1,684,679**	**134,494**	**1,819,173**	1,669,093
Included in above:				
Costs capitalised as part of assets	**(19,705)**	**(446)**	**(20,151)**	(35,171)
Less income netted off in staff costs	**(12,762)**	**–**	**(12,762)**	(9,858)
Total staff costs	**1,652,212**	**134,048**	**1,786,260**	1,624,064
Analysed into operating expenditure				
Employee expenses – staff and executive directors	**1,649,585**	**134,048**	**1,783,633**	1,615,124
Redundancy	**1,936**	**–**	**1,936**	8,374
Internal audit costs*	**691**	**–**	**691**	566
	1,652,212	**134,048**	**1,786,260**	1,624,064

The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.
*Internal audit costs are total costs incurred by the Trust. Income received in relation to providing internal audit services for other trusts is recorded separately within other income and not netted off within staff costs.

Gender pay gap

Information about our gender pay gap is published annually and is available at gender-pay-gap.service.gov.uk as well as on the Trust's website.

Equality, diversity and inclusion

Staff group	Female	Male	Total
Employees	16,031	6,272	22,304
Executive directors	5	6	11
Senior managers	25	22	47
Total	**16,062**	**6,300**	**22,362**

Number of staff employed on 31 March 2025

The Trust is committed to maintaining an inclusive workplace where all staff can thrive. Our commitment to equality, diversity and inclusion is embedded in our values and is a core principle of our 2030 strategy. We recognise that we have more to do to address inequalities across the Trust, and this is shown in our staff survey results and our performance against the Workforce Race Equality Standard and Workforce Disability Equality Standard, as well as our gender pay gap report.

As part of our ongoing commitment we have established an equality, diversity and inclusion programme with 5 strategic aims:

- eliminate discrimination within the Trust
- foster an inclusive and compassionate culture
- improve access to quality work through improved recruitment practices
- advance social mobility by increasing equity of opportunity
- ensure visible governance and accountability.

The Trust has started to implement a number of initiatives to meet these strategic aims, including:

- increasing the numbers of inclusion agents to help raise awareness of best practice and offer peer-to-peer support on equality, diversity and inclusion issues
- ensuring equality objectives are in place for all senior managers
- reviewing our end-to-end recruitment processes

and making improvements to ensure we are inclusive and remove barriers where these exist

- developing and delivering a bespoke equality, diversity and inclusion programme for senior leaders, with a particular emphasis on anti-racism
- delivering anti-racism awareness sessions – scaling up the initiative using volunteer facilitators to deliver these sessions Trust-wide
- reviewing our workplace adjustment processes to ensure fairness and to help better support staff wellbeing, improving access to the necessary support, while maintaining service delivery
- reviewing and updating our equality impact assessment processes to ensure we meet our legal and moral duty as set out in the Equality Act
- continuing our award-winning apprentice recruitment programme and supported internship programme for individuals with autism or disabilities
- establishing a fellowship programme to help improve ethnic diversity amongst our nursing and midwifery senior leaders
- continuing to run and promote a successful reverse mentoring programme which enables staff to share their experience with senior colleagues to enhance cultural awareness and understanding
- providing industry placements for T-Level (health) students.

The Trust follows good practice and takes all reasonable steps to prevent slavery and human trafficking as demonstrated in our Modern Slavery Act 2015 statement which is available on the Trust website.

Staff sickness absence

Staff sickness absence	2024/25	2023/24
Total days lost	**232,599**	208,887
Total staff years	**22,445**	22,230
Average working days lost (per WTE)*	**10**	9

*WTE = Whole Time Equivalent

The sickness absence figures are reported on a calendar basis, rather than for the financial year.

These statistics are published by NHS Digital, using data drawn for January 2024 to December 2024 from the ESR data warehouse.

The latest publication, covering the year to December 2024, can be found on the NHS Digital website.

Safe working environment

Our health and safety team has continued to work closely with staff across the Trust, providing expert advice and guidance to support their health, safety and welfare. Regular interaction with our regulatory authorities and staff representatives has reinforced the importance of maintaining an effective and comprehensive health and safety management system across our clinical and delivery groups.

The health and safety team has ensured that people are trained to carry out the required risk assessments, and that associated control measures are effectively implemented along with a robust review process. There has been a focus on managing the risks from violence and aggression, as well as musculoskeletal disorders through the introduction of a training needs analysis and well-developed training cycle. The team has also refreshed the lone worker policy and provided those staff who are identified as being at risk with a lone worker alarm.

The team has also provided expert advice on the management and control of hazardous substances and introduced additional monitoring to support occupational health surveillance. They have also continued to develop health and safety champions across the Trust who help to maintain and enhance safety standards for everyone.

Occupational health, safety and wellbeing service

Our occupational health, safety and wellbeing service is one of the largest in the NHS, delivering services to Trust staff, and commercially to external businesses. These services are delivered by a multidisciplinary team of doctors, specialist nurses, health and safety specialists, wellbeing advisors, psychologists, manual handling advisers, administrators and researchers.

In July 2024 the team successfully achieved the Safe, Effective, Quality Occupational Health Service reaccreditation with an award of excellence.

The Occupational Health team works closely with teams across the Trust, including recruitment and infection prevention and control, to provide work-related health assessments and to manage infection outbreaks related to staff.

In autumn 2024 the team worked with partners in south east and north west London, to successfully deliver both flu and COVID-19 vaccinations to staff in line with national requirements.

Guy's & St Thomas' Charity continues to support the Trust's award-winning staff health, wellbeing and benefit programme, which is promoted through a culturally sensitive and inclusive approach, including through nearly 500 wellbeing champions.

The staff psychology service is well-established, with psychologists in all clinical groups and a central service for other areas. It includes specialists in racial equity and supports the Trust's anti-racism strategy through culturally sensitive interventions.

The occupational health research team has formed new collaborations with external partners and generated significant research income, including 3 research grants totalling £2.2 million which have funded projects such as the workplace digital skin surveillance service.

Trade union facility time

The following information is published in accordance with the Trade Union (Facility Time Publication Requirements) Regulations 2017. The relevant period is 1 April 2024 until 31 March 2025.

Table 1: relevant union officials

Number of employees (full-time equivalent) who were relevant union officials during the period
12.6

Table 2: percentage of time spent on facility time

Percentage of employee time spent on facility time	Number of employees
0%	0
1%-50%	95
51%-99%	1
100%	1

Table 3: percentage of pay bill spent on facility time

Total cost of facility time	£702,551
Total pay bill	£1,685,547,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.04%

Table 4: paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours, calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	14%

Countering fraud and corruption

The Trust is committed to ensuring the best use of NHS resources. All staff have access to our counter fraud policy and procedure through the Trust intranets and receive fraud awareness training through presentations and interactive 'anti-fraud chats'.

3 counter-fraud specialists work within the Trust's internal audit team to provide guidance and support to staff who raise concerns, and to conduct investigations. Further details on our approach to fraud and corruption and the Trust Bribery Declaration can be found on our website under statutory and strategy publications.

Agency staff

We have continued to focus on reducing the use of agency staff and remaining compliant with NHS England's agency 'cap' which sets maximum pay levels for agency staff. We use robust procedures to monitor and report on agency spend, and to reduce the number of breaches of the cap. Pan London agreements have helped to reduce agency costs, while supporting adherence with approved standards.

Agency usage, as a percentage of all temporary staffing usage, remains at an all-time low but we are still looking to reduce this further.

Following additional NHS England controls, we have further reduced use of agency staff within administrative and estates staff groups, and worked to transfer a number of employees to our staff bank. Where agency usage is still required within these staff groups, we now use the Direct Engagement platform to manage costs as effectively as possible.

Expenditure on consultancy

Expenditure on consultancy in 2024/25 was £122,000 (£5,329,000 in 2023/24). The overall spend on consultancy reduced this year following the successful launch of Epic, our new electronic health record system, in 2023/24.

High paid off-payroll engagements

Table 1: Off-payroll worker engagements as of 31 March 2025, earning £245 per day or greater	
Number of existing engagements as of 31 March 2025	15
Of which, the number that have existed	
for less than one year at the time of reporting	8
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	3
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	4

Table 2: All off-payroll workers engaged at any point during the year ended 31 March 2025, earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2025	15
Of which:	
Not subject to off payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	8
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	7
Number of engagements reassessed for consistency/ assurance purposes during the year end	0
Of which:	
Number of engagements that saw a change to IR35 status following the consistency review	0

*A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Table 3: For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025	
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	0
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 on payroll and off-payroll engagements	26

Off-payroll engagements

The Trust has a policy that all substantive staff are paid through the payroll. No executive Board members were engaged on an off-payroll basis in 2024/25.

On 6 April 2017, public bodies became responsible for collecting tax from those contractors subject to HMRC's IR35 rules; all contractors are subject to a review to determine whether they are affected by the rules. The number of contractors engaged as at 31 March 2025 is shown in the tables above where daily rates exceed £245 per day and the engagement has lasted longer than 6 months.

Staff exit packages

In 2024/25, a total of 132 exit packages were agreed in the year, 70 of which were compulsory redundancies, and 62 were other departures. The total cost of exit packages was £6,768,000.
Summary information for 2024/25 and comparative information for 2023/24 is provided in the table below.

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
<£10,000	8	4	1	1	9	5
£10,000 – £25,000	9	11	17	2	26	13
£25,001 – £50,000	28	6	18	12	46	18
£50,001 – £100,000	20	4	12	14	32	18
£100,001 – £150,000	5	-	11	7	16	7
£150,001 – £200,000	-	-	3	1	3	1
Total number of exit packages by type	**70**	**25**	**62**	**37**	**132**	**62**
Total resource cost £000	**3,144**	**638**	**3,624**	**2,473**	**6,768**	**3,111**

Exit packages: other (non-compulsory) departure payments

There were 62 elements of other departure packages agreed in 2024/25, totalling £3,624,000.
Comparative information for 2023/24 is provided in the table.

	2024/25 Payments agreed	Total value of agreements	2023/24 Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	62	3,624	35	2,410
Exit payments following Employment Tribunals or court orders	-	-	2	63
Total	**62**	**3,624**	**37**	**2,473**

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

Staff turnover

The staff voluntary turnover rate was reported at 8.9% in March 2025, compared to 11.1% reported in March 2024. There has been a steady decrease in our turnover over the past 12 months and a continued decline over the past 2 years. This decline in turnover, coupled with improvements in our staff survey results, provide good evidence of improvements in our staff experience.

Gloria Sirbu received a life-saving kidney-transplant at Evelina London Children's Hospital just before her second birthday. She is one of around 100 children and young people being cared for by our kidney transplant team.

7 Our organisational structure:
disclosures set out in the NHS Code of Governance

The Trust benefits from a strong Board of Directors, whose wide-ranging experience underpins our continued success. Our Council of Governors also play a vital and active role in our work

Our group operating model is structured so that our clinical services are managed and delivered by 4 clinical groups:

- Cancer and Surgery
- Evelina London Women's and Children's
- Heart, Lung and Critical Care
- Integrated and Specialist Medicine.

These groups have responsibility for operational leadership and delivery of Trust strategy in their areas. Within each clinical group, clinical directorates remain at the heart of decision-making and ensure continued strong clinical leadership.

In addition, the Essentia delivery group is our internal team responsible for capital, estates and facilities management, ensuring our buildings and non-clinical support services meet the needs of patients. A range of corporate services also provide Trust-wide support.

The clinical groups and Essentia have their own executive teams that oversee performance in their areas, for which they are accountable to the Chief Executive through quarterly performance review meetings. They also have their own strategic advisory boards, made up of Trust executive and non-executive directors and, in some groups, non-executive advisors. Although these strategic advisory boards have no decision-making or assurance function, they play an important role as a 'critical friend', providing advice and challenge to help the groups:

- set strategic objectives and operational priorities, ensuring these are aligned to the Trust's strategy
- understand the barriers to improved performance and the actions that can be taken to deliver such improvement; and
- manage risks and issues appropriately.

The Trust's corporate governance arrangements, as described in this section, provide a robust framework for the oversight and scrutiny of the Trust's delivery of its strategy and strategic objectives. They also provide assurance that any risks and issues with performance are identified early and addressed appropriately.

Council of Governors

The Council of Governors plays a vital role in the work of the Trust, representing the interests of our members and partner organisations and advising us on how best to meet the needs of patients and the communities we serve.

It has a number of statutory duties, including appointing the Chairman and non-executive directors, deciding on their remuneration and other terms and conditions, as well as approving the appointment of the Chief Executive. The Council of Governors holds the non-executive directors to account individually and collectively for the performance of the Board of Directors. The Council of Governors also receives the Trust's Annual Report and Accounts and the auditor's report.

In February 2025 governors were consulted on the Trust's emerging 2025/26 business plan, and provided a range of views and comments. Governors also contributed to the development of the Trust's Strategy to 2030 'Better, faster, fairer', published in September 2024.

The Council of Governors holds regular meetings, and an annual away day which assesses their performance in discharging their statutory responsibilities and discuss ways in which to improve their effectiveness.

The Council of Governors Strategy,

Transformation and Partnerships Working Group discusses many of its future plans. The Quality and Engagement Working Group discusses patient engagement, quality improvement and safety matters. The Membership Development Working Group enables governors to consider how they can promote membership and ensure they represent their members' views to the Trust Board.

The patient, public and staff members of the Council of Governors are elected from and by the membership to serve for 3 years. They may stand for election for 2 further terms of 3 years. Key partner organisations also nominate partnership governors.

The Trust's constitution requires us to have 40 governors. Elections were held for a number of these seats in summer 2024.

4 governors received expenses totalling £230.72 during 2024/25, compared to £434.28 in 2023/24. See page 61 for a full list of governors.

Code of Governance

The Trust has applied the principles of the NHS Code of Governance on a 'comply or explain' basis. In the few cases where the Trust has diverged from the recommended practice set out in the Code of Governance, it has made appropriate disclosures in this Annual Report and has provided explanations as to how its practices are consistent with the principle to which the provision in the NHS Code of Governance relates. As explained in the Annual Governance Statement on page 76, the Trust keeps its governance arrangements under regular review, including membership of Board committees and their terms of reference. The NHS Code of Governance is based on the principles of the UK Corporate Governance Code.

Nominations Committee

The Nominations Committee is chaired by the Trust Chairman and comprises 6 governors, with a minimum of one governor from each of the 4 constituencies. It makes recommendations to the Council of Governors on the appointment and remuneration of the Chairman and non-executive directors, and considers their appraisals.

The Nominations Committee is responsible for succession planning and ensuring the capabilities of the non-executive directors remain relevant and appropriate to enable the Trust to deliver its strategic objectives. In 2024 the Committee reviewed and evaluated the balance of skills, knowledge, experience and diversity of the Trust's non-executive directors, as well as the end dates of those directors' terms, together with the Trust's priorities, strategic ambitions and the key challenges it is facing. This resulted in a targeted campaign to acquire 2 new non-executive directors with expertise in workforce and digital transformation, further diversifying and strengthening the capabilities of the Board. The Trust engaged Saxton Bampfylde to support it with the identification and appointment of these non-executive directors, Jamie Heywood and Alison Wilcox.

Members of the Nominations Committee in 2024/25

Name	Role
David Al-Basha	Patient governor
Charles Alexander	Chairman
Brian Boag (from February 2025)	Partnership governor
Elfy Chevretton (until June 2024)	Staff governor
Ibrahim Dogus (until July 2024)	Partnership governor
Leah Mansfield (from April 2024)	Patient governor
Margaret McEvoy (until June 2024)	Public governor
Alison Mould (from November 2024)	Public governor
David Phoenix (until December 2024)	Partnership governor
Daghni Rajasingam (from November 2024)	Staff governor
Sheila Reddy (from November 2024)	Public governor

Biographies of the non-executive directors can be found on pages 68-70.

The appointment, renewal or termination of a non-executive director's appointment is managed by the Council of Governors, advised by the Nominations Committee.

In 2024/25, the Council of Governors accepted the Nominations Committee's recommendations to:

- re-appoint Dr Felicity Harvey as a non-executive director of the Trust for a further 2 years to 14 September 2026
- appoint Professor Shitij Kapur as a non-executive director of the Trust from 6 May 2024 until 31 August 2024
- appoint Professor Graham Lord as a non-executive director of the Trust from 1 September 2024

Council of Governors meeting attendance April 2024 – March 2025

Meeting dates: 24 April 2024, 31 July 2024, 23 October 2024, 10 December 2024, 29 January 2025 and 17 March 2025

Patient governors	Elected	Actual / possible attendance
David Al-Basha	August 2022	4 / 6
Emma Barslund Blackman	July 2024	5 / 5
Victoria Borwick	July 2021 (re-elected July 2024)	6 / 6
Michael Bryan	July 2021 (re-elected July 2024)	6 / 6
Felicity Conway	July 2024	5 / 5
Peter Harrison	July 2022	4 / 6
Leah Mansfield	July 2021 (re-elected July 2024)	5 / 6
Michael Mates	July 2024	1 / 5
Charles Mead	July 2024	5 / 5
Joanna McGillivray	July 2022 (stepped down October 2024)	0 / 2
Trudy Nickels	July 2021 (term ended June 2024)	0 / 1
Placida Ojinnaka	July 2018 (term ended June 2024)	1 / 1
John Powell	July 2019 (re-elected July 2022)	5 / 6
Helen Selvarajan	July 2024	2 / 5
Mary Stirling	July 2018 (term ended June 2024)	4 / 4

Public governors	Elected attendance	Actual / possible
Jordan Abdi	July 2021 (term ended June 2024)	0 / 1
Koku Adomza	July 2022	2 / 6
Aya Ayoub	July 2024	2 / 5
Steve Bean	July 2024	4 / 5
John Clark	July 2022	5 / 6
Marcia Da Costa	July 2018 (term ended June 2024)	0 / 1
Katherine Hamer (Lead Governor)	July 2022	5 / 6
Samantha Field	July 2024	2 / 5
Robert Hill	July 2024 (passed away November 2024)	0 / 1
Marianna Masters	July 2021 (term ended June 2024)	1 / 1
Margaret McEvoy	July 2018 (term ended June 2024)	1 / 1
Alison Mould (Deputy Lead Governor)	July 2022	5 / 6
Sheila Reddy	July 2024	5 / 5
Dominic Shaw	July 2024	2 / 5
Sonia Winifred	July 2021 (term ended June 2024)	0 / 1

Staff governors	Constituency	Elected	Actual / possible attendance
Serina Aboim	Community	July 2021 (term ended June 2024)	0 / 1
Nigel Beckett	Clinical	July 2024	4 / 5
Mark Boothroyd	Clinical	July 2021 (term ended June 2024)	0 / 1
Elfy Chevretton	Clinical	July 2021 (term ended June 2024)	1 / 1
Sian Flynn	Non-clinical	July 2021 (term ended June 2024)	0 / 1
Irina Munteanu	Non-clinical	July 2024	3 / 5
Roseline Nwaobe	Non-clinical	August 2022	4 / 6
Rishi Pabary	Clinical	July 2021 (term ended June 2024)	0 / 1
Daghni Rajasingam	Clinical	July 2024	5 / 5
Anu Sam Nimmi	Clinical	July 2024	1 / 5
Mercy Satoye	Clinical	July 2024	0 / 5
Kendra Schneller	Community	July 2024	4 / 5
Raksa Tupprasoot	Clinical	July 2021 (term ended June 2024)	1 / 1
Claire Wills	Non-clinical	August 2022	5 / 6

To view the register of interests of our Council of Governors, please contact:

Trust Secretary
4th Floor, Gassiot House
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH

Partnership governors	Organisation	Appointed	Actual / possible attendance
Sarah Addenbrooke	Royal Borough of Kensington and Chelsea Council	February 2021 (stepped down June 2024)	1 / 4
Annette Boaz	King's College London	July 2024	1 / 5
Brian Boag	London South Bank University	January 2025	1 / 1
Ibrahim Dogus	Lambeth Council	July 2022 (stepped down May 2024)	0 / 1
Jim Dickson	Lambeth Council	May 2024 (stepped down July 2024)	0 / 0
Stephanie Petit	Royal Borough of Kensington and Chelsea Council	June 2024	1 / 5
David Phoenix	London South Bank University	July 2023 (stepped down January 2025)	1 / 5
Darren Summers	South East London Integrated Care Board	July 2024	4 / 5
Jadwiga Wedzicha	Imperial College London	February 2021	1 / 6

- appoint Jamie Heywood as a non-executive director of the Trust from 6 January 2025
- appoint Alison Wilcox as a non-executive director of the Trust from 6 January 2025.

The Chairman evaluates, through appraisal, all non-executive directors and the Senior Independent Director undertakes an evaluation of the Chairman's performance. The Nominations Committee received updates about the results of the appraisals of the Trust Chairman and non-executive directors during the year.

Our membership

The Trust's membership is an essential and valuable asset. It helps guide our work, decision-making and adherence to NHS values. It also provides one of the ways in which the Trust communicates with patients, the public and staff. There are 3 membership categories:

Patients – anyone aged over 18 years who has been a patient within the last 5 years. Patient carers are also offered patient membership.

Public – anyone aged over 18 who is living around Guy's and St Thomas' hospitals, Royal Brompton or Harefield hospitals, or the rest of England and Wales.

Staff – employees whose contract means they can work for the Trust for at least a year. University employees and registered volunteers not eligible for other categories can also join as staff members.

At 31 March 2025 the Trust had 38,805 members, of whom 6,642 were patient members, 7,894 were public members and 24,269 were staff members.

Members receive regular mailings and are invited to our Annual Public Meeting, public meetings of the Board of Directors and Council of Governors, and events such as our health seminars.

In September 2024 around 140 people attended our Annual Public Meeting where members, local people, patients, staff and other stakeholders heard about how we have performed during the year and were able to ask questions.

Board of Directors

Our Board of Directors is made up of our Chairman, Charles Alexander, 10 other non-executive directors and 11 executive directors including the Chief Executive, Ian Abbs. Its role is to:

- set our overall strategic direction within the context of NHS priorities
- monitor our performance against objectives
- provide effective financial stewardship
- ensure that the Trust provides high quality, effective and patient-focused services
- ensure high standards of corporate governance and personal conduct; and
- promote effective dialogue between the Trust and the local communities we serve.

Membership of the Board is balanced, complete and appropriate. The Trust has noted the criteria in the NHS Code of Governance which may impair, or could appear to impair, a non-executive director's independence.

However, the Trust is confident that all of the non-executive directors are independent in character, as they have consistently demonstrated objective and robust scrutiny and constructive challenge in their interactions at the Board, and there are no relationships or circumstances which are likely to affect, or could appear to affect, their judgement.

The Council of Governors appoints the non-executive directors in accordance with the Trust's constitution, which allows them to serve 2 4-year terms, extendable in exceptional circumstances by a further 2 years.

This differs from the guidance in the NHS Code of Governance that non-executive directors should be appointed and subject to re-appointment at intervals of no more than 3 years. The Trust Board of Directors and Council of Governors have taken the view that the scale and complexity of the Trust means non-executive directors need an extended period of time to understand the organisation and its activities before they can be fully effective in their roles. However, the Trust's Constitution, including the clause that stipulates the terms of office, is kept under regular review.

The Trust maintains close oversight of the effectiveness of its corporate governance arrangements and during 2024/25 undertook a review of the effectiveness of each Board committee. This included a review and refresh of the terms of reference of all Board committees,

Public Board meeting attendance April 2024 – March 2025		
Name	Title	Actual/possible
Charles Alexander	Chairman and non-executive director	4 / 4
Simon Friend	Non-executive director and joint Deputy Chair from January 2025	4 / 4
Felicity Harvey	Non-executive director, Senior Independent Director, and joint Deputy Chair from January 2025	4 / 4
Miranda Brawn	Non-executive director	4 / 4
Nilkunj Dodhia	Non-executive director	3 / 4
Jamie Heywood	Non-executive director (from January 2025)	1 / 1
Shitij Kapur	Non-executive director (from May 2024 until September 2024)	0 / 1
Deirdre Kelly	Non-executive director	4 / 4
Graham Lord	Non-executive director (from September 2024)	1 / 2
Sally Morgan	Non-executive director and Deputy Chair (until December 2024)	3 / 3
Pauline Philip	Non-executive director	4 / 4
Ian Playford	Non-executive director	2 / 4
Reza Razavi	Non-executive director (until May 2024)	1 / 1
Alison Wilcox	Non-executive director (from January 2025)	1 / 1
Ian Abbs	Chief Executive	4 / 4
Crystal Akass	Chief People Officer (from August 2024)	2 / 2
Gubby Ayida	Chief Executive, Women's and Children's Clinical Group*	1 / 1
Avey Bhatia	Chief Nurse	2 / 4
Sarah Clarke	Chief Executive, Cancer and Surgery Clinical Group*	1 / 1
Steven Davies	Chief Financial Officer	4 / 4
Louise Dark	Chief Executive, Integrated and Specialist Medicine Clinical Group*	1 / 1
Jon Findlay	Chief Operating Officer	4 / 4
Richard Grocott-Mason	Chief Executive, Heart, Lung and Critical Care Clinical Group*	1 / 1
Julie Screaton	Chief People Officer (until June 2024)	1 / 1
Simon Steddon	Chief Medical Officer	4 / 4
Lawrence Tallon	Deputy Chief Executive (until March 2025)	2 / 4

*Clinical Group Chief Executives became voting Board members in January 2025

Our organisational structure

Committee	Membership	
	Non-executive directors	Executive directors
Board in Committee	• All non-executive directors	• All executive directors
Audit and Risk	• Nilkunj Dodhia (Chair) • Miranda Brawn (until February 2025) • Simon Friend • Jamie Heywood (from February 2025) • Deirdre Kelly	
Finance, Commercial and Investment	• Simon Friend (Chair) • Charles Alexander • Nilkunj Dodhia (until February 2025) • Ian Playford • Pauline Philip	• Ian Abbs • Avey Bhatia • Louise Dark (from February 2025) • Steven Davies • Jon Findlay (until February 2025) • Lawrence Tallon (until March 2025)
Quality and Performance	• Pauline Philip (Chair) • Charles Alexander • Felicity Harvey • Deirdre Kelly • Reza Razavi (until May 2024) • Alison Wilcox (from February 2025)	• Ian Abbs • Gubby Ayida (from February 2025) • Avey Bhatia • Sarah Clarke (from February 2025) • Louise Dark (from February 2025) • Jon Findlay • Richard Grocott-Mason (from February 2025) • Simon Steddon • Lawrence Tallon (until December 2024)
People, Culture and Education	• Miranda Brawn (Chair) • Charles Alexander • Felicity Harvey (until February 2025) • Jamie Heywood (from February 2025) • Deirdre Kelly • Reza Razavi (until May 2024) • Alison Wilcox (from February 2025)	• Ian Abbs • Crystal Akass (from August 2024) • Gubby Ayida (from February 2025) • Avey Bhatia • Julie Screaton (until June 2024) • Simon Steddon (until February 2025) • Lawrence Tallon (until March 2025)
Senior Leadership Talent, Appointments and Remuneration*	• Ian Playford (Chair) • Charles Alexander • Miranda Brawn • Simon Friend • Felicity Harvey • Alison Wilcox (from February 2025)	
Transformation and Major Programmes	• Ian Playford (Chair) • Charles Alexander • Nilkunj Dodhia (from February 2025) • Simon Friend • Felicity Harvey • Jamie Heywood (from February 2025) • Reza Razavi (until May 2024)	• Ian Abbs • Crystal Akass (from February 2025) • Steven Davies • Jon Findlay • Richard Grocott-Mason (from February 2025) • Simon Steddon (until February 2025) • Lawrence Tallon (until March 2025)

*For any decisions relating to the appointment or removal of the executive directors with voting rights, membership of the Committee will include all non-executive directors and the Trust Chief Executive, as required under Schedule 7 of the NHS Act 2006.

which helped to clarify the remit of the committees and to streamline membership.

During 2024/25 the Board carried out its duties in public, in private sessions where appropriate, and through a range of committees as follows:

Board in Committee – which oversees the development and delivery of the Trust's strategy, its key strategic partnerships, as well as research, development and innovation.

Audit and Risk – which supports an effective system of integrated governance, risk management and internal control across the Trust's activities, in support of the achievement of the Trust's objectives. Further information is set out below.

Finance, Commercial and Investment – which monitors the financial performance of the Trust, its longer-term financial planning and oversees the development and implementation of the Trust's financial investment and commercial strategies.

Quality and Performance – which monitors the overall quality and safety of clinical services provided by the Trust and its physical and digital infrastructure, as well as in-year operational performance and activity.

Senior Leadership Talent, Appointments and Remuneration – which is responsible for determining the remuneration and other conditions of service of executive directors and very senior managers, for identifying and appointing candidates to fill the executive director positions on the Trust Board and overseeing succession planning across the Trust's senior leadership. Further information is set out on page 62.

People, Culture and Education – which oversees delivery of the Trust's workforce and education strategies and the embedding of the Trust's culture and values.

Transformation and Major Programmes – which monitors the Trust's major transformation and development work over the medium term, including the delivery of our estates and digital ambitions.

Details of external directorships or other positions of authority held by the directors of the Trust can be found in Note 29 to the Annual Accounts.

7 directors received expenses totalling £10,028.15 during 2024/25.

Partnership working

The Trust Board fully recognises the requirement for health and care organisations to work together in the best interests of patients and the public beyond their own organisational boundaries. A key feature of the work of the Board during 2024/25 has therefore been an increasing focus on partnership working in order to improve equity of access and clinical outcomes for patients and members of the public, particularly across the South East London Integrated Care System.

The Board and its committees regularly receive system-level data and reports from partner organisations such as the South East London Acute Provider Collaborative. This helps the Board to assess the Trust's contribution to system performance and to take the interests of stakeholders into account during discussion and decision-making.

Audit and Risk Committee

The Audit and Risk Committee provides the Board of Directors with an independent review of financial and corporate governance and risk management. It provides assurance through independent external and internal audit, ensures standards are set and monitors compliance in the non-financial, non-clinical areas of the Trust.

The Trust has an in-house internal audit function which meets the requirements of the Public Sector Internal Audit Standards, providing independent and objective assurance to the organisation. The Audit and Risk Committee is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek any information it requires from staff.

Last year, the Committee approved the internal and external audit work plans and received regular reports from both sets of auditors.

The Committee works closely with Grant Thornton UK LLP, the Trust's external auditors, also meeting with them outside formal Committee settings and keeping their work and findings under review. The significant issues relating to the financial statements raised by the external auditors that the Committee considered during the year are included in the notes to

the financial statements. Grant Thornton attended each meeting of the Committee, providing opportunities for the Committee to assess their effectiveness. As a result, the Committee was supportive of the Council of Governors' decision to appoint Grant Thornton UK LLP as the Trust's external auditors for a further 5 years after the current external audit contract ends in July 2025.

Auditor independence and objectivity are safeguarded by the minor and entirely immaterial value of non-audit work Grant Thornton provides to the Trust, which is set out in note 7.2 to the accounts.

At its meeting in June 2025 the Committee reviewed the draft Annual Report and Accounts and approved their submission to the auditors before being laid before Parliament.

During the year, the Committee also received updates about the Trust's Board Assurance Framework and received reports on a number of topics including information governance; cyber security arrangements at both the Trust and its key external suppliers; emergency preparedness, resilience and response; and counter fraud activities.

Senior Leadership Talent, Appointments and Remuneration Committee

The Senior Leadership Talent, Appointments and Remuneration Committee is responsible for determining the remuneration and other conditions of service of executive directors and very senior managers (VSMs), for succession planning and evaluating the balance of skills, knowledge and diversity of the executive directors, as well as for identifying and appointing candidates to fill the executive director positions on the Trust Board.

The Trust acknowledges the value of having a diverse range of voices and opinions at Board level. At 31 March 2025 there were 18 white Board members and 4 Board members (18%) from global majority backgrounds, which is lower than the 52% of the Trust's overall workforce. We value the Board's diversity related to other protected characteristics and remain committed to increasing its ethnic diversity.

During 2024/25 the Committee took steps to ensure the cohort of executive directors has remained strong by:

- appointing Crystal Akass as the new Chief People Officer from August 2024, to succeed Julie Screaton;
- recommending to the Board and Council of Governors the appointment of Amanda Pritchard as the new Chief Executive from September 2025, to succeed Professor Ian Abbs;
- establishing the chief executives of the Trust's 4 clinical groups as voting members of the Trust Board of Directors from January 2025 – ensuring a stronger voice from the key clinical areas.

Biographies of the executive directors can be found on pages 70-71.

Audit and Risk Committee membership and attendance 2024/25

Name	Actual/possible
Nilkunj Dodhia [Chair]	6 / 6
Miranda Brawn [until February 2025]	6 / 6
Simon Friend	6 / 6
Jamie Heywood [from February 2025]	0 / 0
Deirdre Kelly	5 / 6

Senior Leadership Talent, Appointments and Remuneration Committee membership and attendance 2024/25

Name	Actual/possible
Ian Playford [Chair]	6 / 6
Charles Alexander	6 / 6
Miranda Brawn	5 / 6
Nilkunj Dodhia	2 / 2
Simon Friend	6 / 6
Felicity Harvey	4 / 6
Jamie Heywood	2 / 2
Deirdre Kelly	2 / 2
Graham Lord	1 / 2
Pauline Philip	2 / 2
Alison Wilcox [from February 2025]	2 / 3

Working with the Council of Governors

The Board of Directors interacts regularly with the Council of Governors to ensure that it understands their views and those of our members.

Governors are invited to attend 4 public Board meetings a year. These are followed by a meeting of the Council of Governors which includes a session reflecting on the Board meeting.

Governor representatives also observe the Quality and Performance; Finance, Commercial

and Investment; People, Culture and Education; and the Transformation and Major Programmes Board Committee meetings as well as the 5 clinical and delivery group strategic advisory boards. They then report back to their colleagues at the appropriate forums, which may include one of the 3 Council of Governors' working groups or the quarterly 'triangulation' meetings. These meetings enable governors to triangulate everything they have seen and heard through their various interactions with the Trust and to prioritise topics and questions to raise with the Board.

There are many ways in which the Board develops an understanding of the views of governors, including through attendance at the quarterly Council of Governors meetings, the Annual Public Meeting, and informal interactions for example with governor observers before and after Board committee and clinical group strategic advisory board meetings. A small number of non-executive directors attend each 'triangulation' meeting which helps to build relationships between the 2 groups as well as provide further opportunity to hold non-executive directors to account for the Trust's performance.

Governors are invited to meet other members at the Annual Public Meeting. Should a disagreement arise between the Council of Governors and the Board of Directors, it would be referred to a panel consisting of the Chairman, the Chief Executive and 2 governors nominated by the Council of Governors.

The Chairman would not participate in the nomination of governors to this panel. The panel would use all reasonable endeavours to resolve any disagreement.

Trust Executive Committee

The Trust Executive Committee is the primary executive decision-making forum of the Trust. It is chaired by the Chief Executive and membership is comprised of the directors of the Trust's corporate functions, chief executives of the clinical groups and the Managing Director of Essentia. Its role is to:

- set Trust values and oversee the establishment of an organisational culture that aligns with these values and which promotes equality, diversity and inclusion for patients and staff
- prioritise and allocate resources across clinical groups and corporate functions
- oversee the development and management of the Trust's external partnerships, locally, regionally and nationally
- oversee the development and delivery of strategies, programmes, plans and policies that enable the Trust to achieve its strategic and operational objectives
- monitor and scrutinise quality of care, operational performance and financial performance, ensuring the Trust adheres to guidelines and meets standards
- support clinical groups to make operational decisions within their clinical services and, with a clear focus on agreed priorities, provide the Board of Directors with the assurance that the management of clinical and non-clinical services has been subject to scrutiny, and to ensure quality and safety for patients.

The Trust Executive Committee has established a number of committees to enable it to discharge its functions more effectively. These committees are chaired by senior executive directors. The main committees of the Trust Executive Committee are set out below:

Trust Operations Board – ensures our clinical services are safe, effective, caring, responsive and efficient by monitoring and scrutinising the performance of clinical services, and makes decisions on the coordination of resources in response to opportunities, pressures and risks.

Trust Risk and Assurance Committee – oversees the management of risk and safety across the organisation, whilst ensuring that appropriate governance systems and processes are in place to monitor and deliver high quality, safe patient care.

Investment Portfolio Board – which sets and monitors delivery of the overall capital plan for the Trust within the resources agreed by the Board. It also approves, directs and manages the Trust's capital investment portfolio of schemes.

Strategic Finance Committee (until November 2024 and now part of the Trust Executive Committee) – oversaw the Trust's financial performance and implementation of the Trust's financial strategy.

Board of Directors – non-executive directors

Charles Alexander CBE

Chairman

Charles was appointed Chairman of Guy's and St Thomas' with effect from December 2022.

Charles has had a long and distinguished career working at board level across a number of different sectors, including very senior leadership roles at NM Rothschild and GE Capital Europe. He is Chairman of VIVID Housing, a leading housing association and housing development company in south England.

He is a strong supporter of the arts and has served as the lead non-executive director at the Department of Culture, Media and Sport. He spent 6 years volunteering with Trinity Hospice, providing support to patients and families at the end of life.

He was formerly Chair of both the Royal Marsden NHS Foundation Trust and the Royal Marsden Cancer Charity, roles he held between 2016 and 2022, and of King's College Hospital NHS Foundation Trust between December 2022 and January 2024.

Simon Friend

Non-executive director and joint Deputy Chair

Simon is a chartered accountant and was a partner at PricewaterhouseCoopers LLP, where his career spanned more than 35 years. He brings extensive expertise in finance, audit and governance across a range of sectors as well as technical rigour and board experience at the highest level. Simon holds non-executive director roles at Bevan Brittan LLP a national law firm, Otsuka Pharmaceutical Europe Limited and at King's College Hospital NHS Foundation Trust (until 31 March 2025).

Simon was previously a non-executive director of Royal Brompton & Harefield NHS Foundation Trust. He chairs the Finance, Commercial and Investment Board Committee and the Heart, Lung and Critical Care Clinical Group Strategic Advisory Board.

Dr Felicity Harvey CBE

Non-executive director, Senior Independent Director and joint Deputy Chair

Felicity has considerable senior leadership and strategic planning experience. She was Director General for Public and International Health until her retirement from the Civil Service in 2016. Prior to that, Felicity was Director of the Prime Minister's Delivery Unit.

She has been both a member and Chair of the Independent Oversight and Advisory Committee for WHO Health Emergencies. She is a Visiting Professor at the Institute of Global Health, Imperial College, London and non-executive director of Halcyon Topco Ltd (Sciensus Group). Felicity joined the Board in September 2016 and chairs the Cancer and Surgery Clinical Group Strategic Advisory Board.

Professor Miranda Brawn

Non-executive director

Miranda is a business expert, board advisor, investor and philanthropist across many sectors, with a career that spans financial service, law, charity and health.

Before joining the Bar of England and Wales as a barrister and senior banking lawyer, she worked as an investment banker. She has served as an equality commissioner for Lambeth Council and is the Founder, President and Board Chair of The Miranda Brawn Diversity Leadership Foundation.

Miranda is an award-winning champion for diversity, inclusion and sustainability. She commenced 'The Brawn Review: Boardroom Sustainability, Inclusion and Corporate Governance' during her time at the University of Oxford as a Senior Visiting Fellow. Miranda chairs the Trust's People, Culture and Education Board Committee.

Nilkunj Dodhia

Non-executive director

Nilkunj previously served as a non-executive director at Chelsea and Westminster Hospital NHS Foundation Trust, a position he held since November 2015.

Previously, Nilkunj was regional director of McKinsey & Company's health strategy and systems practice. He also served as a non-executive director at Epsom and St. Helier University Hospitals NHS Trust and chaired the South West London Elective Orthopaedic Centre (SWLEOC).

Currently, Nilkunj is an executive at Oracle, where he channels his passion for health technology, digitally enabled transformation, and the utilisation of data to enhance patient care and support caregivers. He holds an MBA from INSEAD and is a fellow of the Institute of Chartered Accountants in England and Wales.

Nilkunj chairs the Trust's Audit and Risk Committee.

Jamie Heywood

Non-executive director

(From January 2025)

Jamie is Chief Executive Officer of Zolar, which provides software and services to small solar installers across Europe to help accelerate the energy transition. He has over 30 years' experience leading growing technology companies across Europe and Asia.

Prior to Zolar, Jamie was regional general manager at Uber, where he was responsible for 12 countries across Northern Europe, including the UK. He has also worked at Amazon as director of their UK electronics divisions, and spent 15 years in mobile telecoms, including senior roles at Virgin Mobile.

Jamie has previously held non-executive roles at Autocab, where he was Chair, and at Alon Cellular.

Professor Deirdre Kelly CBE

Non-executive director

Deirdre has non-executive experience on the boards of a number of healthcare bodies including the Care Quality Commission, the General Medical Council, NHS Blood and Transplant, the Health Research Authority and the Royal Wolverhampton NHS Trust.

She is also a professor of paediatric hepatology at the University of Birmingham and Consultant Paediatric Hepatologist at Birmingham Women's and Children's Hospital NHS Foundation Trust. She set up the Paediatric Liver Unit at Birmingham Women's and Children's Hospital which provides a national and international service for children.

She is currently the National Clinical Lead for the Paediatric Hepatitis C Operational Delivery Network.

Deirdre also chairs the Evelina London – Women's and Children's Clinical Group Strategic Advisory Board.

Professor Graham Lord

Non-executive director

(From September 2024)

Graham joined the Board in September 2024 as Chief Academic Officer, a non-executive director role on the Board of Directors at both Guy's and St Thomas' and King's College Hospitals NHS Foundation Trusts. He is also senior vice president (Health and Life Sciences) at King's College London and executive director of King's Health Partners.

He was previously Vice-President and Dean of the Faculty of Biology, Medicine and Health at the University of Manchester. He was also an honorary consultant transplant nephrologist at Manchester NHS Foundation Trust, and executive director of the Manchester Academic Health Science Centre.

Pauline Philip DBE

Non-executive director

Pauline has experience working in Board-level roles across the NHS, including as Chief Executive at Luton and Dunstable NHS Foundation Trust. From 2002 to 2010, she was the Executive Director responsible for Patient Safety at the World Health Organisation. Since 2016, she has been NHS England's National Director for Emergency and Elective Care.

Pauline is Chair of Beaumont Hospital in Dublin and Chair of Lifebox, a global non-profit organisation that she co-founded with the aim of making surgery and anaesthesia safer worldwide. Pauline chairs the Trust's Quality and Performance Board Committee and the Integrated and Specialist Medicine Clinical Group Strategic Advisory Board.

Ian Playford

Non-executive director

Prior to joining the Board in May 2022, Ian had been a non-executive director at Royal Brompton & Harefield NHS Foundation Trust.

He has over 30 years' experience as a senior executive across the public and private sector. His previous roles include interim chief executive at the Government Property Agency, where he managed the Government's warehouse and science estate. He was also a group property director of Kingfisher PLC and has been a member of the board of HM Courts and Tribunals Service and the Queen Victoria Hospital NHS Foundation Trust.

Ian chairs the Trust's Transformation and Major Programmes, and Senior Leadership Talent, Appointments and Remuneration Board committees, as well as the Essentia Group Strategic Advisory Board.

Alison Wilcox

Non-executive director

(From January 2025)

Alison began her career in the NHS before moving on to a diverse range of roles spanning management consultancy, HR business partnering, strategy and leadership roles with international businesses Hay Group, Vodafone and BT plc.

Until 2022 Alison was group HR director for BT plc, driving a comprehensive transformation agenda to modernise and simplify the business and drive improvements for customers.

She is currently a Trustee Board member and nominations committee chair at Health Data Research UK and a non-executive director at Dwr Cymru (Welsh Water).

Continued overleaf:

Board of Directors – executive directors

Non-executive directors
Continued:

Shitij Kapur

Non-executive director

(from May 2024 until September 2024)

Shitij sat on the Trust Board as the non-executive director nominated by King's College London to bridge the gap between the departure of Reza Razavi and the arrival of Graham Lord. He is Vice-Chancellor and President of King's College London.

Baroness Sally Morgan

Non-executive director and Deputy Chair

(until December 2024)

Sally joined the Board in February 2021 having previously been Chair and non-executive director of Royal Brompton & Harefield NHS Foundation Trust. She chaired the Heart, Lung and Critical Care Clinical Strategic Advisory Group Board.

Sally has held numerous civil service positions including Minister of State in the Cabinet Office and Political Secretary to the Prime Minister. Sally is Master of Fitzwilliam College, Cambridge.

Professor Reza Razavi

Non-executive director

(until May 2024)

Reza joined the Board in May 2016 and served for 8 years. He is Vice President and Vice-Principal of Research at King's College London (KCL), serves as Director of the London Medical Imaging and AI Centre for Value Based Healthcare and is also a children's cardiologist at Evelina London Children's Hospital.

He helped to establish the Trust's cardiovascular MRI service and developed the world's first cardiovascular MRI cardiac catheterisation programme.

Professor Ian Abbs

Chief Executive

Ian became Chief Executive in August 2019. He was appointed Medical Director in January 2011 and Chief Medical Officer in January 2017. He joined the Trust as a consultant renal physician and honorary senior lecturer at King's College London in 1994 and has had a distinguished clinical and academic career, which has included a broad range of senior management positions.

In addition to his clinical work, Ian has played a key role in the development of the Trust's life science partnerships, and has been responsible for many aspects of the Trust's digital transformation and innovation agenda.

Crystal Akass

Chief People Officer

(From August 2024)

Crystal was appointed as Chief People Officer in August 2024. She was previously Chief People Officer at Royal Free London NHS Foundation Trust, from 2021.

Before joining the NHS, Crystal spent 18 years in the UK Civil Service, joining the Home Office and progressing through HR and organisational development roles both there and in the Ministry of Justice. She went on to hold senior roles at the Cabinet Office as HR Director, and Director of People at the Department for Work and Pensions.

Gubby Ayida

Chief Executive Women's and Children's Clinical Group*

Gubby was appointed as Chief Executive of our women's and children's services, which includes Evelina London Children's Hospital, in May 2023. She is a consultant obstetrician and gynaecologist.

Gubby was previously Medical Director of Hillingdon Hospitals NHS Foundation Trust. She also led the Women's and Children's Division at Chelsea and Westminster NHS Foundation Trust and was special advisor to their Board on diversity and inclusion.

Avey Bhatia

Chief Nurse

Avey returned to the Trust as Chief Nurse in November 2020, having trained as a Critical Care nurse at St Thomas'. Her clinical experience includes theatres, general intensive care, coronary care and cardiothoracic nursing.

She was previously Chief Nurse at St George's University Hospitals NHS Foundation Trust, and holds a Masters in Public Administration.

She is also Interim President of the Florence Nightingale Foundation and Honorary Vice President of The Nightingale Fellowship. She is the Trust's Director of Patient Experience, the executive lead for adults' and children's safeguarding and the executive lead for infection, prevention and control.

Sarah Clarke

Chief Executive Cancer and Surgery Clinical Group*

Sarah was appointed as the Chief Executive of our cancer and surgery services in 2021, having joined the Trust as Director of Operations in 2018. She was previously Divisional Director of Cancer Services for The Royal Marsden and was responsible for the operational delivery of their NHS cancer and research services.

Sarah has extensive management experience working in acute and specialist trusts including Divisional Director of Women's and Children's Services at King's College Hospital. She started her career at Deloitte Consulting, before joining the NHS in 2003.

Board of Directors – executive directors

Steven Davies

Chief Financial Officer

Steven was appointed as Chief Financial Officer in January 2022. He joined Guy's and St Thomas' in 2018 as Finance Director.

He has extensive experience of NHS revenue and capital, major projects, change management, contracts, partnerships and commercial activities.

He has worked in the NHS for over 20 years, initially joining the service on the national finance graduate scheme. Steven has worked for a number of NHS organisations in and around London, including Moorfields Eye Hospital NHS Foundation Trust where he was Chief Financial Officer and Deputy Chief Executive.

Louise Dark

Chief Executive Integrated and Specialist Medicine Clinical Group*

(From June 2024)

Louise was appointed as Chief Executive of our integrated and specialist medicine services in June 2024. She was previously Managing Director of King George Hospital, part of Barking, Havering and Redbridge University Hospitals NHS Trust.

A pharmacist by background, Louise has held a wide variety of leadership roles including Programme Director for elective transformation and recovery at NHS London. She was Chief Pharmacist at Lewisham and Greenwich NHS Trust, where she was also Divisional Director of Operations for acute and emergency medicine and clinical support services.

Jon Findlay

Chief Operating Officer

Jon was appointed as Chief Operating Officer in January 2017. Previously Jon was Chief Operating Officer and Deputy Chief Executive at Southend University Hospital NHS Foundation Trust, an executive director role he held since January 2014.

Before working at Southend, Jon was Director of Operations at Guy's and St Thomas' where he was responsible for operational performance and the strategic development of clinical services. He has many years' experience in director-level roles that span clinical operations, service modernisation, performance improvement, human resources and workforce planning.

Richard Grocott-Mason

Chief Executive of Heart, Lung and Critical Care Clinical Group*

Richard is Chief Executive of our adult heart, lung and critical care services which provide care from our Royal Brompton, St Thomas', Harefield and Guy's hospitals.

Richard was medical director of Royal Brompton and Harefield NHS Foundation Trust for 6 years before it became part of Guy's and St Thomas' in 2021. He has been a consultant cardiologist since 1999 and continues to run a weekly adult cardiac outpatient clinic.

Dr Simon Steddon

Chief Medical Officer

Simon joined the Trust as a consultant renal physician in 2005 and became a Clinical Director in 2008 before serving as the Trust's Chief Operating Officer from 2014 to 2016. He was appointed as the Trust's Medical Director in 2016, and then Executive Medical Director in 2019. Simon took up his role as Chief Medical Officer in September 2022. He has a PhD from Queen Mary University of London and an MBA from Westminster Business School.

Lawrence Tallon

Deputy Chief Executive

(Until March 2025)

Lawrence was appointed as Deputy Chief Executive in March 2020. Prior to joining Guy's and St Thomas' he was Director of Strategy, Planning and Performance at University Hospitals Birmingham NHS Foundation Trust. Lawrence has held a wide range of healthcare leadership roles, both in the UK and abroad. He also worked at the Department of Health in the offices of both the Secretary of State and the NHS Chief Executive, and was previously Managing Director of the Shelford Group.

Julie Screaton

Chief People Officer (Until June 2024)

Julie was appointed as Director of Workforce and Organisational Development in June 2017 and became Chief People Officer in 2018. She was previously Regional Director, London and the South East for Health Education England.

*Clinical group chief executives were appointed as voting members of the Trust's Board of Directors in January 2025.

Since launching in 2017, 550 nursing and midwifery staff have been awarded a prestigious professional commendation from our Nightingale Academy. This award is unique to Guy's and St Thomas' and included maternity support workers, healthcare assistants and nursing associates for the first time this year.

8 NHS Oversight Framework

In 2024/25 NHS England's NHS Oversight Framework provided the framework for overseeing systems including providers and identifying potential support needs. Under this Framework, 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: a) 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) b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

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

Segmentation

In October 2024 NHS England moved the Trust from segment 2 to segment 3 of the NHS Oversight Framework as a result of its operational performance regarding waiting times for elective care, diagnostics and cancer treatment. As at 31 March 2025 the Trust remained in segment 3. As described in the 'tiering' section below, the Trust has made significant progress in each of these areas and recognises the importance of a sustained focus on making improvements for the benefit of our patients.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website:

www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

Tiering

NHS England's national tiering programme operates alongside the NHS Oversight Framework and provides additional opportunities for trusts to access bespoke support from NHS England to help address operational challenges.

Since March 2024 the Trust has been in tiering for its cancer performance. Significant progress has been made since then to address the backlog of patients waiting over 62 days for cancer treatment and to recover our performance. This work is both internally focused, and with our partners across south east London to improve shared treatment pathways.

In July 2024 NHS England also placed the Trust into tiering for elective (planned) and diagnostic waiting times. In January 2025 the Trust was removed from tiering for elective care. NHS England acknowledged and commended the significant progress which had been made in improving the timeliness of care for patients waiting for elective treatment, saying that this reflected the Trust's strong commitment to enhancing patient outcomes, its operational focus and its ability to drive meaningful change.

As at 31 March 2025, the Trust remained in tiering for its diagnostics performance, but was also making good progress in reducing the number of patients waiting over 6 weeks for diagnostics tests and procedures, and was ahead of its recovery trajectory in this area.

We are trialling the use of drones to speed up the delivery of urgent blood samples from Guy's Hospital to St Thomas' Hospital, cutting the journey from 30 minutes by road to 2 minutes and reducing our carbon emissions.

9 Statement of the Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Guy's and St Thomas' 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 Guy's and St Thomas' 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 Guy's and St Thomas' 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 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**.

Professor Ian Abbs
Chief Executive Officer and Accounting Officer
25 June 2025

Appendix 1: Annual Governance Statement 2024/25

Scope of responsibility

As Accounting Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 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 Guy's and St Thomas' 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 Guy's and St Thomas' NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Leadership of the risk management process

As Chief Executive I am responsible for overseeing risk management across all organisational, financial and clinical activities across acute and community services. All executive directors report to me and they are held to account through both individual and team objectives that also reflect the strategic objectives of the Board.

The governance arrangements underpinning the Guy's and St Thomas' group operating model are kept under regular review. Executive committees have been established to create clear accountabilities and leadership for managing risk, with alignment to Board committee structures. The Board continues to receive minutes and assurances from each of its committees to demonstrate the Trust's capacity to handle risk. The Trust Board Assurance Framework aligns with national guidance and provides assurance about how the Trust is managing the principal risks to achievement of our strategic objectives.

The Trust Risk Management Policy, which I own as Chief Executive, sets out the accountability and reporting arrangements for risk management and the processes that maintain robust internal control. The policy aims to promote a positive culture towards the management of risk and provides clear, systematic approaches to ensure risk assessment is integral to all clinical, managerial and financial processes. As outlined in our Risk Management Policy, the Chief Medical Officer carries responsibility for ensuring this policy is implemented correctly and is sufficiently effective. The Chief Medical Officer, in conjunction with the Chief Nurse, also holds responsibility for clinical governance and the appropriate monitoring of clinical standards, including morbidity and mortality. These functions are overseen at executive level by the Trust Risk and Assurance Committee.

The Chief Financial Officer oversees the adoption and operation of the Trust's Standing Financial Instructions and is the lead for counter fraud. All executive directors, clinical groups and directorate management teams have a role in ensuring a strong risk management approach is operationally embedded in all aspects of the Trust's activities, both clinical and non-clinical, and that risk management is a core component of job descriptions of the Trust's senior managers. Our Audit and Risk Committee enables non-executive directors to provide objective oversight of our risk management function and leadership.

Equipping staff to manage risk

Managers at all levels of the organisation have a responsibility to identify and manage their local risks and to promote an environment where proactive risk reporting identifies perceived or real threats to patient safety. Each clinical group maintains a group risk register and oversees the management of risk within their respective directorates. Significant risks are escalated through effective performance review meetings and our corporate governance committee structure for inclusion in the corporate risk register, which is reviewed monthly by the Trust Risk and Assurance Committee and quarterly by the Trust Executive Committee.

Trust policies and procedures are authorised statements setting out expectations and standards for staff and services and, in doing so, help the Trust to manage risk. Local procedures and protocols exist for site-specific or group-specific processes that align to Trust policy.

The Trust learns from good practice through a range of mechanisms including clinical supervision, peer review, effective performance management, continuing professional development, clinical audit, the application of evidence-based practice and reflective practice. Executive performance review meetings are in place to hold clinical and delivery groups and our largest corporate services to account and seek assurance on the management of risk within their directorates and functions.

Learning from investigations, particularly around patient safety is managed through our Patient Safety Incident Response Framework (PSIRF). A 'Quality Matters' newsletter is published monthly for all staff and includes key messages and examples of learning. Our Learning for Improvement Group meets monthly with clinical group attendance to share all completed patient safety incident investigations for assurance, as well as learning from all other PSIRF responses and examples of good practices or quality improvement from across the Trust. The Trust Risk and Assurance Committee also receives assurance from our patient experience, learning from deaths, and other patient safety related committees for holistic oversight of learning and improvement.

Our internal audit department undertook their annual review of our risk management and board assurance frameworks in 2024/25. They found the Trust's capacity and ability to handle risk was maintained at substantial assurance and made no significant recommendations. The Trust continues to annually audit its risk management framework policy effectiveness, which comes to the Audit and Risk Committee for noting. Internal audit maintains a robust annual audit plan and audit activity to provide objective, internal assurance to the Board on all manner of risk control such as Trust operations, performance and financial management.

Board and Board committee agendas continue to be structured around a comprehensive forward plan of reports that are closely linked to the Trust's statutory and regulatory responsibilities. This helps ensure the Board and its committees are sighted on the Trust's compliance with these responsibilities and can take timely action where risks to compliance arise.

The risk and control framework

Risk management is guided by the Risk Management Policy, but requires commitment, collaboration and participation from all members of staff. The process starts with systematic identification of risks which are then evaluated, graded and either managed locally (with risk control measures identified and implemented to mitigate the potential for harm), or escalated for possible inclusion in the directorate's, clinical group's or corporate (executive) risk register. The Trust utilises a risk register system to oversee and manage operational risk across the Trust. This allows the central Quality and Assurance team to fulfil the role of Chief Risk Officer to monitor change in risk scores, as well as challenge non-moving risk within the system. The organisation moved to a new risk management

system in 2024/25 for a more effective oversight of risk for all sites and services across the Trust. Thematic reviews of risk types (for example clinical or patient safety) are undertaken periodically and reported to risk oversight committees for assurance on control (for example, high level clinical risks reported to the Trust's Risk and Assurance Committee). The Learning for Improvement Group, chaired by the Deputy Chief Medical Officer for Safety and Clinical Effectiveness meets monthly with multiple internal and external stakeholders to ensure detailed scrutiny of, and learning from, incidents as well as the early identification of emerging themes and associated organisational risks.

A risk management matrix with clear risk descriptors and tolerance levels is used to support a consistent approach to assessing and responding to clinical and non-clinical risks within the boundaries of the Trust's risk evaluation framework. The Trust seeks to reduce risks as far as possible; however, it is recognised that delivering healthcare carries inherent risks that can never be completely eradicated. The Board sets the Trust's risk appetite and outlines this in policy, which is reviewed annually for effectiveness. Our Board committees are aligned to assure that there is independent and strategic focus on both risk and assurance.

The Board reviewed and renewed our current risk appetite and tolerance levels in 2024/25 as part of the renewal of our Risk Management Policy in November 2024. Our current risk appetite statement remains in place for the new financial year. The Trust Executive Committee continues to reinforce the importance of clinical leadership and oversee a number of supporting sub-committees, all with corporate governance assurance lines to the Board. Our clinical groups continue to strengthen their internal governance arrangements within the Trust's corporate governance framework.

The Board Assurance Framework sets out the Trust's principal risks to achieving our strategic objectives and the key controls and assurances available to the Board of Directors on the management of these risks. The Board Assurance Framework incorporates five tiers of assurance encompassing day-to-day operational controls, how we obtain performance oversight of these controls, our sources of internal objective assurance, and external independent assurance.

This year all our principal risks were reviewed in reference to our new strategy and strategic objectives. The review was undertaken in April 2025 by the Board, which identified new risks and recognised existing risks on the Board Assurance Framework. These are outlined as the major in-year risks for 2025/26 later in this statement.

The Audit and Risk Committee, on behalf of the Trust Board, continues to principally rely on internal audit to review the effectiveness of the Trust's system of internal control.

Quality governance arrangements

Our quality governance framework is built upon the principles described within the eight domains of NHS England's well-led framework and the five quality domains outlined by the Care Quality Commission (CQC). The Board actively engages in quality of care with patients, the public, staff and other relevant stakeholders through a number of different mechanisms and forums. The Trust has a robust corporate governance framework in place, which underpins our quality governance arrangements and driven through our Trust Performance and Accountability Framework. It ensures that decision-making is effective, risk is managed and the right outcomes are delivered by use of the corporate governance framework which sets out the procedures, systems and processes that broadly define:

- key responsibilities and accountabilities
- how, when and where decisions are made (both strategic and operational) and performance is monitored
- expected behaviours and ways of working.

The chief executives of each clinical and delivery group sit on the Trust Executive Committee and are held to account for the performance of the group by the Trust Chief Executive at quarterly performance review meetings. Each clinical group contains a number of clinical directorates, led by clinical directors, reporting to them for assurance on quality, performance, workforce and finance. The corporate functions supporting clinical group delivery are directorates with executive leads and include, for example, finance, workforce, digital technology and information and quality and assurance.

Quality committees are in place to monitor and review all elements of quality from complaints, incidents, risks, mortality as examples with clinical group representation to ensure full oversight. Quality targets and measures are reviewed at clinical group level through performance meetings with Trust executive directors and the clinical group executive team. Summary data is provided in monthly performance reports for the Board and through Board sub-committees such as the Quality and Performance Committee. Such reports include information on key quality indicators including patient safety, patient experience and clinical effectiveness.

Assessing the quality of performance information

To deliver on our commitment to uphold the highest standards of governance the Trust makes use of its Integrated Performance Reporting framework to monitor key performance indicators at clinical directorate, clinical group and aggregate Trust level whilst employing peer benchmarking to support the production and management of robust performance information which in turn offers effective insight and strategic direction within the Trust. The reporting framework offers a holistic view of performance across key domains aligned to CQC priorities to further inform delivery of the Trust's strategic priorities. The integrated performance information used is created and analysed by subject matter experts and is provided for Board and public scrutiny, alongside its integration and use at an operational level, thus offering alignment and improved robustness of data quality. A risk-based assessment of the data associated with key indicators helps coordinate our comprehensive internal audit programme aiming to offer the Board assurance with regards to delivering and maintaining good data quality in the Trust.

The Trust successfully negotiated the Epic stabilisation phase following implementation of the new electronic patient record system in October 2023 and transitioned in to the planned optimisation phase in 2024/25 with a shift in focus and strategic direction. The Trust's governance structure surrounding elective access and data quality has been strengthened in 2024/25 with a newly formed central corporate function being established to oversee a set of key strategic priorities including a comprehensive data quality programme supporting improvement to the quality of our performance information.

Assurance on compliance with the Health and Social Care Act 2008

The Trust is fully compliant with the registration requirements of the CQC. The Trust maintains an up to date statement of purpose, reviewed and submitted regularly to the CQC; our latest CQC ratings are published online and link to our CQC licence RJ1 on the CQC's website. A range of mechanisms are in place to provide assurance of compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, as set out in the CQC's guidance for providers. These include a well-established programme of annual quality assessments and multidisciplinary quality reviews and visits to services.

Assurance on compliance with CQC regulations forms part of our existing quality assurance frameworks business as usual. Surveillance and assurance methods include mock well-led inspections, quality assessment frameworks, clinical audit, internal audit, data analysis and policy effectiveness audits. Table-top review of information is also triangulated from the integrated performance reports, executive performance review meetings, risk management data, staff experience and feedback, patient experience, complaints, and soft intelligence throughout the Trust's corporate governance framework.

The CQC last carried out an inspection of the Trust in September 2022, on the maternity services at St Thomas' Hospital. The service was rated

'good' overall with positive findings and further improvement required under the safe domain. The Trust has not had a full well-led inspection and Trust-wide services inspection since 2019, which resulted in a 'good' overall rating with 'outstanding' for well-led. The Trust undertook an external mock well-led inspection in 2022 to aid the Trust's readiness for CQC and the changing regulatory model. Improvement actions were taken forward to further enhance the Trust's governance arrangements so we can continue to maintain our 'outstanding' rating for well-led.

Managing risks to data security

Cyber risk is included on both the Trust corporate risk register and the Board Assurance Framework. An action plan is in place to ensure that appropriate cyber risk mitigations are deployed. All staff receive data security training as part of their corporate induction upon joining the Trust, with annual information governance and information security training mandated for all staff. Phishing simulations are conducted regularly and those staff failing phishing simulation exercises receive further cyber training.

Training requirements are supported by comprehensive policies and guidance to ensure access to relevant and up-to-date information. An information asset owner, with responsibility for managing information risks, is named for each key information asset and is supported by specialist information security and information governance staff. Registers of information assets, flows and uses are maintained, reviewed and updated in year.

Additional assurance is provided by adherence to the Data Protection Act 2018 and UK General Data Protection Regulations (UKGDPR). The requirement for 'Privacy by Design' is achieved by having processes that build information governance and information security requirements into all projects and programmes that involve processing of personal or sensitive data. This includes the use of data protection impact assessments, UKGDPR compliant contracts, systems security reviews for all new systems and data sharing agreements where required. Any data protection breaches are investigated, and appropriate follow up actions are taken.

The Trust has learnt from the cyber-attack on Synnovis, the Trust's third party provider of pathology services, in June 2024 and third party supply chain risk assessment processes have been strengthened to allow continuous monitoring and management of the risk of supplier breaches.

The Trust's annual Data Security and Protection Toolkit submission and improvement plan was submitted to NHS England on 30 June 2024, the Trust has since completed improvements and achieved 'Standards Met'.

Managing risks from legacy IT systems

The Trust continues to manage technology debt in terms and legacy IT solutions. Over 95% of the Trust's server estate is now on a supported operating system with actions underway to decommission, upgrade or replace the remaining legacy systems. The data centre improvement programme remains underway and once complete will deliver improved resilience in terms of availability, backup and recovery arrangements.

Information incidents

All information incidents and near misses are investigated and used as opportunities to improve processes and reduce risks. This is reinforced by information governance and information security awareness training that focuses on the need for safe processing and protection of personal and sensitive data.

In 2024/25, one information incident within the Trust met the threshold for notification to the Information Commissioner's Office (ICO). This related to a member of staff accessing patients records inappropriately.

The ICO notified the Trust that, no further action would be taken as they were satisfied with the remediation actions that had been put in place.

Major in-year risks 2024/25 and in 2025/26

Major in-year risks 2024/25

The principal risks to delivery of the Trust's strategic objectives are recorded on the Board Assurance Framework. They are reviewed and updated at management level before they are brought to the Board, or its committees acting on its behalf, where they are monitored at least quarterly. The Audit and Risk Board Committee has responsibility to ensure the process for the management of these principal risks remains fit for purpose. In 2024/25 this process was strengthened by the introduction of scores for each principal risk, linking each risk score to the Trust's risk appetite statement, and the inclusion of specific actions that would be taken to mitigate the risk to tolerable levels.

In 2024/25 the key risks with potential impact on achieving our strategic objectives were:

- the Trust's activity and productivity levels may not be sufficient to recover in line with our strategic plans, which may impact our ability to provide safe and responsive care to patients and meet national strategic demands
- the Trust may fail to deliver safe, high quality care to patients across all sites and services
- the Trust's estate infrastructure failures may impact on operational and clinical activity
- the Trust may be unable to modernise its environment, estate and maximise the use of the available space in order to support clinical group and Trust strategies, in the context of the constrained financial environment
- the Trust may fail to hire and retain staff and senior leaders with the right skills and behaviours which may undermine the Trust's ability to deliver services in line with agreed quality standards and strategic priorities
- the Trust may be unable to ensure the resilience of its workforce by failing to maintain staff health and wellbeing, which could undermine the Trust's ability to deliver services
- the Trust may be unable to sustain financial efficiencies and secure sufficient income and/or capital for services, curtailing its ability to deliver high quality care
- the Trust may be unable to maintain its current levels of research ambition and partnerships, and may fail to attract sufficient investment and income in order to remain a research industry leader
- the Trust's and systems' priorities may not align, leading to uncertainty that hampers effective system working
- changes to the specialised commissioning financial regime, in particular delegation, could have a significant financial impact on the Trust
- the Trust may not fully realise the opportunities to transform ways of working based on the Epic electronic health record implementation and may not deliver the benefits set out in the business case
- the availability of a sufficient Capital Departmental Expenditure Limit (CDEL) allocation and the ability to generate surpluses may restrict future investment in the Trust's strategic and operational objectives
- operational and programmatic demands may reduce the focus on the development and/or delivery of the Trust's strategic ambitions
- the Trust's leadership and governance arrangements, which are still evolving following the implementation of a new operating model, may not be optimised to enable the Trust to consistently deliver its new strategic priorities
- patient personal data and the Trust's provision of clinical services are at risk of loss or disruption from cyber-attack, which could involve unauthorised change, deletion, theft or locking of patient data and may disrupt or delay the timely provision of critical clinical services to patients.

Whilst most of the risks set out above were similar to, or the same as, the risks in 2023/24, the final risk was added to the Board Assurance Framework midway through the year, following the cyber-attack on Synnovis in June 2024. The risk highlights the importance not only for the Trust to have robust cyber-security arrangements, but to take reasonable steps to ensure its key suppliers also have such arrangements in place.

Major in-year risks 2025/26

As with all NHS organisations, we face continual challenges in balancing the delivery of high-quality care with rising demand, rising acuity and the need to increase both productivity and efficiency to meet challenging activity requirements. Similarly, we face a challenge in balancing delivery of day-to-day care with the longer-term strategic ambitions set out in our new strategy. In April 2025 the Board of Directors reviewed the Board Assurance Framework and agreed a refreshed and more streamlined set of principal risk areas aligned to the new strategy. As part of this review several of the existing risks were consolidated and a new risk was added regarding delivery of the Trust's major programmes and other key priorities in supporting achievement of the strategy. It was also agreed that there were a number of key themes that needed to be woven through most of the principal risks, including data, inequalities and partnership working.

The strategy contains five strategic priorities that the Trust aims to achieve by 2030:

- delivering healthcare excellence
- improving the health of our populations
- valuing all of our people
- innovating for a better future
- modernising our infrastructure.

Delivery of these priorities is underpinned by a Board-approved strategy implementation framework and enabled by annual objectives. In 2025/26 the Trust has four objectives as follows:

- provide faster access to treatment, with a focus on planned care and on diagnosing and treating cancer
- deliver our financial plan, reducing costs and delivering our savings targets so that we remain in control of our future investment decisions
- increase productivity, including though use of technology, so our services are sustainable and we can deliver more care within available resources
- develop, enable and empower our people, building an inclusive and high performance culture where colleagues can thrive and achieve their potential.

As before, to enable these priorities we will continue to work with partners, where this supports the delivery of common goals, and continue to drive innovation.

NHS England well-led framework

The Trust understands the importance of ensuring that its services are well-led and recognises the link between strong leadership and governance arrangements and operational and clinical performance. Some of the main steps taken in 2024/25 to assess and strengthen the Trust's well-led capability included:

- an internal well-led programme that self-assessed the Trust against each of the eight quality statements within the well-led domain of the CQC Single Assessment Framework and identified actions for improvement, many of which have since been implemented;
- an internal review of the effectiveness of governance arrangements at both an executive and Board level, and an internal audit of how the Trust had implemented the recommendations from the external well-led review undertaken by Deloitte in 2022/23. Whilst both reviews concluded that governance and leadership arrangements are strong, improvement opportunities were identified and have been actioned; and
- the inclusion of a risk regarding organisational excellence, with a particular focus on services being well-led, on the Board Assurance Framework, which was regularly monitored at both an executive and Board level.

Risks to foundation trust governance and corporate governance statement assurance

The Trust can demonstrate its compliance with section 4 of the NHS provider licence by the following:

- an annual assessment of compliance with the NHS Code of Governance for Provider Trusts, which is overseen by the Audit and Risk Committee;
- the external well-led review commissioned by the Trust during 2022/23, which gave the Trust assurance that its corporate governance arrangements are fit for purpose and appropriate for the size and complexity of the organisation. As indicated above, these arrangements were further reviewed and strengthened during 2024/25;
- appropriate constitution of all Board committees with terms of reference and assurance reporting to each public Board meeting; and
- a suite of governance documents – including Standing Orders, Standing Financial Instructions, Scheme of Delegation and Accountability Framework – which set out responsibilities and authorities, and which are kept under regular review.

The Trust's Scheme of Delegation details matters reserved for the full Board, whilst the responsibilities delegated to its committees are clearly set out in those committees' terms of reference. All powers of the Trust which have not been retained as reserved by the Board of Directors are exercised on behalf of the Board by the Chief Executive, supported by other executive directors. The Scheme of Delegation also sets out the responsibilities delegated by the Chief Executive to the clinical groups.

Embedding risk management and incident reporting

The ways in which risk management is embedded in the Trust is covered in the risk and control framework above, delivered through our corporate policies on incident and risk management.

All staff are encouraged to report incidents and near misses as part of an open and fair culture. The Trust has implemented mandatory training for level 1 national training on incident and safety management for all staff. Level 2 national training is required for managers across the Trust and has a training programme for managers undertaking learning response investigations.

Staff are prompted by the incident reporting system to follow the 'duty of candour' process, with duty of candour information and training widely available.

During 2024/25, the Trust has continued to demonstrate a healthy incident reporting culture and remains one of the highest reporters of incidents within our cluster. The Trust has seen a continued rise in incidents reported compared with the previous year and the majority of incidents reported remain of no, or low, harm. This trend has continued through the rollout of the new incident reporting system. The Trust moved away from the serious incident framework to the new national Patient Safety Incident Response Framework in December 2023. The Trust is now investing in resources to proactively improve patient safety across its priority incident areas, where patient safety incident investigation reports are reviewed and discussed at our Learning for Improvement Group to ensure learning is shared and implemented. Actions following all patient safety incident investigations are tracked and reported regularly on progress to completion. We are currently undergoing a review of our current patient safety incident response plans to ensure they remain current and focus on the highest areas of risk within the organisation.

In 2024/25, the Trust reported eight 'never events' across the organisation, which was an increase from five in the previous 2023/24 financial year. All reported never events are investigated as patient safety

incident investigations, which are discussed at our Learning for Improvement Group and quality improvement plans undertaken. All reported incidents are reviewed and learning responses applied in accordance with our patient safety response plans to ensure the lessons are learnt and shared across the Trust. Any themes are identified so that future recurrences can be prevented by coordinated work. One theme arising out of never events is the consistent and safe use surgical checklists to improve surgical safety, with four never events and one near miss in the financial year. Surgical safety remains one of the Trust's priority incident areas, where a quality improvement work stream has been established to oversee Trust-wide action and assurance in this area.

Equality Impact Assessments (EQIAs) are a crucial part of the Trust's strategy for meeting its obligations under the Public Sector Equality Duty (PSED) outlined in the Equality Act 2010. The Trust uses EQIAs to evaluate the potential effects of its policies, practices, and services on protected groups, ensuring that equality is integrated into decision-making and that discrimination is avoided. While the guidance and resources for conducting EQIAs have recently been updated, a formal process for assuring and assessing their impact is still in development.

Public stakeholders' involvement in managing risk

The Trust's patient and public involvement policy and guidance describes how the Trust will comply with relevant legislation, and is described in 'Involvement and consultation policy: working in partnership with patients, people and communities'. All departments, both clinical and non-clinical, are responsible for planning and undertaking patient and public involvement initiatives.

The Trust serves diverse and dispersed populations which straddle a broad geography. There is a strong desire to work closely with patients, families, carers and public stakeholders within and across geographies and communities. The Trust provides information and assurance to the public on its performance against its principal risks and objectives in a number of different ways including:

- Guy's and St Thomas' NHS Foundation Trust had 38,805 members at the end of March 2025. These are represented by a Council of Governors that comprises patients, public, staff and stakeholder governors.
- The Council of Governors receives regular updates on the status of the Board objectives and uses this, along with the ratings by NHS England and the CQC, to hold the non-executive directors to account for the performance of the Board.
- Patients, carers and public stakeholders are involved in developing new services and where key changes are proposed to existing services which may impact upon them.
- The Council of Governors or its working groups are informed of any proposed changes, including how potential risks to patients will be minimised, through its relevant working groups.
- The Trust has an agreed process to advise and engage with overview and scrutiny committees when there are proposed changes that may impact on service users.
- The Trust Healthwatch liaison group meets quarterly to enable regular liaison and communication between the Trust and local Healthwatch bodies.

Compliance with developing workforce safeguards recommendations

One of the priorities in our strategy is about valuing all of our people. As part of the annual business planning cycle an annual workforce planning process is run to triangulate staffing with predicted activity levels and finance plans. Clinical and delivery group level plans are aggregated to form an overall Trust plan, with strategies and business cases to close potential workforce shortfalls considered through the relevant committees. Within this broad strategic priority area, our specific objectives to 2030 are to:

- recruit and retain the best people by developing new routes into work, ensuring equitable opportunities to work flexibly to achieve a good work-life balance, and equipping our people to thrive in the new digital healthcare environment
- create a fairer and supportive workplace by delivering on our commitments to equality, diversity and inclusion, and supporting the health and wellbeing of all our colleagues
- provide opportunities to grow and develop through excellent education, learning and development – cultivating an environment which supports everyone to realise their career ambitions.

Workforce metrics are monitored regularly by the Chief Nurse and Chief Medical Officer to ensure safe staffing levels, and reported through both the executive and Board governance framework as appropriate. Longer-term workforce plans include the consideration and implementation of new roles including advances practice with appropriate governance frameworks. To ensure staff have the right skills commensurate with their role, a wide range of training and development is provided both Trust-wide and within directorates and clinical groups. Ongoing training requirements are monitored through annual appraisal and revalidation, performance development review and monthly statutory and mandatory training reports.

Staffing levels are reviewed regularly and e-rostering systems are in place for nursing, medical staff and allied health professionals. Staffing levels are managed to ensure resources are deployed for optimum efficiency taking into account patient acuity. The Trust is compliant with Workforce Safeguards which incorporate the National Quality Board standards. The Trust has a number of workforce controls in place to reduce reliance on temporary staffing; for example, local sign-off with restrictions on usage for specific groups and bands of staff, depending on safe staffing levels.

Key performance indicators are reviewed monthly at Trust, clinical group and cost centre level. The Trust regularly reviews 'Model Hospital' metrics to ensure safe staffing levels and to benchmark workforce productivity, including skill mix and staff costs per weighted activity unit.

Compliance statements

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

The Trust has also published a separate up-to-date register of interests for the full Board of Directors and maintains a separate register of interests for its Council of Governors.

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.

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with and continually reassesses the risk of underperformance against its obligations in order to optimise resource planning.

The Trust's 'Green plan' is its Sustainability strategy (2021-2031) which complies with the 'net zero' statutory target set by the Climate Change Act 2008 and sector targets set in the 'NHS Net Zero' report. The Strategy comprises three strategic themes: Carbon zero; Connecting with nature; and Cycle of resources and is being implemented through a series of management plans and governed through a Sustainability Steering Committee. The Trust will be refreshing its Green Plan in 2025 in accordance with NHS England guidance issued in February 2025, aiming for Board approval in autumn 2025.

Equality, Diversity and Inclusion (EDI)

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This includes Workforce Race Equality Standard Workforce Disability Equality Standard, Equality Impact Assessments and People Strategy objectives.

As indicated previously, one of the Trust's key strategic priorities is to support, develop and empower our staff by building an inclusive culture with a specific focus on anti-racism. However, we recognise that we need to do more to address inequality and health inequalities and we have an extensive work plan, which includes:

- delivering a senior leadership development programme tailored for line managers, the top 250 senior leaders, and board members. With anti-racism as a priority, focusing on developing inclusive leadership capabilities, raising awareness of systemic inequalities, and embedding EDI principles into leadership behaviours and decision-making
- developing an EDI communications and engagement plan that reaches both internal and external stakeholders ensuring consistent messaging, raising awareness of EDI initiatives, and encouraging engagement, transparency, and accountability across the organisation
- developing the maturity of staff networks and working together to co-create and action work across the Trust
- supporting clinical groups to embed inclusive practices and behaviours with associated action plans and accountability with clear governance by the Trust Board
- strengthening the numbers of Inclusion Agents across all directorates and teams to help raise awareness of best practice and offer peer to peer support and sign posting on equality, diversity and inclusion issues
- delivering a refreshed and inclusive end-to-end recruitment process with anti-racism as a priority. To include reviewing current practices, identifying and removing systemic barriers, and embedding inclusive principles at each stage of recruitment to attract and retain diverse talent
- undertaking a comprehensive review and update of processes related to workplace adjustments, ensuring they align with current best practices, legal requirements, and promote an inclusive and accessible working environment for all employees.

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

Key processes for efficient and effective use of resources

The Trust ensures economy, efficiency and effectiveness through a variety of means, including:

- a robust pay and non-pay budgetary control system
- a suite of effective and consistently applied financial controls
- effective tendering procedures
- robust establishment controls
- a risk-based programme of internal audits
- annual external audit
- continuous service and cost improvement and modernisation.

The Trust benchmarks efficiency in a variety of ways, including through the national reference costs index and by use of national benchmarking data, Getting It Right First Time and use of the 'Model Hospital' data sets. This is shared with directorates for use in business planning and to identify improvement opportunities. In addition, the Trust is developing a dedicated productivity domain, drawing on internal and external data, to better align activity, workforce, and financial opportunities. This builds on productivity indicators developed by NHS England as well as local metrics created by the Trust to drive evidence-based operational and financial improvements across the organisation.

The emphasis of internal audit work is on governance and internal control processes. Where scope for improvement is identified during an internal audit review, appropriate recommendations are made for operational implementation. The final internal audit reports, setting out the audit findings and recommendations, are subject to scrutiny by the Audit and Risk Committee.

Data quality and governance

The Quality and Assurance team work alongside the Performance and Information team as a single unit to ensure data provided to the Board is validated and accurate, with performance information being created and scrutinised by subject matter experts and those with the required analytical skills to do so. This includes the necessary governance and thorough oversight to produce and promote excellent data quality.

The Quality and Assurance teams collate data on a monthly basis from a variety of sources including Datix, SharePoint for policies, and local spreadsheets for topics such as National Institute for Health and Care Excellence (NICE) guidance compliance. A senior clinical analyst validates the data and issues the Trust Integrated Performance Report pack to users which supports effective data driven decision making with regards to the Trust's strategic priorities.

In some cases, data is owned by a governance committee, for example the Acutely Ill Patients Group is responsible for the collection and validation of data relating to the deteriorating patient and response times in relation to this. The group would also agree whether that data represented a good position or if improvement was needed.

The Trust has a number of policies and protocols describing the desired outcome or key performance indicators which assists the Trust Board in determining if they are assured by the data they are receiving. For example, the Trust's position relating to mortality outcomes is demonstrated by the Summary Hospital-Level Mortality Indicator and the Hospital Standardised Mortality Ratio which are benchmarked nationally to give Board members a clear picture of the Trust's performance in this area. A range of audits – internal and external – give assurance about the accuracy of data throughout the year.

The Trust's Quality and Performance Board Committee reviews all data and information relating to quality of care and patient experience, supported both by the standardised monthly Integrated Performance Report and other ad-hoc reports.

The Trust employs information assurance processes in the production of the monthly Integrated Performance Report, including local and Trust-wide validation of data and national benchmarking where available, including comparison against the Shelford Group average for all relevant metrics. The Integrated Performance Report is published as part of the Board papers and is available on the Trust's website.

Regular audits are undertaken on the quality of waiting list data, and themes as well as actions for services to improve are fed back and actioned through the formal monthly reporting cycles.

We are aiming to optimise the use of the Epic system to support the delivery of the Trust's strategic and operational planning priorities by capitalising on the opportunities the new system affords the organisation. A series of opportunities have been identified to support more effective utilisation of outpatient capacity including new Epic waiting list validation functionality, patient self-scheduling utilising "fast-pass" functionality, that offers a more effective approach to managing patient appointments, enhanced clinical decision support to reduce unnecessary interventions for patients, and ambient Artificial Intelligence that aims to reduce clinical documentation and administration for clinicians. In addition to this there is an opportunity to tackle highly repetitive administrative processes and to in turn be more efficient by striving for more automation and self-service support in Epic. All of these opportunities aim to offer greater efficiencies and to in turn allow for more effective management of patient pathways, to offer better

utilisation of clinical and administrative resource, and to ultimately improve patient care and help deliver the Trust's commitment to reducing waiting lists and improving productivity overall.

The focus throughout 2024/25 on data quality and assurance supported by clear and effective governance has supported the Trust in meeting its ambition of delivering a financial surplus position, despite the challenging year faced with significant disruptions including the Synnovis critical incident, and making significant gains across the operational performance standards by year-end including large reductions in the number of patients waiting for routine treatment.

Additional impactful and supportive governance arrangements established in 2024/25 that the Trust will build upon in 2025/26 and beyond to allow for effective delivery against its strategic priorities include a new Elective Recovery Board and the creation of a productivity programme that aims to support the Trust's need to increase organisational productivity and reach the ambition of financial sustainability noting the challenging financial climate in which we operate while improving timeliness and striving for equitable access for all.

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 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 and Risk Committee and the Quality and Performance Board Committee, and plans to address weaknesses and ensure continuous improvement of the system are in place.

Processes for maintaining and reviewing the system of internal control

The Board

The Board and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and procedures and monitoring of outcomes agreed as indicators of effective controls.

Through its committees, the Board regularly reviews reports on operational performance which include key national priority and regulatory indicators with additional sections devoted to safety, clinical effectiveness and patient experience. These reports are supported by more granular reports reviewed by Board committees, regular executive review meetings, and performance review meetings between the Trust executive team and executive teams from each of the clinical and delivery groups.

Audit and Risk Committee

The Audit and Risk Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance and internal financial control within the Trust. The Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements.

In May 2025 the Audit and Risk Committee agreed that the cyber-attack perpetrated against Synnovis, the provider of the Trust's pathology services on 3 June 2024, was not a significant internal control weakness. This is consistent with the disclosure in the Annual Governance Statement for the 2023/24 Annual Report and Accounts.

Quality and Performance Committee and Trust Risk and Assurance Committee

The Quality and Performance Committee is a sub-committee of the Board of Directors and provides assurance through monitoring and reviewing the overall quality, safety and performance of services against national standards and the monitoring of in-year financial performance.

The Trust Risk and Assurance Committee reports to the Trust Executive Committee, which, in turn, reports to the Trust Board – primarily through it's Quality and Performance, and Audit and Risk committees – and ensures that appropriate governance systems and processes are in place to monitor any risk to the delivery of high quality, safe patient care, and the effectiveness of our risk management policies. The Trust Risk and Assurance Committee considers risks escalated from clinical and delivery groups and corporate directorates for inclusion on the corporate risk register. These risks can be high scoring or outside of local management control that require enhanced mitigation and oversight. The Trust Risk and Assurance Committee oversees the corporate risk register ensuring that it is maintained, monitored and reviewed as appropriate.

The Risk and Assurance department, within the Office of the Chief Medical Officer, supports the Trust Risk and Assurance Committee in their role and is responsible for:

- facilitating and overseeing the running of the Trust's corporate risk register
- producing regular risk reports to create awareness of key risks, improve accountability for the management of risk and timely completion of risk mitigation plans
- providing training and materials to support the implementation of this policy
- providing expert support and advice to clinical groups / directorates through regular risk forums and meetings
- continuously improving this policy and its supporting strategic framework.

Internal audit

Internal audit works to a risk-based audit plan, agreed by the Audit and Risk Committee. Its remit covers risk management, governance and internal control processes, both financial and non-financial, across the Trust. The work includes identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards.

A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are issued to and followed-up with the responsible executive directors, and the results of audit work and all recommendations arising are reported to the Audit and Risk Committee, which also tracks the subsequent implementation of the recommendations.

Internal audit reports are also made available to the external auditors, who may use these to inform their annual opinion. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. The internal audit team also provides an anti-fraud service to the Trust.

Internal audit work also covers service delivery and performance, financial management and control, human resources, operational and other reviews. Based on the work undertaken, including a review of the Trust's Board Assurance Framework process, the Head of Internal Audit opinion concluded as follows:

"I have considered all of the work conducted by internal audit and counter fraud staff covering the period 1 June 2024 to the date of this opinion. Internal Audit set out a work plan in June 2024 and has completed 29 projects and there has been sufficient coverage of key systems to enable me to form an opinion.

There were no limitations placed on the scope of internal audit work and the service operated in accordance with the Audit Charter, which was refreshed in February 2023.

I have considered all reactive investigations and proactive work conducted by the Guy's and St Thomas' NHS Foundation Trust local counter fraud specialists. This includes oversight of all fraud investigations and personal conduct of specific enquiries during the year.

Generally, there is a sound system of control within the key financial systems. In relation to operational/other systems the balance of limited to substantial assurance opinions has deteriorated in 2024/25 when compared to previous years. These are, primarily, new areas of internal audit activity or which have not been subject to a review for some time and, in many instances, management were already aware of issues within the function/area. However, some areas have been reviewed before and there has been no improvement in the level of assurance.

I am satisfied that the Board Assurance Framework contains the key risks faced by the organisation and that the Board and relevant responsible committee has effective oversight of the key risks.

I confirm that I have monitored compliance with the Public Sector Internal Audit Standards. In my view, Internal Audit complies with those standards that are applicable to the public sector and compliance was independently assessed in 2021 as generally compliant."

Simon Lane CIPFA, Associate Director of Finance, 18 June 2025

Clinical audit

The Trust's Quality Improvement and Clinical Audit committee meets bimonthly with a focus on clinical groups to share the detail of the clinical audits they have completed and in progress. For the areas that do not sit directly into a clinical group they report assurance once a year on their clinical audit and quality improvement activity.

Trust-wide priority audits are discussed at every committee meeting, based on a schedule developed from risks on the corporate risk register, changes to CQC or regulatory models, or if a theme is identified through quality assurance monitoring. National audit reports are shared back to the clinical groups and feedback collected from the participating clinicians on how and if we need to change the processes in the Trust as a result of the audits' recommendations.

The Quality Improvement and Clinical Audit committee reports quarterly to Trust Risk and Audit Committee and focuses on clinical group assurance per report with an update of the published audits and reports from the Healthcare Quality Improvement Partnership and the National Confidential Enquiry into Patient Outcome and Death and the impact of work for the Trust. Each clinical directorate is encouraged to produce and deliver on its annual audit plan that must include relevant national audits and Trust-wide audits, local audits that are critical for quality monitoring and assurance such as infection prevention, cleanliness and any other clinical audit the directorate identifies for quality monitoring.

Work is ongoing to enhance the extraction and data quality from the new electronic health record system into 2025/26, with national audit leads liaising with respective national audit partners whilst this data reporting from Epic is optimised.

To the best of my knowledge no significant issues have been identified in 2024/25. I am confident that the internal control systems are operating well and that the work we have done to maintain and develop our risk management systems will help us to consolidate this position in the future. The Trust is committed to the continuous improvement of the processes of internal control and assurance. A review of the processes and systems that ensure the completeness, effectiveness and accuracy of the Trust's Board Assurance Framework and risk management processes by internal audit concluded that there is substantial assurance overall.

Professor Ian Abbs
Chief Executive Officer
25 June 2025

New Progress Pride Badges, funded by Guy's & St Thomas' Charity, have been introduced across the Trust as a way for our staff to show their commitment to LGBT+ inclusive healthcare.

10 Annual accounts

Foreword to the accounts

These accounts, for the year ended 31 March 2025, have been prepared by the Guy's and St Thomas' NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Professor Ian Abbs
Chief Executive Officer and Accounting Officer
25 June 2025

Independent auditor's report to the Council of Governors of Guy's And St Thomas' NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Guy's And St Thomas' NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2025, which comprise the consolidated statement of comprehensive income, the statements of financial position, the consolidated statement of changes in taxpayer's equity, the statement of changes in taxpayer's equity for the year ended 31 march 2025 and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2025 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and 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 group's and 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 group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the group's and 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 group and 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 group and the Trust and the group's 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 group's and 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 2024/25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024/25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

Responsibilities of the Accounting Officer

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

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and 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 and the group without the transfer of their 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 group and the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit and risk committee, concerning the group's and 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 group and 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, the propensity of externally set financial targets to influence management's approach to revenue recognition and risk of fraud in expenditure completeness.
- We determined that the principal risks were in relation to unusual journals, year-end journals, accrual journals, potential management bias in relation to accounting estimates, and critical judgements. 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 unusual journals, as deemed appropriate by the audit team, year-end journals, post year end journals, and accrual journals;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations 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 potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to land and building valuations, intangible asset valuation. 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 group and Trust audit team members included consideration of their:
  - 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 group and the Trust operates
  - understanding of the legal and regulatory requirements specific to the group and 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 group's and 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, financial statement consolidation process, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group's and the Trust's control environment, including the policies and procedures implemented by the group and the Trust to ensure compliance with the requirements of the financial reporting framework.

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

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

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

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

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

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

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

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

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

We cannot formally conclude the audit and issue an audit certificate for Guy's And St Thomas' NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have 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 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

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

Grant Thornton UK LLP

Joanne Brown, Key Audit Partner
for and on behalf of Grant Thornton UK LLP

London
27 June 2025

Consolidated statement of comprehensive income for the year ended March 31 2025

		March 31 2025	March 31 2024
	NOTE	**£000**	£000
Operating income from patient care activities	3	**2,842,690**	2,546,567
Other operating income	4	**327,945**	345,110
TOTAL INCOME		**3,170,635**	2,891,677
Operating expenses	7.1	**(3,157,314)**	(2,958,066)
OPERATING SURPLUS / (DEFICIT)		**13,321**	(66,389)
FINANCE COSTS			
Finance income	10	**7,599**	6,913
Finance expenses	11	**(6,939)**	(6,828)
Public Dividend Capital charge	35	**(40,494)**	(39,251)
Net finance costs		**(39,834)**	(39,166)
Other gains/(losses)	9	**1,051**	(3,590)
Share of profit/(loss) of associates/joint ventures	19.1	**75**	(395)
Corporation tax (expense)		**(118)**	(529
(DEFICIT)/SURPLUS FOR THE YEAR		**(25,505)**	(110,069)
Other comprehensive (expense)/income			
Impairments	15	**(6,909)**	(50,708)
Revaluations	18	**19,843**	17,650
Other		**–**	(2,150)
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(12,571)**	(145,277)

The notes on pages 96 to 133 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Note 12 includes the Trust's analysis of performance.

Statement of financial position as at March 31 2025

		GROUP		TRUST	
		March 31 2025	March 31 2024	**March 31 2025**	March 31 2024
	NOTE	**£000**	£000	**£000**	£000
NON-CURRENT ASSETS					
Intangible assets	14	**125,458**	151,998	**125,458**	151,998
Property plant and equipment	13	**1,624,390**	1,603,268	**1,624,376**	1,603,234
Right of use assets	16	**163,736**	157,642	**163,719**	157,320
Investment property	17	**71,783**	71,548	**71,783**	71,548
Investments in joint ventures and associates	19.1	**1,235**	1,475	**2,050**	2,305
Other investments/financial assets	20	**1,268**	479	**10,804**	10,080
Trade and other receivables	22.2	**8,221**	15,220	**8,221**	6,858
TOTAL NON-CURRENT ASSETS		**1,996,091**	2,001,630	**2,006,411**	2,003,343
CURRENT ASSETS					
Inventories	21	**49,516**	50,730	**49,516**	50,730
Receivables	22.1	**217,424**	223,838	**205,748**	218,792
Cash and cash equivalents	25	**190,734**	89,863	**185,808**	86,478
TOTAL CURRENT ASSETS		**457,674**	364,431	**441,072**	356,000
CURRENT LIABILITIES					
Trade and other payables	23.1	**(404,274)**	(390,774)	**(403,193)**	(388,508)
Borrowings	23.3	**(40,630)**	(39,341)	**(40,628)**	(39,337)
Other liabilities	23.2	**(40,214)**	(43,561)	**(40,086)**	(43,388)
Provisions	24.1	**(1,703)**	(5,658)	**(1,703)**	(5,658)
TOTAL CURRENT LIABILITIES		**(486,821)**	(479,334)	**(485,610)**	(476,891)
NON-CURRENT LIABILITIES					
Borrowings	23.3	**(273,403)**	(287,086)	**(273,389)**	(286,659)
Provisions	24.1	**(12,362)**	(12,639)	**(12,362)**	(12,639)
TOTAL NON-CURRENT LIABILITIES		**(285,765)**	(299,725)	**(285,751)**	(299,298)
TOTAL ASSETS EMPLOYED		**1,681,179**	1,587,002	**1,676,122**	1,583,154
TAXPAYERS' EQUITY					
Public Dividend Capital		**768,011**	661,263	**768,011**	661,263
Revaluation reserve	18	**540,494**	529,138	**540,494**	529,138
Other reserves		**743**	743	**743**	743
Income and expenditure reserve		**371,931**	395,858	**366,874**	392,010
TOTAL TAXPAYERS' EQUITY		**1,681,179**	1,587,002	**1,676,122**	1,583,154

Professor Ian Abbs
Chief Executive Officer and Accounting Officer
25 June 2025

Consolidated cash flow statement for the year ended March 31 2025

	NOTE	GROUP		TRUST	
		March 31 2025	March 31 2024	**March 31 2025**	March 31 2024
		£000	£000	**£000**	£000
Cash flows from operating activities					
Operating surplus / (deficit) from continuing operations		**13,321**	(66,389)	**11,180**	(66,919)
Non-cash income and expenses					
Depreciation and amortisation	7.1	**122,770**	100,842	**122,452**	100,511
Impairments and reversals of impairments	15	**21,231**	107,792	**21,231**	107,792
Income recognised in respect of capital donations		**(455)**	(5,976)	**(455)**	(5,976)
Decrease in trade and other receivables		**12,745**	16,442	**10,411**	16,465
Decrease / (Increase) in inventories		**1,214**	(2,715)	**1,214**	(2,715)
(Decrease) in other liabilities		**(3,347)**	(24,986)	**(3,302)**	(24,618)
(Decrease) / Increase in trade and other payables		**(847)**	(16,699)	**337**	(16,949)
(Decrease) / Increase in provisions		**(4,398)**	2,592	**(4,398)**	2,592
Corporation tax paid		**(243)**	(369)	**–**	–
Other movements in operating cash flows		**1,594**	(4,384)	**2,484**	(3,904)
NET CASH GENERATED FROM OPERATING ACTIVITIES		**163,585**	106,150	**161,154**	106,279
Cash flows from investing activities					
Interest received	10	**7,599**	6,913	**7,563**	6,913
Purchase of financial assets	20	**(986)**	(333)	**–**	(225)
Proceeds from settlements of financial assets	19.1	**315**	180	**255**	1,400
Purchase of intangible assets		**(5,499)**	(57,213)	**(5,499)**	(57,213)
Purchase of property, plant and equipment		**(85,366)**	(75,062)	**(85,366)**	(75,062)
Proceeds from sale of property, plant and equipment		**937**	–	**937**	–
Receipt of cash donations to purchase capital assets		**455**	5,865	**455**	5,865
NET CASH USED IN INVESTING ACTIVITIES		**(82,545)**	(119,650)	**(81,655)**	(118,322)
Cash flows from financing activities					
Public Dividend Capital received		**106,748**	68,117	**106,748**	68,117
Movement in loans from the Department of Health and Social Care (DHSC	23.4	**(17,009)**	(18,134)	**(17,009)**	(18,134)
Capital element of lease liability repayments	23.4	**(23,384)**	(26,312)	**(23,384)**	(26,312)
Capital element of service concession payments	23.4	**(284)**	(296)	**(284)**	(296)
Interest paid on DHSC loans	23.4	**(4,595)**	(5,011)	**(4,595)**	(5,011)
Other interest	11	**(366)**	(189)	**(366)**	(189)
Interest element of lease liability repayments	23.4	**(1,933)**	(1,562)	**(1,933)**	(1,562)
Interest element of service concession obligations	23.4	**(95)**	(107)	**(95)**	(107)
Public Dividend Capital paid		**(39,251)**	(43,903)	**(39,251)**	(43,903)
NET CASH GENERATED FROM FINANCING ACTIVITIES		**19,831**	(27,397)	**19,831**	(27,397)
Net (decrease) in cash and cash equivalents		**100,871**	(40,897)	**99,330**	(39,440)
Cash and cash equivalents at April 1		**89,863**	130,760	**86,478**	125,918
Cash and cash equivalents at March 31	25	**190,734**	89,863	**185,808**	86,478

Statement of changes in taxpayers' equity

GROUP 2024/25	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2024	661,263	529,138	743	395,858	**1,587,002**
Deficit for the year	–	–	–	(25,505)	**(25,505)**
Net Impairments	–	(6,909)	–	–	**(6,909)**
Revaluations – property, plant and equipment	–	19,248	–	–	**19,248**
Revaluations – right of use assets	–	595	–	–	**595**
Transfer to retained earnings on disposal of assets	–	(1,578)	–	1,578	**–**
Public Dividend Capital received	106,748	–	–	–	**106,748**
Taxpayers' equity as at March 31 2025	**768,011**	**540,494**	**743**	**371,931**	**1,681,179**

GROUP 2023/24	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2023	593,146	564,338	743	505,935	**1,664,162**
Deficit for the year	–	–	–	(110,069)	**(110,069)**
Net Impairments	–	(50,708)	–	–	**(50,708)**
Revaluations – property, plant and equipment	–	16,782	–	–	**16,782**
Revaluations – Intangible	–	11	–	–	**11**
Revaluations – right of use assets	–	857	–	–	**857**
Other	–	(2,142)	–	(8)	**(2,150)**
Public Dividend Capital received	68,117	–	–	–	**68,117**
Taxpayers' equity as at March 31 2024	**661,263**	**529,138**	**743**	**395,858**	**1,587,002**

TRUST 2024/25	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2024	661,263	529,138	743	392,010	**1,583,154**
Deficit for the year	–	–	–	(26,714)	**(26,714)**
Net Impairments	–	(6,909)	–	–	**(6,909)**
Revaluations – property, plant and equipment	–	19,248	–	–	**19,248**
Revaluations – right of use assets	–	595	–	–	**595**
Transfer to retained earnings on disposal of assets	–	(1,578)	–	1,578	**–**
Public Dividend Capital received	106,748	–	–	–	**106,748**
Taxpayers' equity as at March 31 2025	**768,011**	**540,494**	**743**	**366,874**	**1,676,122**

TRUST 2023/24	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2023	593,146	564,338	743	500,784	**1,659,011**
Deficit for the year	–	–	–	(108,774)	**(108,774)**
Net Impairments	–	(50,708)	–	–	**(50,708)**
Revaluations – property, plant and equipment	–	16,782	–	–	**16,782**
Revaluations – intangible	–	11	–	–	**11**
Revaluations – right of use assets	–	857	–	–	**857**
Other	–	(2,142)	–	–	**(2,142)**
Public Dividend Capital received	68,117	–	–	–	**68,117**
Taxpayers' equity as at March 31 2024	**661,263**	**529,138**	**743**	**392,010**	**1,583,154**

Notes to the accounts

1 Accounting policies

1.1 Basis of preparation of the financial statements

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Going concern

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

1.2 Basis of consolidation

The group financial statements consolidate the financial statements of the Trust and all of its subsidiary undertakings made up to the year ended 31 March 2025 and incorporate its share of the results of joint ventures and associates using the equity method of accounting. Subsidiary accounts have been prepared on a going concern basis.

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries have been consolidated in full into the appropriate financial statement lines and group financial statements have been prepared.

The subsidiaries are consolidated from the date on which control is obtained by the Group and cease to be consolidated from the date on which control is no longer held by the Group. Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where differences are material. Inter-entity balances, transactions, unrealised profits arising from intra-group transactions and gains/losses are eliminated in full on consolidation.

The Trust has the following wholly owned trading subsidiaries: Guy's and St Thomas' Enterprises Limited; Pathology Services Limited and; Lexica Health and Life Sciences Consultancy Limited. The accounts for these companies have been consolidated into the group accounts. The Trust has one wholly owned dormant subsidiary.

In accordance with the DHSC GAM 2024/25 a separate Statement of Comprehensive Income for the parent (the Trust) has not been presented by the directors.

All notes in the accounts refer to the Group. The Trust notes are included only where they are deemed to be materially different.

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statements using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution is received from the associate. e.g. share dividends are received by the Trust from the associate.

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where the trust has the rights to the net assets of the arrangements. Joint ventures are accounted for using the equity method.

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement.

1.3 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.

Standard credit terms are 30 days and so payments are expected within one month after satisfying the performance obligations.

1.3.1 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

During 2024/25 the Trust also receives income from commissioners for Best Practice Tariff (BPT) schemes. Delivery under these schemes 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 is accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts. BPT earned on elective activity is included in the variable element of API Contracts and paid in line with actual activity performed. Adjustments for income for the achievement of Commissioning for Quality Innovation (CQUIN) do

not apply in 2024/25, but did during 2023/24.

Where the relationship with a particular integrated care board is expected to be a low volume of activity, 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.

1.3.2 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.

1.3.3 NHS injury cost recovery scheme

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

1.3.4 Other forms of income

Grants and donations

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

Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Revenue from education and training

Health Education England provide funding to maintain education and training capacity, retain students on education and training programmes, and enable students to provide their skills to the NHS to support the response. Income is recognised in line with the requirements of IFRS 15. Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligation.

1.4 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.

1.5 Pension costs

NHS Pension Scheme

Most 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. The contributions are charged to operating expenses as and when they become due.

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.

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.

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost

cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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

NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme. NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme. The employer's contribution rate in 2024/25 was 3% (2023/24: 3%).

1.6 Expenditure on 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.

1.7 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
- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

HM Treasury adopts a standard approach to depreciated replacement cost valuations using a modern equivalent asset basis, and, where it would meet the location requirements of the service being provided, an alternative site can be valued. As at 31st March 2016 a valuation using an alternative site basis was carried out for the first time on assets on the Guy's and St Thomas' Estate. See Note 1.25 for proposed changes to non current asset valuations in future periods.

Land and buildings (including Investment properties) are valued by an independent registered chartered surveyor on a regular basis and in accordance with Royal Institution of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect fair value. As at 31 March 2025 land and buildings for the full Trust estate were valued by Gerald Eve. The same valuer was used in the valuation of the estate at 31 March 2024. Enhancements to leasehold properties are valued at historic cost.

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, with subsequent revaluation on an annual basis.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

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 economic lives in a manner consistent with the consumption of economic or service delivery benefits.

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

- Buildings, 3-72 years
- Dwellings, 24-39 years
- Plant and machinery, 2-20 years
- Transport equipment, 7 years
- IT hardware, 2- 20 years
- Furniture and fittings, 4-15 years.

Buildings and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the professional valuer. The Trust revalues its estates on an annual basis. This has the impact that the useful life for buildings may vary subtly year on year.

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' ceases to be depreciated upon the reclassification. Assets in the course of construction 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 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 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 all of the following criteria from IFRS 5 are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped

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, government grant and other grant funded assets

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

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

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

1.8 Intangible fixed assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets are capitalised when: they are capable of being used in the Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

They are recognised only where it is probable that the future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised

Expenditure on development is capitalised when it meets the requirements set out in IAS 38 only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Trust intends to complete the asset and sell or use it;
- The Trust has the ability to sell or use the asset;
- How the intangible asset will generate probable future economic or service delivery benefits e.g. The presence of a market for it or its output, or, where it is to be used for internal use, the usefulness of the asset
- Adequate financial, technical and other resources are available to the Trust to complete the development and sale or use the asset; and
- The Trust can measure reliably the expenses attributable to the asset during development.

Software

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

Measurement

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

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

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

Amortisation

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

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

- Information technology / development expenditure 2 - 15 years
- Software licences and trademarks, 2 - 15 years.

1.9 Investment property

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held to generate a commercial return, or capital appreciation, or both are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

1.10 Heritage artefacts and archives

The Trust reviews heritage artefacts in accordance with FRS 102-Heritage Assets. Where there is an open market, such assets will be valued at market value, assets with no marketable value will be held at replacement cost.

Where it is impossible to establish a value by either of these methods, the Trust will consider other valuation methodologies such as insurable value, otherwise the asset will be held at nil value but disclosed as a note to the accounts.

Further information on the acquisition, disposal, management and preservation of the Trust's heritage asset as required by FRS 102 can be found in the notes to the financial statements.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using weighted average cost.

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

1.12 Cash and cash equivalents

Cash is cash-in-hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.13 Public Dividend Capital

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

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

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

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

1.14 Value Added Tax

Most of the activities of the NHS Foundation 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 tax is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A)(3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non public sector source.

The tax expense on the surplus or deficit for the year comprises current and deferred tax due to the Trust's trading commercial subsidiaries. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided using the balance sheet liability method, providing for temporary differences between the carrying amounts of the assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not recognised on the taxable temporary differences arising on the initial recognition of good will or for temporary differences arising from the initial recognition of assets and liabilities in a transaction that is not a business combination and that affects neither accounting nor taxable profit.

Deferred taxation is calculated using rates that are expected to apply when the related deferred tax asset is realised or the deferred taxation liability is settled. Deferred tax assets are recognised only to the extent that it is probable that future taxable profits will be available against which the assets can be utilised.

1.16 Other reserves

The other reserves balance of £743k was created by a technical accounting adjustment when the original NHS Trust was created in 1993.

1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised as income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.18 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 and liabilities are classified as subsequently measured at amortised cost and fair value through income and expenditure.

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 expenses. 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 and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

De-recognition

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

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

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from market prices.

Impairment of financial assets

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

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

Expected credit losses are estimated via a provision matrix that assigns differing percentages and timings in terms of categories of debt. These are based on an assessment of: past performance, current/future market and general economic conditions and any other considerations relevant to specific categories of debtor.

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.

1.19 Leases

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

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

1.19A The Trust as lessee

Recognition and initial measurement

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

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

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

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use

or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

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

1.19B The Trust as lessor

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

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

Finance leases

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

Operating leases

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

1.20 Provisions and contingencies

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025 between the range of 4.03% to 4.81%. Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

The NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Resolution which in return settles all clinical negligence claims. Although the 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 the NHS Resolution on behalf of the Trust is disclosed in the notes to the Statement of Comprehensive Income 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 the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excess' payable in respect of particular claims, are charged to operating expenses as and when the liability arises.

Commercial insurance

In addition to the NHS Resolution Property Expenses and Liabilities to Third Parties Schemes, the Trust also holds commercial insurance. The annual premium is charged to operating expenses.

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 the Contingencies note where an inflow of economic benefits is probable.

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

- possible obligations arising from past events, the existence of which 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 obligation cannot be measured with sufficient reliability.

1.21 Third party assets

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

1.22 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 accruals basis with the exception of provisions for future losses.

1.23 Gifts

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

1.24 Early adoption of standards, amendments and interpretations

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

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

IAS 8 requires that the impact of accounting standards that have been issued, but are not yet effective, is disclosed.

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

IFRS 17 Insurance Contracts

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

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

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

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

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £1,365m as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £1,057m at 31 March 2025. The revised valuation assumption may have a material or significant impact on PPE measurement in future periods

1.26 Critical judgements in applying accounting policies

The Trust has made critical judgements in relation to the modern equivalent asset revaluation assumption as at 31 March 2025.

The Trust's valuers, Gerald Eve LLP, carried out a professional valuation of the modern equivalent asset (MEA) required to have the same productive capacity and service potential as existing Trust assets. Through discussion with Gerald Eve, the Trust has considered where its four principal hospitals could be theoretically relocated whilst still delivering the same service delivery. For Harefield, which is located in a reasonably economic location no specific alternative site assumption was made. For Guy's, St Thomas' and Royal Brompton, which are all located in very high value locations, the Trust and Gerald Eve have continued to adopt the same hypothetical alternative site assumptions as previously, that is: for Guy's and St Thomas', a hypothetical alternative site located in the northern half of Lambeth; and for Royal Brompton, a hypothetical alternative site within the adjoining borough of Hammersmith & Fulham. Valuations have been prepared on the basis that the Trust cannot recover VAT on new non-domestic buildings but is able to recover VAT on professional fees associated with construction work. There are a number of additional assumptions that feed into the overall valuation such as gross internal area assumptions for the MEA.

To guide the land values the valuer has obtained details of further land sales across Greater London that have occurred since they last reported and have considered the extent to which these might indicate either a clear positive or negative movement in land pricing. They have highlighted that there continues to be limited new land transactions over the last year. These transactions, together with those considered for the previous year and indicators of general market sentiment, in the round indicate that land values have stabilised following improved finance rates and reduced construction cost inflation. This assumption drives the relatively small change in land values as seen in Note 13.1.

The Trust has deemed that, apart from those involving estimations (see 1.27), no additional disclosures in relation to critical judgements are required with regard to significant effects on the amounts recognised in the financial statements when applying the Trust's accounting policies.

1.27 Sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an ongoing basis.

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:

1) Valuation of land and buildings

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

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

The Trust seeks professional advice from its valuers annually in determining the value of its land and buildings. The Trust based the valuation of land and buildings in 2024/25 and 2023/24 on the views of Gerald Eve for the combined Guy's and St Thomas' and Royal Brompton and Harefield sites. The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer exercised his professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact on the valuation.

The recent introduction of global trade tariffs, alongside other geo-political factors, have increased volatility and uncertainty in global investment markets. The impact of this and a potential further escalation in tariffs could have a detrimental impact on the UK property markets. There is currently a lack of transactions which reflect the current investment and funding environment and as such the valuation may carry a greater degree of uncertainty than would be the case under more stable economic conditions. However, despite the conditions in the prevailing market, the March 2025 valuation is not reported as being subject to material valuation uncertainty as defined by VPS 3 and VPGA 10 of the RICS Valuation - Global Standards.

The net book value at 31 March 2025 of the Trust's property plant and equipment valued by professional valuers and reflected in these financial statements is £1,332,126k (£1,323,176k at March 2024)

There are a number of inputs into the valuation model that could change in either direction such as land values, making it difficult to predict the future impact on the Trust's balance sheet. For illustrative purposes only, a 5% change in the net book value would adjust the balance sheet by approx. £66,606k. The impact of any movement would be split across the Statement of Comprehensive Income and Revaluation Reserve.

The Trust makes a number of other estimates in its financial statements which are not considered to be subject to a material uncertainty.

2 Segmental reporting

From 1 April 2022, the Trust's Operating Model has been structured under 4 large clinical groups and 1 delivery group: Evelina London Women's and Children's Services; Integrated and Specialist Medicine; Cancer and Surgery; Heart, Lung and Critical Care; and Essentia.

For the purposes of reporting however, the Trust currently operates as a single reportable operating segment, which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure in place during 2024/25. The Board of Directors, led by the Chair and Chief Executive (the latter as the chief operating decision maker within the Trust) receives reports of consolidated revenues and expenditure and assesses the overall financial and operational performance of the Trust.

The chief mechanism for financial management and control is a detailed budget report and forecast prepared at account code level each month. An aggregated summary budget is presented by the Chief Financial Officer to the agreed Board and Committee meetings during the year. This report is made available to the public at the quarterly Board meetings and via the Trust's public website.

3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

3.1 Income from patient care activities (by source)

	Year ended March 31 2025 £000	Year ended March 31 2024 £000
NHS England	**1,429,873**	1,345,876
Integrated Care Boards	**1,282,261**	1,087,580
Other NHS providers	**7,894**	5,421
NHS other	**8,376**	3,876
Local authorities	**20,123**	20,045
Non-NHS: private patients	**69,883**	73,683
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	**4,404**	6,596
Injury cost recovery scheme	**1,534**	1,231
Non-NHS: other	**18,342**	2,259
Total income from patient care activities	**2,842,690**	2,546,567
Of which:		
Related to continuing operations	**2,842,690**	2,546,567
Related to discontinued operations	**–**	–

3.2 Income from patient care (by nature)

	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Acute services		
Income from commissioners under API contracts*	**1,944,125**	1,747,572
High cost drugs and devices income from commissioners (excluding pass-through costs)	**389,786**	378,759
Other NHS clinical income**	**150,254**	125,351
Community services		
Income from commissioners under API contracts*	**138,798**	132,378
Income from other sources (eg local authorities)	**20,123**	20,045
All services		
Private patient income	**69,883**	73,683
National pay award central funding***	**5,471**	1,147
Additional pension contribution central funding****	**99,970**	62,315
Other clinical income	**24,280**	5,317
	2,842,690	2,546,567

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024/25 NHS Payment Scheme documentation. www.england.nhs.uk/pay-syst/nhs-payment-scheme

** For categories that fall outside of Elective and Non-elective inpatients, First and Follow up outpatient, A&E and High cost drugs income categories these are included within Other NHS Clinical income.

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

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

Prior year numbers have been represented to move £78m of income from 'Income from commissioners under API contract' to 'High cost drugs and devices'. This is to maintain consistency with the treatment of devices income in the current year.

3.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, 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:

	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Income from services designated as commissioner requested services	**2,748,527**	2,462,798
Income from services not designated as commissioner requested services	**94,163**	83,769
	2,842,690	2,546,567

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

	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Income recognised this year	**4,404**	6,596
Cash payments received in-year	**1,667**	1,652
Amounts added to provision for impairment of receivables	**3,278**	5,764
Amounts written-off in-year	**5,658**	2,012

4 Other operating income (Group)

	NOTE	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Other operating income from contracts with customers:			
Research and development		**82,753**	74,864
Education, training and research		**84,414**	80,631
Non-patient care services to other bodies		**40,908**	47,111
Income in respect of staff recharges		**7,886**	7,995
Other income*		**84,563**	101,026
Other non-contract operating income:			
Research and development		**–**	1,319
Peppercorn leased assets		**–**	111
Education and training – notional income from apprenticeship fund		**2,785**	2,070
Contributions to expenditure – consumables (inventory) donated from DHSC group bodies for COVID response		**–**	450
Charitable and other contributions to expenditure and capital assets		**8,866**	17,300
Operating leases – minimum lease receipts	6.1	**15,770**	12,233
		327,945	345,110

*Other income includes: £21m classified as facilities and services income (£22m 23/24), £17m from clinical tests (£16m 23/24), £10m from income generated by Lexica (£13m 23/24), £5.5m from clinical excellence awards (£6m 23/24), £2.5m from accommodation rentals (£2.5m 23/24). The remaining comes from a range of income activities including income from commercial activities.

5 Additional income disclosures

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

	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Revenue recognised in the reporting period that was within deferred income: contract liabilities at the previous period end.	**41,992**	68,290

5.2 Transaction price allocated to remaining performance obligations

	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
Within one year (Note 23.2)	**36,413**	41,992
Total revenue allocated to remaining performance obligations	**36,413**	41,992

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

6 Operating leases - Trust as Lessor

This note discloses income generated in operating lease agreements where The Trust is the lessor.

6.1 Operating leases income (Group)

	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	**15,770**	12,233
	15,770	12,233

6. Future lease receipts (Group)

	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Future minimum lease receipts due:		
– not later than 1 year	**15,744**	8,464
– later than 1 year but not later than 2 years	**14,272**	8,355
– later than 2 years but not later than 3 years	**13,558**	8,031
– later than 3 years but not later than 4 years	**13,038**	8,090
– later than 4 years but not later than 5 years	**12,704**	6,819
– later than 5 years	**113,866**	79,055
	183,182	118,814

7 Operating expenses (Group)

7.1 Operating expenses comprise:

	NOTE	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Purchase of healthcare from NHS and DHSC bodies		**291**	7
Purchase of healthcare from non-NHS and non-DHSC bodies		**50,937**	53,248
Staff and executive directors costs	8	**1,783,633**	1,615,124
Remuneration of non-executive directors		**323**	355
Supplies and services – clinical (excluding drugs costs)		**418,025**	366,571
Supplies and services – general		**14,278**	12,469
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response		**–**	1,154
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		**398,139**	340,083
Inventories written down (net including drugs)		**292**	1,236
Consultancy		**122**	5,329
Establishment		**32,875**	40,423
Premises – business rates collected by local authorities		**16,891**	7,285
Premises – other		**164,907**	175,449
Transport – other (including patient travel)		**16,769**	20,035
Depreciation on property, plant and equipment and right of use assets	13.1 & 16	**102,319**	91,905
Amortisation	14.1	**20,451**	8,937
Impairments net of reversals	15	**21,231**	107,792
Credit loss allowance		**2,939**	7,122
Change in provisions discount rate		**8**	333
Audit services – statutory audit*		**337**	318
Internal audit – staff costs	8	**691**	566
Clinical negligence – amounts payable to NHS Resolution (premium)		**37,537**	36,306
Legal fees		**3,317**	1,632
Insurance		**2,152**	2,105
Research and development – non-staff		**23,874**	19,482
Education and training – non-staff		**9,846**	7,158
Education and training – notional expenditure funded from apprenticeship fund		**2,785**	2,070
Expenditure on short term leases (current year only)		**466**	992
Redundancy costs (staff costs)	8	**1,936**	8,374
Charges to operating expenditure for on-SoFP IFRIC 12 schemes on IFRS basis		**2,751**	1,832
Hospitality		**336**	269
Other losses and special payments – non-staff		**40**	(115)
Other**		**26,816**	22,220
		3,157,314	2,958,066

* Audit services - statutory audit, the figure is net of VAT. Of the total £337k audit fees (£318k 23/24), £73k (£72k 23/24) relates to fees charged for the audit of the subsidiaries, and £264k (£246k 23/24) on the statutory audit for the Group accounts.

** Other operating expenses largely includes expenditure on commercial activities and NHS Blood and Transplant

7.2 Other auditor remuneration

There were no payments made to our auditor for non-audit work in 2024/25 (2023/24 £6k relating to grant assurance services). These fees are listed net of VAT.

7.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2024/25 is £2million (2023/24 £2million).

8 Employee benefits (Group)

	Group	
	Year ended	Year ended
	March 31 2025 Total £000	March 31 2024 Total £000
Salaries and wages	**1,376,454**	1,269,715
Social security costs	**156,209**	148,414
Apprenticeship levy	**6,794**	6,513
Employer contributions to NHS Pensions	**152,884**	142,129
Pension cost – employer contributions paid by NHSE on provider's behalf (24/25: 9.4%, 23/24:6.3%)	**99,970**	62,315
Termination benefits	**1,936**	8,374
Temporary staff – agency and contract staff	**24,926**	31,633
Total gross staff costs	**1,819,173**	1,669,093
Recoveries in respect of seconded staff	**(12,762)**	(9,858)
Total staff costs	**1,806,411**	1,659,235
Of which:		
Costs capitalised as part of assets	**20,151**	35,171
Analysed into Operating Expenditure (note 7.1)		
Employee expenses – staff and executive directors	**1,783,633**	1,615,124
Redundancy	**1,936**	8,374
Internal audit costs*	**691**	566
Total employee benefits excluding capitalised costs	**1,786,260**	1,624,064

***** Internal audit costs are total costs incurred by the Trust. Income received in relation to providing internal audit services for other trusts is recorded separately within other income and not netted off within staff costs.

8.1 Retirements due to ill-health (Group)

During 2024/25 there were 12 early retirements from the Trust agreed on the grounds of ill-health (14 in the year ended March 31 2024). The estimated additional pension liabilities of these ill-health retirements is £1,579k (£2,058k in 2023/24). These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

9 Other gains and losses

	Group	
	Year ended	Year ended
	March 31 2025 £000	March 31 2024 £000
Loss on disposal of property, plant and equipment	**–**	(41)
Gain on disposal of property, plant and equipment	**1,131**	2
Gain on disposal of right of use assets	**7**	19
Loss on disposal of intangible assets	**(50)**	(2)
Loss on disposal of right of use assets	**(7)**	–
Loss on disposal of peppercorn leased assets	**(37)**	–
Total gains / (losses) on disposal of assets	**1,044**	(22)
Fair value gains/(losses) on investment properties	**235**	(3,586)
Fair value gains/(losses) on investments	**(197)**	–
(Losses)/gains on foreign exchange	**(31)**	18
Total other gains / (losses)	**1,051**	(3,590)

10 Finance income

	Group	
	Year ended	Year ended
	March 31 2025 £000	March 31 2024 £000
Interest on bank accounts	**7,599**	6,913
	7,599	6,913

11 Finance expenses

	Group	
	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Loans from the Department of Health and Social Care. (see note 23.6)	**(4,503)**	(4,931)
Interest on lease obligations	**(1,933)**	(1,575)
Finance costs on service concession arrangements	**(94)**	(108)
Unwinding of discounts on provisions	**(43)**	(25)
Other finance costs	**(366)**	(189)
Total finance expense	**(6,939)**	(6,828)

12 Trust performance – notes to the consolidated statement of comprehensive income

	Group	
	Year ended March 31 2025 £000	Year ended March 31 2024 £000
Total comprehensive income per SOCI	**(12,571)**	(145,277)
Less reserve movements in other comprehensive income/(expense)	**(12,934)**	35,208
Total comprehensive expense before reserve movements	**(25,505)**	(110,069)
Add back in year impairments and reversals of impairments relating to market valuations included in surplus above (see note 15.1)	**19,718**	105,657
DHSC capital equipment and inventory	**–**	704
Capital Donations and Peppercorn income	**(455)**	(5,976)
Adjust service concession (UK GAAP vs IFRS)	**13**	–
Add back loss recognised on peppercorn lease disposals	**37**	–
Add back depreciation on donated assets	**18,874**	11,590
Adjusted financial performance	**12,682**	1,906

The adjusted financial performance is the primary view which is used by the Board of Directors in assessing the performance of the Trust.

The Consolidated Statement of Comprehensive Income shows a deficit of £25,505k (2023/24 Deficit £110,069k) for the Group. When valuation based impairments, depreciation on donated assets, adjustments for capital donations and I&E movements associated with centrally procured inventory are adjusted for, the total surplus for the Group is £12,682k (2023/24 Surplus £1,906k).

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The unconsolidated deficit relating to the Foundation Trust for the year ended 31 March 2025 was £26,714k (2023/24 surplus of £108,774k).

13 Property, plant and equipment

13.1 Property, plant and equipment at 31/03/2025 comprises the following elements:

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	IT hardware	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1 2024	261,261	1,080,770	20,790	162,840	213,759	-	67,953	5,557	**1,812,930**
Additions purchased	-	5,069	4	86,860	5,673	-	62	504	**98,172**
Additions - Assets purchased from cash donations/grants	-	-	-	-	298	-	-	-	**298**
Impairments charged to operating expenses	-	(20,558)	-	(1,263)	-	-	-	-	**(21,821**)
Impairments charged to the revaluation reserve	(490)	(6,387)	-	-	-	-	-	-	**(6,877)**
Reversal of impairments credited to operating expenses	-	771	36	-	-		-	-	**807**
Revaluation to revaluation reserve	2,710	(14,735)	(625)	-	-	-	-	-	**(12,650)**
Reclassifications	-	61,613	-	(99,934)	24,780	1,500	23,305	23	**11,287**
Disposals	-	-	-	-	(16,744)	-	(4,803)	(2,603)	**(24,150)**
Cost or valuation at March 31 2025	**263,481**	**1,106,543**	**20,205**	**148,503**	**227,766**	**1,500**	**86,517**	**3,481**	**1,857,996**
Accumulated depreciation at April 1 2024	-	26,790	-	-	139,224	-	38,774	4,874	**209,662**
Provided during the year	-	34,319	1,562	-	26,573	54	16,643	207	**79,358**
Revaluation to revaluation reserve	-	(30,336)	(1,562)	-	-	-	-	-	**(31,898)**
Disposals	-	-	-	-	(16,149)	-	(4,777)	(2,590)	**(23,516)**
At March 31 2025	**-**	**30,773**	**-**	**-**	**149,648**	**54**	**50,640**	**2,491**	**233,606**
Net book value March 31 2025									
Owned - Purchased	188,931	843,413	19,650	144,822	68,039	1,446	31,507	972	**1,298,780**
On-SoFP Service Concession Arrangements	-	1,986	-	-	49	-	-	-	**2,035**
Owned - Donated / Granted	74,550	230,371	555	3,681	10,030	-	4,370	18	**323,575**
Total at March 31 2025	**263,481**	**1,075,770**	**20,205**	**148,503**	**78,118**	**1,446**	**35,877**	**990**	**1,624,390**

The reclassification line of Property, Plant and Equipment and Intangible Assets nets to zero across all notes. Additions to assets under construction may be moved between the tangible and intangible notes when assets are created causing an imbalance which nets to zero when all notes are viewed together.

A separate schedule for the Trust's property, plant and equipment has not been produced as the subsidiaries assets are considered immaterial.

Freehold and long leasehold properties occupied by the whole of the Guy's and St Thomas' NHS Foundation Trust estate were valued as at 31 March 2025 and 31 March 2024 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuations have all been prepared in accordance with the requirements of the RICS Valuation – Global Standards, the UK national standards, International Valuation Standards and IFRS. The valuations of specialised properties were derived using the Depreciated Replacement Cost (DRC) method, with other in-use properties reported on a Current Value in Existing Use basis. Further disclosures around the valuation are included in note 1.

a) Depreciated Replacement Cost (DRC)

The basis used for the valuation of specialised operational property for financial accounting purposes is Depreciated Replacement Cost (DRC). The RICS Standards at Appendix 4.1, restating International Valuation Application 1 (IVA 1) provides the following definition:

> **"The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."**

Those buildings which qualify as specialised operational assets, and therefore fall to be assessed using the Depreciated Replacement Cost approach, have been valued on a modern equivalent asset basis.

13.2 Property, plant and equipment at 31/03/2024 comprises the following elements:

GROUP AND TRUST	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	IT hardware £000	Furniture and fittings £000	Total £000
Cost or valuation at April 1 2023	**277,921**	**1,114,450**	**22,232**	**203,327**	**215,106**	**56,637**	**5,340**	**1,895,013**
Additions purchased	–	4,095	–	60,616	3,046	277	–	**68,034**
Additions – Assets purchased from cash donations/grants	–	175	–	4,827	151	–	–	**5,153**
Impairments charged to operating expenses	(640)	(65,238)	(22)	(1,614)	–	–	–	**(67,514)**
Impairments charged to the revaluation reserve	(12,900)	(35,108)	(974)	–	–	–	–	**(48,982)**
Reversal of impairments credited to operating expenses	–	2,511	–	–	–	–	–	**2,511**
Revaluation to revaluation reserve	–	(18,445)	(446)	1,135	(88)	(1,613)	–	**(19,457)**
Reclassifications	–	81,665	–	(105,451)	10,884	22,898	217	**10,213**
Disposals	–	–	–	–	(15,340)	(10,246)	–	**(25,586)**
Reclassification to Right of Use Asset	(3,120)	(3,335)	–	–	–	–	–	**(6,455)**
Cost or valuation at March 31 2024	**261,261**	**1,080,770**	**20,790**	**162,840**	**213,759**	**67,953**	**5,557**	**1,812,930**
Accumulated depreciation at April 1 2023	–	24,481	1	–	135,871	43,685	4,451	**208,489**
Provided during the year	–	33,851	693	–	19,864	8,124	425	**62,957**
Revaluation to revaluation reserve	–	(31,542)	(694)	–	(1,212)	(2,789)	(2)	**(36,239)**
Disposals	–	–	–	–	(15,299)	(10,246)	–	**(25,545)**
At March 31 2024	**–**	**26,790**	**–**	**–**	**139,224**	**38,774**	**4,874**	**209,662**
Net book value March 31 2024								
Owned – Purchased	187,571	821,109	20,247	158,248	62,806	29,130	647	**1,279,758**
On-SoFP PFI contracts and other service concession arrangements	–	2,235	–	–	98	–	–	**2,333**
Owned – Donated/Granted	73,690	230,636	543	4,592	11,630	50	36	**321,177**
Total at March 31 2024	**261,261**	**1,053,980**	**20,790**	**162,840**	**74,534**	**29,180**	**683**	**1,603,268**

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for the financial accounting purposes under IAS16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS 1.3 as:

> "The estimated amount for which a property should exchange on the date of the valuation between a willing buyer and a willing seller in an arm's-length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

c) Impairments

Impairments are charged to the revaluation reserve to the extent that the revaluation reserve holds a previous revaluation surplus for that asset. Thereafter, they are charged to operating expenses.

Some assets that increased in value in 2024/25 had an impairment charge to income and expenditure in prior years. For these assets the increase in value resulted in a reversal of the impairment charge from prior years, creating a credit that is contained within the "impairments net of reversals" in the Statement of Comprehensive Income.

14 Intangible assets

14.1 As at March 31 2025

GROUP AND TRUST	Software licences £000	Information technology £000	Assets under construction £000	Total £000
Cost April 1 2024	40,569	156,816	32,570	**229,955**
Additions purchased / internally generated	4,930	412	–	**5,342**
Additions – grants / donations of cash	24	–	133	**157**
Impairments charged to operating expenses	–	–	(250)	**(250)**
Reclassifications	839	9,786	(21,912)	**(11,287)**
Disposals / derecognition	(720)	(5,791)	–	**(6,511)**
Gross cost at March 31 2025	**45,642**	**161,223**	**10,541**	**217,406**
Amortisation April 1 2024	6,386	71,571	–	**77,957**
Provided during the year	4,651	15,800	–	**20,451**
Reclassifications	–	–	–	**–**
Disposals / derecognition	(693)	(5,767)	–	**(6,460)**
Amortisation at March 31 2025	**10,344**	**81,604**	**–**	**91,948**
Net book value March 31 2025	**35,298**	**79,619**	**10,541**	**125,458**
Purchased assets	35,204	79,227	10,541	**124,972**
Donated / granted assets	94	392	–	**486**
Total at March 31 2025	**35,298**	**79,619**	**10,541**	**125,458**

14.2 As at March 31 2024

GROUP AND TRUST	Software licences £000	Information technology £000	Development expenditure £000	Assets under construction £000	Total £000
Cost April 1 2023	11,092	91,680	17,848	133,022	**253,642**
Additions purchased / internally generated	124	8,393	–	47,984	**56,501**
Additions – grants / donations of cash	–	–	–	712	**712**
Impairments charged to operating expenses	–	(41,161)	–	(521)	**(41,682)**
Other impairments to revaluation reserve	–	(9)	–	(1,554)	**(1,563)**
Other adjustments to revaluation reserve	11	–	–	–	**11**
Reclassifications	33,020	121,688	(17,848)	(147,073)	**(10,213)**
Disposals / derecognition	(3,678)	(23,775)	–	–	**(27,453)**
Gross cost at March 31 2024	**40,569**	**156,816**	**–**	**32,570**	**229,955**
Amortisation April 1 2023	8,477	77,066	10,928	–	**96,471**
Provided during the year	1,579	7,358	–	–	**8,937**
Reclassifications	8	10,920	(10,928)	–	**–**
Disposals / derecognition	(3,678)	(23,773)	–	–	**(27,451)**
Amortisation at March 31 2024	**6,386**	**71,571**	**–**	**–**	**77,957**
Net book value March 31 2024	**34,183**	**85,245**	**–**	**32,570**	**151,998**
Purchased assets	34,087	84,838	–	21,550	**140,475**
Donated / granted assets	96	407	–	11,020	**11,523**
Total at March 31 2024	**34,183**	**85,245**	**–**	**32,570**	**151,998**

15 Impairments

15.1 Impairment of assets (Group and Trust)

	NOTE	March 31 2025 £000	March 31 2024 £000
Impairments charged to operating expenditure:			
Impairments arising from professional valuation (PPE)	13.1	**(20,558)**	(65,900)
Reversals of impairments arising from professional valuation (PPE)	13.1	**807**	2,511
Reversals of impairments arising from professional valuation (Right of Use Asset)	16.0	**91**	–
Impairments arising from professional valuation (Right of Use Asset)	16.0	**(58)**	(1,107)
Impairments arising from valuation (Intangible)	14.1	**–**	(41,161)
Abandonment of assets in course of construction (Intangible)	14.1	**(250)**	(521)
Abandonment of assets in course of construction (PPE)	13.1	**(1,263)**	(1,614)
Net impairment charged to expenditure	7	**(21,231)**	(107,792)
Impairments charged to revaluation reserve			
Impairments of land value from professional valuation		**(490)**	(12,900)
Impairments of building and dwellings value from professional valuation		**(6,387)**	(36,082)
Impairments of right of use assets from professional valuation		**(32)**	(163)
Other adjustments (intangibles)		**–**	(1,563)
Total impairments charged to Revaluation reserve		**(6,909)**	(50,708)
Total Net impairments		**(28,140)**	(158,500)
Impairments charged to operating expenses:			
Of which Departmental Expenditure Limit (DEL)		**(1,513)**	(2,135)
Of which Annually Managed Expenditure (AME)		**(19,718)**	(105,657)
		(21,231)	(107,792)

15.2 Analysis of valuation movements and impairments

During 2024/25 impairment transactions relate to:

- The professional valuation of the Trust-wide estate (£19.7m of impairments to operating expenses and £6.9m of impairments to the revaluation reserve) and;
- The abandonment of some assets under construction (£1.5m).

Property Valuation
Land and buildings across the full estate were valued independently by Gerald Eve as at 31 March 2025. The valuation included positive and negative valuation movements. Revaluation losses were taken to the revaluation reserve to the extent there was a revaluation surplus. Any losses over and above the revaluation surplus were charged to the Statement of Comprehensive Income (SOCI).

Where the revaluation resulted in an increase in an asset's value, this increase was credited to the revaluation reserve unless it reversed a revaluation loss previously recognised in operating expenses, in which case it was credited initially to operating income and thereafter to the revaluation reserve.

Intangible Valuation:
The impairment of the electronic patient records intangible asset in 2023/24 was calculated by a third party expert, assessing the value in use which is equal to the cost of replacement. The methodology assessed the changes in market such as inflationary impact as well as assessing the cost capitalised and the impact on the organisation if the effort had to be re-performed and to achieve the same functionality.

The movements arising from the valuations can be summarised as follows:

	March 31 2025 £000	**March 31 2025 £000**	**March 31 2025 £000**	March 31 2024 £000	March 31 2024 £000	March 31 2024 £000
	Revaluation reserve	**SOCI**	**Total**	Revaluation reserve	SOCI	Total
Impairments from professional valuations						
Impairments in land value	**(490)**	**–**	**(490)**	(12,900)	(640)	(13,540)
Impairments in building and dwellings value	**(6,387)**	**(20,558)**	**(26,945)**	(36,082)	(65,260)	(101,342)
Impairments in right of use assets	**(32)**	**(58)**	**(90)**	(163)	(1,107)	(1,270)
Reversal of previous impairments (buildings)	**–**	**807**	**807**	–	2,511	2,511
Reversal of previous impairments arising from professional valuation (Right of Use Asset)	**–**	**91**	**91**	–	–	–
Impairments of intangible assets	**–**	**–**	**–**	–	(41,161)	(41,161)
Total impairments from professional valuation	**(6,909)**	**(19,718)**	**(26,627)**	(49,145)	(105,657)	(154,802)
Abandoned assets under construction	**–**	**(1,513)**	**(1,513)**	–	(2,135)	(2,135)
Other impairments (tangible and intangible)	**–**	**–**	**–**	(1,563)	–	(1,563)
Total net impairments	**(6,909)**	**(21,231)**	**(28,140)**	(50,708)	(107,792)	(158,500)
Revaluations upwards from professional valuation to revaluation reserve						
Increase in value of right of use assets	**595**	**–**	**595**	600	–	600
Increase in value of land to revaluation reserve	**2,710**	**–**	**2,710**	–	–	–
Increase in value of building and dwellings to revaluation reserve	**16,538**	**–**	**16,538**	13,345	–	13,345
Other revaluation adjustments (tangible, intangible and right of use assets)	**–**	**–**	**–**	3,705	–	3,705
	19,843	**–**	**19,843**	17,650	–	17,650
Total movement to PPE arising from professional valuation	**12,371**	**(19,751)**	**(7,380)**	(35,637)	(63,389)	(99,026)
Total movement to Right of Use assets from professional valuation	**563**	**33**	**596**	437	(1,107)	(670)
Total movement to Intangibles from professional valuation	**–**	**–**	**–**	–	(41,161)	(41,161)

16 Leases – The Trust as a Lessee

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

The majority of lease arrangements where the Trust is the lessee involve the leasing of buildings. Other lease arrangements involve the leasing of equipment and vehicles.

16.1 Right of use assets 2024/25

	Property (land and buildings) £000	Plant and machinery £000	Transport Equipment £000	Information technology £000	Total £000	Of which: leased from DSHC group bodies £000
Valuation / gross cost at 1 April 2024	**173,778**	**17,072**	**10,805**	**12,061**	**213,716**	**58,035**
Additions – lease liability	18,653	660	3,205	7	**22,525**	**5,274**
Remeasurements of the lease liability	6,662	204	–	–	**6,866**	**264**
Dilapidation provisions arising	123	–	–	–	**123**	**–**
Impairments charged to operating expenses	(58)	–	–	–	**(58)**	**–**
Impairments charged to the revaluation reserve	(32)	–	–	–	**(32)**	**–**
Reversal of impairments credited to operating expenses	91	–	–	–	**91**	**–**
Revaluations	(750)	–	–	–	**(750)**	**–**
Disposals/derecognition – lease termination	(8,891)	(8)	(27)	(1,578)	**(10,504)**	**(545)**
Disposals/derecognition – peppercorn lease termination	(37)	–	–	–	**(37)**	**–**
Valuation/gross cost at 31 March 2025	**189,539**	**17,928**	**13,983**	**10,490**	**231,940**	**63,028**
Accumulated depreciation at 1 April 2024	**37,273**	**6,670**	**7,251**	**4,880**	**56,074**	**8,487**
Provided during the year – right of use asset	14,618	3,056	2,282	1,660	**21,616**	**4,408**
Provided during the year – peppercorn leased asset	1,345	–	–	–	**1,345**	**–**
Revaluations	(1,345)	–	–	–	**(1,345)**	**–**
Reclassifications	–	–	–	–	**–**	**–**
Disposals/derecognition – lease termination	(7,873)	(8)	(27)	(1,578)	**(9,486)**	**(233)**
Accumulated depreciation at 31 March 2025	**44,018**	**9,718**	**9,506**	**4,962**	**68,204**	**12,662**
Net book value at 31 March 2025	**145,521**	**8,210**	**4,477**	**5,528**	**163,736**	**50,366**
Net book value of right of use assets leased from other NHS providers						4,394
Net book value of right of use assets leased from other DHSC group bodies						45,972
						50,366

16.2 Right of use assets 2023/24

	Property (land and buildings) £000	Plant and machinery £000	Transport Equipment £000	Information technology £000	Total £000	Of which: leased from DSHC group bodies £000
Valuation / gross cost at 1 April 2023	**155,412**	**15,217**	**8,125**	**11,760**	**190,514**	**51,566**
Additions – lease liability	7,354	1,138	2,643	–	**11,135**	**–**
Additions – peppercorn leases	111	–	–	–	**111**	**–**
Remeasurements of the lease liability	7,114	–	–	(7)	**7,107**	**6,469**
Impairments charged to operating expenses	(1,107)	–	–	–	**(1,107)**	**–**
Impairments charged to the revaluation reserve	(163)	–	–	–	**(163)**	**–**
Revaluations	(1,105)	717	37	308	**(43)**	**–**
Disposals/derecognition – lease termination	(293)	–	–	–	**(293)**	**–**
Reclassifications from PPE	6,455	–	–	–	**6,455**	**–**
Valuation/gross cost at 31 March 2024	**173,778**	**17,072**	**10,805**	**12,061**	**213,716**	**58,035**
Accumulated depreciation at 1 April 2023	**18,884**	**3,288**	**2,589**	**3,274**	**28,035**	**4,138**
Provided during the year – right of use asset	18,530	3,382	3,977	2,291	**28,180**	**4,349**
Provided during the year – peppercorn leased asset	768	–	–	–	**768**	**–**
Revaluations	(900)	–	–	–	**(900)**	**–**
Reclassifications	–	–	685	(685)	**–**	**–**
Disposals/derecognition – lease termination	(9)	–	–	–	**(9)**	**–**
Accumulated depreciation at 31 March 2024	**37,273**	**6,670**	**7,251**	**4,880**	**56,074**	**8,487**
Net book value at 31 March 2024	**136,505**	**10,402**	**3,554**	**7,181**	**157,642**	**49,548**
Net book value of right of use assets leased from other NHS providers						2,783
Net book value of right of use assets leased from other DHSC group bodies						46,765
						49,548

16.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position.
A breakdown of borrowings is disclosed in note 23.

Group	2024/25 £000	2023/24 £000
Carrying value at 1 April	**131,180**	**139,540**
Lease additions	22,525	11,135
Lease liability remeasurements	6,866	7,107
Interest charge arising in year	1,933	1,575
Early terminations	(1,015)	(303)
Lease payments (cash outflows)	(25,317)	(27,874)
Carrying value at 31 March	**136,172**	**131,180**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure. These payments are disclosed in Note 7.1.

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

16.4 Maturity analysis of future lease payments at 31 March 2025

Group	Total	Of which leased from DHSC group bodies:
	March 31 2025 £000	March 31 2025 £000
Undiscounted future lease payments payable in:		
– not later than 1 year;	**24,747**	**4,722**
– later than 1 year and not later than 5 years;	**79,538**	**23,111**
– later than 5 years	**46,687**	**29,285**
Total gross future lease payments	**150,972**	**57,118**
Finance charges allocated to future periods	**(14,800)**	**(6,402)**
Net lease liabilities at 31 March 2025	**136,172**	**50,716**
Of which:		
Leased from other NHS providers		**4,432**
Leased from other DHSC group bodies		**46,284**
		50,716

16.5 Maturity analysis of future lease payments at 31 March 2024

Group	Total	Of which leased from DHSC group bodies:
	March 31 2024 £000	March 31 2024 £000
Undiscounted future lease payments payable in:		
– not later than 1 year;	**22,821**	**4,788**
– later than 1 year and not later than 5 years;	**79,459**	**22,203**
– later than 5 years	**36,462**	**25,667**
Total gross future lease payments	**138,742**	**52,658**
Finance charges allocated to future periods	**(7,562)**	**(3,053)**
Net lease liabilities at 31 March 2024	**131,180**	**49,605**
Of which:		
Leased from other NHS providers		**2,807**
Leased from other DHSC group bodies		**46,798**
		49,605

17 Investment property

Investment property carrying values

	GROUP AND TRUST	
	2024/25	2023/24
	£000	£000
Carrying value at April 1	**71,548**	75,134
Movement in fair value	**235**	(3,586)
Carrying value at March 31	**71,783**	71,548

Investment properties were valued by Gerald Eve as at 31 March 2025. Valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and International Financial Reporting requirements. The assets were valued by reference to the market conditions prevailing at the valuation date. Under IFRS13 this valuation is classed as a level 2 valuation (i.e. based on observable market data). The largest element of the Investment Property portfolio is the Chelsea Farmer's Market.

18 Revaluation reserve movements

Property, plant and equipment

	GROUP AND TRUST	
	2024/25	2023/24
	£000	£000
Revaluation reserve at April 1	**529,138**	564,338
Impairments (Note 15.1)	**(6,909)**	(50,708)
Revaluations	**19,843**	17,650
Transfer to I&E reserve upon asset disposal	**(1,578)**	–
Other	**–**	(2,142)
Revaluation reserve at March 31	**540,494**	529,138

19 Subsidiaries and interests in associates and joint ventures

The Guy's and St Thomas' principal subsidiary undertakings, associates and joint ventures as included in the Financial Statements at March 31 2025 are set out below. The accounting date of the financial statements for the subsidiaries, SpotOn Clinical Diagnostics and KHP MedTech is March 31 2025. The accounting date for Synnovis Analytics, Services and Group is December 31 2024. For the joint venture/associate undertakings that have different accounting year-end dates, interim accounts to March 31 have been used.

	Country of incorporation	Beneficial interest	Principal activity
Subsidiary undertakings			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
Pathology Services Ltd*	UK	100%	Healthcare services
Lexica Health and Life Sciences Consultancy Limited*	UK	100%	Healthcare services
The Chelsea Private Hospital Ltd	UK	100%	Dormant
Associates and joint ventures			
KHP MedTech Innovations Ltd*	UK	30%	Healthcare services
SpotOn Clinical Diagnostics Ltd*	UK	30%	Healthcare services
King's Health Partners Ltd**	UK	25%	Healthcare services
Synnovis Group LLP*	UK	24.5%	Healthcare services
Synnovis Services LLP*	UK	24.5%	Healthcare services
Synnovis Analytics LLP*	UK	24.5%	Healthcare services

* Not directly owned by Guy's and St Thomas' NHS Foundation Trust

** Limited by guarantee – no cash investment has been made, Guy's and St Thomas' NHS Foundation Trust holds 25% voting rights.

19.1 Investments in joint ventures and associates

	GROUP	
	2024/25 £000	2023/24 £000
Carrying value at April 1	**1,475**	2,050
Additions	**–**	–
Share of profits / (losses)	**75**	(395)
Profit Distribution / Dividends received	**(315)**	(180)
Carrying Value at March 31	**1,235**	1,475

20 Other investments / financial assets

	GROUP		TRUST	
Non-current	**2024/25**	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Carrying value at April 1	**479**	146	**10,080**	10,589
Additions	**986**	333	**724**	891
Fair value losses	**(197)**	–	**–**	–
Loan repayments	**–**	–	**–**	(1,400)
Carrying value at March 31	**1,268**	479	**10,804**	10,080

2024/25 Group other investments / financial assets

Organisation	**Current £000**
Cydar Investments	146
Zeus Sleep	150
KHP Ventures	972
	1,268

2024/25 Trust other investments / financial assets

Organisation	**£000**	**Interest rate**	**Maturity date**
Pathology Services Ltd (loan + interest)	7,926	Base rate +2%	Mar 2029
Guy's and St Thomas' Enterprises Limited (loan + interest)	2,878	Base rate +2%	Dec 2029
	10,804		

Trust Loans with Pathology Services Limited (PSL), Guy's and St Thomas' Enterprises Limited are removed from the Group Accounts following consolidation adjustments.

21 Inventories

	GROUP AND TRUST	
	March 31 2025	March 31 2024
	£000	£000
Drugs	**9,903**	11,397
Consumables	**39,613**	39,333
	49,516	50,730

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £450k of inventory items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income in 2023/24.

22 Trade and other receivables

22.1 Current

	GROUP	
	March 31 2025 £000	March 31 2024 £000
Contract receivables: invoiced	**124,929**	137,321
Contract receivables: not yet invoiced	**85,182**	80,133
Capital receivables	**10,236**	3,365
Allowance for impaired receivables	**(41,886)**	(46,229)
Prepayments	**23,984**	22,707
VAT and other tax receivable	**4,456**	11,873
Clinical pension tax provision reimbursement funding from NHSE	**137**	95
Other receivables	**10,386**	14,573
	217,424	223,838

22.2 Non-current

	GROUP	
	March 31 2025 £000	March 31 2024 £000
Contract receivables	**3,230**	2,764
Capital receivables	**823**	8,362
Clinical pension tax provision reimbursement funding from NHSE	**4,168**	4,094
	8,221	15,220

22.3 Allowances for credit losses

	GROUP AND TRUST	
	2024/25 Contract receivables and contract assets £000	**2023/24 Contract receivables and contract assets £000**
Allowances as at 1 April	**46,229**	40,422
New allowances arising	**14,828**	12,880
Reversal of allowances	**(11,889)**	(5,758)
Utilisation of allowances	**(7,282)**	(1,315)
Allowances as at 31 March	**41,886**	46,229

23 Current liabilities

23.1 Trade and other payables

	GROUP	
	March 31 2025 £000	March 31 2024 £000
Trade payables	**108,370**	106,866
Capital payables	**51,515**	38,411
Accruals	**175,250**	182,764
Receipts in advance	**1,852**	1,449
Social security costs	**18,826**	18,572
Other taxes payable	**21,969**	19,672
PDC dividend payable	**1,325**	82
Pension contributions payable	**22,454**	20,812
Other payables	**2,713**	2,146
	404,274	390,774

23.2 Other liabilities

	GROUP	
Current	**March 31 2025 £000**	March 31 2024 £000
Deferred income: contract liabilities	**36,413**	41,992
Deferred grants	**3,801**	1,569
	40,214	43,561

23.3 Borrowings

	GROUP	
Current	**March 31 2025 £000**	March 31 2024 £000
Capital loans from Department of Health and Social Care (DHSC)	**17,765**	17,856
Lease liabilities	**22,487**	21,363
Obligations under other service concession contracts (excluding lifecycle)	**378**	122
	40,630	39,341
Non-current	**£000**	£000
Capital loans from Department of Health and Social Care (DHSC)	**157,821**	174,831
Lease liabilities	**113,685**	109,817
Obligations under other service concession contracts (excluding lifecycle)	**1,897**	2,438
	273,403	287,086
Total borrowings (current and non-current)	**314,033**	326,427

23.4 Reconciliation of liabilities arising from financing activities 2024/25

GROUP	Loans from DHSC £000	Lease liabilities £000	Service concession obligations £000	Total £000
Carrying value as at 1 April 2024	**192,687**	**131,180**	**2,560**	**326,427**
Cash movements:				
Financing cash flows – payments and receipts of principal	(17,009)	(23,384)	(284)	**(40,677)**
Financing cash flows – payments of interest	(4,595)	(1,933)	(95)	**(6,623)**
Non-cash movements:				
Additions	–	22,525	–	**22,525**
Lease liability remeasurements	–	6,866	–	**6,866**
Application of effective interest rate	4,503	1,933	94	**6,530**
Early termination	–	(1,015)	–	**(1,015)**
Carrying value at 31 March 2025	**175,586**	**136,172**	**2,275**	**314,033**

23.5 Reconciliation of liabilities arising from financing activities 2023/24

GROUP	Loans from DHSC £000	Lease liabilities £000	Service concession obligations £000	Total £000
Carrying value as at 1 April 2023	**210,901**	**139,540**	**2,855**	**353,296**
Cash movements:				
Financing cash flows – payments and receipts of principal	(18,134)	(26,312)	(296)	**(44,742)**
Financing cash flows – payments of interest	(5,011)	(1,562)	(107)	**(6,680)**
Non-cash movements:				
Additions	–	11,135	–	**11,135**
Lease liability remeasurements	–	7,107	–	**7,107**
Application of effective interest rate	4,931	1,575	108	**6,614**
Early termination	–	(303)	–	**(303)**
Carrying value at 31 March 2024	**192,687**	**131,180**	**2,560**	**326,427**

23.6 Schedule of borrowings from the Department of Health and Social Care

Loan start date	Loan end date	Interest rate %	Total loan drawn down £000	Principal and accrued interest outstanding April 1 2024 £000	Principal repaid during 2024/25 £000	Interest paid during 2024/25 £000	Interest charge (I&E) for 2024/25 £000	Principal and accrued interest outstanding March 31 2025 £000
Jun-11	Jun-36	3.27	75,000	43,061	(3,405)	(1,375)	1,335	39,616
Mar-12	Mar-37	2.85	80,000	48,354	(3,728)	(1,351)	1,347	44,622
* Apr-14	Apr-29	2.54	30,000	13,351	(2,400)	(321)	293	10,923
* Jun-15	Jun-30	2.06	20,000	9,696	(1,480)	(191)	182	8,207
Feb-16	Feb-41	1.9	25,000	17,387	(1,020)	(325)	323	16,365
Feb-16	Feb-41	1.9	14,000	9,946	(582)	(186)	185	9,363
Feb-16	Feb-41	1.9	33,768	25,576	(1,499)	(478)	475	24,074
Feb-16	Feb-31	1.38	27,232	17,346	(2,477)	(230)	226	14,865
Nov-17	Nov-42	1.76	10,000	7,970	(418)	(138)	137	7,551
			315,000	**192,687**	**(17,009)**	**(4,595)**	**4,503**	**175,586**

***** Loans transferred from the Royal Brompton and Harefield NHS Foundation Trust. For disclosure purposes the full history of the loan has been disclosed, rather than just the movement since 1 February 2021.

No security has been pledged against these loans.

All borrowing relates to capital loans that were secured to support the Trust's plans to redevelop its hospital sites and upgrade IT and other infrastructure.

24 Provisions for liabilities

24.1 Overall provisions

GROUP AND TRUST

	March 2025 £000	March 2024 £000
Current		
Pensions: injury benefit	**103**	98
Pensions: early departure	**30**	36
Legal claims	**352**	221
Clinician pension tax reimbursement	**137**	95
Other*	**1,081**	5,208
	1,703	5,658

	March 2025 £000	March 2024 £000
Non-current		
Pensions: injury benefit	**1,445**	1,372
Pensions: early departure	**206**	263
Clinician pension tax reimbursement	**4,168**	4,094
Other*	**6,543**	6,910
	12,362	12,639

Total provisions	March 2025 £000	March 2024 £000
Pensions: injury benefit	**1,548**	1,470
Pensions: early departure	**236**	299
Legal claims	**352**	221
Clinician pension tax reimbursement	**4,305**	4,189
Other*	**7,624**	12,118
	14,065	18,297

24.2 Changes in provisions

	Pensions - injury benefits £000	Legal claims £000	Pensions early departure £000	Clinician pension tax reimbursement £000	Other* £000	Total £000
As at April 1 2024	1,470	221	299	4,189	12,118	**18,297**
Change in Discount Rate	7	–	1	(39)	–	**(31)**
Arising during the year	149	242	28	55	560	**1,034**
Utilised during the year	(114)	(6)	(29)	(110)	(4,506)	**(4,765)**
Reversed unused	–	(105)	(70)	–	(548)	**(723)**
Unwinding of discount	36	–	7	210	–	**253**
At March 31 2025	**1,548**	**352**	**236**	**4,305**	**7,624**	**14,065**

24.3 Expected timing of cash flows

Timing of provisions	Pensions - injury benefits £000	Legal claims £000	Pensions early departure £000	Clinician pension tax reimbursement £000	Other* £000	Total £000
Within one year	103	352	30	137	1,081	**1,703**
Between one and five years	389	–	112	461	3,805	**4,767**
After five years	1,056	–	94	3,707	2,738	**7,595**
	1,548	**352**	**236**	**4,305**	**7,624**	**14,065**

***** Other provisions largely consist of provisions for dilapidations and provisions for redundancies.

As at 31 March 2025 £393m is included in provisions of NHS Resolution in respect of clinical negligence liabilities of Guy's and St Thomas' NHS Foundation Trust (£372m at March 31 2024).

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

25 Cash and cash equivalents movement

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.

	GROUP		TRUST	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
At April 1	**89,863**	130,760	**86,478**	125,918
Net change in year	**100,871**	(40,897)	**99,330**	(39,440)
At 31 March	**190,734**	89,863	**185,808**	86,478
Broken down into:				
Cash at commercial banks and in hand	**5,530**	5,297	**604**	1,912
Cash with the Government Banking Service	**185,204**	84,566	**185,204**	84,566
Total cash and cash equivalents	**190,734**	89,863	**185,808**	86,478

26 Contractual capital commitments

	GROUP AND TRUST	
	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	**12,744**	19,659
Intangible assets	**5,071**	15,947
	17,815	35,606

27 Contingencies

Contingent liabilities

	GROUP AND TRUST	
	31 March 2025	31 March 2024
	£000	£000
Contingent liability for claims	**(92)**	(128)
Net contingent liability	**(92)**	(128)

Contingent liabilities recorded are in respect of Public and Employee liability cases and the Property Expenses Scheme as advised by the NHS Resolution. This represents the best estimate of future liabilities based on available input from NHS professionals in the respective areas.

28 Events after the reporting date

On 30 May 2025, Guy's and St Thomas' Enterprises Limited sold Lexica Health and Life Sciences Consultancy Limited to WSP. From 31 May 2025, Lexica will therefore no longer be consolidated into the results of the Group.

29 Related party transactions

Guy's and St Thomas' NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. It falls within the Department of Health and Social Care's (DHSC) consolidation boundary. DHSC is regarded as a related party. The DHSC is the parent department of the Trust. During the year Guy's and St Thomas' Foundation Trust has had a 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
- Integrated Care Boards and NHS England
- Special Health Authorities
- Non-Departmental Public Bodies
- Other Department of Health and Social Care bodies

Per note 19, the Trust has 4 wholly owned subsidiaries. There are no material transactions between the Trust and its subsidiaries. Related party transactions were made on terms equivalent to those that prevail in arm's length transactions and are eliminated when preparing the group consolidated accounts.

The Trust works closely with its partners in King's Health Partners: King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and King's College London.

The Trust had a number of transactions with non consolidated charities with connections to the Trust. Details, along with other related parties, are included in the table below.

	Amounts due (invoiced) from related parties		**Amounts owed (invoiced) to related parties**	
	2024/25 £000	2023/24 £000	**2024/25 £000**	2023/24 £000
Non-NHS Related party transactions				
Guy's & St Thomas' Charity	**2,414**	4,139	**–**	–
King's College London	**13,327**	9,618	**17,444**	2,843
Synnovis*	**4,730**	3,863	**389**	210
Royal Brompton and Harefield Hospitals Charity	**120**	575	**–**	–

	Income from related party		**Expenditure with related party**	
	2024/25 £000	2023/24 £000	**2024/25 £000**	2023/24 £000
Non-NHS Related party transactions				
Guy's & St Thomas' Charity	**11,838**	8,012	**–**	–
King's College Hospital	**41,276**	33,221	**30,161**	23,229
Royal Brompton and Harefield Hospitals Charity	**1,407**	1,856	**–**	–

* Includes transactions with Synnovis Group LLP, Synnovis Services LLP, Synnovis Analytics LLP.
During 2024/25 the Trust has processed invoices of £124m from Synnovis and has raised invoices of £20m to Synnovis.

Since September 2020 Dr Felicity Harvey has been a Non-Executive Director at Sciensus (formerly 'Healthcare at Home'), which provides services to Guy's and St Thomas' as well as many other NHS Organisations for the provision of medicines in the home of patients with long term conditions on expensive medicines. The Trust has recorded £101m of invoices from Sciensus during 2024/25,being coded to 'Drugs' in Note 7. The Trust has a creditor of £2.9m with Sciensus as at 31 March 2025.

Simon Friend is the Independent Non-Executive Director at Bevan Brittan LLP, who provide some legal services to the Trust. The Trust is showing £200k of expenditure with Bevan Brittan LLP during 2024/25 and a creditor of £15k as at 31 March 2025. Simon Friend was also a Non-Executive Director on the Board at King's College Hospital Foundation Trust until 31 March 2025.

Nilkunj Dodhia is a Director at Oracle, an organisation that has contracts with the Trust. The Trust has recorded £947k of invoices from Oracle during 2024/25, and a creditor of £8k as at 31 March 2025.

The Council of Governors includes representatives from organisations that work closely with the Trust including Lambeth Council, Southwark Council, Royal Borough of Kensington and Chelsea Council, and London South Bank University.

Aside from these transactions none of the other Board members, the members of the Council of Governors, members of the key management staff or parties related to them have undertaken any material transactions with Guy's and St Thomas' NHS Foundation Trust.

30 Financial assets and liabilities

30.1 Carrying value and fair value of financial assets

GROUP	Held at amortised cost	Held at fair value through I&E	Total Book value	Held at amortised cost
	March 31 2025 £000	**March 31 2025 £000**	**March 31 2025 £000**	March 31 2024 £000
Carrying values of financial assets as at 31 March				
Trade and other receivables (excluding non-financial assets) – with NHS and DHSC bodies	**96,986**	**–**	**96,986**	95,187
Trade and other receivables (excluding non-financial assets) – with other bodies	**95,914**	**–**	**95,914**	103,955
Other investments / financial assets	**1,235**	**1,268**	**2,503**	1,954
Cash and cash equivalents	**190,734**	**–**	**190,734**	89,863
Total carrying value of financial assets at 31 March	**384,869**	**1,268**	**386,137**	290,959

30.2 Carrying value and fair value of financial liabilities

GROUP	Held at amortised cost	Held at amortised cost
	March 31 2025 £000	March 31 2024 £000
Carrying values of financial liabilities as at 31 March		
Loans from DHSC	**175,586**	192,687
Obligations under leases	**136,172**	131,180
Obligations under service concession contracts	**2,275**	2,560
Trade and other payables (excluding non financial liabilities) – with NHS and DHSC bodies	**31,475**	32,000
Trade and other payables (excluding non financial liabilities) – with other bodies	**296,902**	286,749
Provisions under contract	**7,385**	7,131
Total at 31 March	**649,795**	652,307

The carrying value and fair value of the financial assets and financial liabilities are not materially different.

30.3 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.

	Group and Trust	
	March 31 2025 £000	March 31 2024 £000
In 1 year or less	**376,360**	364,468
In more than 1 year but not more than 5 years	**164,089**	167,824
In more than 5 years	**151,038**	159,152
	691,487	691,444

30.4 Loan disclosure

	Current	Non current	Total	Weighted average interest rate %
	£000	£000	£000	
March 31 2025				
Fixed interest rate instruments	**17,765**	**157,821**	**175,586**	2.45%
March 31 2024				
Fixed interest rate instruments	17,856	174,831	192,687	2.44%

30.5 Financial risk management

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

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

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust makes some purchases in foreign currency and these are converted to Sterling at the spot rate on the day of payment, and overall the Trust has minimal exposure to currency rate fluctuations.

Interest rate risk

Where appropriate, the Trust may borrow from Government and commercial sources, as disclosed in Note 23. The borrowings are for 1 – 25 years, in line with the life of the associated assets. Interest rates on the ITFF (Govt) loans are fixed. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

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

Liquidity risk

Most of the Trust's operating costs are incurred under contracts with NHS commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital programme from its own resources and donations, and where necessary by accessing loans from government and commercial bodies.

31 Third party assets

Guy's and St Thomas' NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. These are split into the following:

£186k (£183k at March 31 2024) which relates to monies held by the Trust on behalf of patients.

£3,053k (£2,996k at March 31 2024) is held as client monies on behalf of tenants.

These amounts have been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025	31 March 2024
	£000	£000
Monies on deposit	**3,239**	3,179
Total Third Party Assets	**3,239**	3,179

32 Losses and special payments

	Group and Trust			
Losses	**Year ended March 31 2025 Cases**	**Year ended March 31 2025 £000**	Year ended March 31 2024 Cases	Year ended March 31 2024 £000
Cash losses	**3**	**–**	7	–
Bad debts and claims abandoned	**1,624**	**7,666**	795	2,767
Stores losses, theft and other	**24**	**316**	34	1,247
Total losses	**1,651**	**7,982**	836	4,014

Special payments	**Year ended March 31 2025 Cases**	**Year ended March 31 2025 £000**	Year ended March 31 2024 Cases	Year ended March 31 2024 £000
Ex gratia payments	**29**	**20**	29	11
Special severance payments	**–**	**–**	–	–
Total special payments	**29**	**20**	29	11
Total losses and special payments	**1,680**	**8,002**	865	4,025
Of which losses of £300,000 or more:	**–**	**–**	1	603

During 2023/24 a write off to stock of £603k was processed due to the expiration of seasonal vaccine stock. £330k has subsequently been received from SEL ICB and the vaccine manufacturer, resulting in a net cost of £273k to the Trust.

The amounts quoted above are reported on an accruals basis but exclude provision for future losses.

33 Heritage assets

Historic artefacts

The remains of a Roman boat lie in Guy's Hospital site, beneath the Cancer Treatment Centre. The artefact has been disclosed as a non-operational heritage asset. As well as being of significance in its own right, the artefact assists in interpreting and presenting our hospital to the public and provides a valuable research resource for heritage professionals. Subject to conditions not deteriorating, the Roman Boat will remain preserved in situ and thus will remain on the Trust's land. The ground conditions around the boat are subject to regular monitoring. Should conditions deteriorate to a certain level, then a decision will be taken to remove the boat. The Trust holds scheduled monument consent from the Department for Culture, Media and Sport.

The Trust does not consider that reliable cost or valuation information can be obtained for the Roman boat, and even if valuations can be obtained, the cost would be onerous compared with the additional benefits derived by the Trust and the users of the accounts. This is because of the nature of the asset held and the lack of comparable market values. The Trust therefore does not recognise this asset on its Statement of Financial Position.

Donated artefacts received during the year had a value of nil (nil 2023/24). There were no disposals of artefacts during either year.

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

The Trust incurred £366k (£324k 2023/24) in charges relating to the late payment of Commercial Debts.

35 Public Dividend Capital (PDC) dividend

The Trust is required to demonstrate that the PDC dividend payable is in line with the actual rate of 3.5% of average relevant net assets. The dividend payable relating to the period to March 31 2025 was £40,494k (£39,251k 2023/24).

Contacts

Chief Executive
If you have a comment for the Chief Executive, contact:
Ian Abbs, Chief Executive
Tel: 020 7188 0001

Patient Advice and Liaison Service (PALS)
If you require information, support or advice about our services, contact:

PALS

Tel: 020 7188 8801 (St Thomas')
or 020 7188 8803 (Guy's)
Email: gstt.pals-gstt@nhs.net

Tel: 020 7349 7715 (Royal Brompton)
or 01895 826572 (Harefield)
Email: gstt.pals-rbhh@nhs.net

Membership
If you are interested in becoming a member of our NHS Foundation Trust, contact:
Tel: 0800 731 0319
Email: gstt.members@nhs.net

Recruitment
If you are interested in applying for a job at Guy's and St Thomas', contact:
The Recruitment Centre
Tel: 020 7188 0044
www.guysandstthomas.nhs.uk/careers

Further information
If you have a media enquiry or require further information, contact:
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Guy's and St Thomas' NHS Foundation Trust

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