GSTT Public Council of Governors meeting

Wednesday 22 July 2026, 18:00 - 19:30

Robens suite and online

Agenda

18:00 - 18:00
0 min

1. Welcome and apologies

Charles Alexander

18:00 - 18:00
0 min

2. Declarations of interest

18:00 - 18:05
5 min

3. Minutes of previous meeting (28 April 2026) and review of actions

[3] 20260429 Public CoG Meeting Minutes vDraft.pdf (3 pages)

18:05 - 18:25
20 min

4. Annual Report and Accounts 2025/26

Amanda Pritchard and Steven Davies

[4.1] Guy's and St Thomas' Annual Report 202526.pdf (150 pages)
[4.2] GSTT AAR NHS FT 2025-26 Final 26 June 2026.pdf (36 pages)
[4.3] GSTT Final Audit Findings Report June 2026.pdf (60 pages)

18:25 - 18:40
15 min

5. NHS Health Bill – implications for the Council of Governors and Trust members

[5] Summary of future arrangements for patient public and staff voice following changes to Council of Governors functions FINAL.pdf (3 pages)

18:40 - 18:50
10 min

6. Governors' reports for information

6.1. Lead Governor's Report

[6.1] Lead Governor's Report Jul26.pdf (3 pages)

6.2. Membership Development Working Group

Charles Mead

[6.2] 20260512 MDWG meeting minutes.pdf (3 pages)

6.3. Strategy Transformation and Partnership Working Group

Thomas Sheridan

[6.3] 20260519 STPWG meeting minutes.pdf (3 pages)

6.4. Quality and Engagement Working Group

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[6.4] 20260623 QEWG 23 June notes (final).pdf (6 pages)

18:50 - 19:20
30 min

7. Q&A with Trust Chair and non-executive directors

19:20 - 19:25
5 min

8. Any other business

COUNCIL OF GOVERNORS

Wednesday 29 April 2026, 6pm – 7.30pm
Governors' Hall, St Thomas' Hospital and MS Teams

Governors present:	Steven Bean	Charles Mead	Daghni Rajasingam
	Kathryn Blake	Margaret McEvoy	Sheila Reddy
	Victoria Borwick	Patrick Miller	Thomas Sheridan
	Michael Bryan	Gavin Morrison	Darren Summers
	Felicity Conway	Alison Mould	Cordwell Thomas
	Katherine Etherington	Mary O'Donovan	Peter Yeh
	Leah Mansfield	Samuel Oloye	
In attendance:	Charles Alexander (Chair)	Simon Friend	Pauline Philip
	Edward Bradshaw (minutes)	Felicity Harvey	Amanda Pritchard
	Avey Bhatia	Sara Hanna (to item 6)	Elena Spiteri
	Steven Davies	Jamie Heywood	Ingrid Wolfe (to item 6)
	Jon Findlay		

1. Welcome and apologies

1.1. The Chair welcomed attendees in the room and online to the meeting of the Council of Governors (the Council). Apologies had been received from governors Nimmi Anu Sam, Aya Ayoub, Emma Barslund Blackman, Nigel Beckett, Annette Boaz, David Bridson, Samantha Field, Emily Hickson, Michael Mates, Yvonne McPherson, Stephanie Petit, Mercy Satoye, Kendra Schneller, Helen Selvarajan, Dominic Shaw, and Jadwiga Wedzicha, and from non-executive directors Miranda Brawn, Nilkunj Dodhia, Deirdre Kelly, Graham Lord, Ian Playford, and Alison Wilcox.

2. Declarations of interests

2.1. No declarations of interest were received.

3. Minutes of the meeting held on 29 January 2026

3.1. The minutes of the previous meeting were approved as an accurate record. Two actions had been recorded at the last meeting, both of which had been discharged.

4. Cardio-Respiratory & Intensive Care (CRIC) service update

4.1. Governors received a verbal update on progress towards the temporary transfer of children's cardio-respiratory and intensive care inpatient services from Royal Brompton Hospital to the St Thomas' Hospital site, which had been mandated by NHS England. The programme had been running for several months and was in its final stages of preparation, with oversight in place across workforce, clinical governance, estates, IT, equipment, operational logistics and partner engagement.

4.2. A clinical readiness assessment had recently been undertaken, providing assurance that key risks and safety considerations had been identified and mitigated. The Trust had entered a period of pre-transfer operational planning, including a controlled reduction in activity to minimise the number of children requiring physical transfer on the day of the transfer, phased movement of services between wards, and structured staff induction and training to ensure safe service delivery from day one.

4.3. It was noted that the transfer was being managed using established tactical and escalation arrangements, with senior clinical and operational visibility during and immediately after the move. In the Trust's view, the principal risk related to staff anxiety, which increased the importance of leadership

visibility, wellbeing support and open communication to address concerns and maintain a focus on safe and effective care.

4.4. Governors sought assurance regarding contingency arrangements should demand increase during the transition period. It was confirmed that mutual aid arrangements with partner organisations were in place and that elective activity would only be adjusted when it was clinically safe to do so. Confidence was expressed that the Trust had sufficient workforce, capacity and system support to complete the transfer – planned for mid-May – safely.

5. Population health update

5.1. The Council received a presentation on the Trust's developing population health approach, noting that this work had been established as a Trust-wide function building on earlier experience within children's services. Population health was described as an outcome-focused, data-led approach to improving health and reducing inequalities by shifting the system from reactive treatment towards prevention, early intervention and proactive care based on population need.

5.2. The approach had included the use of population-level data to identify unmet need, inform service design and target interventions, with a focus on health equity and outcomes rather than activity alone. An illustrative case study relating to childhood asthma demonstrated how integrating clinical care with social and environmental interventions could reduce avoidable hospital attendance, improve wellbeing and address inequalities. This work had been supported by evaluation and learning mechanisms intended to enable continuous improvement.

5.3. Discussion highlighted the importance of robust evaluation to distinguish the impact of health system interventions from wider environmental and policy changes, and it was noted that controlled studies and ongoing research partnerships had been used to support this. Questions were raised about housing, air quality and wider economic pressures, with acknowledgement that many determinants of health sat beyond direct NHS control. The Trust's role as an advocate and partner within the wider system, including collaboration with local authorities, research partners and regional programmes, was emphasised.

5.4. Governors welcomed the work and reflected on the need for distributed leadership, organisational commitment and alignment across partners to embed a population health mindset. The initiative was recognised as ambitious, long-term and strategically significant for the Trust.

6. CQC well-led inspection update

6.1. An update was provided on regulatory engagement with the Care Quality Commission (CQC). It was confirmed that service-level inspections had commenced, with a well-led inspection to follow later in the inspection cycle. The timing of the well-led inspection had not yet been confirmed, though a minimum notice period was expected.

6.2. The well-led inspection was an assessment of the strength of the Trust's leadership and governance and would focus on areas including risk management, quality improvement and responsiveness to patient and staff feedback. Governors would be invited to participate in a focus group as part of the inspection process. To help prepare governors for this and provide further insight into the inspection approach, a briefing pack had been circulated, and a mock focus group session had been arranged for the following week. Participation in the CQC focus group was encouraged but not mandatory.

7. Council of Governors and the ten-year health plan

7.1. The Council considered anticipated changes arising from the Government's ten-year health plan and associated legislative proposals, including the planned removal of the statutory requirement for NHS foundation trusts to have councils of governors and members. While the detailed legislative position remained uncertain, it was noted that the direction of travel implied greater central oversight and changes to existing accountability arrangements.

7.2. It was emphasised that the Council of Governors' statutory role and responsibilities remained unchanged unless and until legislation received royal assent, and that normal governor business would continue in the meantime. The potential loss of formal structures was acknowledged as a significant change; however, it was also framed as an opportunity for the Trust to develop more effective and inclusive mechanisms for patient, public and stakeholder engagement.

7.3. Governors were invited to work collaboratively with the Trust, including executive and non-executive directors and relevant managers, to help shape alternative arrangements aligned with the principles set out in the ten-year plan, with a focus on meaningful representation, accountability and insight. The importance of learning from developments across London and nationally, including engagement through governor networks and peer trusts, was noted. Further discussion was proposed through existing forums and forthcoming governor development events.

ACTION: Corporate Affairs to add topic to the next triangulation meeting and governor away day agendas.

8. Governors' reports for information

8.1. Governors noted reports provided for information, including updates from the Lead Governor and its working groups. Specific positive achievements highlighted included improvements in service performance measures and continuing engagement activity. The Lead Governor thanked Leah Mansfield for her hard work as chair of both the Quality and Engagement, and Strategy, Transformation and Partnerships working groups over the last few years. Governors were encouraged to note a draft action plan that had been developed following discussions at the previous Membership Development Working Group meeting.

9. Q&A with Trust Chair and non-executive directors

9.1. A question-and-answer session was held covering safety, quality, access and patient experience. Governors raised concerns regarding never events and healthcare-associated infections, noting an increase compared with previous years. It was confirmed that each incident had been reviewed in detail, common themes had been identified, and further actions were underway through established governance and quality committees, with a renewed organisational focus on safety culture and learning.

9.2. Issues relating to patient access, including difficulties with telephone contact and communication, were reiterated as ongoing concerns requiring further attention. Governors also raised questions regarding the implementation of advice and guidance within new primary care arrangements, particularly around patient visibility, waiting times and avoidance of patients being left in uncertainty. It was noted that further work was ongoing to design robust processes that supported patient understanding and timely care.

9.3. The Chair and non-executive directors acknowledged the issues raised, reaffirmed the Trust's commitment to transparency, learning and improvement, and thanked governors for their role in representing patient and public perspectives.

10. Any other business

10.1. There was no other business. The next meeting of the Council of Governors would be held on 22 July 2026.

NHS
Guy's and St Thomas'
NHS Foundation Trust

Annual Report and Accounts 2025/26

Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2025/26

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, and most respected 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 23,900 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: Thoracic surgeon Stephanie Fraser, wearing protective vest and collar. Stephanie and colleagues are leading a pilot at Guy's Hospital that combines artificial intelligence with robotic technology, speeding up diagnosis for patients with suspected lung cancer.

2025 marked 30 years since the first ventricular device was implanted in a patient at Harefield Hospital.

Contents

This year we marked 15 years of providing community services for adults and children across Lambeth and Southwark, working in close partnership with local NHS organisations, GPs, local authorities and the voluntary sector.

1 Chairman's statement

I would like to take this opportunity to recognise the hard work and dedication of our colleagues working across our 5 hospitals and in the community. Their commitment has enabled Guy's and St Thomas' to successfully navigate another busy year, meet our financial obligations and deliver a strong performance against most national standards.

The year 2025/26 was marked by continued operational and financial pressures across the NHS. Despite this, our teams remained steadfast in their commitment to providing safe, high-quality care to our patients, while continuing to reduce waiting times and deliver our longer-term plans. This includes progressing plans to expand the Evelina London Children's hospital – a significant investment in the future of care for children and young people.

I am proud that we remain in the top segment of the national ranking for NHS trusts, which reflects our strong performance across a wide range of measures. We recognise that some patients are still experiencing unacceptably long waits and addressing these delays remains our absolute priority in the year ahead.

As one of the country's largest and most influential NHS organisations, we recognise the vital role we play within our local communities – not only as a provider of outstanding healthcare, but as an anchor institution with a wider responsibility for improving health and wellbeing. During the year, we continued to develop our plans to move more care into the community and to focus, with our partners, on a new model of neighbourhood healthcare.

We continue to collaborate closely with our partners in south east and north west London to respond to growing demand, improve access to care and tackle health inequalities. This includes working with our local Integrated Care Boards, the South East London Acute Provider Collaborative and our King's Health Partners organisations. These relationships are essential to improve patient care and the health of our populations, as well as to deliver our ambitious research agenda, and we look forward to strengthening them further.

We are extremely proud of the diversity of our staff and the communities we serve. While we recognise there is more to do to become a truly inclusive, welcoming and equitable organisation, our NHS Staff Survey results show that we are making positive progress towards these goals.

I would like to express my heartfelt thanks to Guy's & St Thomas' Foundation and our charities, whose continued support helps fund pioneering research, innovations in care and vital investment in the wellbeing of our valued staff.

On behalf of the Board, and as Chairman of the Council of Governors, I would also like to thank our governors for their essential role in providing challenge, scrutiny and support.

I want to thank my fellow Board members for their commitment and leadership during the year. I also wish to pay tribute to Ian Abbs, who stepped down as Chief Executive Officer in September 2025 after 5 decades of service to the Trust and the NHS. His leadership, particularly through the unprecedented challenges of the COVID-19 pandemic, has left a lasting legacy.

I am delighted to welcome Dame Amanda Pritchard as our new Chief Executive. I would also like to thank Simon Steddon, who stepped down as Chief Medical Officer at the end of March 2025, and to recognise Ian Abbs for stepping into this role on an interim basis.

Charles Alexander, Chairman
24 June 2026

We recognise the commitment, attitude, respect and enthusiasm of our staff with monthly CARE awards.

2 Performance report

Annual performance statement from the Chief Executive

Throughout 2025/26, colleagues across the Trust worked incredibly hard to provide safe, compassionate and high-quality care to as many patients as possible. Thanks to their efforts, we finished the year in a strong position, performed well against national operational standards and delivered our financial plan.

I would like to thank all our staff for their hard work during 2025/26. Since joining in September, I have been consistently impressed by the breadth, quality and expertise of our services, and by the commitment and compassion colleagues showed to our patients and each other.

2025/26 has been a positive year for Guy's and St Thomas', with significant progress made in increasing our clinical activity and reducing the number of people on our waiting list, particularly those who have been waiting the longest for treatment. The quality of care we provide remains exceptional and we ended the year with a small financial surplus.

Our overall performance is assessed by NHS England against a range of measures including quality of care, financial performance and waiting times. I am pleased to report that the Trust remains in the highest performing category (segment 1) of the National Oversight Framework. Our position in the league table improved from 15th of 134 acute trusts in quarter 1, to 12th at the end of quarter 4. This reflects sustained Trust-wide performance improvements and the continued hard work and commitment of our colleagues.

In further recognition of our strong performance, NHS England awarded the Trust the second highest provider capability rating of green/amber for 2025/26, which is used alongside our segmentation in the National Oversight Framework to determine what support may be needed by providers.

Throughout the year we have reduced our overall waiting list by 15,000 patients. We have met the national requirement that 80% of patients who are referred to us urgently with suspected cancer receive a definitive diagnosis, or cancer is ruled out within 28 days. However, we are some way off meeting the national standard that cancer treatment should begin within 62 days. This is a top priority as we know how important it is for our patients and their families. Similarly, we have more to do to reduce the time that patients wait for diagnostic tests and procedures.

The emergency department at St Thomas' has been extremely busy, with high numbers of patients attending. We performed well throughout the year against the target that 78% of patients should be admitted, transferred or discharged within 4 hours. It was therefore disappointing that we were unable to maintain this performance in the final months of the year due to exceptional demand. The strong performance of our urgent and emergency services was recognised by our regulator, the Care Quality Commission (CQC), following their service inspection in March when we maintained our ratings of 'Outstanding' in our emergency department at St Thomas', and 'Good' in our urgent care Centre at Guy's.

Our financial performance underpins all that we do, including our ability to invest in service improvements. The Trust reported a surplus of £5.2 million in 2025/26, ahead of our breakeven plan. This was largely due to additional income received, for additional activity in the final months of the year, as well as the redistribution of deficit support

Annual performance statement

funding. Despite our considerable efforts, we found it difficult to fully identify and deliver our cost improvement plans and at the end of March there was a gap of £18.6 million against the Trust's £102.1 million savings target for the year.

Our ambitious plans for the future can only be realised if we deliver on our short-term priorities and operational commitments. To support this, we launched our Future Ready initiative, which encourages a whole-organisation focus on improving patient care, increasing efficiency, reducing costs, and reimagining how our services can be delivered to improve the experience of those who use them.

Over the past year, we have celebrated a number of important milestones across the Trust, including Guy's Hospital 300th anniversary, 20 years of the Evelina London Children's Hospital building and 15 years since community services joined the Trust. These anniversaries were a great opportunity to highlight our significant growth, innovation and the dedication of our colleagues supporting our patients and communities every day.

Building on these strong foundations, we are now developing Integrated Neighbourhood Teams to provide more joined-up, personalised care closer to home, and are progressing our ambitious Children's Hospital Programme to transform Evelina London into a world-class centre for the comprehensive care of children and young people.

We have continued to work with our academic partners to train the healthcare professionals of the future and drive research and innovation to transform the future of patient care.

The publication of our new Green Plan to 2028, and our increased focus on understanding and addressing health inequalities through our Population Health Hub, are further important steps forward in delivering our strategic ambition to improve the 'health of our populations'.

Everything we do for our patients, each other and our wider communities is driven by our values: we are caring, ambitious and inclusive. Our people are our greatest asset, and we are committed to creating an environment where everyone feels truly welcome, supported and valued. We are proud of the diversity of our organisation and recognise the important contribution this makes to the delivery of safe, high-quality care that meets the needs of our patients.

Since joining the Trust in September, I have been struck by how much has changed since 2019, but also by what remains constant: the deep care our people show for patients, their teams and our communities. I am confident that our collective talent, energy and commitment mean we are well placed to build on this year's achievements and respond to the challenges ahead in the positive way that our patients, and the communities we serve, need and expect.

Dame Amanda Pritchard
Chief Executive Officer
24 June 2026

Overview

About our organisation

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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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.

In 2026 we began working with primary care and other local partners in Lambeth and Southwark as a pilot site for the National Neighbourhood Health Implementation Programme to provide more joined-up, accessible and personalised community-based care.

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.'

Our values: caring, ambitious, inclusive, guide us in everything we do, and our 'Better, faster, fairer healthcare for all' strategy provides 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 an anchor organisation 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.

Our priorities

The Trust's 4 main priorities in 2025/26 were:

- 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 through 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.

Together these support the delivery of safe, high-quality care and enable our strategy to 2030: 'Better, faster, fairer healthcare for all'.

Key operational and financial risks

As with all NHS organisations, we face the continual challenge of balancing the delivery of high-quality care with rising demand for our services, rising patient acuity and the need to increase both productivity and efficiency to meet challenging activity requirements.

Further details of our key risks for 2025/26 are set out on page 84 and 85 of the Annual Governance Statement.

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 a comprehensive productivity programme, remains a key priority in 2026/27. Further details of the financial risks are available on page 17 of this report. The principal strategic risks for the organisation in 2026/27 are available on pages 84 and 85 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.

Performance analysis – clinical

Thanks to the hard work and dedication of our staff, the Trust delivered a strong performance by the end of March 2026. Our position in Segment 1 of the NHS Oversight Framework reflected the good progress made in reducing the number of patients waiting for treatment and our strong performance against the 4-hour urgent and emergency care standard.

The Trust's clinical performance is measured against key national standards which are set by NHS England. These include: the number of patients waiting over 62 days for their first cancer treatment, the number of patients waiting over 18 weeks for routine treatment, the number of patients waiting over 6 weeks for a routine diagnostic test or procedure, and the 4-hour target for urgent and emergency care. Delivery is monitored by the Board of Directors and its Quality and Performance Committee.

This year a new NHS Oversight Framework was introduced which ranks trusts' performance against key metrics on a quarterly basis. The Trust was placed in the highest-performing category (segment 1) following the initial publication of rankings in June 2025, and maintained this position in subsequent rankings for quarters 2, 3 and 4. Further information is available on page 79.

Our performance against the key standards is described below.

Urgent and emergency care

During 2025/2026 the Trust's urgent and emergency care performance has been amongst the best in the country, and until January we consistently achieved the national standard that 78% of patients were admitted or discharged within 4 hours. However, due to the increased demand in the final quarter of the year, we were unable to maintain this and, in March, our performance against the 4-hour standard was 74.39%.

While we narrowly missed the national standard, this provides a strong foundation for further improvement. Over the year, we have strengthened operational oversight and enhanced clinical leadership across our emergency pathways.

Our patient flow improvement programme has focused on increasing the use Same Day Emergency Care, reducing unnecessary admissions, and ensuring patients receive the right care in the right place at the right time. We have also made sustained improvements in ambulance handovers, achieving a median offload time of 22 mins and 31 seconds.

Increasing activity

We have worked extremely hard to deliver our operational plan and increase the number of patients we were able to treat. In 2025/26 we saw an additional 46,778 new outpatients and completed 41,653 surgical procedures, an increase of 9.3% and 3.3% respectively compared to 2024/25. This was achieved through initiatives such as extended working hours and weekend work, targeted investment in our planned theatre refurbishment programme, and participation in a number of national 'sprint' programmes to treat additional patients. We also had a Trust-wide focus on reducing the amount of time patients spend in hospital by supporting them to go home as soon as it's safe to do so.

These efforts were interrupted by several episodes of industrial action by resident doctors in response to a national pay dispute. While our teams worked hard to maintain services across our hospital and community sites, our business continuity plans required the cancellation of some planned

appointments, so that we could prioritise urgent care, cancer treatment and those patients who had been waiting the longest.

Across the year, industrial action resulted in an activity reduction of 4.3% including 1,043 inpatient and day case procedures and 5,623 new and follow-up appointments, reducing our ability to increase our activity as much as planned.

To help address the ongoing pressures on our operating theatre capacity, we have continued to expand our robotic surgery programme, which is one of the largest in the UK, and now has 15 robotic systems. This year we added a knee robot and a robotic navigational bronchoscopy system, as well as additional robotic surgery devices at Harefield and St Thomas' hospitals.

Further information about our service improvements and innovations in patient care are available in the Directors' Report on pages 37 and 38.

Reducing waiting times

In total the Trust's overall waiting list reduced by 12% (14,866) from 120,654 at the beginning of the year to 105,788 at the end of March 2026.

We have continued to focus on reducing the number of patients waiting longest for treatment, including delivering 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 these efforts, the Trust was placed into the NHS England's regulatory tiering programme for planned (elective) waits in October 2025. We have significantly improved our performance over the year, and we have also reduced the number of patients waiting over 52 weeks for treatment by 28.5%, from a high of 2,722 in June 2025 to 775 at the end of March 2026.

At the end of the year, we had 8 patients who had waited more than 65 weeks for treatment, with 1 patient waiting more than 78 weeks, which represents a significant reduction since the peak of 287 patients waiting over 65 weeks in August 2025.

We are working hard to ensure that these patients are treated as quickly as possible and we are committed to ensuring that no patients experience these longest waits for treatment in future.

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 which is now used by more than 940,000 patients from Guy's and St Thomas' and King's College Hospitals. This gives patients greater involvement and control over their care – this includes details about their appointments and information about any test, treatment or procedure. Going forward we will enable many patients to choose or reschedule appointments at a time of their choice as well as make use of appointments cancelled by other patients, wherever possible.

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 considerable progress, particularly in reducing diagnostic waiting times, and we have welcomed the support received.

Our performance against the Faster Diagnosis Standard has shown sustained improvement, and in March 86.8% of patients received their diagnosis within 28 days, exceeding the national standard of 80%. At the start of the year the Trust was ranked 13 out of 132 trusts for the Faster Diagnosis Standard and in March 2026 we ranked 6th highest nationally.

Performance against the national standard for 2025/26 that 70% of patients should begin their cancer treatment within 62 days remains our greatest operational challenge - particularly for some tumour groups where the Trust is the main provider of specialist care and receives referrals for complex treatment 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 in 2026/27 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, where increased demand for complex specialist care exceeds current capacity, and for breast cancer.

As a result, we remained below plan against the 62-day standard, with an overall performance of 65% (70% for patients referred directly to the Trust) in March 2026. A number of operational challenges, including pathology waiting times, loss of independent sector capacity, and staffing challenges in some areas, have affected our ability to improve as quickly as planned. However, the number of cancer patients waiting longer than 62 days for their cancer treatment to begin reduced from 418 in March 2025, to 307 at the end of the year.

We welcome the Government's National Cancer Plan which sets out a clear vision and priorities for cancer care, including improving outcomes for rare cancers, earlier cancer diagnosis and a focus on innovation. We will continue our efforts to support innovative treatments and provide teams with the right resources, technology and capacity to deliver cancer care as quickly as possible.

We will continue to work across the sector, as part of the South East London Cancer Alliance, and with our referring trust partners, to ensure the fastest possible access to specialist diagnostics, specialist multi-disciplinary teams and the most appropriate treatments.

Diagnostic tests

Diagnostic services, including imaging, pathology and genomics, support over 85% of our clinical pathways. We provide a broad range of tests, procedures and specialist services that enable early diagnosis and the delivery of high-quality care.

In the last year the Trust saw a 5.2% increase in patients being referred onto our diagnostics waiting list, exceeding service capacity in several areas such as imaging and sleep studies. This reflects a national trend, driven by an ageing population, rising prevalence of long-term conditions requiring ongoing monitoring, and increased demand for urgent screening, particularly for cancer. Our local communities also experience high levels of deprivation and long-term conditions, which further contributes to this growing demand.

These pressures have made it challenging to meet the national standard that fewer than 1% of patients should wait longer than 6 weeks for a diagnostic test. However, targeted improvement programmes are delivering results. For example, we have reduced the number of patients waiting over 6 weeks for an echocardiogram by 82%, and our children's audiology service has reduced long waits by 86% over the past year.

Imaging, in particular, has seen a significant increase in demand and we are working hard to increase activity and invest in new technologies and equipment to ensure high-quality care and patient experience. Over the last year the Trust has invested in a new fluoroscopy unit and a general x-ray room.

To support the vital role of diagnostics in prevention and early detection, and to enable more care to be delivered closer to home, we continue to work with sector partners and our stakeholders to expand community diagnostic capacity across south east and

north west London.

While this work is ongoing, performance has not yet improved to meet our year-end plan, and at March 2026 34.18% of patients have been waiting more than 6 weeks, against a target of 12%. As a result, the Trust has remained in NHS England's regulatory tiering programme for diagnostics since March 2024.

We remain committed to improving diagnostic performance, achieving constitutional standards, and ensuring our patients are offered the most appropriate pathway to secure high standards of care and clinical decision making, whether this is in the hospital or closer to home and in the community.

Community care

Our adults' 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 and GP surgeries.

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

In 2025/26 over 639,200 community patient contacts were delivered by multi-disciplinary teams which include pharmacists, nurses, doctors, allied health professionals, social workers and support workers.

Our community teams are at the heart of our commitment to improve the health of our local population and develop integrated neighbourhood teams. Our work to tackle health inequalities is described on pages 23 to 31.

Performance analysis – financial

Financial performance analysis

The Trust's Adjusted Financial Performance at the end of the financial year was a surplus of £5.2 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 £39.3 million.

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, at the end of the financial year the Trust reported a surplus of £5.2 million before technical adjustments.

The adjustments are shown in the table below and include: impairments of £35.1 million arising from revaluation of land and buildings; the £9.4 million impact of income and expenditure associated with capital donations, which was £0.7 million above plan, made up of in-year donations of £4 million and £13.1 million in depreciation and amortisation of capital donations; and 1 minor technical adjustment.

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.

Cost improvement programme

At the start of the year, the Trust set an ambitious cost improvement programme target of £102.1 million, reflecting the level of savings required to deliver the financial plan, achieve national efficiency targets, and support increased patient activity. Delivery remained challenging during the year and required a combination of workforce controls, operational productivity improvement, and tighter financial management. To support this, the Trust implemented a Mutually Agreed Resignation Scheme, strengthened vacancy controls, particularly across administrative and corporate

Financial performance against plan	Plan £'000	Actual £'000	Variance £'000
Total (deficit)	(8,708)	**(39,307)**	(30,599)
Less: Impairment movements	-	**(35,140)**	(35,140)
Capital donations & donated depreciation	(8,708)	**(9,388)**	(680)
Technical accounting adjustments	-	**(2)**	(2)
Adjusted Financial Performance	-	**5,223**	5,223

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 £5.2 million

areas, and established a Productivity Programme focused on opportunities linked to administration, patient flow, surgery, ambulatory care, and private patient income. At the end of the year, the Trust had identified £83.5 million of potential savings and had delivered £73.3 million of these – 72% of the target.

Cash flow

The Trust began the financial year with £191 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 decreased by £22 million, to £169 million. For details of the Trust's net cash balances, see note 26 in the annual accounts. These changes during the year are the result of capital support from NHS England, movements in working capital, investment in property and other intangible assets, and proceeds from the sale of a subsidiary, Lexica Health and Life Sciences Consultancy Limited. The operating surplus after adding back non-cash items resulted in £100 million of net cash generated from operating activities.

The Trust spent a net £123 million on investments, including payments of £160 million purchasing intangible assets and property, plant and machinery whilst investment receipts included £9 million from the settlement of assets, £8 million in interest and £16 million from the sale of a subsidiary. A net £1 million was received in Public Dividend Capital receipts and payments, lease liability repayments, and loan repayments. Full details can be found in the statements of cash flows in the annual accounts on page 102.

Charitable funding

The Trust received £17 million from charitable sources during the year, £4 million of which consisted of donations towards capital expenditure and included funds from Guy's & St Thomas' Foundation and the National Institute for Health and Care Research (NIHR).

Capital expenditure

In 2025/26, the Trust incurred capital costs of £156 million, and £4 million of donated assets, on property, plant and equipment (£98 million and £0.3 million of donated assets in 2024/25). The Trust also spent £18 million on intangible assets, mostly software and other information technology assets (£5 million in 2024/25). 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 £176 million left outstanding in principal and interest on drawn down loans totalling £315 million. During the year, the Trust made principal repayments of £17 million and interest payments of £4 million, creating a cash outflow of £21 million, and interest of a further £4 million was charged. At the year end, total borrowings equated to £158 million. See note 24.6 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 £35 million (£20 million charge in 2024/25). In addition, impairments were charged to the revaluation reserve of £81 million (£7 million in 2024/25). Together, and including a small charge for assets abandoned in the course of construction, the net impairment charge is £116 million (£28 million in 2024/25). 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 16 to the annual accounts.

External audit services

Grant Thornton UK LLP received £415,000 in audit fees (excluding VAT) in relation to the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2026. For more details, see note 7.1 to the annual accounts.

Financial risks and mitigations

The Trust continues to face material financial sustainability risk driven by a gap between income and expenditure on an underlying basis. This is linked to uncertainty in the external funding environment, including changes to the national tariff, Integrated Care System financial frameworks and the ongoing transition away from funding via block contracts. Together, these factors create volatility in income flows and limit the Trust's ability to plan with certainty, increasing the risk of a widening deficit over the medium term.

There is a significant constraint on the Trust's ability to invest in its strategic priorities due to national capital expenditure limits. The level of capital funding available is insufficient to fully support delivery of the Trust's estates and digital ambitions. In addition, there remains delivery risk within the capital programme, including the potential for cost overruns or schemes not delivering expected benefits, which could further reduce available headroom and impact financial performance.

Operational financial risks remain inherent in the scale and complexity of the Trust's financial processes. These include risks around the accuracy of financial reporting, for example through accruals and coding, as well as exposure to fraud and regulatory non-compliance. While robust controls and assurance processes are in place, these risks require ongoing management to ensure that the Trust's financial position is reported accurately and remains compliant with statutory requirements.

Finally, there are risks associated with delivery of the financial plan itself. Failure to deliver cost improvement programmes or continued deficits could lead to increasing cash flow pressures, affecting the Trust's ability to meet its financial obligations and sustain service delivery. These risks reinforce the importance of disciplined financial management, realistic planning assumptions, and continued engagement with system partners and national bodies.

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 2026/27 to 2030/31 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 £500 million.

Procurement

During 2025/26, the Procurement Shared Service successfully embedded a new operating model across its 5 member trusts, strengthening collaboration and delivering enhanced consistency of service. Key operational improvements were implemented across customer service, performance reporting, strategic sourcing, governance, and savings delivery, further enhancing the effectiveness and resilience of the service.

A comprehensive transformation programme was initiated during the year focused on modernising and optimising the end-to-end supply chain. This programme encompasses inbound logistics, optimisation of significant supply chain assets, and enabling improvements in technology and workforce capability to support long-term efficiency and sustainability.

Collectively, the Shared Service delivered more than £11 million of value to member trusts during the year. Building on this strong performance, advancing clinical engagement and partnership working will remain a key strategic priority for 2026/27.

Trends in activity, income and expenditure

Chart 1: Completed patient spells

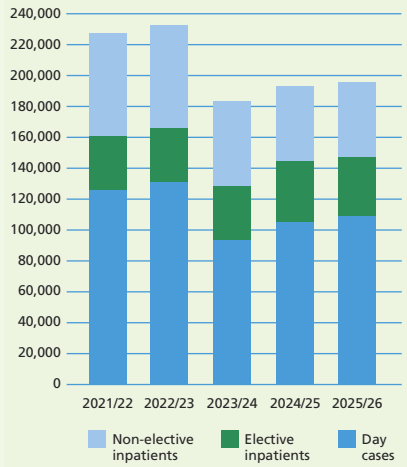


Chart 2: Outpatient attendances

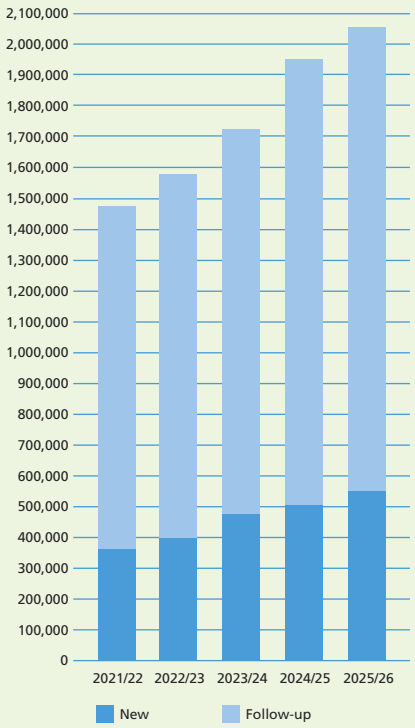
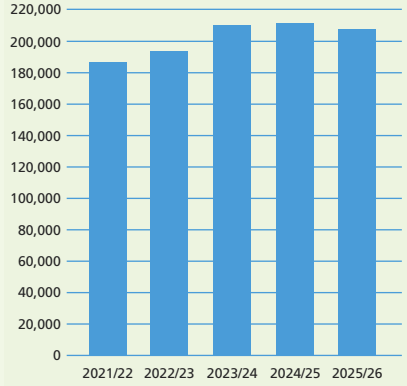


Chart 3: A&E attendances



During 2025/26, we saw 2,055,000 outpatients, 86,000 inpatients, 110,000 day-case patients and 207,000 accident and emergency attendances.

We also provided over 639,200 contacts in the community.

Chart 4: Operating income £millions

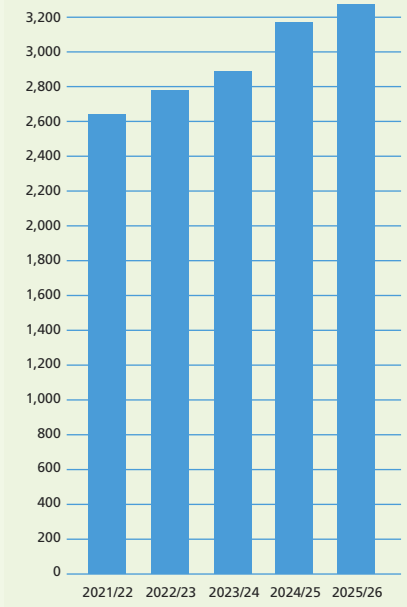
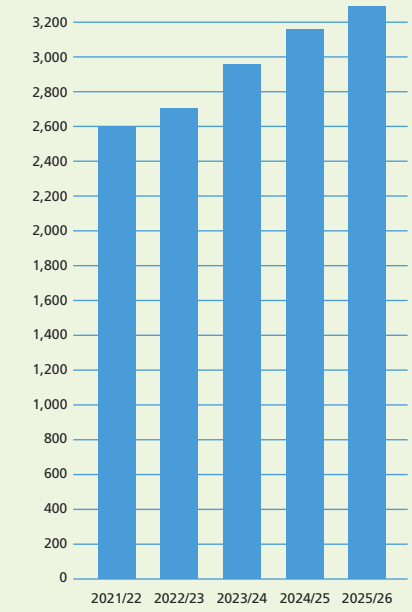


Chart 5: Operating expenditure £millions



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

In January 2026, we published our Green Plan to 2028, available on our website at **www.guysandstthomas.nhs.uk/about-us/sustainability**.

The plan sets out how we will protect the environment across 10 focus areas over the next 3 years, while continuing to provide the best possible care for our patients. It was developed through extensive engagement with colleagues, patients, visitors and partners, including workshops, drop-in sessions and surveys.

As part of the Green Plan we have committed to incorporating sustainability into everything we do, which means treating our patients in the most environmentally friendly way. It also means transforming our green spaces, improving the air we breathe, minimising waste and championing cleaner, greener ways of getting around. As well as creating a healthier local environment, these measures will improve the health and wellbeing of our patients, colleagues and visitors.

While we have a long way to go to reach Net Zero we are pleased to have reduced our NHS Carbon Footprint (the emissions we directly control) by 7% over the year. Our NHS Carbon Footprint Plus (which we can only influence) has remained flat.

Empowering our workforce

We educate and empower our colleagues to make sustainable choices in their everyday lives, both at work and home. This year we launched a Green Champions Network, now with 50 members, who have dedicated time to lead sustainability activities across the Trust. Colleagues are also building practical skills through the Sustainable Healthcare Academy, delivered by NHS-approved provider LDN Apprenticeships, enabling them to apply sustainable practices directly in their roles.

We have continued to drive behaviour change through the Trust's Gloves Off campaign which aims to reduce unnecessary use of non-sterile gloves. Since launching the campaign in September 2024, we have saved 2.58 million gloves, £315,000, 12.9 tonnes of plastic waste and 67.1 tonnes of CO2e (equivalent to 57 return flights from London to New York). We have won 3 national awards for this work.

Reducing emissions

We received Government funding to install solar panels in 5 of our community sites across Lambeth and Southwark. This will help us power our services with clean energy and reduce our energy bills, providing savings which can be reinvested into frontline care.

We also received funding to install electric vehicle chargers across 8 community and hospital sites which will enable us to further electrify our core fleet to reduce carbon emissions and improve local air quality.

LED lighting upgrades across the Evelina London Children's Hospital, Royal Brompton Hospital and our community sites deliver energy savings of 60–70%, with an estimated annual cost savings of £250,000, alongside improved lighting quality, reduced heat output and enhanced wellbeing through smart sensors.

We have developed an Energy-as-a-Service model with external partners, to decarbonise and futureproof our building energy. The proposed solution will use a low temperature hot water system combined with air source heat pumps, and potential connection to a District Energy Network. This project is anticipated to achieve over a 50% CO_2 equivalent reduction by 2029, which would exceed NHS Net Zero targets.

We have continued to support our colleagues, patients and visitors to use more active and sustainable means of transport to reduce our carbon emissions. We only offer electric vehicles through our salary sacrifice scheme, and electric vehicles now make up over 90% of this fleet. As part of our Green Plan we are working towards ensuring at least 30% of Trust vehicles, including specialist patient transport vehicles, are electric by 2028.

We have also made further progress on improving fleet efficiency by disposing of our most underutilised vehicles. Despite this, our core fleet CO2e emissions increased by 13% over the year, which was due to our programme to bring all patient transport in-house, and improving the quality of our data.

Nitrous oxide is an anaesthetic gas that is responsible for 2 thirds of our anaesthetic carbon footprint. Where it is still needed for patient care, we are making sure it is used efficiently and we have

Environmental impact performance indicators 2025/26

Overall carbon footprint	2025/26	2024/25*	% change 25/26 vs 24/25
NHS Carbon Footprint (we can directly control this), tCO2e	59,902	64,745	-7%
NHS Carbon Footprint Plus (including emissions we can only influence), tCO2e	346,767	347,575	0%

Please note: tCO2e is tonnes of carbon dioxide equivalent

Carbon footprint per key area	2025/26	2024/25*	% change 25/26 vs 24/25
Utilities			
Water ($m^{3)}$	724,702	736,873	-2%
Imported Electricity (kWh)	62,334,790	60,259,718	3%
Gas (kWh)	186,096,744	200,017,942	-7%
Oil (kWh)	1,535,876	2,102,277	-27%
tCO2e for building energy use	55,470	59,898	-7%

Waste, acute hospitals	2025/26	2024/25*	% change 25/26 vs 24/25
All waste (tonnes)	5,864	5,642	4%
High temperature disposal (tonnes)**	201	537	-63%
Alternative Treatment (tonnes)	1,338	1,385	-3%
Offensive Waste (tonnes)**	1,395	975	43%
Landfill waste (tonnes)	–	–	–
Recycling by % of total domestic waste	50%	47%	6%
tCO2e all waste	683	1,005	-32%

Travel and transport	2025/26	2024/25*	% change 25/26 vs 24/25
Core fleet (cars, vans and minibuses), vehicles	285	307	-7%
tCO2e***	1,243	1,100	13%
Air pollution – tNOx	3.04	2.62	16%
Air pollution – tPM2.5	0.13	0.12	9%
Salary sacrifice fleet, vehicles	334	297	12%
tCO2e	255	287	-11%
Grey fleet, mileage	222,642	288,094	-23%
tCO2e	72	93	-23%
Air travel, mileage	1,431,274	1,141,850	25%
tCO2e****	420	508	-17%
Public transport, mileage claimed	17,660	14,909	18%
tCO2e	2	1	3%
Cycling, mileage claimed	4,074	2,798	46%

Anaesthetic gases	2025/26	2024/25*	% change 25/26 vs 24/25
Desflurane tCO2e	0	0	0%
Isoflurane tCO2e	102	102	0%
Sevoflurane tCO2e	188	181	4%
Nitrous oxide pure tCO2e	885	886	0%
Nitrous oxide mixed– Entonox tCO2e	658	634	4%

* Please note that these figures may vary from those reported in the 2024/25 Annual Report where more accurate data became available following publication.

** This is in line with the NHSE Clinical Waste Strategy targets encouraging a shift away from high-temperature incineration towards the lower carbon offensive waste stream.

*** CO2e emissions increased despite a decrease in fleet size as data quality and stability improved following patient transport services being brought in-house in 2024/25.

**** CO2e emissions decreased despite a rise in air mileage. This is due to reduced emissions per air mile and a relative increase in long-haul flights that are less polluting per mile than short-haul flights.

secured funding from NHS England to further reduce nitrous oxide wastage across our hospitals. We have now decommissioned 2 out of 5 piped nitrous oxide systems and expect to see emissions reduce next year.

Greenspace and air quality

With funding from Impact on Urban Health, part of Guy's & St Thomas' Foundation, we are making progress in addressing 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. Particulate matter pollution at St Thomas' main entrance reduced by 16% between 2022 and 2025.

We have received funding from the Centre for Sustainable Healthcare to deliver the Healthy by Nature programme. The project provides a dedicated Nature Recovery Ranger to support patient recovery and staff wellbeing, while enhancing local biodiversity through landscaping and nature-based activities.

Reducing waste

Greenhouse gas emissions from all waste fell by over 30% over the year, largely due to our ongoing focus on treating offensive but non-infectious waste at lower temperatures. We also increased our recycling rate to 60%, up from 56%.

We have introduced reusable sharps containers to dispose of needles, blades and razors preventing plastic waste being sent to high-temperature incineration. We expect the project to reduce carbon emissions from plastic incineration by 89%, the equivalent of 500 tonnes of CO2e a year.

We have installed specially designed walking aids collection points at several of our sites so patients can easily drop off crutches and metal walking sticks which they no longer need. More than 375 sets of walking aids have been returned for reuse since September 2025, which equates to 3,360kg reduction in carbon emissions and over £2,300 cost savings.

Our catering teams have implemented sustainable menu changes including seasonal, plant-based dishes and ethical meat substitutions. The Trust has also donated 18,405 meals over the past year through food waste donation partners Olio and the Felix Project, supporting local families and preventing this food going to waste. Menu changes and food waste reduction at Royal Brompton Hospital alone have saved 44 tonnes of CO2e annually.

We have reintroduced an online platform, which allows staff to reuse unwanted furniture and equipment saving £35,000 in procurement and disposal costs.

We're also saving paper, cutting energy use and reducing costs through our 'Pause Before you Print' campaign, and through MyChart and Epic, our electronic health record, and the ongoing roll out of digital communication with patients.

Task Force on Climate-related Financial 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 footprint, which we have been able to report across all Trust sites and activity since 2023/24 (please see table on page 20).

The phased approach incorporates the disclosure requirements relating to governance, strategy, risk management, as well as metrics and targets which are described 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 Green Plan is overseen at an executive level by the Green Plan Delivery Board, which has representation from all clinical and delivery groups and our corporate teams. The delivery board meets every 2 months and reports biannually to the Trust

Executive Committee.

The Green Plan Delivery Board is chaired by our Board-level net zero lead, whose role is to drive forwards the sustainability agenda and promote environmental considerations through the delivery board and its members.

We have established net zero clinical leads to help embed sustainability within clinical pathways, share best practice and deliver high-quality, low-carbon care across the organisation.

Our sustainability team continues to work across Guy's and St Thomas' and King's College Hospital NHS Foundation Trusts to integrate sustainability into all aspects of our work, ensuring our efforts to protect the environment are central to our quality improvement activities.

● Strategy

Work to meet the Taskforce's recommended disclosures in relation to strategy, risk management and metrics is being developed – with a particular focus on ensuring we can deliver the level of analysis required.

In 2026/27, we will publish a Climate Change Adaptation Plan setting out the key risks to the organisation, how these could impact our Trust strategy, operations and finances as well as our priorities to address these.

● 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 team and include the 'severe weather plan', 'heatwave plan' and Corporate Business Continuity Plan.

Our Climate Change Adaptation Plan will include a climate change risk assessment which will be integrated into the corporate risk register.

Further information about our approach to managing climate-based risk is set out on page 87 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 2025/26 are outlined on page 20 and are used to track our progress to net zero as well as other sustainability programme targets.

Our Green Plan to 2028 sets out the targets and objectives for each of our 10 focus areas and these will be reviewed as we develop our Climate Change Adaptation Plan.

Tackling health inequalities

In line with the NHS 10-year plan, our 'Better, faster, fairer healthcare for all' strategy sets out the Trust's commitment to tackle differences in health and healthcare access across our communities. We are building our capability to understand where equalities exist so we can adapt our services and deliver fairer, faster, more equitable healthcare to all those we serve.

Demand for healthcare is rising, driven by an ageing population with increasing frailty and more people living with multiple long-term conditions. There are also significant, unfair and avoidable differences in health outcomes between people from different socioeconomic backgrounds and ethnic groups, which can be even greater for people with disabilities.

This report sets out our response to NHS England's statement on information on health inequalities, published in November 2025, which supports us to fulfil our legal duties and take an evidence-led improvement approach to tacking inequalities. It also provides a review of the extent to which the Trust has exercised its functions consistently with NHS England's statement, including how we collect, analyse and use information on health inequalities aligned with the Core20PLUS5 approach to inform action and improve outcomes.

Throughout this report, deprivation is measured using the Index of Multiple Deprivation (IMD) which is reported on a scale of 1-10, or quintiles 1-5, where 1 refers to 'most deprived'.

Understanding population health needs

Our local communities

We serve diverse communities across 2 integrated care systems: South East London and NHS West and North London. We deliver local hospital and community services across Lambeth and Southwark, working closely with a range of partners to deliver care through more than 3 million patient contacts a year.

People in the richest and poorest communities in Lambeth and Southwark can face a difference in life expectancy of up to 12 years, and of 17 years in the number of years lived in good health. Across south east London, rates of preventable deaths from conditions such as cancer and cardiovascular disease are higher than average, around 150,000 residents are living with 3 or more long-term conditions, and the area has one of the highest rates of pre-term births in London.

50% of our inpatients experience high levels of deprivation, within quintiles 1 and 2 on the Index of Multiple Deprivation. For emergency admissions, this increases to 59% of patients, with a higher proportion of patients from Black, Asian and mixed communities.

As a Trust serving a diverse population, we are committed to understanding and addressing inequalities in access, experience and outcomes – particularly for racialised communities. By monitoring these differences, we can design and deliver more culturally sensitive care and reduce unfair variation. While there are examples of positive action across the Trust, we recognise the need for a more coordinated and systematic approach to drive sustained improvement.

Consistent with the Core20PLUS5 approach, our priority populations include people living in the most deprived communities, alongside locally identified groups experiencing poorer access, experience or outcomes. These include racialised communities, inclusion health groups (such as people experiencing homelessness, vulnerable migrants and those with complex social needs), and those with multiple long-term conditions and frailty.

Population Health Hub

The Guy's and St Thomas' Population Health Hub was established in 2025 and brings together expertise from across the Trust and our university partners to improve health outcomes for defined patient groups. Funded by Guy's and St Thomas' Charity, the Hub supports our strategic priority of 'improving the health of our populations'.

Recognising the important role robust data plays in a successful population health programme, the Hub has been working with South East London Integrated Care Board to improve data architecture, quality, access

and analytics to support population health.

Through the Hub we have worked with partners across south east London to identify patient cohorts with multiple long-term conditions and frailty who would benefit from care delivered closer to home. With support from the Trust's AI Centre, the Hub is identifying patients in North Lambeth who would most benefit from an integrated care programme that spans primary and secondary care and has enabled evidence-based clinical interventions for patients along their clinical pathways.

Our Population Health Hub also plays a central role in our work to develop Integrated Neighbourhood Teams which coordinate care across services, so patients can receive the support they need closer to home.

Improving data quality, collection and analysis

Over the past year, we have worked to collect more robust data that will enable us to identify inequalities and understand the health needs of specific communities and patient groups. This includes:

- developing the population health dashboard – this allows us to track patient population data by protected characteristic, Index of Multiple Deprivation (IMD), and the Income Deprivation Affecting Children Index (IDACI). This insight enables our clinical teams, at service level, to see the proportion of their patient population who are most deprived, and to analyse this information along with other characteristics such as ethnicity and age.
- widening data collection – to enable us to analyse inequalities at key steps in the patient pathway, including how long they wait, how much time they spend in hospital, whether they used patient-initiated follow-up or 'did not attend', and if they have a range of health conditions.
- developing tailored staff training – we are improving our skills and capacity in population health through tailored training sessions for clinical teams about our population health approach, why it's important and how we capture data on protected characteristics.
- developing 2 new data-led tools – the first will help us measure how fairly services are delivered, using key areas such as the waits for diagnostic tests, so we can track progress in reducing inequalities. The second will build on our DNA (Did Not Attend) predictor tool, expanding its use to support practical improvements across our waiting lists.
- maximising Epic – we are continuing to develop our electronic health record to support the collection of information which enables us to understand and address inequalities.

Together, this work will help us improve equitable access to care and support the development of innovative approaches to enhance patient access, experience and outcomes.

We recognise that although data quality is improving, there are still gaps in key demographic fields and improving the completeness and consistency of protected characteristic data is a priority for 2026/27. We will support this through staff training, improvements to Epic, stronger data validation, and by collecting and using a wider range of protected characteristic data, such as disability, where this is appropriate and feasible, to support a more comprehensive understanding of inequalities.

Understanding healthcare access, experience and outcomes

NHS England's statement on information on health inequalities sets out a measurement framework to support the collection and analysis of data to identify where inequalities could be affecting patient access and experience. We are working to embed the measurement framework across the Trust and have only included data which is considered sufficiently robust within this report.

The table on page 25 sets out the operational and Core20PLUS5 priorities, where we have investigated inequality indicators relating to deprivation, sex, age and ethnicity.

Planned (elective) care

Age – During 2025/26 patients aged 35 to 44 years old were found, on average, to wait the longest for treatment. This age group was less likely to be seen within 18 weeks for planned (elective) treatment. Young children and people aged 80 - 89 waited the shortest time for treatment.

To make a fair comparison between age groups, we

Priority inequality measures for 2025/26

Priority area	Service or area	Inequalities across the following indicators
Operational priorities	Planned (elective) Care	Percentage of people waiting 18 weeks or less for treatment Rate of patients by sociodemographic variable (age, sex, deprivation, ethnicity) per 100 pathways waiting 52 weeks or more for treatment
	Urgent and Emergency Care	Mean time spent in emergency department
	Cancer	Cancer diagnosis at stage 1 and 2
	Community services	Patients on community waiting list for more than 18 weeks Rates of missed appointments (Did Not Attend)
	Patient experience	Variations in the Friends and Family Test results
Core20 PLUS5 adults	Maternity	Gestational age at booking - under 10 weeks, and over 10 weeks Completeness of ethnicity reporting
	Smoking cessation	Inpatient quit attempts through in-house tobacco dependence treatment service Inpatients who maintain cessation at 28 days after supported quit attempt
Core20 PLUS5 children and young people	Urgent and emergency care	Inequalities in children and young people's emergency department attendances
	Oral health	Hospital-based tooth extractions due to dental caries
	Diabetes	Children and young people with type 1 and 2 diabetes receiving NICE care processes
	Trust ethnicity reporting	Overall completeness and percentage of records not stated

Inequalities in waiting times for planned (elective) care

	Age group	Avg. wait (days)	18 week performance (%)	52-week waits per 100 pathways
Age groups with the shortest waits and fewest 52 week waits per 100 pathways.	0-4	75	78.5%	0.5
	0-14	95	72.2%	2.2
	80-84	90	74.2%	3.2
	85-89	88	75.4%	3.1
Age groups with longest waits and most 52 weeks per 100 pathways.	30-34	107	67.8%	3.6
	35-39	108	67.7%	3.7
	40-44	108	67.6%	3.8
	50-54	103	69.7%	3.9

Please note: We have standardised our patient 52 week wait data, for smaller numbers this is more meaningful than percentages.

looked at how many patients out of every 100 are waiting over 52 weeks, rather than using percentages. This shows that people aged 40-44 and 50-54 are more likely to face longer waits. This is a concern, as these groups are experiencing increasing health needs.

National datasets have found the number of working age people reporting at least one long-term condition has risen to 36%, with the number of people inactive because of long-term sickness and reporting 5 or more long-term illnesses - such as musculoskeletal disorders, hypertension, diabetes and mental health conditions - is increasing. Our data also shows some patients aged 90 and over are waiting more than 52 weeks, which is being urgently investigated.

Deprivation – For patients waiting over both 18 and 52 weeks, we found strong evidence that patients living in areas of greater deprivation (quintile 1 of the Index of Multiple Deprivation, which includes the 20% most deprived communities) were, on average, waiting more than 3 days longer for treatment than patients who live in more affluent areas.

Living in areas of deprivation, which is generally associated with a lower income, has been shown to present distinct barriers to accessing healthcare, as well as other resources that enable people to lead healthy lives. This often also means more missed healthcare appointments and worse health outcomes.

IMD	Average wait (days)	18 week performance %	52 week waits per 100 pathways
1 (most deprived)	101.2	70.1%	3.5
2	100.2	70.5%	3.3
3	100.8	70.3%	3.4
4	99.8	70.8%	3.2
5 (least deprived)	98.3	71.7%	3.0

Please note: We have standardised our patient 52 week wait data, for smaller numbers this is more meaningful than percentages.

Ethnicity – Within our 18-week data, patients from mixed heritage communities are on average waiting longer for treatment than other ethnic groups. However, 52-week data is more variable, with patients from Asian communities experiencing more 52-week waits than other communities.

Ethnicity	Average wait (days)	18 week performance %	52 week waits per 100 pathways
Asian	99.4	71.2%	3.5
Black	99.8	70.5%	3.3
Mixed	103.1	69.7%	3.4
Other	99.0	70.8%	3.2
White	101.2	70.4%	3.0

Sex – Our data does not show clear inequalities between men and women in average waiting times. However, there are considerably more women than men waiting for treatment, with approximately 4,900 more female patients waiting each month.

Although a greater number of women are waiting for treatment in total, the proportion of men waiting more than 18 and 52 weeks is slightly higher for male patients. These differences may be influenced by the types of services accessed by men and women, or by wider factors such as employment patterns affecting access to treatment.

Sex	Average number of patient pathways per month	Average wait (days)	18 week performance %	52 week waits per 100 pathways
Female	20859	100.1	70.4%	3.2
Male	15959	100.4	70.7%	3.5

We are improving our collection and reporting of patients who are intersex or identify as having differences in sex development in 2026/27, along with improving our collection of all protected characteristics.

Urgent and emergency care

Age – Our data shows a linear relationship between age and time spent within our emergency department at St Thomas' Hospital, with on average, older patients spending more time waiting for treatment. In March 2026, only 65% of adults aged over 70 years were seen in 4 hours.

On average 92% of children and young people aged under 18 years are seen within the 4-hour national target. In March 2026, 97% were seen in under 4 hours.

(Further information is available on page 29).

Deprivation – The Trust serves a diverse population with high levels of deprivation and our data shows that patients living in the most deprived areas are less likely to be seen within 4 hours when attending the emergency department. This may reflect that patients from areas of greater deprivation generally experience poorer health and have more complex needs, but it could also suggest that our processes are compounding existing inequalities in some way. Further work is needed to understand this better.

Ethnicity – Our data also shows that patients from Black communities are less likely to be seen within 4 hours, compared with other ethnic and cultural groups. While there is quite a bit of variation within this data, there are known inequalities in access, experience and outcomes for diverse racialised communities when using urgent and emergency care.

Sex – Female patients also appear to be less likely to be seen within 4 hours in the emergency department. However, further investigation is needed to understand the reasons for this difference and how this relates to differences in health needs.

Cancer

Age – Early diagnosis of cancer at stage 1 has been found to significantly improve survival rates for patients. In exploring access and outcomes for cancer patients, our data suggests working age adults aged 40 – 54 years are less likely to have their cancer diagnosed at stage 1 when compared with older and younger patients. This may reflect delays to accessing care due to work and caring responsibilities, a need to improve access to screening or a failure to recognise symptoms during the normal ageing process.

Deprivation – National datasets have found that death rates from cancer are also 60% higher for people living in the most deprived areas. Our data shows that there are fewer patients from IMD 1 (most deprived) being diagnosed at stage 1, compared to patients in IMD 5 (least deprived). Through the South East London Cancer Alliance, we work closely with our diverse communities across south east London, including to provide culturally sensitive health information and to improve access to and uptake of screening and treatment. Reducing inequalities within our cancer services is a priority area for the Trust in 2026/27.

Ethnicity – Emerging trends from our data suggest that Black patients are less likely to be diagnosed at stage 1. In the 2021 census, Black communities were found to make up roughly 24% of the south east London population, but appear to be underrepresented in our cancer data, particularly in relation to early diagnosis.

The South East London Cancer Alliance recently collaborated with a local theatre to stage a powerful production exploring the experiences of Black men recovering from prostate cancer which was designed to spark conversations about prostate cancer within the Black community and encourage Black men to speak to their GP about their greater risk of prostate cancer.

Sex – Our data also suggests that women are, on average, more likely to be diagnosed with cancer at stage 1. However, this is a complex picture across the different types of cancer, and also depends on the availability and uptake of screening programmes which will influence the time to diagnosis.

Community services

The Trust provides a wide range of community services in different settings, including health promotion services and specific support for people with complex health needs.

Deprivation – Our data shows that patients in Lambeth and Southwark living in the most deprived areas (IMD quintiles 1 and 2) were significantly more likely to miss their appointments than those patients living in less deprived areas (14.2% and 14.4% when compared with 12.2% for patients living in quintile 5).

IMD	Percentage of missed appointments
1 (most deprived)	14.2%
2	14.4%
3	13.6%
4	13.7%
5 (least deprived)	12.2%

Our data also shows that patients living in the most deprived areas are more likely to be referred to our community services than those in the least deprived

areas. Further work to reach and support these communities to prevent ill health is a key ambition of the NHS 10-year plan and remains a priority for the Trust.

Age – Missed appointments are more common among younger adults. People aged 20–39 have a DNA rate of 17–18%, compared with 13–14% for those aged 60 and over. Our community services are reviewing this and working to improve access by offering more flexible appointment options for patients.

Patient experience

Data from the 2025 Family and Friends Test, highlights variation in the experience of adult inpatients, outpatients and patients having day-case procedures, by ethnic and cultural background, particularly from Global Majority groups Black African, Black Caribbean, Arab and mixed ethnicities.

Women from Black Caribbean and Indian backgrounds reported poorer experiences. In addition, although these numbers are low, women from Black and Asian communities have higher maternal mortality rates. This is consistent with national findings and we are actively seeking to understand and address inequalities within our maternity and neonatal services.

The greatest variation in experience is for patients who chose not to state their ethnicity. We recognise that we must do more to ensure patients feel confident and comfortable to share this information, and are working to improve how staff ask patients about protected characteristics, including explaining how this information is used to improve patient experience

Core20PLUS5 – adults

Core20PLUS5 is a national strategy to reduce healthcare inequalities which focuses on the 20% of the national population living in the most deprived areas; plus local populations and groups who experience poorer than average health access, experiences or outcomes across the 5 key clinical areas that present the greatest opportunities to narrow the life expectancy gap.

Maternity services

Gestational age at booking – Our data shows that fewer women are booking their first maternity appointment with the Trust early in pregnancy compared to the national average. Only 27% of women book within the first 10 weeks (0–70 days), compared to 67% nationally, and more women are booking later:

- 32% between 10–13 weeks (compared to 19% nationally)
- 32% between 13–20 weeks (compared to 7% nationally)

Deprivation and age – Our data shows that younger women aged 18 – 29 years, and patients from Global Majority backgrounds who access our maternity services, are more likely to be living within areas of greater deprivation.

Living in areas of deprivation can create many barriers to accessing healthcare, including maternity care. Our data shows that women living in the most deprived areas have a higher rate of missed appointments: 4.1% in quintile 1, compared to 2.9% in quintile 5.

When we compare who uses the Trust's maternity services with national datasets, the Trust has a higher number of women using its services from areas of deprivation than the national average.

- a higher proportion of women from Quintiles 2 and 3 (more deprived)
- a similar proportion of women from Quintile 1 (most deprived)
- significantly fewer women from Quintile 5 (least deprived):
  5.7% for the Trust when compared to 15.0% nationally.

Ethnicity recording – We record the ethnicity of most women using our maternity services. For women who booked their care with us, ethnicity is recorded in 95% of cases, and for those who have given birth with us, it is recorded in 97% of cases.

Smoking cessation

Smoking remains strongly associated with most indicators of disadvantage, including deprivation and has been found to have a significant adverse impact on recovery times following surgery. Building on the commitments in the NHS Long Term Plan and the Core20Plus5 approach we offer patients tailored withdrawal programmes during their inpatient treatment and to support their longer-term health outcomes.

Age – Patients engaging in tobacco withdrawal were mostly aged between 55 – 59, with 38% aged between 55 – 70 and just 6.3% under 30 years of age. This is consistent with national data and local trends.

More older patients maintained abstinence at 28 days compared with those in younger age groups.

Deprivation – Our data shows that the majority (62.8%) of patients were from the most deprived communities (quintiles 1 and 2), with only 18% of patients living in more affluent areas. Patients living in more affluent areas had the highest quit rate at 28 days (20.5%), compared with 13.9% for patients living in the most deprived areas. The stress of living in deprived neighbourhoods has been associated with higher rates of smoking.

Ethnicity – 56.3% of patients using our smoking cessation services identified as White, 11.5% identified as Black, and just 4.8% were from Asian communities. Black communities make up approximately 24.6% of south east London residents, while Asian communities are approximately 10.3%, suggesting that these patients are underrepresented in the use of this service.

Those of Asian ethnicity had the highest quit rate at 21%, other ethnic categories had a success rate of 17.3%, while the lowest rate of 8.3% was in the Mixed ethnic group.

Sex – Over the last year, more men (61.5%) received support from our in-house tobacco withdrawal service than women (38.5%). 16.8% of men reported that they had maintained abstinence from tobacco at 28 days, compared to 12.9% of women.

Core20PLUS5 – children and young people

Urgent and emergency care

Deprivation – A higher proportion of children and young people from the most deprived areas attend the emergency department. They make up 52% of the local population but 62% of those attending the Trust's urgent or emergency care services.

Ethnicity – In Lambeth and Southwark, Black children and young people account for a higher proportion of emergency department attendances when compared to other groups. Black, African, Caribbean and Black British children and young people make up 30% of the population but 34% of those attending. White children make up 40% of the of the population, but only 33% of all those attending.

Frequent attenders – A higher proportion of frequent attenders in the emergency department are also from the most deprived areas (quintiles 1 and 2) although there are significant differences in terms of ethnicity.

Oral health

Our data shows that 64 children were admitted for hospital-based extractions due to dental caries in 2025/26, although more work is needed to fully understand the data.

Deprivation – Just under half of these children and young people (29) were living in areas of greater deprivation (IMD deciles 1 – 3).

Ethnicity and age – More children and young people from Black, Asian and Mixed ethnicities made up this group than those who were White British. There were also fewer White British children and young people, aged 6 and under compared with other ethnicities.

Diabetes

The National Children and Young People Diabetes Network and NHS England's paediatric diabetes programme have challenged all children's diabetes services to ensure equity of access to diabetes care and technology. In response our service at Evelina London has implemented a range of improvements, including:

- improved access to the latest technology
- starting all newly diagnosed patients on real-time continuous glucose monitoring through a wearable device
- access to a High HbA1c Support Clinic, which encourages people to use technology to measure the amount of glucose in the red blood cells
- support to access help with travel costs and free lunches when free school meals are missed
- peer support events so that patients and families can meet others in a similar situation who are using technology.

These changes have had a real impact in reducing inequalities. In 2021/2022 the proportion of patients using a Real-Time Continuous Glucose Monitor was 35.1% for patients from Global Majority and non-White

communities, and 42.9% for patients from White communities.

By 2025/26, not only have these proportions increased to 96.8% for Global Majority and non-White communities, and to 100% for White communities, but the inequalities between these communities having access to this technology has decreased from 7.8% to 3.2%.

Ethnicity reporting completeness

For 2025/26 the Trust has a completed ethnicity record for 78.7% of patients, this is just below our internal target of 80%. The Trust is fully committed to achieving and exceeding the 80% target for 2026/27.

Using information to take action on health inequalities

Inclusion health

Our Health Inclusion Team provides specialist services to communities which experience multiple overlapping risk factors associated with poorer health outcomes such as poverty, trauma, and stigma. This includes people experiencing homelessness, dependent substance use, sex workers, vulnerable migrants and refugees, Gypsy, Roma and Travellers, people involved in the criminal justice system and other vulnerable groups such as care leavers.

Our services include screening and assessment, and both clinical and non-clinical interventions. During 2025/26, the most common needs for patients accessing the service were social and health problems, chronic conditions, addiction and acute conditions.

Over the last year the Trust's Health Inclusion Team saw 3,646 patients. Where ethnicity has been recorded, 39.4% identified as White, 24.4% identified as Black or Black British, 14.2% identified as Asian or Asian British.

Of those seeking support for homelessness, a greater proportion were aged 18 – 29 years than any other age group and 58.8% identified as male. Amongst refugees and asylum seekers, a larger proportion were aged 50 – 64 years, with 61.5% identifying as male.

Improving access, experience and outcomes by reducing missed appointments

The Trust's new population health dashboard has enabled a clearer understanding of inequalities amongst those patients who missed, or do not attend (DNA) their appointments. Our data shows that across multiple specialties, DNAs are more common amongst the most deprived patient groups:

- Within high-risk, chronic disease pathways our data shows strong socioeconomic inequalities in how patients engage with our services. For example patients accessing our cardiac failure specialties have a DNA rate of 6.6% for those living in the most deprived group (IMD 1) compared to 0.4% for patients living in the least deprived group (IMD 10).
- In our preventative and rehabilitation services, the DNA rate is also highest amongst the most deprived populations, especially in pulmonary rehabilitation, smoking cessation and special care dentistry, highlighting significant inequalities in engagement amongst these high-need groups.
- Across the Trust, the communities with the highest percentage of underutilised appointments are Mixed White Black Caribbean, Black – Black British Background, Asian – Asian British Bangladeshi and Asian – any Asian Background.

These findings will be considered as part of the work the Trust will be doing to remove barriers to healthcare and improve access and engagement, and ultimately health outcomes.

The DNA Predictor Tool – The Trust is using advanced analytics and AI to identify patients who are more likely to miss their appointments. We have developed a new DNA Predictor Tool, which combines clinical, demographic and socioeconomic data to help us target support more effectively.

The tool has been piloted in a number of specialties including rheumatology, children's ophthalmology, dentistry, as well as head and neck and ENT surgery. The pilot involved prioritising reminder calls and rebooking support for those patients found to have a very high risk of being unable to attend their appointments and enabled services to reduce the number of missed appointments by 25%. We are currently planning a wider role out of the tool.

DNA toolkit – The Trust has also worked with 6 other London trusts through an Outpatient Learning Improvement Network programme to develop a DNA toolkit. The toolkit includes a self-assessment tool to help trusts identify gaps in their approach to reducing DNAs, as well as a framework for sharing resources, evidence and best practice. Alongside the Trust's Population Health Dashboard, the toolkit is helping specialties to reduce DNAs by targeting support and resources to those patients and communities experiencing the greatest barriers to healthcare.

New community heart valve clinics

Working with colleagues at King's College Hospital, we have set up community clinics in south London to support earlier identification and treatment of heart valve disease.

The pilot clinics are based in GP surgeries in Lambeth and Lewisham, in areas where treatment rates are lower. Data shows that Black and south Asian people, women, and those in more deprived areas are less likely to be diagnosed and treated. By providing quicker, local access to tests, we aim to reduce these inequalities.

In the first 6 months, staff screened 168 patients across 2 clinics, more than half of whom were from Global Majority backgrounds. Of those screened, 57% had valve disease or other significant findings, and 35% had at least moderate valve disease requiring further care. These results show that by bringing services into the community, more people will access care, helping to reduce this healthcare gap.

Healthy living programme for type 2 diabetes

The Healthy Eating and Active Lifestyles for Diabetes (HEAL-D) programme was co-developed with people from the Black African and Black Caribbean communities who experience a higher incidence of type 2 diabetes.

A 7-week online programme gives people living in south London advice on managing their diabetes, and shares healthier ways to cook traditional foods, based on recipes from local people. Most classes also include a light to moderate exercise class with a physiotherapist. Local people can refer themselves or be referred by their GP and aims to support them to take greater control of their health needs.

Improving access to dental care

Our dental hospital at Guy's has introduced virtual advice and guidance clinics, enabling local dentists to get advice about their patients from a hospital consultant, reducing the need for patients to travel to central London and providing care closer to home where possible.

Patients benefit from more flexible appointments and easier access to care closer to home. Evidence shows that, despite higher rates of preventable dental conditions, patients from Global Majority backgrounds were less likely to travel for treatment. Local access has increased uptake, with 58% of virtual clinic patients from these backgrounds compared to 44% in traditional clinics.

Publishing information on health inequalities

The Improving the Health of our Populations Committee oversees delivery of the Trust's strategic priority to improve the health of our populations, including identifying and addressing inequalities in access to care and outcomes. During 2026/27, there will be a particular focus on strengthening how this work is reflected more widely within our governance arrangements at both executive and Board level and how health inequality reporting is routinely incorporated into performance reporting across the Trust.

2026/27 population health delivery programme

For 2026/27, a full programme of work will be delivered as part of the Trust's transition towards value-based care. Central to this will be our efforts to improve knowledge amongst staff that will help them to better understand and reduce health inequalities.

This work will be underpinned by access to innovative data-led tools and evidence of what works and will be informed by the views of patients. It will also monitor our progress to improve access to care and patient experience and outcomes. The 5 initial areas of focus agreed by the Trust are women's health, cancer, cardiovascular disease, elective waiting lists, and outpatient services.

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 institution, and as one of the largest employers in the area, we are committed to widening access to jobs and driving social mobility 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. We ensure that our recruitment processes are fair and equitable and provide pathways to employment for those facing specific barriers. This includes initiatives such as:

T-Level placements – we have started our third cohort of industry placements for T-Level Health students from La Retraite School, Southbank Sixth Form and Southwark College. Previous cohorts have successfully progressed onto our nursing and midwifery degree programme, apply for Healthcare Support Worker roles, or join our staff bank.

Partnership working – this year sees the 15th Anniversary of our partnerships with CareTrade, delivering The Autism Project, which is celebrated in their 'Changing Lives' campaign.

This year we have worked in partnership with both Lambeth and Royal Borough of Kensington and Chelsea local authorities to offer work placements to young people who are, or have been, in care. We continue to support local schools with work experience opportunities and this year we are focusing on reviewing our processes to increase the number of placements available and ensure that access is equitable.

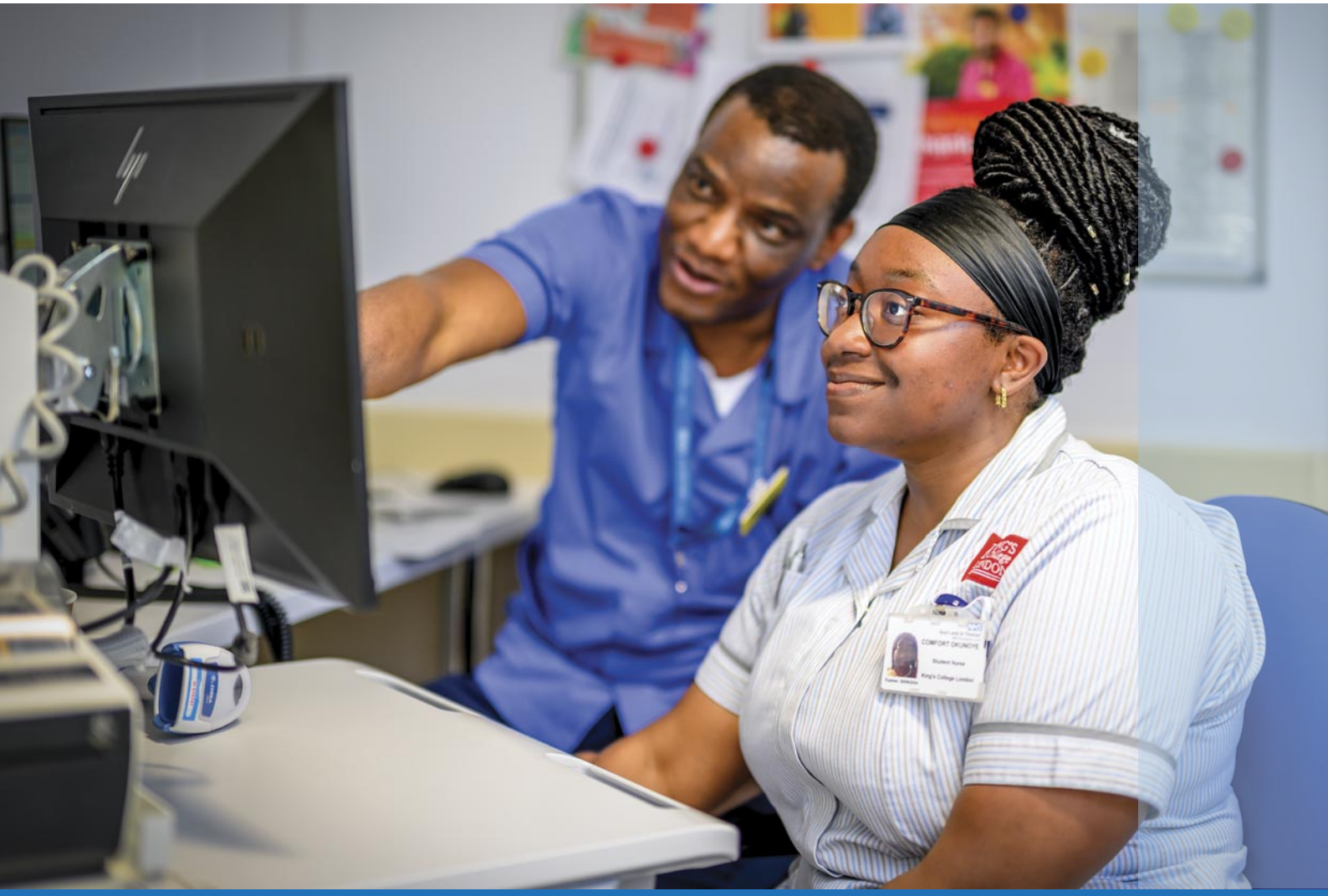
Internship programme – our supported internship programme continues to provide valuable work placements for young people with autism, learning disabilities or learning difficulties and goes from strength to strength. This year, programme graduates have been successfully employed into a variety of roles 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 on our website and through reporting to NHS England.

To reduce inequalities in candidates' experience of our recruitment processes, we have reviewed our approach through an equality, diversity and inclusion lens to ensure fair access to jobs. As part of this, we have updated our website with clear, easy-to-read guidance on the application process, including information on interview adjustments and signposting to support and resources to help applicants succeed.

We have also strengthened our inclusive recruitment and selection training, ensuring hiring managers understand bias and apply processes consistently and fairly.

Dame Amanda Pritchard
Chief Executive Officer
24 June 2026



As world famous teaching hospitals, we train the doctors, nurses, allied healthcare professionals and dentists of the future.

3 Accountability report

In 2025 we celebrated the 20th anniversary of Evelina London Children's hospital, marking 2 decades of delivering specialist care to babies, children, young people, and their families from this award winning building on the St Thomas' campus.

4 Directors' report

Despite the challenging operational and financial context across the NHS we have continued to focus on delivering our strategic plans, improving our services and providing high-quality care to as many patients as possible.

We have continued to develop our services to help achieve our strategic ambition to provide better, faster, fairer healthcare for all. For example:

New Harold Moody Health Centre – we worked with partners across the South East London Integrated Care System to open the new Harold Moody Health Centre in Southwark. The new building opened in July 2025 and houses 2 GP practices and community health services. It puts our health services at the heart of the Aylesbury Estate and aims to make a positive impact on the health of our local community.

New bereavement suite – in October 2025 we opened our first dedicated bereavement suite to improve support for families experiencing early pregnancy loss at St Thomas' Hospital. This was in response to identifying a gap in support for parents experiencing baby loss before 18 weeks of pregnancy, and offers parents a calm, less-clinical, private space where they can begin to process their loss.

Children's Hospital Programme – we have continued to progress our ambitious Children's Hospital Programme to transform Evelina London into a world-class centre delivering comprehensive care to children and young people. Over the past year, we have developed our plans to significantly expand Evelina London Children's Hospital and continued detailed preparation for the transfer of specialist cancer services for children living in south London and much of south east England.

Central to this programme is the integration of our inpatient children's services following the merger with Royal Brompton and Harefield NHS Foundation Trust. In May 2026, we moved children's inpatient heart, lung and critical care services from Royal Brompton Hospital to Evelina London Children's Hospital as part of a planned temporary change. Appropriate engagement on permanent changes to these services will start during 2026.

Co-locating these world-leading services with our maternity and neonatal units at St Thomas' Hospital, would enable us to provide a seamless 'life-course' of care from fetal diagnosis through to adulthood, and be fully compliant with national commissioning standards for children's congenital heart disease.

We remain fully committed to working with patients, their families, staff and other partners to design services that meet the needs of the patients and the communities we serve and to ensure the continuity of care during transition periods.

Guy's Surgical Centre – we have progressed our plans for a new surgical centre at Guy's Hospital following government approval. The centre will be dedicated to non-emergency surgery and include 6 new operating theatres in a purpose-built facility. Planned (elective) orthopaedic surgery will transfer from Guy's main theatres to the new centre, and free up vital additional capacity to support other surgical specialties across the Trust.

Integrated Neighbourhood Teams – Guy's and St Thomas', working with primary care and other local partners, has been selected as a pilot site for the National Neighbourhood Health Implementation Programme. We are developing multi-agency and multi-disciplinary teams to work together across Lambeth and Southwark to provide more

joined-up, accessible and personalised community based care for our local communities.

NHS South East Genomic Medicine Service – NHS England have confirmed their intention to award the Trust the contract for the NHS South East Genomic Medicine Service. The new contract brings together existing NHS England commissioned genomic medicine services and will mean the Trust continues to lead the delivery of genomics services across south east England. This includes responsibility for genomic testing and embedding genomics into clinical pathways, in line with both the ambitions of the 10 Year Health Plan and the Trust's aspirations to be a global leader in genomics and precision medicine.

Innovation to improve care

Throughout the year, we have continued to work with our partners to deliver pioneering specialist treatment to our patients. For example:

Life-changing gene therapy treatment – we became the first NHS trust to treat a patient with Hemgenix, a new and potentially life-changing drug for haemophilia B. This one-off gene therapy infusion could eliminate the need for regular treatment.

First dissolvable fix for heart defect – specialist teams at Royal Brompton Hospital and Evelina London Children's Hospital carried out the UK's first procedure to repair a heart defect in an 11-year-old using a biodegradable device. This innovative device seals the hole immediately and then gradually dissolves as the patient's own tissue grows, supporting a permanent repair.

AI and robot lung cancer pilot – we launched a new pilot which uses AI and robotic-assisted biopsy to identify and diagnose lung cancer more quickly, helping patients to avoid prolonged uncertainty and access treatment earlier.

New regenerative treatment for voice disorders – we became the first NHS trust in the UK to offer plasma injections for chronic voice disorders. The treatment uses a patient's own blood to promote healing and regeneration in the vocal cords, offering new hope to patients with long-term voice problems.

New national transplant initiative – Harefield Hospital has been selected as one of the UK's first centres to take part in a national Assessment and Recovery Centre programme, designed to increase organ transplants by enabling more thorough assessment of donated organs.

Standards of care

Under the Care Quality Commission's (CQC) regulatory framework, Guy's and St Thomas' NHS Foundation Trust remains registered to provide services without conditions or restrictions, having met all essential standards for quality and safety.

Last Trust inspection

The Trust's last full CQC inspection took place in March and April 2019, at which time we were pleased to maintain an overall rating of 'good', with our adult community services rated as 'outstanding'. The Trust was rated 'outstanding' for caring and well-led services, and 'good' for effective and responsive services.

Our 'safe' domain was rated as 'requires improvement' and this area has not yet been re-inspected. We continue to prioritise improvements in safety through directorate-led quality assessments, robust risk and governance assurance frameworks, and our ongoing ward accreditation programme. Further information about our commitment to quality and safety improvement is available in our annual Quality Report published on our website.

The Royal Brompton and Harefield hospital sites were last assessed by the CQC in October and November 2018, prior to our merger, and continue to hold an overall rating of 'good'.

Urgent and emergency services inspection

On 10 and 11 March 2026 the CQC inspected the Trust's urgent and emergency services. St Thomas' services, which includes an adult's emergency department, Evelina London children's emergency department and an urgent treatment centre, maintained its 'outstanding' rating overall. The CQC renewed their 'outstanding' rating for the site's services being responsive and well-led and upgraded its rating for the services being caring from 'good' to 'outstanding' and again rated them 'good' for being safe and effective.

The urgent care centre at Guy's Hospital provides walk-in care for adults and children with minor illnesses and injuries. The CQC again rated Guy's urgent care service as 'good' for being safe, responsive and well-led, and upgraded its rating for being caring from 'good' to 'outstanding'. Inspectors also rated the service as 'good' for being effective, which was not previously rated.

At the time of writing, we anticipate further service inspections followed by a well-led overview.

Maternity services inspection

Prior to this, our last service-specific inspection took place in September 2022, and was focused on maternity services at St Thomas' Hospital. The service was rated 'good' overall, with positive findings, and there was no change to the Trust's overall CQC ratings, however, maternity services were rated 'requires improvement' for safety.

In response, we are continuing to deliver a comprehensive programme of improvement through our 'Maternity Good to Outstanding' programme. This includes the refurbishment of the Maternity Assessment Unit to improve the environment for women, families and staff; increasing midwifery and medical staffing to enable 7 day dedicated medical cover; introducing a new midwifery telephone helpline; and improving governance and oversight through the monthly Maternity Assessment Unit Improvement Board meetings.

Monitoring the quality of care

Throughout 2025/26, the Trust's Quality and Performance Board Committee has continued to monitor a comprehensive set of clinical and non-clinical performance indicators set out in our integrated performance report. This report is also published as part of our public Board papers on the Trust website ahead of each public Board meeting, maintaining our commitment to openness and transparency regarding our performance.

We remain focused on reducing waiting lists for planned (elective) care, with particular emphasis on quality, safety, and clinical effectiveness. The Patient Safety Incident Response Framework (PSIRF) is now fully embedded across the Trust, supporting our ongoing work to learn from incidents and share best practice throughout the organisation.

We are committed to learning from patient feedback and have undertaken a comprehensive review and simplification of the Trust's complaints management processes. We continue to improve our responsiveness to concerns that are raised and significantly reduced the number of overdue complaints in the last quarter of the year.

Ensuring our services are well-led

Although the Trust has not had a full well-led or Trust-wide CQC inspection since 2019, the Board continues to review and strengthen its leadership and governance arrangements.

We also 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 runs an internal programme to promote organisational excellence in line with the 8 quality statements under the CQC's well-led domain, which helps to ensure strong leadership and governance, 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 65.

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

Listening to our patients

Listening to our patients and service users is central to delivering safe, high-quality care. By understanding their experiences, needs and priorities we can improve services, ensure compassionate person-centred care and deliver better outcomes.

Feedback from a wide range of channels including Friends and Family Tests, national patient surveys, concerns raised through our Patient Advice and Liaison Services

(PALS) as well as nominations for our Care Awards, help us learn, adapt and continuously improve our services to meet the needs of the communities we serve.

Our patient and public governors continue to play a vital role in bringing patient and community perspectives to the Board. Foundation Trust members are also engaged directly through members' seminars, our Annual Public Meeting and Patient-Led Assessment of the Care Environment (PLACE) visits.

Engaging our patients and the public

We maintain strong relationships with local Healthwatch organisations through regular liaison meetings, and by sharing updates on service developments, survey results and progress against our Quality Priorities. Their insights, particularly from diverse communities, continue to inform improvements in care. This year, we supported Healthwatch teams to carry out outreach programmes across our hospital and community sites. Although Healthwatch has statutory 'enter and view' powers, no on-site visits took place in 2025/26.

The Trust was not required to undertake any formal public consultations involving Local Authority scrutiny functions this year. However, we continued to respond to scrutiny committees' requests for information on service delivery and performance. We are continuing to work with NHS England and other commissioners to ensure multiple Joint Overview and Scrutiny Committees are informed about the temporary change to children's inpatient heart and lung care and related services. We will also work with them on the process for determining the permanent location of these services.

We have continued to deliver our Patient and Public Engagement Strategy, which covers the period to 2030, with many examples of meaningful involvement and engagement across the Trust. For example:

- we are working with partners across Lambeth and Southwark to involve patients with long term conditions in shaping Integrated Neighbourhood Teams – a first step towards developing Neighbourhood Healthcare in line with the NHS Long Term Plan
- parents and carers have contributed to our strategic cancer and surgery programmes, including the proposed designs for the Guy's Surgical Centre to help create calmer, more welcoming spaces
- patients with genetic conditions shared their experiences of gene therapy to inform engagement plans for the Advanced Therapeutic Medicines and Pharmaceuticals Programme
- as part of our Digital Patient Panel, around 60 patients and carers continue to help improve the experience of using the MyChart patient app, which supports our electronic health record system and the delivery of care across the Trust. Their input has helped improve proxy access arrangements for children and young people, and enhanced clinical questionnaires which are used to support service delivery in many areas
- we are continuing to involve children, young people and families in the development of the Principal Treatment Centre for children's specialist cancer services at Evelina London Children's Hospital, and engaged families in planning temporary changes to children's inpatient heart and lung services delivered across the Royal Brompton and Evelina London sites
- our women's services have worked to strengthen the role of the Maternity Neonatal Voices Partnership as part of the 'Maternity Good to Outstanding' programme, and parents have helped design the new bereavement suites for families experiencing early pregnancy loss
- our heart and lung teams have continued to work with adult patients and carers through the Cardiovascular and Respiratory Partnership Patient and Carer Advisory Group, supporting service improvements across King's Health Partners. Patients co-designed and delivered an event at Harefield Hospital, attended by around 80 people, which aimed to promote education and improve communication in critical care for patients and carers.

System working and partnerships

Our 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 across our local healthcare system and beyond:

Patients – our patients, and the communities we serve, are our most important partners. We continue to use tools such as the MyChart patient app to enable patients to have greater involvement in their care, which reflects the 'analogue to digital' shift in the Government's 10-year health plan.

Integrated care systems – the Trust works as part of the South East London Integrated Care System, and works with the North West London Integrated Care System.

Acute Provider Collaborative – we value our close relationships with other local NHS providers, including 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 improvement and equity of access.

Community partners – we work in partnership with Lambeth Together and Partnership Southwark, which brings together a range of organisations, including primary care, local councils, and the voluntary and community sectors to improve neighbourhood based care.

Primary care partners – our partnerships with primary care colleagues are vital to support a sustainable local health system and deliver our strategic priority to improve the health of our populations. Together we have been selected as a pilot for the National Neighbourhood Health Implementation Programme which will further develop the role of our integrated neighbourhood teams and support our ambitions to deliver more care without the need for an inpatient hospital stay.

Charity partners – Our close partnership with Guy's & St Thomas' Foundation supports a range of initiatives, including work to improve health equity, such as the Population Health Hub. We work together to align our strategic priorities, including in relation to our charities which support the work of the Trust: Guy's & St Thomas' Charity, Evelina London Children's Charity and Guy's Cancer Charity. For heart and lung care and research, we are also supported by Royal Brompton and Harefield Hospitals Charity.

King's Health Partners – we are a founding partner of King's Health Partners Academic Health Sciences Centre, which brings together Guy's and St Thomas', King's College Hospital, and South London and Maudsley NHS Foundation Trusts with our shared university partner King's College London. We work together within the wider system to improve healthcare, including through research and innovation. In June 2025 King's Health Partners published a new strategy to 2030, which focuses on personalised healthcare, accelerating the use of digital technology and improving population health.

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 accelerate research and innovation and includes a focus on reducing health inequalities.

Academic partners – working with King's College London, London South Bank University, University of Greenwich, Brunel University and Coventry University, we are one of the largest healthcare educators in Europe. We also work closely with Imperial College London and Imperial College Healthcare Partners in north west London.

Clinical networks and alliances – as part of the South London Office for Specialised Services we deliver a range of transformation initiatives. The Trust also leads, or is a member of, a number of clinical networks for specialist adult and children's services serving patients in south east and north west London, southern England and further afield, which reflects the geographical reach of our specialist services. As a major provider of cancer services, we are part of both the South East London Cancer Alliance and Royal Marsden Partners West London Cancer Alliance.

Commercial Partnerships

The Trust has continued to maintain its longstanding commitment to innovation and business development, by proactively pursuing commercial opportunities that generate additional income to support the delivery of NHS services. Throughout 2025/26 we have progressed a range of initiatives:

- **managed service partnerships** – ongoing collaborations with Johnson & Johnson Managed Services, Diaverum, and Active Care Group (Remeo) which have contributed positively to service delivery
- **global network expansion** – work to extend the Trust's international reach, including our strategic partnership with Cedars-Sinai Medical Centre in the USA and our ongoing relationship with the Hinduja Foundation in India in collaboration with King's College London
- **consolidation of expertise** – we are developing commercial capabilities in both our clinical groups and corporate services and now have a dedicated network of clinical leads to strengthen consulting, innovation and private practice activities
- **expansion of private patient capacity** – developments include increased capacity at Wimpole Street, with dedicated units for dermatology and women's health, complementing existing facilities for cardiac and respiratory care.

Additionally, **Guy's and St Thomas' Enterprises Limited**, wholly owned by the Trust, manages a portfolio of wholly or partly owned companies, including:

- **Synnovis** – a pathology joint venture between the Trust, King's College Hospital NHS Foundation Trust, and Synlab UK & Ireland
- **Meridian Health Ventures** (formerly KHP Ventures) – a partnership with King's College London, King's College Hospital NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, Guy's & St Thomas' Foundation and others, to advance 'MedTech' innovation through support for start-ups and small and medium-sized enterprises
- **Investment in spin-out technology companies** – these include KHP Med Tech Innovations Ltd, Cydar Ltd, Spot-On Clinical Diagnostics Ltd, Zeus Sleep Ltd, The Learning Lab Ltd, Hologen Ltd and XRnostics Ltd
- **Lexica Health and Life Sciences Consultancy Limited** – Guy's and St Thomas' Enterprises Limited sold Lexica, a specialist in estates, life science and infrastructure projects, to WSP in May 2025.

For further information regarding subsidiaries and interests in associates and joint ventures, refer to Note 20 of the Accounts.

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 2025/26, Board membership comprised the following executive directors: Chief Executive, Ian Abbs (to 4 September 2025); Chief Executive, Amanda Pritchard (from 5 September 2025); Chief People Officer, Crystal Akass; Chief Nurse, Avey Bhatia; Interim Deputy Chief Executive, Steven Davies; Chief Operating Officer, Jon Findlay; Chief Medical Officer, Simon Steddon and Interim Chief Financial Officer, Damien O'Brien.

The chief executives of the Trust's 4 clinical groups are also Board members: 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), Felicity Harvey (Senior Independent Director and joint Deputy Chair); Miranda Brawn; Nilkunj Dodhia; Jamie Heywood; Deirdre Kelly; Graham Lord; Pauline Philip; Ian Playford; and Alison Wilcox.

Biographies of the Board members are set out on pages 74-77 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 30 to the Annual Accounts.

The Board of Directors is not aware of any relevant

Better payment practice code				
	Year ended 31 March 2026		Year ended 31 March 2025	
Measure of compliance	**Number**	**£000**	Number	£000
Total bills paid in the year	**334,691**	**2,276,869**	364,044	2,132,884
Total bills paid within target	**297,215**	**1,730,975**	290,094	1,598,692
Percentage of bills paid within target	**89%**	**76%**	80%	75%

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 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.

Better Payments Practice Code

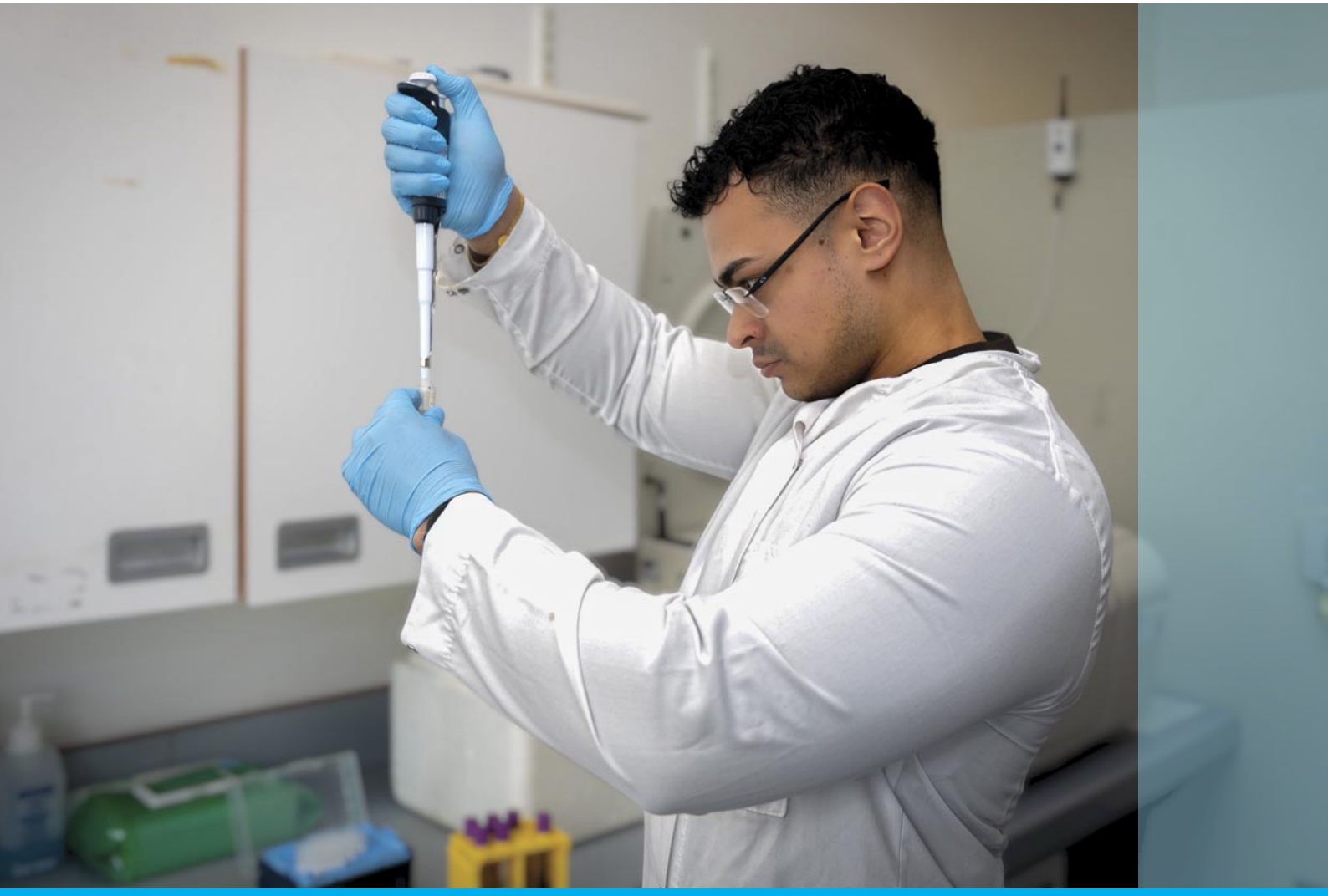
The Trust has a responsibility to meet the Better Payments Practice Code which requires NHS trusts to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target is to pay 95% of invoices, in terms of value and volume, within 30 days. Throughout 2025/26 we've made good progress to improve our payment performance, however further work is required to achieve the 95% target.

Income disclosures

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.

Dame Amanda Pritchard
Chief Executive Officer
24 June 2026



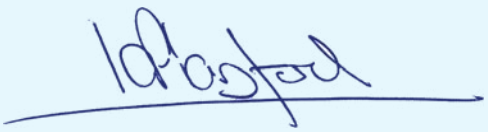
During 2025/26, we delivered more than 1,400 clinical research studies involving over 27,600 participants, making us the second highest recruiting Trust for clinical research in the UK.

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 2025/26.

The Committee approved a cost of living increase equivalent to 3.25% of executive and very senior managerial salaries with effect from 1 April 2025.



Ian Playford
Chair, Senior Leadership Talent, Appointments and Remuneration Committee
24 June 2026

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 2025/26 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 2025/26 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 intranet. 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 59 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 2025/26

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. Non-executive directors – excluding the Chairman and joint deputy chairs – were awarded an increase from £20,000 to £22,000 with effect from 1 April 2025. There has been no other increase to the non-executive remuneration in 2025/26.

At its meeting in October 2025, the Senior Leadership Talent, Appointments and Remuneration Committee agreed that for the 2025/26 financial year, the pay award (equal to 3.25%) would be distributed as equal value uplifts worth £4,781 to each Very Senior Manager (VSM) contract holders. This reflected an agreed fair pay commitment to reduce the gap between highest and lowest earners and supported ongoing alignment with the new pay framework for this cadre, which came into effect on 1 April 2025.

All new appointments from this date have been made with adherence to this framework, including where a case to appoint within the 'exception zone' has been required.

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 2025/26 are shown on page 72.

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 annualised costs of the highest-paid director in 2025/26 was £340,000-£345,000 (£335,000-£340,000 in 2024/25). Based on the midpoint of the banded remuneration, this represents an increase of 1.5% between 2024/25 and 2025/26 (11.6% between 2023/24 and 2024/25).

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £23,875 to £362,956 (£22,369 to £337,050 in 2024/25). The percentage change in average employee remuneration between 2024/25 and 2025/26 was an increase of 1.4% (6.5% between 2023/24 and 2024/25). 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.

One employee received remuneration in excess of the highest-paid director in 2025/26 and none in 2024/25.

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 2026. Where staff are part-time, their salaries have been annualised for the purposes of the ratio calculation.

Fair pay disclosures

2025/26	25th percentile	Median	75th percentile
Total remuneration (£)	42,770	54,480	68,228
Pay ratio	8.01	6.29	5.02
2024/25			
Total remuneration (£)	41,284	54,393	62,112
Pay ratio	8.18	6.20	5.43

The figures presented exclude pension benefits in line with Foundation Trust Annual Reporting Manual requirements. There are no performance-related pay nor bonus arrangements.
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 contracts in place during 2025/26 for executive directors:

Service contracts

Executive director	Date of service contract	Unexpired term	Notice period
Ian Abbs	Jan 2011	Sept 2025	6 months
Amanda Pritchard	Sept 2025	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
Damien O'Brien	June 2025	Open ended	3 months
Simon Steddon	Jul 2019	March 2026	6 months*

*This differential in notice period is as a result of a policy change by the Trust and not any agreements made on a personal basis with the postholder. The Chief Executive position has a 6 month notice period as standard.

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 enables 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 £170,000. 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 2025/26 and 2024/25.

Single total figure 2025/26

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 (until 5 September 2025)	140-145	9,100	-	150-155
C.Akass	Chief People Officer	200-205		52.5-55	255-260
G.Ayida*	Chief Executive, Women's and Children's	225-230		55-57.5	285-290
A.Bhatia	Chief Nurse	200-205		65-67.5	265-270
S.Clarke	Chief Executive, Cancer and Surgery	190-195		-	190-195
L.Dark	Chief Executive, Integrated and Specialist Medicine	190-195		335-337.5	530-535
S.Davies	Interim Deputy Chief Executive (from 1 April 2025 until 31 March 2026)	240-245		-	240-245
J.Findlay	Chief Operating Officer	215-220		45-47.5	265-270
R.Grocott-Mason*	Chief Executive, Heart, Lung and Critical Care	265-270		65-67.5	330-335
D.O'Brien	Interim Chief Financial Officer (from 1 April 2025 until 31 March 2026)	190-195		80-82.5	275-280
A.Pritchard	Chief Executive (from 1 September 2025)	175-180		102.5-105	280-285
S.Steddon*	Chief Medical Officer (until 31 March 2026)	270-275		82.5-85	355-360
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	20-25			20-25
D.Kelly	Non-Executive Director	20-25			20-25
G.Lord	Non-Executive Director	20-25			20-25
P.Philip	Non-Executive Director	20-25			20-25
I.Playford	Non-Executive Director	20-25			20-25
A.Wilcox	Non-Executive Director	20-25			20-25

***** Remuneration for both board and clinical roles.

Salaries and fees

No senior manager received any annual or long-term performance bonuses in 2025/26.

Professor Graham Lord is a Non-Executive Director at King's College Hospital NHS Foundation Trust. Salaries and wages disclosed for Professor Graham Lord in the table above relate purely to his role on the GSTT Board.

Taxable benefits relate to rental of Trust accommodation.

During 2025-26 no Senior manager has received payment for loss of office and there have been no payments to past senior managers in relation to their previous role as a Senior manager.

Pension related benefits

I.Abbs and S.Clarke were not members of the NHS Pension Scheme for the year 2025/26.

S.Davies opted out of the NHS Pension Scheme from 1/04/2025. There are therefore no pension disclosures for 25/26 relating to S.Davies.

J.Findlay and G.Ayida opted into the NHS Pension Scheme in May 2025.

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 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 a Non-Executive Directors 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 GSTT 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 01/09/2024. There are no in-year reportable pension related benefits.

J.Screaton opted out of the NHS Pension Scheme from 1/04/2024. There are therefore no pension disclosures for 24/25 relating to J. Screaton.

R.Grocott-Mason is opted into the NHS Pension scheme, but had no reportable pension related benefits for 24/25.

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.

Salary and pension entitlements of senior managers

2025/26 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 2026 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2025 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2026 £000
C.Akass Chief People Officer	2.5-5	0-2.5	10-15	0-5	132	26	186
G.Ayida* Chief Executive, Women's and Children's	2.5-5	0-2.5	0-5	0-5	0	53	73
A.Bhatia Chief Nurse	2.5-5	0-2.5	90-95	235-240	2,097	86	2,244
L.Dark Chief Executive, Integrated and Specialist Medicine	15-17.5	35-37.5	65-70	160-165	1,072	333	1,447
J.Findlay* Chief Operating Officer	2.5-5	0-2.5	5-10	0-5	66	36	127
R.Grocott Mason Chief Executive, Heart, Lung and Critical Care	2.5-5	2.5-5	70-75	195-200	112	33	165
D.O'Brien Interim Chief Financial Officer	5-7.5	0-2.5	30-35	0-5	361	48	440
A.Pritchard Chief Executive	5-7.5	7.5-10	100-105	235-240	1,907	102	2,153
S.Steddon Chief Medical Officer	5-7.5	0-2.5	105-110	265-270	2,366	99	2,539

***** G.Ayida and J.Findlay joined the NHS Pension Scheme in May 2025.

I.Abbs, S.Davies and S.Clarke were not NHS Pension Scheme members for the year 2025/26.

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.

Dame Amanda Pritchard
Chief Executive Officer
24 June 2026

We officially opened the Harold Moody Health Centre in July 2025. This community health centre is a collaboration between the Trust, local GP practices, NHS South East London, NHS Property Services, and Southwark Council.

6 Staff report

We employ around 23,900 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 2025/26	Total 2024/25
Administration and estates staff	5,708	213	**5,921**	**5,979**
Healthcare assistants and other support staff	1,175	487	**1,662**	**1,526**
Medical and dental staff	3,146	389	**3,535**	**3,513**
Nursing, midwifery and health visiting staff	6,877	426	**7,303**	**7,317**
Nursing, midwifery and health visiting learners	1,422	229	**1,651**	**1,701**
Scientific, therapeutic and technical staff	3,646	135	**3,781**	**3,659**
Social care staff	5	–	**5**	**5**
Total average numbers	**21,979**	**1,879**	**23,858**	**23,700**

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

Communicating with staff

We remain committed to effective communication with colleagues, keeping them informed of changes across the organisation, involving them in decision-making and engaging them in the Trust's financial and operational 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 2025 NHS Staff Survey we continued to improve on our score for the 'staff engagement' theme and ranked third nationally for our category of 'acute, and acute and community trusts'.

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 colleagues can find policies, guidance and online tools.

In November 2025 we launched the first phase of our new, Trust-wide intranet, which colleagues can access from their personal mobile devices at a time and place which suits them. This new intranet will fully replace our 2 outdated intranets by the end of 2026.

Our annual internal communications survey enables us to understand how effective our communications are and adjust our strategy accordingly. In our 2026 survey, 91% of colleagues said they had used our new intranet, and we saw a 9% increase in those saying they find the intranet useful compared to the previous year. We are anticipating a further improvement over the months ahead, as we continue to move content over onto the platform and increase the functionality that it offers.

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 colleague representatives to ensure the voices of employees are listened to and considered.

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.

2025 NHS Staff survey

The NHS Staff Survey is the largest annual workforce survey in the world. The 2025 survey comprised 126 questions aligned to the 7 NHS People Promise areas and 2 themes.

Overview of results

In 2025 Guy's and St Thomas' achieved a response rate of 49%, with 11,873 responses from a usable sample of 24,070 staff. This is 2% above the national average for our category of 'acute, and acute and community trusts', and the second highest level of participation for the Trust ever, giving us confidence that the results reflect the experiences of our people. We are proud that:

- we scored above the national average in all 7 People Promise elements as well as the staff engagement and morale themes
- while national scores have declined across several areas, the Trust achieved statistically significant year-on-year improvement in all 9 areas
- we achieved the highest score nationally for the 'We are always learning' theme, which was driven by strong results in staff appraisals
- 18 out of 21 'sub-theme' areas achieved the highest scoring results in 5 years
- 'diversity and equality' and 'negative experiences' both scored above the national average for the first time in 5 years, reflecting progress in areas where we have historically struggled to achieve positive results
- advocacy scores have continued to rise with more colleagues recommending the Trust as a place to work and receive care. See table below
- 93% of colleagues said they were proud to work for the Trust
- 99% of colleagues said they were aware of the Trust values.

Staff engagement

Research consistently shows that engaged staff deliver better health and care outcomes. The engagement questions in the table below provide insight into colleagues' motivation, involvement and advocacy and are well above the national average. It's reassuring that colleagues from Global Majority backgrounds reported some of the highest levels of staff engagement across the Trust.

Areas for improvement

While the results reflect positive progress and a strong sense of pride across the organisation, we know there are areas where we need to do better and remain committed to delivering further improvement.

There are ongoing concerns about fair opportunities for career progression, and despite overall improvement, some colleagues continue to experience discrimination, bullying and harassment across the organisation.

Engagement theme question	National average 2025	Trust score 2025	Trust ranking
Staff agreeing that the care of patients/service users is the organisation's top priority	72%	85%	3rd nationally and 2nd in London.
Staff recommending the Trust to a friend or relative as a place to receive care or treatment	61%	83%	4th nationally and 2nd in London.
Staff recommending the Trust as a place to work	58%	75%	2nd nationally and 2nd in London.

NHS Staff Survey Results

Comparison of NHS Staff Survey results for 2022-2025 against national average (acute and acute and community trusts).

	National Average 2022	Trust Score 2022	National Average 2023	Trust Score 2023	National Average 2024	Trust Score 2024	National Average 2025	Trust Score 2025
Response rate	44%	41%	45%	38%	49%	57%	47%	**49%**
People Promise Elements								
We are compassionate and inclusive	7.25	7.37	7.31	7.33	7.29	7.44	7.28	**7.58**
We are recognised and rewarded	5.73	5.80	5.94	5.82	5.92	5.99	5.87	**6.15**
We each have a voice that counts	6.65	6.84	6.70	6.76	6.67	6.89	6.60	**7.02**
We are safe and healthy	5.92	5.99	6.11	6.03	6.13	6.20	6.07	**6.32**
We are always learning	5.35	5.63	5.62	5.58	5.64	5.86	5.57	**6.21**
We work flexibly	6.00	6.06	6.20	6.05	6.24	6.25	6.22	**6.47**
We are a team	6.64	6.68	6.75	6.68	6.75	6.81	6.75	**6.97**
Themes								
Staff engagement	6.80	7.11	6.91	7.04	6.84	7.15	6.74	**7.28**
Morale	5.68	5.79	5.90	5.82	5.93	6.01	5.84	**6.21**

Please note: There are a number of small adjustments in figures reported for 2022 to 2024 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 2025 benchmark group proportions.

We are now above average in 'diversity and equality' for the first time. While this reflects improved experiences for colleagues from the Global Majority and those with disabilities or long-term health conditions, this is still not as positive as it should be.

Workload and staffing pressures affect parts of the organisation, with a disproportionate impact on colleagues with long-term health conditions. Our focus remains on addressing the underlying causes of these issues, not just managing the symptoms.

Our overall culture scores are strong, but fairness, respect and psychological safety are not experienced consistently by everyone. Ensuring all colleagues feel safe, respected and able to speak up will be a key area of focus in the year ahead.

Over the past year we have focused on:

- embedding our values – we delivered workshops to over 300 managers to support consistent role modelling of our values and created a new set of resources to support this. Our values are now central to induction, training, appraisals and communications across the Trust, which is reflected by the fact that 99% of colleagues said they were aware of our values – caring, ambitious inclusive.
- improving career opportunities – we continued to strengthen career development and progression across the Trust through a structured and inclusive programme of support. Participants in our Positive Action Programme reported increased confidence in advancing their careers. Engagement with our online Careers Hub increased, alongside a rise in the number of career conversations through our new performance development review process. We also grew the number of active mentoring relationships.

To support this progression, we introduced new inclusive recruitment and selection training for managers and have continued to strengthen leadership capability through our People Manager Programme. We launched a new Introduction to Leadership pathway and ensured leadership standards were embedded within performance and development reviews.

- equality, diversity and inclusion – we strengthened our approach to equality, diversity and inclusion by improving accountability, governance and

oversight, and by embedding equality more consistently into decision-making through higher-quality equality impact assessments.

We continued to address inequalities in colleague experience by expanding our Anti-Racism in Action sessions through trained local facilitators, and are developing a bespoke anti-racism leadership programme to strengthen capability, confidence and accountability at senior levels.

Further details are available on pages 59-60.

- supporting health and wellbeing – thanks to generous support from our Charity, we continued to deliver our extensive 'Showing We Care About You' staff wellbeing programme. We focused on preventing burnout through webinars and best practice sharing, alongside targeted support to help colleagues recover and return to work.

Next steps

We are working closely with internal stakeholders to address priority improvement areas from the NHS Staff Survey. These will be delivered through Trust-wide and locally-owned action plans supported by robust governance to drive improvements throughout the organisation.

Progress will be monitored and communicated transparently through our internal channels including all-staff Team Briefings, local forums and 'You said it. We did it' webinars.

We remain committed to improving the experience of colleagues by further embedding our values and behaviours framework; addressing inequalities and strengthening anti-racism capability; and supporting managers to lead teams in a safe, compassionate and inclusive environment.

This approach underpins our ambition for Guy's and St Thomas' to be one of the best places to work and to receive care – now and in the future.

Freedom to Speak Up

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 signal' emails share good practice, including learning from serious incidents.

The Trust's Freedom to Speak Up service 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, supported by 2 full-time, and 1 part-time deputy guardians.

In the past year we have restructured our Freedom to Speak Up service so that all concerns are managed directly by the guardians. We have removed the Speak Up Champions and established a new volunteer Ambassador for Speaking Up role. The ambassadors help to publicise the service, educate colleagues on how the service works, and to identify and address the barriers to speaking up. Each ambassador receives training to enable them to fulfil the role as effectively as possible.

The guardians and ambassadors work alongside our local inclusion agents, wellbeing champions and the Trust Guardian of Safe Working, to provide colleagues with an integrated and inclusive support network. The guardians play an active and visible role in raising awareness and dealing with concerns, while ensuring that our governance processes for raising concerns are robust and effective.

Our 2025 NHS Staff Survey results demonstrate increasing confidence among our people in raising concerns, and in the Trust's willingness and ability to address the concerns raised. We include questions in our annual appraisal process to assess colleagues' awareness of the ways they can speak up, providing the opportunity for targeted education where needed. In 2025, our appraisals showed that that 92.3% of responders were aware of the different options available to raise concerns.

The number and type of speak up contacts are shared on a quarterly basis with the National

Employee costs (including executive directors)

	Permanently employed £000	Agency, bank and seconded staff £000	Year ended 31 March 2026 Total £000	Year ended 31 March 2025 Total £000
Salaries and wages	**1,345,318**	**99,398**	**1,444,716**	1,376,454
Social security costs	**185,108**	**8,651**	**193,759**	156,209
Apprenticeship levy	**6,679**	**369**	**7,048**	6,794
Pension cost: employer's contributions to NHS pensions	**161,164**	**3,346**	**164,510**	152,884
Pension cost: employer contributions paid by NHSE on provider's behalf (9.4%)	**105,167**	**2,385**	**107,552**	99,970
Termination benefits	**1,339**	**–**	**1,339**	1,936
Temporary staff – agency / contract staff	**–**	**14,052**	**14,052**	24,926
Total gross staff costs	**1,804,775**	**128,201**	**1,932,976**	1,819,173
Included in above:				
Costs capitalised as part of assets	**(13,344)**	**(1,770)**	**(15,114)**	(20,151)
Less income netted off in staff costs	**(17,427)**	**–**	**(17,427)**	(12,762)
Total staff costs	**1,774,004**	**126,431**	**1,900,435**	1,786,260
Analysed into operating expenditure				
Employee expenses – staff and executive directors	**1,771,918**	**126,431**	**1,898,349**	1,783,633
Redundancy	**1,339**	**–**	**1,339**	1,936
Internal audit costs*	**747**	**–**	**747**	691
	1,774,004	**126,431**	**1,900,435**	1,786,260

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.

Guardian's Office and published on the Model Health System website. Regular reports are also provided to the Trust Board.

Equality, diversity and inclusion

Staff group	Female	Male	Total
Employees	16,981	6,299	23,280
Executive directors	6	5	11
Senior managers	28	23	51
Total	**17,015**	**6,327**	**23,342**

Number of staff employed on 31 March 2026

We are proud of our diverse workforce and are committed to creating an inclusive workplace where all our people can thrive. This commitment to equality, diversity and inclusion is embedded in our values and is a core principle of our 2030 strategy.

During the year, we streamlined our Equality, Diversity and Inclusion Programme, which is generously funded by Guy's and St Thomas' Charity, to focus on the areas of greatest impact, strengthen accountability and raise the profile at Board level.

Our approach is structured around 4 core themes: anti-racism, disability inclusion, LGBT+ inclusion and overall inclusive culture.

Key initiatives include:

Inclusive recruitment and selection – we have carried out a comprehensive review of our recruitment processes to identify any barriers or gaps which prevent equal opportunities. We are developing a delivery plan including diverse interview panels, updated job descriptions, and inclusive recruitment training, to reduce barriers and improve representation across the Trust.

Leadership development – we are developing and delivering a bespoke equality, diversity and inclusion programme for senior leaders, with a particular emphasis on anti-racism.

Anti-Racism in Action – we continue to carry out regular Trust-wide and local engagement sessions to raise awareness of systemic barriers and support local

improvement actions. To date, over 2,400 colleagues, including senior leaders, have taken part and we will continue to expand the programme over the coming year.

New neurodiversity strategy – the new strategy sets out our commitment to providing outstanding, equitable and accessible care for neurodivergent individuals of all ages. Thanks to funding from Guy's & St Thomas' Charity, we carried out extensive engagement to make sure that the lived experiences of our patients and colleagues are at the heart of our plans.

Workplace adjustments – we are improving our workplace adjustment offer through a revised policy and manager support sessions to strengthen understanding and accessibility, helping colleagues stay well at work and fulfil their potential.

We have clear plans to further enhance support for disabled colleagues, underpinned by stronger governance and an ambition to achieve Disability Confident Leader status by December 2026.

Equality impact assessments – we have reviewed and updated our equality impact assessment resources to ensure we meet our legal and moral duty as set out in the Equality Act and to ensure that decisions, policies, and projects are fair, inclusive, and effective in addressing inequalities.

Positive action programmes – we have continued to deliver a range of talent development initiatives for Global Majority colleagues, supporting confidence, career progression, and promotion opportunities.

Fellowship programme – our fellowship programme continues to help address the gap in senior leaders who identify as being from the Global Majority. The Kofoworola Abeni Pratt Fellowship supports the development of nurses, midwives and allied health professionals and strengthens diversity in leadership.

Reciprocal mentoring scheme – we are developing plans to relaunch the programme to connect colleagues across roles, enhance understanding, and break down barriers to progression.

While some progress has been made, we know we have more to do to address the cultural and structural inequalities which remain through sustained action and improved accountability.

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 reviewed annually and available on the Trust website under statutory and strategy publications.

Staff sickness absence

Staff sickness absence	2025/26	2024/25
Total days lost	**234,697**	232,599
Total staff years	**22,772**	22,445
Average working days lost (per WTE)*	**10**	10

*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 2025 to December 2025 from the ESR data warehouse.

The latest publication, covering the year to December 2025, can be found on the NHS Digital website.

Safe working environment

The health, wellbeing and safety of our workforce are closely linked to the quality, safety and experience of care we provide for patients. Our health and safety service works across clinical and corporate services to proactively manage risk.

During the year, we introduced a new risk, quality and compliance platform to strengthen how we monitor, manage and learn from non-clinical risks and adverse events. We also prioritised action to address the rise in violence and aggression towards colleagues, including by strengthening training to better protect staff.

The team has continued to work closely with regulators and colleagues across the Trust to improve compliance with health and safety legislation, including the control of hazardous substances and manual handling. We have continued to develop health and safety champions and partnerships with staff-side representatives to maintain and enhance safety standards across the Trust.

Occupational health, safety and wellbeing service

The occupational health, safety and wellbeing service is one of the largest accredited NHS-based services in the country, and provides services both internally to the Trust and commercially to local and national businesses. The service is delivered by a multidisciplinary team of doctors, specialist nurses, health and safety specialists, wellbeing advisors, psychologists, manual handling advisers, administrators and researchers providing a wide range of occupational health, safety and wellbeing support.

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

In 2025 the team continued to work with partners in south east London to deliver flu vaccinations to colleagues across our hospital and community sites and exceeded national improvement targets for vaccination delivery.

Guy's & St Thomas' Charity continues to support the Trust's award-winning staff health, wellbeing and benefits programme. Delivered with a culturally sensitive and inclusive approach, it is enhanced significantly by the support of around 600 local wellbeing champions. The programme offers self-referral access to expert support including physiotherapy, dietetics, menopause clinics, 1:1 counselling and psychological therapy, spiritual care support and financial guidance.

The staff wellbeing psychology service delivers evidence based psychological consultation, assessment and intervention at a 1:1, team and Trust-wide level. Psychologists support the Trust's anti-racism and equality and diversity strategies and, as part of the prevention strategy, support staff to increase mental health awareness, respond to distressing incidents and support positive behaviour within the Trust.

Agency staff

We have continued to work within NHS Framework conditions, adhering to NHS England's agency price caps, which set out maximum pay levels for agency staff.

Working with Trust managers and agencies, we have met the NHS England requirement to remove agency usage at Bands 2 and 3 across all staff groups and continuously work towards reducing the use of agency staff within the Trust.

We have continued to use a direct engagement platform to control costs where agency staff are still required, allowing for visibility of demand, transparency of costs and robust approval procedures.

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.

Expenditure on consultancy

Expenditure on consultancy in 2025/26 was £115,000, representing a slight decrease from £122,000 in 2024/25.

High paid off-payroll engagements

Table 1: Off-payroll worker engagements as of 31 March 2026, earning £245 per day or greater	
Number of existing engagements as of 31 March 2026	11
Of which, the number that have existed:	
for less than one year at the time of reporting	7
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
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 2026, earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2026	11
Of which:	
Not subject to off payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	7
Subject to off-payroll legislation and determined as out-of-scope of IR35*	4
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 2025 and 31 March 2026	
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.	23

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 2025/26.

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 2026 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 2025/26, a total of 150 exit packages were agreed in the year, 28 of which were compulsory redundancies, and 122 were other departures. The total cost of exit packages was £4,519k.
Summary information for 2025/26 and comparative information for 2024/25 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	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25
<£10,000	4	8	27	1	31	9
£10,000 – £25,000	9	9	36	17	45	26
£25,001 – £50,000	7	28	40	18	47	46
£50,001 – £100,000	7	20	19	12	26	32
£100,001 – £150,000	1	5	0	11	1	16
£150,001 – £200,000	0	0	0	3	0	3
Total number of exit packages by type	**28**	**70**	**122**	**62**	**150**	**132**
Total resource cost £000	**1,033**	**3,144**	**3,486**	**3,624**	**4,519**	**6,768**

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

Exit packages: other (non-compulsory) departure payments

There were 122 elements of other departure packages agreed in 2025/26, totalling £3,486k.
Comparative information for 2024/25 is provided in the table below.

	2025/26		2024/25	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	7	168	62	3,624
Exit payments following Employment Tribunals or court orders	3	162	0	0
Mutually agreed resignations (MARS) contractual costs	111	3,148	0	0
Non-contractual payments requiring HMT approval (special severance payments)	1	8	0	0
Total	**122**	**3,486**	**62**	**3,624**

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

Staff turnover

The Trust's voluntary turnover rate was reported at 6.3% in March 2026, compared to 8.9% reported in March 2025, representing a steady decrease in our turnover over the past 12 months and a continued decline over the past 3 years. This decline in turnover, coupled with significant year-on-year improvements across all people promise elements and themes in the NHS Staff Survey, provide good evidence of steady improvements in our staff experience.

We run a dedicated walking aid return and reuse scheme to reduce waste and save the NHS money. This is one of many initiatives helping us deliver environmentally friendly and sustainable healthcare.

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 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 November 2025 governors were consulted on the Trust's emerging 2026/27 business plan and provided a range of views and comments to the Board to help inform the development of the plan.

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

The Council of Governors Strategy, Transformation and Partnerships Working Group discusses many of the Trust's 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 2025. See page 67 for a full list of governors.

4 governors received expenses totalling £148.65 during 2025/26, compared to £230.72 in 2024/25.

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 82, 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 about 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.

Members of the Nominations Committee in 2025/26

Name	Role
David Al-Basha (until June 2025)	Patient governor
Charles Alexander (to April 2025)	Chairman
Brian Boag	Partnership governor
Yvonne MacPherson (from December 2025)	Patient governor
Leah Mansfield	Patient governor
Alison Mould	Public governor
Mary O'Donovan (from March 2026)	Partnership governor
Daghni Rajasingam	Staff governor
Sheila Reddy	Public governor

In June 2025 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 annual exercise helped the Committee give assurance to the Council of Governors about the capability of the non-executive directors and also ensured the Committee would be able to make recommendations to the Council of Governors in relation to non-executive director succession planning, when the need arises.

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 2025/26, the Council of Governors accepted the Nominations Committee's recommendation to reappoint Ian Playford as a non-executive director of the Trust for a further 4 years to April 2030.

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,

Council of Governors meeting attendance April 2025 – March 2026

Meeting dates: 30 April 2025, 23 July 2025, 22 October 2025 and 28 January 2026

Patient governors	Elected	Actual / possible attendance
David Al-Basha	July 2022 (term ended June 2025)	0 / 1
Emma Barslund Blackman	July 2024	4 / 4
Kathryn Blake	July 2025	3 / 3
Victoria Borwick	July 2021 (re-elected July 2024)	4 / 4
Michael Bryan	July 2021 (re-elected July 2024)	4 / 4
Felicity Conway	July 2024	4 / 4
Peter Harrison	July 2022 (stepped down August 2025)	1 / 1
Leah Mansfield	July 2021 (re-elected July 2024)	4 / 4
Michael Mates	July 2024	0 / 4
Yvonne McPherson	July 2025	2 / 3
Charles Mead	July 2024	3 / 4
Patrick Miller	July 2025	2 / 3
Gavin Morrison	August 2025	2 / 2
John Powell	July 2019 (re-elected July 2022, term ended June 2025)	1 / 1
Helen Selvarajan	July 2025	1 / 3

Public governors	Elected	Actual / possible attendance
Koku Adomza	July 2022 (term ended June 2025)	1 / 1
Aya Ayoub	July 2024	1 / 4
Steve Bean	July 2024	2 / 4
John Clark	July 2022 (term ended June 2025)	1 / 1
Katherine Etherington	July 2022 (re-elected July 2025)	4 / 4
Samantha Field	July 2024	1 / 4
Margaret McEvoy	July 2025	3 / 3
Alison Mould	July 2022 (re-elected July 2025)	4 / 4
Sheila Reddy	July 2024	3 / 4
Dominic Shaw	July 2024	3 / 4
Thomas Sheridan	July 2025	2 / 3
Peter Yeh	July 2025	3 / 3

Staff governors	Constituency	Elected	Actual / possible attendance
Nimmi Anu Sam	Clinical	July 2024	0 / 4
Nigel Beckett	Clinical	July 2024	4 / 4
Irina Munteanu	Non-clinical	July 2025 (stepped down February 2026)	1 / 4
Roseline Nwaoba	Non-clinical	July 2022 (term ended June 2025)	1 / 1
Samuel Oloye	Non-clinical	July 2025	3 / 3
Daghni Rajasingam	Clinical	July 2024	3 / 4
Mercy Satoye	Clinical	July 2024	0 / 4
Kendra Schneller	Community	July 2024	2 / 4
Cordwell Thomas	Non-clinical	July 2025	2 / 3
Claire Wills	Non-clinical	July 2022 (term ended June 2025)	1 / 1

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
Brian Boag	London South Bank University	January 2025 (stepped down April 2025)	0 / 1
Annette Boaz	King's College London	July 2024	1 / 4
David Bridson	Lambeth Council	May 2025	2 / 3
Emily Hickson	Southwark Council	June 2022	4 / 4
Mary O'Donovan	South London and Maudsley NHS Foundation Trust	September 2021	4 / 4
Stéphanie Petit	Royal Borough of Kensington and Chelsea Council	June 2024	0 / 4
Darren Summers	South East London Integrated Care Board	July 2024	2 / 4
Jadwiga Wedzicha	Imperial College London	February 2021	0 / 4

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 2026 the Trust had 38,780 members, of whom 6,418 were patient members, 7,504 were public members and 24,858 were staff members.

Members receive regular news about the Trust and are invited to attend our regular health seminars. In 2025/26 we delivered 13 online health seminars which were attended by around 1,400 patients, public and staff. They provided information about the latest developments, innovations, and new treatments and offered opportunities for our members to learn more about our work to provide high quality care and improve the health of our populations. The seminars also help to strengthen the relationship between the Trust and the communities we serve.

In September 2025 around 130 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, Amanda Pritchard. Biographies of the Board members can be found on pages 74-77.

5 non-voting executive directors also routinely attend Board meetings: Andrew Asbury, Managing Director – Essentia; Anita Knowles, Director of Communications; Denis Lafitte, Chief Digital Information Officer; Jackie Parrott, Chief Strategy Officer; and Tendai Wileman, Chief of Staff and Director of Organisational Change.

The role of the Board 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 a robust internal system of governance, risk and control; 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 2025/26 undertook a comprehensive Board effectiveness evaluation to identify opportunities where Board governance could be further strengthened.

Public Board meeting attendance April 2025 – March 2026		
Name	Title	Actual/possible
Charles Alexander	Chairman and non-executive director	4 / 4
Felicity Harvey	Non-executive director, Senior Independent Director, and joint Deputy Chair	4 / 4
Simon Friend	Non-executive director and joint Deputy Chair	4 / 4
Miranda Brawn	Non-executive director	3 / 4
Nilkunj Dodhia	Non-executive director	3 / 4
Jamie Heywood	Non-executive director	4 / 4
Deirdre Kelly	Non-executive director	4 / 4
Graham Lord	Non-executive director	4 / 4
Pauline Philip	Non-executive director	4 / 4
Ian Playford	Non-executive director	2 / 4
Alison Wilcox	Non-executive director	1 / 4
Ian Abbs	Chief Executive (to 5 September 2025)	2 / 2
Amanda Pritchard	Chief Executive (from 6 September 2025)	2 / 2
Crystal Akass	Chief People Officer	4 / 4
Gubby Ayida	Chief Executive, Women's and Children's Clinical Group	3 / 4
Avey Bhatia	Chief Nurse	4 / 4
Sarah Clarke	Chief Executive, Cancer and Surgery Clinical Group	3 / 4
Steven Davies	Interim Deputy Chief Executive (from 1 April 2025 to 31 March 2026)	4 / 4
Louise Dark	Chief Executive, Integrated and Specialist Medicine Clinical Group	3 / 4
Jon Findlay	Chief Operating Officer	4 / 4
Richard Grocott-Mason	Chief Executive, Heart, Lung and Critical Care Clinical Group	2 / 4
Damien O'Brien	Interim Chief Financial Officer (from 1 April 2025 to 31 March 2026)	4 / 4
Simon Steddon	Chief Medical Officer (to 31 March 2026)	4 / 4

Committee	Membership	
	Non-executive directors	Executive directors
Board in Committee	• All non-executive directors	• All executive directors
Academic Committee in Common*	• Graham Lord (Chair) • Felicity Harvey	• Simon Steddon • Damien O'Brien
Audit and Risk	• Nilkunj Dodhia (Chair) • Simon Friend • Jamie Heywood • Deirdre Kelly	
Finance, Commercial and Investment	• Simon Friend (Chair) • Charles Alexander • Ian Playford • Pauline Philip	• Ian Abbs (until 5 September 2025) • Avey Bhatia • Louise Dark • Steven Davies • Damien O'Brien • Amanda Pritchard (from 6 September 2025)
Quality and Performance	• Pauline Philip (Chair) • Charles Alexander • Felicity Harvey • Deirdre Kelly • Alison Wilcox	• Ian Abbs (until 5 September 2025) • Gubby Ayida • Avey Bhatia • Sarah Clarke • Louise Dark • Jon Findlay • Richard Grocott-Mason • Amanda Pritchard (from 6 September 2025) • Simon Steddon
People, Culture and Education	• Miranda Brawn (Chair) • Charles Alexander • Jamie Heywood • Deirdre Kelly • Alison Wilcox	• Ian Abbs (until 5 September 2025) • Crystal Akass • Gubby Ayida • Avey Bhatia • Steven Davies • Amanda Pritchard (from 6 September 2025)
Senior Leadership Talent, Appointments and Remuneration**	• Ian Playford (Chair) • Charles Alexander • Miranda Brawn • Simon Friend • Felicity Harvey • Alison Wilcox	
Transformation and Major Programmes	• Ian Playford (Chair) • Charles Alexander • Nilkunj Dodhia • Simon Friend • Felicity Harvey • Jamie Heywood	• Ian Abbs (until 5 September 2025) • Crystal Akass • Gubby Ayida • Steven Davies • Jon Findlay • Richard Grocott-Mason • Damien O'Brien • Amanda Pritchard (from 6 September 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.
** Membership also includes non-executive directors and executive directors from King's College Hospital NHS Foundation Trust and King's College London.

During 2025/26 the Board carried out its duties in public and through a range of committees as follows.

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.

Academic Committee in Common – which was established in May 2025. Its membership includes Board members of the Trust and King's College Hospital NHS Foundation Trust, and senior representatives from King's College London. Its role is to strengthen collaboration between the 3 organisations so they can achieve their shared clinical-academic goals, deliver impactful research, and resolve cross-organisational system issues.

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

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 for overseeing succession planning across the Trust's senior leadership. Further information is set out on page 72.

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.

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.

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 2026 the Committee reviewed the draft 2025/26 Annual Report and Accounts and recommended its approval by the Board of Directors prior to it 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.

Audit and Risk Committee membership and attendance 2025/26	
Name	Actual/possible
Nilkunj Dodhia [Chair]	5 / 5
Simon Friend	5 / 5
Jamie Heywood	4 / 5
Deirdre Kelly	4 / 5

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 2026 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 2025/26 the Committee took steps to ensure the cohort of executive directors remained strong by:

- appointing Julian Kelly as the new Chief Strategy and Transformation Officer from 1 April 2026
- appointing Ian Abbs as the new Interim Chief Medical Officer from 13 April 2026.

Board of Directors Disclosures

Details of external directorships or other positions of authority held by the directors of the Trust can be found in Note 30 to the Annual Accounts.

7 directors received expenses totalling £8,379.50 during 2025/26, compared to 7 directors receiving £10,028.15 in 2024/25.

Senior Leadership Talent, Appointments and Remuneration Committee membership and attendance 2025/26	
Name	Actual/possible
Ian Playford [Chair]	6 / 6
Charles Alexander	6 / 6
Miranda Brawn	6 / 6
Simon Friend	5 / 6
Felicity Harvey	6 / 6
Alison Wilcox	5 / 6

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 2025/26 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.

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:

- oversee the establishment of an organisational culture that aligns with the Trust's 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:

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 clinical governance systems and processes are in place to monitor and deliver high quality, safe patient care.

Improving the Health of our Populations Committee – provides strategic direction and oversight for the Trust's work to improve population health, using data, prevention, and joined-up services to deliver the commitments in the strategy.

Investment Portfolio Board – 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.

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 MBE

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, and at Otsuka Pharmaceutical Europe Limited.

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

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 recently retired as 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. She is also a Trustee of Muscular Dystrophy UK.

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

Professor Graham Lord

Non-executive director

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, as well as Honorary Consultant in Nephrology, transplantation and Professor of Medicine at King's College London.

He was previously Vice-President and Dean of the Faculty of Biology, Medicine and Health at the University of Manchester and executive director of the Manchester Academic Health Science Centre.

Graham chairs the Academic Committee in Common.

Dame Pauline Philip

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

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

Dame Amanda Pritchard

Chief Executive

(From 6 September 2025)

Amanda took up the role of Chief Executive following nearly 4 years as Chief Executive of NHS England. The first woman to lead the health service, during her tenure the NHS responded to COVID-19, published the first ever NHS Long Term Workforce Plan and began its recovery from the pandemic with emergency care access, elective and cancer performance, acute sector productivity, and staff survey results all improving.

Previously, Amanda spent 2 years as Chief Operating Officer of NHS England where she led the NHS operationally through COVID-19.

Before joining NHS England in 2019, Amanda was Chief Executive of Guy's and St Thomas'. She began her NHS career as a graduate management trainee in 1997 after studying at Oxford University. She was awarded a damehood in the 2026 New Year Honours list and is married with 3 children.

Crystal Akass

Chief People Officer

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 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 joined the Trust in 2023 as Chief Executive of Evelina London Women's and Children's Clinical Group. She is a consultant Obstetrician and Gynaecologist.

Before joining the Trust, Gubby was Medical Director of Hillingdon Hospitals NHS Foundation Trust, and Medical Director of the Women's and Children's Division at Chelsea and Westminster NHS Foundation Trust which provided maternity services across 2 acute hospital sites. Other leadership positions have included specialist advisor to the Chelsea and Westminster Board for equality, diversity and inclusion; and Associate Medical Director for Strategic Programmes.

Professor Avey Bhatia OBE

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 has held a series of senior leadership roles across NHS trusts, and is President of the Florence Nightingale Foundation and Honorary Vice President of The Nightingale Fellowship.

In 2025, Avey was appointed as Professor of the Practice of Nursing at King's College London. She was awarded an OBE for her services to nursing and the NHS in 2025. She is the Trust's Director of Patient Experience, 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 NHS Foundation Trust and was responsible for the operational delivery of 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.

Louise Dark

Chief Executive Integrated and Specialist Medicine Clinical Group

Louise was appointed as Chief Executive of our integrated and specialist medicine services in 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.

Board of Directors – executive directors

Steven Davies

Interim Deputy Chief Executive

(From 1 April 2025 to 31 March 2026)

Steven was appointed as interim Deputy Chief Executive in April 2025, after holding the Chief Financial Officer role since 2022. He joined Guy's and St Thomas' in 2018 as the Director of Finance.

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.

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.

Dr 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 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.

Damien O'Brien

Interim Chief Financial Officer

(From 1 April 2025 to 31 March 2026)

Damien was appointed as interim Chief Financial Officer in April 2025. He joined Guy's and St Thomas' in 2022 as Operational Finance Director.

He is a chartered accountant who has worked in the NHS for over 20 years, initially joining Royal Berkshire NHS Ambulance Trust as a finance trainee. Damien has held senior finance roles in a number of NHS organisations, including spending 6 years at Royal Brompton and Harefield NHS Foundation Trust prior to the merger with Guy's and St Thomas'. He also spent some time working in the commercial sector earlier in his career.

Dr Simon Steddon

Chief Medical Officer

(Until 31 March 2026)

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.

Professor Ian Abbs

Chief Executive

(Until 5 September 2025)

Ian 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. Ian returned to the Trust as interim Chief Medical Officer from 13 April 2026.

Our neonatal unit is one of the country's leading units providing specialist care to newborn babies.

8 NHS Oversight Framework

Segmentation

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of 5 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) its segment based on its scored performance across 5 domains (access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)

b) a financial override which may limit a segment to be no better than 3

c) additional metrics which are not scored, such as improving health and reducing inequality

d) capability assessments which consider the organisation's leadership and governance.

During 2025/26 Guy's and St Thomas' was placed into segment 1 of the NHS Oversight Framework for its performance during quarter 1. We maintained this position following subsequent reviews at the end of quarter 2, quarter 3 and quarter 4.

NHS England also maintains league tables that rank trusts by the type of service they provide. This enables people to compare organisations and services providing transparency and accountability across the health system.

The Trust's position in the league table of 134 acute trusts improved from 15th in quarter 1, to 12th in quarter 2, 10th in quarter 3 and 12th in quarter 4.

Our segmentation and ranking in the league table reflects sustained performance improvements and the continued hard work and commitment of our colleagues. Maintaining this position in 2026/27 will require us to build on these achievements and continue to strengthen operational performance, financial management, quality of care and colleague experience.

Segmentation information is published at
www.england.nhs.uk/nhs-oversight-framework/segmentation and-league-tables/.

Tiering

During 2025/26 NHS England's national tiering programme operated alongside the NHS Oversight Framework and provided additional opportunities for trusts to access bespoke support from NHS England to help address operational challenges.

The Trust was in tiering for its cancer performance from March 2024 and has made significant progress in reducing the backlog of patients waiting over 62 days for cancer treatment and improve our overall performance. This work is both internally focused, and with our partners across south east London to improve shared treatment pathways.

The Trust was also in tiering for diagnostics performance since early 2024. As explained in our Performance Report, increasing demand for diagnostic tests made it difficult to improve our performance and meet the national standard that fewer than 1% of patients should wait longer than 6 weeks for their diagnostic test or procedure. Support from NHS England helped us to make improvements, but further work remains in this important area.

In October 2025 NHS England placed the Trust into tiering for planned (elective) waiting times to support the Trust in eliminating all patients waiting over 65 weeks for treatment as quickly as possible. Many of these patients 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.

Provider Capability Assessment

NHS England's Provider Capability Assessment is used alongside the Trust's segmentation in the NHS Oversight Framework to determine which actions and support may be needed by providers. In February 2026 the Trust was allocated an overall capability rating of Green/Amber for 2025/26.

This is the second highest rating on a scale of 4. It indicates that there are some concerns across one or more areas, but these are not yet affecting quality of care, delivery of core services, finance or the wider reputation of the NHS.

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 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.

Dame Amanda Pritchard
Chief Executive Officer and Accounting Officer
24 June 2026

Appendix 1:
Annual Governance Statement 2025/26

Scope of responsibility

As Accounting Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 2026 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' 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 reports 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 its 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. Following a review of executive responsibilities in March 2026, the Chief Nursing Officer carries responsibility for ensuring our Risk Management Policy is implemented correctly and is sufficiently effective. The Chief Nursing Officer, in conjunction with the Chief Medical Officer, 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 executive lead for counter fraud. 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 intranet 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.

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-level risk register and oversees the management of risk within their respective directorates. Significant risks that are unable to be effectively controlled within clinical groups are escalated through performance review meetings and the corporate governance committee structure for inclusion on 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. Risk management training is available online for risk managers, as well as in person advanced training for governance colleagues and senior management delivered by the Trust's Quality and Assurance directorate.

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) and Incident Management Policy. A 'Quality Matters' newsletter is published throughout the year 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.

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 changes in risk scores and challenge non-moving risk within the system. 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 are 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. Board committees are aligned to and own strategic risks 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; this remained in place during 2025/26 and will do so into 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 keep their internal governance arrangements within the Trust's corporate governance framework under review.

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 four 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.

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. Our internal audit department undertook their annual review of our risk management and board assurance frameworks in 2025/26. 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 the effectiveness of its risk management policy, the result of which is reported to the Audit and Risk Committee. 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.

Quality governance arrangements

Our quality governance framework is built upon the principles described within the Care Quality Commission's (CQC) and NHS England's jointly developed well-led guidance for trusts and aligned to the 5 quality domains outlined by the CQC. The Board actively engages in overseeing the quality of care, using feedback from patients, the public, staff and other relevant stakeholders that is obtained 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 Accountability and Performance 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 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. The corporate functions supporting clinical group delivery are directorates with executive leads and include, for example, finance, workforce, and data, technology and information (DT&I).

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 the Quality and Performance Board Committee. Such reports include information on key quality indicators including patient safety, patient experience and clinical effectiveness.

Assessing the quality of performance information

To support its commitment to maintaining the highest standards of governance, the Trust utilises the Integrated Performance Reporting Framework to monitor key performance indicators across clinical directorates, clinical groups and at an aggregate Trust level, aligned to the Trust's Accountability and Performance Framework. This is supplemented by peer benchmarking to ensure that performance information is robust, comprehensive and supports effective insight and decision making. The framework is further strengthened by established benchmarking initiatives and tools, including Getting It Right First Time (GIRFT) and Model Hospital, alongside participation in the pan London Learning Improvement Network (LIN) and the Shelford Group.

High quality performance information, alongside robust national benchmarking, is fundamental to the Trust's ambition to deliver effective patient care and directly informs its assessment and segmentation under the NHS Oversight Framework.

The reporting framework offers a holistic view of performance across key domains aligned to CQC priorities and NHS England's Insightful Provider Board guidance 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 continues to enhance its reporting infrastructure to strengthen operational performance management and decision making. A targeted improvement programme is underway to redesign the reporting and accountability framework, including the Integrated Performance Report, alongside a review of the Trust's data quality and validation strategy to ensure alignment with workforce changes.

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 mock 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 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 and incident management data, staff experience and feedback, patient experience, complaints, and soft intelligence throughout the Trust's corporate governance framework.

In March 2026 the CQC carried out an inspection of the Trust's urgent and emergency services at St Thomas' and Guy's hospitals. Whilst the final inspection report had not been received by the date of publication of this Annual Report and Accounts, initial feedback was positive and provided useful insight on the quality of our services. Before this, our last CQC service inspection was for maternity services at St Thomas' Hospital in September 2022. The maternity 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.

Managing risks to data security

A Trust Cyber Resilience Strategy is in place to mitigate cyber risk, which 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/cyber security training mandated for all staff. Phishing simulations are conducted regularly and those staff failing phishing simulation exercises receive further cyber security 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 through adherence to the Data Protection Act 2018 and the General Data Protection Regulations (GDPR). This is evidenced through an internal audit of Data Protection led by the Data Protection Officer.

The requirement for Data Protection Impact Assessments (DPIAs) and the principles of Privacy by Design and Default are met through established processes that embed information governance and information security requirements into all projects and programmes involving the processing of personal or sensitive data. Alongside DPIAs, the Trust uses GDPR compliant contracts, systems security reviews for all new systems, and Data Sharing Agreements. Any personal data breaches are investigated, reported to the Information Commissioner's Office (ICO) where required, and appropriate follow up actions are taken.

Information governance risks are managed locally within the Information Governance Team, and escalated where required to the directorate risk register, and, if they are unable to be effectively controlled within the directorate, to the corporate risk register.

The Trust's annual Data Security and Protection Toolkit submission and improvement plan was submitted to NHS England in June 2025, achieving 'Standards Met'.

We continue to strengthen our approach to managing cyber security risks associated with our key third party suppliers. This includes incorporating appropriate checks within procurement processes, taking a risk based approach to assessing suppliers' security arrangements, and ensuring contracts set clear expectations in relation to data protection and information security. We maintain regular oversight of higher risk suppliers and, where appropriate, seek additional assurance, including through recognised standards. We are also continuing to develop our approach to ensure that risks are identified at an early stage and managed consistently over time.

Managing risks from legacy IT systems

The Trust continues to manage technology debt in terms of legacy IT solutions. This is supported by a programme of work to achieve a supported technology estate. Risk management activity has continued during 2025/26 to decommission, upgrade or replace legacy systems.

Information incidents

Information incidents and near misses are investigated by the relevant Trust department with support from the information governance team. Serious incidents are used as opportunities to improve processes and reduce risks. This approach is reinforced by annual information governance and information security awareness training, which emphasises the safe processing and protection of personal and sensitive data.

In 2025/26, one information incident met the threshold for notification to the ICO. A member of staff clicked a link in an email believed to originate from a trusted website, and NHS England's Cyber Operations team later advised that there was a high likelihood the entire contents of the user's downloads folder had been exfiltrated, requiring a full review of all files within it. The device was immediately isolated, the user's password and authentication token were reset, and the malicious URLs were blocked. No further action was taken by the ICO.

Major in-year risks 2025/26 and in 2026/27

Major in-year risks 2025/26

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 relevant Board committees, where they are monitored at least quarterly. The full Board reviews the full Board Assurance Framework twice a year. The Audit and Risk Board Committee has responsibility to ensure the process for the management of these principal risks remains fit for purpose. This process includes the use 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 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 Trust's new strategy that had been published in September 2024. As part of this review several of the existing risks were consolidated and new risks were added regarding the extent of the organisational transformation needed to deliver the Trust's strategy; the importance of increasing productivity levels to balance delivery of both operational and financial responsibilities; and the Trust's need for a high performing and future ready workforce. 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.

Therefore, the principal risks to achievement of our strategic objectives in 2025/26 were:

- the Trust's activity may not be sufficient to meet the trajectories in our operating plan, resulting in patients being unable to access our services in a timely manner and lead to continued or increased regulatory intervention

- the Trust may fail to deliver safe, high-quality care to patients across all sites and services, whilst providing excellent standards of customer service that results in a high-quality patient experience
- the Trust's estates infrastructure may be insufficiently resilient to protect the Trust from current and emerging risks such as water, fire and ventilation, which may pose a risk to patient safety or negatively impact operational performance and patient outcomes
- the Trust's digital infrastructure may be insufficiently resilient to protect the Trust from current and emerging risks, such as cyber threats, that may negatively impact operational performance and patient outcomes
- 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 clinical, operational and financial benefits set out in the business case
- the Trust may fail to effectively deliver multiple large-scale and complex transformation programmes concurrently, due to limitations in capacity, capability, governance, or stakeholder engagement. This could result in delays, increased costs, reduced quality of outcomes, and failure to achieve strategic objectives, ultimately affecting patient care and organisational sustainability
- the Trust's productivity levels may be insufficient to enable it to balance delivery of both its operational and financial responsibilities and therefore may impact delivery of its strategic priorities
- the Trust may be unable to sustain sufficient income to deliver a sustainable financial position, which may result in regulatory intervention and impair its ability to deliver high quality care, provide timely access to services and fulfil its strategic agenda
- the availability of capital expenditure funding and the Trust's ability to fund capital investments may be insufficient to both maintain existing infrastructure and deliver transformational programmes to deliver the Trust's strategic objectives
- the insufficient workforce enablement, development and transformation may impair the Trust's ability to achieve the right people capacity, capability and change-ready organisational culture to meet the demands of healthcare now and into the future – ensuring safe, efficient and optimal care for patients and a healthy, high performing, and inclusive working environment for colleagues who provide it
- if the Trust does not consistently optimise its ways of working, establish clear frameworks and standards, and ensure strong, visible leadership, organisational excellence will be compromised, potentially undermining our ability to deliver high-quality patient care and achieve our strategic objectives
- the Trust may fail to fully deliver on its clinical academic research ambitions as set out on the strategy.

Major in-year risks 2026/27

As with all NHS organisations we face ongoing 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 activity requirements and stretching financial plans. Similarly, we face a challenge in balancing delivery of day-to-day care with the longer-term strategic ambitions set out in our strategy. In April 2026 the Board of Directors undertook a comprehensive review of the Board Assurance Framework and agreed that the 2025/26 risks continued to represent the main threats to delivery of its strategic objectives. The review did, however, lead to a small number of relatively minor changes to ensure the principal risks reflected the changing challenges and opportunities – both internal and external – facing the organisation. These changes were still being finalised at the time of publishing the Annual Report and Accounts.

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 2025/26 to assess and strengthen the Trust's well-led capability included:

- an internal well-led programme that self-assessed the Trust, both at a corporate level and for each of its 4 clinical groups, against all 8 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;
- the development of a draft well-led information dashboard to enable closer oversight of key metrics across all 8 well-led quality statements;
- completion of an internal Board effectiveness evaluation in November 2025, which assessed the strength of structures and processes alongside culture and behaviours at Board level. This review concluded that the Trust's governance was fundamentally strong, with a solid foundation of highly capable people and established structures while identifying opportunities to strengthen what is already in place, maximise the value those arrangements create, and improve organisational efficiency and agility. An associated action plan was agreed and is being delivered;
- the commissioning of external support to build on the findings of the internal Board effectiveness evaluation and provide an independent perspective on opportunities to further strengthen organisational effectiveness and decision-making; and
- the inclusion of an organisational excellence risk on the Board Assurance Framework, with a particular focus on the importance of strong, visible leadership.

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 internal Board effectiveness evaluation and external review of organisational effectiveness, both referred to above;
- 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 and Performance 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, as well as monitoring of duty of candour compliance through key performance indicators.

During 2025/26 the Trust has continued to demonstrate a healthy incident reporting culture and remains one of the highest reporters of incidents across our peer group. 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. We continue to have a strong and open reporting learning culture across our sites and services, ensuring incident management forms an essential part of risk management.

The Trust moved away from the serious incident framework to the new national Patient Safety Incident Response Framework (PSIRF) 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 have recently reviewed our current patient safety incident response plans to ensure they remain current and focus on the highest areas of risk within the organisation. Our Trust Patient Safety Incident Response Plan (PSIRP) is published on our Trust website and demonstrates our approach to patient safety risk management in action.

In 2025/26, the Trust reported 10 'never events' across the organisation, which was an increase from 8 in 2024/25. All reported never events are investigated as patient safety incident learning response, which are led by our Trust patient safety team and discussed at our Learning for Improvement Group. All reported incidents are reviewed and learning responses applied in accordance with our incident policy 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 continues to be the consistent and safe use surgical checklists to improve surgical safety, with 7 never events relating to retained foreign objects following interventional procedures in the financial year. Surgical safety remains one of the Trust's patient safety 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 key component of the Trust's approach to meeting its duties under the Public Sector Equality Duty (PSED) as set out in the Equality Act 2010. They are used to assess the potential impact of policies, practices, and services on protected groups, ensuring equality considerations are embedded in decision-making and that risks of discrimination are identified and mitigated.

Updated EQIA guidance and supporting resources are in place and actively promoted across the organisation. Many governance forums, including the Investment Portfolio Board, require the completion of an EQIA prior to the submission and approval of business cases.

A formalised Trust-wide assurance framework to systematically monitor the quality, consistency, and impact of EQIAs is currently in development. In the interim, support continues to be provided to colleagues, alongside ongoing updates to guidance and resources to strengthen consistency of application and continuous improvement.

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 38,780 members at the end of March 2026. 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, often through 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 to value 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 NHS England's 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, more robust 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 is working towards ensuring that it is compliant with its obligations under the Climate Change Act and the Adaptation Reporting requirements.

The Trust launched its new Green Plan to 2028 in January 2026. This supersedes the Trust's previous Sustainability strategy. The Green Plan consists of 10 focus areas: Workforce and Leadership, Net Zero Clinical Transformation, Digital Transformation, Medicines, Travel and Transport, Estates and Facilities, Supply Chain and Procurement, Food and Nutrition, Air Quality, and Adaptation.

The Trust Green Plan follows the guidance of February 2025 and, as such, complies with the Climate Change Act 2008 and sector targets set in the NHS Net Zero report. Delivery of the Green Plan is overseen by a Board-level net zero lead, who also chairs the Trust's Green Plan Delivery Board. Members of this Delivery Board include senior management from across the Trust corporate functions and clinical groups.

In October 2022 the Trust commissioned an estates focused climate change risk assessment. The Trust is currently developing a new estates strategy that will include long-term infrastructure changes required to ensure estate resilience to the effects of climate change. The Trust will publish its Climate Change Adaptation Plan in 2026, which will include an action plan to address the risks of climate change on the Trust operations.

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 the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Pay Gap reporting and associated action plans, Equality Impact Assessments and People Strategy objectives.

All People and HR policies are currently compliant with equality, diversity and human rights legislation, including the Equality Act 2010. Arrangements are in place to keep policies under review and to ensure continued and strengthened compliance as new employment legislation and statutory requirements are implemented.

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 the Anti-Racism in Action (ARIA) 2 programme, a flagship initiative supporting the organisation's commitment to becoming an anti-racist organisation. The sessions are designed to build awareness, deepen understanding, and support the practical application of anti-racist principles across the workforce, with a focus on enabling meaningful behavioural and cultural change
- building on the foundations of ARIA, delivering a senior leadership development programme tailored for line managers, the top 250 senior leaders, and Board members. This programme focuses on strengthening inclusive leadership capabilities, raising awareness of systemic inequalities, and embedding EDI principles into leadership behaviours and decision-making. It is explicitly aligned to and informed by the principles and learning from ARIA, ensuring consistency of messaging and approach across all leadership levels and strengthening managers understanding of their responsibilities, expected actions, and duty to embed inclusive and anti-racist practice in their leadership 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
- delivering a Positive Action Programme for Global Majority staff, designed to support development, confidence, and progression opportunities. Cohort 2 is currently underway. Early evaluation of Cohort 1 indicates positive impact, including increased participant confidence, strengthened understanding of career progression pathways, and improved awareness of opportunities for advancement within the organisation
- 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 of processes relating to workplace adjustments to ensure alignment with current best practice and legal requirements, and to support a more inclusive and accessible working environment for all employees. A programme of work is in place to further strengthen and standardise the approach, with the aim of delivering an improved end-to-end process by the end of 2026. This will include the development of a formal policy, supporting manager guidance, and the identification and resolution of current process gaps and delays to ensure greater consistency, clarity, and timeliness of delivery
- reviewing and repurposing the current Reverse Mentoring programme into a Reciprocal Mentoring model. This updated approach will focus on creating a more balanced, two-way learning opportunity, supporting mutual development, shared understanding, and inclusive leadership across the organisation. The revised model is intended to strengthen cultural intelligence, deepen insight across different levels and backgrounds, and support more meaningful organisational learning and change.

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

Over the past year the Trust has continued to mature its data quality and assurance arrangements, further strengthening confidence in the accuracy, consistency and reliability of information reported to the Board. Building on the progress made previously, the Quality and Assurance and Performance and Information teams now operate as a fully integrated function. This has enabled the more consistent application of data standards, strengthened analytical oversight, and further improved governance arrangements supporting the production of the Integrated Performance Report.

The Quality and Assurance team collates and synthesises monthly data from a range of corporate and local systems, including Datix, SharePoint (regarding policy compliance), and guidance monitoring from the National Institute for Health and Care Excellence (NICE). Final validation and triangulation are undertaken by a senior clinical analyst prior to publication of the Integrated Performance Report, ensuring a robust evidence base to support data driven decision making aligned to the Trust's strategic priorities.

Clear data ownership is embedded within established governance structures. Where responsibility sits with specific forums, such as the Acutely Ill Patients Group, those groups are accountable for validating data and determining whether performance remains within acceptable parameters. This approach reinforces clear lines of accountability and ensures that quality and safety metrics are interpreted and assured by appropriate subject matter experts.

The Trust operates a defined suite of policies and protocols that set required performance standards and key indicators, enabling the Board to assess levels of assurance and understand the underpinning methodology for each measure. Nationally benchmarked indicators, including the Summary Hospital level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR), are routinely reviewed against national comparators to provide appropriate context for Board oversight. Assurance is further strengthened through internal and external audit activity, with findings informing targeted improvement actions.

As the next stage in this maturity, the Trust is refreshing its reporting framework and developing a new iteration of the Integrated Performance Report. This will strengthen alignment with key external frameworks, including NHS England's Insightful Provider Board guidance and the NHS Oversight Framework, alongside closer alignment to the Trust's Healthcare Excellence Framework, strategic priorities, and five year business planning commitments. This refreshed approach will ensure the Integrated Performance Report provides clearer, more targeted insight to support effective Board oversight, assurance, and decision making.

The Trust has an established validation and data quality strategy in place, which is currently under review ahead of the forthcoming year. This review will ensure validation activity is increasingly targeted and risk based, particularly in relation to elective waiting list data. This supports the maintenance of a clean and accurate waiting list, strengthens patient safety, and enables the Trust to plan and deliver care more effectively.

Benchmarking is routinely used as an additional assurance mechanism to support the accuracy and credibility of reported data. Performance is reviewed against peer organisations and national standards to identify anomalies, validate trends, and provide external context for Board oversight.

Formal governance forums play a central role in assuring data quality and performance. Oversight is provided through established structures, including the Elective Oversight Forum and the Trust Operations Board, which review performance, challenge data where required, and ensure corrective actions are implemented. Ultimately, data is reviewed by the Quality and Performance Board Committee and the full Board, with all papers formally published, ensuring transparency and robust scrutiny at every level.

The Trust continues to optimise its Epic electronic health record system to improve data quality and consistency, strengthen clinical and operational insight, and support delivery of the Trust's strategic priorities. System optimisation is focused on improving data capture at source, reducing manual intervention, and enabling more timely and reliable reporting.

The Trust has started to use artificial intelligence (AI) tools to support some of our work, particularly in areas like administration and data analysis. As with any new technology, this is being done within our existing data and information governance frameworks, with appropriate oversight and safeguards in place to ensure we continue to meet our data protection and security requirements. We are also working through what this means for us longer term, including how we strengthen our approach to governing the use of AI so that it supports high-quality, transparent and accountable decision-making.

Looking ahead, the Trust is increasingly focused on productivity and value, with a clear ambition to deliver sustainable improvements over the coming years. Accurate, timely and assured data underpins this agenda, enabling informed decision making, effective resource deployment, and long term financial and operational sustainability.

This sustained focus on strong governance, data assurance and performance management is reflected in the Trust's current position within Segment 1 of the NHS Oversight Framework, providing external assurance that the Trust is operating effectively and within expected levels of performance and control.

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.

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 the 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 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. All corporate risks have a responsible executive owner, and the Trust Executive Committee receives a report on the Corporate Risk Register at least quarterly and is the executive committee ultimately responsible for the corporate risks.

The Risk and Assurance department, within the Office of the Chief Nurse, 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 2025 to the date of this opinion. Internal Audit set out a work plan in May 2025 and has completed 24 projects. There has been sufficient coverage of key systems by internal audit and other assurance providers to enable me to form an opinion and reach a conclusion on the general control environment.

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 May 2025.

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. I have also considered the work of external and internal assurance sources including feedback from the recent CQC inspections of the Trust's urgent and emergency services.

There are multiple assurance sources across the Trust, most of which report into the Trust Risk and Assurance Committee and include external reviews and internal groups which monitor key control processes such as Clinical Audit, the Estates Technical Assurance Group and Digital Governance Board. Where control weaknesses are identified within assurance functions these are being addressed by management.

In relation to operational or other systems, the balance of limited to substantial assurance opinions arising from internal audit work has deteriorated when compared to previous years; however, a number of these relate to specific functions which do not impact on Trust level risk or strategic objectives.

I am satisfied that the Board Assurance Framework contains

the key risks faced by the organisation and that the Board and relevant responsible committee have effective oversight of the key risks.

The overall governance, control and risk framework across the organisation remains robust.

The relevant standards for Internal Audit are those set out within the Global Internal Audit Standards and the UK Public Sector Application Note. Taken together, these are referred to as the Global Internal Audit Standards in the UK Public Sector. Internal Audit teams are not expected to demonstrate full conformance from 1 April 2025, but to work in accordance with the new standards to build conformance from that date. I have assessed compliance against the standards and consider that the service generally conforms to the key requirements which underpin the quality and accuracy of reporting. There are some gaps in relation to the overall strategy and vision for the internal audit function. In addition, the current external quality assessor for internal audit has provided a high-level review of compliance which indicates the service is in a strong position to generally conform to the new standards".

Simon Lane CIPFA, Associate Director of Finance, 13 May 2026

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 audit 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. Detail on the Trust's national and clinical audit processes, function and improvements are published in our annual Quality Account.

To the best of my knowledge no significant issues have been identified in 2025/26. 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.

Dame Amanda Pritchard
Chief Executive Officer
24 June 2026

We introduced 12 'taxis' to our patient transport. The electric hybrid vehicles are fully wheelchair accessible and include other features making it easier for people who are less mobile.

10 Annual accounts

Foreword to the accounts

These accounts, for the year ended 31 March 2026, 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.

Dame Amanda Pritchard
Chief Executive Officer and Accounting Officer
24 June 2026

Independent auditor's report to the Council of Governors of Guy's & 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 & St Thomas' NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2026, which comprise the Consolidated statement of comprehensive income, the Statement of financial position, the Consolidated cash flow statement, the Statement of changes in taxpayers' equity, and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2026 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 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the 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 2025-26 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 2025/26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

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

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Accounting Officer's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2025/26, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the 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 2025-26).
- 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's and the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, the propensity of externally set financial targets to influence management's approach to revenue and expenditure recognition. 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, accrual journals and manual journals which have the effect of decreasing the level of expenditure;
  - revenue testing of income and year end receivable/income accruals from non-patient care revenues to invoices and cash payment or other supporting evidence, alongside testing of invoices issued in the period prior to and following 31 March 2026 to determine whether income is recognised in the correct accounting period;
  - expenditure testing of expenditure invoices in the period before and after 31 March 2026 to determine whether the expenditure has been recognised in the correct accounting period;
  - 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 management override of controls and the potential for fraud in revenue and expenditure recognition. 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 2026.

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 March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;

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

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

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

We cannot formally conclude the audit and issue an audit certificate for Guy's & St Thomas' NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

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

Grant Thornton UK LLP

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

London
26 June 2026

Consolidated statement of comprehensive income for the year ended 31 March 2026

		31 March 2026	31 March 2025
	NOTE	£000	£000
Operating income from patient care activities	3	**2,936,264**	2,842,690
Other operating income	4	**338,957**	327,945
TOTAL INCOME		**3,275,221**	3,170,635
Operating expenses	7.1	**(3,292,609)**	(3,157,314)
OPERATING (DEFICIT) / SURPLUS		**(17,388)**	13,321
FINANCE COSTS			
Finance income	11	**7,956**	7,599
Finance expenses	12	**(6,793)**	(6,939)
Public Dividend Capital charge	36	**(39,598)**	(40,494)
Net finance costs		**(38,435)**	(39,834)
Other gains	9	**3,583**	1,051
Share of profit of associates / joint ventures	20.1	**274**	75
Corporation tax (expense)		**–**	(118)
(DEFICIT)/FROM CONTINUING OPERATIONS		**(51,966)**	(25,505)
Gain on disposal of discontinued operations and the deficit from discontinued operations	10	**12,659**	–
(DEFICIT)/FOR THE YEAR		**(39,307)**	(25,505)
Other comprehensive (expense)/income			
Impairments	16	**(81,057)**	(6,909)
Revaluations	19	**11,408**	19,843
Other		**(4)**	–
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(108,960)**	(12,571)

The notes on pages 104 to 141 form part of these accounts.

Note 13 includes the Trust's analysis of performance.

Statement of financial position as at 31 March 2026

		GROUP		TRUST	
		31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	NOTE	**£000**	£000	**£000**	£000
NON-CURRENT ASSETS					
Intangible assets	15	**127,547**	125,458	**127,547**	125,458
Property plant and equipment	14	**1,603,022**	1,624,390	**1,603,022**	1,624,376
Right of use assets	17	**162,947**	163,736	**162,947**	163,719
Investment property	18	**75,941**	71,783	**75,941**	71,783
Investments in joint ventures, associates and subsidiaries	20.1	**1,419**	1,235	**2,050**	2,050
Other investments/financial assets	21	**1,668**	1,268	**–**	10,804
Trade and other receivables	23.2	**8,570**	8,221	**8,570**	8,221
TOTAL NON-CURRENT ASSETS		**1,981,114**	1,996,091	**1,980,077**	2,006,411
CURRENT ASSETS					
Inventories	22.1	**52,696**	49,516	**52,696**	49,516
Receivables	23.1	**218,716**	217,424	**218,721**	205,748
Cash and cash equivalents	26	**168,849**	190,734	**165,440**	185,808
TOTAL CURRENT ASSETS		**440,261**	457,674	**436,857**	441,072
CURRENT LIABILITIES					
Trade and other payables	24.1	**(406,751)**	(404,274)	**(406,683)**	(403,193)
Borrowings	24.3	**(39,191)**	(40,630)	**(39,191)**	(40,628)
Other liabilities	24.2	**(40,911)**	(40,214)	**(40,911)**	(40,086)
Provisions	25.1	**(2,494)**	(1,703)	**(2,494)**	(1,703)
TOTAL CURRENT LIABILITIES		**(489,347)**	(486,821)	**(489,279)**	(485,610)
NON-CURRENT LIABILITIES					
Borrowings	24.3	**(257,365)**	(273,403)	**(257,365)**	(273,389)
Provisions	25.1	**(11,380)**	(12,362)	**(11,380)**	(12,362)
TOTAL NON-CURRENT LIABILITIES		**(268,745)**	(285,765)	**(268,745)**	(285,751)
TOTAL ASSETS EMPLOYED		**1,663,283**	1,681,179	**1,658,910**	1,676,122
TAXPAYERS' EQUITY					
Public Dividend Capital		**859,075**	768,011	**859,075**	768,011
Revaluation reserve	19	**470,879**	540,494	**470,879**	540,494
Other reserves		**743**	743	**743**	743
Income and expenditure reserve		**332,586**	371,931	**328,213**	366,874
TOTAL TAXPAYERS' EQUITY		**1,663,283**	1,681,179	**1,658,910**	1,676,122

Dame Amanda Pritchard
Chief Executive Officer and Accounting Officer
24 June 2026

Consolidated cash flow statement for the year ended March 31 2026

	NOTE	GROUP 31 March 2026 £000	GROUP 31 March 2025 £000	TRUST 31 March 2026 £000	TRUST 31 March 2025 £000
Cash flows from operating activities					
Operating (deficit) / surplus from continuing operations		**(17,388)**	13,321	**(17,054)**	11,180
Operating (deficit) from discontinued operations	10	**(3,059)**	–	**–**	–
Non-cash income and expenses					
Depreciation and amortisation	7.1	**116,900**	122,770	**116,895**	122,452
Impairments and reversals of impairments	7.1	**35,157**	21,231	**35,157**	21,231
Income recognised in respect of capital donations		**(3,694)**	(455)	**(3,694)**	(455)
(Increase) / Decrease in trade and other receivables		**(10,328)**	12,745	**(13,046)**	10,411
(Increase) / Decrease in inventories		**(3,180)**	1,214	**(3,180)**	1,214
Increase / (Decrease) in other liabilities		**697**	(3,347)	**825**	(3,302)
(Decrease) / Increase in trade and other payables		**(14,387)**	(847)	**(13,371)**	337
(Decrease) in provisions		**(234)**	(4,398)	**(234)**	(4,398)
Corporation tax paid		**–**	(243)	**–**	–
Other movements in operating cash flows		**(327)**	1,594	**233**	2,484
NET CASH GENERATED FROM OPERATING ACTIVITIES		**100,157**	163,585	**102,531**	161,154
Cash flows from investing activities					
Interest / Dividends received	11	**7,956**	7,599	**21,179**	7,563
Purchase of financial assets	21	**(462)**	(986)	**–**	–
Proceeds from settlements of financial assets		**9,054**	315	**10,804**	255
Purchase of intangible assets		**(18,449)**	(5,499)	**(18,449)**	(5,499)
Purchase of property, plant and equipment		**(141,429)**	(85,366)	**(141,429)**	(85,366)
Proceeds from sale of property, plant and equipment	9	**20**	937	**20**	937
Receipt of cash donations to purchase capital assets		**3,694**	455	**3,694**	455
Cash movement from disposals of business units and subsidiaries (not absorption transfers)		**16,292**	–	**–**	–
NET CASH USED IN INVESTING ACTIVITIES		**(123,324)**	(82,545)	**(124,181)**	(81,655)
Cash flows from financing activities					
Public Dividend Capital received		**91,604**	106,748	**91,064**	106,748
Movement in loans from the Department of Health and Social Care (DHSC)	24.4	**(17,008)**	(17,009)	**(17,008)**	(17,009)
Capital element of lease liability repayments	24.4	**(24,216)**	(23,384)	**(24,216)**	(23,384)
Capital element of service concession payments	24.4	**(295)**	(284)	**(295)**	(284)
Interest paid on DHSC loans	24.4	**(4,173)**	(4,595)	**(4,173)**	(4,595)
Other interest	12	**(118)**	(366)	**(118)**	(366)
Interest element of lease liability repayments	24.4	**(2,461)**	(1,933)	**(2,461)**	(1,933)
Interest element of service concession obligations	24.4	**(82)**	(95)	**(82)**	(95)
Public Dividend Capital paid		**(41,429)**	(39,251)	**(41,429)**	(39,251)
NET CASH USED IN FINANCING ACTIVITIES		**1,282**	19,831	**1,282**	19,831
Net (decrease) / increase in cash and cash equivalents	26	**(21,885)**	100,871	**(20,368)**	99,330
Cash and cash equivalents at 1 April		**190,734**	89,863	**185,808**	86,478
Cash and cash equivalents at 31 March	25	**168,849**	190,734	**165,440**	185,808

Statement of changes in taxpayers' equity

GROUP 2025/26	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2025	768,011	540,494	743	371,931	**1,681,179**
Deficit for the year	–	–	–	(39,307)	**(39,307)**
Withdrawal of revaluation model for intangible assets on 1 April 2025	–	(2)	–	2	**–**
Net Impairments	–	(81,057)	–	–	**(81,057)**
Revaluations – property, plant and equipment	–	11,391	–	–	**11,391**
Revaluations – right of use assets	–	17	–	–	**17**
Transfer to retained earnings on disposal of assets	–	(7)	–	7	**–**
Transfers between reserves	–	45	–	(45)	**–**
Other	–	(2)	–	(2)	**(4)**
Public Dividend Capital received	91,064	–	–	–	**91,064**
Taxpayers' equity as at 31 March 2026	**859,075**	**470,879**	**743**	**332,586**	**1,663,283**

GROUP 2024/25	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 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 31 March 2025	**768,011**	**540,494**	**743**	**371,931**	**1,681,179**

TRUST 2025/26	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2025	768,011	540,494	743	366,874	**1,676,122**
Deficit for the year	–	–	–	(38,623)	**(38,623)**
Withdrawal of revaluation model for intangible assets on 1 April 2025	–	(2)	–	2	**–**
Net Impairments	–	(81,057)	–	–	**(81,057)**
Revaluations – property, plant and equipment	–	11,391	–	–	**11,391**
Revaluations – right of use assets	–	17	–	–	**17**
Transfer to retained earnings on disposal of assets	–	(7)	–	7	**–**
Transfers between reserves	–	45	–	(45)	**–**
Other	–	(2)	–	(2)	**(4)**
Public Dividend Capital received	91,064	–	–	–	**91,064**
Taxpayers' equity as at 31 March 2026	**859,075**	**470,879**	**743**	**328,213**	**1,658,910**

TRUST 2024/25	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 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 31 March 2025	**768,011**	**540,494**	**743**	**366,874**	**1,676,122**

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 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

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 up to the year ended 31 March 2026 and incorporate its share of the results of joint ventures and associates using the equity method of accounting. Subsidiary accounts at 31 March 2026 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.

As at 31 March 2026 the Trust has the following wholly owned trading subsidiaries: Guy's and St Thomas' Enterprises Limited and Pathology Services Limited. The accounts for these companies have been consolidated into the group accounts. Lexica Health and Life Sciences Consultancy Limited was a wholly owned subsidiary until 30 May 2025 when 100% of the shares were sold to WSP. The results from Lexica have been consolidated into the group accounts up to 30 May 2025, when control ceased. The Trust has one wholly owned dormant subsidiary.

In accordance with the DHSC GAM 2025/26 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.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on

elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

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.

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 can alternatively fall within the provisions of IAS 20 for government grants. Where expenditure is financed by a grant, the funding element is recognised as income through the Statement of Comprehensive Income. To defer this income, a condition imposed by the funder must be a requirement that the future economic benefits embodied in the grant are consumed as specified by the grantor or must be returned to them.

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.

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.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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 2025/26 was 3% (2024/25: 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.

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

Subsequent expenditure

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

Measurement

Valuation

All property, plant and equipment 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, 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 is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis. A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements. As at March 31 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.

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.

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 2026 land and buildings for the full Trust estate were valued by Newmark (previoulsy known as Gerald Eve). The same valuer was used in the valuation of the estate at 31 March 2025. 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.

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. Freehold land is considered to have an infinite life and is not depreciated.

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, 3-73 years
- Dwellings, 20-39 years
- Plant and machinery, 2-30 years
- Transport equipment, 7 years
- IT hardware, 3- 20 years
- Furniture and fittings, 7-15 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.

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, controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably and the cost is greater than £5,000.

Internally generated intangible assets

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

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

Software

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

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

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

Impairments

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

Amortisation

Intangible assets are amortised over their expected useful 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.

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

Financial assets and liabilities are classified as subsequently measured at amortised cost or 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. 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 2026 between the range of 3.64% to 5.32%. Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

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. 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 2025/26.

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 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements

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

IFRS 19 Subsidiaries without Public Accountability: Disclosures

The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to valuation of property, plant and equipment (PPE) assets

The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £1,299,523k as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for some of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £1,028,079k at 31 March 2026. The revised valuation assumption will likely have a material 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 2026.

The Trust's valuers, Newmark 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. During the year, the Trust and Newmark revisited the hypothetical alternative site assumption from prior years. As a result, the Trust agreed to continue to adopt the same hypothetical alternative site assumption as previously for Guy's and St Thomas', that is: a hypothetical alternative site located in the northern half of Lambeth. For Royal Brompton, the hypothetical alternative site has been changed from the Borough of Hammersmith and Fulham to the Harefield site in Hillingdon. 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.

As part of this year's valuation, the valuer has reviewed available market evidence which shows some reductions to specialised land values in central London locations. These market movements and the amended MEA assumption drives the change in land values as seen in Note 14.1.

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 is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis. A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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 2025/26 and 2024/25 on the views of Newmark 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.

Global political uncertainty remains higher than usual and the recent military intervention in Iran has significantly affected global oil supplies and supply chains. Along with other factors this is has potential to feed into inflation, Gilt rates, yields and potentially impact occupational demand and trading volumes. Such factors can quickly affect investor behaviour. The conclusions set out in the valuation report reflect economic factors as at the valuation date and may carry a greater degree of uncertainty than would normally be the case under more stable economic conditions

However, despite the conditions in the prevailing market, the March 2026 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 2026 of the Trust's property plant and equipment valued by professional valuers and reflected in these financial statements is £1,267,523k (£1,332,126k at 31 March 2025).

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. £63,376k. 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: Evelina London Women's and Children's Services; Integrated and Specialist Medicine; Cancer and Surgery; Heart, Lung and Critical Care.

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 2025/2026. 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 31 March 2026 £000	Year ended 31 March 2025 £000
NHS England	**747,557**	1,429,873
Integrated Care Boards	**2,062,519**	1,282,261
Other NHS providers	**7,560**	7,894
NHS other	**8,180**	8,376
Local authorities	**20,688**	20,123
Non-NHS: private patients	**81,801**	69,883
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	**7,033**	4,404
Injury cost recovery scheme	**1,451**	1,534
Non-NHS: other	**(525)**	18,342
Total income from patient care activities	**2,936,264**	2,842,690
Of which:		
Related to continuing operations	**2,936,264**	2,842,690
Related to discontinued operations	**–**	–

3.2 Income from patient care (by nature)

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Acute services		
Income from commissioners under API contracts*	**1,989,536**	1,944,125
High cost drugs and devices income from commissioners (excluding pass-through costs)	**431,733**	389,786
Other NHS clinical income**	**156,481**	150,254
Community services		
Income from commissioners under API contracts*	**140,514**	138,798
Income from other sources (eg Local authorities)	**20,688**	20,123
All services		
Private patient income	**81,801**	69,883
National pay award central funding***	**–**	5,471
Additional pension contribution central funding****	**107,552**	99,970
Other clinical income	**7,959**	24,280
	2,936,264	2,842,690

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation: www.england.nhs.uk/pay-syst/nhs-payment-scheme

**Other NHS Clinical income includes Winter Surge funding (£24m), Low Volume Activity (£19m) and System support funding (£32m) as well as smaller ad hoc sources of NHS funding.

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

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

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 31 March 2026 £000	Year ended 31 March 2025 £000
Income from services designated as commissioner requested services	**2,846,504**	2,748,527
Income from services not designated as commissioner requested services	**89,760**	94,163
	2,936,264	2,842,690

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

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Income recognised this year	**7,033**	4,404
Cash payments received in-year	**2,196**	1,667
Amounts added to provision for impairment of receivables	**1,181**	3,278
Amounts written-off in-year	**631**	5,658

4 Other operating income (Group)

	NOTE	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Other operating income from contracts with customers:			
Research and development		**85,640**	82,753
Education, training and research		**89,884**	84,414
Non-patient care services to other bodies		**37,774**	40,908
Income in respect of staff recharges		**7,347**	7,886
Other income*		**83,930**	84,563
Other non-contract operating income:			
Education and training – notional income from apprenticeship fund	7.1	**3,387**	2,785
Charitable and other grant contributions to expenditure and capital assets		**16,867**	8,866
Operating leases – minimum lease receipts	6.1	**15,734**	15,770
		340,563	327,945
Of which:			
Related to continuing operations		**338,957**	327,945
Related to discontinued operations	10	**1,606**	–
		340,563	327,945

*Other income includes: £19m classified as facilities and services income (£21m 24/25), £21m from clinical tests (£17m 24/25), £1.6m from income generated by Lexica (£10m 24/25), £6m from clinical excellence awards (£6m 24/25), £3m from accommodation rentals (£2.5m 24/25). The remaining balance 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 31 March 2026 £000	Year ended 31 March 2025 £000
Revenue recognised in the reporting period that was within deferred income: contract liabilities at the previous period end.	**36,413**	41,992

5.2 Transaction price allocated to remaining performance obligations

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
Within one year (Note 24.2)	**39,914**	36,413
Total revenue allocated to remaining performance obligations	**39,914**	36,413

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. The majority of lease arrangements where the Trust is the lessor involve the leasing of building space.

6.1 Operating leases income (Group)

	Year ended 31 March 2026	Year ended 31 March 2025
Lease receipts recognised as income in year:	**£000**	£000
Minimum lease receipts	**15,734**	15,770
	15,734	15,770

6.2 Future lease receipts (Group)

	Year ended 31 March 2026	Year ended 31 March 2025
Future minimum lease receipts due at 31 March 2026:	**£000**	£000
– not later than 1 year	**14,685**	15,744
– later than 1 year but not later than 2 years	**13,853**	14,272
– later than 2 years but not later than 3 years	**13,170**	13,558
– later than 3 years but not later than 4 years	**12,740**	13,038
– later than 4 years but not later than 5 years	**12,426**	12,704
– later than 5 years	**103,298**	113,866
	170,172	183,182

7 Operating expenses (Group)

7.1 Operating expenses comprise:

	NOTE	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Purchase of healthcare from NHS and DHSC bodies		**527**	291
Purchase of healthcare from non-NHS and non-DHSC bodies		**54,022**	50,937
Staff and executive directors costs	8	**1,898,349**	1,783,633
Remuneration of non-executive directors		**330**	323
Supplies and services – clinical (excluding drugs costs)		**447,351**	418,025
Supplies and services – general		**16,356**	14,278
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		**406,653**	398,139
Inventories written down (net including drugs)		**434**	292
Consultancy		**115**	122
Establishment		**39,898**	32,875
Premises – business rates collected by local authorities		**12,921**	16,891
Premises – other		**136,877**	164,907
Transport – other (including patient travel)		**11,337**	16,769
Depreciation on property, plant and equipment and right of use assets	14.1 & 17	**97,539**	102,319
Amortisation	15.1	**19,361**	20,451
Impairments net of reversals	16.1	**35,157**	21,231
Credit loss allowance		**(1,282)**	2,939
Change in provisions discount rate		**(86)**	8
Audit services – statutory audit*		**498**	396
Internal audit – staff costs	8	**747**	691
Clinical negligence – amounts payable to NHS Resolution (premium)		**39,667**	37,537
Legal fees		**4,076**	3,317
Insurance		**2,027**	2,152
Research and development – non-staff		**23,538**	23,874
Education and training – non-staff		**10,146**	9,846
Education and training – notional expenditure funded from apprenticeship fund	4	**3,387**	2,785
Expenditure on short term leases (current year only)		**–**	466
Redundancy costs (staff costs)	8	**1,339**	1,936
Charges to operating expenditure for on-SoFP IFRIC 12 schemes on IFRS basis		**2,517**	2,751
Hospitality		**240**	336
Other losses and special payments – non-staff		**12**	40
Other**		**33,221**	26,757
		3,297,274	3,157,314
Of which:			
Related to continuing operations		**3,292,609**	
Related to discontinued operations	10	**4,665**	

* Audit services – statutory audit: The £498k charged to operating expenditure in 25/26 is inclusive of non-recoverable VAT. Audit fees for statutory audits excluding VAT totalled £415k (£337k 24/25). £57k of the £415k relates to fees charged for the audit of the subsidiaries (£73k 24/25), and £358k for the statutory audit of the Group accounts (£264k 24/25).

** 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 2025/26 (2024/25 nil).

7.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2025/26 is £2,000k (2024/25 £2,000k).

8 Employee benefits (Group)

	Group	
	Year ended	Year ended
	31 March 2026 Total £000	31 March 2025 Total £000
Salaries and wages	**1,444,716**	1,376,454
Social security costs	**193,759**	156,209
Apprenticeship levy	**7,048**	6,794
Employer contributions to NHS Pensions	**164,510**	152,884
Pension cost – employer contributions paid by NHSE on provider's behalf (9.4%)	**107,552**	99,970
Termination benefits	**1,339**	1,936
Temporary staff – agency and contract staff	**14,052**	24,926
Total gross staff costs	**1,932,976**	1,819,173
Recoveries in respect of seconded staff	**(17,427)**	(12,762)
Total staff costs	**1,915,549**	1,806,411
Of which:		
Costs capitalised as part of assets	**15,114**	20,151
Analysed into Operating Expenditure (note 7.1)		
Employee expenses – staff and executive directors	**1,898,349**	1,783,633
Redundancy	**1,339**	1,936
Internal audit costs*	**747**	691
Total employee benefits excluding capitalised costs	**1,900,435**	1,786,260

***** Internal audit costs are total costs incurred by the Trust for provision for internal audit and counter fraud services. Income received in relation to providing internal audit and counter fraud 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 2025/26 there were 13 early retirements from the Trust agreed on the grounds of ill-health (12 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £1,852k (£1,579k in 2024/25). 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
	31 March 2026	31 March 2025
	£000	£000
Loss on disposal of property, plant and equipment	**(566)**	–
Gain on disposal of property, plant and equipment	**20**	1,131
Gain on disposal of right of use assets	**50**	7
Loss on disposal of intangible assets	**–**	(50)
Loss on disposal of right of use assets	**(12)**	(7)
Loss on disposal of peppercorn leased assets	**–**	(37)
Total (losses) / gains on disposal of assets	**(508)**	1,044
Fair value gains on investment properties	**4,158**	235
Fair value (losses) on investments	**(62)**	(197)
(Losses) on foreign exchange	**(5)**	(31)
Total other gains	**3,583**	1,051

10 Discontinued operations

On 30 May 2025, the Group disposed of its 100% shareholding in Lexica Health and Life Sciences Consultancy limited ("Lexica"). There were no disposals of subsidiaries in the year ended 31 March 2025.

		Group	
		Year ended	Year ended
	NOTE	**31 March 2026** **£000**	31 March 2025 £000
Operating income of discontinued operations	4	**1,606**	–
Operating expenses of discontinued operations	7.1	**(4,665)**	–
Operating deficit		**(3,059)**	–
Gain on disposal of discontinued operations		**15,718**	–
Total	SOCI	**12,659**	–

At the date of disposal, the carrying amounts of the net assets of Lexica in the consolidated group position were as follows:

	£000
Non-current assets	**23**
Current assets (excl. cash)	**3,640**
Cash and cash equivalents	**1,206**
Current liabilities	**(4,295)**
Net assets disposed of	**574**

The gain on disposal as reported in the group position is calculated as follows:

	£000
Cash consideration received (after share purchase agreement adjustments)	**16,799**
Less transaction costs	**(507)**
Net consideration received:	**16,292**
Less: net assets disposed of	**(574)**
Gain on disposal	**15,718**

11 Finance income

	Group	
	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Interest on bank accounts	**7,747**	7,599
Other finance income	**209**	–
	7,956	7,599

12 Finance expenses

		Group	
		Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Interest on loans from the Department of Health and Social Care	24.4	**(4,089)**	(4,503)
Interest on lease obligations	24.4	**(2,461)**	(1,933)
Finance costs on service concession arrangements	24.4	**(82)**	(94)
Unwinding of discounts on provisions		**(43)**	(43)
Other interest charges		**(118)**	(366)
Total finance expense		**(6,793)**	(6,939)

13 Trust performance – notes to the consolidated statement of comprehensive income

	Group	
	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Total comprehensive expense per SOCI	**(108,960)**	(12,571)
Less reserve movements in other comprehensive income/(expense)	**69,653**	(12,934)
Total comprehensive expense before reserve movements	**(39,307)**	(25,505)
Add back in year impairments and reversals of impairments relating to market valuations included in surplus above (see note 16.2)	**35,140**	19,718
Capital Donations and Peppercorn income	**(3,694)**	(455)
Adjust service concession (UK GAAP vs IFRS)	**2**	13
Add back loss recognised on peppercorn lease disposals	**–**	37
Add back depreciation on donated assets	**13,082**	18,874
Adjusted financial performance surplus	**5,223**	12,682

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 £39,307k (2024/25 Deficit £25,505k) for the Group. When valuation based impairments, depreciation on donated assets, and adjustments for capital donations are adjusted for, the total surplus for the Group is £5,223k (2024/25 Surplus £12,682k).

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 2026 was £38,623k (2024/25 surplus of £26,714k).

14 Property, plant and equipment

14.1 Property, plant and equipment at 31 March 2026 comprises the following elements:

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	IT hardware	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2025	263,481	1,106,543	20,205	148,503	227,766	1,500	86,517	3,481	**1,857,996**
Additions purchased	-	11,393	-	135,561	6,172	-	2,831	-	**155,957**
Additions - Assets purchased from cash donations/grants	-	122	-	3,426	113	-	-	-	**3,661**
Impairments charged to operating expenses	(2,711)	(34,745)	-	(17)	-	-	-	-	**(37,473)**
Impairments charged to the revaluation reserve	(49,589)	(30,907)	(495)	-	-	-	-	-	**(80,991)**
Reversal of impairments credited to operating expenses	-	2,347	1	-	-		-	-	**2,348**
Revaluation to revaluation reserve	3,600	(23,063)	(112)	-	-	-	-	-	**(19,575)**
Reclassifications	-	61,766	-	(137,693)	24,095	-	49,160	(329)	**(3,001)**
Disposals	-	-	-	-	(11,656)	-	(990)	(95)	**(12,741)**
Cost or valuation at 31 March 2026	**214,781**	**1,093,456**	**19,599**	**149,780**	**246,490**	**1,500**	**137,518**	**3,057**	**1,866,181**
Accumulated depreciation at 1 April 2025	-	30,773	-	-	149,648	54	50,640	2,491	**233,606**
Provided during the year	-	34,619	698	-	21,113	214	15,894	142	**72,680**
Revaluation to revaluation reserve	-	(30,268)	(698)	-	-	-	-	-	**(30,966)**
Disposals	-	-	-	-	(11,090)	-	(980)	(91)	**(12,161)**
At 31 March 2026	**-**	**35,124**	**-**	**-**	**159,671**	**268**	**65,554**	**2,542**	**263,159**
Net book value 31 March 2026									
Owned - Purchased	155,541	826,663	19,234	145,870	79,188	1,232	69,746	328	**1,297,802**
On-SoFP Service Concession Arrangements	-	1,738	-	-	-	-	-	-	**1,738**
Owned - Donated / Granted	59,240	229,931	365	3,910	7,631	-	2,218	187	**303,482**
Total at 31 March 2026	**214,781**	**1,058,332**	**19,599**	**149,780**	**86,819**	**1,232**	**71,964**	**515**	**1,603,022**

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.

a) Valuation

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 2026 and 31 March 2025 by an external valuer, Newmark 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 - Accounting Policies.

Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis. A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

b) 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 2025/26 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.

14.2 Property, plant and equipment at 31 March 2025 comprises the following elements:

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	IT hardware	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 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 31 March 2025	**263,481**	**1,106,543**	**20,205**	**148,503**	**227,766**	**1,500**	**86,517**	**3,481**	**1,857,996**
Accumulated depreciation at 1 April 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 31 March 2025	**-**	**30,773**	**-**	**-**	**149,648**	**54**	**50,640**	**2,491**	**233,606**
Net book value 31 March 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 31 March 2025	**263,481**	**1,075,770**	**20,205**	**148,503**	**78,118**	**1,446**	**35,877**	**990**	**1,624,390**

15 Intangible assets

15.1 As at 31 March 2026

Group and Trust	Software licences £000	Information technology £000	Assets under construction £000	Total £000
Cost 1 April 2025	45,642	161,223	10,541	**217,406**
Additions purchased / internally generated	13,706	1,709	3,001	**18,416**
Additions – grants / donations of cash	33	–	–	**33**
Reclassifications	6,822	3,430	(7,251)	**3,001**
Disposals / derecognition	(1,115)	(36,599)	–	**(37,714)**
Gross cost at 31 March 2026	**65,088**	**129,763**	**6,291**	**201,142**
Amortisation 1 April 2025	10,344	81,604	–	**91,948**
Provided during the year	6,050	13,311	–	**19,361**
Disposals / derecognition	(1,115)	(36,599)	–	**(37,714)**
Amortisation at 31 March 2026	**15,279**	**58,316**	**–**	**73,595**
Net book value 31 March 2026	**49,809**	**71,447**	**6,291**	**127,547**
Purchased assets	49,735	71,329	6,291	**127,355**
Donated / granted assets	74	118	–	**192**
Total at 31 March 2026	**49,809**	**71,447**	**6,291**	**127,547**

15.2 As at 31 March 2025

Group and Trust	Software licences £000	Information technology £000	Assets under construction £000	Total £000
Cost 1 April 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 31 March 2025	**45,642**	**161,223**	**10,541**	**217,406**
Amortisation 1 April 2024	6,386	71,571	–	**77,957**
Provided during the year	4,651	15,800	–	**20,451**
Disposals / derecognition	(693)	(5,767)	–	**(6,460)**
Amortisation at 31 March 2025	**10,344**	**81,604**	**–**	**91,948**
Net book value 31 March 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 31 March 2025	**35,298**	**79,619**	**10,541**	**125,458**

16 Impairments

16.1 Impairment of assets (Group and Trust)

	NOTE	31 March 2026 £000	31 March 2025 £000
Impairments charged to operating expenditure:			
Net impairments arising from professional valuations PPE	14.1	**(35,108)**	(19,660)
Impairments arising from professional valuation (Right of Use Asset)	17	**(32)**	(58)
Abandonment of assets in course of construction (Intangible)	15.1	**–**	(250)
Abandonment of assets in course of construction (PPE)	14.1	**(17)**	(1,263)
Net impairment charged to expenditure	7	**(35,157)**	(21,231)
Impairments charged to revaluation reserve			
Impairments of PPE arising from professional valuation		**(80,991)**	(6,877)
Impairments of right of use assets from professional valuation		**(66)**	(32)
Total impairments charged to Revaluation reserve	19	**(81,057)**	(6,909)
Total Net impairments		**(116,214)**	(28,140)
Impairments charged to operating expenses:			
Of which Departmental Expenditure Limit (DEL)		**(17)**	(1,513)
Of which Annually Managed Expenditure (AME)		**(35,140)**	(19,718)
		(35,157)	(21,231)

16.2 Analysis of valuation movements and impairments

Property Valuation

Land and buildings across the full estate were valued independently by Newmark as at 31 March 2026. 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.

The movements arising from the valuations can be summarised as follows:

	31 March 2026 £000	**31 March 2026 £000**	**31 March 2026 £000**	31 March 2025 £000	31 March 2025 £000	31 March 2025 £000
	Revaluation reserve	**SOCI**	**Total**	Revaluation reserve	SOCI	Total
Impairments from professional valuations						
Impairments in land value	**(49,589)**	**(2,711)**	**(52,300)**	(490)	–	(490)
Impairments in building and dwellings value	**(31,402)**	**(34,745)**	**(66,147)**	(6,387)	(20,558)	(26,945)
Impairments in right of use assets	**(66)**	**(36)**	**(102)**	(32)	(58)	(90)
Reversal of previous impairments (buildings and dwellings)	**–**	**2,348**	**2,348**	–	807	807
Reversal of previous impairments arising from professional valuation (Right of Use Asset)	**–**	**4**	**4**	–	91	91
Total impairments from professional valuation	**(81,057)**	**(35,140)**	**(116,197)**	(6,909)	(19,718)	(26,627)
Abandoned assets under construction	**–**	**(17)**	**(17)**	–	(1,513)	(1,513)
Total net impairments	**(81,057)**	**(35,157)**	**(116,214)**	(6,909)	(21,231)	(28,140)
Revaluations upwards from professional valuation to revaluation reserve						
Increase in value of right of use assets	**17**	**–**	**17**	595	–	595
Increase in value of land to revaluation reserve	**3,600**	**–**	**3,600**	2,710	–	2,710
Increase in value of building and dwellings to revaluation reserve	**7,791**	**–**	**7,791**	16,538	–	16,538
	11,408	**–**	**11,408**	19,843	–	19,843
Total movement to PPE arising from professional valuation	**(69,600)**	**(35,108)**	**(104,708)**	12,371	(19,751)	(7,380)
Total movement to Right of Use assets from professional valuation	**(49)**	**(32)**	**(81)**	563	33	596

17 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.

17.1 Right of use assets 2025/26

	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 2025	**189,539**	**17,928**	**13,983**	**10,490**	**231,940**	**63,028**
Additions – lease liability	4,298	–	1,409	–	**5,707**	**–**
Remeasurements of the lease liability	20,094	–	–	–	**20,094**	**16,819**
Impairments charged to operating expenses	(36)	–	–	–	**(36)**	**–**
Impairments charged to the revaluation reserve	(66)	–	–	–	**(66)**	**–**
Reversal of impairments credited to operating expenses	4	–	–	–	**4**	**–**
Revaluations	(709)	–	–	–	**(709)**	**–**
Disposals/derecognition – lease termination	(1,616)	(1,967)	–	(85)	**(3,668)**	**–**
Valuation/gross cost at 31 March 2026	**211,508**	**15,961**	**15,392**	**10,405**	**253,266**	**79,847**
Accumulated depreciation at 1 April 2025	**44,018**	**9,718**	**9,506**	**4,962**	**68,204**	**12,662**
Provided during the year – right of use asset	17,969	2,589	1,947	1,628	**24,133**	**5,507**
Provided during the year – peppercorn leased asset	726	–	–	–	**726**	**–**
Revaluations	(726)	–	–	–	**(726)**	**–**
Disposals/derecognition – lease termination	(798)	(1,152)	–	(68)	**(2,018)**	**–**
Accumulated depreciation at 31 March 2026	**61,189**	**11,155**	**11,453**	**6,522**	**90,319**	**18,169**
Net book value at 31 March 2026	**150,319**	**4,806**	**3,939**	**3,883**	**162,947**	**61,678**
Net book value of right of use assets leased from other NHS providers						17,779
Net book value of right of use assets leased from other DHSC group bodies						43,899
						61,678

17.2 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

17.3 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 24.

Group	2025/26 £000	2024/25 £000
Carrying value at 1 April	**136,172**	**131,180**
Lease additions	5,707	22,525
Lease liability remeasurements	20,094	6,866
Interest charge arising in year	2,461	1,933
Early terminations	(1,675)	(1,015)
Lease payments (cash outflows)	(26,677)	(25,317)
Carrying value at 31 March	**136,082**	**136,172**

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.

17.4 Maturity analysis of future lease payments at 31 March 2026

Group	Total	Of which leased from DHSC group bodies:
	31 March 2026 £000	31 March 2026 £000
Undiscounted future lease payments payable in:		
– not later than 1 year;	**23,743**	**5,912**
– later than 1 year and not later than 5 years;	**74,908**	**29,145**
– later than 5 years	**54,346**	**34,310**
Total gross future lease payments	**152,997**	**69,367**
Finance charges allocated to future periods	**(16,915)**	**(6,989)**
Net lease liabilities at 31 March 2026	**136,082**	**62,378**
Of which:		
Leased from other NHS providers		**16,462**
Leased from other DHSC group bodies		**45,916**
		62,378

17.5 Maturity analysis of future lease payments at 31 March 2025

Group	Total	Of which leased from DHSC group bodies:
	31 March 2025 £000	31 March 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

18 Investment property

Investment property carrying values

	GROUP AND TRUST	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**71,783**	71,548
Movement in fair value	**4,158**	235
Carrying value at 31 March	**75,941**	71,783

Investment properties were valued by Newmark as at 31 March 2026. 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.

19 Revaluation reserve movements

Property, plant and equipment

	GROUP AND TRUST	
	2025/26	2024/25
	£000	£000
Revaluation reserve at 1 April	**540,494**	529,138
Impairments (Note 16.1)	**(81,057)**	(6,909)
Revaluations	**11,408**	19,843
Transfer to I&E reserve upon asset disposal	**(7)**	(1,578)
Withdrawal of revaluation model for intangible assets on 1 April 2025	**(2)**	–
Transfer to other reserves	**45**	–
Other	**(2)**	–
Revaluation reserve at 31 March	**470,879**	540,494

20 Subsidiaries and interests in associates and joint ventures

Guy's and St Thomas' principal subsidiary undertakings, associates and joint ventures as included in the Financial Statements at 31 March 2026 are set out below. The accounting date of the financial statements for the subsidiaries, SpotOn Clincial Diagnostics and KHP MedTech is 31 March 2026. The accounting date for Synnovis Analytics, Services and Group is 31 December 2025. For the joint venture/associate undertakings that have different accounting year-end dates, interim accounts to 31 March 2026 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
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.

Lexica Health and Life Sciences Consultancy Limited was a 100% owned subsidiary of the Trust, until 30 May 2025 when it was 100% sold by GST Enterprises Ltd to WSP. Consolidation of Lexica's results into the GSTT position ceased following the sale (see note 10).

20.1 Investments in joint ventures and associates

	GROUP	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**1,235**	1,475
Share of profits / (losses)	**274**	75
Profit Distribution / Dividends received	**(90)**	(315)
Carrying Value at 31 March	**1,419**	1,235

21 Other investments / financial assets

	GROUP		TRUST	
Non-current	**2025/26**	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Carrying value at 1 April	**1,268**	479	**10,804**	10,080
Additions	**462**	986	**444**	724
Fair value losses	**(62)**	(197)	**–**	–
Loan repayments	**–**	–	**(11,248)**	–
Carrying value at 31 March	**1,668**	1,268	**–**	10,804

Group Other Investments/Financial Assets Carrying values

	2025/26	2024/25
Organisation	**£000**	£000
Cydar Limited	131	146
Zeus Sleep Limited	150	150
Meridian Health Ventures Limited Partnership	1,187	972
Learning Laboratory Limited	200	–
	1,668	**1,268**

Trust other investments / financial assets

Trust 'Other Investments' related to loans with Pathology Services Limited and Guy's and St Thomas' Enterprises Limited. Both loans were fully repaid during 2025-26, with interest accruing up to the point of settlement.

22 Inventories

	GROUP AND TRUST	
	31 March 2026	31 March 2025
	£000	£000
Drugs	**9,467**	9,903
Consumables	**43,229**	39,613
	52,696	49,516

23 Trade and other receivables

23.1 Current

	GROUP	
	31 March 2026 £000	31 March 2025 £000
		Restated*
Contract receivables: invoiced	**124,793**	124,929
Contract receivables: not yet invoiced	**93,529**	85,182
Capital receivables	**1,043**	1,272
Allowance for impaired receivables	**(39,888)**	(41,886)
Prepayments	**24,172**	23,984
PDC dividend receivable	**506**	–
VAT and other tax receivable	**7,719**	4,456
Clinical pension tax provision reimbursement funding from NHSE	**122**	137
Other receivables	**6,720**	19,350
	218,716	217,424
Of which:		
Receivable from NHS and DHSC bodies	**79,156**	96,986

*Prior year restatement relates to a reclassification of £8,964k from capital receivables to other receivables.

23.2 Non-current

	GROUP	
	31 March 2026 £000	31 March 2025 £000
Contract receivables	**3,890**	3,230
Capital receivables	**823**	823
Clinical pension tax provision reimbursement funding from NHSE	**3,857**	4,168
	8,570	8,221
Of which:		
Receivable from NHS and DHSC bodies	**3,857**	4,168

23.3 Allowances for credit losses

	GROUP AND TRUST	
	2025/26 Contract receivables and contract assets £000	**2024/25 Contract receivables and contract assets £000**
Allowances as at 1 April	**41,886**	46,229
New allowances arising	**14,172**	14,828
Changes in the calculation of existing allowances	**(5,613)**	–
Reversal of allowances	**(9,841)**	(11,889)
Utilisation of allowances	**(716)**	(7,282)
Allowances as at 31 March	**39,888**	41,886

24 Current liabilities

24.1 Trade and other payables

	GROUP	
	31 March 2026	31 March 2025
	£000	£000
		Restated*
Trade payables	**118,199**	108,370
Capital payables	**69,704**	51,515
Accruals	**125,853**	162,929
Receipts in advance	**2,761**	1,852
Social security costs	**21,838**	18,826
Other taxes payable	**22,521**	21,969
PDC dividend payable	**–**	1,325
Pension contributions payable	**24,105**	22,454
Other payables	**21,770**	15,034
	406,751	404,274
Of which:		
Receivable from NHS and DHSC bodies	**30,474**	31,475

*Prior year restatement relates to a reclassification of £12,321k from Accruals to Other payables.

24.2 Other liabilities

	GROUP	
Current	**31 March 2026**	31 March 2025
	£000	£000
Deferred income: contract liabilities	**39,914**	36,413
Deferred grants	**997**	3,801
	40,911	40,214

24.3 Borrowings

	GROUP	
	31 March 2026	31 March 2025
Current	**£000**	£000
Capital loans from Department of Health and Social Care (DHSC)	**17,681**	17,765
Lease liabilities	**21,260**	22,487
Obligations under other service concession contracts (excluding lifecycle)	**250**	378
	39,191	40,630
Non-current	**£000**	£000
Capital loans from Department of Health and Social Care (DHSC)	**140,813**	157,821
Lease liabilities	**114,822**	113,685
Obligations under other service concession contracts (excluding lifecycle)	**1,730**	1,897
	257,365	273,403
Total borrowings (current and non-current)	**296,556**	314,033

24.4 Reconciliation of liabilities arising from financing activities 2025/26

GROUP	Loans from DHSC £000	Lease liabilities £000	Service concession obligations £000	Total £000
Carrying value as at 1 April 2025	**175,586**	**136,172**	**2,275**	**314,033**
Cash movements:				
Financing cash flows – payments and receipts of principal	(17,008)	(24,216)	(295)	**(41,519)**
Financing cash flows – payments of interest	(4,173)	(2,461)	(82)	**(6,716)**
Non-cash movements:				
Additions	–	5,707	–	**5,707**
Lease liability remeasurements	–	20,094	–	**20,094**
Application of effective interest rate	4,089	2,461	82	**6,632**
Early termination	–	(1,675)	–	**(1,675)**
Carrying value at 31 March 2026	**158,494**	**136,082**	**1,980**	**296,556**

24.5 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**

24.6 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 1 April 2025 £000	Principal repaid during 2025/26 £000	Interest paid during 2025/26 £000	Interest charge (I&E) for 2025/26 £000	Principal and accrued interest outstanding 31 March 2026 £000
Jun-11	Jun-36	3.27	75,000	39,616	(3,405)	(1,252)	1,223	36,182
Mar-12	Mar-37	2.85	80,000	44,622	(3,728)	(1,245)	1,241	40,890
* Apr-14	Apr-29	2.54	30,000	10,923	(2,400)	(261)	232	8,494
* Jun-15	Jun-30	2.06	20,000	8,207	(1,480)	(160)	152	6,719
Feb-16	Feb-41	1.9	25,000	16,365	(1,020)	(305)	303	15,343
Feb-16	Feb-41	1.9	14,000	9,363	(582)	(175)	173	8,779
Feb-16	Feb-41	1.9	33,768	24,074	(1,499)	(449)	446	22,572
Feb-16	Feb-31	1.38	27,232	14,865	(2,476)	(196)	192	12,385
Nov-17	Nov-42	1.76	10,000	7,551	(418)	(130)	127	7,130
			315,000	**175,586**	**(17,008)**	**(4,173)**	**4,089**	**158,494**

***** 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.

25 Provisions for liabilities

25.1 Overall provisions

Group and Trust

	31 March 2026 £000	31 March 2025 £000
Current		
Pensions: injury benefit	**104**	103
Pensions: early departure	**30**	30
Legal claims	**390**	352
Clinician pension tax reimbursement	**122**	137
Other*	**1,848**	1,081
	2,494	1,703

	31 March 2026 £000	31 March 2025 £000
Non-current		
Pensions: injury benefit	**1,353**	1,445
Pensions: early departure	**192**	206
Clinician pension tax reimbursement	**3,857**	4,168
Other*	**5,978**	6,543
	11,380	12,362

Total provisions	31 March 2026 £000	31 March 2025 £000
Pensions: injury benefit	**1,457**	1,548
Pensions: early departure	**222**	236
Legal claims	**390**	352
Clinician pension tax reimbursement	**3,979**	4,305
Other*	**7,826**	7,624
	13,874	14,065

25.2 Changes in provisions

	Pensions - injury benefits £000	Pensions early departure £000	Legal claims £000	Clinician pension tax reimbursement £000	Other* £000	Total £000
As at 1 April 2025	1,548	236	352	4,305	7,624	**14,065**
Change in Discount Rate	(80)	(6)	–	(305)	–	**(391)**
Arising during the year	59	17	225	–	663	**964**
Utilised during the year	(107)	(31)	–	(122)	(413)	**(673)**
Reversed unused	–	–	(187)	(153)	(48)	**(388)**
Unwinding of discount	37	6	–	254	–	**297**
At 31 March 2026	**1,457**	**222**	**390**	**3,979**	**7,826**	**13,874**

25.3 Expected timing of cash flows

Timing of provisions	Pensions - injury benefits £000	Pensions early departure £000	Legal claims £000	Clinician pension tax reimbursement £000	Other* £000	Total £000
Within one year	104	30	390	122	1,848	**2,494**
Between one and five years	388	111	–	521	3,240	**4,260**
After five years	965	81	–	3,336	2,738	**7,120**
	1,457	**222**	**390**	**3,979**	**7,826**	**13,874**

***** Other provisions largely consist of provisions for dilapidations and provisions for redundancies.

As at 31 March 2026 £407,484k is included in provisions of NHS Resolution in respect of clinical negligence liabilities of Guy's and St Thomas' NHS Foundation Trust (£392,692k at 31 March 2025).

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.

26 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	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
At April 1	**190,734**	89,863	**185,808**	86,478
Net change in year	**(21,885)**	100,871	**(20,368)**	99,330
At 31 March	**168,849**	190,734	**165,440**	185,808
Broken down into:				
Cash at commercial banks and in hand	**4,112**	5,530	**703**	604
Cash with the Government Banking Service	**164,737**	185,204	**164,737**	185,204
Total cash and cash equivalents	**168,849**	190,734	**165,440**	185,808

27 Contractual capital commitments

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Property, plant and equipment	**19,059**	12,744
Intangible assets	**–**	5,071
	19,059	17,815

28 Contingencies

Contingent liabilities

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Contingent liability for claims	**(163)**	(92)
Net contingent liability	**(163)**	(92)

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.

29 Events after the reporting date

There are no reportable events after the reporting date.

30 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 20, the Trust has 2 wholly owned subsidiaries as at 31 March 2026 and 1 dormant subsidiary. On 30 May 2025, GST Enterprises sold its 100% share in Lexica to WSP.

During 2025/26 there were 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.

Details of Non-NHS related parties, are included in the table below.

	Receivables		**Payables**	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Non-NHS Related party transactions				
King's College London	**22,727**	18,076	**20,824**	22,556
Synnovis*	**9,801**	5,533	**22,181**	31,718

	Income		**Expenditure**	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Non-NHS Related party transactions				
King's College Hospital	**41,897**	41,276	**35,540**	30,161
Synnovis*	**15,819**	19,446	**158,483**	137,622

***** Includes transactions with Synnovis Group LLP, Synnovis Services LLP, Synnovis Analytics LLP.

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 £114,942k of invoices from Sciensus during 2025/26,being coded to 'Drugs' in Note 7. The Trust has a creditor of £4,139k with Sciensus as at 31 March 2026.

Simon Friend is the Independent Non-Executive Director at Bevan Brittan LLP, who provide some legal services to the Trust. The Trust is showing £227k of expenditure with Bevan Brittan LLP during 2025/26 and a creditor of £3k as at 31 March 2026.

Nilkunj Dodhia is a Director at Oracle, an organisation that has contracts with the Trust. The Trust has recorded £1,134k of invoices from Oracle during 2025/26, and a creditor of £216k as at 31 March 2026.

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, South London and Maudsley NHS Foundation Trust, Imperial College, Kings College London and South East London ICB.

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.

31 Financial assets and liabilities

31.1 Carrying value and fair value of financial assets

Group	Held at amortised cost	Held at fair value through I&E	Total Book value
	£000	£000	£000
Carrying values of financial assets as at 31 March 2026			
Trade and other receivables (excluding non-financial assets) – with NHS and DHSC bodies	**79,156**	**–**	**79,156**
Trade and other receivables (excluding non-financial assets) – with other bodies	**111,754**	**–**	**111,754**
Other investments / financial assets	**1,419**	**1,668**	**3,087**
Cash and cash equivalents	**168,849**	**–**	**168,849**
Total carrying value of financial assets at 31 March 2026	**361,178**	**1,668**	**362,846**

Group	Held at amortised cost	Held at fair value through I&E	Total Book value
	£000	£000	£000
Carrying values of financial assets as at 31 March 2025			
Trade and other receivables (excluding non-financial assets) – with NHS and DHSC bodies	**96,986**	**–**	**96,986**
Trade and other receivables (excluding non-financial assets) – with other bodies	**95,914**	**–**	**95,914**
Other investments / financial assets	**1,235**	**1,268**	**2,503**
Cash and cash equivalents	**190,734**	**–**	**190,734**
Total carrying value of financial assets at 31 March 2025	**384,869**	**1,268**	**386,137**

31.2 Carrying value and fair value of financial liabilities

Group	Held at amortised cost	Held at amortised cost
	31 March 2026 £000	31 March 2025 £000
Carrying values of financial liabilities as at 31 March		
Loans from DHSC	**158,494**	175,586
Obligations under leases	**136,082**	136,172
Obligations under service concession contracts	**1,980**	2,275
Trade and other payables (excluding non financial liabilities) – with NHS and DHSC bodies	**30,474**	31,475
Trade and other payables (excluding non financial liabilities) – with other bodies	**295,320**	296,902
Provisions under contract	**7,423**	7,385
Total at 31 March	**629,773**	649,795

The carrying value and fair value of the financial assets and financial liabilities are not materially different.

31.3 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	
	31 March 2026 £000	31 March 2025 £000
In 1 year or less	**372,757**	376,360
In more than 1 year but not more than 5 years	**153,927**	164,089
In more than 5 years	**144,826**	151,038
	671,510	691,487

31.4 Loan disclosure

	Current	Non current	Total	Weighted average interest rate %
	£000	£000	£000	
31 March 2026				
Fixed interest rate instruments	**17,681**	**140,813**	**158,494**	2.45%
31 March 2025				
Fixed interest rate instruments	17,765	157,821	175,586	2.45%

31.5 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 24. 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 31 March 2026 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.

32 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:

£185k (£186k at 31 March 2025) which relates to monies held by the Trust on behalf of patients.

£3,110k (£3,053k at 31 March 2025) 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 2026	31 March 2025
	£000	£000
Monies on deposit	**3,295**	3,239
Total Third Party Assets	**3,295**	3,239

33 Losses and special payments

	Group and Trust			
Losses	**Year ended 31 March 2026 Cases**	**Year ended 31 March 2026 £000**	Year ended 31 March 2025 Cases	Year ende 31 March 2025 £000
Cash losses	**1**	**–**	3	–
Bad debts and claims abandoned	**393**	**1,111**	1,624	7,666
Stores losses, theft and other	**21**	**441**	24	316
Total losses	**415**	**1,552**	1,651	7,982

Special payments	**Year ended 31 March 2026 Cases**	**Year ended 31 March 2026 £000**	Year ended 31 March 2025 Cases	Year ended 31 March 2025 £000
Ex gratia payments	**24**	**12**	29	20
Special severance payments	**1**	**8**	–	–
Total special payments	**25**	**20**	29	20
Total losses and special payments	**440**	**1,572**	1,680	8,002
Of which losses of £300,000 or more:	**–**	**–**	–	–

The amounts quoted above are reported on an accruals basis but exclude provision for future losses.

34 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 2024/25). There were no disposals of artefacts during either year.

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

The Trust incurred £48k (£366k 2024/25) in charges relating to the late payment of Commercial Debts.

36 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 31 March 2026 was £39,598k (£40,494k 2024/25).

Contacts

Chief Executive
If you have a comment for the Chief Executive, contact:
Amanda Pritchard, 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 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: 020 7188 7346
Email: gstt.members@nhs.net

Recruitment
If you are interested in applying for a job at Guy's and St Thomas', contact:
www.guysandstthomas.nhs.uk/careers

Further information
If you have a media enquiry or require further information, contact:
Anita Knowles, Director of Communications
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Guy's and St Thomas' NHS Foundation Trust

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Guy's and St Thomas' NHS Foundation Trust

Auditor's Annual Report
Year ending 31 March 2026

26 June 2026

Contents

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of completing our work under the NAO Code and related guidance. Our audit is not designed to test all arrangements in respect of value for money. However, where, as part of our testing, we identify significant weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all irregularities, or to include all possible improvements in arrangements that a more extensive special examination might identify. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting, on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

01 Introduction and context

Introduction

This report brings together a summary of all the work we have undertaken for Guy's and St Thomas' NHS Foundation Trust (the Trust) during 2025/26 as the appointed external auditor. The core element of the report is the commentary on the value for money (VfM) arrangements. The responsibilities of the NHS Foundation Trust are set out in Appendix A. The Value for Money Auditor responsibilities are set out in Appendix B.

Opinion on the financial statements

Auditors provide an opinion on the financial statements which confirms whether they:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025/26, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We also consider the Annual Governance Statement and the relevant disclosures within the Annual Report including the Remuneration Report and the Staff Report.

Auditor's powers

Auditors of a Foundation Trust have a duty to consider whether there are any issues arising during their work that indicate possible or actual unlawful expenditure or action leading to a possible or actual loss or deficiency that should be referred to the relevant NHS regulatory body.

Auditors of Foundation Trusts also have the duty to consider whether to issue a report in the public interest (PIR), where it is appropriate to do so.

Value for money

Under Schedule 10 paragraph 1(d) of the National Health Service Act 2006, we are required to be satisfied whether the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources (referred to as Value for Money). The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas:

- financial sustainability
- governance
- improving economy, efficiency and effectiveness.

Our report is based on those matters which come to our attention during the conduct of our normal audit procedures which are designed for the purpose of completing our work under the NAO Code and related guidance. Our audit is not designed to test all arrangements in respect of value for money. However, where, as part of our testing, we identify significant weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all irregularities, or to include all possible improvements in arrangements that a more extensive special examination might identify.

The NHS – context

Recovering performance amid high demand, workforce pressure and financial constraint.

National

Past

Historic Pressures

Long waits, rising demand and persistent backlogs in investment has created sustained pressure on hospital capacity, workforce and flow.

Infrastructure strain

Ongoing productivity challenges and ageing infrastructure has left acute providers struggling to keep pace with rising activity and complexity.

Present

Performance gaps

National care performance is mixed across the NHS with regional variations. Cancer and diagnostics performance continues to be seen as a challenge, for large Acute Trusts.

Pressured finances

Acute Trusts must deliver 4% productivity gains and reduce cost bases by 1% amid tight budgets and rising demand.

Future

Recovery Focus

Acute Trusts will be expected to accelerate elective recovery, improve A&E and ambulance performance, and strengthen flow models such as same-day emergency care (SDEC).

Pathway Shift

National reforms will increasingly shift care closer to home, requiring acute providers to redesign pathways with community partners in a devolved system.

Local

The Trust is a large teaching and research trust based across five hospitals in south London. The Trust delivers a range of acute, specialist and community services.

The Trust continues to deliver its planned financial position but like other Trust's must continue to deliver an increasing proportion of recurrent savings if it is to achieve financial sustainability and reduce its underlying deficit over the medium term. Overall, the Trust has delivered a positive performance against national targets but knows it continues to struggle to deliver its operational performance targets for cancer and diagnostic waiting times which it is taking action to address. Overall, the Trust has good arrangements in place as evidenced through no significant weaknesses being identified. The challenges the Trust are facing are similar across the NHS landscape and they continue to focus on transformation and look to others, in how they could do things differently.

It is within this context that we set out our commentary on the Trust's value for money arrangements in 2025/26.

02 Executive Summary

Executive summary – our assessment of value for money arrangements

Our overall summary of our Value for Money assessment of the Trust's arrangements is set out below. Further detail can be found on the following pages.

Criteria	2024/25 Assessment of arrangements		2025/26 Risk assessment	2025/26 Assessment of arrangements	
Financial sustainability	A	No risks of significant weaknesses identified; two improvement recommendations raised in relation to development of a medium-term financial strategy and savings schemes.	No risks of significant weakness identified	A	No significant weaknesses in arrangements identified, one improvement recommendation made setting out the need to continue to accelerate the identification, development and approval of recurrent savings over the medium term whilst recognising, like others, a structural deficit without more fundamental reform will be difficult to achieve.
Governance	G	No significant weaknesses identified or improvement recommendations raised.	No risks of significant weakness identified	G	No significant weaknesses in arrangements identified.
Improving economy, efficiency and effectiveness	A	No significant weaknesses identified; two improvement recommendations raised relating to Cancer and Diagnostic performance, and outstanding internal audit actions.	No risks of significant weakness identified	A	No significant weaknesses in arrangements identified, two improvement recommendation made relating to data quality and improving cancer and diagnostic waiting times performance.

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Executive Summary

We set out below the key findings from our commentary on the Trust's arrangements in respect of value for money.

Financial sustainability

In 2025/26, the Trust reported a £5.0m surplus, supported by £4.9m of additional deficit support funding awarded for delivering its planned break-even position. Strong cost control helped the Trust deliver £73.3m (72%) of its £102.1m savings plan, with 55% of savings recurrent.

However, despite delivering financial balance, the underlying deficit worsened, rising to £88m in 2025/26 (from £65m in 2024/25).

Looking ahead, the Trust has agreed a three-year break-even plan to reduce the underlying deficit to £35m in 2026/27, £10m in 2027/28, and achieve break-even in 2028/29. This increases pressure to deliver significantly higher recurrent savings while sustaining and improving operational performance. For 2026/27, the Trust's savings requirement increases to £150.3m, with £114.3m (76%) expected to be recurrent. Delivery of these recurrent savings is critical to reducing the underlying deficit. We have raised one improvement recommendation on page 18.

Progress is also constrained by uncertainty over commissioner income, driven by delays in agreeing a significant number of commissioning contracts. The Trust is updating its financial strategy, which will be finalised once commissioner contracts are agreed.

Governance

The Trust has effective governance, financial management and risk arrangements in place to support oversight, decision-making and regulatory compliance. Risk management is embedded through a Board Assurance Framework aligned to the organisational strategy. Board and committee decision-making is underpinned by clear information and regular assurance from sub-committees.

The Trust operates an appropriate budget-setting process, with regular financial performance reporting to the Executive Committee, Finance and Capital Investment Committee and the Board. This supports strong budgetary control.

The Trust has appropriate arrangements to support informed and effective decision-making and monitors and ensures appropriate legal and regulatory standards.

Executive Summary

We set out below the key findings from our commentary on the Trust's arrangements in respect of value for money.

Improving economy, efficiency and effectiveness

The Trust has appropriate performance management arrangements in place demonstrated by continued improvement within the NHS Oversight Framework, where the Trust was ranked 10th nationally at Quarter 3 2025/26. Improvements have been achieved in referral-to-treatment backlogs and targets which are no longer under enhanced scrutiny by NHS England. However, whilst cancer waiting times have improved it remains below standard and the Trust remains in Tier One for cancer and diagnostic waiting time performance. The Trust should strengthen its recovery arrangements by ensuring improvement actions are brought together, clearly measurable and regularly evaluated. We have raised an improvement recommendation on page 26.

The Trust has made progress in strengthening data quality and addressing legacy challenges following the implementation of the EPIC electronic patient record system. Internal Audit have also identified data quality issues. However, the Trust is not yet able to fully demonstrate a sustained and systematic approach to data quality and should implement a formal Board-level assurance framework for pathway and waiting-list data quality to support recovery following EPIC implementation.

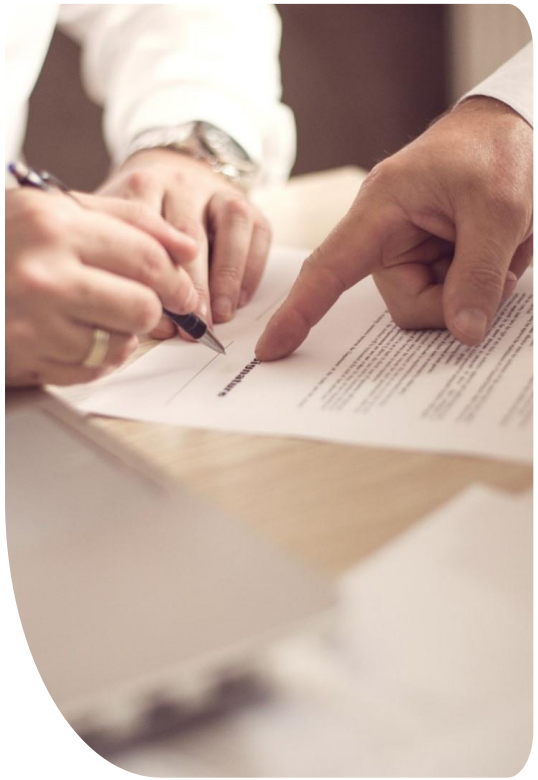
We have raised an improvement recommendation on page 25.

The Trust continues to work in partnership across providers, local authorities and the Integrated Care Board and through its shared service SmartTogether (procurement and contract management support), provides procurement efficiencies.

Executive summary – auditor's other responsibilities

This page summarises our opinion on the Trust's financial statements and sets out whether we have used any of the other powers available to us as the Trust's auditors.

Auditor's responsibility	2025/26 outcome
Opinion on the Financial Statements	We have completed our audit of your financial statements and issued an unqualified audit opinion on 26 June 2026, following the Audit Committee meeting on 17 June 2026.
Use of auditor's powers	We did not make a referral under Schedule 10 paragraph 6 of the National Health Service Act 2006. We do not consider that any unlawful expenditure has been made or planned for. No other issues have been identified during our work which require us to issue a Public Interest Report (PIR).



03 Opinion on the financial statements and use of auditor's powers

Opinion on the financial statements

These pages set out the key findings from our audit of the Trust's financial statements, and whether we have used any of the other powers available to us as the Trust's auditors.

Audit opinion on the financial statements

We issued an unqualified opinion on the Trust's financial statements on 26 June 2026.

The full opinion is included in the Trust's Annual Report for 2025/26, which can be obtained from the Trust's website.

Grant Thornton provides an independent opinion on whether the Trust's financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its expenditure and income for the year then ended,
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025/26, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We conducted our audit in accordance with: International Standards on Auditing (UK), the Code of Audit Practice (2024) published by the National Audit Office, and applicable law. We are independent of the Trust in accordance with applicable ethical requirements, including the Financial Reporting Council's Ethical Standard.

Findings from the audit of the financial statements

The Trust provided draft accounts in line with the national deadline.

Draft financial statements were of a good standard and supported by detailed working papers. The finance team worked well with the auditors to conclude the audit in a timely manner. While we have not identified any significant issues, our work has identified some minor areas where improvements can be made and these are captured in the Audit Findings Report alongside agreed management responses.

Audit Findings Report

We report the detailed findings from our audit in our Audit Findings Report to the Trust's Audit and Risk Committee on 17 June 2026.

An updated version of the report was provided to the Trust on 25 June 2026. Requests for this Audit Findings Report should be directed to the Trust.

Other reporting requirements and use of auditor's powers

Remuneration and Staff Report

Under the Code of Audit Practice (2024) published by the National Audit Office, we are required to audit specified parts of the Remuneration Report and the Staff Report included in the Trust's Annual Report for 2025/26.

These specified parts of the Remuneration Report and the Staff Report have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26 (FT ARM).

Annual Governance Statement

Under the Code of Audit Practice (2024) published by the National Audit Office, we are required to consider whether the Annual Governance Statement included in the Trust's Annual Report for 2025/26 does not comply with the guidance issued by NHS England, or is misleading or inconsistent with the information of which we are aware from our audit.

We have nothing to report in this regard.

04 Value for Money commentary on arrangements

Value for Money – commentary on arrangements

This page explains how we undertake the value for money assessment of arrangements and provide a commentary under three specified areas.

All NHS Trusts are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. NHS Trusts report on their arrangements, and the effectiveness of these arrangements as part of their annual governance statement.

Under the National Health Service Act 2006, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas:

Financial sustainability

Arrangements for ensuring the Trust can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years).

Governance

Arrangements for ensuring that the Trust makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, making decisions based on appropriate information.

Improving economy, efficiency and effectiveness

Arrangements for improving the way the Trust delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

Financial sustainability – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Rating
identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them	The Trust set a breakeven financial plan for 2025/26, and delivered a surplus of £5.0m, following the receipt of £4.9m additional deficit support funding (DSF) provided in March 2026, in recognition of the Trust and the wider system delivering against financial plans for the year. The Trust has a three-year breakeven financial plan, starting in 2026/27. However, the Trust still has a significant underlying deficit and ended the year with an underlying deficit of £88m an increase on the previous year (£65m). The Trust intends to reduce the underlying deficit to £35m in 2026/27, reducing to £10m in 2027/28, achieving breakeven in 2028/29. However, this is dependent on delivering a significantly increased savings requirement for 2026/27, with a total savings target of £150.3m. Delivery of the forward plan is further constrained by uncertainty over commissioner income, driven by challenges arising from ICB restructuring, which has delayed the agreement and signing of a large number of its commissioning contracts. At the time of reporting, the Trust was in the process of updating its medium term financial strategy, with the revised strategy to follow once contracts with its commissioners have been resolved.	A
plans to bridge its funding gaps and identify achievable savings	Recurrent savings delivery remains a key challenge for the Trust. In 2025/26, the Trust delivered £73.3m (72%) of its savings against a plan of £102.1m, of which only 55% (£40.5m) was recurrent, compared to 2024/25 when the Trust delivered £57.7m (80%) of its planned savings recurrently. The total savings requirement for 2026/27 has increased to £150.3m, an uplift of £48m (47%) with the intention that £114.3m will be delivered recurrently. This level of savings with a significant proportion delivered recurrently is required to improve the Trust's underlying run rate and reduce the underlying deficit. We set out further detail and raise an improvement recommendation on page 18.	A

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Financial sustainability – commentary on arrangements (continued)

We considered how the Trust:	Commentary on arrangements	Rating
plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities	The Trust continues to draw on its understanding of costs of delivering services. Its productivity programme brings together five key areas of focus: flow and beds, surgical productivity, ambulatory care, administration and private patients. The programme is designed to identify medium-term opportunities for improvement as well as initiatives that can be accelerated to support delivery within the current financial year. Oversight is provided by the Productivity Steering Group, which reports to the Transformation and Major Programmes Board Committee.	G
ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning which may include working with other local public bodies as part of a wider system	The Trust has appropriate arrangements in place to ensure its financial plan is consistent with wider organisational plans. Its five-year Integrated Delivery Plan sets out how it's the Trust's Strategy 2030 will be delivered and is structured around 32 Trust-wide strategic initiatives, supported through a clinically led, system-aligned approach. The Board maintains oversight of this integrated planning process and receives assurance that the assumptions are consistent with system-level priorities.	G
identifies and manages risk to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions in underlying plans	The Trust has appropriate arrangements in place to manage its financial risks. Financial reports are regularly presented to the Finance, Commercial and Investment Committee and/or Board and provide oversight of the financial risks facing the Trust, supported by clear commentary on the key actions being taken to address any areas of underperformance. The delay in signing its commissioning contracts pose a financial risk to the Trust and if not agreed could impact on the Trust's ability to deliver its planned financial position in 2026/27. The Board also reviews the Board Assurance Framework twice a year, which includes strategic risks relating to financial sustainability and capital investment, with the Finance, Commercial and Investment Committee responsible for overseeing these risks.	G

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Financial sustainability (continued)

Area for Improvement identified: identifying and delivering recurrent savings

Findings: The Trust needs to continue to deliver a higher level of recurrent savings in 2026/27, compared to 2025/26, to reduce its underlying deficit.

Evidence: The Trust's savings target for 2026/27 is £150.3m, an increase of around £48m from the 2025/26 target. Of this total, £114.3m (76%) is planned to be delivered recurrently, with £36m (24%) from non-recurrent schemes. In 2025/26 the Trust delivered savings in the region of 3% of its operating expenses and this increases to 4.6% of operating expense in 2026/27.

Whilst we recognise that the Trust has a track record of over delivering on its recurrent savings, the recurrent element of the savings requirement has increased markedly, from £39.6m in 2025/26 to £114.3m in 2026/27. The scale of this increase presents a significant challenge, and delivery of recurrent savings will be critical to reducing the underlying deficit. The Trust recognises the need for tighter governance and greater accountability in identifying and delivering recurrent saving schemes.

We recognise that the Trust is working in partnership with other providers in South East London to identify and deliver transformational and cross cutting service redesign across multiple trusts and has engaged a third party to support this review. The findings will be available later in the year.

Impact: Failure to identify and deliver sufficient recurrent savings in 2026/27 would place the Trust's financial plan at risk and contribute to a further deterioration in its underlying financial position.

Improvement Recommendation 1

IR1: The Trust should:

- Consider how it could strengthen its arrangements for early identification of recurrent CIP schemes
- keep its governance arrangements under review to maximise delivery and to ensure progress is in line with plan throughout the year.

	Savings/Cost Improvement Programme			
	Recurrent	% recurrent	Non-recurrent	**Total**
	£m		£m	£m
2024/25 **plan**	41.7	44	52.1	**93.8**
2024/25 **actual**	57.7	80	14.4	**72.1**
2025/26 **plan**	39.6	39	62.6	**102.1**
2025/26 **actual**	40.6	55	32.6	**73.3**
2026/27 **plan**	114.3	76	36.0	**150.3**

Governance – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Rating
monitors and assesses risk and how the Trust gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud	The Trust has established clear arrangements for monitoring and managing risk. The Board reviews the full Board Assurance Framework (BAF) twice a year. The BAF is aligned with the Trust's new organisational strategy. Risks are linked to the Trust's strategic objectives, consequences, key controls and gaps. Arrangements for assurance over internal controls, including fraud prevention and detection, and Internal Audit are in place and report to the Audit and Risk Committee. There is an opportunity to continually review the sources of assurance the Audit and Risk Committee (and wider Board) receive, recognising internal audit is only one source of those assurances through a refreshed assurance map. As the NHS landscape gets more complex with an increasing focus at a national level of sharing practices, the Trust should continue to ensure internal audit have access to the relevant skills, aligned to risk to support transformation and improvement. To date we do not have any concerns that internal audit does not have the skills or capacity this is a future observation, related to the growing risk profile of the NHS and the challenges, the Trust face, in respect of transformation. The Trust has adequate arrangements for end of year reporting. The Head of Internal Audit (HOIA) opinion report, the Annual Report and Annual Governance Statement (AGS) were presented to Audit and Risk Committee in May 26. The HOIA opinion report followed the Global Internal Audit Standards (GIAS) reporting requirements, stating overall governance, control and risk framework across the organisation remains robust.	G
approaches and carries out its annual budget setting process	The Trust operates an appropriate annual budget-setting process that aligns with NHSE planning timelines and includes engagement with clinical groups, corporate functions and South East London system partners. Progress and key developments in the planning process are regularly reported to the Executive Committee, Finance and Capital Investment Committee (FCIC) and the Private Trust Board.	G

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Governance – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Rating
ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information; supports its statutory financial reporting; and ensures corrective action is taken where needed, including in relation to significant partnerships	The Trust has arrangements in place to maintain strong budgetary control and timely financial oversight. Financial performance is routinely reported to the FCIC and the Board, providing updates on the current financial position and the key drivers behind it. There is also evidence that corrective action is taken where necessary. As noted earlier the Trust has yet to agree a significant proportion of its commissioning contracts and the Trust is in negotiations with a range of ICBs to reach agreement.	G
ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency, including from audit committee	The Trust has established arrangements to support well-informed and robust decision-making. Board and committee decisions are underpinned by detailed and well-structured papers, alongside informed contributions from senior officers, which together enable constructive challenge and debate. In addition, the Board receives regular summary reports from its sub-committees, highlighting key discussions, risks, and decisions taken since the previous meeting, ensuring that Board members have clear oversight of emerging issues. The Trust does not currently use Triple A (Alert, Advise and Assure) reporting in its reporting to the Board. This is a structured framework commonly used by Trusts to escalate key issues to the Board and the Trust may wish to consider this in its Board reporting.	G

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Governance – commentary on arrangements (continued)

We considered how the Trust:	Commentary on arrangements	Rating
monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of staff and board member behaviour	The Trust maintains effective governance and risk management arrangements to support compliance with legislative and regulatory standards. These include updated Standing Financial Instructions, last reviewed in May 2025, and registers of interests, gifts and hospitality for decision-making staff. A dedicated register for the Board of Directors is also maintained and publicly available on the Trust's website. In 2025/26 Internal Audit completed a review of the Trust's Fit and Proper Persons requirements, issuing a limited assurance rating. The review identified gaps in policy, governance, documentation, annual assessments, and compliance monitoring. All ten recommendations were accepted by the Trust and work is already underway to address them, as a result we have not raised an improvement recommendation.	G

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Grant Thornton insights – Assurance mapping

As risks increase ensuring internal audit continue to add value and support the Trust

Looking to the future the Trust could:

- Refresh the governance map which sets out the various sources of assurance the Trust and the Committee receive in addition to the work of internal audit in the year. For example, this would capture the work on cyber and data security, specialist providers have undertaken.
- As the risks facing the NHS increase in the future there is an opportunity to ensure that internal audit continue to have the skills and capacity to support the Trust, in providing assurance over likely increasing complex risks alongside the continued ability to share wider practices to support the Trust in its transformation journey.

What is the impact?

- This would ensure internal audit continue to be an integral source of assurance and value add in their activities, aligned to the risks within the BAF.
- Allow the committee to take a holistic view of assurances and identify any potential gaps linked to future risks and challenges and plan, for how these assurances will be sought and received.

Improving economy, efficiency and effectiveness – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Rating
uses financial and performance information to assess performance to identify areas for improvement	The Trust's Board papers provide comprehensive coverage of performance across operational performance, quality and financial performance. The Trust has demonstrated improvements in referral to treatment (RTT) times and some aspects of cancer waiting times, but sustained improvement in diagnostics (6-week breaches) has been more difficult to achieve. As A result, the Trust remains in Tier One (enhanced monitoring and scrutiny by NHSE) for cancer and diagnostic waiting times, and fortnightly support meetings are held with NHS England. The Trust has developed an action plan to address cancer waits and is in the process of agreeing its action plan for diagnostic waits. Internal scrutiny arrangements remain in place to continue to improve and to maintain its RTT performance. As further improvements are required, we have raised an improvement recommendation on page 26. The Trust has arrangements in place to improve and provide assurance over data quality and progress has been made in resolving legacy issues following the implementation of the EPIC electronic patient record (EPR) system. The Trust has reduced inactive patient pathways and long waits, but further improvements are required. In addition, an Internal Audit review of the 18-week RTT target identified an error rate of 18%, highlighting the need for continued strengthening of data quality controls and implementation of their recommendations. We have raised an improvement recommendation on page 25 to strengthen data quality.	A
evaluates the services it provides to assess performance and identify areas for improvement	The Trust continues to demonstrate continued improvement in the NHS Oversight Framework (NOF) rankings and was ranked 10th out of 134 at Quarter 3 2025/26. There have been no recent CQC inspections; the last detailed inspection took place in 2019, with a maternity review in 2022, both of which received a 'good' overall rating.	G

G No significant weaknesses or improvement recommendations.
A No significant weaknesses, improvement recommendations made.
R Significant weaknesses in arrangements identified and key recommendation(s) made.

Improving economy, efficiency and effectiveness – commentary on arrangements (continued)

We considered how the Trust:	Commentary on arrangements	Rating
ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives	The Trust has appropriate arrangements in pace to ensure its delivers its role within significant partnerships. Its Strategic Strategy sets out its commitment and the importance of partnership working. Regular updates on existing and new partnerships were provided to the Board throughout 2025/26 including other providers (acute and mental health), local authorities and SELICB.	G
commissions or procures services, assessing whether it is realising the expected benefits	The Trust has arrangements in place to manage its strategic contracts, involving its shared service SmartTogether, individual service areas, and Board committees. Contract performance is overseen through reports to the Quality and Performance Committee and the Finance, Commercial and Investment Committee. Through SmartTogether, the Trust is achieving procurement efficiencies by delivering both cash-releasing savings and cost avoidance, including reducing costs by collaborating and increasing purchasing volumes where possible. We have identified notebale practice on page 27. The Trust has arrangements in place to monitor and assure delivery of planned benefits following implementation of its electronic patient record system EPIC.	G

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Improving economy, efficiency and effectiveness

Area for Improvement: data quality

Findings: Following the implementation of EPIC, the Trust identified pathway data issues, including patients not previously visible on active pathways. Internal Audit's review of RTT also identified a material error rate. Although the Trust has taken action and continues to work through these issues, progress has been constrained by the complexity of the work and limited specialist capacity. As a result, the Trust has needed to prioritise validation activity, which means not all data quality risks have yet been fully addressed.

Evidence: The introduction of the new EPR system identified a significant number of patients who were not on an active patient pathway patients and included some long waits which were not previously visible to the Trust. This is complex work and has required specialist skills and capabilities to address. The Trust has prioritised the order in which the work is undertaken and limited the data validation work that could be undertaken. The Trust is working with South East London ICB to address its data quality issues.

Impact: Until the Trust can demonstrate a sustained and systematic approach to data quality assurance, there remains a risk that pathway information is incomplete or inaccurate, which may affect patient safety, operational decision-making and the reliability of reported performance.

Management may wish to consider:

- a single recovery plan for pathway/data-quality issues;
- clear ownership at executive level;
- risk-based prioritisation of validation work;
- routine reporting of backlog, progress and residual risk;
- linkage between data quality assurance and performance reporting.

Improvement Recommendation 2

IR2: The Trust should implement a formal Board-level assurance framework for pathway and waiting-list data quality to support recovery following EPIC implementation. This should provide clear executive accountability, prioritise validation activity based on risk, and give the Board regular visibility over remediation progress and the residual risk to patient safety and performance reporting.

Improving economy, efficiency and effectiveness

Area for Improvement: waiting times

Findings: The Trust's waiting times for cancer services and diagnostic services remain a challenge and the Trust remains in Tier One. Tier One is the highest level of escalation arrangements which NHS England (NHSE) require the trusts to operate under.

Evidence: The Trust has introduced internal monitoring arrangements and continues to have regular fortnightly meetings with NHSE. These meetings look at performance and the actions being taken to improve performance. Its RTT times have improved and RTT is no longer considered within these meetings, however, cancer waits and diagnostics remain. The backlog of patients has reduced, and the Trust has seen steady improvement in the 62-day target. However, the number of patients waiting over 6 weeks for a specific diagnostic service has fluctuated during 2025/26. The Trust has demonstrated its ability to improve performance but has yet to translate this into sustainable improvements in cancer and diagnostic services.

Impact: Long waiting times could have a detrimental impact on the outcome of the treatment for individual patients.

Management may wish to consider:

- a single recovery plan for cancer and diagnostics;
- quantified trajectories and milestones;
- clearer evaluation of which interventions are having impact;
- comparative benchmarking to assess whether progress is sufficient;
- triggers for escalation where trajectories are missed.

Improvement Recommendation 3

IR3: The Trust should strengthen its recovery arrangements for cancer and diagnostic services by ensuring improvement actions are brought together within a clearly measurable and regularly evaluated performance improvement framework, with defined trajectories, named accountability and timely escalation where progress is not sufficient to deliver sustained improvement.

Grant Thornton insights – notable practice

The Trust has notable arrangements for managing contracts

What the Trust is doing well

- The Trust's procurement shared service, SmartTogether, provides contract management support for the Trust and is achieving procurement efficiencies by delivering both cash-releasing savings and cost avoidance opportunities by working across the shared service and region.
- The SmartTogether team has 'tiered' its contracts as Gold, Silver or Bronze depending on the size, complexity and importance, in line with established good practice and Cabinet Office guidance. Central support is available to support divisional staff to manage the more complex contracts.
- The Trust has arrangements to actively manage the value delivered by existing contracts. The SmartTogether team undertakes deep dives are undertaken looking at the contract management arrangements across a specific service. These reviews are presented to the Finance and Capital Investment Committee to provide assurance and enable scrutiny and challenge and to gain an understanding of supplier performance. These reviews have been undertaken where there is an issue within a specific service.

What is the impact?

- Improved efficiencies as working across a number of trust increases the contract volume.
- Improved assurance and oversight arrangements with visibility for the Finance and Capital Investment Committee.

05 Summary of Value for Money Recommendations raised in 2025/26

Improvement recommendations raised in 2025/26

	Recommendation	Relates to	Management Actions
IR1	The Trust should: • consider how it could strengthen its arrangements for early identification of recurrent CIP schemes • keep its governance arrangements under review to maximise delivery and to ensure progress is in line with plan throughout the year.	Financial sustainability (page 18)	Actions: The Trust is working to ensure that CIP identification is ongoing, and not seen as an annual process. The establishment of the Productivity programme and Productivity Steering Group will support transformational recurrent CIPs across the coming years, supporting earlier identification moving forward. Responsible Officer: Executive Director of Finance Executive Lead: Chief Finance and Investment Officer Due Date: March 2027

Improvement recommendations raised in 2025/26

	Recommendation	Relates to	Management Actions
IR2	The Trust should implement a formal Board-level assurance framework for pathway and waiting-list data quality to support recovery following EPIC implementation. This should provide clear executive accountability, prioritise validation activity based on risk, and give the Board regular visibility over remediation progress and the residual risk to patient safety and performance reporting.	3Es (page 25)	Actions: We continue to progress our data quality recovery work to improve our waiting list safety. We are also working on the validation impact we need to see. We report to TRAC on admin safety and waiting list. Responsible Officer: Deputy Chief Operating Officer / Director of Performance and Planning Executive Lead: Chief Operating Officer Due Date: March 2027
IR3	The Trust should strengthen its recovery arrangements for cancer and diagnostic services by ensuring improvement actions are brought together within a clearly measurable and regularly evaluated performance improvement framework, with defined trajectories, named accountability and timely escalation where progress is not sufficient to deliver sustained improvement.	Improving 3Es (page 26)	Actions: A new tiering and operational plan has been agreed with clear actions to improve performance in both diagnostics and cancer. Responsible Officer: Deputy Chief Operating Officer / Director of Performance and Planning Executive Lead: Chief Operating Officer Due Date: September 2026

07 Appendices

Appendix A: Responsibilities of the NHS Foundation Trust

Public bodies spending taxpayers' money are accountable for their stewardship of the resources entrusted to them. They should account properly for their use of resources and manage themselves well so that the public can be confident.

Financial statements are the main way in which local public bodies account for how they use their resources. Local public bodies are required to prepare and publish financial statements setting out their financial performance for the year. To do this, bodies need to maintain proper accounting records and ensure they have effective systems of internal control.

All local public bodies are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. Local public bodies report on their arrangements, and the effectiveness with which the arrangements are operating, as part of their annual governance statement.

The Foundation Trust's directors are responsible preparing the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The directors are required to comply with the Department of Health & Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. An organisation prepares accounts as a 'going concern' when it can reasonably expect to continue to function for the foreseeable future, usually regarded as at least the next 12 months.

The Foundation Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Appendix B: Value for Money Auditor responsibilities

Our work is risk-based and focused on providing a commentary assessment of the Trust's Value for Money arrangements

Phase 1 – Planning and initial risk assessment

As part of our planning we assess our knowledge of the Trust's arrangements and whether we consider there are any indications of risks of significant weakness. This is done against each of the reporting criteria and continues throughout the reporting period.

Phase 2 – Additional risk-based procedures and evaluation

Where we identify risks of significant weakness in arrangements we will undertake further work to understand whether there are significant weaknesses. We use auditor's professional judgement in assessing whether there is a significant weakness in arrangements and ensure that we consider any further guidance issued by the NAO.

Phase 3 – Reporting our commentary and recommendations

The Code requires us to provide a commentary on your arrangements which is detailed within this report. Where we identify weaknesses in arrangements we raise recommendations.

A range of different recommendations can be raised as follows:

Key recommendations – the actions which should be taken by the Trust where significant weaknesses are identified within arrangements.

Improvement recommendations – actions which are not a result of us identifying significant weaknesses in the Trust's arrangements, but which if not addressed could increase the risk of a significant weakness in the future.

Information that informs our ongoing risk assessment

Cumulative knowledge of arrangements from the prior year	Key performance and risk management information reported to the Board
Interviews and discussions with key officers	NHS Oversight Framework (NOF) rating
Progress with implementing recommendations	Care Quality Commission (CQC) reporting
Findings from our opinion audit	Annual Governance Statement including the Head of Internal Audit annual opinion

Appendix C: Follow up of 2024/25 improvement recommendations

	Prior Recommendation	Raised	Progress	Current position	Further action
IR1	The Trust should update its financial strategy and medium-term financial plan in 2025/26 to show the financial impact of the initiatives arising from the productivity programme, with different scenarios modelled to show options to financial sustainability in the medium term.	2024/25	The Trust submitted a compliant breakeven financial plan for 2026/27 and the subsequent two years. However, at the time of reporting, the financial strategy has not yet been finalised or implemented. This is due to be implemented in Summer 2026, once contracts with commissioners have been resolved. No further action required.	Due to be completed summer 2026	No further action required
IR2	The Trust needs to add more pace and urgency to its process for identifying and working up recurrent cost savings (by end of Q1 at the latest) to reduce the risk of slippage and under delivery in 2025/26.	2024/25	In 2025/26, the Trust delivered £73.3m (72%) of its savings against a plan of £102.1m, of which only 55% was recurrent. Looking ahead, the total savings requirement for 2026/27 increases substantially to £150.292m, an uplift of approximately £48m (47%) compared to 2025/26. Within this, the recurrent savings requirement rises sharply to £114.3m, an increase of £74.7m (189%). This represents a significant escalation in both scale and pace and presents a material challenge for the Trust.	Closed and replaced by new recommendation	See page 18

Appendix C: Follow up of 2024/25 improvement recommendations

	Prior Recommendation	Raised	Progress	Current position	Further action
IR3	Management need to ensure actions arising from the work of internal audit are implemented in line with the agreed timeline. There should be more focused attention on implementing internal audits actions, ensuring all overdue actions are implemented as soon as possible.	2024/25	Significant progress to implement IA recommendations is evidenced with 83 overdue recommendations reported in May 2025, reducing to 43 reported in May 2026. We note that the CFO has supported the drive to implement recommendations, and although there is still some way to go, the trajectory is on the right path.	Closed	No further action required
IR4	The Trust should continue to ensure it maintains focus on achieving sustained improvements against its cancer and diagnostics metrics, with ongoing senior management oversight. Effectiveness of arrangements in place should be considered on an ongoing basis, and if these are not deemed to be improving performance, they should be revisited in 2025/26.	2024/25	The Trust has introduced internal monitoring arrangements and continues to have regular fortnightly meetings with NHSE. These meetings look at performance and the actions being taken to improve performance. Its RTT times have improved and RTT is no longer considered within these meetings, however, cancer waits and diagnostic remain. The backlog of patients has reduced, and the Trust has seen steady improvement in the 62-day target. However, the number patients waiting over 6 weeks for a specific diagnostic service has fluctuated during 2025/26. The Trust has demonstrated its ability to improve performance but has yet to translate this into sustainable improvements in cancer and diagnostic services.	Closed, replaced by new recommendation	See IR3 page 26

Audit Findings for Guy's and St Thomas' NHS Foundation Trust

For the year ended 31 March 2026

25 June 2026

Guy's and St Thomas NHS Foundation Trust

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London
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Grant Thornton UK LLP
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26 June 2026

Dear Audit and Risk Committee,

Audit Findings for Guy's and St Thomas NHS Foundation Trust for the 31 March 2026

This Audit Findings presents the observations arising from the audit that are significant to the responsibility of those charged with governance to oversee the financial reporting process and confirmation of auditor independence, as required by International Standard on Auditing (UK) 260. Its contents have been discussed with management and are being presented at this Committee.

As auditor we are responsible for performing the audit, in accordance with International Standards on Auditing (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities for the preparation of the financial statements.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

We encourage you to read our transparency report which sets out how the firm complies with the requirements of the Audit Firm Governance Code and the steps we have taken to manage risk, quality and internal control particularly through our Quality Management Approach. The report includes information on the firm's processes and practices for quality control, for ensuring independence and objectivity, for partner remuneration, our governance, our international network arrangements and our core values, amongst other things. This report is available at 2025-transparency-report.pdf (link to transparency report)

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during our audit.

Joanne Brown

Partner
For Grant Thornton UK LLP

Contents

Headlines

Summary of the key findings and other matters arising from the statutory audit of Guy's and St Thomas' Trust ('the Trust') and the preparation of the group and Trust's financial statements for the year ended 31 March 2026 for those charged with governance.

Financial statements

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to report whether, in our opinion:

- The group and Trust's financial statements give a true and fair view of the financial position of the group and Trust and of its income and expenditure for the period; and
- The group and Trust's financial statements, and the parts of the Remuneration and Staff Report to be audited, have been properly prepared in accordance with the Department of Health and Social Care (DHSC) group accounting manual 2025/26 (GAM).
- The group and Trust's parts of the Remuneration Report and Staff Report to be audited, have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26 (FT ARM).

We are also required to report whether other information published together with the audited financial statements in the Annual Report, is materially consistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

Our findings are summarised on pages 16-24. We have identified adjustments of £2.52m to the financial statements which would impact your reported position. We have also identified a number of disclosure amendments. These amendments are detailed at page 30. We have also raised recommendations for management as a result of our audit work. These are set out in Appendix B. Our follow up of recommendations from the prior year's audit are detailed in Appendix C.

Presently we are not aware of any matters which would require a modification of your audit opinion of the financial statements.

Our work is complete.

We have concluded that the other information to be published with the financial statements, is consistent with our knowledge of your organisation and the financial statements we have audited.

Our anticipated audit report opinion will be unmodified.

Headlines

Summary of the key findings and other matters arising from the statutory audit of Guy's and St Thomas' Trust ('the Trust') and the preparation of the Trust's financial statements for the year ended 31 March 2026 for those charged with governance.

Value for Money (VFM) arrangements

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to consider whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Auditors are required to provide a commentary on the Trust's overall arrangements, and set out our key recommendations on any significant weaknesses in arrangements identified during the audit.

Auditors are required to report their commentary on the Trust's arrangements under the following specified criteria:

- Improving economy, efficiency and effectiveness;
- Financial sustainability; and
- Governance.

As part of planning our audit work, we considered whether there were any risks of significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have not identified any risks of significant weakness. For further detail of the our findings, please see separate Auditor's Annual Report which we are also prese noting to this meeting of the Audit and Risk committee.

We have completed our Value for Money arrangements work and our findings are set out in our Auditor's Annual Report which we are providing to those charged with governance at todays meeting.

During our audit work no significant weaknesses have been identified.

We have also identified improvement recommendations, which are set out in our Auditor's Annual Report.

Statutory duties

The National Health Service Act 2006 ('the Act') and the National Audit Office Code of Audit Practice also requires us to:

- report to you if we have applied any of the additional powers and duties ascribed to us under the Act; and
- to certify the closure of the audit.

We have not exercised any of our additional statutory powers or duties.

We cannot formally conclude the audit and issue an audit certificate for the Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of the National Health Service Act and the National Audit Office Code of Audit Practice, until the National Audit Office has concluded their work in respect of consolidation returns for the year ended 31 March 2026.

The Trust has also been selected as a sampled component by the NAO meaning they require a greater level of detail in our response to them. An additional fee of £5k has been agreed in relation to this work.

Our approach to materiality

On receipt of draft financial statements, we reconsidered planning materiality based on the 2025/26 figures in the draft financial statements using the same metrics at planning. Our approach to determining materiality is set out below.

Materiality area	Initial (per audit plan) (£'m)	Final (£'m)	Qualitative factors considered
Materiality for the Group financial statements	53.5	65.0	This is equivalent to approximately 2% of the operating expenses for the period ended 31 March 2026. This was updated on receipt of the draft financial statements following an increase in the Trust's expenditure compared to the prior year.
Performance materiality for the Group financial statements	37.54	45.5	Performance materiality has been set at 70% of financial statements materiality. This reflects our risk-assessed knowledge of potential for errors occurring. Performance materiality is used for the purposes of assessing the risks of material misstatement and determining the nature, timing, and extent of further audit procedures. This is the amount we set at less than materiality for the financial statements as a whole, to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.
Materiality for the Trust's Financial statements	50.0	61.7	This has been set on the same basis as the Group materiality, however, per our central guidance the materiality of a component of a group cannot be higher than 95% of the Group materiality, we therefore have applied this cap to the Trust.
Performance materiality for the Trust's Financial statements	35.0	43.2	This has been set at 70% of the Trust's materiality on the same basis as the Group performance materiality.

Our approach to materiality

On receipt of draft financial statements, we reconsidered planning materiality based on the 2025/26 figures in the draft financial statements using the same metrics at planning. Our approach to determining materiality is set out below.

Materiality area	Initial (per audit plan) (£'m)	Final (£'m)	Qualitative factors considered
Other Components Performance Materiality	Not reported in audit plan	23.7	This threshold is used to inform our analytical procedures over the subsidiaries as part of the Group audit opinion. While the detailed audit of the subsidiaries will be performed using a lower threshold, this level has been set to ensure that any unusual movements are identified through analytical procedures across the Trust's three components: Pathology Services Limited, Guy's and St Thomas' Enterprises Limited, and Lexica Health and Life Sciences Consultancy Limited, which was sold off in May 2025.
Reporting threshold	1.0	1.0	This balance is set at £1m as this is the reporting threshold for any errors identified as part of our work on the National Audit Office's Whole of Government Accounts (WGA) exercise.
Remuneration report	Not reported in audit plan	0.1 for the whole remuneration report	Due to the public interest in senior officer remuneration disclosures, we apply specific audit procedures to this work and set a lower materiality level for this area. We design our procedures to detect errors in specific accounts at a lower level of precision which we have determined to be applicable for senior officer remuneration disclosures. We evaluate errors in this disclosure for both quantitative and qualitative factors against this lower level of materiality.
Losses and special payments, gifts and contingent liability	Not reported in audit plan	0.3	Losses and special payments, gifts and contingent liability disclosures triviality is capped at £300k by NAO.

Group audit scope and risk assessment

In accordance with ISA (UK) 600 Revised, as group auditor we are required to obtain sufficient appropriate audit evidence regarding the financial information of the components and the consolidation process to express an opinion on whether the group financial statements are prepared, in all material respects, in accordance with the applicable financial reporting framework. As part of this standard we have set a lower performance materiality as part of our procedures for reviewing the balances held by the three subsidiaries held by the Trust, with this being set at £23.7m. Please note in our individual subsidiary audits lower thresholds are being used and this is purely for the work required for us to express our Group audit opinion.

Note although the Trust prepares Group accounts for transparency purposes and to ensure oversight is maintained of the subsidiaries, the subsidiaries themselves are not material to the Trust and our procedures in relation to the subsidiaries focus on the consolidation process and analytical procedures. Note due to this both the Group and the Trust have the same risks identified in our audit planning work.

Fraud and litigation

We have not been made aware of any actual or attempted frauds in the year during our planning procedures performed to date. Should any factors arise in relation to fraud risk or actual or attempted fraud we ask that you inform us of this at the earliest possible opportunity.

Component	Risk of material misstatement to the group	Planned audit approach and level of response required under ISA (UK) 600 Revised	Response performed by	Risks identified	Auditor
Guy's and St Thomas NHS Foundation Trust	Yes	Full scope audit performed by Grant Thornton UK LLP.	Group auditor	See later slides noting significant risks identified and other procedures performed.	Grant Thornton UK LLP
Pathology Services Limited	No	Analytical procedures at group level. We then audit the subsidiary separately this audit takes place after we provide our Group audit opinion.	Group auditor	N/A	Grant Thornton UK LLP
Guy's and St Thomas Enterprises Limited	No	Analytical procedures at group level. We then audit the subsidiary separately this audit takes place after we provide our Group audit opinion.	Group auditor	N/A	Grant Thornton UK LLP
Lexica Health and Life Sciences	No	Analytical procedures performed at group level, with the subsidiary consolidated into the Group SOCI for the start of FY25/26 prior to disposal. Additional procedures were performed to assess the accounting entries relating to consolidation and disposal.	Group auditor	N/A	Grant Thornton UK LLP

Overview of significant and other audit risks identified

The below table summarises the significant risks discussed in more detail on the subsequent pages.

Significant risks are defined by ISAs (UK) as an identified risk of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum due to the degree to which risk factors affect the combination of the likelihood of a misstatement occurring and the magnitude of the potential misstatement if that misstatement occurs.

Other risks are, in the auditor's judgment, those where the risk of material misstatement is lower than that for a significant risk, but they are nonetheless an area of focus for our audit.

Risk title	Risk level	Change in risk since Audit Plan	Fraud risk	Level of judgement or estimation uncertainty	Findings
Risk 1: Management override of controls	Significant	↔	✓	Medium	●
Risk 2: Fraud in revenue recognition - Patient income	Normal	↓	✓	Medium	●
Risk 2: Fraud in revenue recognition - Other operating income	Significant	↔	✓	Medium	●
Risk 3: Fraud and Expenditure recognition	Significant	↔	✓	Medium	●
Risk 4: Valuation of Land and Buildings	Significant	↔	✗	High	●
Risk 5: Valuation of Investment Properties	Significant	↔	✗	High	●

Key

↑ Assessed risk increase since Audit Plan
↔ Assessed risk consistent with Audit Plan
↓ Assessed risk decrease since Audit Plan

● No adjustment or change in disclosure required
● Non-material adjustment or change in disclosure required
● Material adjustment or change in disclosure required

Overview of significant risks – financial statements

Risk identified in our Audit Plan	Audit procedures performed	Key observations
Management override of controls (Group and Trust) In accordance with ISA (UK) 240, we have identified a risk of fraud in management override of controls. In particular, management estimates, reversals of prior year accruals after the prior year audit has been signed off and of and transactions outside the course of business as a significant risk of material misstatement.	We have: • evaluated the design effectiveness of management controls over journals • analysed the journals listing and determined the criteria for selecting high risk unusual journals; • gained an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness; • challenged management's key judgements and estimates and considering whether these judgements and estimates are individually or cumulatively indicative of management bias; • Identified and tested unusual journals made during the year and the accounts production stage for appropriateness and corroboration; • Undertook reviews of and tested Journals related to user IDs identified in our ITGC work as having inappropriate super user access rights.	Our audit work is complete and has not identified any issues in respect of management override of controls.

Overview of significant risks – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
ISA 240 improper revenue recognition - Other operating income (Group and Trust) Other operating income £339m (£328m 24/25) comprises of several revenue streams. We have assessed the risk of fraud in revenue recognition in the applicable revenue streams and, given the income is clearly material and comprises variable amounts, we have scoped the whole of Other Operating income as a significant risk.	We have: • evaluated the Trust's accounting policy for recognition of income from other operating income for appropriateness and compliance with the DHSC Group Accounting Manual (GAM) 2025-26; • updated our understanding of the system for accounting for other operating income and evaluate the design of associated controls; • used the DHSC mismatch report, we will investigate unmatched revenue and receivables balances over the NAO £1m threshold, corroborating your unmatched balances to supporting evidence; • agreed on a sample basis income and year end receivable/income accruals from non-patient care revenues to invoices and cash payment or other supporting evidence; • completed testing on sample basis of invoices issued in the period prior to and following 31 March 2026 to determine whether income is recognised in the correct accounting period, in accordance with the amounts billed to the corresponding parties; and	Our work on this area is complete and no audit issues have been identified from our work.

Overview of significant risks – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
Fraud in expenditure recognition (Group and Trust) We assessed the likely risk the Trust may manipulate expenditure to meet externally set targets. Given the financial pressures experienced by the Trust to meet its agreed budget, we consider there is a risk of fraud in expenditure recognition, namely Management could inappropriately: • Exclude or defer recognition of 2025/26 expenditure; • capitalise expenditure which is in fact revenue related; and • Understate year end accruals.	We have: • evaluated your accounting policy for recognition of expenditure for appropriateness and compliance with the DHSC Group Accounting Manual 2025/26; • understood and assessed the Trust's process for recording expenditure accruals and deferrals, and any relevant controls; • performed an analytical review of accruals by classification to understand and critically assess the completeness of expenditure accruals; • focused our testing on manual journals which impact the control total through decreasing the level of expenditure and we will assess whether there was an appropriate basis for posting these journals and the amount is supported by appropriate evidence; • inspected a sample of expenditure invoices in the period before and after 31 March 2026 to determine whether the expenditure has been recognised in the correct accounting period and whether accruals are complete; • inspected invoices recorded and payments made after the end of the financial year to assess whether they had been included in the correct accounting period; and • completed testing of a sample of capital additions recorded in 2025/26, corroborating these to evidence that the transaction has been classified appropriately.	Our work on this area is now complete and no audit adjustments have been identified. In completing the work we have noted the following minor process issue: • Accrual testing identified four sampled cases where the accrued costs and prepayments had been calculated on a monthly basis rather than using a daily apportionment. Where the costs are invoiced part way through a month any monthly calculation will give rise to a less precise estimation of expenditure and prepayment. While the impact is not material, this results in minor differences in the recorded payable balances. This has been included in the Action plan.

Overview of significant risks – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
Closing Valuation of Land and Buildings (Group and Trust) The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. We therefore identified the valuation of land and buildings included in the closing balance at 31 March 2026 as a significant risk requiring special audit consideration.	We have: • evaluated management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work; • written to the valuer to confirm the basis on which the valuations were carried out; • evaluated of the competence, capabilities and objectivity of the valuation expert; • challenged the information and assumptions used by the valuer to assess completeness and consistency with our understanding, including through use of our auditor's expert (Wilks, Head & Eve); • completed testing, on a sample basis, of revaluations made during the year to ensure they have been input correctly into the Trust's asset register, revaluation reserve, and Statement of Comprehensive Income; and • evaluated the assumptions made by management for any assets not revalued during the year and how management has satisfied themselves that these are not materially different to current value.	Our work in this are is now complete. We have noted the following points in respect of the Trust's approach: • Land and buildings are measured at valuation, based on assessments performed by an external independent valuer, in accordance with the Trust's accounting policy. • During the year, the Trust updated its modern equivalent asset (MEA) assumption for the Royal Brompton site to reflect a revision to the hypothetical alternative location. This resulted in downward valuation of £32m, including an impairment charge of £7m recognised in the financial statements. Given the inherent estimation uncertainty associated with property valuations, including assumptions relating to rebuild costs, obsolescence and site requirements, the valuation remains sensitive to changes in key inputs. Based on the procedures performed, we did not identify any indicators that the valuation approach applied is inappropriate. The valuation methodology, including the updated MEA assumption and related professional judgement, are considered reasonable and consistent with the requirements of the applicable accounting framework.

Overview of significant risks – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
Closing Valuation of Investment Properties (Trust) The Trust holds Investment Property sits at £75.9m at the 31st March 2026. The valuation of Investment Property is a key accounting estimate which is sensitive to changes in assumptions and market conditions. We therefore identified the valuation of investment properties included in the closing balance at 31 March 2026 as a significant risk requiring special audit consideration.	We have: • evaluated management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work; • written to the valuer to confirm the basis on which the valuations were carried out; • evaluated of the competence, capabilities and objectivity of the valuation expert; • challenged the information and assumptions used by the valuer to assess completeness and consistency with our understanding, including through use of our auditor's expert (Wilks, Head & Eve); • completed testing, on a sample basis, of revaluations made during the year to ensure they have been input correctly into the Trust's asset register, revaluation reserve, and Statement of Comprehensive Income; and • evaluated the assumptions made by management for any assets not revalued during the year and how management has satisfied themselves that these are not materially different to current value.	Our work in this area is now complete. We have noted the following points in respect of the Trust's approach: • Investment properties are measured at fair value, with movements recognised in income and expenditure in accordance with the Trust's accounting policy. • The carrying value of investment properties increased from £71.8m in 2024/25 to £75.9m in 2025/26, reflecting fair value movements during the year. Based on the procedures performed to date, we did not identify any indicators that the valuation approach applied is inappropriate, and the methodology is consistent with the prior.

Other risks – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
ISA 240 improper revenue recognition - Operating income from patient care activities (Trust) We have performed a risk assessment over all material revenue streams arising from patient care activities. Based on our initial assessment, risks relating to private patient income, income from activity-based API contracts requiring year-end estimates, and other variable/ activity - based income were identified as potential areas of increased susceptibility to manipulation and initially assessed as a significant risk of fraud. However, following further audit procedures and enhanced understanding obtained during the audit, including the stability of contractual agreements, improved consistency and predictability in variable consideration, and the results of prior year substantive audit procedures, we have reassessed this risk. Based on this, we consider that the risk of material misstatement due to fraud in these revenue streams has reduced from a significant risk to a normal risk.	We have: • evaluated the Trust's accounting policy for recognition of income from patient care activities for appropriateness and compliance with the DHSC Group Accounting Manual (GAM) 2025/26; • updated our understanding of the system for accounting for income from patient care and evaluate the design of associated controls; • investigated unmatched revenue and receivables balances over the NAO threshold of £1m, corroborating your unmatched balances to supporting evidence; • agreed, on a sample basis, income from patient care activity transactions recorded in the year and year end receivable balances to contracts/agreements or other supporting evidence such correspondence from Department of Health/NHSE or Commissioners; • agreed on a sample basis operating income from patient care activities and related year end receivable/income accruals to supporting documentation, including invoices and cash receipts and other relevant evidence; • completed testing on sample basis of invoices issued in the period prior to and following 31 March 2026 to determine whether income is recognised in the correct accounting period, in accordance with the amounts billed to the corresponding parties; and • agreed any additional funding due at the year end to the confirmation received from NHSI and agree that this was appropriately recorded.	**Patient Care income - API Contracts** Our review of API contract income identified instances where contracts had not been signed by counterparties. While no issues were identified in relation to revenue recognition based on the procedures performed, this remains a control weakness. This issue has been included in our Action Plan – see Appendix B. The Trust continues to recognise provisions (expected credit loss allowances) of £6.3m against receivables from NHS counterparties. This is consistent with our prior year finding reported in the Annual Findings Report. However, under the GAM, balances with NHS counterparties should be excluded from expected credit loss provisioning.

Other findings – accounting policies

Accounting area	Summary of policy	Comments	Assessment
Revenue recognition	Patient care income: Recognised under IFRS 15 as performance obligations are satisfied, with block income recognised over time and API income based on activity delivered Specialised services, drugs and devices: Recognised based on actual usage or activity, forming part of variable consideration within the overall contract Research income: Recognised over time as performance obligations are satisfied; certain elements accounted for under IAS 20 (government grants) where applicable Other clinical income (low-volume or fixed arrangements): Recognised in line with contract terms, typically over the period services are delivered. Injury cost recovery income (RTA): Recognised when treatment is complete and entitlement is confirmed, at agreed tariff rates Education, training, grants and other income: Recognised in line with IFRS 15 or IAS 20, depending on the nature of funding, and matched to the period of service delivery or expenditure incurred Across all streams, income is adjusted for accruals and deferred income to ensure it reflects services delivered in the reporting period.	We note • The revenue recognition policy is appropriate and compliant with IFRS 15 and the DHSC GAM, reflecting recognition of income as performance obligations are satisfied. • Judgement exercised by management is mainly in respect of the estimation of accruals and variable consideration, impacting the timing and classification of income rather than total recognised amounts. • Disclosures made by the Trust are generally adequate / appropriate, although these could be further enhanced with clearer explanation of variable income considerations and the associated key judgements. • Overall, the policy is consistent with NHS sector practice, with no significant deviations from peer organisations.	

Assessment:
- Marginal accounting policy which could potentially be open to challenge by regulators
- Accounting policy appropriate but scope for improved disclosure
- Accounting policy appropriate and disclosures sufficient

Other findings – accounting policies (continued)

Accounting area	Summary of policy	Comments	Assessment
Expenditure recognition	Employee costs: Recognised in the period in which employee services are received, including salaries, national insurance, and pension contributions. Clinical and non-clinical supplies and services: Recognised on receipt of goods or services, measured at fair value, including drugs, medical supplies, and contracted services. Operating expenses (general expenditure): Recognised on an accruals basis when the Trust receives goods or services, ensuring costs are matched to the relevant accounting period. Depreciation and amortisation (including leases): Recognised over the useful economic lives of assets, including depreciation of owned assets and right-of-use assets under leases, with associated finance costs recognised separately Provisions and impairment charges: Recognised where there is a present obligation and probable outflow of resources, with amounts estimated on a best-estimate basis. Premises cost: Recognised on an accruals basis as services are received, including rent, rates, utilities, and maintenance. Where premises are leased, costs include depreciation of right-of-use assets and interest on lease liabilities; for owned assets, costs include depreciation and running	We note • The policies are appropriate and compliant with the relevant framework (IFRS and GAM), ensuring expenditure is recognised in the period in which it is incurred. • The use of judgements is limited, with these mainly relating to accruals and provisions, which may affect the timing of expense recognition, but not materially the total expenditure reported • Disclosures are adequate and clearly describe the accruals-based recognition, with consistent application across expenditure categories • Overall the policy is consistent with NHS sector practice, with no significant departures from peer organisations	

Assessment:
- Marginal accounting policy which could potentially be open to challenge by regulators
- Accounting policy appropriate but scope for improved disclosure
- Accounting policy appropriate and disclosures sufficient

Other findings – accounting policies (continued)

Accounting area	Summary of policy	Comments	Assessment
Valuation methods	Property, plant and equipment are recognised at cost and subsequently measured at current value in existing use, based on professional valuations. Where active markets do not exist (e.g. specialised assets), values are determined using a depreciated replacement cost (DRC) methodology on a modern equivalent asset basis. Assets are periodically revalued to ensure carrying values are not materially different from current values, with revaluation gains and losses recognised in reserves or expenditure as appropriate. Intangible assets are measured at cost less amortisation and impairment, following transition from a revaluation model. Overall, valuation reflects the current service potential of assets, using appropriate methodologies depending on asset type and market availability.	We note • The Trust's valuation methodology is appropriate and consistent with the DHSC GAM and IFRS, with assets measured at current value in existing use. The use of depreciated replacement cost (DRC) for specialised assets is suitable where active market evidence is unavailable, ensuring values reflect service potential rather than market price. • There have been no significant changes to valuation methodology in the year. Any changes in asset values are driven by movements in assumptions (e.g. indices, condition, useful lives) rather than methodology. Had alternative valuation methods been applied, this could impact asset carrying values, depreciation charges, and revaluation reserves, although no such changes have been identified in the current year. • While the valuation methodology is appropriate and consistent with the applicable framework, disclosures could be enhanced. In particular, the presentation of revaluation movements does not fully align with GAM requirements, as adjustments arising from the elimination of accumulated depreciation are not appropriately reflected across the relevant lines, reducing transparency over valuation movements.	

Assessment:
- Marginal accounting policy which could potentially be open to challenge by regulators
- Accounting policy appropriate but scope for improved disclosure
- Accounting policy appropriate and disclosures sufficient

Other findings – accounting policies (continued)

Accounting area	Summary of policy	Comments	Assessment
Judgements and estimates	Critical judgements primarily relate to property valuation on a modern equivalent asset (MEA) basis, including assumptions on alternative site use for major hospital locations, market evidence, and valuation inputs. Aside from these valuation-related judgements, no additional critical judgements have materially impacted the financial statements. Estimation uncertainty arises from these valuation assumptions and other management estimates, which are based on historical experience and other relevant factors. Overall, the approach reflects management's assessment of asset values and service potential, with a risk that changes in assumptions could result in future adjustments to reported balances.	The policy is appropriate and compliant with IAS 1 and GAM as: • It distinguishes between judgements and estimates • It identifies key areas of estimation uncertainty • It explains the nature of assumptions used (e.g. MEA, market evidence, site assumptions) • Based on the procedures performed, we consider management's accounting policy to be appropriate. However, disclosures could be enhanced. Although key assumptions are outlined, there is limited transparency around the sensitivity of valuations to changes in these assumptions and the potential impact on reported balances, given the inherent estimation uncertainty.	

Assessment:
- Marginal accounting policy which could potentially be open to challenge by regulators
- Accounting policy appropriate but scope for improved disclosure
- Accounting policy appropriate and disclosures sufficient

Other findings – key judgements and estimates

This section provides commentary on key estimates and judgements in line with the enhanced requirements for auditors.

Key judgement or estimate	Summary of management's approach	Auditor commentary	Assessment
Expected Credit Loss Allowance The Trust has set an expected credit loss allowance of £39,888k prior year £41,886k. The balance is primarily set using the Trust's bad debt provision matrix for the below two balances: • £17.5m of allowances made against invoices raised by the Trust to public sector entities making up the Whole of Government accounts (WGA). This follows the Bad debt provision matrix method. • £22.4m of allowances made by the Trust against invoices raised by the Trust against non-WGA bodies. This also follows the Bad debt provision matrix model. In addition, the Trust also sets allowances outside of this matrix for disputed income largely from API contracted income with commissioners. The balance of £11m relates to amounts due from NHS bodies. Of this, £5.9m relates to periods prior to 2025/26, with the remaining £5.1m relating to income recognised in respect of 2025/26 API contracts.	During 2025/26, management refined key assumptions (e.g. overseas visitors, staff debt, and embassy balances) to reflect improved recovery patterns, resulting in a reduction in overall provision levels. The model is supported by data from Oracle debtor listings, ageing reports, and credit control records, with input from finance teams on disputed balances. NHS balances – Bad Debt Matrix The Trust is aware that establishing an expected credit loss allowance for NHS/WGA debts is not compliant with IFRS 9. Both IFRS 9 and the GAM do not allow for allowances against these entities. However, the Trust adopts this approach because it has £17.4m in NHS debtors that are older than 180 days, of which £7.4m is recorded in the ledger as being under dispute. Consequently, the Trust considers it appropriate to account for this risk by raising an allowance against this balance, despite it not being permitted under IFRS 9.	We note • The ECL calculation is based on aged receivables data and debtor classifications, which we found to be complete and consistent with the Trust's underlying records. The population appropriately distinguishes between WGA and non-WGA balances. For non-WGA debtors (£22.4m), the total impairment provision recognised is £13.5m, primarily relating to higher-risk categories such as foreign embassies (£3.1m provision on £13.9m gross balance) and overseas visitors (£10.4m provision on £14.0m gross balance). • Foreign embassy receivables are significantly aged, with £7.52m having been outstanding for more than one year, with a weighted average ageing of 857 days. Management has recognised an impairment on balances aged over three years on the basis that recovery is typically achieved, albeit with extended payment timelines. This is consistent with our audit testing, which identified that embassy payments are often received with significant delay. The Trust's policy is to fully provide for balances outstanding for more than three years, based on historical recovery patterns..	The ECL methodology is generally appropriate for non-WGA balances and supported by underlying data and observed recovery patterns. However, the application to NHS/WGA balances (£17.5m) is not compliant with IFRS 9 resulting in an overstatement of the gross provision and a presentation misstatement. The Statement of Comprehensive Income impact is £2.52m, representing the movement in the provision.

Other findings – key judgements and estimates

Key judgement or estimate	Summary of management's approach	Auditor commentary	Assessment
Expected Credit Loss Allowance (continued)	**Foreign Receivables- Bad debt matrix** The Trust holds overseas visitor debtor balances of £14.0m, against which an impairment allowance of £10.4m has been recognised based on the BDP matrix, reflecting the estimated level of non-recoverability. The recovery of overseas visitor debtors remains challenging across the NHS. The Trust has a significant balance of receivables from foreign embassies, primarily arising from legacy Royal Brompton and Harefield (RBH) balances recorded in a separate system (Compucare) for private patient income. These receivables amount to £13.9m, against which an impairment allowance of £3.0m has been recognised. The Trust's policy includes full provision for balances outstanding for more than three years. The debtor profile is notably aged, with a weighted average ageing of approximately 857 days, increasing the level of estimation uncertainty in recoverability. **Financial management allowances** The Trust recognises FM specific invoice provisions, which have decreased as compared to 2024/25, reflecting the transfer of relevant activities to SEL ICB during the year. These activities are now funded under a block contract arrangement, reducing the need for such provisions. Overall, the allowance recognised against accrued contract income has reduced from £9.84m in the prior year to £1.79m in 2025/26. This balance relates to NHS counterparties and remains non-compliant with IFRS 9.	• However, the application of ECL to NHS/WGA balances is not appropriate under IFRS 9, as these counterparties are considered low credit risk. This reflects a misapplication of accounting policy rather than a flaw in estimation assumptions. As a result, the gross provision is overstated, impacting the presentation of income, expenditure, receivables, and consolidation returns, although there is no impact on the reported surplus or deficit.	Disclosures could be enhanced to more clearly distinguish between WGA and non-WGA balances and the associated accounting treatment.

Other findings – key judgements and estimates

Key judgement or estimate	Summary of management's approach	Auditor commentary	Assessment
Land and building valuations and Investment Property Valuations	The Trust's land and buildings comprises of: • Specialised building assets of £1,028m which are required to be valued at depreciated replacement cost (DRC) at year end, on a modern equivalent asset basis. • Land assets of £194m associated with these buildings which are measured on a DRC basis, with assumptions made around alternative locations and the size of the land required if an MEA site was built. • The remainder of land and buildings subject to revaluation are required to be valued in existing use (EUV) at year end. This comprises of assets with a value of £43m. • There are also assets within the building category valued at cost with a value of £28,348k. These pertain to enhancements made to assets that the Trust leases, which, per IFRS 16, necessitate capitalisation. As per the standards it is reasonable to hold these assets on a cost basis, depreciating them over the life of the lease and therefore not requiring a formal revaluation. The Trust also holds an Investment property (£75,941k). This is solely made up of the Chelsea Farmer Market site asset. This site is required to be revalued annually. The Chelsea Farmer's market's valuation is based on the assumption a future buyer would use the current planning permission to turn the site into a residential development. Currently, any plans to proceed with this are on hold due to the effects of delays in site development caused by Cross Rail. This impacts the liquidity of the Trust able to accessing the sites value due to the hold put on the site in relation to this, this has been factored into the valuation of the site. The Trust has engaged Newmark to undertake the valuations. With the same valuer used as in the prior year.	We have: • understood processes and controls around the identification and determination of estimates. We have understood methods, assumptions and data used and challenged where necessary; • discussed management's determination of accounting estimates as necessary. We have understood the development and validation of models, data integrity and the selection of inputs; • considered the competence, capabilities and objectivity of the valuation expert used by the Trust. We have not identified any concerns; • considered the data and assumptions used by management to derive the accounting estimate. We have not noted any issues with the completeness and accuracy of this underlying information; • considered the appropriateness of the MEA assumptions used, and have confirmed the appropriateness of the change made to the Royal Brompton & Harefield valuation since the prior year; • we have considered the movements in the valuations of individual assets and their consistency with indices provided by Wilks, Head & Eve as our auditor's expert. This work has not raised any issues with the 2025/26 valuations; • confirmed that there have been no changes to the valuation method this year; and • assessed the reasonableness of the disclosures related to accounting estimates. **Conclusion** No issues have been found.	No issues have been noted from the procedures performed.

Other findings – information technology

This section provides an overview of results from our assessment of information technology (IT) environment and controls which included identifying risks from the use of IT related to business process controls relevant to the financial audit. This includes an overall IT general control (ITGC) rating per IT system and details of the ratings assigned to individual control areas. For further detail of the IT audit scope and findings please see separate 'IT Audit Findings' report.

			ITGC control area rating			
IT application	Level of assessment performed	Overall ITGC rating	Security management	Technology acquisition, development and maintenance	Technology infrastructure	Related significant risks/other risks
Oracle	ITGC assessment (design and implementation effectiveness only)	●	●	●	●	We identified two significant control findings relating to the ITGC procedures, in addition to two points brought forwards from the prior year. Our findings can be found in Appendix B. We have also provided management with our detailed report which provides the detail of the full findings from our work. In response to issues identified, we have undertaken additional work and testing of Journals posted by accounts deemed as having inappropriate security access/user rights. No issues were identified from this work.

Assessment

- ● Significant deficiencies identified in IT controls relevant to the audit of financial statements
- ● Non-significant deficiencies identified in IT controls relevant to the audit of financial statements/significant deficiencies identified but with sufficient mitigation of relevant risk
- ● IT controls relevant to the audit of financial statements judged to be effective at the level of testing in scope
- ● Not in scope for testing

Other findings

Matter	Commentary	Auditor view
Service Auditor Reports		
Under ISA 315R, auditors are required to understand and assess relevant internal controls of the systems relevant to the preparation of financial statements. This includes systems provided by service organisations. An independent auditor produces a service auditor report to provide management with assurance over the internal control environment of the system they use and as external auditors we review these service auditor reports when undertaking our work. The following systems used by the Trust are provided by service organisations. The data from these systems are relevant to preparation of financial statements of the Trust. • The Electronic Staff Record Programme (ESR)	NHS Business Services Authority and IBM UK Limited: The Electronic Staff Record Programme The audit team have reviewed the ISAE 3000 Audit Type II service auditor report which assesses the design and operating effectiveness of controls of the ESR system provided by NHS Business Services Authority for period 1 April 2025 to 31 March 2026. This report noted no significant findings and concluded an unmodified opinion. We reviewed this report as part of our risk assessment and our testing of design and implementation of relevant controls at the Trust.	Assurance has been gained over the design and implementation over the controls at the service organisations for the below systems: • The Electronic Staff Record Programme (ESR) No control deficiencies were identified, and therefore there is no impact on our audit opinion.

Communication requirements

Issue	Commentary
Matters in relation to fraud	We have previously discussed the risk of fraud with the Audit and Risk Committee. We have not been made aware of any other incidents in the period and no other issues have been identified during the course of our audit procedure.
Matters in relation to related parties	We are not aware of any related parties or related party transactions which have not been disclosed
Matters in relation to laws and regulations	The Trust has kept us aware of any matters coming out of the Cyber attack in June 2024, this has included the latest communication with the Information Commissioner's Office (ICO). We can see per the correspondence that the Trust along with Kings College Hospital remains engaged in full with the ICO and any questions emerging from the cyber attack. From the communications shared with us there is no present indication from the ICO that the Trust is in breach of its relevant legal obligations. Internal audit identified weaknesses in pension auto-enrolment and opt-out processes, including missing documentation (SD502 forms) and the use of an automated process to opt out employees without appropriate authorisation. These issues have resulted in instances of non-compliance with NHS Business Services Authority (NHSBA) and The Pensions Regulator (TPR) requirements, with a potentially wider population of affected employees. Management has indicated that the overall risk is considered low, as employees who did not intend to opt out would likely have identified the issue through the absence of pension contributions and raised queries with HR; no such queries have been reported to date. There remains a risk of unreported non-compliance and completion of the ongoing review will be key. We have not been made aware of any other significant matters or are aware of any non-compliance with relevant laws and regulations and we have not identified any incidences from our audit work. Therefore, to date we have no matters to report in respect of this in our audit opinion.
Written representations	A letter of representation has been requested from the Trust which was presented at the Audit and Risk committee on the 17th June.
Accounting practices	We have evaluated the appropriateness of the Trust's accounting policies, accounting estimates and financial statement disclosures. A number of minor amendments were made to the accounting policies to enhance the transparency of the disclosures within the Accounts, which are set out in our audit adjustment slides.
Confirmation requests from third parties	We requested from management permission to send confirmation requests to the Trust's banking providers. This permission was granted and the requests were sent and have been received as part of our final accounts work. We requested management to send letters to those solicitors who worked with the Group during the period. Confirmations were received from all relevant parties.
Disclosures	Our review found no material omissions in the financial statements.
Audit evidence and explanations	All information and explanations requested from management was provided.

Other responsibilities

Issue	Commentary
Going concern	In performing our work on going concern, we have had reference to Statement of Recommended Practice – Practice Note 10: Audit of financial statements of public sector bodies in the United Kingdom (Revised 2024). The Financial Reporting Council recognises that for particular sectors, it may be necessary to clarify how auditing standards are applied to an entity in a manner that is relevant and provides useful information to the users of financial statements in that sector. Practice Note 10 provides that clarification for audits of public sector bodies. Practice Note 10 sets out the following key principles for the consideration of going concern for public sector entities: • the use of the going concern basis of accounting is not a matter of significant focus of the auditor's time and resources because the applicable financial reporting frameworks envisage that the going concern basis for accounting will apply where the entity's services will continue to be delivered by the public sector. In such cases, a material uncertainty related to going concern is unlikely to exist, and so a straightforward and standardised approach for the consideration of going concern will often be appropriate for public sector entities • for many public sector entities, the financial sustainability of the reporting entity and the services it provides is more likely to be of significant public interest than the application of the going concern basis of accounting. Our consideration of the Trust's financial sustainability is addressed by our value for money work, which is covered elsewhere in this report. Practice Note 10 states that if the financial reporting framework provides for the adoption of the going concern basis of accounting on the basis of the anticipated continuation of the provision of a service in the future, the auditor applies the continued provision of service approach set out in Practice Note 10. The financial reporting framework adopted by the Trust meets this criteria, and so we have applied the continued provision of service approach. In doing so, we have considered and evaluated: • the nature of the Group and Trust and the environment in which it operates • the Group and Trust's financial reporting framework • the Group and Trust's system of internal control for identifying events or conditions relevant to going concern • management's going concern assessment. On the basis of this work, we have obtained sufficient appropriate audit evidence to enable us to conclude that: • a material uncertainty related to going concern has not been identified; and • management's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Other statutory powers and duties

Issue	Commentary
Other information	We are required to give an opinion on whether the other information published together with the audited financial statements (including the Annual Report), is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated as per ISA720- The Auditor's Responsibilities Relating to Other Information. We have received the full report and completed our review, with no inconsistencies identified. We plan to issue an unmodified opinion in this respect - refer to Appendix E.
Auditable elements of Remuneration Report and Staff Report	We are required to give an opinion on whether the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the requirements of the Act, directed by the Secretary of State with the consent of the Treasury. We have audited the elements of the Remuneration Report and Staff Report, including the Fair Pay Multiple Disclosures, have been properly prepared in accordance with the FT ARM, as required by the code, and have identified a number of small amendments which are in the process of being reviewed and updated by the Trust in the reports. We propose to issue an unqualified opinion on this.
Referral to NHS England	Under Schedule 10 paragraph 6 of the National Health Service Act 2006, auditors can report to the relevant regulatory body if they have reason to believe that the audited body is: • about to make, or has made, a decision which would involve unlawful expenditure • about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency. We did not make any referral to the regulator.

Other responsibilities under the Code

Issue	Commentary
Matters on which we report by exception	We are required to report on matters by exception in several areas: • the Annual Governance Statement does not comply with guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit; • the information in the annual report is materially inconsistent with the information in the audited financial statements or is apparently materially incorrect based on, or is materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit, or otherwise misleading; • if we have applied any of our statutory powers or duties; or • where we are not satisfied in respect of arrangements to secure value for money and have reported significant weaknesses. We have nothing to report on these matters.
Review of accounts consolidation schedules and specified procedures on behalf of the group auditor	We are required to give a separate statement on the Trust accounts consolidation schedules and to carry out specified procedures (on behalf of the NAO) on these schedules under group audit instructions. In the group audit instructions, the Trust was selected as a sampled component. We have nothing to report on these matters.
Certification of the closure of the audit	We cannot formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2026 in accordance with the requirements of the NHS Act 2006 until the National Audit Office has concluded their work in respect of consolidation returns for the year ended 31 March 2026. This work will not be complete until after the completion of our financial statement's opinion, as the NAO, under ISA 600, has requirements to undertake a greater level of review of component auditors' work. As this is the second year of implementation of the standard, and given the work is being undertaken by another auditor, timing remains subject to the completion of their procedures. The Trust has been selected as a sampled component, which requires a greater level of detail in the procedures to be performed from us in this work.

Audit adjustments

We are required to report all non-trivial misstatements to those charged with governance, whether or not the accounts have been adjusted by management.

Impact of unadjusted misstatements

The table below provides details of adjustments identified during the audit which have not been made within the final set of financial statements. The Audit Committee is required to approve management's proposed treatment of all items recorded within the table below.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on net deficit £'000	Reason for not adjusting
A balance of £17,453k relating to NHS/WGA counterparties has been incorrectly recognised as an ECL allowance within receivables, contrary to IFRS 9 and GAM, which do not permit impairment on low credit risk balances. The Statement of Comprehensive Income impact is £2,516k, representing the movement in the provision.	Expenditure (2,516)	ECL Allowance 17,453 Reserves (14,937)	(2,516)	Management has not adjusted the balance as it reflects standard NHS practice, where debtor balances with NHS and other WGA bodies may include disputed amounts
Overall impact	(2,516)	2,516	(2,516)	

Audit adjustments

We are required to report all non-trivial misstatements to those charged with governance, whether or not the accounts have been adjusted by management.

Misclassification and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

Disclosure	Misclassification or change identified	Adjusted?
Statement of cash flows	Discontinued operations are presented in the Statement of Comprehensive Income; however, the related cash flows are not separately disclosed in the Statement of Cash Flows as required by IFRS 5. This limits users' ability to understand the cash flow impact of discontinued operations.	X
Throughout	A number of immaterial accounting policies and disclosures have been included in the financial statements. These should be removed to avoid obscuring material information within the financial statements.	X
Note 1.3 Revenue from Contracts with Customers	Enhance revenue accounting policy disclosures to clarify how variable consideration is estimated and constrained, and to set out key judgements in applying IFRS 15, including the basis for recognising revenue over time or at a point in time.	X
Note 3.2 Income from patients care activities (by nature)	The disclosure of 'Other NHS clinical income' lacks clarity on the composition of the balance. Management has agreed to enhance the disclosure to provide a clearer breakdown, consistent with other notes.	✓
Note 6 Operating leases	A general description of the leasing arrangements should be disclosed. In addition, the Trust should disclose how it manages risk associated with any rights it retains in underlying assets	X
Note 6.2 Future lease receipts	Testing identified variances in 2 of 5 samples between the operating lease schedule and auditor recalculations. We have assessed the potential extrapolated misstatement (which relates to future lease receipt disclosures only) is £20.7m.	X
Note 7 Operating expenses	Statutory audit service reports that this includes fees for the audit of the subsidiaries. This line should be for fees payable to the external auditor for the Trust in respect of the audit of the group accounts only. Although the Trust has provided clarifying narrative in the footnote, the presentation within the disclosure remains inconsistent with presentation requirements.	X
Note 10 Discontinued Operations	The Trust has not provided sufficient disclosures in relation to the disposal of subsidiaries, as required under IAS 7. An enhancement to financial statement disclosures is required rather than a numerical adjustment.	✓
Note 14.2 Property, plant and equipment	Audit testing identified a delay in the reclassification of completed assets (extrapolated misstatement of £19.5m), resulting in overstatement of AuC and understatement of PPE. This arose from the delays in the timely provision of information between project managers and the capital accounting team. Reclassifications near year-end also created timing differences between the FAR and Oracle Fusion, leading to reconciliation discrepancies and a disclosure misstatement.	X

Audit adjustments

Disclosure	Misclassification or change identified	Adjusted?
Note 23.1 Trade and Other receivables	A reclassification has been identified between "Capital receivables" and "Other receivables" for prior year comparatives, resulting in £8,964k difference compared to the audited prior year financial statements. However, this is to ensure appropriate cash flow presentation, avoiding incorrect classification as proceeds from PPE disposals.	✓
Note 23.1 Trade and Other receivables	The note is missing the disclosure for "of which receivable from NHS and DHSC group bodies" (current/non current).	✓
Note 30 Related Party Transactions	Management has identified and updated the prior year comparative, revising Note 30 from invoiced to accrued spend. In addition, Synnovis income and expenditure, omitted in the prior year, has been included in the current year as a related party disclosure, improving completeness of disclosure note.	✓
Other financial commitment	The Trust did not disclose the other financial commitments analysis by the following period 1) not later than one year, 2) later than one year and not later than five years, 3) later than five years. It is not requested under NHS accounting template, but mentioned under GAM 5.232. Hence, auditor raised the recommendation point for the trust to disclose in the next FY.	X
Remuneration report	We identified some disclosure enhancements which management have implemented to ensure clarity of the remuneration report.	✓
Remuneration report disclosures	We identified some areas where the Trust could improve its remuneration report disclosures, which we will discuss further as part of the preparation for the 2026/27 audit. • The Trust currently prepares the fair pay disclosure without including taxable benefits received. While we do not consider management's approach inappropriate, we note that it is not fully consistent with the disclosure requirements under FT ARM 2.99. • The Trust's calculation of the year-on-year percentage change in average employee remuneration was based on the total number of employees rather than the full-time equivalent employees (FTE) which is inconsistent with FT ARM 2.91. • The Trust discloses that some senior officers' salaries include an element of remuneration in relation to clinical roles. The Trust should consider improvements to this disclosure by referencing the element of remuneration that relates to the clinical role.	To review in 2026/27
Disclosure points to address 2026/27	Note 2 – Disclosure of segmental reporting. Note 24.6 – Inclusion of disclosures in respect of the prior year values Note 30 – Expansion of note to include specific names of public sector entities and other changes to improve disclosures to ensure improved compliance with IAS24	To review in 2026/27

Impact of unadjusted misstatements in the prior year

Where there are unadjusted misstatements identified in the prior year impacting current year opening balances, set these out here.

These were reported in the prior year and are not material but are matters we do consider in our current year position we are pleased to note the current year misstatements are much lower in value compared to the prior year position.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on net surplus/deficit £'000	Reason for not adjusting
Lexica Health Sciences was held for sale at year end (FY 2024/25) and disposed of post year end. In line with IFRS 5, its results and balances should be presented as discontinued operations and held for sale. SOCI: £10.1m income and £9.5m expenditure reclassified to discontinued operations. SOFP: £6.9m of assets (mainly receivables and cash) reclassified to assets held for sale, and £1.4m of liabilities (mainly payables) to liabilities held for sale.	Other operating income 10,140 Discontinued Income Services (10,140) Discontinued service expenditure 9,542 Operating expenditure (9,542)	Assets Held For Sale 6,948 Cash (3,034) Receivables (3,607) Other asset (847) Trade Payables 1,418 Other liability 14 Liabilities Held for Sale (1,432)	Nil impact on surplus or deficit reclassification only	There is no impact on net assets or underlying performance, and the adjustment relates to compliance with IFRS 5 presentation requirements rather than measurement.
Overall impact	NIL	NIL	NIL	

- From our review of the Trust's ledger and discussions with the Income team, we found that £3.9m of income was recognised in the 2025-26 financial year that had been understated in the prior year. From our review of this matter, we noted the Trust were not aware or notified at the year end that this income was expected, therefore it would not have been appropriate in 2025-26 to have recongised this. The movement represents a 0.14% change in patient care income from the prior year.
- Given the balance is not material and the Trust were not aware of it in the 2025-26 year we are satisfied no prior adjustments are required in relation to this matter.

Value for Money arrangements

Approach to Value for Money work for the year ended 31 March 2026

The National Audit Office issued its latest Value for Money guidance to auditors in March 2026. The Code requires auditors to consider whether a body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In undertaking our work, we are required to have regard to three specified reporting criteria. These are as set out below.

Financial sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services.

Governance

How the body ensures that it makes informed decisions and properly manages its risks.

Improving economy, efficiency and effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services.

In undertaking this work we have not identified any significant weaknesses in arrangements. Our Auditor's Annual Report accompanies this Audit Findings Report as issued. The summary outcome table is included within the Auditor's Annual Report (AAR). Please refer to AAR for details.

Independence considerations – Grant Thornton UK and Cinven Transaction

Ethical Standards and ISA (UK) 260 require us to give you timely disclosure of all significant matters that may bear upon the integrity, objectivity and independence of the firm or covered persons (including its partners, senior managers, managers and network firms). In this context, we disclose the following, as previously disclosed this same information in the Indicative Audit Plan, as presented to the Audit and Risk Committee but include in our Audit Findings report. We noted to the Audit and Risk Committee details of how we have undertaken reviews and put in place steps relating to independence matters associated with this. We have deemed it important to include this detail in our Audit Findings report for transparency and completeness purposes.

GTUK's investment from Cinven (the Private Equity Group) Independence

In 2025, GTUK group received a strategic investment from Cinven Private equity.

The Trust has a JV partnership with a majority owned portfolio entity of Cinven, Synlab. The Trust is bringing a financial compensation claim against the JV investment entity and the portfolio entity of Cinven

During the 2025 audit GTUK completed an auditor independence assessment as to whether their investor relationship with Cinven caused their independence to be impaired in respect of the audit of the Trusts and responsibilities around Value for Money (VFM) reporting and presented this to the audit committee. We have updated our assessment for the 2026 audit.

We have concluded consistently with the prior year that we do not consider our independence to be impaired. To safeguard any perception threat, we will continue to use a Safeguarding partner on the audit of the Trusts, it is anticipated that their role would be high level in nature

Independence considerations

We confirm that we have implemented policies and procedures to meet the requirement of the Financial Reporting Council's Ethical Standard.

Further, we have complied with the requirements of the National Audit Office's Auditor Guidance Note 01 issued in February 2025 which sets out supplementary guidance on ethical requirements for auditors of local public bodies.

As part of our assessment of our independence we note the following matters:

Matter	Conclusion
Relationships with Grant Thornton	We are not aware of any relationships between Grant Thornton and the Trust that may reasonably be thought to bear on our integrity, independence and objectivity.
Employment of Grant Thornton staff	We are not aware of any former Grant Thornton partners or staff being employed, or holding discussions in respect of employment, by the Trust as a director or in a senior management role covering financial, accounting or control related areas.
Business relationships	We have not identified any business relationships between Grant Thornton and the Trust.
Gifts and hospitality	We have not identified any gifts or hospitality provided to, or received from, a member of the Trust's/Group's board, senior management or staff that would exceed the threshold set in the Ethical Standard.

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention and consider that an objective reasonable and informed third party would take the same view.

The firm and each covered person (and network firms) have complied with the Financial Reporting Council's Ethical Standard and confirm that we are independent and are able to express an objective opinion on the financial statements.

We have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. No non-audit services were identified which were charged from the beginning of the financial period to the current date. Details of fees charged are set out on the following page.

Fees and non-audit services

We confirm below our final fee (exclusive of VAT) and confirm there were no fees for the provision of non-audit services.

For the purposes of our audit we have made enquiries of all Grant Thornton teams within the Grant Thornton International Limited network member firms providing services to Guy's and St Thomas' NHS Foundation Trust. We have adequate safeguards in place to mitigate the perceived self-interest threat from these fees.

Audit fees

Audit of Trust (includes £5k fee due to the Trust being selected as a sampled component)	£363,400
Subsidiary Audits	£56,220
Total	£419,620

The above fees are exclusive of VAT and out of pocket expenses.

The fees reconcile to the financial statements as follows:

- fees per financial statements £415k
- Fee for WGA / NAO review* £5k
- Total fees per above £420k

After accounting for the above, the fees reconcile to the financial statements noting a trivial rounding difference

This covers all services provided by us and our network to the Trust, its directors and senior management and its affiliates, that may reasonably be thought to bear on our integrity, objectivity or independence.

11 Appendices

A. Communication of audit matters with those charged with governance

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	●	
Overview of the planned scope and timing of the audit, form, timing and expected general content of communications including significant risks	●	
Planned use of internal audit	●	
Confirmation of independence and objectivity	●	●
A statement that we have complied with relevant ethical requirements regarding independence. Relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged. Details of safeguards applied to threats to independence	●	●
Significant matters in relation to going concern	●	●
Significant matters in relation to going concern	●	●
Views about the qualitative aspects of the Group's accounting and financial reporting practices including accounting policies, accounting estimates and financial statement disclosures		●
Significant findings from the audit		●
Significant matters and issue arising during the audit and written representations that have been sought		●
Significant difficulties encountered during the audit		●
Significant deficiencies in internal control identified during the audit		●
Significant matters arising in connection with related parties		●
Identification or suspicion of fraud involving management and/or which results in material misstatement of the financial statements		●
Non-compliance with laws and regulations		●
Unadjusted misstatements and material disclosure omissions		●
Expected modifications to the auditor's report, or emphasis of matter		●

ISA (UK) 260, as well as other ISAs (UK), prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table here.

This document, the Audit Findings, outlines those key issues, findings and other matters arising from the audit, which we consider should be communicated in writing rather than orally, together with an explanation as to how these have been resolved.

Respective responsibilities

As auditor we are responsible for performing the audit in accordance with ISAs (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance.

The audit of the financial statements does not relieve management or those charged with governance of their responsibilities.

Distribution of this Audit Findings report

Whilst we seek to ensure our audit findings are distributed to those individuals charged with governance, as a minimum a requirement exists for our findings to be distributed to those charged with governance and those members of senior management with significant operational and strategic responsibilities. We are grateful for your specific consideration and onward distribution of our report, to those charged with governance.

B. Action plan

We set out here our recommendations for the Trust which we have identified as a result of issues identified during our audit. The matters reported here are limited to those deficiencies that we have identified during the course of our audit and that we have concluded are of sufficient importance to merit being reported to you in accordance with auditing standards.

Assessment	Issue and risk	Recommendation
Medium	**Inventory Control** A control deficiency was identified in Omnicell stock cabinets (notably at Olive Ward), where discrepancies between system and physical stock indicated weaknesses in stock recording. This gives risk to a risk that the Inventory records may be inaccurate, leading to misstatement of balances and potential patient safety impacts. While we are aware management has implemented remedial actions (cycle counts, supervision, staff reminders); continued monitoring is required to ensure consistent application.	Management should strengthen controls over stock cabinet inventory by ensuring mandatory and enforced real-time recording of all stock movements, regular independent cycle counts with supervisory review and documented sign-off and ongoing monitoring of discrepancies, with timely investigation and resolution. **Management response** • All stock movements are captured via the Omnicell standard operating procedures for replenishing and dispensing. SOP's have been reviewed and are up to date. Training has been refreshed for Supply Chain Colleagues, and Online Omnicell training will be rolled out to all end users from September 2026. Non-compliance by end users is monitored weekly and a report submitted to the areas lead to be addressed accordingly. • Cycle counts are completed throughout the month to ensure every cabinet is counted every month, a supervisor spot check and audit will be conducted randomly once a week. • The discrepancy investigation process is in place and these are cleared daily. For discrepancies found during cycle count audits these are rectified at source immediately, with the wider corrective actions completed with the individuals concerned

Assessment

- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

B. Action plan (continued)

Assessment	Issue and risk	
Medium	**Lease Contract Management and Monitoring** Through testing of operating leases, it was noted that one lease contract expired in December 2022 and remains under renewal, with the lessee continuing to occupy the property and make rental payments. While central lease listings are maintained and subject to periodic review, this highlights that not all lease agreements are formalised on a timely basis. This gives rise to potential legal, financial reporting, and control risks due to reliance on informal arrangements. There is also scope to strengthen processes around linkage to ledger coding and alignment with financial reporting disclosures.	**Recommendation** Management should strengthen lease management controls by ensuring that all lease agreements are reviewed and formally renewed on a timely basis. This should include enhanced monitoring of lease expiry dates through central listings, with clear ownership and escalation processes for leases nearing expiry to support effective monitoring and accurate financial reporting. **Management response** The Trust maintains and regularly reviews a schedule of lease agreements, where GSTT is the lessor. We acknowledge that occasionally lease negotiations may take extended periods of time, however progress is tracked and monitored throughout, involving lawyers at different stages in the negotiation process. We will continue to review our existing processes around lease management and where appropriate look to strengthen controls.
Low	**Accrual Apportionment Process** Our accrual testing identified that, accruals were calculated on a monthly basis rather than using a daily apportionment. This results in less precise estimation of expenditure, as the accrued amounts do not fully reflect the exact period to which the costs relate. While the resulting variances are not material, this indicates that accruals are not consistently calculated using the most accurate methodology, leading to minor differences in the recorded payable balances. The use of monthly apportionment reduces the precision of expenditure recognition and may result in small timing differences between the period in which costs are incurred and recognised.	**Recommendation** Management should standardise the accrual methodology to apply daily apportionment where appropriate, to improve the accuracy of expenditure recognition and ensure consistency across the Trust's accrual calculations. **Management response** We will review the relevant accrual methodologies, and where appropriate amend calculations to reflect a daily apportionment.

Assessment
- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

B. Action plan (continued)

Assessment	Issue and risk	
Low	**Intangible asset review** During our impairment review, we noted that management's assessment of intangible assets has been limited to assets with nil net book value that are over 10 years old. The Trust has not yet completed a detailed asset-level review of intangible assets. While management has indicated that a review is planned for FY 2026/27, this represents a control deficiency in the current year. There is a risk that intangible assets are not appropriately assessed for continued use, useful economic life, or impairment on a timely basis. This may result in overstatement of asset values or inappropriate amortisation charges in the financial statements.	**Recommendation** Management should undertake a detailed asset-level review of intangible assets on at least an annual basis, including assessment of continued use, useful economic life, and impairment indicators, with appropriate documentation and review controls in place. **Management response** We will enhance our existing year-end procedures, by introducing a structured 'asset-level' review of intangibles assets to ensure that assessments and supporting documentation are appropriately completed and subject to oversight. This review will confirm continued use, assess useful economic lives, and consider any indicators of impairment, with outcomes documented through our established reporting processes.

Assessment
- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

C. Follow up of prior year recommendations

We identified the following issues in the audit of the Trust's 2024/25 financial statements, which resulted in 14 recommendations being reported in our 2024/25 Audit Findings Report. To date, 5 recommendations have been closed, with the remaining matters still outstanding.

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
In progress	**Unsigned API contracts** During our FY24/25 income testing of API contracts, we encountered difficulties in obtaining signed contracts. This issue has become increasingly prevalent since the Covid pandemic and has persisted thereafter. NHSE has indicated that they expect all contracts to be signed by both parties prior to the year-end. However, in our audit testing, we identified a number of Contracts that had not been signed by both parties. Whilst the contract with the Trust's main commissioner, SEL ICB and the Contract Variation for NHSE were signed, a number of others had not been. In addition, for several of the contracts provided, the values did not reconcile with the payments or the ledger, as they were based on earlier versions that did not account for inflationary adjustments made in accordance with central guidance. The absence of formal documentation for key contracts is not deemed appropriate. While we recognise that this is a widespread issue across the NHS and that commissioners also contribute to this situation, it results in additional audit work required to verify the balances and raises concerns about the actions taken when disputes arise. The Trust per NHSE requirements has a requirement to split contracted income out per the PFR requirements. This is made challenging by commissioners paying lump sums each month via remittances. With payments including multiple elements that then require splitting out. The Trust has manual processes to record this but it is not coded from the Trial balance and this creates the risk of error.	Following prior year findings, management has taken steps to improve the availability and status of signed contracts. This has resulted in some improvement during the year, with key contracts now formalised and a reduction in the number of unsigned agreements. However, based on current year testing, 3 out of 16 contracts remain unsigned, indicating that further progress is required to fully address the issue. Management continues to engage with commissioners to obtain formalised agreements in line with NHSE expectations that contracts should be agreed and signed prior to year end. In addition, while processes for allocating income in line with PFR requirements have been maintained, these continue to rely on manual adjustments, and further work is ongoing to enhance controls and reduce the risk of error in classification and reporting. **Recommendation** We recommend that the Trust continue to engage with commissioners to formalise contract arrangements for future years. While we observed an increase in the number of contracts available this year compared to the previous year, it still did not meet the expectations set out by NHSE. The Trust should review its process for recording income classification splits in line with NHSE/PFR requirements. The process would be strengthened by having a greater link between the Trial balance codes and the PFR categories. **Management update** A revised 2024/25 signatory page has been issued to Kent ICB and is awaiting signature . Work continues to ensure the Sussex ICB contract is signed off.

Assessment
- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
In progress – Partially addressed	**Oracle Fusion** Since the implementation of Oracle Fusion, we have noted in our reports that the ledger will often post unusual entries in the same Journals of invoice values. This will result in invoices with a much lower value having significant debit and credit postings in the ledger. In 2024/25 we noted the activity of this had increased further and we tested the 5 largest invoice postings we found relating to this in the ledger. These 5 invoices had total gross postings into the ledger that came to over £143 trillion. Due to the size of these balances, we undertook a review of this matter with the Accounts payable team and finance systems. It was noted that the process for matching PO details may be incorrect due to: – The scanner appears to have misread the invoice, mistaking the VAT amount on invoices for the quantity of the item and then multiplying the VAT amount against the PO value, resulting in these large postings. – Errors where a team member had created a quantity purchase order, instead of a price purchase order. This is an error caused by the PO requisitioner and is correctly being identified by the system but resulting in very large postings into the ledger. We are satisfied from the system that the controls in place ensure when the invoice does not match the expected value the system creates from the Purchase order these are then put on hold. These are then subsequently reviewed by the Accounts Payable team and corrected. This has meant no fails have been identified in our work.	We still noticed significant amount of gross posting into the ledger as compared to the actual net amount recognised in the financial statement. This is observed in our additions testing and non-pay operating expenditure testing. Due to this recommendation, we understand we would need to look at the transaction using the invoice number or accounting document name instead. This gives the net value of the reference rather than all the figures that net of against one another. We have sampled from these values and then having selected the samples. We can also ensure we are clear on the VAT treatment as all lines related to each invoice are numerically captured in our sample. This mitigates the risk of picking up very high value items posted by Oracle (often in the billions), that net to invoice amounts in the thousands. Although the entry might have been reduced, there are still unusual entries with the same Journals of invoice values in the ledger. **Recommendation** The issue from our review appears to have two causes. Firstly, an issue around errors in the requisition of quantity purchase orders. This issue should be rectified via training, and we note the Trust is pro-actively doing this via lunch and learn session's with staff. We note the Trust may also seek to have further controls for when they identify errors in the PO process. With more detailed follow up training when these issues are identified with the relevant staff members. Secondly from the review undertaken there appears to be an issue around the scanning of some invoices. This results in the system misreading columns and taking the VAT value in some instances as the quantity. We would recommend the system team further review this issue and undertake testing to fully understand the cause of the issue. **Management update** The incidence is reduced in the 2025/26 accounts.

Assessment
- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
● Closed	**Balancing figures in the Trust and Group's Cash Flow Statement** This recommendation was raised in the 2020-21 and was also present in the 2021-22, 2022-23 and 2023-24 financial years. Through our work on the Cash Flow statement, it was identified that the line "other movements in operating cash flows", is effectively a balancing figure for the statement in 2021-22. This was again the case in the two prior years. In 2024/25 the balancing figure has reduced to £2,351k for the Group and is £1,594k for the Trust. Based on discussions with management the issues link to non cash adjustments passing through operating expenditure for fair value adjustments of the Synlab Debtor and Leases. Whilst there is no impact on the bottom line, we note that the Cash Flow Statement is a prime statement, and it is important for the Trust to understand fully movements in their Cash position for the year. If the Trust's finance team have large movements, they cannot explain this creates risks regarding future cash flow forecasts. It also creates a risk regarding possible misappropriation of the balance, if movements cannot be traced within it.	As part of our FY2025/26 Cash Flow statement review, we noted a manual value of £327k disclosed in 'Other movements in Operating Cash Flows' relating to a balancing figure. Although the amount has reduced as compared to prior year, it is not in line with generally accepted accounting principles. However, given the trivial value, we are satisfied to close this recommendation. **Recommendation** We recommend management seek to gain more precise controls in ensuring all lease payments are captured, this is to ensure significant reconciling items in the Cash flow statement do not persist. Management should seek to reconcile this difference to the causes of it so these adjustments can then be reflected in the Cash flow statement with no reconciling figures used. **Management update** The entry is reduced in the 2025/26 accounts.

Assessment
- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
In progress – partially addressed	**Timely billing and payments with Trusts work in partnership with** The Trust continues to work closely with Kings College London and Kings College Hospital. In our review in FY2024/25 of the Agreement of balances exercise and review of payables and receivables we identified a number of old balances relating to these arrangements and mismatches. From our other procedures such as the agreement of balances exercise, there are often disagreements relating to the balances owed. We note that we have found evidence from both sides of the arrangement in our testing that billing could be done in a prompter more formal manner. This informal working arrangement can lead to disputes in relation to liabilities with partners within the arrangement and potentially the failure to correctly allocate costs between the partnership arrangements in place.	From our review, there remained a number of old balances with these bodies: • In receivables, Kings College London had an outstanding balance of £16.3m, the average age of the invoices was 396 days • In payables, Kings College London had an outstanding balance of £16.5m, over three months overdue of £10.8m. Unallocated amount of £1.4m • In payables, Kings College Hospital had an outstanding balance of £8.8m, of which £7.7m unallocated amount. Our review of Agreements of Balances identified variances with King's College Hospital. Mismatches in excess of the NAO threshold of £1m remained following the second submission; however, these were understood, and the receivables balance is expected to be resolved by KCH updating their balances. **Recommendation** The Trust should ensure clearer agreements and more prompt billing for work within the activities that it works with Kings College London and Kings College Hospital are in place. **Management update** During the year the Trust has worked closely with KCH to ensure that respective debtors and creditor positions are carefully managed and monitored. This will continue throughout 26-27 and is considered business-as-usual. KCL do not participate in the Agreement of balances exercise but work is continuing with KCL teams to review creditor and debtor positions and progress invoices to payment.

Assessment
- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
Closed	**Operating segments** Although from our work we are satisfied the Trust does not currently report on a segmental basis and deem the current year's disclosure appropriate. However, given the Trust's size and the fact the Trust has five distinct clinical groups, the size of some of these Groups individually being larger than other NHS Trust's, it is our view that management should consider reporting on a segmental basis going forwards. In our view this would provide the reader of the accounts more meaningful information about the Trust's in year financial performance. Given the size of the Trust the lack of segmental reporting reduces the level of transparency and oversight that can be gained to those reviewing the accounts.	The Trust continues to present healthcare as a single operating segment, consistent with prior years and peer practice, and this is technically compliant with IFRS 8. However, reporting by division would enhance transparency and provide greater insight for users, in line with the NHSE template and practice at a number of NHS trusts. As the matter has been highlighted for management's consideration within the audit adjustment slide for future reporting periods, we have closed this recommendation. **Recommendation** We recommend that management considers implementing segmental reporting going forward to enhance transparency, as it represents best practice and provides greater clarity over performance across different service areas. **Management update** Closed. The Trust presented a paper and rationale for the suggested operating segment disclosure to the February 2026 Audit Committee. This was discussed and accepted as an approach for 25-26. Operating segment disclosures are reviewed annually with the Audit Committee and the appropriateness of the disclosure will be re-assessed as part of 26-27 planning.
Closed	**Raising of Expected Credit Loss Allowances against NHS Receivables** Per the GAM this practise is not permitted as credit loss allowances should only be raised against entities that are likely to default on future payments per IFRS 9. Although we accept the Trust does this for commercial reasons within the Agreement of balance exercise and the value is not material, this is not deemed best practise. **Risk** The Trust is failing to fully comply with the GAM in relation to the treatment of these balances.	Our review of the expected credit loss allowance identified that provisions of £17.5m continue to be recognised against NHS and other WGA balances. While management has undertaken a review of the credit loss allowance, this treatment is not fully aligned with the NHS GAM, which generally restricts the recognition of expected credit losses on intra-government balances. As this matter has been reflected within the current year audit adjustments, we have closed this recommendation. **Recommendation** The Trust should not raise expected credit loss allowances against NHS receivables. **Management update** The outstanding debt has been considered at risk on the basis of historical trend and current debt recovery attempts, and therefore a provision for non-payment has been deemed appropriate. A review of the credit loss allowance was covered in the February 2026 ARC meeting.

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
Closed	**Identification of Related Parties** Per IAS 24 related parties should only be disclosed if the individual meets the criteria of having control within the related party. Upon review of the Trust's current disclosure it is not clear if each interest held that is disclosed would meet these criteria. The Trust note for transparency reasons they prefer to disclose all interests held within the note. However this is not compliant with IAS24 and the requirement to direct or disclose the readers to these interests is included within the Annual report separately. **Risk** The Trust is failing to fully comply with IAS 24 in relation to the related parties note	We have assessed whether related party relationships arise from board members' interests and found no additional disclosures required under GAM and IAS 24. While management has enhanced the assessment process, additional disclosure has been included for transparency which is not fully aligned with IAS 24. As this matter has been reflected within the current year audit adjustments, we have closed this recommendation. **Recommendation** We note management have improved arrangements in undertaking a more detailed assessment but due to transparency reasons continue not to comply with IAS 24 in this area. **Management update** The Trust has reviewed the current disclosures and consider them appropriate. The appropriateness of the disclosure will continue to be reviewed as part of 26-27 planning.
In progress	**Fully depreciated Assets** Within the prior year we identified a number of assets were fully depreciated, with a nil Net Book value. **Risk** The Trust's PPE assets and useful lives for these capital costs could be understated and not reflect the accurate value for the assets effected.	Review of the asset listing identified fully depreciated assets with a gross cost of £144m remaining on the balance sheet, including material balances within plant and machinery (£77.6m), IT equipment, and internally generated assets. Management has updated the useful economic life (UEL) for new plant and machinery assets in-year, increasing the maximum UEL from 20 years to 30 years. However, the UEL of existing depreciable assets has not been reassessed, increasing the risk that the assets will continue to be used beyond their depreciated life. Although no material misstatement identified, this highlights a control weakness in asset lifecycle management and supports the need for more robust and timely asset review and reassessment procedures. **Recommendation** Management should perform a comprehensive review of existing assets, reassessing their useful economic lives where appropriate to ensure depreciation policies are applied consistently and reflect actual asset usage. **Management update** We will review our approach towards useful economic life remeasurement for existing assets and ensure that significant adjustments are captured and implemented.

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
In progress – will be re-reviewed next year to determine if delays continue	**Cut off in relation to the recognition of Right of Use assets and the Completion of Assets Under construction** During FY24/25 audit, we conducted testing on Assets Under Construction that were reclassified as having been brought into use, as well as on Additions to Right of Use assets. Our testing revealed 4 number of points. While the Capital team were aware of this issue, they had taken the approach that they would not reflect these movements until completion certificates or formal leases were fully certified. This is not compliant with the accounting standards. There was therefore a risk that, if this process continues, ether would be large misstatements in the presentation of the Property Plant and equipment note. This is a particular risk if the assets relate to those that are subject to revaluation, with the Trust not recognising capital charges in the correct year and in the year of bringing the asset into the register being double charged for these assets. This impacts the Trust's control total and can impact budget positions. With leases and assets that are brought into use it is key formal documentation such as formal leases and completion documents are completed promptly. Not doing so can create risks around the management and operation of these assets.	Our testing identified that delays in reclassifying Assets Under Construction to assets in use persist, as the Capital team continues to wait for formal completion certificates or leases before recognising transfers. While management has maintained regular engagement with relevant representatives from portfolio boards to monitor project progress, the current approach remains non-compliant with accounting standards and creates a risk of misstatement within PPE, including incorrect recognition of capital charges and potential impact on the Trust's control total. Similar cut-off issues were noted for right-of-use assets; however, management has introduced strengthened controls, including monthly cross-team meetings, which are expected to mitigate future risk. Prompt completion of supporting documentation remains critical to ensure accurate accounting treatment and effective asset management. **Recommendation:** The capital team needs to ensure the processes undertaken ensure updates to leases held and adjustments to assets are done so on a timely basis. If changes are known of, they should be made in the correct financial year. We would also recommend that greater control is taken to ensure completion statement and formal signed leases are formalised when these events take place. Finally, we would recommend the capital finance team prepare a reconciliation of the capital programme back to the Asset Under Construction assets in the Fixed Asset register. Ensuring all asset classes within the balance can be mapped back to the programme. The capital team should then track when capital projects are completed and ensure all relevant assets are updated on a timely basis. **Management update** Completed – regular engagement with relevant representatives from portfolio boards.

Assessment
- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
Closed	**Historic Management of old assets held in Plant and Machinery and IT Hardware** In our review of Disposals in 2022-23, we noted the Trust had undertaken an exercise to identify historical assets to determine if they were still in use. As part of this exercise it was identified that assets with a cost of £7.99m could not be located. All these assets had an age greater than 10 years and we have not identified issues locating other assets in our work. However, this raises concerns about the management of historic assets. **Risk** The above issue highlights potential weaknesses in how assets are managed in particularly given the number of sites the Trust has. We note this creates the risk of misappropriation of assets, inefficient allocation of assets across sites and other risks associated with the capital management of assets. We note this is a particular risk given the challenging CDEL budgets the Trust has, with the financial management of capital being a key operational objective.	Upon reviewing the May 2026 Internal Audit progress report for the issue raised relating to IT devices, we noted that this issue has not yet been implemented or closed. However, as this matter is being actively tracked through Internal Audit, we have therefore closed this finding. **Recommendation** We recommend that management review the findings of the recent Internal Audit report and ensure that a clear action plan is developed and implemented to address the outstanding issue relating to IT devices. Progress against the action plan should be monitored, with all actions fully implemented, appropriately evidenced, and tracked through to timely formal closure of the finding. **Management update** We will review the findings of the recent internal audit report and ensure that an action plan is developed and implemented.

Assessment
- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
In progress	**IT - Users with sensitive / elevated system privileges and segregation of duty conflicts in Oracle Fusion** During the review of privileged user accesses within Oracle Fusion, we noted that 5 users from Finance System Support Team have access to sensitive / elevated privileges. This included 'Application Implementation' related roles assigned to users when Oracle Fusion is first implemented, allowing the application to be configured as required. Each of the Application Implementation roles allows the user assigned with this role to make changes to the Oracle Fusion system configuration with differing levels of access. All 5 accounts identified above also have the 'IT Security Manager' or 'Application Administrator' role assigned to them. The administrative privileges along with application implementation related roles creates an IT segregation of duties conflict. We undertook additional testing in our Journals work due to this issue, from the work performed no errors or misstatements were identified with the Journals posted by these Journal users. Assigning excessive privileged access roles increases the risk that system-enforced internal control mechanisms could be bypassed resulting in users being able to make unauthorised changes to system configuration parameters, create unauthorised accounts and make unauthorised updates to user account privileges.	The issue remains ongoing. Refer to the current year IT findings section for further detail. No significant changes in privileged access arrangements were identified during the year. Additional testing of journals posted by users with elevated access did not identify any errors or misstatements. We also identified instances of inadequate control over the self-assignment of roles within Oracle Fusion by privileged users, including for a vendor account and a Systems Manager. While improved from the prior year, this increases the risk of inappropriate access, segregation of duties conflicts, and the potential to bypass system controls. **Recommendation** Access should be based on the principle of least privilege and commensurate with job responsibilities. Management should define segregation of duty policies and processes and ensure that there is an understanding or roles, privileges assigned to those roles and where incompatible duties exist. It may be helpful to create matrices to provide an overview of the privileges assigned to roles. Management should adopt a risk-based approach to reassess the segregation of duty matrices on a periodic basis. This should consider whether the matrices continue to be appropriate or required updating to reflect changes within the business. Controls over privileged access should be strengthened by prohibiting self-assignment, requiring formal approvals, and performing regular reviews to ensure access remains appropriate and in line with the principle of least privilege. Appropriate audit trails of access requests and approvals should also be maintained. Perform a review of all users including Generic users and their access rights in Oracle Fusion and confirm if these align with their designated roles and responsibilities **Management update** The Trust recognise the concern raised regarding elevated privileges. The Finance Systems team requires certain administrative roles to perform essential duties; however, we will reassess these privileges and remove any that are not strictly necessary. The team has been reminded that a formal change request must be raised whenever privileges are required, and that self-assignment of job roles must not occur. Where access cannot be reduced without impacting our jobs roles, we will document the rationale. Access to these roles remains limited exclusively to the Finance Systems team.

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
In progress	**IT - Inadequate control over generic user accounts within Oracle Fusion** It was noted that the finance team member and third-party vendors, have access to Oracle Fusion through a generic admin accounts. For these accounts we were unable to evidence sufficient controls in relation to the passwords used for these generic accounts The generic user accounts has critical accesses as they have been assigned with 'Application Implementation' as well as 'Administrative Privileges', which allows user to create, modify and delete accesses & configurations within Oracle Fusion. User activity logs of the generic accounts are logged but they are not being monitored proactively. The use of generic or shared accounts with high-level privileges increases the risk of unauthorized or inappropriate changes to the application. Where unauthorized activities are performed, they will not be traceable to an individual.	During the current year review, we identified the use of generic administrator accounts within Oracle Fusion by both finance team members and third-party vendors. These accounts have elevated privileges, including application implementation and administrative access, which enables users to modify system configurations and user access. We noted control weaknesses, including limited monitoring of activity logs, and for certain accounts, passwords not being stored in a secure vault and instead managed manually. One account had no activity during the audit period, reducing immediate risk; however, overall the use of shared accounts with high-level access presents a segregation of duties and accountability risk. **Recommendation** Where possible, privileged/ generic accounts should be removed, and individuals should have their own uniquely identifiable user accounts created to ensure accountability for actions performed. With management ensuring appropriate password controls are in place regarding these accounts. Alternately, management should implement suitable controls to limit access and monitor the usage of these accounts (i.e. through increased use of password vault tools / logging and periodic monitoring of the activities performed). Where monitoring is undertaken this should be formally documented and recorded. **Management update** The Finance Systems team does not currently have access to a password vault, which is the reason for the existing arrangements for the accounts referenced. We recognise this is not ideal and will explore options to improve the security of shared credentials where feasible. The Omnicell account is used solely for integration purposes and is accessed by no more than two authorised individuals. What the account can do is restricted by the job roles the account has. For Version1, individual accounts are not technically possible due to the nature of the service model. This was discussed during the previous audit, and Version1 mitigates the associated risks through the use of a secure password vault. We remain mindful of the need to balance operational requirements with risk management and will continue to review this arrangement. Regarding the Sysadmin account, although it has not been used recently, maintaining this account is essential to ensure system administrators can regain access in the event of a lockout. The password is stored securely in a password-protected file and is accessible only to authorised personnel. We will review whether additional safeguards can be introduced to align more closely with best practice.

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
Not yet addressed	**IT - Absence of formal User Access Revocation Process in Oracle Fusion** Formal user management procedures have not been established to ensure consistent processes are followed for removing and reviewing user access. Due to this we were unable to assess this control as the client did not adequately provide the necessary documentation, data, and supporting evidence required to evaluate the effectiveness of this control. The reason for this issue is due to the number of users the Trust has on the system, due to the number of users with requisition access and this creates issues regarding ensuring compliance when staff members leave. **Risk** Inappropriate user access may result from having accounts left open of individuals who have left the organisation. Although we note the trust has mitigating controls these are manual and does not fully address this risk. We note following a recent Internal Audit report in May 2025, noted deficiencies in the Trust's IT Hardware Asset Management Policy. We discussed the impact of this finding with the Trust in relation to this recommendation. It was noted that the Oracle system has a single Windows sign on system which mitigates this risk. In addition the finance system also has a number of controls within it in relation to payments that those with access could not override.	A design control deficiency was identified in the user access revocation process, as there is no formal mechanism to ensure timely notification of leavers to the Finance Systems team. Access reviews are performed quarterly; however, this approach is not sufficiently timely. Data reconciliation identified that 78 leavers retained active access to Oracle Fusion, of which 19 users logged in after their leaving date, indicating a risk of unauthorised access. This highlights a weakness in the timeliness and effectiveness of access removal controls. **Recommendation** Management should ensure that comprehensive user administration procedures are in place to revoke application and AD access in a timely manner. For a user administration process to be effective, IT must be provided with timely notifications from HR and/ or line managers. Management should consider performing user access reviews on all terminated accounts to ensure all accounts have been disabled in a timely manner. Where old or unused accounts have been identified, these should be immediately revoked. We would also recommend management undertake penetrative checks regarding this and the deficiency highlighted by Internal audit in relation to devices. The Trust in doing this may wish to cover other systems as our understanding is this deficiency around user access revocation is not specific to Oracle Cloud. In 2024/25 our follow up noted that the finance systems team conducts ad-hoc checks of last logins of the users in Oracle. However there continues to be no formal communication process for Workforce to the Finance Systems Team of left users to support user deactivation. We do not consider this mitigating control sufficient. **Management update** Due to the lack of a trust-wide system for tracking leavers, we rely on several available tools to help identify users who have left the organisation. In some cases, individuals leave and later return under a different assignment number, or retire and subsequently rejoin, which means ESR reports are not always conclusive. We will continue to use multiple sources to validate leaver information and strengthen our processes wherever possible.

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
● Not yet addressed	**IT - Lack of evidence to test the design & implementation of controls over table changes & quarterly patch releases in Oracle Fusion** Our IT audit team noted that: • Critical Table Changes – The Trust's change process is in place with their support partners, Version 1 who have a formal process for initiating changes to the system. We therefore accept this is a low risk area, however, due to the relationship we were unable to undertake testing of this control being in place to demonstrate that critical table changes were appropriately approved & tested prior to implementation in production • Quarterly Patch Releases - GT noted that the relevant documentation, testing and approvals provided for the sample in some areas lacked as complete information as is considered best practise. Information regarding who completed the testing, the result of the testing and indications of approvals prior to implementation could not be fully observed. Change management testing prior to releasing the change into the production environment could lead to a loss of data integrity, processing integrity and/or system down-time. We were unable to fully observe this control in our audit procedures. A lack of consistent application of change management processes and controls could lead to a loss of data integrity, processing integrity and/or system down-time. Again we could not fully demonstrate this control was in place. This finding primarily reflects the fact we are unable to audit that this is being undertaken, we note from discussions with management the processes described as being in place are reasonable.	GT reviewed change logs for Oracle Fusion and identified a configuration change to the FND_PROFILE_OPTION_LEVELS table performed by the "versiononesupport" account on 19 June 2025, which falls within the FY25/26 audited period. However, no supporting evidence was provided to confirm that this change was formally requested, tested, and approved prior to deployment in the production environment. Hence, GT was unable confirm if these steps were performed as per the change management procedures. **Recommendation** The change management procedures should clearly define roles and responsibilities, outline different types of changes, and specify the documentation requirements for each. They should also set out appropriate testing procedures and authorisation processes based on the type of change, as well as ensure adequate segregation of duties between individuals requesting changes and those developing or implementing them. **Management update** The support partner was unable to trace the change, and we acknowledge the concern this raises. We have discussed the issue with them, clarified the importance of maintaining full traceability, and reinforced the expectation that all changes must be properly recorded and auditable. They have been reminded that this should not occur in future.

Assessment
- ● High – Significant effect on control system and financial statements
- ● Medium – Effect on control system and financial statements
- ● Low – Best practice for control systems and financial statements

D. Draft management letter of representation

Grant Thornton UK LLP
8 Finsbury Circus
London
EC2M 7EA

[**Date**]

Dear Grant Thornton UK LLP

Guy's St Thomas' NHS Foundation Trust

Financial Statements for the year ended 31 March 2026

This representation letter is provided in connection with the audit of the financial statements of Guy's St Thomas' NHS Foundation Trust (the "Trust") and its subsidiary undertaking[**s**] (the "group") as shown in Appendix I to this letter, for the year ended 31 March 2026 for the purpose of expressing an opinion as to whether the group and Trust financial statements give a true and fair view in accordance with International Financial Reporting Standards, the NHS Foundation Trust Annual Reporting Manual 2025/26 and the Department of Health and Social Care Group Accounting Manual 2025-26 and applicable law.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

I. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated [**date**], for the preparation of the group and Trust's financial statements in accordance with International Financial Reporting Standards, the NHS Foundation Trust Annual Reporting Manual 2025/26 and the Department of Health and Social Care Group Accounting Manual 2025-26 (the "GAM"); in particular the financial statements are fairly presented in accordance therewith.

II. We have complied with the requirements of all statutory directions affecting the group and Trust and these matters have been appropriately reflected and disclosed in the financial statements.

III. The Trust has complied with all aspects of contractual agreements that could have a material effect on the group and Trust financial statements in the event of non-compliance. There has been no non-compliance with requirements of any regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

IV. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

V. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable. Such accounting estimates include **[**add details**]**. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with the GAM and adequately disclosed in the financial statements. We understand our responsibilities includes identifying and considering alternative methods, assumptions or source data that would be equally valid under the financial reporting framework, and why these alternatives were rejected in favour of the estimate used. We are satisfied that the methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in accordance with the GAM and adequately disclosed in the financial statements.

D. Draft management letter of representation

VI. In calculating the amount of income to be recognised in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be derived by the group and Trust in accordance with International Financial Reporting Standards and the GAM. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

VII. We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

VIII. Except as disclosed in the group and Trust financial statements:

- there are no unrecorded liabilities, actual or contingent;
- none of the assets of the group and Trust has been assigned, pledged or mortgaged; and
- there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

IX. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

X. All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

XI. We have only accrued for items received before the year-end.

XII. We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The group and Trust's financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

XIII. We have considered the unadjusted misstatements schedule included in your Audit Findings Report and attached. We have not adjusted the financial statements for these misstatements brought to our attention as they are immaterial to the results of the Trust and its financial position at the year-end .The financial statements are free of material misstatements, including omissions.

XIV. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards. We can confirm there are no material legal matters or other such provisions or matters that would impact the financial statements and any matters of this nature have been communicated to the auditor.

XV. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

D. Draft management letter of representation

XVI. We have updated our going concern assessment. We continue to believe that the group and Trust's financial statements should be prepared on a going concern basis and have not identified any material uncertainties related to going concern on the grounds that:

- the nature of the group and Trust means that, notwithstanding any intention to cease its operations in their current form, it will continue to be appropriate to adopt the going concern basis of accounting because, in such an event, services it performs can be expected to continue to be delivered by related public authorities and preparing the financial statements on a going concern basis will still provide a faithful representation of the items in the financial statements;
- the financial reporting framework permits the group and Trust to prepare its financial statements on the basis of the presumption set out under a) above; and
- the group and Trust's system of internal control has not identified any events or conditions relevant to going concern

We believe that no further disclosures relating to the group and Trust's ability to continue as a going concern need to be made in the financial statements.

XVII. We confirm that the Trust's senior managers encompass the Trust Chair and non-executive directors and the voting executives only. The Remuneration Report's senior officers is complete and contains all senior officers at the Trust in 2024-25.

XVIII. We have considered and reviewed our accounting treatment for accruals - both expenditure and income and provisions and are satisfied that these have been accounted for in accordance with appropriate accounting standards.

XIX. We confirm all Property Plant and equipment asset classes and Intangible assets have appropriate asset lives.

XX. We confirm all of the Modern Equivalent Asset assumptions made by the Trust, which is informed in the valuation report of land and buildings by Newmark, are consistent with the Trust's operational and service requirements.

XXI. The Trust has considered all possible impairment events in relation to Assets Under Construction in both Property Plant and Equipment and Intangible Assets.

XXII. RAAC – We have considered the impact of Reinforced Autoclaved Aerated Concrete on our Financial Statements. We have no knowledge of any material events or circumstances that would require adjustments to be made to our Financial Statements.

XXIII. The Trust has identified all Hosted arrangements and accounted for these appropriately within the accounts.

XXIV. We can confirm information provided to the audit in relation to the sale of Lexica Health and Life Sciences Consultancy Limited is accurate.

Information Provided

XXV. We have provided you with:

- access to all information of which we are aware that is relevant to the preparation of the group and Trust's financial statements such as records, documentation and other matters;
- additional information that you have requested from us for the purpose of your audit; and
- unrestricted access to persons within the group and Trust from whom you determined it necessary to obtain audit evidence.

D. Draft management letter of representation

XXVI. We have communicated to you all deficiencies in internal control of which management is aware.

XXVII. All transactions have been recorded in the accounting records and are reflected in the financial statements. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

XXVIII. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the group and Trust, and involves:

- management;
- employees who have significant roles in internal control; or
- others where the fraud could have a material effect on the financial statements.

XXIX. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, analysts, regulators or others.

XXX. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

XXXI. We have disclosed to you the identity of the group and Trust's related parties and all the related party relationships and transactions of which we are aware.

XXXII. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Annual Governance Statement

XXXIII. We are satisfied that the Annual Governance Statement fairly reflects the Trust's risk assurance and governance framework, and we confirm that we are not aware of any significant risks that are not disclosed within the Annual Governance Statement.

Approval

The approval of this letter of representation was minuted by the Trust's Audit and Risk Committee at its meeting on 17 June 2026.

Yours faithfully

Name……

Position……

Date……

E. Audit opinion

Our anticipated audit report opinion will be unmodified

F. Proposed Changes to Valuation of PPE

A sector-wide review of PPE valuation requirements proposes changes to improve consistency, transparency, and robustness of asset valuations across NHS Trusts and Foundation Trusts.

1. Valuation Cycles

Changes to the valuation cycle from 2026/27.

An adaptation to the application of IAS 16 Property, plant and equipment to the frequency of revaluations means Trusts should value their property assets either on:

- A 5 yearly revaluation of all assets supplemented by annual indexation in intervening years, or
- A rolling programme of valuations over a 5-year cycle, with annual indexation applied to assets during the four intervening years.

Non-property assets should be revalued using appropriate indices.

In addition, the requirement to revalue an asset when its fair value differs materially from its carrying value has been withdrawn.

Valuations may still be required where there is a potential impairment.

2. Changes to Valuation Methodologies

Proposal to remove the 'alternative site' assumption from 2028-29.

Valuations will therefore reflect current use and existing site conditions only, rather than a hypothetical optimal or alternative location.

This aligns asset values more closely to service delivery realities within the NHS estate.

Key Implications for NHS Trusts

Increased consistency and comparability of property valuations across the NHS.

The carrying values of operational healthcare assets may change significantly in 2028/29. The timetable should provide Trusts with sufficient lead time to incorporate the changes into their valuation strategies and procurement plans. However, early liaison with both valuers and auditors may be needed to ensure smooth transition

Paper A: Summary of the Council of Governors' current views regarding future arrangements for patient, public and staff voice following the anticipated abolition of the Council of Governors

For: GSTT Council of Governors and members of the Board of Directors

Purpose: To present governors' initial views regarding the preferred direction for future patient, public and staff voice arrangements following the expected abolition of statutory Council of Governors functions from April 2027.

Context

The NHS 10-year plan, published in July 2025 stated:

We will remove the requirement for foundation trusts (FTs) to have governors. While governors have provided helpful advice and oversight for some FTs, we expect the next generation of NHS FTs to put in place more dynamic arrangements to take account of patient, staff and stakeholder insight. This should include systematic measures of patient reported experiences and outcomes.

The NHS Modernisation Bill – which is currently making its way through Parliament – is expected to enable the removal of statutory Council of Governors functions and the associated Foundation Trust membership model from April 2027. GSTT will therefore need to decide what, if anything, should replace the current arrangements.

At the Council of Governors meeting on 29 April the Trust committed to "working collaboratively with governors to create a new model – if required – to receive patient, public and staff voices within a non-statutory framework, taking into account any further national direction that may be issued." To date, no guidance has been issued by NHS England or the Department for Health and Social Care to help foundation trusts decide or shape any new arrangements.

On 3 July the GSTT Council of Governors held its annual away day, where a primary focus of the discussions was to reach a collective view about what the new arrangements should be, in order to aid the Trust's considerations. During the away day it was agreed that the Trust should not seek to recreate the Council of Governors under another name. However, allowing the current model to fall away without replacement would risk losing important functions: independent patient, public and staff voice; visible escalation; structured engagement; public-facing accountability; and a route for issues that cut across existing Trust structures.

This creates an opportunity for GSTT to develop a simpler, more representative and more purposeful model, using the flexibility expected under the new statutory framework that could also help shape arrangements across the NHS.

Recommended approach

Following the away day, governors recommend that the Trust should develop a **GSTT Patient, Public and Staff Voice Model.**

This would include:

1. **A central Patient, Public and Staff Voice Forum**
   Around 20 to 25 members, including patient, public, carer and staff voices, with representation designed to reflect the communities and services GSTT serves.
2. **A representative pool for Trust committees and engagement routes**

Forum members could contribute to relevant Board-level committees, patient experience work, population health activity, service change programmes and staff experience work including statutory consultations where appropriate.

3. **A focused annual work programme**
   The forum would undertake 3 to 4 focused reviews each year on agreed Trust priorities, and areas raised by patients, public and staff using a call-for-evidence style approach. Reviews would produce short reports, recommendations and formal Trust responses.
4. **An annual public meeting or report**
   GSTT would retain a visible public-facing accountability route, setting out what was heard, what changed, what remains unresolved and the Trust's response to the recommendations and what comes next
5. **A renewed public engagement/membership offer**
   Subject to UK GDPR and relevant data protection requirements, GSTT could invite current members, neighbourhood and community partners, specialist patient groups and wider communities to opt in to a new public engagement network, broadening reach beyond the existing statutory membership model.
6. **A supporting London learning layer**
   GSTT could work with other London trusts to share good practice, public seminars, templates and learning. This would support the Trust model, not replace it, and would position GSTT as a leading organisation shaping credible post-CoG arrangements.

Why this option

This approach gives the Board a practical route between two weaker alternatives: recreating the current Council of Governors model, or doing nothing. The proposed approach would:

- preserve the strongest elements of the current arrangements;
- reduce cost and complexity;
- avoid routine NED accountability sessions becoming burdensome;
- create clearer outputs through focused reviews;
- support Board assurance through existing committees;
- provides proportionate, timely and transparent accountability;
- broaden public engagement after statutory membership ends;
- provide a model that could be shared across London and beyond.

Options considered

Option	Summary	Assessment
A. GSTT Patient, Public and Staff Voice Model	Central forum, representative pool, focused reviews, annual public reporting, renewed engagement offer and London links.	**Recommended.** Best balance of renewed focus, simplification, Board support and public legitimacy.
B. Strengthen existing routes only	Rely on PPE, Patient Experience, PALS, complaints, staff networks, Staff Side, IHOP and improved reporting.	Simpler, but risks losing independent cross-cutting voice.
C. London/system model	Prioritise London-wide or place-	Useful as a supporting layer, but

first	based arrangements.	too diffuse as GSTT's main response.
D. Do nothing	Allow current arrangements to lapse when statutory duties end.	Not recommended. Lowest burden, but highest risk to voice and accountability.

Proposal:

The Council of Governors and members of the Board are asked to:

1. Note governors' initial views regarding 'successor' arrangements for the Council of Governors, should it be abolished.
2. Agree governors should develop a more detailed design paper – and present this at the next Council of Governors meeting in October – that covers composition, selection, reporting routes, costs, transition arrangements, public engagement/membership, and draft terms of reference.
3. Agree to remain receptive to input from other stakeholders and any national guidance that may be issued, as the Trust designs new arrangements for patient, public and staff voice.

COUNCIL OF GOVERNORS
WEDNESDAY 22 JULY 2026

Report title:	**Lead Governor's report**
Report author:	Katherine Etherington
Purpose of report:	For awareness/noting only
	The Lead Governor
Previously presented at:	-
Key points of report:	• A report from the Lead Governor to acknowledge what the Governors have achieved over the last three months and to outline plans for the next three months.
Primary BAF risk:	Risk 11: Organisational excellence
Supporting material:	N/a
Recommendation(s):	The BOARD is asked to: 1. **Note** the report.

1.1. Since April there has been a lot of activity amongst the Council of Governors. I would like to thank all governors who attended the recent Away Day, more details of which are set out below. I also chaired the first London Governor Conference with attendance from various trusts across London which was incredibly insightful and useful, and I would encourage all governors to read the notes of the meeting. The past few months have seen many working groups convene and start to think about what is next for the Council of Governors. We have also welcomed a new member of the Council, David Chatt, staff governor, following the departure of Cordwell Thomas to pastures new. I know you will all join me in welcoming David.

1.2. The London Governor Conference in June was attended by fellow governors from King's, University College London Hospital, and Homerton. During the Conference governors considered the implications of proposed legislative changes to councils of governors and explore how the most valuable elements of governor activity could be retained in future. The discussion highlighted widespread uncertainty across trusts, alongside a shared view that patient, public and staff voices must continue to have meaningful routes into decision-making. Conference attendees identified structured governor visits, observational assurance, community engagement, staff voice, public education events and clear mechanisms for escalating feedback as key strengths worth preserving. While there was limited support for formal lobbying to retain existing statutory structures, there was strong consensus that successor arrangements should focus on representation, accountability, visible responses to feedback, collaboration with patient experience teams and inclusion of diverse communities. Attendees also agreed on the value of establishing a London-wide network to share good practice, support transition planning and help shape future engagement models. A discussion paper will be developed by myself, Tommie Sheridan and Alison Mould to reflect these principles and set out possible options for future arrangements. The group plans to reconvene in the autumn to discuss the paper produced, gather feedback from other trusts, and reflect any emerging national policy developments. It was also agreed that this paper would take into account discussions at the Guy's and St Thomas' Away Day in July. The paper will also be shared with the National Lead Governor's Association which I think will provide some useful feedback and challenge.

1.3. The Annual Away Day, this year held on 3 July 2026, was well attended and focussed on what we would like to achieve ahead of the anticipated abolition of foundation trust councils of governors. Governors considered the implications of the Government's proposals and the future of patient, public, staff and member engagement within GSTT. Governors expressed strong support for retaining a mechanism that preserves independent challenge, community representation and accountability, particularly in relation to holding Non-Executive Directors (NEDs) to account for engagement, listening and escalation of concerns. There was broad consensus that governors provide a valuable independent voice, bringing together the perspectives of patients, staff, members and local communities in a way that complements, rather than duplicates, existing engagement channels.

1.4. Discussion focused on developing a successor model that would retain the most effective aspects of the current arrangements, including representation of local populations, patient and public voice, staff engagement, structured feedback and escalation routes, and oversight of

issues affecting quality of care and patient experience. Ideas included the creation of a representative advisory body of approximately 20–25 individuals drawn from patients, public, staff and carers, potentially operating through focused task-and-finish groups. Governors emphasised the importance of ensuring any future arrangements are representative, straightforward and evidence-based, whilst avoiding duplication of existing structures such as Patient and Public Engagement (PPE), Patient Experience teams, staff engagement mechanisms and the Improving the Health of Our Populations (IHOP) Committee.

1.5. Governors also highlighted concerns regarding how staff concerns and public feedback would be escalated to Board level in the absence of a Council of Governors, noting the need to maintain clear links between staff engagement, staff wellbeing and patient outcomes. Members stressed the importance of understanding current engagement and assurance arrangements before proposing new structures and suggested that governors should play an active role in shaping future options for consideration by the Board. There was support for continuing member health seminars, exploring opportunities for London-wide collaboration and shared learning, and maintaining advocacy for retaining meaningful public accountability and influence within NHS governance arrangements as national policy develops.

1.6. Following the Away Day, we have pulled together a paper of recommendations for what we would think should be the new look and responsibility of a patient, public and staff voice group. This has been circulated to the Council for comment and will be presented to the Board at the Council of Governors meeting.

1.7. I would like to remind you all that being a member of the Council is what you make it. If you would like to attend a training session, visit or sit on a committee or working group, please contact Corporate Affairs. Similarly, if you would like to contribute to the ongoing work being on the future of patient, public and staff voice, please do not hesitate to contact myself or Alison.

1.8. Finally, on behalf of all the governors, I would like to thank Edward Brashaw for all of his work to support the Council of Governors. Ed has been a constant supporter of the work the Council does, answers some very, at times, tricky questions and generally offers support to all members of the Council. It has been a privilege to work alongside him and he will be sorely missed by many. We all wish him the very best in his next role and hope he stays in touch!

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS
MEMBERSHIP DEVELOPMENT WORKING GROUP

Tuesday 12 May 2026
5.30pm – 7.00pm, MS Teams

Governors in attendance:	Charles Mead (Chair)	
	Steve Bean	Margaret McEvoy
	Kathryn Blake	Alison Mould
	Victoria Borwick	Gavin Morrison
	Felicity Conway	Pater Yeh
	Leah Mansfield	Samuel Oloye
Trust staff in attendance:	Edward Bradshaw	Stephanie Calvert
	Elena Spiteri	

1. Welcome and apologies

1.1. The Chair welcomed members to the meeting of the Membership Development Working Group ('the Group' or 'MDWG'). The Chair explained that the main purpose was to review the draft action plan arising from the previous meeting.

1.2. Apologies for absence were received from Stephanie Petit and Jadwiga Wedzicha.

1.3. It was noted that the Group should continue to focus on three areas: member engagement, governor engagement, and patient/public involvement.

2. Declarations of interest

2.1. No relevant interests were declared.

3. Action Plan

3.1. It was agreed that Action 1.1, on expanding the scope of seminars, should be removed, and that seminars should continue to be delivered based on member feedback and staff suggestions.

3.2. Action 1.2: Members' seminars: The Group supported the scheduling of up to two member seminars each year on Trust performance topics, including the NHS Oversight Framework and the Annual Report and Accounts. A seminar on the strategic plan was not prioritised at this stage, noting that members and governors already receive substantial information on this through existing presentations, members' health seminars and other working groups.

3.3. Governors emphasised the need to understand members' interests and priorities. The Membership Office confirmed that registration data and post-event feedback are collected and could be shared with governors. It was also noted that future governor newsletters could highlight feedback received and identify seminars delivered in response to member suggestions.

3.4. The Group considered that the current APM (Annual Public Meeting) format is not provide sufficient opportunity for members to engage in detail with the Annual Report and Trust performance from the previous financial year. It was noted that this issue had already been raised with Communications colleagues and should be pursued further.

ACTION: Tell presenters to simplify their presentations at health seminars (even if slides are complicated) - talk to them as patients not fellow clinicians.

3.5. Action 1.3: Governor-to-member town hall: The Group supported a governor town hall-style event in principle. The Deputy Lead Governor agreed to work with the Trust Secretary and Membership Office to develop outline proposals and an agenda for consideration at the Governors' Away Day. An indicative timeframe of October to November was noted.

3.6. The Group also discussed the possibility of open public question-and-answer sessions on services. While examples of good practice were noted, concerns were raised about scope, personal case discussions and legal risk. No action was agreed at this stage.

3.7. In relation to governor engagement, several items were paused or deprioritised in light of the uncertain future of the governor role.

3.8. Actions 2.2 and 2.3: Greater guidance about expectations of governors and limits of the governor role & Assess and advertise required time commitment of governors: It was agreed that no further action would be taken at this stage given the uncertain future of the governor role.

3.9. Action 2.4: Governor engagement – governor-only quarterly meetings chaired by the Lead Governor: A proposal to hold governor-only meetings was supported, with the next meeting confirmed for 3 June at 4.00pm at St Thomas' Hospital, to be held in person. It was noted that the invitation still needed to be circulated to all governors.

3.10. Action 2.5: Governor engagement – more opportunity for governors to apply individual skills: The Group considered whether further work should be taken forward on creating more opportunities for governors to apply their individual skills and expertise. Given the current uncertainty about the future of the governor role, it was agreed that this action should be placed on hold until further notice.

3.11. Action 2.6: Governor engagement – more deep dives by governors: The Group discussed the proposal to use 'deep dives' to help governors build a stronger evidence base on issues of public, patient or strategic importance, in order to inform discussion at Triangulation and Council of Governors meetings. It was agreed that deep dives should be focused, time-bound pieces of work, with topics identified in advance and allocated to the most appropriate forum or working group.

3.12. Action 2.7: Governor engagement – attendance at Integrated Delivery Boards as observers: The Trust Secretary agreed to explore whether governors could attend the Integrated Delivery Boards for Southwark and Lambeth in an observer capacity.

3.13. Action 2.8: Governor engagement – staff governor involvement: The Group discussed lower attendance by staff governors and reaffirmed the value of their contribution.

3.14. Action 2.9: Governor engagement – future of the governor role from 2027/28: The Group discussed the possible implications of expected national changes and agreed that the Trust should remain prepared to respond once the national position becomes clearer. The possibility of a further joint working group, involving governors and Trust representatives, was noted for later consideration once more detail is available.

3.15. The Group noted that any future model would likely require a process of co-design involving governors, Trust representatives and others, once greater clarity is available nationally.

3.16. Action 3.10: Patient engagement – governor participation in clinical group patient panels: The Group noted ongoing work to explore governor involvement in clinical group patient panels. Focus groups remained a possible future action but were placed on hold for the time being.

4. Healthwatch and Patient insight

4.1. The Group discussed the value of stronger links with Healthwatch and with existing patient experience reporting as a way of strengthening governors' understanding of patient and public views. It was

suggested that engagement with local Healthwatch organisations should be explored, including whether Healthwatch representatives could share relevant insight with governors.

ACTION: Membership Office to discuss prospect of Healthwatch CEOs attending a governor meeting with Gavin Morrison.

4.2. The Group noted that patient experience and PALS reports available through the Quality and Engagement Working Group should continue to be used as a source of insight.

5. Any other business

5.1. It was agreed that the minutes of this meeting, the updated action plan, the minutes of the previous MDWG meeting, and the slides from the last away day should be circulated in advance of the next away day.

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS
STRATEGY, TRANSFORMATION & PARTNERSHIPS WORKING GROUP

19th May 2026
5.30pm – 7.00pm, MS Teams

Governors in attendance:	Tommie Sheridan, Chair Kathryn Blake Nigel Beckett Felicity Conway Victoria Borwick	Yvonne McPherson Margaret McEvoy Gavin Morrison Leah Mansfield
Trust staff in attendance:	Jackie Parrott Robin Firth (Joined for item 5 only) Anna Grinbergs-Saull (Joined for item 5 only)	Simon Bampfylde (Joined for item 6 only) Nina van Zyl Sally Halford (Joined for item 5 only)

1. Welcome

1.1. The Chair introduced himself as the new chair and welcomed everybody to the Strategy, Transformation and Partnership Working Group. Apologies were noted.

2. Minutes of previous meeting

2.1. The minutes of the meeting held on 17th February 2026 were approved.

3. Declaration of interest

3.1. There were no declarations of interest.

4. Previous meeting report and matters arising

4.1. No action points from the previous meeting were raised.

5. Satellite and home haemodialysis services

5.1. Robin Firth (General Manager for Transplant, Renal and Urology), and Sally Halford (Matron for Transplant, Renal & Urology) presented on the planned re-procurement of satellite and home haemodialysis services. A briefing letter and Frequently Asked Questions document were shared in advance of the meeting. The presenters noted the following points during the meeting.

5.2. Current dialysis service: The existing dialysis service was described as an integrated model, including six satellite dialysis units distributed across South East London (three staffed by the Trust, three staffed by an independent provider (Diaverum), who also provide facilities management at all six units).
It was explained that the partnership model has evolved over a 15-year contract and has been broadly positive, with high-quality outcomes and strong working relationships between the Trust and the independent provider. The Trust also provides a home dialysis offer, with specialist Trust teams responsible for patient training, clinical care, and ongoing support.

5.3. Rationale for re-procurement: The re-procurement is required under procurement law, as the current contract is due to expire in 2027. It was emphasised that this process represents a significant opportunity for the Trust to:

- Review the service model comprehensively
- Improve patient experience
- Introduce innovation where appropriate
- Future-proof services against demand and workforce pressures

.
The presenters provided an overview of the re-procurement timeline. The evaluation framework will be weighted towards quality and patient care (60%), with cost (40%) also considered, reflecting the scale of investment and importance of value for money.
A strong emphasis was placed on patient and public involvement. Plans are in place to ensure ongoing engagement with patients and carers throughout procurement evaluation, implementation planning and service mobilisation.

5.4. Key discussion points

- The group emphasised the importance of ensuring that engagement approaches capture the full diversity of patient voices, particularly those who are frail, vulnerable or digitally excluded.
- Members acknowledged the significant impact of dialysis on patients' daily lives.
- The expansion of home dialysis was strongly supported, with presenters assuring the group that decisions are clinically led and patient-centred, rather than cost-driven.
- There was discussion around challenges to future planning as historical projections have indicated significant growth while recent trends have been more uncertain, requiring careful planning assumptions.
- Governors expressed interest in the role of innovation, particularly health technology. It was confirmed that the procurement process is designed to encourage providers to propose innovative solutions and allows flexibility to incorporate new technologies
- Environmental sustainability was highlighted as an emerging priority, including opportunities through Green Nephrology initiatives to reduce environmental impact of dialysis delivery.

6. Integrated Neighbourhood Teams

6.1. Simon Bampfylde (Director of Strategy for Integrated Specialist Medicine) introduced the Integrated Neighbourhood Teams programme as a central element of the Trust's strategy for delivering more effective, integrated care. The programme responds to a well-recognised system challenge, a small proportion of the population accounts for a disproportionately high level of healthcare utilisation and patients with complex needs often experience fragmented, difficult to navigate services. INTs aim to address this by providing coordinated, person-centred care at neighbourhood level. They recognise that many drivers of poor health are non-medical, including housing, social isolation and access to support services.

6.2. Implementation: The programme formally launched on 1 April 2026 and is currently in a test-and-learn phase. Progress to date includes:

- Establishment of neighbourhood structures across Lambeth and Southwark
- Recruitment of new roles, inc. clinical leads and care coordinators
- Initial alignment of community services
- <100 patients seen to date, with expectations to rapidly scale

The programme aims to scale to a level comparable with a large urban population, demonstrating integrated care at meaningful system scale for the first time. There is a strong emphasis on system-wide transformation, including integration with social care and wider public services.

6.3. Key discussion points

- The group discussed the age thresholds currently in place to identify cohorts
- The group highlighted structural challenges within the workforce including increased specialisation of clinicians and a need for more generalist, holistic care models
- Social prescribing and broader community-based interventions were confirmed as integral to the model, with emerging roles focused on connecting patients to services.
- The importance of robust evaluation was strongly emphasised.
- Members noted that benefits from preventative interventions will accrue over time, however INTs require upfront investment and strong alignment between primary, community and secondary care.

7. Report updates for committees attended by Governors

7.1. No report updates from Governors

8. AOB

8.1. There were no items of AOB.

The next meeting would be held on ***22 September at 5.30pm – 7pm. Meeting to be held on Microsoft Teams.***

COUNCIL OF GOVERNORS
QUALITY AND ENGAGMENT WORKING GROUP

Tuesday 23 June 2026
5.30pm – 7.00pm, MS Teams

Governors in attendance:	Margaret McEvoy, Chair	Gavin Morrison
	Steve Bean	Mary O'Donovan
	Emma Blackman	Yvonne McPherson
	Kathryn Blake	Kendra Schneller
	Victoria Borwick	Alison Mould
	Felicity Conway	
	Leah Mansfield	
Trust staff in attendance:	Sarah Allen	Elena Spiteri
	Oliver Cook	Mark Tsagli
	Anna Grinbergs-Saull	Holly Wharton
	Oliver Cook	Maggie Boreham
	Ciara Mackay	

1. Welcome

1.1. The chair welcomed attendees to the Quality and Engagement Working Group meeting.

2. Minutes of the previous meeting and matters arising.

2.1. The minutes of the meeting held on 24 March were approved as an accurate account of the meeting.

2.2. Governors noted the responses provided by the Head of Patient Experience to the actions arising from the previous meeting. It was noted that the written responses to the actions would be circulated with the minutes of the 23rd of June meeting. See Annex 1.

3. Supporting the needs of vulnerable patients

3.1 The Director of Nursing for Safeguarding and Vulnerable Adults and the Trust's Planning and Performance Manager delivered a presentation on the Trust's arrangements and governance structures in place for supporting and protecting vulnerable patients.

- Supporting vulnerable patients is a key priority for the Trust**.** A dedicated portfolio oversees initiatives aimed at improving the experience and outcomes of vulnerable people using our services. This includes:
    - Individuals with safeguarding needs, including both children and adults at risk, as well as those experiencing abuse, neglect, or exploitation.
    - Patients requiring additional support, including people with learning disabilities, autism, neurodivergent conditions, mental health needs, dementia, delirium, and those receiving end-of-life care.
- A number of operational committees oversee and support the Trust's work to improve outcomes for vulnerable patients. Governors are represented on some of these groups, including the Trust End of Life Care Committee, Safeguarding Operational Groups (Children

and Adults), Mental Health Board, and Learning Disability Committee. The Vulnerable Persons Assurance Committee provides the highest level of safeguarding assurance within the Trust and chaired by the Chief Nurse and the Planning and Performance Manager.
    - The Trust's Risk and Assurance Committee provides oversight of patient safety and quality, with Patient Safety Partners playing an active role in providing independent feedback and assurance.
- Providing personalised care for vulnerable patients is important. The introduction of a Reasonable Adjustment Digital Flag enables staff to identify patients with additional needs and deliver appropriate, person-centred care.
- Equally important is ensuring the voices of vulnerable patients are heard. Patient engagement, co-production, feedback surveys and involvement activities are used to shape and improve services.
- The Trust is committed to ensuring staff across all services have the knowledge, skills and support required to provide the care needed for vulnerable patients.
    - The Oliver McGowan Mandatory Training session helps to improve staff understanding of learning disability and autism.
    - Specialist teams provide expert advice and support to frontline staff, including the Corporate Safeguarding Team, a dedicated Mental Health Lead in the Emergency Department, and liaison staff working in partnership with South London and Maudsley NHS Foundation Trust (SLAM).
- The Mental Health strategy, developed with patients and staff, focuses significantly on education and engagement with partners and patients.
    - The Trust recently received a fixed budget from SE London to invest in the development of mental health roles.
- Dedicated community learning disability services support adults across Lambeth, Southwark and Lewisham, and a similar specialist service exists within the acute services.
- There are also a dedicated specialist palliative care services across all our four hospital sites as well as a palliative care at home service.
- The Trust supports the national STOMP programme (Stopping over medication of people with a learning disability and autistic people).
- The Trust's Neurodiversity strategy was developed through extensive engagement with more than 500 patients, carers and family members, ensuring their lived experience informs service development.
- The End-of-Life Care strategy has also been co-produced with patients and carers, helping to ensure services reflect the needs, wishes and experiences of those receiving end-of-life care.

The Trusts Performance and Planning Manager provided additional detail on the Reasonable Adjustment Digital Flag plans and a background on the legal duty to ensure services are accessible to people with disabilities. Governors noted:

- The Trust already records some reasonable adjustment information locally, but recent work has focused on making this information clearer, more visible and more consistent across Epic.
- The programme has two phases: first phase - local identification, recording, flagging, meeting and reviewing of reasonable adjustments; second phase - digital sharing of the information across systems.
- Pilot work has involved GSTT Adult Learning Disability Services, Special Care Dentistry, Evelina Children’s Neuroscience Centre, children with vulnerabilities teams, patient engagement teams and patient experience colleagues across King’s and GSTT.

3.2 Governor questions related to the following:

- Inequalities in accessing healthcare by adults with learning disabilities and shortening waiting times to access services.
- Out of hours support for staff relating to safeguarding issues.
- Advocacy for palliative care patients who don't have family members/carers with them.

4. Quality Assurance. Trust quality priorities: update:

4.1. The Trust Quality and Assurance Manager, Senior Quality and Assurance Manager provided an update on the Trust's quality priorities for 2026-27.

- It was noted that the quality priorities presented to Governors at the last meeting for 2026 have been approved.
- The team plan to continue to focus on delivering 3 quality priorities from 2025/26 (including three new ones set out below) which will enable further improvement on the experience of patients through better communications, improving patient safety by progressing the work on violence and abuse, and progressing the implementation of Martha's Rule.
- Patient Safety:
    - Reduce instances of verbal or physical violence and abuse by patients. Ensuring that patients get the help they need and that staff are supported in recognising, dealing with and recovering from these incidents.
    - A revised WHO Surgical Safety Checklist will be rolled out to key areas within the Trust. Feedback from the pilot will inform any changes before wider implementation across the Trust.
- Clinical effectiveness:
    - Martha's Rule: For 2026/27, the focus will be on designing a digital solution for Component 1of Martha's Rule. This will be implemented across all inpatient areas, enabling patients to share daily information with the staff caring for them. Martha's Rule is also being piloted in the Community wards.
    - Ambulatory care: this major project will review outpatient activity using a data-led approach to prioritise waiting lists according to patient risk, ensuring that those with the greatest clinical need are seen first.
    - Epic functionality: staff knowledge, training and digital capability will be strengthened to maximise use of the electronic health record system.
- Patient Experience:
    - Digital contact routes: The Trust is exploring digital solutions to make it easier for patients to contact the organisation, reducing reliance on telephone calls that may not always be answered promptly.
    - Clinic waiting times: patients' experience of attending clinics will be improved through clearer information and regular updates about expected waiting times.

4.1 Governors thanked the team for the presentation, recognising that this is a critical area of the Trust's work. They welcomed the progress being made in addressing the Trust's key priorities.

5. Patient and public engagement and patient experience updates

5.1. The Patient Experience (PE) Annual Report and Patient and Public Engagement (PPE) quarter 1 report were circulated in advance of the meeting. The Head of Patient Experience gave key highlights of the report circulated. The Senior PPE Manager took questions and comments.

5.2. The following Patient Experience key items in the report were highlighted:

- Strong performance in the 2024 Adult Inpatient and 2024 Children and Young People' s National Surveys.

- Re-establishment of SMS messaging service for local patient surveys in the Heart Lung and Critical Care (HLCC) clinical group.
- Continued positive impact of mealtime volunteers.
- More than 38,000 patients supported by MyChart patient helpdesk.
- Over 17,800 hours contributed by Volunteers at the Trust.
- Improvement in Friends and Family Test (FFT) responses for Maternity Services.
- Short notice changes to appointments and getting appointments are some of the challenges.

5.3. Governors sought clarification on the following:
- Changes that have been made in maternity services.
- Waiting times for treatment.

5.4. Governors noted that the Patient and Public Engagement paper provides an overview of key engagement activity. Governors expressed an interest in receiving a further summary of all engagement projects supported by the Patient and Public Engagement (PPE) team across the Trust. It was noted that these details are provided in the Trust PPE Annual Report, which can be shared with Governors once the report is publicly available.

Action: Trust staff to share the PPE Annual Report once it has been published.

6. Reports/updates from committees recently attended by Governors

6.1. None discussed.

7. Any other business

7.1. Nursing and Midwifery Research Committee**:** the Governor representative informed the group that they were standing down from the committee. They commended the excellent work undertaken by staff involved in the committee, including Allied Health Professionals.

7.2. Another Governor representative advised that they would be stepping down from a number of committees for personal reasons. It was noted that this would create further opportunities for other Governors to join those committees.

The next meeting will be held on 10th November 2026

8. Annex 1

COUNCIL OF GOVERNORS
Quality and Engagement Working Group meeting

Update on actions/matters arising at meeting on 24th March 2026.

Action 1: **Advice and guidance implementation and monitoring to be added to a future meeting agenda.**

QEWG chair noted and to add to list of topics for presentation at future meetings.

Action 2: Update on Contacting Us Programme and impact

The following update has been provided by the programme team:

The Contacting GSTT Programme has been running since May 2025 to support the alleviation of identified issues with call answer rates and patient satisfaction through digital means. As part of this work:

- An intensive study was conducted to see why patients call us, finding that 70% of calls are about appointments, and demonstrating that self-scheduling is inseparable from reducing call volumes.

- Self-scheduling rollout has been progressed, with over 30,000 appointments being self-scheduled in the last year. There is more work for the Trust to do to get close to the UK average and to the UK's top-performer by expanding to different service types and increasing patient utilisation of the tools.

- We developed a method to advertise self-scheduling tools to patients, called Channel Shifting. This was tested with patients and evaluated by the Health Innovation Network to ensure optimisation. Guidance has been produced to support services to adopt this once they have tools enabled.

- A tool that allows patients to opt to receive a call back from services instead of waiting on hold, aptly called 'Callback', was piloted in a service. It increased answered calls by nearly 15% in one month, and more than halved patient waiting time, with glowing patient feedback. Guidance has also been produced to help services launch this software, supported by colleagues in the Telecommunications Team.

- The remit for Patient-Initiated Messaging in the Trust was explored and fully outlined, and a proposal has been created for the Trust.

From 1st June the charity grant for this project will continue for the patient scheduling aspects of the programme only.

Action 3: Trust staff to provide an update on the Maternity Good to Outstanding Programme.

The following update has been provided by the Chief Midwife regarding work to improve women and birthing people's experience:

The Patient Experience and Engagement workstream within the Maternity Good to Outstanding Programme has developed a keen focus on listening to women, birthing people and families,

translating feedback into practical co-produced service changes, and strengthening trust between staff and service users. Listening events, thematic feedback analysis and walkabouts involving maternity teams, communications colleagues and the MNVP (Maternity and Neonatal Voices Partnership) have identified priority areas including the postnatal ward, Hospital Birth Centre, optimising electronic patient record communication of information via MY Chart and effectiveness of antenatal call-handling services. This has already led to tangible improvements, including enhanced antenatal contact systems, environmental improvements on the postnatal ward, orientation filming projects, increased support for fathers and community-based engagement initiatives designed to better reach and listen to women and families to reduce inequalities in maternal and newborn health outcomes. The MNVP Chairs with our maternity and neonatal leadership teams also provide their valuable voice in ensuring our quality and safety governance processes always have a patient centred approach to reflect women, babies and family's needs at all times. Additionally, within the programme the Postnatal Flow Workstream has been developing more targeted patient-experience interventions aimed at improving safety, infant feeding support, discharge preparedness and emotional support on the postnatal ward. A significant area of co-production has involved extensive involvement of women and families in the re-design and improvement of our soon to be refurbished Maternity Assessment Unit.

Action 4: Head of Patient Experience to provide a demographic breakdown of volunteers at the Trust

During 2025-26 we had 606 volunteers generously providing 17,898 hours of their time to the Trust

Age
Our volunteers are aged between 16 years and over 90 years
78% of our volunteers are of working age (16-65 years) and of these 32% are aged between 16-30 years.

Ethnicity
54% of volunteers are from a White background, 12% identify as from an Asian background, 11% from a Black background, 3% from a Chinese background, 3% from a mixed background, 3% from other backgrounds and 14% did not state which background they were from.

Disability
79% of volunteers identified as not having a disability, 9% of volunteers said they had a disability and 11% did not answer the question.