

NHS

Guy's and St Thomas'
NHS Foundation Trust

Annual Report
and Accounts
2017/18



Guy's and St Thomas'
NHS Foundation Trust
Annual Report and Accounts
2017/18

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

Guy's and St Thomas' NHS Foundation Trust comprises two of London's best known teaching hospitals with a long history of high quality care, clinical excellence and innovation, Evelina London Children's Hospital and community services in Lambeth and Southwark.

We are among the UK's busiest, most successful foundation trusts. We provide a full range of local hospital and community services for people in Lambeth and Southwark, as well as specialist care for patients from further afield, including cancer, renal and cardiothoracic services.

Evelina London Children's Hospital at St Thomas' provides many specialist services, including treatment for complex heart conditions, as well as general services for local children. Guy's is home to the largest dental school in Europe.

We have a long tradition of clinical and scientific achievement and – as part of King's Health Partners – we are one of England's six Academic Health Sciences Centres (AHSCs), bringing together world-class clinical services, teaching and research. We work closely with our AHSC partners – King's College Hospital and

South London and Maudsley NHS Foundation Trusts and King's College London, our shared university partner.

We have one of the National Institute for Health Research's (NIHR) Biomedical Research Centres, established with King's College London in 2007, as well as dedicated clinical research facilities.

We have around 16,200 staff, making us one of the biggest employers locally. We aim to reflect the diversity of the local communities we serve and continue to develop new and existing partnerships with local people, patients, neighbouring NHS organisations, local authorities and charitable bodies and GPs.

We strive to recruit and retain the best staff as the dedication and skills of our employees lie at the heart of our organisation and ensure that our services are high quality, safe and patient focused.

King's Health Partners is one of only six AHSCs in England and brings together an unrivalled range and depth of clinical and research expertise, spanning both physical and mental health. Our combined strengths drive improvements in care for patients, allowing them to benefit from breakthroughs in medical science and receive leading edge treatment at the earliest possible opportunity.

For more information, visit www.kingshealthpartners.org



Contents

- 1 Chairman's statement 5**
- 2 Performance report 7**
- 3 Accountability report 21**
- 4 Directors' report 23**
- 5 Remuneration report 31**
- 6 Staff report 39**
- 7 Our organisational structure: 49
disclosures set out in the
NHS Foundation Trust Code of Governance**
- 8 Single oversight framework 57**
- 9 Statement of the Accounting 59
Officer's responsibilities**
- 10 Quality report 67**
- 11 Annual accounts 99**



We provide a range of specialist services for older people in our dedicated unit at St Thomas',
in local care centres and in people's homes.

Chairman's statement

Guy's and St Thomas' has, once again, come through a difficult year with our financial position intact and an impressive record of achievements.

Despite unprecedented demand on our services, with record levels of attendance at A&E, terror attacks and the tragedy of Grenfell, all of the staff working in our hospitals and in the community have remained steadfast in their commitment and dedication to the needs of our patients.

As we approach the 70th birthday of the NHS, I am reminded of how proud I am to be part of such a remarkable organisation.

As a Trust, we have a responsibility to be a system leader and have therefore taken the decision this year to create a healthcare alliance with Dartford and Gravesham NHS Trust as a founding member. This alliance will enable us to work together across clinical and corporate areas in our drive to build services around the patient, provide consistently excellent care, and improve efficiency and effectiveness.

As part of our commitment to provide care closer to where people live, in 2017 we opened both a cancer centre and a kidney treatment centre at Queen Mary's Hospital Sidcup. This means that patients don't always have to come into central London for treatment.

We have also completed the development and expansion of the emergency floor at St Thomas', ensuring that the 140,000 patients who visit our emergency department each year are cared for safely in a more comfortable environment.

The Council of Governors continues to support the organisation to meet the needs of patients and provides constructive challenge to the Board in line with its statutory duties. This year, following elections, we welcomed new governors to the Council and thanked those who completed their terms of office.

The Trust continues to benefit greatly from its participation in King's Health Partners, our Academic Health Sciences Centre, and through

close working with local health and social care organisations.

By working together, we bring our collective expertise to bear to improve care for our patients and to enable people to take a more active role in supporting their own health and wellbeing. And this year, through King's Health Partners, we have made continued progress in our efforts to join up the identification and treatment of mental and physical healthcare, recognising the importance of this to many of our patients.

The Trust also continues to be viewed as a leader in sustainable healthcare, and we work hard to reduce our environmental impact as well as to support a wide range of health and wellbeing initiatives for our staff. This year the Trust was highly commended in three categories of the NHS Sustainability Awards.

We remain grateful for the generous contribution of Guy's and St Thomas' Charity whose continued support enables us to deliver innovative patient care and research, as well as to improve our buildings and the environment.

The Trust also benefits from close working relationships with our local MPs, commissioners, local authorities, the Metropolitan Police, and other employers in the area to ensure that we play an active part in the life of our community in Lambeth, Southwark and further afield.

Finally, I would like to thank Board colleagues for their continued support, particularly Ann Macintyre, Steve McGuire, and Emma Duncan who all stepped down this year.

I would also like to welcome Julie Sreaton, our new Director of Workforce and Organisational Development, who joined the Board in June.

Sir Hugh Taylor, Chairman
23 May 2018



Staff have worked hard to remain focused on delivery of high quality care in our emergency department despite an increase in demand for our services.

Performance report

Annual performance statement from the Chief Executive

The Trust has again performed well both operationally and financially during 2017/18 despite the very challenging external environment that has included terror attacks, the Grenfell fire and an extremely difficult winter across the NHS.

Continued exceptional levels of demand for our services mean that we have struggled to achieve national access targets sustainably, although performance has shown steady improvement, particularly in the final quarter (January to March).

Our overall waiting list grew significantly during the first half of the year, and this has had a lasting effect on our ability to achieve the maximum referral to treatment time and cancer access targets. Recognising the adverse impact this has on our patients, we have focused significant energy on tackling a range of operational issues to enable us to treat patients as quickly as possible, including those who have waited the longest or with suspected or diagnosed cancer, for whom prompt access to our services is especially important.

In common with other hospitals, our emergency department also experienced significant pressure throughout the year, and performance against the A&E target was made more difficult as we continued with the major redevelopment of the emergency floor at St Thomas'.

As ever, our staff, both in hospital and community services, worked extremely hard to respond to these pressures, and remain focused on the delivery of high quality patient care, while also striving to achieve both operational and financial targets.

Our stable financial position has allowed us to continue to progress a number of quality and service improvements, including our ambitious capital programme. We are pleased to have completed a number of developments during the past year, including opening local cancer and renal centres at Queen Mary's Hospital Sidcup and a new Rare Diseases Centre at St Thomas'. These are described in the directors' report.

At the start of the year we agreed a control total with NHS Improvement which required us to deliver a small underlying deficit of £3 million. Taking into account capital donations and impairments, as well as planned levels of Sustainability and Transformation Funding (STF), this equated to a planned surplus of £15.2 million.

We are pleased to report that despite the extremely difficult financial climate across the NHS, we ended the year £3.5 million ahead of plan (the control total agreed with NHS Improvement), delivering a surplus of £500,000. This entitled us to bonus payments from the STF and our final reported position is a surplus of £40.8 million.

This is a very positive achievement and a tribute to the considerable efforts and commitment of staff across the Trust. As well as delivering cost savings and efficiencies, we benefited from extra income for additional activity and bonus and incentive payments because we met our financial performance targets and also exceeded our financial plan overall.

As a result we will be able to continue to invest in increased capacity and service improvements that benefit our patients.



Amanda Pritchard, Chief Executive
23 May 2018

Overview

Guy's and St Thomas' NHS Foundation Trust provides a full range of local hospital and community services for people in Lambeth and Southwark, as well as specialist care for patients from further afield. The Trust was formed in 1993 from the merger of Guy's and St Thomas' Hospitals. Evelina London Children's Hospital was opened in 2005 and in 2011, Lambeth and Southwark community services joined the Trust.

As an NHS foundation trust, we are accountable to Parliament and regulated by Monitor, now part of NHS Improvement. We are still part of the NHS and must meet national standards and targets, but we have more financial freedom to retain surpluses and choose how we reinvest this money. Our governors and members ensure that we are accountable and listen to the needs and views of our patients.

At St Thomas' we provide a wide range of very specialist services and sub-specialties. The site is home to Evelina London Children's Hospital, as well as one of the largest intensive care units in the UK. We have many regional and national centres of excellence, including a major cardiovascular centre and a comprehensive range of women's and children's services, many of which benefit from being colocated on a single site.

Our services at Guy's also serve a wide population from across south London and further afield through a growing network of outreach clinics and satellite centres. As well as dental, renal, urology and orthopaedic services, cancer services at Guy's are a key strategic

priority for the Trust and King's Health Partners, with many services colocated with research activities in the Cancer Centre, which opened in 2016.

We have a long tradition of clinical and scientific achievement. In 2007, we were awarded one of the National Institute for Health Research's (NIHR) Biomedical Research Centres, with King's College London.

In 2009, King's Health Partners was accredited as one of the UK's first academic health sciences centres (AHSCs), bringing together world-class clinical services, teaching and research. We work closely with our AHSC partners – King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London, our shared university partner.

We have around 16,200 employees, making us one of the biggest employers locally. We aim to reflect the diversity of the local communities we serve and continue to develop new and existing partnerships with local people, patients, neighbouring NHS organisations, local authorities and charitable bodies and GPs.

We strive to recruit and retain the best staff: the dedication and skill of our employees are what make our hospitals and community services successful.

Financial risks

In 2018/19, the Trust faces a number of financial risks which are listed below and then described in further detail on pages 14 and 15:

- achieving the required efficiency savings for 2018/19
- failure to deliver our control total and secure Sustainability and Transformation Fund income
- the ability of our commissioners to afford increases in activity required to deliver national waiting times
- the Trust's capacity to deliver activity to the required standards and activity levels
- reductions in local authority funding.

Operational risks

A number of operational risks, in addition to the financial risks above, which are described more fully in the annual governance statement, have also been identified.

These include:

- our ability to deliver required activity levels given the sustained increase in demand for our services
- our ability to deliver access standards, particularly the accident and emergency four hour wait and the cancer maximum 62 day wait
- our ability to recruit and retain sufficient staff given current workforce pressures.

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

Despite an extremely challenging external environment we have seen a steady improvement in operational performance, particularly in the second half of the year. This could not have been achieved without the hard work of our staff as well as their continued determination to improve the care and experience of patients who use our services.

The Trust's performance is monitored against key national standards. In addition, our Board of Directors reviews progress against a range of internal and external metrics through our Integrated Quality and Performance Report.

Our emergency floor transformation programme continued to make good progress during the year. As each new phase was completed, clear improvements in working practice were realised. We completed the last major phase with the opening of a new 'majors' area in March and this will help achieve our performance against the four hour A&E target and improve the experience of patients.

The number of patients attending each day continues to grow and we often experience a surge in demand in the early evening. Despite this, our staff continued to work tirelessly to ensure our patients were seen and treated as quickly as possible.

In common with emergency departments across the capital, we saw demand reach unprecedented levels, particularly in February and March. Despite this, we continued to be one of the best performing trusts in London and we achieved our performance trajectory as agreed with our regulator, NHS Improvement. We were also able to provide mutual aid to neighbouring

hospitals at key periods during the winter months.

Infection control remains a priority and we believe the vigilance of staff contributed to our ability to avoid bed closures and maintain capacity this winter. 79.9% of frontline staff, above our target of 75%, were vaccinated against flu – an overall increase of 1,700 compared with the previous year.

During 2017/18 we introduced the electronic referral system (ERS) to help with management of our cancer two-week wait referrals. This had an immediate positive impact on our ability to provide first appointments within seven days and was a significant contributing factor which enabled the Trust to achieve the two-week wait standard for most of the year.

In May 2017 we opened a cancer centre at Queen Mary's Hospital Sidcup, which, together with our new Cancer Centre at Guy's, helped to improve care for patients with a suspected diagnosis of cancer or requiring cancer treatment.

We continued to struggle to meet the target that 85% of cancer patients receive treatment within 62 days of referral. However, sustained efforts to tackle this in the second half of the year have improved our performance against the target where it relates to patients referred

directly to Guy's and St Thomas'. Performance has been more difficult to improve for those patients referred to us for specialist cancer treatment by other hospitals.

Through hard work and significant investment in our administrative support services, we achieved the 62 day standard in January and March for patients referred directly to Guy's and St Thomas', although it remains a challenge to achieve this sustainably.

We continue to work closely with our neighbouring hospitals to reduce unnecessary delays and we are hopeful that we will be able to reduce waiting times for diagnosis and treatment across the South East London Cancer Network in the months ahead.

Achievement of the 31 day targets for first and subsequent cancer treatments was inconsistent and is now a particular focus for improvement.

We continued to experience exceptional growth in demand for our services in 2017/18, leading to a significant increase in the number of patients waiting for planned treatment in the first half of the year. As a result, we struggle to meet the target that 92% of outpatients are seen within the 18 weeks referral to treatment target.

To help tackle this we have

Performance report

Key performance indicators

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	C. <i>difficile</i> acquisitions (including: cases deemed not to be due to lapse in care and cases under review)	51	27	●	5	11	7
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	88%	●	89%	87%	87%
A&E access	95% A&E patients wait less than 4 hours	95%	89%	●	88%	89%	89%
Cancer access initial appointments	Urgent cancer referrals seen within 2 week wait	93%	96%	●	92%	95%	98%
	Symptomatic breast patients seen within 2 week wait	93%	95%	●	88%	97%	98%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	69%	●	65%	67%	71%
	% patients treated within 62 days from screening referral	90%	69%	●	84%	65%	62%
	% patients treated within 31 days of decision to treat	96%	94%	●	94%	94%	95%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	91%	●	90%	87%	92%
	Chemotherapy treatments within 31 days	98%	99%	●	98%	99%	100%
	Radiotherapy treatments within 31 days	94%	92%	●	89%	93%	93%
Community care information completeness	Referral to treatment information completeness	50%	68%	●	65%	64%	70%
	Referral information completeness	50%	81%	●	72%	73%	95%
	Activity information completeness	50%	69%	●	71%	69%	69%

worked with local commissioners to develop alternative services, some of which are based in the community. These ensure patients are referred to the most appropriate service for their treatment, for example, integrated health and social care rapid response and rehabilitation and reablement teams.

Our clinical teams have worked hard to treat patients who have waited the longest and we have increased capacity through additional evening and weekend clinics and operating lists. We have also focused on improving our administrative processes, all of which have had a positive impact on our performance in the second half of the year, reducing our backlog and stabilising our overall waiting list at around 60,000.

Demand for children's services provided by Evelina London remains high. Increases in planned (elective) and emergency activity have enabled waiting times to remain stable and a number of service improvements, such as emergency and elective pathway redesign, have supported this. Additional inpatient facilities,

including increased capacity for critical care and day-case procedures, will open in summer 2018, enabling further improvement.

We struggled to consistently achieve the standard that 99% of patients receive their diagnostic test within six weeks, often due to problems with our administrative processes or capacity in some services. We have worked hard to address this during the year, and this has included working with other trusts to provide additional local capacity to support cancer diagnosis and speed up access to treatment.

A comprehensive programme of work commenced during the year to increase the number of Continuing Healthcare Assessments completed out of hospital, in line with new national targets. This included a new 'discharge to assess' pathway that was launched in October.

An early evaluation of the Neighbourhood Nursing 'test and learn' pilot in Brixton found that the model brought benefits for patients, carers, staff and the health and social care system. The model was extended to north Southwark during 2017.

An evaluation was also completed of the neuro-rehabilitation pathway which is delivered jointly with King's College Hospital. The clinical outcomes demonstrated increased levels of independence following neuro-rehabilitation, and patient feedback has been positive. The work of the team reduced unnecessary hospital admissions, reduced the length of hospital stays and ensured patients are cared for in an appropriate environment.

Integration of health and social care services continued in both Lambeth and Southwark. A joint manager for the new Integrated Care Southwark service was appointed, and in Lambeth the Guy's and St Thomas' in-house reablement service has been taking referrals since September.

Emergency hospital admissions for Lambeth and Southwark residents aged over 75 remained stable and reductions in length of stay were seen. Services that contributed to this were @home, pal@home, enhanced rapid response, reablement and strength and balance classes.

Performance analysis – financial

At the start of the year, the Trust planned to deliver a £3 million deficit, in line with the control total agreed with NHS Improvement. Compared to this target, a £0.5 million surplus was achieved, representing an improvement of £3.5 million against the original plan. This was achieved through cost savings and efficiencies, non-recurrent action and extra income arising from additional activity.

Having delivered and exceeded the control total, the Trust was eligible for Sustainability and Transformation Funding (STF), including incentive and bonus funding. This totalled £28.4 million, including £0.4 million STF that related to 2016/17, and reflects the Trust's positive financial performance.

The control total is calculated before accounting for capital donations (£12.4 million), depreciation on donated assets (-£11.2 million) and the reversal of impairments arising from the revaluation of land and buildings (£10.8 million). When these are taken into account, the total surplus for the year was £40.8 million.

Our financial performance

The Trust's control total, agreed with NHS Improvement, meant that we set a plan to deliver a £3 million deficit. After accounting for the depreciation charge on donated assets (-£8.9 million) and the receipt of STF funding (£22.1 million) and capital donations (£5 million), this equated to a planned surplus for the year of £15.2 million. The control total set by NHS Improvement was exceeded by £3.5 million. This performance resulted from increased income, savings and efficiencies, and the delivery of key targets that have allowed us to receive a substantial element of the planned Sustainability and Transformation Funding (STF) plus additional STF incentive and bonus payments for exceeding our control total.

Cost Improvement Programme

At the start of the year, the Trust set a £99 million Cost Improvement Programme (CIP), reflecting the level of savings required to deliver our

financial plan, achieve national efficiency targets and treat an increased number of patients within the funding available from our commissioners. This target was met through a range of efficiency measures and additional income. Local savings at a directorate level were complemented by Trust-wide savings, many of which were delivered through the *Fit for the Future* Programme to improve quality, safety and efficiency. Together, these actions enabled the Trust to achieve 92% or £90.9 million of the planned Cost Improvement Programme.

Sustainability and Transformation Funding

The financial plan included £22.1 million STF baseline funding from NHS Improvement which required us to achieve agreed financial and performance targets. The funding received from the original STF baseline allocation was £16 million, against a maximum of £22.1

million. This reflects the achievement of our financial performance targets, and a shortfall against the expected A&E trajectory.

A further STF incentive scheme providing additional funding to trusts that exceeded their financial plan was announced during the year. The Trust received an additional £3.5 million of STF incentive funding under this scheme. A further £0.4 million was received relating to 2016/17 financial performance following changes made to the funding at a national level. At the end of the year, an additional STF bonus of £2 million was received, plus general STF incentive funding of £6.4 million, bringing total STF funding in 2017/18 to £28.4 million, £6.3 million above plan.

Performance against plan

By delivering a surplus of £0.5 million against our control total we ended the year £3.5 million ahead of plan, and £7.5 million favourable on our underlying surplus. Capital

donations towards the cost of our capital programme exceeded the original expectations set out in our financial plan by £7.4 million, as additional funding was secured during the year for new capital projects. The annual revaluation of the Trust's land and buildings led to a net £10.8 million impairment reversal, which reflects changes in the basis of the valuation, but no physical change in the functionality of the buildings or their ability to support patient care. The reversal

reflects an increase in the value of buildings that have in prior years decreased in value. The impairment was not included in the plan and represents a technical accounting adjustment that is reflected in our final financial position. Variances in our underlying financial performance were partially offset by the increased capital donations and the net impairment reversal. Once these adjustments (which we do not include in the underlying financial position used by the Trust Board to

monitor performance during the year) have been reflected, the Trust achieved an overall surplus of £40.8 million, £25.7 million ahead of the original plan for a £15.2 million surplus.

Cash flow

The Trust began the financial year with £140.4 million of cash and cash equivalents. The majority of the cash results from surpluses achieved in previous years and is earmarked for the Trust's capital programme. During the year cash balances decreased by £5.6 million to £134.8 million. For details of the Trust's net cash balances, see note 25 in the Annual Accounts on page 132. The cash movement during the year is a result of the financing of capital projects, including a lower net receipt of loan funding. The operating surplus after adding back non-cash items resulted in £81.6 million of net cash generated from operating activities. The Trust spent a net £67.8 million on investing activities, which included £81.8 million purchasing intangible assets and property, plant and machinery, receipts of £12.4 million in capital donations and £1.6 million in interest. A net £19.4 million was paid in loan interest and Public Dividend Capital dividends and draw downs. Full details can be found in the Consolidated Cash Flow Statement in the Annual Accounts on page 111.

Charitable funding

The Trust received £17.7 million from charitable sources during the year, £12.4 million of which

Table 1: Financial performance against plan

	2017/18 Plan £000	2017/18 Actual £000	Variance £000
Control total excluding STF baseline	(3,000)	542	3,542
Depreciation on donated assets	(8,916)	(11,245)	(2,329)
STF baseline funding	22,094	15,963	(6,131)
STF incentive funding (finance)	–	3,542	3,542
STF incentive funding (general)	–	6,432	6,432
STF bonus funding	–	2,014	2,014
STF prior year funding	–	419	419
Underlying surplus	10,178	17,667	7,489
Capital donations	5,000	12,399	7,399
Impairments (market value)	–	10,758	10,758
Surplus for the year	15,178	40,824	25,646

Table 2: Financial performance comparison

	2017/18 Actual £ million	2016/17 Actual £ million	Change £ million
Income excluding capital donations	1,468.2	1,414.2	54.0
Expenditure excluding impairments and sale of assets	1,450.6	1,378.4	72.2
Underlying surplus	17.6	35.8	(18.2)
Capital donations	12.4	32.3	(19.9)
Impairments	10.8	(25.5)	36.3
Surplus for the year	40.8	42.6	(1.8)

Table 3: Cash flow

	2017/18 £ million	2016/17 £ million
Operating surplus before finance and other costs	66.5	66.4
Non-cash income and expense	15.1	(6.5)
Net cash generated from operating activities	81.6	59.9
Investing activities	(67.8)	(72.2)
Financing	(19.4)	35.2
Net increase / decrease in cash	(5.6)	22.9

Trends in activity, income and expenditure

Chart 1: Completed patient spells

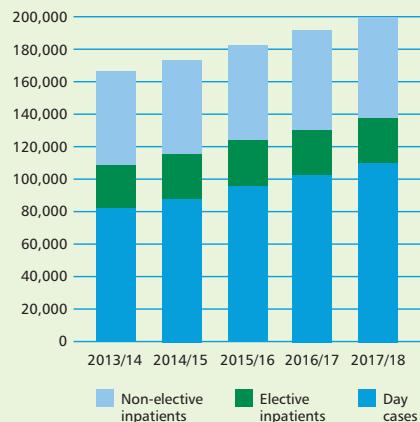


Chart 2: Outpatient attendances

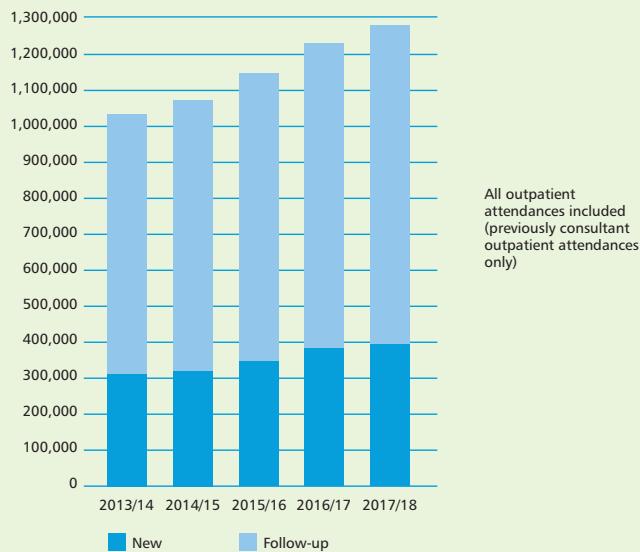
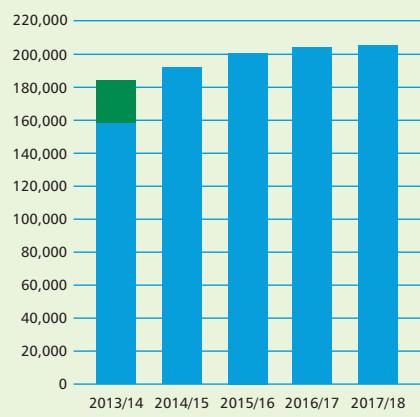


Chart 3: A&E attendances



During 2017/18, we saw in total 1,282,000 outpatients, 89,000 inpatients, 111,000 day case patients and 205,000 accident and emergency attendances. We also provided over 810,000 contacts in the community, bringing our total patient contacts in the year to 2.4 million.

- A&E attendances, including attendances at the urgent care centre at Guy's
- Shows attendances at the urgent care centre at Guy's when this service was managed by local GPs, not the Trust

Chart 4: Income £millions

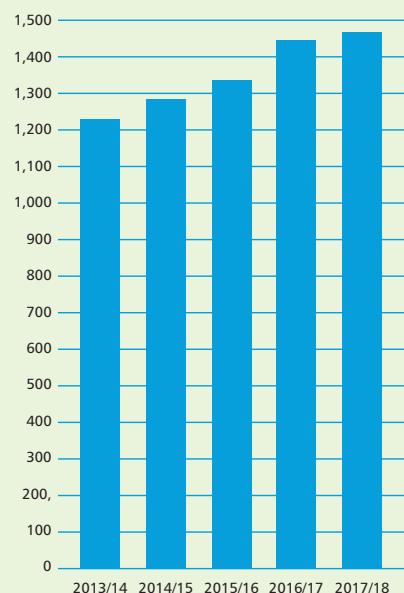
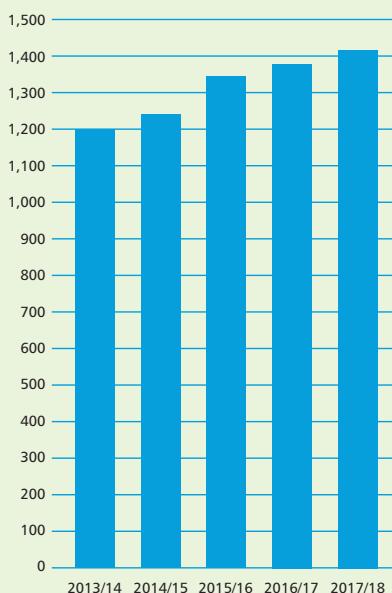


Chart 5: Expenditure £millions



consisted of donations towards capital expenditure and this funding came principally from Guy's and St Thomas' Charity.

Capital expenditure

In 2017/18, the Trust spent £73.2 million on property, plant and equipment (£88.7 million 2016/17). The Trust also spent £8.6 million on intangible assets, mostly software and other IT (£9.3 million 2016/17). 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 Independent Trust Financing Facility had agreed loans totalling £269 million, and the Trust had drawn down a net £221.2 million of these after repayments. During the year, a further £10 million loan was approved by the Department of Health and Social Care. The Trust drew down borrowing of £12.7 million and made principal repayments of £10.5 million, bringing total borrowings to £223.4 million. To date, total repayments of £30.6 million have been made leaving a further £25 million to be drawn down in future years. See note 23 in the Annual Accounts on page 131 for more details. In addition to the £279 million of agreed loans, a further

£90 million loan has been agreed by the Independent Trust Financing Facility committee and this is currently awaiting confirmation from the Department of Health and Social Care.

Revaluation of land and buildings

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. In addition, some property, plant and equipment projects and intangible projects were impaired when projects were abandoned. This year, the full impact on the income statement is a benefit of £10.8 million compared to a £25.4 million charge in 2016/17. These entries, referred to as impairments, do not reflect any physical damage to our land and buildings, loss of utility or financial loss, and they have no implications for patient care. This year the benefit is a net reversal of impairment charges, reflecting the increase in value of buildings that had decreased in value in prior years. More details can be found in note 15 to the Accounts on page 126.

External audit services

Grant Thornton received £128,000 in audit fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2018. In addition, the Trust paid a further £10,000 to Grant Thornton for their quality audit work. For more details, see note 5.2 to the Accounts on page 119.

Events since the end of the financial year

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

Identifying potential financial risks

In 2018/19, the Trust faces a number of financial risks. These include:

Delivering required efficiency savings to support our financial plan: the Trust is required to deliver £92.2 million efficiency savings. This is more than 9% of the Trust's cost base on which savings can be made. There is a risk that we cannot identify sufficient efficiencies to fully address the financial challenge, or that we cannot deliver these at the required pace.

Failure to deliver our control total: if the Trust fails to achieve the performance trajectories agreed for A&E, the Trust will lose up to 30% of its Sustainability and Transformation Fund (STF) income, while failure to meet our financial target would mean the loss of all our STF money.

Commissioner affordability: although the Trust has agreed contracts with its principle commissioners these, in the main, do not include the full estimated costs of meeting national waiting times standards. We have agreed cost and volume contracts with these commissioners to mitigate the financial risk of over-performance. However, if commissioners cannot afford to fund the in-year performance required to deliver

national waiting times, this poses a risk to our financial plan and our ability to meet our control total, and would therefore require discussion with NHS England and NHS Improvement.

Capacity: the Trust does not have sufficient capacity to deliver national waiting times standards, and the cost of outsourcing activity is greater than the cost estimates included in the financial plan. Plans to increase capacity remain an investment priority for the Trust.

Local authority funding reductions: the Trust will be affected by reductions in local authority funding for public health, including services such as health visiting, sexual health and school nursing. In addition, possible reductions to social services and care home provision may lead to delays in discharging patients from hospital, increased length of stay and associated costs.

Capital planning

Our capital programme has always underpinned delivery of our strategic ambitions. However, the availability of capital is now at odds with our operational and strategic requirements. We will need to continually balance multiple demands including:

- an urgent need for additional theatre and critical care capacity following a Board review of our five year demand and activity forecasts and safety issues
- maintaining our infrastructure (estate, IT and medical equipment) to ensure we provide safe, compliant services

Our capital priorities are set out below:

Capital priority	Description
Theatres at both Guy's and St Thomas'	Urgent capacity requirement
Critical care and haemodialysis unit at St Thomas'	Urgent capacity requirement
Expansion of Evelina London Children's Hospital	To accommodate growth of local and specialised children's activity and first stage of achieving our longer term vision for Evelina London
Children's clinical research facility	To support and develop our children's research ambitions – this is core to many treatment options and also offers academic benefits
Medical equipment and infrastructure backlog	Annual replacement programme for high risk areas
IT investment	Key infrastructure and IT enablers to drive greater efficiency and productivity
Electronic health record	We will finalise the full business case to make a decision about investment internally and/or with partners
Orthopaedics joint venture	Work with a commercial partner to increase efficiency, capacity and quality to meet increasing demand
Energy performance contract	Improving energy efficiency
PET (Positron Emission Tomography) redevelopment – phase 2	New imaging suite with two PET CT scanners and a cyclotron for the manufacture of radio isotopes
Community properties	A detailed review is underway to establish investment needs in line with our clinical strategy
Cardiovascular Institute and Evelina London Institute development	Business case development

- the need to invest in the transformation (capital and revenue) to drive more efficient delivery models and ways of working, both internally and with partners including in the south east London STP, wider clinical networks and the Trust's healthcare alliance. This especially relates to investment in digital transformation and analytics
- investing in our strategic ambitions and schemes with a

favourable return on investment which are important for medium to long term planning.

Our capital priorities listed in the table above reflect these demands. In light of this context we will:

- continue to explore alternative funding sources, including reviewing our estate development strategy in partnership with King's College London and Guy's and St Thomas' Charity, as well as

exploring commercial opportunities. The Trust has agreement in principle from the Department of Health and Social Care for an additional loan of £100 million (of which £10 million has been approved by NHS Improvement) which is critical in addressing the projected operational capacity constraints

- focus on maximising utilisation of our current infrastructure which is linked to many of our *Fit for the Future* plans. Our ability to invest in technology will be a major enabler or constraint
- discuss options for potential properties identified as surplus to our clinical service and estate requirements. This will be dependent on relevant consultation and partnerships with local councils, clinical commissioning groups, community and mental health providers, NHS Property Services and King's Health Partners.

Fit for the Future

Our refreshed *Fit for the Future* programme for the next two years builds on a strong platform that has already supported directorates to deliver numerous quality, safety and efficiency improvements. There is high staff engagement with the programme and our collective focus aims to create a culture of continuous improvement where 'everyone does improvement', and staff feel empowered to deliver change and transformation. This staff engagement will continue through our annual *Fit for the Future* week, successful Dragons' Den competition and the awarding of *Fit*

for the Future badges. These badges are presented at the monthly team briefing to recognise staff who have gone the extra mile to implement an improvement in their area which has benefited staff, patients and their families.

Our three major transformation programmes under the *Fit for the Future* programme have begun to deliver benefits across the organisation:

- care redesign – this is supporting evidence-based pathway redesign, engaging the whole multi-disciplinary team to optimise the way that services are delivered
- digital patient journey – this is driving improvements in administrative processes and considering how best to use digital technologies to make our services more responsive to the needs of patients, referrers and staff
- transforming our ways of working – this is creating modern working environments that encourage flexible working and collaboration, while reducing our reliance on costly rented office accommodation.

In addition, we continue to support the 10 *Fit for the Future* workstreams, all of which are now fully embedded, with the ability to evolve as the needs of the organisation change. We also continue to invest in our staff through the *Fit for the Future* Academy, training hundreds of staff to ensure they have the necessary skills to drive change. Going forward we will align our transformation work with our plans to procure an Electronic Health Record.

Delivering the Carter recommendations

We continue to support NHS Improvement with the development and implementation of the recommendations of the Carter Review. We are pursuing both the specific recommendations and the wider use of benchmarking to inform our improvement efforts. In particular:

- we have worked with clinical directorates to combine the model hospital tool with other sources of data to generate new insights and improvements
- we have created an opportunities 'heat map' to inform directorates and services about their improvement opportunities
- our *Fit for the Future* workstreams reflect the key drivers of productivity from the Carter agenda. Through these initiatives we continue to deliver £15-20 million of efficiencies annually.

Procurement

During 2017 the Trust established a procurement shared service (SmartTogether) with Lewisham and Greenwich NHS Trust and Dartford and Gravesham NHS Trust to support local collaboration and operational efficiency in line with the Carter recommendations.

In November, NHS Improvement published a Procurement League Table to assess the relative performance of procurement departments. The Trust was ranked 18th out of 136 acute providers and was the highest ranked acute provider in London, reflecting our strong performance.

Performance analysis – sustainability and environmental

Environmental impact performance indicators 2017/18

Area	Acute hospitals		Trend 17/18 v 16/17	Community services		Trend 17/18 v 16/17
	2017/18	2016/17		2017/18	2016/17	
Water	521,651 m ³	562,321 m ³	-7%	38,020 m ³ *	20,676 m ³	84%
Water cost	£860,844	£1,009,270	-15%	£82,430	£26,412	212%
Imported electricity	177,303 GJ	178,708 GJ	-1%	3,073 GJ	2,136 GJ	44%
Gas	708,340 GJ	655,768 GJ	8%	7,760 GJ	6,001 GJ	29%
Energy cost	£9,868,141	£9,107,242	8%	£283,383	£146,201	94%
CO ₂ emissions from building energy use	53,401 tonnes	54,620 tonnes	-2%	886 tonnes	601 tonnes	47%
High temperature disposal	432 tonnes	445 tonnes	-3%			
Alternative treatment (offensive waste)	1,609 tonnes	1,599 tonnes	1%			
Landfill waste	20 tonnes	16 tonnes	25%			
Recycling by % of total	37%	35%	5%			
Cost of waste	£1,133,028	£1,078,182	5%			

*The 2017/18 increase in annual consumption relates to the inclusion this year of renal dialysis service usage.

The Trust has a growing sustainability programme that continues to minimise our environmental impact. Guided by our sustainability strategy, we are viewed as a leader in sustainable healthcare and aim to be one of the most sustainable healthcare organisations in the UK.

Our SAVE programme (Sustainable Actions delivering Valuable Efficiencies) which aims to support directorates to deliver savings through efficient use of resources and utilities, has doubled in scope since last year, achieving over £150,000 in savings. Fourteen directorates are involved in the programme and we aim to include all directorates in 2018/19. As part of SAVE, the perioperative, critical care and pain directorate achieved £15,000 savings by introducing a surgical waste management system.

In response to staff demand, we have introduced a coffee cup recycling system. This new service

allows us to upcycle disposable coffee cups into paper products and will help the Trust save over £10,000 each year.

This year, we also worked with Evelina Hospital School's staff and pupils, using children's drawings as signs to designate clean air zones around the hospital. The drawings will also be included in 'clean air maps' that will help staff, patients and visitors find the healthiest route from major tube and bus stations to our hospital sites.

Helping our staff to stay active is embedded in our sustainability plans and our approach is supported by the Trust's sustainable travel plan. We continue to support staff to travel actively by providing facilities for cyclists and tax-free cycle purchase schemes as well as fortnightly lunchtime walks which are open to staff and patients.

The Trust carefully considers its impact on the environment when making purchasing decisions and

also in strategic decision making. Sustainability is reflected in business plan development, as well as service tenders.

Last year the Trust was delighted to win a Green Apple Award in the health innovation category for its sustainability work. The Trust was also highly commended in three categories in the NHS Sustainability Awards: for leadership, food and finance.

Our energy performance contract is on target to deliver £1 million in savings over 10 years. This includes an ambitious programme to switch to LED lighting, which consumes on average 55% less energy, and also has reduced our lighting maintenance costs by 80%.

The Trust's award-winning waste team is now managing StockDoc, our Trust-wide furniture reuse platform, which delivered £58,000 worth of savings in three months.

Equality and diversity

The Trust serves the diverse local communities of Lambeth and Southwark, as well as caring for patients from further afield. This diversity is reflected in both the profile of our patients and staff, and brings many benefits.

We are constantly striving to ensure that our services meet the needs of all people regardless of their age, disability, ethnicity, gender, race, religion or belief, and sexual orientation, in accordance with the Equality Act 2010 and our public sector equality duties.

In 2016, the Board of Directors sponsored the development of revised equalities objectives and continues to support this with the development of refreshed Equality, Diversity and Inclusion priorities for 2018-2020 and work to embed these into day-to-day business.

The objectives aim to drive improvements in patient care and staff experience, reducing inequalities for our diverse workforce and patient population.

These objectives include:

- improving the way we develop, design and deliver services to meet the needs of our most vulnerable patients, including providing accessible information
 - ensuring that our environment, facilities and services are accessible to all
 - helping people, including vulnerable people, to participate in public life by widening access to employment and new skills
 - reviewing our patient and staff experience to ensure all groups of people receive a positive experience
 - ensuring all groups of staff have equality of opportunity for career progression, and our senior management group reflects the diversity of the wider organisation and patient population.
- The Trust has a duty to ensure all its processes, practices and outcomes are fair for both patients and staff. This is monitored by the Trust's head of equality, diversity and inclusion, and through both local and statutory reporting.
- The Trust also recognises the importance of respecting and protecting the human rights of our patients, staff and members. This is embedded as a core element in staff training, when designing processes and within our communications and decision making.
- The Trust is committed to safeguarding all our patients, including the most vulnerable. We participate in our local, multi-agency safeguarding boards and 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 team consists of separate adults and children's teams, which work closely with our statutory bodies providing support, guidance and decisions on all safeguarding issues. They also provide training to all staff as part of the wider Trust's training programmes. This includes Barbara's Story, an award-winning training film which raises awareness of dementia and the issues faced by vulnerable patients and their families. Each clinical directorate has a dementia and delirium champion and a learning disabilities champion who work with colleagues to implement best practice in their area. The Trust is also a member of the Dementia Action Alliance and is working with partners to provide better services for people with dementia, including through the creation of dementia-friendly communities.
- The Trust provides a comprehensive language and accessible support service to meet the communication needs of our diverse population. The service provides interpreters for patients and their carers, patient information in other languages, as well as in other formats including easy read, Braille, large print and audio when required. We also offer web-based British Sign Language. Collaborative working between services has seen the roll out of 'communication aid' boxes and 'activity' boxes which consist of communication resources such as portable hearing amplifiers, magnifying sheets, white boards, symbols and images, and activity books to support patients with particular communication needs as well as patients with dementia.
- It is important that our services and our buildings are fully accessible for patients, families and carers. The Trust has invested in a comprehensive accessibility audit to ensure we improve physical access for patients with disabilities, patients with sensory loss and those who are frail or elderly. Accessibility information has been

published on our website to inform patients and carers of our facilities prior to them attending their appointment. Patients can see what the area/department or ward looks like, and what facilities, for example, accessible toilets, flooring and lighting are available. This work is part of a wider accessibility strategy.

The Trust has supported many projects through its Widening Participation programme. These include: attending careers fairs in local schools and colleges, providing 700 work experience placements (126 for people from local communities) and supporting young people from severely disadvantaged backgrounds to undertake paid internships through partnerships with Lambeth College and the EY Foundation. We have also supported 260 members of the armed forces community through Step into Health, employing 11 people at Guy's and St Thomas' and helping a further 40 to secure employment in NHS organisations across London. We have supported 22 people who were homeless or in unstable/temporary housing through our Work Ready programme, 20 of whom went on to secure employment or education.

A multi-faith spiritual care team is available to support patients and staff, and reflects the diverse faiths and beliefs of our local population.

Under the Equality Act 2010, employers are required to set out arrangements for how they meet specific employment duties. The Trust collects a range of

employment data to monitor diversity and inequalities, and publishes the results in an annual workforce monitoring report on our website and through reporting to NHS England.

The Trust undertakes equality impact assessments to provide assurance that our policies, functions and services are not discriminatory. When any remedial action is identified by the assessment, we develop and implement an action plan to address this. In 2018 the reporting data also included information about our gender pay gap for the first time.

A handwritten signature in blue ink, appearing to read "Amanda Pritchard".

Amanda Pritchard,
Chief Executive
23 May 2018



The therapies team provides a wide range of services in a variety of settings including inpatients, outpatients, community and GP practices. They also help provide coordinated care as part of multidisciplinary teams across the Trust.

3

Accountability report

Directors' report 23

Remuneration report 31

Staff report 39

Our organisational structure: 49
disclosures set out in the NHS
Foundation Trust Code of Governance

Single oversight framework 57

Statement of the Accounting 59
Officer's responsibilities



We have ambitious plans to further develop Evelina London to meet the needs of an increasing number of children requiring our specialist services.

Directors' report

Guy's and St Thomas' has performed well both operationally and financially during 2017/18 which was another exceptionally busy and demanding year. Our staff continue to work hard to balance high quality patient care with achieving our performance targets in a challenging financial environment.

The Trust continued to deliver excellent patient care, while driving forward quality and service improvements for the benefit of our patients. We have also maintained a strong financial position which has allowed us to continue to deliver our ambitious capital programme.

Our staff have worked exceptionally hard to maintain performance against national and local targets and to comply with the requirements of our main regulators, the Care Quality Commission and NHS Improvement. We continue to work closely with our local clinical commissioning groups, with specialist commissioners and with our local Health and Wellbeing Boards in a rapidly changing external environment.

Delivering high quality care

Under the Care Quality Commission's (CQC) system for regulating health and social care organisations, Guy's and St Thomas' is registered to provide services without conditions or restrictions, having complied with all the essential standards for quality and safety.

The Trust's services were last assessed by the CQC in September 2015, and we were pleased to achieve an overall rating of 'Good'. This is a significant achievement given the size and complexity of the Trust, and is a tribute to the commitment and effort of staff across the organisation. The Trust was rated 'Outstanding' for caring services, and 'Good' for effectiveness, responsiveness, and being well led. The Trust expects the next CQC inspection to take place in 2018/19 and will be actively preparing for this in the coming months.

We continue to focus on a range of activities to improve and assure safety, including through

the consistent application of the five steps of the World Health Organization (WHO) surgical safety checklist, and by consistently sharing the outcomes and learning from incidents. In line with NHS Improvement guidance, the Trust has undertaken significant work this year to comply with national requirements on learning from deaths and to ensure that such learning is shared and used to improve care.

The Trust continues to perform well in the Patient-Led Assessments of the Care Environment (PLACE). Last year, we achieved a score of 99.8% for cleanliness, with the other elements measured also scoring highly.

Sustaining operational performance against a wide range of national and local measures, including NHS Improvement's compliance framework, remains an enormous challenge. It requires a sustained effort from frontline staff and managers, and we work hard to support them, for example through weekly 'Safe in our hands' briefings, monthly team briefings and the Trust's *Fit for the Future* programme, which brings together visible clinical leadership and improvements in quality, safety and efficiency. A monthly serious incident assurance panel, chaired by a non-executive director, receives reports by clinicians on the outcome of investigations conducted in line with the Trust's serious incident framework.

The Board has continued to assess its compliance with the principles of the NHS Foundation Trust Code of Governance, including regular reviews of the make up and responsibilities of Board committees and their terms of reference. Further details can be found in the organisational structure chapter

on page 49 and in the full Compliance Statement on the Trust's website.

The Trust's Quality and Performance Committee monitors the delivery of the Trust's quality priorities which have been developed in consultation with stakeholders from our local community. These are described fully in the quality report on pages 70 and 71.

The committee also monitors the full range of clinical and non-clinical performance indicators which are reported monthly through the integrated quality and performance report (IQPR). This report is published on the Trust website and this, together with regular updates to 'Our Quality Story', ensures that we are open and transparent about our performance. It is also scrutinised alongside the quality report by the Trust's external auditors as part of a rigorous assurance process.

We continue to work hard to reduce hospital infections and retain a sharp focus on quality, safety and clinical effectiveness. Our quality priorities are also informed by complaints and the feedback that we receive from patients, families and carers.

We take complaints very seriously as they form a crucial part of our learning from patients. We have received complaints relating to clinical care and to other aspects of the patient experience, such as patient transport and communications issues. We continue to work hard to improve the management of complaints and recognise that we need to do

more to improve the quality and, in particular, the timeliness of our complaint responses.

Our CQC report, a wide range of performance measures and patient feedback, all provide valuable information about where and how we can improve care for patients. We use this information to drive positive change across the Trust, with close oversight from the Board of Directors and our Council of Governors.

Our local and wider role

The Trust provides a full range of local hospital services to people living in Lambeth, Southwark and surrounding boroughs as well as a wide range of specialist services for local people and patients from further afield.

We continue to collaborate across King's Health Partners and with organisations across south east England and London, as well as nationally and internationally, to improve services, research and education.

At St Thomas' we have one of the busiest emergency departments in London and provide a wide range of very specialist services and sub-specialties. The site is home to Evelina London Children's Hospital, as well as one of the largest intensive care units in the UK. We have many regional and national centres of excellence, including a major cardiovascular centre and a comprehensive range of women's and children's services, many of which benefit from being colocated on a single site.

Our services at Guy's continue to serve a wide population from across

south London and further afield through a growing network of outreach clinics and satellite centres. As well as dental, renal, urology and orthopaedic services, including complex surgery, our Cancer Centre is located at Guy's. Improving cancer services, working closely with partners across south east London, remains a key strategic priority for the Trust and King's Health Partners. Guy's Tower is a major hub for research and includes a wide range of specialist facilities which continue to strengthen our position as a leader in genomics, imaging and regenerative medicine.

Evelina London Children's Hospital continues to develop a comprehensive network of specialist children's services across south east England. By supporting expert care closer to home and improving access to our full range of specialist services, Evelina London will provide better care to children and young people, particularly those with complex clinical needs.

The Trust continues to play a key role in the development of the Accountable Clinical Network for cancer services in south east London, with a focus on improving waiting times, care and outcomes for cancer patients.

As part of the Trust's commitment to providing care closer to where people live, in 2017 we opened both a cancer centre and a kidney treatment centre at Queen Mary's Hospital Sidcup. This means that patients don't always have to come into central London for treatment.

We provide community health services for adults and children

across Lambeth and Southwark, allowing us to deliver seamless care for our patients. We deliver services in a variety of locations, including in GP practices, health centres, schools, community buildings and in patients' homes.

We work in partnership with colleagues from across the local health economy – including local authorities and voluntary/ community groups – to provide holistic care, and we are an active member of the Southwark and Lambeth Strategic Partnership. The partnership brings together staff from health and social care, as well as local residents and service users through a Citizens' Forum and has been working on the development of local care networks, and joining up mental and physical healthcare.

We continue to work closely with Healthwatch in both boroughs and meet regularly to keep them informed of potential service changes and to discuss progress in delivering our quality priorities. In addition, we have recently sought contributions from Healthwatch in developing our new quality and patient and public engagement strategies.

We have responded to Healthwatch enquiries about adult podiatry services, and Healthwatch Lambeth helped evaluate a Trust training course 'caring with carers' that was designed for unpaid carers who support people with dementia. Their report informed the delivery of further courses.

We have provided space for Healthwatch to talk to visitors and patients who attend our hospitals and community sites to promote

their work and seek people's views on future Healthwatch priorities.

Healthwatch have powers to 'enter and view' healthcare premises to observe the delivery of services and the care environment. Healthwatch Lambeth visited our podiatry services as part of their 'Right for Everyone' project, which focused on assessing the quality and accessibility of services for people with learning disabilities. We are awaiting their report.

The Trust continues to play an active role in Our Healthier South East London (OHSEL), the name for our local sustainability and transformation partnership (STP).

We have worked closely with OHSEL partners to improve maternity and cancer services and we are developing plans to improve the performance of local urgent care and emergency services.

As part of OHSEL's plan to improve orthopaedic services, we contributed to the establishment of a South East London Orthopaedic Network. Consultant orthopaedic surgeon Peter Earnshaw stepped down from his role as clinical director for surgery at the Trust after being appointed as the clinical lead for the network.

We have been actively involved in a number of engagement activities with staff and local people to explore plans for modernising services and improving health outcomes through the use of digital technology.

We are pleased that OHSEL was rated as 'advanced' by NHS England and the Department of Health and Social Care in their assessment of STPs.

In November 2017, the Trust announced a new 15-year partnership with Johnson & Johnson Managed Services to improve the efficiency of the procurement of medical devices, surgical instruments and implants. Over the next three years, the partnership will support the development of a new Orthopaedics Centre of Excellence, providing additional theatres that will enable the Trust to respond to increasing demand for orthopaedic services. We expect to involve patients and local stakeholders in plans for developing the new centre.

The Trust was not required to undertake any formal public consultation exercises this year.

The Trust is committed to involving patients, families, carers and foundation trust members in the delivery and development of services. With the support of governors, members and staff we are currently refreshing our patient and public engagement strategy to ensure it continues to support the Trust's strategic priorities. A new strategy will be published in summer 2018.

More than 50 members and patients joined staff teams as patient assessors for our Patient-Led Assessments of the Care Environment (PLACE), visiting hospital and community services. The Trust scored above the national average in five out of six categories, including cleanliness, food and privacy.

The Trust scored just below the national average – 82.2% compared with a national average of 82.6% – for a measure

considering how well healthcare environments support the provision of care for people with a disability. The Trust is committed to ensuring that our buildings are accessible to people with disabilities. In July this year, we adopted DisabledGo, an online accessibility guide for our hospitals and community centres, to make it easier for patients to visit Trust services.

System leadership

Building on the work of the national vanguard programme acute care collaborative with Dartford and Gravesham NHS Trust, we have taken the decision to create a healthcare alliance with Dartford and Gravesham as a founding member. This alliance will enable us to work together across clinical and corporate areas in our drive to build services around the patient, provide consistently excellent care, create sustainable workforce solutions and use our shared scale to improve efficiency and effectiveness.

This year we have focused on establishing the governance arrangements, and priorities of the new healthcare alliance which will be formally launched in 2018, although it will not be a new legal entity as both trusts will remain sovereign organisations.

King's Health Partners

The Trust is proud to be part of King's Health Partners, our Academic Health Sciences Centre (AHSC). Working closely with our colleagues at King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London, we

continue to use our combined clinical, research and educational strength and expertise to benefit our local communities and those patients we serve from further afield.

We have made excellent progress this year in our partnership's work to join up the identification and treatment of mental and physical healthcare. Through the King's Health Partners Mind and Body Programme, more than 20,000 patients across more than 50 different clinics have now been screened for signs of anxiety or depression alongside their physical health needs at our two acute trusts. Our Three Dimensions of Care for Long-Term Conditions programme continues to develop and provide holistic mind and body care for people with heart failure, COPD and hypertension.

We want our staff to lead the way in changing how we care for people, and nearly 400 staff have now signed up to be 'Mind and Body Champions'. To ensure that 'mind and body' is built into our own way of working, we have also established a new mental health board at Guy's and St Thomas', led by senior nursing staff.

Building on the work in our Clinical Academic Groups, a number of clinical academic institute programmes (cardiovascular, diabetes, obesity and endocrinology, haematology and neurosciences) are bringing colleagues together from across our partnership to develop plans for working as 'one team' to improve patient care and research. Good progress is also being made to align our collective

academic strength in women's and children's health.

We have also announced plans to explore a partnership with Royal Brompton & Harefield NHS Foundation Trust that would revolutionise cardiovascular and respiratory services and research for the benefit of our patients.

The Local Care Record, which connects electronic patient records across the three NHS trusts and primary care has expanded again this year, meaning that safer, better care and improved clinical decision making is now being supported across all six boroughs in south east London.

Our research and innovation activities continue to grow. We were awarded £10 million by the UK Research Partnership Investment Fund to establish a world-class Advanced Therapies Centre. The Centre will occupy two floors of Guy's Tower, significantly increasing our research infrastructure and supporting our NIHR Biomedical Research Centre.

We were also named as one of five leading sites to receive funding as part of a new UK Dementia Research Institute.

In the last year, all three trusts within King's Health Partners increased their number of clinical research studies. For the third year in a row, Guy's and St Thomas' topped the national league table for the overall number of participants in studies.

As a founding member of the South London NHS Genomic Medicine Centre, together we are continuing to deliver the groundbreaking 100,000 Genomes Project.

The King's Health Partners Learning Hub continues to support staff through a wide range of free e-learning materials. There are now more than 11,500 registered users accessing nearly 100 different resources including training focused on the relationship between mental and physical health.

Overseas, our global health partnerships in Sierra Leone, Somaliland and the Democratic Republic of Congo continue to support the development of sustainable healthcare systems.

Investing in our future

The Trust continues to make substantial capital investments in innovative, high quality equipment and technology to help us deliver excellent patient care. We also invest in our buildings to enhance the environment for patients, visitors and staff.

Following the opening of the new Cancer Centre at Guy's in 2016, the Trust opened both a new cancer centre and kidney treatment centre at Queen Mary's Hospital Sidcup in 2017.

We have also completed the development and expansion of the emergency floor at St Thomas', ensuring that the 140,000 patients who visit the emergency department each year are cared for safely and efficiently in a brighter and more comfortable environment. We are increasing the number of critical care beds at St Thomas' in response to increasing demand.

Evelina London Children's Hospital also continues to see increasing numbers of patients every year, and we are developing

comprehensive plans to increase capacity. A major project to convert space previously used for offices into two new clinical areas – a cardiology ward and a critical care unit – is nearing completion. We have also opened new facilities for outpatients and fetal cardiology, and a new children's blood testing centre.

We have expanded our PET imaging facility through a joint venture with King's College London, and this will enable us to remain an internationally renowned centre for imaging research, bringing associated benefits for our patients. Operational commissioning of the centre continues. Also, in conjunction with King's College London, we have made good progress in planning a new education and training centre at St Thomas'.

With generous support from Guy's and St Thomas' Charity and other donors, we have created a new centre for patients with complex genetic conditions and rare diseases. The Rare Diseases Centre at St Thomas' is the first of its kind in the UK to provide a space designed for adults and children with life-long genetic and skin conditions that affect many organs in the body.

Developing commercial partnerships

The Trust has a long tradition of innovation. We are committed to exploring commercial opportunities that will generate additional income to support the delivery of NHS services and build on our key strengths in patient care, research

and education. We have one of the largest and most successful commercial teams in the NHS.

A number of initiatives have progressed during the year, including:

- continuing to deliver our longstanding contract with the Ministry of Defence to provide a comprehensive range of hospital, primary and community health services to British Forces and their families in northern Europe, in partnership with SSAFA, the Armed Forces charity
- signing a ground-breaking commercial partnership with Johnson & Johnson Managed Services, the pharmaceutical and medical equipment company, to deliver an Orthopaedics Centre of Excellence
- expanding our commercial education programme, for example by increasing the number of programmes for visiting healthcare professionals.

The Trust's wholly-owned subsidiary, Guy's and St Thomas' Enterprises, manages its fully and partially owned companies including:

- Essentia Trading Ltd, our estates and infrastructure company
- Viapath, our pathology joint venture with King's College Hospital NHS Foundation Trust and Serco
- a number of spin-off technology companies including Cydar and Spot On.

A full list of subsidiaries and interests in associates and joint ventures can be found in note 19 to the accounts on page 128.

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 2017/18, Board membership comprised of the following executive directors: Chief Executive, Amanda Pritchard; Chief Financial Officer, Martin Shaw; Chief Medical Officer and Director of Patient Safety, Ian Abbs; Chief Nurse and Director of Patient Experience and Infection Control, Eileen Sills; Director of Essentia (capital, estates and facilities), Steve McGuire (to September 2017); Director of Workforce and Organisational Development, Ann Macintyre (to June 2017) and Julie Screamton (from June 2017); Chief Operating Officer, Jon Findlay.

And the following non-executive directors: Chairman, Hugh Taylor; Sheila Shribman (Vice-Chair); Emma Duncan (to June 2017); Felicity Harvey; Gilda Niles; John Pelly; Reza Razavi; Priya Singh; and Steve Weiner.

See pages 54 and 55 for biographies.

All of our Board of Directors meet the standards of the Fit and Proper Persons Test. There has been one declaration of interest from Felicity Harvey, non-executive director, at the Corporate Management Committee on 13 December 2017 which could be deemed to be a conflict of interest. There have been no declarations of donations to political parties. Details of external directorships or other positions of authority held by the

directors of the Trust can be found in Note 30 (Related Parties) to the Annual Accounts on page 133.

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's 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 on to the external auditors where appropriate.

The Trust complies with the requirement of the better payment practice code to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Performance against the code is set out in the table above.

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 on page 112.

Better payment practice code			
Measure of compliance	Year ended March 31 2018		Year ended March 31 2017 Number £000
	Number	£000	
Total bills paid in the year	328,363	706,205	341,733 726,335
Total bills paid within target	264,914	520,279	279,516 541,459
Percentage of bills paid within target	81%	74%	82% 75%

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 directors confirm that the Trust complies with the cost allocation and charging guidance issued by HM Treasury.

The directors also consider 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 our performance, business model and strategy.



Amanda Pritchard

Chief Executive

On behalf of the Board of Directors



More patients and healthy volunteers participated in research at Guy's and St Thomas' than any other NHS trust in England.

5

Remuneration report

Chairman's annual statement

As the Chairman of the Remuneration Committee (the committee), I am pleased to present our remuneration report for 2017/18.

There were no changes to the Trust's remuneration policy for very senior managers in 2017/18.

Taking into consideration the national 1% pay settlement applicable to the *Agenda for Change* and medical and dental workforces from 1 April 2017, the committee approved a 1% cost of living increase to executive and senior managerial salaries with effect from April 2017, and continued the flexible approach of allowing senior managers the choice between receiving the 1% increase as either consolidated into pensionable salary or as a non-pensionable supplement.

There were a number of changes to the Trust's executive team during 2017/18. In June 2017, Ann Macintyre retired from the Trust and was succeeded as Director of Workforce and Organisational Development by Julie Scream who joined the Trust from Health Education England. Also during 2017, following the Board's decision to transfer responsibility for the Trust's digital information strategy and portfolio from Essentia to a new directorate under a Chief Digital Information Officer, and in light of the formal separation of Essentia Trading Ltd from the Trust, the post of Executive Director of Essentia was made redundant. As a consequence the postholder, Steve McGuire left the Trust in September 2017. These changes are reflected in the annual report on remuneration.

At the time of appointment in January 2016, it was agreed that the salary for the Chief Executive and Accountable Officer would progress to the benchmark rate of £270,000 a year from January 2018, subject to the postholder's successful performance. In November 2017, the committee met to discuss the Chief Executive's performance and salary progression. The committee was unanimous in praising the Chief Executive's performance and in approving salary progression. Her new salary level is therefore formally raised to £270,000. However, the Chief Executive elected not to accept the resulting increase in pay in 2017/18.

Also in November, the committee approved a proposal to strengthen the senior management structure within the finance directorate through the creation of a new role of Chief Financial Officer. Martin Shaw, Director of Finance, was confirmed as Chief Financial Officer from November 2017. His salary was unchanged.

As a result of ongoing changes to the leadership of the organisation, the scheduled full review of executive and senior management salaries has been deferred beyond 2017/18.



Sir Hugh Taylor

Remuneration Committee Chairman

23 May 2018

Remuneration policy report 2017/18

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 Board of Directors' Remuneration Committee, which consists of the Chairman and all non-executive directors.

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

$$\text{Salary} + \text{Pension} = \text{Total remuneration}$$

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 Scheme and the 2015 Scheme. New executive directors are entitled to join the 2015 Scheme, which is a career average revalued earnings scheme. Where an individual is a member of the 1995/2008 Scheme and is subsequently appointed to the Board, he or she may remain a member of that 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. 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 2017/18 are set out in the single total figure table in the annual report on remuneration.	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 2017/18 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. A new external recruit will be eligible to join the NHS Pension Scheme. The main features of the 2015 Scheme include: <ul style="list-style-type: none">• 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 14.3%.
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. Salaries for senior managers are formally reviewed every three 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 six months' notice.

The Trust's normal 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 of 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 base salary increases for the Trust's *Agenda for Change* workforce, which is considered to be the most relevant comparison as this population reflects 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 2017/18

The remuneration and expenses for the Trust Chairman and non-executive directors are determined by the Council of Governors, taking account of the guidance issued by organisations such as the NHS Confederation and the NHS Trust Development Authority.

Remuneration Committee

The Remuneration Committee decides the pay, allowances and other terms and conditions of the executive directors and other senior managers, including directors' compensation in the event of early termination of contracts.

The Trust's Chairman is chair of the Remuneration Committee and all non-executive directors are members of the committee.

Remuneration Committee membership and attendance 2017/18	
Name	Actual/Possible
Hugh Taylor	2 / 2
Emma Duncan	0 / 0
Felicity Harvey	1 / 2
Girda Niles	1 / 2
John Pelly	2 / 2
Reza Razavi	2 / 2
Sheila Shribman	1 / 2
Priya Singh	2 / 2
Steve Weiner	1 / 2

Remuneration report

The following individuals also attend the Remuneration Committee either regularly or as required:

Attendee	Regular attendee	Attends as required
Amanda Pritchard, Chief Executive	x	
Julie Screamton, Director of Workforce and Organisational Development	x	
Catherine Briggs, Reward Manager		x

Other individuals may also be invited to attend 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.

Median remuneration and fair pay multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The remuneration of the highest paid director compared to the median remuneration of the workforce was as follows:

Median remuneration and fair pay multiple		
	March 31 2018	Restated March 31 2017
Highest paid director's total remuneration	£252,500	£252,500
Median total remuneration	£38,805	£38,154
Remuneration ratio	6.51	6.62

The calculation is based on full-time equivalent staff working for the Trust on March 31 2018. Where staff are part time, their salaries have been annualised for the purposes of the median ratio calculation.

Service contracts

The following table contains details of the service contracts in place during 2017/18 for executive directors:

Service contracts			
Executive director	Date of service contract	Unexpired term	Notice period
Ian Abbs	Jan 2011	Open ended	6 months
Jon Findlay	Dec 2016	Open ended	6 months
Ann Macintyre	Nov 2009	Open ended	6 months
Steve McGuire	Apr 2003	Open ended	6 months
Amanda Pritchard	Apr 2012	Open ended	6 months
Julie Screamton	Jun 2017	Open ended	6 months
Martin Shaw	Oct 1998	Open ended	6 months
Eileen Sills	Feb 2005	Open ended	6 months

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 (which represents 10 of England's leading academic healthcare organisations) and similar private sector organisations. This will enable the Trust to attract and retain individuals with the appropriate experience to fulfil the Trust's senior managerial roles.

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

During the year, Steve McGuire, Director of Essentia, received payments for loss of office. The payments made were in line with the Trust employment contract. A total of £241,046 was paid, made up of a £81,046 payment in lieu of notice and a £160,000 redundancy payment. These payments reflect the six month contractual notice period and the redundancy entitlement of two year's pay which is subject to the NHS cap at £80,000 per annum respectively.

Salary and benefits of senior managers

The following tables contain details of the salary and benefits of the Trust's senior managers in 2016/17 and 2017/18.

Single total figure 2017/18					
Name	Title	Salaries and fees (bands of £5k) £000	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000	
I. Abbs	Chief Medical Officer and Director of Patient Safety	200–205	–	200–205	
J. Findlay	Chief Operating Officer	160–165	207.5–210	370–375	
A. Macintyre	Director of Workforce and Organisational Development (until July 2017)	40–45	–	40–45	
S. McGuire*	Director of Essentia (until Sep 2017)	320–325	–	320–325	
A. Pritchard	Chief Executive	250–255	65–67.5	315–320	
M. Shaw	Chief Financial Officer	160–165	22.5–25	185–190	
E. Sills	Chief Nurse and Director of Patient Experience	175–180	5–7.5	185–190	
J. Screamton	Director of Workforce and Organisational Development (from June 2017)	125–130	22.5–25	145–150	
E. Duncan	Non-executive director (until Jul 2017)	5–10	–	5–10	
F. Harvey	Non-executive director	15–20	–	15–20	
G. Niles	Non-executive director	15–20	–	15–20	
J. Pelly	Non-executive director	15–20	–	15–20	
R. Razavi	Non-executive director	15–20	–	15–20	
S. Shribman	Vice-Chair	15–20	–	15–20	
P. Singh	Non-executive director	15–20	–	15–20	
H. Taylor	Chairman	60–65	–	60–65	
S. Weiner	Chairman of the Audit Committee	20–25	–	20–25	

*Steve McGuire received a redundancy payment of £160k and payment in lieu of notice of £81k.

No senior manager received any taxable benefit, annual or long-term performance bonuses in 2017/18 or 2016/17.

Single total figure 2016/17					
Name	Title	Salaries and fees (bands of £5k) £000	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000	
I. Abbs	Chief Medical Officer and Director of Patient Safety	200–205	–	200–205	
J. Findlay	Chief Operating Officer (from Dec 2016)	40–45	12.5–15	50–55	
R. Kerr	Executive Vice Chairman	115–120	–	115–120	
A. Macintyre*	Director of Workforce and Organisational Development	160–165	37.5–40	195–200	
S. McGuire	Director of Essentia	160–165	–	160–165	
A. Pritchard	Chief Executive	250–255	195–197.5	445–450	
M. Shaw	Chief Financial Officer	160–165	37.5–40	195–200	
E. Sills	Chief Nurse and Director of Patient Experience	175–180	27.5–30	200–205	
S. Steddon	Acting Chief Operating Officer (until Dec 2016)	125–130	20–22.5	150–155	
R. Drummond**	Non-executive director (until Dec 2016)	10–15	–	10–15	
E. Duncan	Non-executive director (from Aug 2016)	10–15	–	10–15	
F. Harvey	Non-executive director (from Sep 2016)	5–10	–	5–10	
F. Nestle	Non-executive director (until May 2016)	0–5	–	0–5	
G. Niles	Non-executive director	15–20	–	15–20	
J. Pelly	Non-executive director (from Jan 2017)	0–5	–	0–5	
R. Razavi	Non-executive director (from May 2016)	15–20	–	15–20	
S. Shribman	Vice-Chair (from Jun 2016)	15–20	–	15–20	
P. Singh	Non-executive director	15–20	–	15–20	
D. Summers	Vice-Chair (until Jun 2016)	0–5	–	0–5	
H. Taylor	Chairman	60–65	–	60–65	
S. Weiner	Chairman of the Audit Committee	20–25	–	20–25	

*The salaries and fees figure for 2016/17 includes a one-off, non-pensionable payment of £9,000 which was approved by NHS Confederation in recognition of work undertaken at a national level. **During the period that Robert Drummond was a non-executive on the Trust Board, he was also chair of the Guy's and St Thomas' Enterprises Ltd Board. He received £15,000 in relation to this role. His total remuneration over the period to December 16 from both roles was £28,000.

Remuneration report

2017/18 Salary and pension entitlements of senior managers							
	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash equivalent transfer value at 1 April 2017 (£000)	Real increase in cash equivalent transfer value (£000)	Cash equivalent transfer value at 31 March 2018 (£000)
Name/Title	£000	£000	£000	£000	£000	£000	£000
A. Macintyre Director of Workforce and Organisational Development	0	0	60-65	175-80	1,301	-1	1,309
A. Pritchard Chief Executive	5-7.5	0	55-60	125-130	655	63	724
M. Shaw* Chief Financial Officer	0-2.5	5-7.5	75-80	225-230	0*	0*	0*
E. Sills Chief Nurse and Director of Patient Experience	0-2.5	2.5-5	70-75	215-220	1,381	104	1,498
J. Findlay Chief Operating Officer	7.5-10	20-22.5	55-60	145-150	820	198	1,027
J. Screaton Director of Workforce and Organisational Development	0-2.5	0	45-50	125-130	792	59	875

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

* The NHS Pensions Agency (NHSPA) does not calculate a cash equivalent transfer value (CETV) for individuals over 60.



Amanda Pritchard, Chief Executive
23 May 2018



Staff report

Last year, we employed around 16,200 staff, clinical and non-clinical, all of whom contribute to providing high quality patient care in our hospitals and across the local community. Our staff work hard to improve efficiency and deliver the best possible care to our patients.

The majority of the Trust's staff are permanently employed clinical staff directly involved in delivering patient care. We also employ a significant number of scientific, technical and administrative staff who provide vital expertise and support. The table below provides a breakdown of our workforce.

Staff numbers

Staff group	Permanently employed	Agency, Bank and seconded staff	Total 2017/18
Administration and estates	3,754	306	4,060
Healthcare assistants and other support staff	871	284	1,155
Medical and dental	1,953	179	2,132
Nursing, midwifery and health visiting staff	4,600	646	5,246
Nursing, midwifery and health visiting learners	956	234	1,190
Scientific, therapeutic and technical staff	2,239	136	2,375
Social care staff	1	–	1
Total	14,374	1,785	16,159

The numbers above are the average number of staff (Whole Time Equivalent) employed at the Trust.

Communicating with staff

The Trust is committed to involving staff in decision-making, engaging them in key developments, and keeping them informed of change across the organisation.

We work hard to ensure that all staff are aware of both internal and external developments that may affect the organisation, such as financial pressures and changes in the wider NHS.

We place great importance on staff engagement as there is a positive correlation between this and staff motivation, commitment, involvement in change and ultimately a positive impact on the quality of patient care. In 2017/18, we continued to score highly in both the NHS Staff Survey and in the quarterly Staff Friends and Family Test – see overleaf for details.

Our range of well-established communications channels include a monthly team briefing from the Chief Executive, a regular email bulletin to all staff, daily messages on all PC desktops and an extensive intranet where staff can find policies, guidance and online tools. The Trust's corporate induction programme is a valuable source of information for new recruits.

We hold regular face-to-face briefings on both clinical and management issues, helping to engage staff who do not have regular access to computers, and the Knowledge and Information Centre at St Thomas' provides email and computer access for staff. Staff can also download a staff app 'My GSTT' to their own mobile device, enabling them to access key Trust information anytime, anywhere. The

Trust produces 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 and other staff representatives to ensure employees' voices are heard. The joint staff committee meets quarterly, acting as a valuable consultative forum for key developments affecting staff, with sub-groups established to look at policy and pay issues. The Trust has six staff governors who contribute to the assurance and development of the organisation and represent staff members' views at Board level.

All staff are encouraged to raise concerns, voice opinions and make improvements in their areas. Our 'Showing we care by speaking up' initiative encourages all staff to feel confident and able to speak up about any concerns they have about patient safety or the way the Trust is run. The Trust's transformation programme, *Fit for the Future*, engages staff in improving the quality, safety and efficiency of services and patient care.

Staff survey

We know that the quality and safety of our services depends on our staff, and that there is a strong link between positive staff engagement and patient experience and safety. We measure our success in terms of staff engagement and creating a good work environment through the annual NHS Staff Survey and the Staff Friends and Family Test, which is undertaken three times a year and in which we consistently scored above the national average.

These survey and test results are closely monitored and discussed at the Trust Management Executive and Board meetings.

Our staff survey results continue to be very positive and we achieved the highest engagement score of all 'combined acute and community trusts' in the 2017 NHS Staff Survey. Our score was also higher than all trusts in the 'acute trusts' and 'community trusts' groups. Our results were above average in 23 of the 32 key findings and below average in only four. The Trust has achieved the best score nationally within our comparator group in eight key findings including staff recommending the Trust as a place to work and receive care/treatment.

Although the Trust scored well overall, some areas require improvement. The Trust will continue with its approach of having Trust-wide and directorate level action planning. The progress on the delivery of the actions will be managed locally and regular updates will be fed back to existing forums such as the Trust Management Executive and equality, diversity and inclusion steering group.

Long working hours may be linked to the high levels of engagement and to the commitment that staff have to the Trust and its patients. However, to ensure that excessive hours are not being worked and that staff are well rested, there are initiatives in place to improve ward processes and ensure handover takes place on time. The HALT campaign encourages staff to take a break when they are 'hungry, angry, late or tired'.

The score for staff experiencing discrimination at work in the last 12 months includes discrimination by patients as well as by colleagues. The 'Keep our staff safe' campaign aims to remind patients that the Trust's staff deserve to be treated well. The Trust continues to work to improve relations between all staff, through promoting the Trust's values, including respecting others, and through training for managers.

Our score for the 'percentage of staff believing that the organisation provides equal opportunities for career progression or promotion' has been one of the ongoing areas for improvement, as it has in other London NHS trusts.

A dedicated equality, diversity and inclusion steering group has been formed to ensure that measures are introduced to bring about a positive change and enhance the staff perception of the equality and diversity agenda within the organisation. We are also launching a 'Big Conversation' to engage the wider workforce in our efforts to tackle these issues in 2018.

It is reassuring to see that there have been significant reductions in staff witnessing potentially harmful errors, near misses or incidents and also in staff reporting experience of violence. This is as a direct result of the measures introduced over the past few years that have led to greater awareness among staff.

We share learning and ideas for improving safety with staff through campaigns, email messages such as

Staff survey

	2017/18 Trust	2017/18 National average	2016/17 Trust	2016/17 National average**	Trust improvement/ deterioration
Response rate	36%	43%	38%	40%	Deterioration
Areas of best performance					
Staff recommendation of the organisation as a place to work or receive treatment	4.18*	3.75*	4.20*	3.71*	No statistically significant change
Effective use of patient/service user feedback	3.93*	3.69*	3.95*	3.68*	No statistically significant change
Fairness and effectiveness of procedures for reporting errors, near misses and incidents (*)	3.93*	3.73*	3.93*	3.73*	No statistically significant change
Staff agreeing that their role makes a difference to patients/service users	93%	90%	94%	91%	No statistically significant change
Staff reporting good communication between senior management and staff	43%	33%	42%	32%	No statistically significant change
Areas of weakest performance					
Percentage of staff working extra hours	77%	71%	76%	71%	No statistically significant change
Percentage of staff experiencing discrimination at work in the last 12 months	14%	10%	14%	10%	No statistically significant change
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	82%	85%	83%	87%	No statistically significant change
Percentage of staff appraised in the last 12 months	84%	86%	87%	86%	Deteriorated
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	28%	27%	27%	26%	No statistically significant change

*Scored out of 5 **Trust is compared with other combined acute and community trusts

'Safety signals' and our 'Quality matters' newsletter. The Trust monitors all incidents and near misses that are reported and analyses the causes so that we can continue to learn lessons and take action.

Speak up guardian

At Guy's and St Thomas' we are committed to creating a culture where everyone feels able and confident to speak up. The Trust's 'Showing we care by speaking up' initiative was established in 2015 to encourage all staff to speak up about concerns they may have about patient safety or the way the Trust is run. The initiative is led by two 'freedom to speak up guardians', supported by a large network of 90 'speaking up advocates' within directorates.

The guardians play an active and visible role in raising awareness, developing staff and dealing with

concerns, while ensuring that our governance processes are robust and effective.

Guy's and St Thomas' scores higher than the national average in the NHS Staff Survey in relation to staff feeling safe and confident raising concerns about unsafe clinical practice which demonstrates a positive speaking up culture.

During 2017/18, 103 contacts were made through the speaking up services. The number of contacts and their nature are openly and transparently shared on a quarterly basis with the National Guardian's Office and published publicly on their website.

Equality and diversity

We serve diverse local communities in Lambeth and Southwark. This diversity is reflected in the profile of our patients and workforce, and brings many benefits.

Staff group	Male	Gender Female	Total
Executive directors	3	3	6
Other senior managers	126	201	327
Employees	4,077	11,516	15,593
	4,206	11,720	15,926

Number of staff employed on 31 March 2018.

The Trust remains committed to providing services and employment opportunities that are inclusive across all strands of equality; age, disability, gender, ethnicity, race, religion and belief and sexual orientation – in accordance with the Equality Act 2010 and our public sector equality duties.

Our equality objectives set out our priorities to drive improvements in patient care and staff experience which aim to reduce inequalities for our diverse workforce and patient population. The head of equality, diversity and inclusion is responsible for monitoring progress against these priorities and regularly reports back on our performance. The Trust has in place a comprehensive plan to ensure better and fairer outcomes in recruitment and progression, as well as ambitious targets to improve diversity in senior management, ensuring all staff have the opportunity to achieve their full potential.

The Trust continues to develop fair recruitment practices to ensure equal access to employment opportunities for all. We continue to support staff with disabilities, including anyone who becomes disabled during their employment. We are committed to the Department of Work and Pensions' 'Disability Confident' employer scheme, which is designed to help recruit and retain people with disabilities, and we aim to achieve the top level in the scheme of 'Disability Confident Leader'.

The Trust leads and participates in a number of projects and initiatives to widen access to employment. These include:

- an award-winning apprentice recruitment programme
- unconscious bias training, provided for all new starters, recruiting managers and frontline staff
- a vibrant network to support lesbian, gay, bisexual and transgender (LGBT) staff
- support for Black History Month and promotion of the legacy of Mary Seacole, to recognise and celebrate the diversity of our workforce
- award-winning projects to support people with learning disabilities to gain access to employment
- a partnership with McKinsey and Thames Reach to support formerly homeless people to gain employment
- leading the London, Surrey and Kent 'Step Into Health' programme which supports people from the armed forces to access employment opportunities in the NHS.

The Trust participates in the Department of Work and Pensions' Access to Work scheme. This scheme supports staff to return to work after a period of ill health or if they have or have developed a disability. The Trust provides guidance to managers and all staff about the scheme as well as funding to make reasonable adjustments in the workplace. Our occupational health team also has a dedicated rehabilitation nurse manager to support staff who develop physical disabilities or long-term conditions during their employment.

Safe working environment

This has been a dramatic year for health and safety both at a local level – with the Trust managing the impact of terrorist-related events and the tragic Grenfell Tower fire – and nationally with central government considering the impact of the Brexit vote on the UK's health and safety regime and its obligations under EU law.

In response to the tragic events surrounding the Grenfell Tower fire we have reviewed our infrastructure and management of fire safety. We have also worked

Staff sickness absence	2017/18	2016/17
Total days lost	106,139	100,462
Total staff years	14,021	13,346
Average working days lost (per WTE)*	8	8

*WTE = Whole Time Equivalent

The sickness absence figures are reported on a calendar basis, rather than the financial year. These statistics are published by NHS Digital, using data drawn for January 2017 to December 2017 from the ESR data warehouse. The latest publication, which covers up to December 2017, can be found on the NHS Digital website.

Employee costs (including executive directors)

	Permanently employed £000	Agency, bank and seconded staff £000	Year ended March 31 2018 Total £000	Year ended March 31 2017 Total £000
Salaries and wages	602,753	52,828	655,581	612,047
Social security costs	66,782	3,350	70,132	64,409
Apprenticeship Levy	3,237	–	3,237	–
Pension cost: employer's contributions to NHS pensions	74,148	1,941	76,089	71,299
Other employment benefits	–	–	–	–
Termination benefits	342	–	342	732
Temporary staff – external bank	–	6,573	6,573	4,643
Temporary staff – agency & contract staff	–	28,762	28,762	38,820
Total gross staff costs	747,262	93,454	840,716	791,950
Included in above:				
Costs capitalised as part of assets	(12,422)	(1,314)	(13,736)	(13,706)
less income netted off in staff costs	(6,960)	–	(6,960)	(6,046)
Total staff costs	727,880	92,140	820,018	772,198
Analysed into Operating Expenditure				
Employee expenses – staff and executive directors	727,081	92,138	819,219	771,091
Redundancy	342	–	342	732
Internal audit costs	457	2	459	375
	727,880	92,140	820,020	772,198

with various regulatory bodies to ensure that we maintain a safe environment for patients and staff.

The health and safety team have focused on initiatives to improve the health and safety culture across the Trust, with particular emphasis on leadership and staff engagement; competency; improving communication; hazard control and risk assessment. Risk assessment training has been provided for staff in both hospital and community settings. Priority has been given to those who cannot attend scheduled training events, such as staff working night shifts. We have actively sought volunteers to join our new team of health, safety and wellbeing champions.

During the year we have run campaigns to reduce violence and

Trade union facility time

The following information is published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017. The relevant period is 1 April 2017 until 31 March 2018.

Table 1: relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
87	82.64

Table 2: percentage of time spent on facility time

Percentage of employee time spent on facility time	Number of employees
0%	61
1%-50%	25
51%-99%	1
100%	0

Table 3: percentage of pay bill spent on facility time

Total cost of facility time	£141,300.82
Total pay bill	£743,683,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Table 4: paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours, calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	20.36%
---	--------

aggression across the Trust. We are particularly proud of our work with representatives from the Suzie Lamplugh Trust who have helped us develop training and useful tools to protect our staff in the community.

We have updated our work on stress in the workplace and implemented a new psychological health and wellbeing policy.

Occupational health

Our occupational health service is committed to a strong focus on health, safety and wellbeing for staff, patients and visitors. The service is one of the largest in the country, employing a multidisciplinary team of doctors, nurses, safety specialists and administrative staff. It serves 70,000 people including Trust staff, and employees in local and national businesses.

Our occupational health services include pre-commencement screening, work-related health checks, vaccination and immunisation programmes, and advice on reducing risks in the workplace.

We also offer guidance to staff and managers on maintaining wellness in the workplace. We provide advice and information for managers on managing sickness absence and how to support staff to return to work including a dedicated telephone advice line five days a week. We are also investigating a diabetic care pathway for staff to ensure there are suitable adjustments at work and to reduce sickness absence.

We know that our staff value initiatives that support their health and wellbeing. We offer a wide range of opportunities to support staff through our award-winning '5 ways to a healthier you' programme. The programme offers opportunities to self-refer to receive nutritional and weight loss advice and support through our staff dietetics services, and access to physiotherapy and smoking cessation services. Specialist referral services include cognitive behavioural therapy for mental wellbeing, along with advice, information and counselling via the Employee Assistance Programme. The Trust supports many local

Exit packages

Staff exit packages

In 2017/18, a total of 16 exit packages were agreed in the year, 14 of which were compulsory redundancies. The total cost of these exit packages was £687,000. Summary information for 2017/18 and comparative information for 2016/17 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	
	2017/18	2016/17	2017/18	2016/17	2017/18	2016/17
<£10,000	4	3	0	1	4	4
£10,000 – £25,000	4	5	1	0	5	5
£25,001 – £50,000	2	0	0	0	2	0
£50,001 – £100,000	2	2	1	0	3	2
£100,001 – £150,000	1	0	0	0	1	0
£150,001 – £200,000	1	1	0	0	1	1
Total number of exit packages by type	14	11	2	1	16	12
Total resource cost £000	589	401	98	4	687	405

Exit packages: other (non-compulsory) departure payments

There were two non-compulsory departures which attracted exit packages in 2017/18 and comparative information for 2016/17 is provided in the table below.

	2017/18			2016/17		
	Payments agreed	Total value of agreements	Number	Payments agreed	Total value of agreements	Number
				£000	Number	
Contractual payments in lieu of notice	1	81		1	4	
Exit payments following Employment Tribunals or court orders	1	17		–	–	
Total	2	98		1	4	

and national health and wellbeing initiatives through roadshows, promotions and educational events.

The Trust offers a staff flu vaccination programme to all staff. In 2017/18 we vaccinated 79.9% of frontline staff, exceeding the 70% CQUIN target set by the Department of Health and Social Care. The programme was championed by our Chief Nurse and senior managers and was supported by staff acting as peer vaccinators.

Countering fraud and corruption

The Trust is committed to ensuring the best use of NHS resources. All staff have access to our counter fraud

policy and procedure through the Trust intranet and receive fraud awareness training as part of the Trust induction programme. A counter fraud specialist works within the Trust's internal audit team to provide guidance and support to staff who raise concerns, and to conduct investigations.

Agency staff

The Trust has continued its focus on reducing the use of agency staff and remaining compliant with NHS Improvement's agency 'cap' which sets maximum pay levels for agency staff. We use robust procedures to monitor and report on agency spend and to reduce the number of breaches of the cap. Action plans are in

Staff report

High paid off-payroll engagements

All off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months	
Number of existing engagements as of 31 March 2018	9
<i>Of which, the number that have existed:</i>	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	2
for between two and three years at the time of reporting	3
for between three and four years at the time of reporting	2
for four or more years at the time of reporting	1

All new off-payroll engagements, or those that reached six months in duration, in 2017/18, for more than £245 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	3
<i>Of which:</i>	
number assessed as subject to IR35	1
number assessed as not subject to IR35	2
number engaged directly (via PSC contracted to department) and are on the departmental payroll	1
number of engagements reassessed for consistency / assurance purposes during the year	7
number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of Board members, and/or senior officials with significant financial responsibility in 2017/18	
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "Board members, and/or senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	76

place to continue to drive down costs while maintaining high standards of care. Where breaches do occur, they are mainly attributed to nationally recognised shortage occupation groups.

We have continued to make significant savings in agency expenditure this year with plans to reduce this spend further. The Trust has been instrumental in driving forward a pan-London agreement to standardise the pay rates for agency workers. This agreement ensures consistency of approach and supports us in managing the market rates for agency workers.

We continue to maintain a Trust-wide ban on agency staff at Bands 1-4 and have implemented a 'master vendor' approach for agency bookings of information technology staff which has brought

significant savings for this group over the year.

Regular meetings take place with the directorates within the Trust with the highest agency expenditure to support them in reducing costs. Plans to reduce spending in other areas are reviewed and challenged at monthly performance review meetings.

Expenditure on consultancy

Expenditure on consultancy in 2017/18 was £1,410,000.

Off-payroll engagements

The Trust has a policy that all substantive staff are paid through the payroll. No Board member or senior officials with significant financial responsibility were engaged on an off-payroll basis in 2017/18.

The Trust has needed to engage a number of contractors to support fixed-term assignments in areas such as information technology, commercial services and asset management on an off-payroll basis.

The number of contractors engaged is shown in the tables opposite where daily rates exceed £245 per day and the engagement has lasted longer than six months.

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 new rules. All the existing engagements outlined have been subject to an assessment and consequently no further assurance was sought.



We completed the major redesign and expansion of the emergency floor in March ensuring that the 140,000 patients that visit our emergency department each year are cared for safely and efficiently in a better environment.

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

Our governors play a vital and active role in the work of the Trust. We also benefit from a strong Board of Directors, whose wide-ranging experience underpins our continued success.

Council of Governors

The Council of Governors continues to play a vital part in the work of the Trust, advising us on how best to meet the needs of patients and the wider community.

It has a number of statutory duties, including appointing the Chairman and non-executive directors, deciding on their remuneration as well as ratifying 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, and contributes to the Trust's annual business planning process.

The Council of Governors runs a membership engagement, development and involvement working group which facilitates governors' consultation with their members. The Trust responds to ad-hoc requests and encourages the public to attend our Annual Public Meeting in September.

The Council of Governors also runs a service strategy working group which is the main vehicle for the Trust to discuss plans with governors. There is also a quality and engagement working group which is a forum for the Trust and governors to discuss patient engagement, quality improvement and safety matters. Governors are also party to discussions about elements of the Trust's strategy when items are taken at meetings of the Trust Board and Council of Governors.

This year, the Council of Governors approved the re-appointment of one non-executive director through the Nominations Committee chaired by the Trust Chairman.

The patient, public and staff members of

the Council are elected from and by the Foundation Trust membership to serve for three years. They may stand for re-election for a second and final term.

An election for a new governor to represent the community staff took place in 2017.

In addition, some of the organisations we work most closely with nominate stakeholder governors, and one new stakeholder governor was appointed in 2017.

The constitution currently requires us to have 31 governors. During 2017/18, one governor received expenses totalling £307.90. See page 51 for the full list of governors.

Code of Governance

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. It keeps its governance arrangements under regular review, including membership of Board committees, their terms of reference and Board performance assessments. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Nominations Committee

The Nominations Committee makes recommendations to the Council of Governors on the appointment and remuneration of the Chairman and non-executive directors, and considers the independent appraisal of the Chairman.

This year, Sheila Shribman's first term as a non-executive director came to an end on 12 June 2017. The Nominations Committee recommended her re-appointment to serve for a further four years from 13 June 2017.

Our organisational structure

Members of the Nominations Committee*	
Name	Role
Heather Byron	Patient governor
John Chambers	Staff governor
Tom Hoffman	Public governor
Hugh Taylor	Chairman
Warren Turner	Stakeholder governor

*The Nominations Committee is serviced by Peter Allanson, Trust Secretary and Head of Corporate Affairs.

Our membership

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

Patients – anyone aged over 18 years who has been a patient within the last five years. Carers who are not eligible for other categories are also offered patient membership.

Public – residents of Lambeth, Southwark, Lewisham, Wandsworth and Westminster aged over 18 years.

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

We have 25,200 members, of whom 3,922 are patient members, 5,737 are public members and 15,541 are staff members.

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

This year, the Council of

Governors' membership engagement, development and involvement working group, has been working to implement the membership strategy as part of the Trust's effort to develop a membership that reflects the communities it serves.

Board of Directors

Our Board of Directors is made up of our Chairman, Hugh Taylor, eight other non-executive directors (seven from June 2017 following Emma Duncan's resignation) and seven (six from September 2017 following Steve McGuire's departure) executive board directors including the Chief Executive, Amanda Pritchard. Its role is to:

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

Membership is balanced, complete and appropriate. The Trust is confident that all of the non-executive directors are independent in character and there are no relationships or circumstances which are likely to affect, or could appear to affect, their judgment. We therefore have not appointed a senior independent director.

Every three or four years the

Board commissions a full external review; one is due in May-June 2018 which will be reflected in next year's Annual Report. The Chairman evaluates through appraisal all non-executive directors and the governors' Nominations Committee commissions an external evaluation of the Chairman's performance.

Ann Macintyre left the Trust in June 2017 and was replaced by Julie Screamton. Emma Duncan resigned in June 2017 and Steve McGuire left in September 2017.

The Council of Governors appoint the non-executive directors in accordance with the Trust's constitution which allows them to serve two four-year terms, extendable in certain circumstances by a further two years. The appointment, renewal and termination of a non-executive director is handled by the Council of Governors in general meeting; they are advised by their Nominations Committee.

In September 2017, over 250 people attended our Annual Public Meeting, where members, local people, patients, staff and other stakeholders heard about how we have performed during the year; had an opportunity to meet and ask questions of the Board of Directors and the Council of Governors; saw a film about the work of our children's nurses and heard presentations about Evelina London, the Nightingale Academy, and how our community teams support patients to live independently at home.

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.

Council of Governors – Nominated Lead Governor: Devon Allison

Trust Board Directors attended every Council of Governors meeting.

Patient governors	Elected from	Actual/possible attendance
Devon Allison (lead governor)	July 2016	4/4
Heather Byron	July 2016	1/4
Anita Campolini	July 2015	2/4
John Duncan	July 2015	1/4
Jonathan Farley	July 2015	3/4
David Maurice	July 2016 (until Sept 2017)	1/2
Darren Oldfield	July 2015	4/4
Giuseppe Sollazzo	Oct 2017 (replaced David Maurice)	2/2
Giles Taylor	July 2015	2/4

Public governors	Elected from	Actual/possible attendance
Kevin Burnand	July 2015	3/4
Yvonne Craig-Inskip	July 2015	3/4
Linda Goldsmith	July 2016 (until November 2017)	3/3
Kate Griffiths-Lambeth	July 2015	2/4
Tom Hoffman	July 2015	4/4
James Palmer	July 2016	4/4
John Porter	July 2016	3/4
Jenny Stiles	July 2016	3/4

Staff governors	Constituency	Elected from	Actual/possible attendance
Thelma Bangura	Community	September 2014 (until August 2017)	0/2
John Chambers	Clinical	July 2015	3/4
Noreen Ging	Clinical	February 2017	4/4
Tony Hulse	Clinical	July 2015	3/4
Anita Macro	Community	September 2017	2/2
Vicky Rogers	Non-clinical	July 2016	4/4
Bryn Williams	Non-clinical	July 2016	4/4

Stakeholder governors	Organisation	Appointed from	Actual/possible attendance
John Balazs	Lambeth CCG	December 2015	3/4
Robert Davidson	Southwark CCG	December 2015	1/4
Jane Fryer	NHS England	October 2015	0/4
Matthew Patrick	South London and Maudsley NHS Foundation Trust	November 2013	0/4
Lucilla Poston	King's College London	January 2017	3/4
Mohammed Seedat	Lambeth Council	April 2017	1/4
Sue Slipman	King's College Hospital	December 2015	1/4
Warren Turner	London South Bank University	September 2014	1/4
Bill Williams	Southwark Council	June 2016	1/4
Sonia Winifred	Lambeth Council	May 2015 (until April 2017)	1/1

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

Trust Secretary and Head of Corporate Affairs
4th Floor, Gassiot House
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH

Tel: 020 7188 7346

Our organisational structure

Audit Committee membership and attendance	
Name	Actual/possible
Steve Weiner (Chair)	3/4
John Pelly	4/4
Priya Singh	4/4

Audit Committee

The Audit 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 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.

At its meetings in May 2017 the committee reviewed the draft Annual Report and Accounts, including the quality accounts, and approved their submission to the auditors before being lodged in the library of the House of Commons. During the year, the Committee also reviewed the Trust's Board Assurance Framework and Risk Register, including those submitted to NHS Improvement, and received

Board meeting attendance April 2017 – March 2018		
Name	Title	Actual/possible
Dr Ian Abbs	Chief Medical Officer and Director of Patient Safety	8/8
Emma Duncan	Non-executive director	1/3
Dr Felicity Harvey	Non-executive director	5/8
Girda Niles	Non-executive director	7/8
Jon Findlay	Chief Operating Officer	8/8
Ann Macintyre	Director of Workforce and Organisational Development	3/3
Steve McGuire	Director of Essentia	0/4
John Pelly	Non-executive director	7/8
Amanda Pritchard	Chief Executive	8/8
Prof Reza Razavi	Non-executive director	4/8
Julie Screamton	Director of Workforce and Organisational Development	5/5
Martin Shaw	Chief Financial Officer	8/8
Dr Sheila Shribman (Vice Chair)	Non-executive director	7/8
Eileen Sills	Chief Nurse and Director of Patient Experience and Infection Control	4/8
Dr Priya Singh	Non-executive director	8/8
Hugh Taylor	Chairman	7/8
Steve Weiner	Non-executive director	6/8

Committee	Membership April 2017 – March 2018
Adult local services	Girda Niles (Chair), Felicity Harvey, Hugh Taylor, Ian Abbs, Jon Findlay, Ann Macintyre (to June 2017), Amanda Pritchard, Julie Screamton (from June 2017), Eileen Sills
Audit	Steve Weiner (Chair), John Pelly, Priya Singh
Cancer services	Hugh Taylor (Chair), Felicity Harvey, Reza Razavi, Sheila Shribman, Jon Findlay, Ann Macintyre (to June 2017), Julie Screamton (from June 2017), Amanda Pritchard, Eileen Sills
Children's services (up to May 2017)	Sheila Shribman (Chair), Emma Duncan, Hugh Taylor, Ian Abbs, Jon Findlay, Amanda Pritchard
Corporate management	Hugh Taylor (Chair), all Board members
Digital (from May 2017)	David Perry (Chair, NED adviser), Felicity Harvey, Priya Singh, Hugh Taylor, Steve Weiner, Ian Abbs, Jon Findlay, Amanda Pritchard, Eileen Sills
Quality and performance	Priya Singh (Chair), Reza Razavi, Hugh Taylor, Girda Niles, John Pelly, Sheila Shribman, Ian Abbs, Jon Findlay, Ann Macintyre (to June 2017), Steve McGuire (to September 2017), Amanda Pritchard, Julie Screamton (from June 2017), Martin Shaw, Eileen Sills
Remuneration	Hugh Taylor (Chair), all non-executive directors
Evelina London Board (from May 2017)	Sheila Shribman (Chair), Steve Weiner

reports on a number of topics including information governance, use of interims and consultants, internal audit and counter fraud performance. External auditors attended the committee regularly, providing an opportunity for the committee to assess their effectiveness.

KPMG LLP resigned as the Trust's external auditors with effect from 31 March 2017.

Following a competition the Council of Governors recommended at its meeting in July 2017 that Grant Thornton UK be appointed as external auditors to the Trust for the next three financial years including 2017/18.

Remuneration Committee

The Remuneration Committee decides the pay, allowances and other terms and conditions of the executive directors and other senior managers, including directors' compensation in the event of early termination of contracts.

Remuneration Committee membership and attendance	
Name	Actual/possible
Hugh Taylor (Chair)	2/2
Emma Duncan	0/0
Felicity Harvey	1/2
Girda Niles	1/2
John Pelly	2/2
Reza Razavi	2/2
Sheila Shribman	1/2
Priya Singh	2/2
Steve Weiner	1/2

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 four public Board meetings a year. The Board meeting is followed immediately by a meeting of the Council of Governors. This second meeting, attended by members of the Board, opens with a session reflecting on the business discussed and agreed by the Board.

Members of the Council of Governors attend Board committees, apart from the Audit and Remuneration Committees.

Governors are invited to send two delegates to all unitary Board committees which they attend as participating observers. These governors then report back to their colleagues using the three working groups they run.

Members of the Board attend meetings of the Council of Governors' working groups. In addition they hold 'accountability sessions' twice a year for the governors to question the Board on a range of topics.

Governors are invited to meet other members at the series of health seminars run by the Trust through the year, as well as 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 two 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 Management Executive

The membership of the Trust Management Executive (TME) brings together executive board directors, Trust directors, clinical directors and other senior managers. Its role is to:

- scrutinise draft plans and policies which would have implications across the Trust or for several parts of the Trust
- scrutinise reports on operational performance such as those on quality or risk
- scrutinise major investment proposals of over £1 million
- agree Trust-wide policies
- develop strategic plans and proposals for consideration by the Executive Team and the Trust Board
- consider matters where the support of clinical and managerial leaders is of critical importance
- consider matters which are of concern to a majority of the group.

The following committees report to the Trust Management Executive:

- Information Governance Committee
- Investment Portfolio Board
- IT Programme Board
- Joint Pathology Committee
- Professional Assurance Board
- Research and Development Committee
- Trust Risk and Assurance Committee.

Our organisational structure

Board of Directors – executive directors



Amanda Pritchard
Chief Executive and
Chief Accountable Officer

Amanda was appointed as Chief Executive in January 2016, having been Acting Chief Executive from October 2015. Prior to that she served as Chief Operating Officer at the Trust for three and a half years.

Amanda joined Guy's and St Thomas' from Chelsea and Westminster NHS Foundation Trust where she spent six years as Deputy Chief Executive having previously held a variety of senior strategic and operational management roles.

Amanda spent 10 months leading the health team in the Prime Minister's Delivery Unit in 2006, and has also held a number of other NHS management positions.

Amanda has three children, the youngest of which was born at St Thomas' Hospital in 2014.



Dr Ian Abbs
Chief Medical Officer and
Director of Patient Safety

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

In addition to his clinical work, Ian has played a key role in the development of Clinical Academic Groups within King's Health Partners.



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 across the two hospital sites.

He has 14 years' experience working in director level in roles that have spanned clinical operations, service modernisation, performance improvement, human resources and workforce planning.



Martin Shaw
Chief Financial Officer

Martin joined the NHS in 1981. He joined West Lambeth Health Authority in 1983, where he held a variety of posts and was Deputy Director of Finance until 1993 when he joined Guy's and St Thomas' as Business and Financial Planning Manager, before becoming Strategy Director and Projects Director. He was appointed Finance Director of the Trust in 1998 and made Chief Financial Officer in 2017.

Martin chairs the Healthcare Financial Management Association's Finance Directors' Group and the Shelford Finance Directors' Group.



Julie Sorean
Director of Workforce and
Organisational Development (from June 2017)

Julie was appointed as Director of Workforce and Organisational Development in June 2017.

Julie has wide ranging experience of leading workforce and organisational development teams in the NHS, having worked at regional and trust level.

In her previous position, as Regional Director, London and the South East for Health Education England, Julie was responsible for £1.4 billion of investment in education, training and workforce development across London, Kent, Surrey and Sussex. Her role included providing support to eight Sustainability and Transformation Plans.



Dame Eileen Sills DBE
Chief Nurse and Director of Patient Experience and Infection Control

Eileen was appointed Chief Nurse in 2005. Having qualified as a registered nurse in 1983, Eileen has held a number of general management and senior nursing leadership posts in London. She was awarded a CBE in 2003 for services to nursing, and a DBE in January 2015.

Eileen holds two visiting professorships, at King's College London and London South Bank universities. She is also the Chair of the grant committee for the Burdett Trust for Nursing. Eileen has a national reputation for strong, visible, clinical leadership.

Sir Ron Kerr CBE
Executive Vice Chair (to March 2017)

Ron joined Guy's and St Thomas' as Chief Executive in 2007. He stepped down on 1 October 2015 after 30 years in senior NHS leadership roles.

He continues to provide advice and support to the executive team on a part time basis since stepping down as Executive Vice Chair.

Ann Macintyre
Director of Workforce and
Organisational Development
(to June 2017)

Ann joined the Trust in November 2008 with more than 30 years' NHS experience working at national, regional and local level.

Ann was the joint Chair of the national JCC (seniors), which is the negotiating committee for consultant medical staff in England. She also chaired national negotiations for the reform of the consultant contract across England and Ireland.

Steve McGuire
Director of Essentia (capital, estates and facilities) (to Sept 2017)

Steve joined the Trust as its first Director of Capital, Estates and Facilities Management in April 2003 from Leeds Teaching Hospitals NHS Trust where he had been the Director of Property and Support Services.

Steve led Essentia, which provides the Trust with the majority of its non-clinical services.

Steve is a Chartered Engineer, and previously worked for the British Coal Corporation.

Board of Directors – non-executive directors



Sir Hugh Taylor
Chairman

Hugh was appointed as Chairman of Guy's and St Thomas' in February 2011. He had a long and distinguished career in the civil service which included senior roles in the Department of Health and NHS Executive, the Cabinet Office and the Home Office.

His most recent appointment before joining the Trust was as Permanent Secretary at the Department of Health, from which he retired in July 2010.

Hugh chairs the Cancer Services, Corporate Management and Remuneration Committees as well as the Board. He is a resident of Southwark.



Dr Felicity Harvey CBE
Non-executive director

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 June 2016. Prior to that, she was director of the Prime Minister's Delivery Unit.

After qualifying in medicine in 1980 at St Bartholomew's Medical College, London, she completed an International MBA.

Her previous roles include private secretary to the Chief Medical Officer and Head of Medicines, Pharmacy and Industry Group at the Department of Health. Felicity joined the Board in September 2016.



Girda Niles
Non-executive director

Girda is a local social business coach specialising in strategy for social businesses and those who want to make a social difference. She has extensive strategic experience in the community and voluntary sectors, social enterprise, financial management and training. Through her previous role as a non-executive director of Lambeth Primary Care Trust, she has a thorough understanding of how health and social care systems work.

Girda joined the Board in January 2012 and chairs the Adult Local Services Committee.



John Pelly OBE
Non-executive director

John qualified as an accountant in 1978 and spent the early part of his career in the commercial sector.

He joined the NHS in 1990 as Finance Director of West Lambeth Health Authority, becoming Finance Director of Guy's and St Thomas' NHS Trust on the two hospitals' merger in 1993. John was subsequently Chief Operating Officer of Guy's and St Thomas' NHS Trust until he took up the position of Chief Executive of Queen Elizabeth Hospital NHS Trust in south London.

In 2008 he was appointed Chief Executive of Moorfields Eye Hospital NHS Foundation Trust, a position he held until his retirement from the NHS in November 2015. John joined the Board in January 2017.



**Professor
Reza Razavi**
Non-executive director

Reza is Assistant Principal for Research and Innovation at King's College London. He is also Director of Research at King's Health Partners and a children's cardiologist at Evelina London Children's Hospital.

His research focus is on imaging and biomedical engineering related to cardiovascular disease. Reza helped to establish the Trust's cardiovascular MRI service and developed the world's first cardiovascular MRI cardiac catheterisation programme.



Dr Sheila Shribman
Non-executive director
and Vice-Chair

Sheila was the Department of Health's National Clinical Director for Children, Young People and Maternity for seven years until March 2013.

She was a consultant paediatrician for more than 25 years and was Medical Director of Northampton General Hospital for 11 years where she led the successful integration of children's hospital, community and mental health services, working closely with the local authority. Sheila joined the Board in June 2013 and chairs the Evelina London Board.



Dr Priya Singh
Non-executive director

Priya was formerly an Executive Director at the Medical Protection Society and has a background in general practice. She brings substantial medico-legal, risk and strategic experience to her role on the Board.

Priya's career at the Medical Protection Society spanned more than 20 years and she was responsible for the provision of professional services to 290,000 doctors, dentists and other health professionals.

Priya joined the Board in November 2015 and chairs the Quality and Performance Committee.



Steve Weiner
Non-executive director

Steve lives locally in Southwark. He has spent most of his career in finance with international consumer goods group, Unilever. He recently retired from his role as Group Treasurer and part of Unilever's finance leadership team.

He has extensive experience in making operational and commercial decisions involving large budgets and complex financial constraints and in leading and developing multicultural teams.

Steve joined the Board in July 2014 and chairs the Audit Committee.

Emma Duncan

Emma is the social policy editor of The Economist. She writes regularly for The Times and occasionally for a wide range of other publications. She joined the Board as non-executive director in August 2016 and stepped down in June 2017.



90% of our patients rated the quality of care they received as 7 out of 10 or higher in the Care Quality Commission's annual national inpatient survey 2017.

NHS Improvement's single oversight framework provides the framework for overseeing NHS trusts and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, trusts are segmented from 1 to 4, where '4' reflects those in special measures and '1' reflects those with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach, or suspected breach, of its licence.

Segmentation

NHS Improvement assigned a score of '2' to Guy's and St Thomas' NHS Foundation Trust for month 12, 2017/18 performance.

Finance and use of resources

The finance score is based on five measures which are scored from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. From autumn 2017 a new 'use of resources' (UoR) assessment has been introduced to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients. Under this framework, NHS Improvement will periodically undertake UoR assessments of providers. Currently, these new assessments have begun with non-specialist acute trusts with the aim of rolling out across the sector when more information is available. Therefore the Trust has yet to have a UoR assessment. Until a provider has undergone a UoR assessment, NHS Improvement will use the finance score, alongside other evidence, of whether a provider is making optimal use of its resources, to identify potential support needs under this theme.

Given that finance and use of resources is only one of the five themes feeding into the single oversight framework, our overall rating above is not the same as the overall finance score shown in the table below.

Metric	2017/18 Month 12 score	2016/17 Month 12 score
Capital service capacity	1	1
Liquidity	1	1
Income and expenditure margin	1	1
Distance from financial plan	1	1
Agency spend	1	2
Overall score	1	1

Agency spend

At the start of the financial year, NHSI suggested that it would be appropriate for the Trust to spend no more than £33.2 million on agency staff. The equivalent spend for 2016/17 was £33.7 million. During the year (2017/18), the Trust spent £28 million on agency – 15.6% lower than the target.



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 Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, 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, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, 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 Directions issued by NHS Improvement, 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, and
- prepare the financial statements on a going concern basis.

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 her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Amanda Pritchard

Chief Executive and Accounting Officer

23 May 2018

Annual Governance Statement 2017/18

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2018 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Trust has in place a risk management policy which clearly sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust. Operational responsibility for the implementation of risk management has been delegated to executive and other named directors. Risk management is a core component of the job descriptions of senior managers within the Trust. A range of risk management training is provided to staff and there are policies. All relevant risk policies are available to staff via the Trust intranet. The Trust learns from good practice through a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, and performance management, continuing professional development, clinical audit and application of evidence based practice. Learning from root cause analysis investigations directly feeds into our quality improvement programme, including the 'Always Safe' campaign which provides Trust staff with information on incidents, reality rounds, Schwartz rounds, safety huddles and safety alerts.

The risk and control framework

The risk management policy and supporting procedures set out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled. A risk management matrix is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and incidents. The Trust's appetite for risk is articulated through the boundaries within the risk evaluation matrix that have been defined by the Board of Directors in the risk management policy. Risks assessed as significant are monitored to ensure mitigating actions are undertaken to reduce risks to an acceptable level. Serious untoward incidents and serious risks are reported to the Board of Directors via the established governance committee structures. A serious incident assurance panel, chaired by a non-executive Board member, is in place to monitor the quality of investigation of serious incidents and progress in embedding subsequent learning.

The Board Assurance Framework supports the process for monitoring ongoing compliance with the requirements for registration set by the Care Quality Commission (CQC) and sets out the principal risks to delivery of key priorities and overarching strategic priorities (Trust objectives). It

identifies the assurances available to the Board of Directors in relation to the achievement of the objectives and these are also mapped to key controls. The executive director with delegated responsibility for managing and monitoring each risk is clearly identified.

During 2017/18, the Board Assurance Framework was used to present the key risks to the organisation. This work is being reframed into an 'assurance map' to further strengthen this area going forward into 2018/19.

The Board plays a role in procurement as outlined in the scheme of delegation as part of compliance with the Trust's policies and procedures to ensure that resources are used efficiently and effectively.

The Trust has not identified any risks to compliance with the NHS Foundation Trust condition 4 (FT governance).

In order to assure itself of the validity of its Corporate Governance Statement, required under NHS Foundation Trust condition 4(8) (b), the Trust has assessed the extent with which it complies with the Code of Governance and this was reviewed by the Audit Committee. The Board has recently commissioned a review of Board capability and capacity which will be carried out in 2018/19. The review will also cover elements of CQC's well-led domain as they apply to the Board.

The Quality and Performance Committee approves the quality priorities for the Trust. The priorities include a number of indicators agreed with stakeholders from our local community together with national indicators of quality including access to services and patient feedback.

The Board reviews a range of metrics on quality and organisational health in the Integrated Quality and Performance Report at the Quality and Performance Committee.

The Board is satisfied that the Trust has in place adequate action plans to respond to staff and patient surveys and continues to support efforts to increase participation.

A range of tools are in place to monitor compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which are set out in the Care Quality Commission's five domains of safe, effective, caring, responsive and well-led. Tools used include the ward accreditation scheme, leadership walkabouts and more recently internal quality visits to services, with input from our governors and the quality and assurance team.

The Trust uses reality rounds, peer-to-peer and quality reviews to provide assurance on compliance with the core domains and evidence on best practice and high-quality care.

Information governance

The Trust achieved a 'Satisfactory' rating in its self-assessment against the 2017-18 Information Governance Toolkit, the primary tool for information governance assurance. The Trust maintained its high level of performance with a declared score of 92%, the same as the previous year's submission.

All staff receive information governance training as part of corporate induction when joining the Trust. Training requirements have been reviewed during the year and are supported by comprehensive policies and guidance to ensure staff have access to up-to-date information.

An information asset owner (IAO) with responsibility for managing information risks is named for each department, supported by specialist information security and information governance staff. Registers of information assets, flows and uses are maintained and were thoroughly reviewed and updated in-year.

All information incidents are investigated, with near misses used as opportunities to improve processes and reduce risks. In 2017/18, one incident was classified as a 'Level 2' serious incident requiring investigation (SIRI) in the Information Governance Incident Reporting Toolkit, and reported to the Information Commissioner's Office (ICO). The incident related to the loss of unencrypted removable media containing summary patient information. Processes contributing to the incident were reviewed. No action was taken by the ICO.

The Trust has a detailed General Data Protection Regulation (GDPR) action plan which is overseen by the Information Governance

Committee, chaired by the Chief Medical Officer/Deputy Chief Executive. Work has focused on further developing the established information governance framework. Particular attention is being paid to raising the awareness of staff and patients about the new rights and obligations under GDPR.

In 2017 a number of NHS organisations were affected by a ransomware attack. The Trust responded well to what was an unprecedented incident, with no reports of harm to patients or of patient data being compromised or stolen. However, as other industries have learned, no organisation can be completely immune from a cyber-attack and there is no room for complacency. Significant work has taken place during 2017/18 to mitigate the risks, and further work is planned for 2018/19.

Major risks 2017/18

The key risks to delivery of the Trust's objectives are recorded in detail in the Board Assurance Framework and monitored quarterly by the Board or its committees acting on behalf of the Board. In 2017/18, the key risks with potential impact on achieving our objectives were:

- deterioration or variation in the quality of our services due to stresses on a stable workforce, organisational change, performance pressures, adapting to new technologies, increasing demand and patient complexity
- failing to deliver our financial plan due to the scale of the financial challenge facing the wider NHS
- a mismatch between our capacity and demand resulting in failure to achieve our activity and performance plans
- our ability to act on safeguarding issues impacted by an increasingly complex safeguarding environment
- inability to recruit to vacancies due to a range of factors including national shortages and industrial action
- insufficient capital to deliver our estates capacity plan with potential impact on staff and patient experience and ability to meet national targets
- our preparedness to harness digital technology to meet business needs and take advantage of transformative opportunities
- the scale and complexity of the Trust and competing policy demands mean there is a risk that our governance systems may not be effective
- inability to maintain research infrastructure due to loss of funding from a reduction in funding as a result of Brexit
- the ability to consistently deliver the national cancer waiting time targets
- the ability to consistently deliver the accident and emergency maximum four hour wait.

The Trust established controls or implemented actions to manage these risks, summarised below.

- We regularly reviewed and took action in relation to information which may have indicated deterioration in the quality of our services, for example A&E performance and cancer targets.
- We appointed a Board-level director, the Chief Digital Information Officer to lead the Trust's digital transformation programme.
- Led by our executive team and clinical directors, we undertook detailed analysis of key issues causing variation in our performance against national targets, implementing actions to address key capacity, flow and process issues.
- Our ability to meet national waiting time targets remains challenging in light of physical constraints and sustained rising demand. We worked within the South East London Sustainability and Transformation Plan (SELSTP) to address these challenges. We continued our internal work to improve patient pathways, and sought additional funding to invest in capital projects to improve our estates capacity.

● **Cancer waits:** the Trust is committed to achieving compliance with the 85% 62-day standard and worked hard during 2017/18 to achieve this. The Trust's performance against the internal 62-day cancer standard continued to demonstrate improvement with an internal performance which was above trajectory at 87.1%, but overall performance fell short of the operational standard at 75%. Significant work was undertaken internally to improve performance against the target, but the required improvement was not achieved across south east London, despite significant work being undertaken, including to increase diagnostic capacity, review pathway management and strengthen leadership support to improve the position across the sector.

- **Accident and emergency standard:** accident and emergency continued to experience surges in demand and also high volumes of patients with mental health needs. Significant refurbishment work also impacted on capacity and flow during different points in the year. The Trust also experienced very significant winter pressures over a number of months and saw the highest levels of daily attendances on several days. Despite this we were able to provide support to the sector. These factors impacted on our ability to consistently deliver the target despite significant interventions and actions. The end of year position on the A&E standard was 89%, which did not meet the required 95% or the STF trajectory.
- **During 2017/18 the Trust's RTT position** has remained below the 92% standard for new and follow up outpatient appointments and planned admissions. Work continues to meet our recovery trajectory, and data quality issues are being addressed through an extensive data validation exercise. The Trust also identified a number of issues with delayed appointments and a delayed appointments programme has been set up to address these problems.
- We have a safeguarding team, training, and procedures in place as required by statute. During 2017/18, we built a greater level of skill and awareness through training across the clinical workforce, with particular emphasis on mental capacity assessments. There continues to be a sustained increase in safeguarding referrals for both adults (22%) and children (23%), due to some of the external changes, and changes in complexity of patients.
- We have continued to implement the Trust workforce strategy including approaches to recruitment and retention, and health and wellbeing, to mitigate the risk of workforce shortages.
- We made good progress on our current five-year capital plan with most projects progressing or completed. The Independent Trust Financing Facility (ITFF) agreed a loan for capital funding to enable us to increase clinical capacity and some of these funds were released in 2017/18.
- We reviewed our information technology arrangements and have begun to implement the digital strategy approved in 2017 to support patient and business needs, and to take advantage of digital transformative opportunities.
- We reviewed top level governance arrangements and implemented new terms of reference for our Trust Management Executive and will undertake an external Board review on governance in 2018/19.

Major risks 2018/19

As with all NHS organisations, we face continual challenges in balancing the need to deliver high quality care in the context of increasing demand and acuity, while increasing productivity. This is against a backdrop of constraints including staffing capacity. We recognise that strategic and transformational change internally and across geographical health economies will be required to address the risks identified below. The principal strategic risks for 2018/19 are that we may be unable to maintain high quality care if we do not:

- sustain financial efficiencies and secure sufficient income for our services
- transform services through shifting to place based care, new payment systems, accountable care systems

- collectively respond to new operational models and navigate the overall strategic landscape and complexity with the right leadership and skills to address all the competing priorities
- shape the opportunities within research and life sciences with appropriate partners to transform services, attract investment and rapidly translate research into practice and care
- manage demand and capacity and deliver operational performance targets
- respond effectively through partnership models to financial and workforce instability in other providers in the health and social care economies
- successfully implement specialised network systems and industry research partnerships to develop research opportunities
- invest and develop digital and technological infrastructure and skills to support the business
- have sufficient workforce (both clinical and non-clinical) with the correct skills and competence
- embrace societal expectations through new models of care and employment for both patients and staff.

We are developing our response as part of the wider NHS health economy in Lambeth and Southwark and beyond, recognising that we treat both local people and patients who travel to our hospitals from further afield. Our plans form part of the South East London Sustainability and Transformation Plan (SEL STP) and we also play an important role in a number of clinical networks that join up services provided across several NHS trusts.

We are working with partners in Lambeth and Southwark to develop place based care through Local Care Networks. The first focus has been on care coordination for people with multiple long-term conditions. Through the Lambeth Together strategic alliance, we will be developing a delivery alliance for place based care. In Southwark discussions have commenced on developing legal entities that can hold financial responsibility for place based care.

We will continue to develop our ambitions as a healthcare alliance, building on our Vanguard programme with Dartford and Gravesham NHS Trust which will include developing new, integrated models of care and also making greater use of standardised approaches to care delivery that will help to improve quality and reduce cost.

Equality duties

The Trust is required to demonstrate how it takes due regard of the General and Public Sector Duties under the Equality Act 2010.

The Trust is currently refreshing its equality, diversity and inclusion strategy and plan in line with the requirements of the Public Sector Equality Duties. The equality, diversity and inclusion objectives relate to both our patients and workforce. The objectives are integral to Trust activity and will form part of the ongoing commitment to our patients, workforce and our local engagement to ensure the objectives are met. All relevant Trust policies are subject to an equality impact assessment. This is monitored at the Trust Joint Policy Forum. Equality impact assessments are an integral part of the Trust's Patient and Public Engagement toolkit. They are used to inform the engagement strategy when there is a transformation or change in service. This ensures the Trust proactively engages with all patient groups including those seldom heard.

The Trust publishes a workforce race equality standards report annually. The data is reported on and used to produce Trust-wide and local action plans in collaboration with our staff side colleagues. Disclosures in relation to staff engagement and the opportunities available to disabled employees are contained within the performance report and staff report (sections 2 and 6 of the Annual Report).

The accessibility steering group is set up to ensure our commitment to and compliance with patient accessibility for both services and information. This group ensures we are meeting the needs of all our patients with communication requirements – both through

correspondence and at appointments – complying with the Accessible Information Standard. Our commitment to physical accessibility is also monitored and we respond proactively to any issues identified through our complaints, PALS and patient experience teams. We work with local departments and our Essentia teams, to ensure all our buildings and facilities are accessible to all.

Incident reporting

All staff are encouraged to report incidents and near misses within an open and fair culture. During 2017/18, the Trust has continued to focus on encouraging incident reporting and has seen a continued rise in incident numbers compared with the previous year, demonstrating a healthy reporting culture. The majority of incidents reported are no harm or low harm incidents. The Trust's commissioners have highlighted improvements in processes, structures and outcomes for the management of serious incidents, including timeliness and quality of reports. We have also demonstrated good reporting when benchmarked against other organisations.

In 2017/18, the Trust had 10 never events. Reduction in the number of never events remains a key objective. All incidents reported have been fully investigated to ensure lessons are learnt and shared across the Trust. A presentation to the public Board of Directors meeting in January 2018 included examples of actions taken as a result of learning identified in these investigations, including the revised role of the surgical safety group which meets monthly to drive improvements in safety for patients undergoing invasive procedures – including procedures undertaken outside the main operating theatre. The surgical safety group has monitored compliance with the WHO surgical safety checklist and, as a direct result of never events, has updated the surgical count policy.

A number of improvements have been made as a result of the triangulation of incidents, near misses and patient feedback, for example, environmental features critical to ensure the safety of patients suffering from a mental health crisis have been included in the refurbishment of the emergency department. There have also been significant improvements to the patient transport service that brings patients from Kent following complaints and feedback from patients. In addition, the 'Always Safe' patient safety campaign aims to raise staff awareness of serious incidents and encourage staff to feedback about how we can improve safety further.

A range of training programmes are in place, including induction for all staff and for junior doctors and also for newly-appointed consultant staff. As part of their preceptorship programme, training is given to newly-qualified nurses and midwives on the importance of incident reporting as being a central component of safe patient care.

The electronic incident reporting system has been updated to include automatic feedback when an incident is investigated. Additional fields have been included to prompt staff to ensure the Duty of Candour process is followed. Training on the Duty of Candour continues to be provided to raise awareness about being open when an incident occurs. In addition, leaflets have been produced for patients and staff to explain the process. The feedback email to staff now also provides more information to help staff manage incidents.

During the year the Trust found itself at the centre of two major terror attacks, which included the tragic murder of a member of staff. The Trust activated its emergency and business continuity plans on each occasion and played an important role in London's immediate and longer term response.

The resilience of staff was tested during these times, and significant resources and time and effort were put in place to support all those involved and to identify lessons for future learning.

Complaints

The Trust has a complaints policy which supports the organisation to comply with the requirements of the Local Authority Social Services and National Health Service Complaints [England] Regulations (2009) and the NHS Constitution.

The Trust is committed to the principles of the Parliamentary Health Service Ombudsman.

The organisation has a good record of delivering quality responses but there is room for improvement in relation to the timeliness of complaints responses. A significant piece of work is being undertaken across the Trust to provide more timely responses to complainants and to reduce the number of outstanding complaints and this has led to significant improvement in performance in the final quarter of the year.

Patient involvement in risk

The Trust's patient and public involvement and consultation process ensures compliance with relevant legislation, and is described in 'Putting patients first: a policy for involvement and consultation'. All departments, both clinical and non-clinical, are responsible for planning and undertaking patient and public involvement initiatives, where appropriate. The Trust completes an annual patient and public engagement audit, which is reported to the Board.

When developing plans for significant service changes, the Trust has to show how stakeholders might be affected and to ensure they are consulted and how their views will be taken into consideration in developing proposals for change. Equality impact assessments are part of this process.

The Trust has an agreed process to advise and engage with Southwark and Lambeth Overview and Scrutiny Sub-Committees when there are proposed service changes that may impact on the people who use our services. The Trust works closely with patients and public stakeholders to ensure that the impact on any changes on patients is minimised.

The Trust Healthwatch liaison group meets quarterly to enable regular liaison and communication between the Trust and local Healthwatch bodies in Lambeth and Southwark. This group identifies opportunities for the involvement of Healthwatch in Trust activities. Healthwatch colleagues use these meetings to receive updates and comment on quality and risk performance reports.

As a foundation trust, we also inform the Trust's Council of Governors through its relevant working groups of proposed changes, including how potential risks to patients will be minimised.

Compliance statements

The Trust is compliant with the registration requirements of the Care Quality Commission. The Trust received one unannounced visit in March 2018, which identified some areas for improvement and immediate actions were undertaken to rectify the areas identified and the evidence was shared with the CQC.

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

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

The Trust has undertaken risk assessments and developed an adaptation plan to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP 09), to ensure that this organisation's obligations under the Climate Change Act 2008 are complied with. The resilience management team are responsible for ensuring the organisation meets NHS England Emergency Preparedness, Resilience and Response (EPRR) requirements, have developed risk-specific plans for inclement weather, heat wave, cold weather and flooding which may affect business continuity, and may occur as a result of climate change or as normal seasonal variance. These risk-specific plans are maintained yearly or at any notification or assessment of risk change.

Sustainability and carbon reduction have been included, for

governance purposes, into the Emergency Preparedness, Resilience and Response arrangements for the Trust. This is managed by the Trust sustainability team with EPRR response to specific risks such as heat wave, cold weather, flooding covered in EPRR risk-specific plans, managed by the EPRR team. The Trust is working towards its 34% carbon reduction target by 2020 through an ambitious energy efficiency investment plan.

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

As part of their annual audit, our external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not.

The key processes to ensure that resources are used economically, efficiently and effectively across clinical services include directorate performance reviews, the Trust's *Fit for the Future* programme and regular monitoring of clinical indicators on quality and safety. This includes reviewing and analysing Model Hospital data, collated by NHS Improvement, which is shared with directorates with a view to identifying improvement opportunities.

The emphasis of internal audit work is on governance and internal control processes. Individual assignments have also raised issues relating to economy, efficiency and effectiveness. Where scope for improvement, in terms of value for money, was identified during an internal audit review, appropriate recommendations were made and action plans were agreed with management for implementation.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare a quality account for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of the annual quality report which incorporates the requirements in the NHS Foundation Trust Annual Reporting Manual.

The Chief Medical Officer is the nominated Trust executive for the quality report. The draft priorities have been consulted on internally through the Quality and Performance Committee and the operational executive and their teams. The developing priorities have also been shared for comment with external stakeholders, local and national commissioners through the commissioners' quality meeting, the governors through the quality and engagement working group and with our local Healthwatch teams.

For the annual quality report, the Trust employs the same information assurance processes as used in the monthly production of the Integrated Quality and Performance Report (IQPR).

Regular and transparent performance reporting, to both internal and external audiences, acts as an additional assurance check on the quality of the information in use. To this extent, the annual quality report is an extension of our monthly reporting process. The IQPR is published as part of our Board papers and accessible performance information is provided through 'Our Quality Story', both of which appear on the Trust's website.

A risk-based assessment of the information assurance associated with key indicators has helped determine the programme of audits undertaken by the Trust's internal audit department, with a strong emphasis on the collection and reporting of waiting time data.

For 2017/18, two of the waiting time performance measures will be reviewed by the Trust's external auditors, as part of the limited assurance opinion they provide for the quality report.

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 the content of the quality report included in this Annual Report and other performance information available to me. 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 of Directors, the Audit Committee and the Quality and Performance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. Through its committees, the Board regularly reviews the Integrated Quality and Performance report (IQPR) which covers the key relevant national priority and regulatory indicators, including CQUIN targets; with additional sections devoted to safety, clinical effectiveness and patient experience. The report is supplemented by more detailed briefings on any areas of adverse performance. The Integrated Quality and Performance Report is backed up by a cascade of more granular reports reviewed by Board committees, regular performance review meetings between the Chief Operating Officer and the directorates and individual services, including analysis at individual practitioner level.

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection.

The Audit 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 Audit Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements.

Internal audit work to a risk-based audit plan, agreed by the Audit Committee, and covering 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 are reported to the Audit Committee. 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 provide 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 covered 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 staff during 2017/18, including audits undertaken during the year which related to the previous year's plan. I have also considered reactive and proactive work conducted by the Trust's local counter fraud specialist. This includes oversight of all internal audit reports, fraud investigations and personal conduct of specific projects during the year."

In my opinion, with the exception of those areas in which limited assurance reports have been issued as reported to the committee during the year, the controls in those areas reviewed are adequate and effective. Where weaknesses have been identified these are being addressed by management and actions have been confirmed through follow up work by internal audit.

I am satisfied that the Board Assurance Framework, as presented to the Audit Committee in 2017/18 over the course of the year is representative of the key risks faced by the organisation and note that a new assurance map is being developed to further strengthen this area.

I confirm that I have monitored compliance with the Public Sector Internal Audit Standards. In my view, the department complies with those that are applicable to the public sector."

The Trust Risk and Assurance Committee reports to the Trust Management Executive and the Quality and Performance Committee, on its work on establishing a system for reviewing the Trust's clinical procedures and guidelines, contributing to maintaining the system of internal control.

The Medical Director commissioned a review of the Trust clinical audit group following the resignation of the Chair. A revised terms of reference were developed and approved which gave a new focus to clinical audit by including quality improvement (QI) in the remit and changing the reporting structures to allow increased Board oversight of clinical audit and QI by shifting accountability from the Trust Risk and Assurance Committee to the Quality and Performance Committee.

A policy is in place which describes the responsibilities and accountabilities for staff at all levels in devising, conducting, reporting and acting on the findings of quality improvement projects/clinical audits. Specialty and directorate quality improvement/clinical audit leads are responsible for developing, monitoring and reporting an annual quality improvement/clinical audit programme that reflects local and Trust objectives, risks and issues around service improvement, quality and patient safety. The programme includes audits on adherence to policy or guidelines eg on consent and Duty of Candour, and use of safety checklists. All audit projects are registered on an electronic system and monitored to completion and subsequent re-audit.

Direktorate quality improvement/clinical audit leads are members of the Trust's Quality Improvement and Clinical Audit Committee which is responsible and accountable to the Trust Management Executive. The Trust's Quality Improvement and Clinical Audit Committee is responsible for agreeing the Trusts' annual QI/clinical audit programme, monitoring directorate clinical audit plans, ensuring that audit results are acted upon, approving and monitoring Trust-wide audit projects and ensuring that the Trust participates in all appropriate national audits. The annual quality report includes detailed information about the Trust's participation in national clinical audits.

Conclusion

The Trust remains a going concern. We again struggled to manage two of our identified major risks, the accident and emergency four-hour maximum wait and the cancer 62-day maximum wait. These two issues are described, together with action taken to manage them, in the 2017/18 risks on page 61.



Amanda Pritchard
Chief Executive
23 May 2018



More than 6,500 babies were delivered in our maternity unit at St Thomas' Hospital in 2017/18.

10 Quality report

Statement on quality from the Chief Executive 2017/18

This quality report sets out the approach we are taking to improve quality and safety at Guy's and St Thomas'. Our priority is to provide high quality, safe care for all patients, and to learn from our mistakes if we fall short of these standards.

We are committed to driving improvement and a culture of excellence throughout the organisation, as demonstrated by some key achievements over the past year:

- 90% of our patients rated the quality of care they receive at Guy's and St Thomas' as 7 out of 10 or higher in the Care Quality Commission's annual national inpatient survey
- we achieved the highest engagement score of all 'combined acute and community trusts' in the 2017 NHS Staff Survey. While we are not complacent, and are working to address areas where we need to improve, we are proud of this because we know that an engaged workforce has a positive impact on the quality of patient care
- our clinical research facility became the first NHS-managed facility in London, and the second in the UK, to receive a special award recognising its high standards
- more patients are involved in clinical research at Guy's and St Thomas' than any other NHS trust in England – an important achievement as investment in research leads to better treatments and improves the quality of patient care
- a project which has improved the quality of information available to women who have had uterine fibroids won a prestigious Health Service Journal (HSJ) Value in Healthcare Award
- we won an impressive seven awards at the Building Better Healthcare Awards, which celebrate innovation, architecture, people, products and services that are helping to transform patient care across the country.

Our staff are committed to providing safe, high quality care to our patients. Key to this is ensuring that we have a positive and supportive reporting culture and we learn and share lessons from serious incidents, never events and near misses.

Reducing the number of never events remains a key priority. In 2017/18, the Trust had 10 'never events'. All incidents have been fully investigated to ensure lessons are learnt and shared across the Trust. We have also extended the remit of our surgical safety group to lead safety improvements for patients undergoing invasive procedures, including procedures undertaken outside the theatre department.

In addition, our 'Always Safe' patient safety campaign aims to raise staff awareness of serious incidents and encourage feedback about how we can improve safety further.

In line with NHS Improvement guidance, the Trust has undertaken significant work this year to comply with national requirements on learning from deaths and to ensure that such learning is shared and used to improve care.

Our Chief Nurse Eileen Sills continues to lead our weekly 'Safe in our hands' forum where quality and performance issues are discussed and debated by staff in a 'no blame' environment.

We have continued to build on the Nightingale Project, a nurse-led initiative in partnership with King's College London and South Bank University. This aims to ensure that patients receive safe, effective care delivered with the utmost kindness, with a renewed focus on the fundamentals of

care. As part of this project we also launched the 'Nightingale Nurse Award', a new professional award to recognise our most outstanding nurses.

In addition, the Executive Team comes together to lead a monthly face-to-face team briefing session open to all staff and we all participate in regular executive director 'out and about' visits to various areas of the Trust to listen to staff.

Finally, it remains to say that I am confident that the information in this quality report reflects the services we provide to our patients.

A handwritten signature in blue ink that reads "Amanda Pritchard".

Amanda Pritchard

Chief Executive

23 May 2018

Our quality priorities for 2018/19

We aim to provide world-class clinical care, education and research that improve the health of the local community and of the wider populations that we serve. This ambition is reflected in our strategic objectives and is underpinned by our quality strategy and quality goals.

We are refreshing our quality strategy for 2018-23 to help us to improve healthcare provision both in community and hospital settings and also to mitigate any risks to quality from our challenging financial plan. Our view is that quality, safety and efficiency are intrinsically linked and are mutually beneficial. This principle underpins our quality priorities together with our *Fit for the Future* programme.

We have developed a set of quality priorities and ensured that these are embedded across the Trust through directorate business plans for 2018/19.

How we chose our priorities

We consulted widely with our staff, governors and commissioners on the quality strategy and associated quality goals and this has resulted in a number of priorities being identified for further consultation and development. The draft priorities were shared with commissioners, Healthwatch, our governors, the Trust Management Executive and directorate management teams. The final priorities for 2018/19 were agreed by The Quality and Performance Committee.

The chosen priorities support three quality themes:

Patient safety – having the right systems and staff in place to minimise the risk of harm to our patients and being open and honest and learning from mistakes if things do go wrong.

Clinical effectiveness – providing the highest quality care with world-class outcomes while also being efficient and cost effective.

Patient experience – meeting our patients' emotional as well as their physical needs.

Progress in achieving our quality priorities will be monitored by quarterly reporting to the Trust's Quality and Performance Committee.

Quality report

Our quality priorities for 2018/19

Patient safety

Our quality priorities and why we chose them	What success will look like
Surgical safety We will carry out a team debriefing following at least 75% of all operating theatre lists. Perioperative briefing and debriefing is known to improve patient safety and improve team culture of surgical teams and the efficiency of their work within the operating theatre. Perioperative briefing is already in place.	<ul style="list-style-type: none">– We will have early awareness of issues that have been identified through the briefings, enabling prompt response and learning by theatres management.– We will see improvements in patient safety resulting from action on the briefings.– Staff will report high satisfaction with the contribution of the briefings to patient safety and team culture.
Mental health assessment We will undertake a brief mental health assessment on patients attending the emergency department with a known mental health condition, suspected mental health needs or where a patient's mental health deteriorates during admission, to ensure appropriate intervention. The emergency department has seen an increase in the number of individuals attending with mental health needs and recognises the requirement for prompt assessment and onward referral.	<ul style="list-style-type: none">– There will be a 30% increase in the number of mental health assessments undertaken in the emergency department compared with 2017/18.– Timely referral to mental health services will be evident for those patients assessed as a priority.– Audit will demonstrate improvement in assessment and ongoing referrals.
Medicines management We will reduce inappropriately omitted doses of critical medicines by 10%. If patients do not receive timely medication it can impact on the efficiency of the drug regime and their treatment plan.	<ul style="list-style-type: none">– Audit will demonstrate a 10% reduction on data provided through the electronic systems, supported by qualitative data from incident reporting.– There will be improved visibility of critical drugs, for example those used to treat sepsis, infection, bleeding or long term conditions such as Parkinson's or diabetes.– We will have an improved system for follow-up of medicines on arrival on the ward and report an increase in the proportion of patients' own drugs brought into the Trust with the London Ambulance Service.

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like
Radiology turnaround times We will ensure there is a timely report available to inform the patient treatment plan. Delays in turnaround times can impact on the patient treatment pathway and may lead to patient harm.	<ul style="list-style-type: none">– We will deliver 14 day reporting on plain films and reduce the number of other images unreported for over one month.– Recruitment to essential positions will be completed.– Data will be captured on the radiology software system, CRIS, to enable regular monitoring to Trust management and commissioners.
Theatre cancellations We will reduce 'on the day' patient theatre cancellations by the Trust and the number of patients cancelled more than once. Theatre cancellations by the Trust cause distress to the patient and their family, and may lead to deterioration in their condition.	<ul style="list-style-type: none">– Patients will be treated in a timely way and no more than 0.7% of patients will be cancelled on the day of surgery and the number of repeated cancellations will decrease.– We will undertake audit to demonstrate compliance with this priority.
End of life care We will support patients and/or carers to understand and make choices about their treatment, consistent with the Mental Capacity Act. Dignity and choice around end of life care are recognised as important to staff, individuals and their families.	<ul style="list-style-type: none">– Patients will feel safe and confident about their care and be enabled to make informed choices about when they are at the end of their life.– Audit of healthcare records and family feedback will demonstrate this has been achieved.– Staff will demonstrate through audit and patient/carer feedback that they are able to respond to patients approaching the end of their lives in a way that supports this.

Patient experience

Our quality priorities and why we chose them	What success will look like
Complaints We will improve, by 30%, the response times to complainants against each of the complaints handling triage categories. The Trust recognises the impact of delayed responses on complainants.	<ul style="list-style-type: none">– By March 2019 the increased timeliness in complaints handling will be embedded against the triage categories.– Regular scrutiny through Trust committees of the improvement trajectory will provide evidence of sustained progress.– Patients will report reduced delays in receiving responses.

Patient experience (continued)

Our quality priorities and why we chose them	What success will look like
<p>Pain management We will ensure patients have effective pain management from admission to discharge. Feedback from patient surveys has identified that pain management could be improved.</p>	<ul style="list-style-type: none"> – We will demonstrate through audit and patient experience surveys that patients are receiving timely and appropriate assessment of their pain; resulting in effective pain management.
<p>Age appropriate care All young people under our care who are transitioning from children's services into adult services will have a personalised care plan to allow a smooth transition of care. It is recognised that there is risk associated with the transition from children's services to adult services.</p>	<ul style="list-style-type: none"> – Each young person will have an appropriate transition care plan. – Patient experience surveys will demonstrate high levels of satisfaction with the transition period.

Progress against priorities for 2017/18

Our quality priorities and why we chose them	What success will look like	How did we do?
<p>We will continue to improve the identification and treatment of sepsis</p>	<ul style="list-style-type: none"> – We will meet the 2017/18 national CQUIN goals for the identification and treatment of sepsis. • Screening of 90% of inpatient and emergency department patients combined. • Treatment within one hour of inpatient and emergency department patients combined. • Reduction in antibiotic use. 	<p>We partially achieved this. Our sepsis team has worked to identify and track patients to ensure best practice is followed throughout the Trust. Data for Q3 shows:</p> <ul style="list-style-type: none"> screening – fully compliant; time to treatment – emergency department, non-compliant; inpatients fully compliant; antimicrobial use – fully compliant. <p>Antimicrobial resistance and sepsis continue to be priorities for the Trust and the focus for 2018/19 will be on identifying barriers to best practice in our emergency department and implementing solutions.</p>
<p>We will increase staff confidence in the use of mental capacity assessments and deprivation of liberty safeguards</p>	<ul style="list-style-type: none"> – Staff will say they feel confident in the application of the Mental Capacity Act. – We will deliver the 2017/18 safeguarding adults audit programme. – We will achieve an 85% positive response to audit and reality round questions in our hospital and community services assessed as 'likely' to care for patients who lack capacity. 	<p>We achieved this. Our safeguarding team has been working hard to increase their visibility and staff knowledge of the Mental Capacity Act. Reality rounds (audit of staff knowledge) were undertaken in our hospitals and in community services. Over 90% of staff reported confidence in identifying safeguarding concerns, knew what actions were required of them and knew how to contact the safeguarding team.</p>
<p>We will improve the safety of invasive procedures with the development of local safety standards for invasive procedures (LocSSIPs); these will be based on the national standards (NatSSIPs)</p>	<ul style="list-style-type: none"> – We will see fewer incidents with harm in patients undergoing an invasive procedure. – LocSSIPs will be in use for all identified invasive procedures. 	<p>We partially achieved this. We have made good progress with implementing LocSSIPs for all invasive procedures. A policy on how the safety checks should be undertaken was approved and made available for staff, supported by a series of electronic checklists which are available on our electronic patient record system. Areas that conduct invasive procedures outside traditional theatre settings are now included in our annual audit of surgical safety. There remain a few areas yet to be engaged with the process and this will be completed in the first half of 2018.</p>

Quality report

Progress against priorities for 2017/18

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like	How did we do?
We will embed the first phase of The Nightingale Project in key clinical areas to reduce variation in care	<ul style="list-style-type: none">Phase one of the project will be embedded with a reduction in variation in practice on the wards and increased standardisation.We will see improvement against metrics linked to The Nightingale Project in our local patient surveys.We will be in the highest quartile for staff satisfaction and ability to speak up.	<p>We achieved this.</p> <p>We have trained over 1,000 of our nurses via a one-day simulation course and all of our wards have successfully implemented the key principles and tools of the Nightingale programme.</p> <p>We have introduced an accreditation scheme for our wards based on regular review and audit of performance and this is supported by assessment visits by our Chief Nurse and directors of nursing. An induction session is in place for all new nursing and midwifery staff.</p> <p>Staff survey results show that staff satisfaction has increased.</p>
We will reduce the number of falls with harm	<ul style="list-style-type: none">All patients at risk of falling will have a multi-factorial and ongoing assessment; identified risks will be mitigated to reduce the likelihood of a fall occurring.We will be assured that all no harm falls are reported and see a reduction in the total number of falls per 1,000 occupied bed days.	<p>We achieved this.</p> <p>Our falls group continues to lead work across the Trust to reduce the number of falls and the harm to patients who do fall. The group is supported by directorate falls groups and falls champions on the wards.</p> <p>We have seen considerable improvements in falls prevention and management across all directorates despite increasing patient admissions, many of whom are frailer and sicker. Our rate of falls is 5.2 per 1,000 bed days, down from 5.4 last year and below the national figure of 6.6. On average, we see 1.8 falls each month that result in harm to the patient, compared to three per month in 2016/17.</p>
We will carry out mortality reviews of patient deaths that happen while patients are under our care, and implement a consistent process to ensure any opportunity to learn from these events is identified	<ul style="list-style-type: none">We will build on our existing systems and implement a consistent process for review of the death of any patient in our care. This will be evidenced through audit of a sample of death reviews drawn from the information collected on the Datix database.	<p>We achieved this.</p> <p>We have established a Trust mortality surveillance group that meets monthly to monitor reporting, reviewing and learning from deaths to ensure that this is in line with national requirements. The group works closely with our health informatics, safeguarding and homeless teams to ensure inpatient deaths among the mandated reporting groups are identified and a Structured Judgement Review is undertaken.</p> <p>Family and carer involvement remains a key area of focus and there is ongoing monitoring and support for directorates to ensure families are fully involved in the process if they wish. We are also looking at other options to ensure relative and carer involvement in this process, for example, through a family liaison officer working with bereaved family members and carers to support them during any investigation process.</p>

Patient experience

Our quality priorities and why we chose them

What success will look like

How did we do?

We will ensure our patients receive the fundamentals of care with a particular focus on pain and nutrition management

- Patient surveys will demonstrate that patients receive appropriate support at mealtimes to meet their nutritional needs and preferences.
- Audit of healthcare records will demonstrate that all patients have an ongoing and comprehensive assessment of their pain with a plan of care in place that is continuously evaluated in conjunction with the patient.

We partially achieved this.
We have reviewed and made changes to our mealtime coordinator role. This role is now designated to a registered nurse and one of the priorities is to ensure that each patient receives the correct meal and any support that they need. Patient feedback is reviewed. A multidisciplinary pain committee has been established and a new electronic pain tool has been developed which is designed to support nurses to assess patients' level of pain and is currently being piloted. Testing of the tool is scheduled and we will roll it out to staff later in the year.

We will consider how consent is taken to ensure a consistent approach

- We will see an improvement in performance against the questions concerning provision of information in the consent audit tool.

We partially achieved this.
Our latest audit results (February 2018) show that recording on the consent form that written information had been given to patients has improved slightly but needs further work.
Our patient survey results, part of our consent audit, showed that fewer patients said they had received written information. However, over 90% of patients said that the risks and benefits of the procedure had been explained to them and over 90% said that they were given enough information to make an informed choice.

We will improve communication with patients to ensure we meet the Duty of Candour

- Audit will demonstrate that we are meeting the requirements of Duty of Candour and are communicating with patients and their families at the time of an incident, then following up with a letter covering the discussion and what will happen next.
- We will deliver training in the Duty of Candour to 20% more staff over 2016/17.

We partially achieved this.
We continue to audit Duty of Candour on a regular basis and our results are improving year on year. We still need to ensure that follow-up letters are always sent following a notifiable incident, and this point is being emphasised at training events. Unanticipated withdrawal of training support that was provided by the RCP led to a pause in our training programme and we saw an increase of 9% in numbers trained.

We will improve what happens when patients contact the Trust by telephone

- By September 2017 there will be a plan in place setting out how telephone communication by patients into the Trust will be improved. The plan will have outcome measures and improvement against these measures will be demonstrated by the end of 2017/18.

We did not achieve this.
A considerable amount of work has been completed to understand the complexities of our current telephone systems. Further work is needed to understand the various options for improvement. To progress any of these options is likely to require considerable capital investment (in excess of £1million) and, while this would lead to improved patient experience, it is unlikely that a compelling business case could be made in the current financial climate.

Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by Guy's and St Thomas' NHS Foundation Trust. These are common to all quality accounts and can be used to compare us with other organisations.

A review of our services

During 2017/18 Guy's and St Thomas' provided 102 hospital and community NHS services. A detailed list is available in the Trust's Statement of Purpose on our website www.guysandstthomas.nhs.uk/about-us/publications/publications.aspx.

The Trust has reviewed data available on the quality of care in all of these services through its performance management framework and its assurance processes. The income generated by the services reviewed in 2017/18 represents 100% of the total income received for the provision of NHS services in 2017/18.

Participation in clinical audits and national confidential enquiries

A clinical audit aims to improve patient care by reviewing services against agreed standards of care and making changes where necessary. National confidential enquiries investigate an area of healthcare and recommend ways to improve it.

We are committed to participating in relevant national audits and national confidential enquiries to help assess the quality of healthcare nationally and to make improvements in safety and effectiveness.

During 2017/18, we took part in 48 national clinical audits and 5 national confidential enquiries. By doing so we participated in 96% of national clinical audits and 100% of national confidential enquiries in which we were eligible to participate.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2017/18 are shown in the tables on the following pages, together with those that we participated in and for which data collection was completed during 2017/18. The information provided also includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in national clinical audits 2017/18

Audit title	Participation	% of cases submitted
Women and children's health		
Maternal, newborn and infant clinical outcome review programme	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric intensive care audit network (PICANet)	Yes	100%
Maternity and perinatal audit (NMPA)	Yes	100%
Paediatric diabetes	Yes	100%
Diabetes in pregnancy	Yes	100%
Acute care		
Adult critical care (case mix programme – ICNARC CMP)	Yes	100%
Emergency laparotomy audit (NELA)	Yes	100%
National joint registry (NJR)	Yes	98%
Major trauma: the trauma audit and research network (TARN)	Yes	100%
Fractured neck of femur (care in the ED)	Yes	100%
Pain in children (care in the ED)	Yes	100%
Procedural sedation in adults (care in the ED)	Yes	100%
Long-term conditions		
Chronic obstructive pulmonary disease (COPD)	Yes	100%
Inflammatory bowel disease (IBD)	No	Unforeseen staffing issues caused us to miss the deadline for data entry.
Learning disability mortality review programme	Yes	100%
Parkinson's audit	Yes	98%
Diabetes foot-care audit	Yes	100%
National diabetes inpatient audit	Yes	100%
Older people		
Fracture liaison service database	Yes	100%
Inpatient falls	Yes	100%
National hip fracture database	Yes	100%
Sentinel stroke national audit programme (SSNAP)	Yes	100%
Dementia	Yes	100%
Heart		
Acute coronary syndrome or acute myocardial infarction (MINAP)	Yes	100%
Adult cardiac surgery audit (ACS)	Yes	100%
Cardiac arrest audit (NCAA)	Yes	100%
Cardiac rhythm management (CRM)	Yes	100%
Congenital heart disease (paediatric cardiac surgery)	Yes	No cases have been submitted to the audit at the time of writing due to delays in the supplier releasing their new audit platform.
Congenital heart disease (adults)	Yes	No cases have been submitted to the audit at the time of writing due to delays in the supplier releasing their new audit platform.

Participation in national clinical audits 2017/18

Audit title	Participation	% of cases submitted
Heart		
Coronary angioplasty/percutaneous coronary interventions	Yes	100%
Heart failure	Yes	100%
National vascular registry	Yes	100%
Cancer		
Bowel cancer (NBOCAP)	Yes	57%
Lung cancer (NLCA)	Yes	100%
Oesophago-gastric cancer (NOGCA)	Yes	40% – we are confident that we have submitted all appropriate cases to the audit. As a tertiary referral centre we suspect that other hospitals' cases are recorded as ours and we are pursuing this with the audit supplier.
Head and neck cancer	Yes	100%
Radical prostatectomy	Yes	100%
National prostate cancer audit	Yes	100%
Breast cancer in older people	Yes	100%
Blood and transplant		
National comparative audit of blood transfusion programme	Yes	100%
Serious hazards of transfusion	Yes	100%
Other		
Ophthalmology audit: adult cataract surgery	No	We were not able to participate as our IT systems are incompatible with the audit supplier's requirements.
Percutaneous nephrolithotomy	Yes	100%
Stress urinary incontinence	Yes	100%
Cystectomy audit	Yes	85%
Nephrectomy audit	Yes	100%
Urethroplasty audit	Yes	100%
Endocrine and thyroid national audit	Yes	100%
Intermediate care	Yes	100%

Participation in national confidential enquiries 2017/18

Audit title	Participation	% of cases submitted
Young people's mental health	Yes	Study still open (83% – 5 out of 6 cases submitted to date)
Chronic neurodisability	Yes	Study still open (95% – 20 out of 21 cases submitted to date)
Cancer in children, teens and young adults	Yes	100%
Acute heart failure	Yes	Study still open (67% – 2 out of 3 cases submitted to date)
Perioperative management of surgical patients with diabetes	Yes	Study still open (50% – 16 out of 32 cases submitted to date)

The reports of all national clinical audits published were reviewed during 2017/18 and we intend to take the following actions to improve the quality of the healthcare we provide.

National audit of dementia

We performed well in this audit, scoring above the national average in all categories. We have updated our dementia study days and are working closely with the emergency department to ensure that all patients with dementia are CAM (confusion assessment method) scored on admission. Our delirium and dementia team will be conducting audits of 'This is me' on our wards to review the collection of person-centred information. Our delirium and dementia clinical nurse specialists will be actively promoting the Carer Passport and highlighting the availability of extended visiting hours for carers of patients with dementia.

National audit of chronic obstructive pulmonary disease

We have achieved the highest scores in London and are in the top four trusts nationally for this audit. We are making a number of changes to improve the screening and referral process including screening all patients who attend our emergency department with breathlessness for COPD. We have increased our 'walk rounds' for our acute admitting ward, emergency department and emergency medical unit from daily to three times a day. We are trialling extended hours of availability for our respiratory team, 8am to 8pm, Monday to Friday and 8am to 5pm at weekends.

National hip fracture database

We performed well for length of stay, patients being able to return to their previous place of residence and the number of eligible patients who received a hip replacement. We scored poorly for assessing patients for nutritional risk and are implementing changes to ensure that all hip fracture patients are seen by a dietitian as a matter of routine.

National congenital heart disease audit

We will be conducting some long-term outcome audits for some of the procedures we have carried out since the inception of the national audit. Data collection is currently nearing completion in one and a second is about to start. These audits, along with the

national audit, are key to delivering better insight in both the short term and the longer term for these relatively rare conditions and will allow us to improve the information provided to families.

National audit of intensive care (case mix programme)

Our intensive and critical care units perform well in the majority of the key quality indicators reported in the audit. We reported last year that our rate of unplanned readmission was higher than the national average and that we would be undertaking a project to reduce unplanned readmissions. We are pleased that the latest audit results show that three out of our four units are now demonstrating favourable results in this area. We will continue to work with the remaining unit to bring performance in line with the other units. We are also undertaking work to understand why one unit has a standardised mortality ratio that is higher than our other three units.

National audit of blood transfusion (serious hazards of transfusion)

We have reviewed the 2016 audit report and prepared a gap analysis for the hospital transfusion committee. The key recommendation is the development and implementation of a bedside checklist for transfusion, which we will now introduce. We have already developed and implemented a transfusion associated circulatory overload checklist to enhance patient safety during blood transfusion.

National audit of breast cancer in older people

Audit data shows that we are one of the top performing centres in this field and that treatment decisions are based on clinical need and appropriate treatment and not on age. We also adapt treatment to reflect both physical and mental health issues. Our length of stay is above average; some of this is due to being a tertiary referral centre accepting patients from a wide catchment area so some patients require an overnight stay as they are further from home. We intend, where possible, to assess patients' home

circumstances prior to admission to try and pre-empt any difficulties in them returning home promptly after their surgery.

National diabetes inpatient audit

Audit results show that the Trust provides a high standard of diabetes care to inpatients. We have a higher prevalence of diabetes than the national average and our patients are more complex. Patient satisfaction with their care is higher than the national average. We have noted an increase in the numbers of medication errors over the past year and, following investigation, we have made changes to our electronic prescribing system and continue to monitor errors as they are reported.

National pregnancy in diabetes audit

The results demonstrate that we provide excellent care for women with diabetes during pregnancy with very low rates of major complications. We have a high uptake of preconception care by women with type 1 diabetes but a low rate for women with type 2 diabetes. We have recently applied to be part of a national quality improvement collaborative to try and address this. Our results also show that we may have a higher proportion of women with "large for gestational" age babies than the national average and a higher incidence of admissions to the special care baby unit. This may be associated with data collection methodology and we are looking at this in more detail to determine the cause.

National bowel cancer audit

We provide a good standard of care to this group of patients and our adjusted 90 day mortality rate is a third lower than the national average. Our case ascertainment result is low compared to the number of patients indicated by hospital episode statistics (HES) data. HES data includes patients with advanced disease who are not suitable for surgery. In the past we have entered data only for surgical patients but plan to include data collection for palliative patients from this year.

National vascular surgery registry

The 2017 national audit report shows that we are performing well and have improved our compulsory

data submission from previous years to 100%. Audit data shows that we are the largest centre in England for performing infra-renal abdominal aortic aneurysm (AAA) repairs, complex AAA repairs and ruptured AAA repairs with better outcomes for patients than the national average. We need to improve the time from referral to treatment for elective AAA patients and will be piloting a redesigned pathway this year.

National audit of inpatient falls

The most recent audit report shows that the Trust performs better than the national average in 5 out of 7 key quality indicators, indicating that patients are receiving good falls prevention support. There has been a particular improvement in three of the indicators since the previous audit report. Our falls group has added further actions to the Trust-wide falls action plan and continues to work closely with other groups including dementia and delirium, safeguarding, and continence to reduce the numbers of, and patient harm received from, inpatient falls.

National diabetes foot-care audit

One of the key findings of this audit was that more of our patients with severe foot ulcers required hospital admission. This highlights the importance of early expert assessment of new diabetic foot ulcers. To improve this we have instituted a six month hospital rotation for our community based podiatrists to enhance their skills and experience and to improve their service as a foot protection team thereby improving outcomes for patients.

National stroke audit

We achieved 8 of the 10 key indicators for quality in this audit. The results showed that we need to improve access to clinical psychology and that we need to provide seven day access to a second therapy service in addition to the seven day physiotherapy that is already in place. We have secured funding for a clinical psychologist to join the stroke unit and we will be preparing a business case for the provision of seven day occupational therapy services.

Local clinical audit

Reports of 202 local clinical audits were reviewed over the last year. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality and safety of our services following local audits.

Acute medicine

Our junior doctors undertook an audit of the care of patients who attend the emergency department with fractured neck of femur. The audit showed that we were not meeting national guidelines in a number of areas. To improve this, a sticker has been designed to be attached to the patient record to act as an aide memoire. These stickers have also been successfully used to improve the care of patients presenting with other conditions such as sepsis.

Cardiovascular

An audit of the use of eplerenone (a drug that can reduce mortality following a heart attack) showed that not all patients who could benefit were prescribed the drug. Following the audit, pharmacy staff worked closely with staff on the wards and changes were made to the electronic prescribing system, Trust guidelines and training materials used at the start of the junior doctors' cardiology rotation.

Children's community services

An audit demonstrated that medical reports were not being submitted within deadlines. This could lead to delays for children with special educational needs or disabilities receiving a comprehensive education, health and care plan to ensure that their needs are met. A number of actions were agreed and put in place, and re-audit showed that the number of reports submitted on time has increased from 44% to 81%. Further audit will be conducted to ensure further improvement.

Community adults

Physiotherapy staff audited the management of adult patients with lower limb amputations to measure compliance with national guidance. As a result, changes were made to paperwork to enable closer monitoring of patients' progress towards goals and all patients are now given an individual exercise programme that is reviewed throughout their rehabilitation.

Dental

An audit in paediatric dentistry showed that 47% of children were referred by their general dental practitioner (GDP) for hospital treatment without radiographs. This causes delay to children's treatment while radiographs are requested and sent in by general dental practitioners. In some cases, children were exposed to additional radiation if the GDP was unable to send the radiograph and new images were taken at the hospital. Following the audit, a number of changes were introduced including liaison with general dental practitioners to highlight the issue, changes to referral forms and changes to our systems to facilitate electronic transfer of images. Further audit showed that the number of referrals without a radiograph has reduced to 20% and further actions aim to reduce this further.

Oncology, haematology and cellular pathology

The national end of life care audit (2016) showed that the Trust's performance was above average but highlighted variability in some aspects of symptom control and that individual care plans were not consistently aligned with the 'Five priorities for care of the dying person'. The Trust's palliative care team undertook further local audit and are implementing a comprehensive quality improvement programme to ensure that every patient receives care in line with national best practice guidance.

Quality improvement and patient safety

The Trust quality improvement and patient safety team undertook a Trust-wide audit of conscious sedation. As a result, a Trust-wide training programme was introduced and 'Safety signals' were sent out to highlight best practice. Further audit will be conducted to demonstrate improvements in practice.

Falls improvement group

Our falls improvement group conducted audits of the documentation of falls prevention as well as post falls assessments and staff knowledge around falls prevention. The results have been widely disseminated to wards via our falls champions and ward action plans have been devised for areas needing improvement. We have also made changes to our Trust-wide and local training programmes.

Surgical safety group

The annual Trust-wide 5 Steps to Safer Surgery audit looks at compliance with the World Health Organization (WHO) surgical safety checklist and pre and post theatre list briefings; 1,429 patients on 494 operating lists were observed from all areas and all specialties across the Trust.

The results showed that pre-list team briefing was held for 98% of lists (92% in 2016), and that the WHO checklist was completed in full for 92% of patients (91% in 2016). There has been an improvement in compliance every year since the audit was first undertaken. There has also been an improvement in compliance with the number of team debriefings that are held at the end of the list, from 39% in 2016 to 44% in 2017/18, although it remains the least well completed stage. Work is continuing to improve this, and it is hoped that by autumn 2018, an electronic system for recording team briefings and debriefings will be embedded across the Trust.

The action plan from the audit is developed and monitored by the surgical safety group, with oversight from the Trust Risk and Assurance Committee.

Our participation in clinical research

Guy's and St Thomas' is committed to carrying out pioneering research to find the best treatments and cures for some of the most complex illnesses for the benefit of patients locally, nationally and internationally, and is at the leading edge of national and international research.

We are part of King's Health Partners – one of six academic health sciences centres in the UK. A wide range of research was carried out last year, some of which included the areas we specialise in such as allergy, dental, women's health, cardiovascular disease and renal transplantation. 168 non-commercial studies began in 2017/18 and 144 commercial studies were also initiated.

Last year, over 17,800 patients took part in research which was approved by our research ethics committee. During 2017/18, over 1,400 clinical research studies were active during the year. We used the nationally recommended systems and protocols to manage these studies and to ensure that the results were translated into practice in a timely and safe manner where appropriate.

Statements from the Care Quality Commission

Guy's and St Thomas' NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and our current registration status is 'registered without conditions or restrictions'.

The CQC has not taken enforcement action against Guy's and St Thomas' NHS Foundation Trust during 2017/18.

The Trust's services were assessed by the CQC in September 2015, and we were pleased to achieve an overall rating of 'Good'. The Trust was rated 'Outstanding' for caring services, and 'Good' for effectiveness, responsiveness, and being well-led. We were rated as 'Requires improvement' for safety. We were delighted that Evelina London Children's Hospital and the emergency department (A&E) at St Thomas' were rated 'Outstanding'.



Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Outstanding
Responsive?	Good
Well-led?	Good

The CQC highlighted three areas where the Trust needed to take action: consistently documenting venous thromboembolism (VTE) risk assessments in maternity; midwifery staffing levels in the antenatal day assessment unit (ADAU); and improving the effectiveness of governance links between surgical directorates. The Trust developed a detailed action plan to address these issues and in October 2016 the CQC met with us to review progress against the action plan. In December 2016, following submission of evidence, the CQC told us they were satisfied that the actions were complete.

Action plans were put in place to respond to the additional recommendations made by the CQC in their inspection about the ways in which we assure safety, including through the consistent application of all five steps of the WHO surgical safety checklist and by consistently sharing the outcomes and learning from incidents.

A multidisciplinary surgical safety group, chaired by the Chief of Surgery, is now in place and meets regularly. It plays a key role in strengthening surgical governance arrangements, including improving the safety of all invasive procedures and sharing learning in a timely way across the Trust and between surgical specialties and areas not traditionally seen such as 'theatre-type' environments such as interventional radiology and the cardiac catheter laboratories.

Key changes have been made to documentation and processes as a result of updated national guidance relating to never events and serious incidents to improve safety and effectiveness. This includes updates to the WHO surgical checklist and the surgical count policy. An additional programme of work around team working is planned in theatres to further improve safety.

The Trust received one unannounced visit from the Care Quality Commission in March 2018 which identified some areas for improvement. Immediate actions were undertaken to rectify the areas identified and the evidence was submitted to the CQC.

Previous reports of the inspections of St Thomas' Hospital and Guy's Hospital are available on the CQC website (www.cqc.org.uk).

Our CQUIN performance

For 2017/18 our CQUIN targets were worth £20 million of income, and we are currently on track to achieve most of this as we have achieved most of the associated milestones.

Our data quality

We place a very high priority on the accuracy and reliability of the descriptions of the care we provide. How we code a particular procedure or illness is important as it helps inform the wider health community about disease trends and enables us to assess the effectiveness of interventions.

The Trust has identified significant opportunities to improve existing clinical coding processes. These are being addressed through an extensive change programme, which forms part of the *Fit for the Future* programme. A steering group, chaired by a deputy medical director, meets fortnightly to review progress across a range of process and quality indicators.

The Trust continues to achieve high completeness scores on its external data flows. The percentage of records in the published Secondary Uses Service up to the end of February 2018 that included a patient's valid NHS number was 98.8% of inpatients, 99% of outpatients and 90.3% of accident and emergency patients. All showed an improvement from last year. The percentage of records which had the patient's valid GP registration code was 100% of inpatients, 100% of outpatients and 99.9% of accident and emergency patients.

As community sites are still not required to upload data, only our hospital sites submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

Information governance toolkit

Good information governance means keeping the information we hold about our patients and staff safe. The 'information governance toolkit' is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to the Department of Health and Social Care in order to assess compliance.

We achieved a 'satisfactory' (green) rating in our self-assessment against the 2017/18 information governance toolkit.

Clinical coding error rate

The Payment by Results Pricing and Costing audit by NHS Improvement no longer extends to clinical coding audits and focuses purely on reference costs. The Trust maintains a regular programme of clinical coding audit, conducted by classification service approved auditors in line with the information governance toolkit. The Trust achieved the highest level (level 3) in 2017/18.

The clinical coding error rate split by category was:

- primary diagnosis incorrect – 7%
- secondary diagnosis incorrect – 2%
- primary procedures incorrect – 5%
- secondary procedures incorrect – 5%.

Learning from deaths

We have adopted the national approach to learning from deaths as set out in the National Quality Board publication. Our policy was published in September 2017 and is available to the public.

A monthly mortality surveillance group, led by a senior consultant, monitors the process of review and escalation and extracts the learning from across the Trust to support improvements in patient safety and experience.

We use the Structured Judgement Review (SJR) methodology to complete case record reviews of patient deaths. This is based on the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

SJR methodology allows good practice, care issues and learning to be identified throughout the case review under five phases of care: admission and initial management; ongoing care; care during a procedure in a non-theatre environment or perioperative care; end of life care; and overall care. A focus for 2018/19 will be to enhance the experience of carers and relatives through improved liaison.

During the period April 2017 to January 2018:

	Q1	Q2	Q3	Q4	Total
Number of patients who died	236	238	288	293	1,055
Number of deaths subjected to case review or investigation	170	207	203	247	827
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided	3	2	3	3	11

Learning from deaths

Organisational learning	Actions/outcome
Communication: to develop and improve communication skills between teams at handover. The aim is to improve the continuity of patients' care when transferring between specialties.	As part of the mortality review process, there will be cross-specialty morbidity and mortality reviews to identify these issues. Identifying mortality leads for each specialty will play a key role with this practice.
Falls: failure to identify delirium in some cases. Learning identified regarding the monitoring and assessment of postural hypotension (ie standing and lying blood pressures).	Implementation of the Delirium 5 bundle in clinical areas to help staff identify patients who are delirious and the steps that need to be taken to ensure patients are adequately assessed. Ongoing quality improvement work relating to falls and raising awareness of the assessment and monitoring of postural hypotension.
Cardiac arrest calls and hospital locations: recent issues with the resuscitation team finding areas within the Trust.	A risk assessment has been undertaken regarding signage in the Cancer Centre at Guy's. Switchboard will be trialling scripted and structured questions to ensure the correct location can be identified when a cardiac arrest call is received.
Transfer of patients from other providers: issues relating to the lack of medical or nursing escort and patients arriving from other hospitals with higher than expected acuity.	A review of the current referral process and how this is documented when patients are referred to the Trust for specialist care is underway.
Nutrition: awareness of patient's dietary requirements as recommended by the speech and language team. Food charts not being commenced on admission. Inaccurate fluid balance recording.	Trust-wide 'Safety signal' highlighting the risks to patients if recommendations are not followed. Sign up to safety campaign included ensuring staff successfully identify nutritional issues on admission, refer on to specialists when required and ensure a nutritional care plan is in place where appropriate. Compliance with the Malnutrition Universal Screening Tool (MUST) within 24 hours has been added to the ward dashboard to raise awareness.
Communication: issues with access to the Co-ordinate My Care system which provides information about advanced care planning, including access to primary care and GP notes.	Training is being provided on how to access the system and GP records. IT will support work to update current systems to ensure records are available to clinicians.

Learning from deaths

Organisational learning	Actions/outcome
End of life care	<p>There has already been an increase in consultant and multidisciplinary team engagement in reviewing the quality and experience of care at the end of life. The Trust also has a thriving network of champions across the organisation spreading the message that end of life care is everybody's business.</p> <p>Improvements need to be made around advanced care planning. These conversations need to occur early with the patient to establish what their wishes are when they are at the end of their lives. Often these conversations happen in the community with GPs. The IT system Co-ordinate My Care (CMC) plays a key role in this.</p>
Death certification	<p>There are ongoing specialty audits to identify issues and gaps in knowledge which will direct a quality improvement project. Work continues with the bereavement team to make death certificates more easily available to clinical teams. The aim is to scan death certificates onto EPR so they can be viewed by clinical teams.</p>
Electronic discharge letters	<p>Work is underway with the IT team to improve the format of electronic discharge letters. Training and education for junior doctors is also underway.</p>

Seven day hospital services

We are working hard to implement seven day hospital services, including achieving the four priority clinical standards identified as 'must do' for all Trusts by 2020. We have agreed with NHS Improvement that we will strive to fast track these standards and deliver compliance in 2018.

- Standard two: time to first consultant review – our performance has improved over the last few months and our latest audit data from October 2017 shows 71% compliance.
- Standard eight: ongoing daily review by consultants, twice daily for high dependency patients – we are largely compliant in our high dependency units.
- Standard five: access to diagnostic tests – national audit showed that we are compliant with this standard and we are continuing our work to ensure that less urgent diagnostic tests are performed and reported promptly.
- Standard six: access to consultant interventions – we are fully compliant with this standard.

National core set of quality indicators

In 2012 a statutory core set of quality indicators came into effect. Eight indicators apply to acute hospital trusts. All trusts are required to report their performance against these indicators in the same format with the aim of making it possible for a reader to compare performance across similar organisations.

For each indicator shown below our performance is reported, together with the national average and the performance of the best and worst performing trusts where this data is available.

Mortality

The summary hospital level mortality indicator (SHMI) is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 100. A score below 100 denotes a lower than average mortality rate and therefore indicates good, safe care.

We believe our performance reflects that:

- the Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived
- data is collated internally and then submitted on a monthly basis to the Health and Social Care Information Centre (HSCIC) via the Secondary Uses Service (SUS). The SHMI is then calculated by HSCIC, with results reported quarterly on a rolling year basis.

	Apr 14 – Mar 15	Apr 15 – Mar 16	Jul 16 – Jun 17	Oct 16 – Sep 17
SHMI	79.3	76	75	73
Banding	3	3	3	3
% Deaths with palliative care coding	46.7%	47.5%	51.5%	50.6%

Source: HSCIC (data updated quarterly on a rolling basis)
SHMI Banding 3 = mortality rate is lower than expected

To further improve the quality of our services, we continue to deliver quality improvement programmes focused on how we treat patients with serious infection or acute kidney injury, and on the management of frail older patients, particularly those with dementia. We continue to monitor closely mortality data by ward, speciality and diagnosis. Reviews of in 'hospital deaths' are carried out to identify any factors that may have been avoidable so that these can inform our future patient safety work.

Patient reported outcome measures

Patient reported outcome measures (PROMs) measure quality from the patient perspective, and seek to calculate the health gain experienced by patients following one of four clinical procedures. We are reporting on patients who have had a hip replacement, knee replacement and varicose vein treatments where significant numbers of questionnaires were submitted. Hernia repair outcome data was not compared due to insufficient data for significance (defined as fewer than 30 cases) so this is not reported here.

We believe our performance reflects that:

- the Trust has a process in place for collating data on patient reported outcomes
- data is then sent to Capita on a monthly basis who collate and calculate PROMS scores and send it on to the Health and Social Care Information Centre (HSCIC)
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out on the next page.

Patients who have had these procedures are asked to complete a short questionnaire which measures a patient's health status or health related quality of life at a moment in time. The questionnaire is completed before, and then some months after surgery, and the difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient.

Primary hip replacement	2012/13	2013/14	2014/15	2015/16	2016/17*
Guy's and St Thomas'	0.42	0.47	0.45	0.47	0.44
National average	0.44	0.44	0.44	0.44	0.44
Highest	0.54	0.54	0.52	0.51	0.54
Lowest	0.32	0.31	0.33	0.32	0.30

Primary knee replacement	2012/13	2013/14	2014/15	2015/16	2016/17*
Guy's and St Thomas'	0.31	0.31	0.29	0.31	0.29
National average	0.32	0.32	0.32	0.32	0.32
Highest	0.42	0.42	0.42	0.40	0.40
Lowest	0.21	0.21	0.20	0.20	0.25

Varicose vein	2012/13	2013/14	2014/15	2015/16	2016/17*
Guy's and St Thomas'	N/A**	N/A**	0.05	0.10	N/A**
National average	0.09	0.09	0.09	0.10	0.09
Highest	0.18	0.15	0.15	0.15	0.15
Lowest	0.01	0.02	-0.01	0.02	0.02

*2016/17 data provisional. ** Insufficient data (to date) for HSCIC comparison.

Scores for the Trust show that the perceptions of health gain among patients having hip or knee replacement or varicose vein treatment are broadly consistent with the national average. We are a specialist referral centre and we often treat patients with complex treatment needs whose perception of health gain may be influenced by other health factors.

Clinicians regularly review scores at a service and Trust level to ensure that what we learn from patient feedback is incorporated into our quality improvement programmes.

Readmission within 28 days of discharge

The most recent information available from NHS Digital (formerly the Health and Social Care Information Centre (HSCIC)) was published in December 2013. Using data from the Healthcare Evaluation Data (HED) system in combination with local Trust digital systems, we are able to access full year information for 2017/18. The former provides national average performance rates, and the capacity to benchmark our performance against our peers.

We believe our performance reflects that:

- the Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived
- data is collated internally and then submitted on a monthly basis to NHS Digital via Secondary Uses Service (SUS). This data is then used by the Healthcare Evaluation Data system to calculate readmission rates. Data comparing us with peers, and highest and lowest performers, is not available for the reporting period.

Readmissions	2016/17			2017/18		
	Under 16	16 and over	Total	Under 16	16 and over	Total
Discharges	17,249	78,054	95,303	18,186	78,656	96,842
28 day readmissions	634	7,317	7,951	813	7,416	8,229
28 day readmission rate	3.7%	9.4%	8.3%	4.5%	9.4%	8.5%

Source: Trust information system

Quality report

We continue to take the following actions to reduce the number of patients requiring readmission:

- we have a Trust Risk and Quality Committee (TRAC) which monitors readmissions on a monthly basis and identifies any areas where there is a trend or change which may be a cause for concern
- our elderly care team reviews all cases at multidisciplinary team meetings and is actively seeking to improve clinical practice
- we are also working with GPs and community teams to review patients who have been readmitted so that we can agree specific actions for these patients.

Patient experience

Our score for the five questions in the national inpatient survey relating to responsiveness and personal care are consistent with the national average as shown below. The data is compared to peers, highest and lowest performers and our own previous performance.

Patient experience	2012/13	2013/14	2014/15	2015/16	2016/17
Guy's and St Thomas'	71.4	73.1	71.4	77.3	78.3
National average	68.1	68.7	68.9	77.3	76.7
Highest	84.4	84.2	86.1	88	87.3
Lowest	57.4	54.4	59.1	70.6	66.1

Source: HSCIC

Staff recommendation to friends and family

The Trust has high levels of staff engagement and our results in both our NHS staff survey and the Friends and Family Test show that staff perception of the Trust's services continues to be high. We believe the willingness of staff to recommend the Trust as a place to be treated is a strong and positive indicator of the standard of care provided.

We believe our performance reflects that:

- the Trust outsources the collection of data for the NHS Staff Survey
- data is collected by Quality Health and submitted annually to NHS England
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

Staff recommendation	2013/14	2014/15	2015/16	2016/17	2017/18
Guy's and St Thomas'	87%	85%	89%	89%	88%
Average for combined acute/community trust	66%	68%	70%	68%	69%
Highest combined acute/community trust	94%	93%	93%	95%	n/a
Lowest combined acute/community trust	40%	36%	46%	48%	n/a

Source: www.nhsstaffsurveys

Patient recommendation to friends and family

We believe that patient recommendation to their friends and family is a key indicator of the quality of care we provide.

We believe our performance reflects that:

- the Trust has a process in place for collating data on the Friends and Family Test
- data is collated internally and then submitted on a monthly basis to the Department of Health and Social Care
- data is compared to our own previous performance, and is shown in the table below.

Friends and Family Test	2015/16		2016/17		2017/18	
	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Guy's and St Thomas'						
Response rate	15.7%	30.4%	15.3%	23.6%	21.9%	20.4%
% would recommend	85%	95.6%	87.3%	97%	83.8%	95.7%
% would not recommend	8.2%	1.7%	7%	1.3%	7%	1.6%

Source: Trust information system

Venous thromboembolism

Venous thromboembolism (VTE) or blood clots, are a major cause of death in the UK. Some blood clots can be prevented by early assessment of the risk for a particular patient. Over 95% of our patients are assessed for their risk of thrombosis and bleeding on admission to hospital.

Our clinical staff remain at the forefront of venous thromboembolism care nationally and internationally, including through clinical research and service development.

We believe our performance reflects that:

- the Trust has a process in place for collating data on venous thromboembolism assessments
- data is collated internally and then submitted on a monthly basis to the Department of Health and Social Care
- data is compared to peers, highest and lowest performers, and our own previous performance, and is shown in the table below.

VTE assessments	2013/14	2014/15	2015/16	2016/17	2017/18
Guy's and St Thomas'	96.3%	97.1%	97.2%	96.6%	95.4%
National average	96%	96%	96%	–	–
Best performing trust	100%	100%	100%	–	–
Worst performing trust	81%	88%	79.9%	–	–

Source: HED and Trust information system

Infection control

The Trust continues to implement a range of measures to tackle infection and improve the safety and quality of our services. These include a strong focus on antibiotic stewardship and improved environmental hygiene, supported by continuous staff engagement and education.

We believe our performance reflects that:

- the Trust has a process in place for collating data on *C.difficile* cases
- data is collated internally and submitted on a daily basis to Public Health England
- data is compared to peers, highest and lowest performers, and our own previous performance, and is shown in the table below.

Infection control	2014/15	2015/16	2016/17	2017/18
Guy's and St Thomas'				
Trust apportioned cases	51	51	36	27
Trust bed-days	321,749	324,000	331,097	338,235
Rate per 100,000 bed-days	15.9	15.7	10.9	7.9
National average	15.1	14.9	13.0	–
Best performing trust	0	0	0	–
Worst performing trust	62.2	66	82.7	–

Source: Public Health England and Trust information system

Patient safety incidents

The National Reporting and Learning System (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database and is designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission. To avoid duplication of reporting, all incidents resulting in severe harm or death are reported to the NRLS, who then report them to the Care Quality Commission.

There is no nationally established and regulated approach to the reporting and categorising of patient safety incidents, so different trusts may choose to apply different approaches and guidance when reporting, categorising and validating patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. These judgements may differ between professionals, and data reported by different trusts may not be directly comparable.

We believe our performance reflects that:

- the Trust has a process in place for collating data on patient safety incidents
- data is collated internally and then submitted on a monthly basis to the National Reporting and Learning System
- data is compared to peers, highest and lowest performers, and our own previous performance, and is shown in the table below.

Patient safety incidents	Apr 14 – Sep 14	Oct 14 – Mar 15	Apr 15 – Sep 15	Oct 15 – Mar 16	Apr 16 – Sep 16	Oct 16 – Mar 17
Guy's and St Thomas'						
Total reported incidents	7,146	6,929	8,154	6,961	9,398	9,120
Rate per 1,000 bed-days	45.3	41.8	49.5	42.2	58.8	56.1
National average (acute non-specialist)	36.4	40.4	38.1	38.6	40.2	40.9
Highest reporting rate	75.0	82.2	74.7	75.9	71.8	68.9
Lowest reporting rate	0.0	0.0	18.1	14.8	21.1	23.1

Guy's and St Thomas'						
Incidents causing severe harm or death	17	22	21	22	39	44
% incidents causing severe harm or death	0.2%	0.3%	0.26%	0.3%	0.4%	0.5%
National average (acute non-specialist)	0.5%	0.5%	0.22%	0.46%	0.4%	0.44%
Highest reporting rate	3.4%	5.2%	2.39%	4.45%	1.7%	2.1%
Lowest reporting rate	0%	0.1%	0.03%	0%	0%	0%

Source: HSCIC

The number of patient safety incidents reported continues to reflect a positive culture for reporting all patient safety incidents, including near misses. The number and percentage of incidents resulting in severe harm or death remains broadly consistent with the national average. All serious incidents are investigated using root cause analysis methodology. We continue to work closely with commissioners and the National Reporting and Learning System (NRLS) to ensure that any changes made to incident classifications following a root cause investigation are reported to NRLS and that data provided to NRLS is reviewed and validated against Trust data to ensure it is consistent.

We continue to use the outcomes of root cause investigations of patient safety incidents to develop quality improvement projects which aim to improve the quality and safety of our services.

Our performance against NHS Improvement Single Oversight Framework indicators

NHS Improvement uses a number of national measures to assess access to services and outcomes, and to make an assessment of governance at NHS foundation trusts. Performance against these indicators acts as a trigger to detect potential governance issues and we are required to report on most of them every three months.

Our performance against these indicators can be seen in the table below.

Key performance indicators

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	C. <i>difficile</i> acquisitions (including: cases deemed not to be due to lapse in care and cases under review)	51	27	●	5	11	7
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	88%	●	89%	87%	87%
A&E access	95% A&E patients wait less than 4 hours	95%	89%	●	88%	89%	89%
Cancer access initial appointments	Urgent cancer referrals seen within 2 week wait	93%	96%	●	92%	95%	98%
	Symptomatic breast patients seen within 2 week wait	93%	95%	●	88%	97%	98%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	69%	●	65%	67%	71%
	% patients treated within 62 days from screening referral	90%	69%	●	84%	65%	62%
	% patients treated within 31 days of decision to treat	96%	94%	●	94%	94%	95%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	91%	●	90%	87%	92%
	Chemotherapy treatments within 31 days	98%	99%	●	98%	99%	100%
	Radiotherapy treatments within 31 days	94%	92%	●	89%	93%	93%
Community care information completeness	Referral to treatment information completeness	50%	68%	●	65%	64%	70%
	Referral information completeness	50%	81%	●	72%	73%	95%
	Activity information completeness	50%	69%	●	71%	69%	69%

In addition to these indicators, we certified compliance with the requirements to ensure that people with a learning disability can access healthcare. We continue to strengthen consistency and standardisation of practice across our hospital and community services.

Statements

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2017/18 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2017 to March 2018
 - papers relating to quality reported to the Board over the period April 2017 to March 2018
 - feedback from commissioners dated 4 May 2018
 - the 2016 national patient survey published May 2017
 - feedback from governors on chosen audit for the quality report, dated 27 February 2018
 - feedback from local Healthwatch organisations dated May 2018
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2017
 - the 2016 national patient survey published May 2017
 - the 2017 national staff survey published December 2017
 - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2018
 - CQC Inspection Report dated 24 March 2016
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the quality report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board



Sir Hugh Taylor, Chairman

23 May 2018



Amanda Pritchard, Chief Executive

23 May 2018

Independent Practitioner's Limited Assurance Report to the Council of Governors of Guy's and St Thomas' NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Guy's and St Thomas' NHS Foundation Trust to perform an independent limited assurance engagement in respect of Guy's and St Thomas' NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from commissioners dated 4 May 2018;
- feedback from governors dated 27 February 2018;
- feedback from local Healthwatch organisations dated May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated August 2017;
- the national patient survey published in May 2017;
- the national staff survey published in December 2017; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 9 May 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including

Quality report

Statements

documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Guy's and St Thomas' NHS Foundation Trust as a body, to assist the Council of Governors in reporting Guy's and St Thomas' NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Guy's and St Thomas' NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Guy's and St Thomas' NHS Foundation Trust.

Our audit work on the financial statements of Guy's and St Thomas' NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Guy's and St Thomas' NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Guy's and St Thomas' NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Guy's and St Thomas' NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Guy's and St Thomas' NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these

circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Guy's and St Thomas' NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

The indicator reporting the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period did not meet the six dimensions of data quality in the following respects:

- Accuracy – Our testing identified three errors in the twenty cases tested where either the clock start or stop date was incorrectly set.
- Validity – Our testing identified an error in one of the twenty cases tested where the referral did not meet the criterion as an eligible patient.
- Relevance – Our testing identified errors in two cases where the reported position was incorrectly classified as a breach or non-breach.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Chartered Accountants, London

23 May 2018

Lambeth CCG statement on Guy's and St Thomas' NHS Foundation Trust 2017/18 quality accounts –

On behalf of NHS Lambeth and Southwark Clinical Commissioning Groups and NHS England

Local commissioners welcome the opportunity to respond to this comprehensive document.

We recognise that it is currently an extremely challenging time for NHS services and we commend the Trust for their commitment and positive achievements over the past year with the continued focus on quality improvement and also the focus upon improving outcomes for the local population. We also welcome ongoing collaboration with the Trust to improve service provision further.

The report is very well written. However, there are a number of areas that we feel require highlighting and clarification please:

The rationale for selection of quality priorities is not always clear. We feel there is scope to be more involved in the collaborative planning, reviewing and celebrating the successes of the quality priorities.

We recognise that the Trust did not achieve their 17/18 priority for improving telephony and are very keen to further understand what the organisation intend to do about this.

Finally, commissioners seek further understanding as to which (if any) of the 2017/18 priorities are being carried over and if so, whether they were only partially achieved or not achieved please.

We look forward to working with the Trust further over the coming year with continued dialogue via the monthly CQRG process.

Ann Middleton

Assistant Director of Governance

NHS Lambeth Clinical Commissioning Group

4 May 2018

Statements

Guy's and St Thomas' NHS Foundation Trust Quality Accounts 2017/18: Response from Healthwatch Southwark

The new priorities

Although the report does not explain fully how they have been set, most of the new priorities are on issues of core importance. Baselines and often specific improvement targets are missing, which makes it hard to comment on the level of ambition shown and to assess progress.

Surgical safety and medicines management are vital elements of safe care. We also support the continuation of the pain management goal given that the management tool is being tested.

We are aware of substantial concern around RTTs, including cases where delayed outpatient appointments contributed to harm. We would like to see more information on whether/how the radiology turnaround times and theatre cancellations targets can help address this.

- **Mental health assessment:** Help in a mental health crisis is one of HWS's five priority areas. The emphasis of this goal is slightly different and we would like further detail: how will patients who have 'suspected' mental health needs be identified? If patients present with primarily physical concerns, how will staff ensure that screening does not cause distress? The quality and outcome of assessments is also crucial: which staff will undertake assessments and how are they trained? How will the ED ensure that assessments result in appropriate interventions?

- **End of life care:** A focus on end of life care seems apt given some concerns raised through audits listed in the Account, such as variability in symptom control and issues with access to Coordinate My Care. While we support an emphasis on patient/family involvement, this goal could therefore be broadened.

- **Complaints:** Given our focus on patient voice we support this target; delays in learning from problems are unacceptable. We would like to see this target expanded to include less formal concerns raised via PALS – HWS has heard from patients having problems contacting the service or getting a response.

- **Age appropriate care.** This is not a topic where we have received patient feedback and we would be interested to hear more about the specific issues that have been raised.

Last year's priorities

We commend the Trust on substantial work towards achieving many of the goals. Overall, we would like to see clearer alignment between the detail under 'what success will look like' and what has been achieved, including figures and particularly on patient feedback.

We approve the commitment to identifying barriers in the ED to achieving time-to-treatment targets for sepsis and would like to see an update on this.

It is disappointing that the commitment to improve the Trust's telephone systems cannot be met for financial reasons; this has been raised by patients with HWS as an issue.

Missing information

Some data is not yet available in this draft, including the surgical safety audit, data on readmissions within 28 days of discharge, and data on whether the nutrition target has been met.

We would have liked to see detail on issues highlighted in the March 2018 CQC visit, a breakdown of themes identified through complaints and Serious Incidents, and information about RTTs.

Healthwatch Southwark

May 2018

Guy's and St Thomas' NHS Foundation Trust Quality Accounts 2017/18: Response from Healthwatch Lambeth

General comments

Healthwatch Lambeth acknowledges the good trends in the Trust's performance. We agree with the three priorities and would be very keen to continue contributing to priority 3 (patient experience). It is also much easier for us to comment on this priority compared to the clinical aspect.

The formatting can be further improved for easy read. For example, the two columns on page 70 could be tidied up to specify: priority and why it is chosen; the approaches used; and success/outcome indicators.

To understand the context of data reporting, you may also want to include both percentages and numbers, in addition to some analysis of quantitative data.

Specific comments

Page 72

- Review of patients' death. We welcome the rationale behind the proposed Family Liaison Officer as we appreciate the value of family, carer and relative's engagement in the care of the patient. We would like to know more about this plan/role in due course.
- Patient experience – patients receiving the correct meal. We know of a very small number of patients who stated that they did not receive the food they needed and that there was no communication with them about options. We would be interested to know more on the survey data when it becomes available.

Page 73

- Consent. Patients survey – 90% of what number of patients?
- We acknowledge the significance of the Duty of Candour audit and acknowledge the challenge brought about by the unanticipated withdrawal of training support. It would help to know what 9% increase in numbers trained equates to.
- Capital investment – Communication between patients, carers and the Trust set the quality of patients' experience. We understand that in the current economic climate, the capital investment of £1 million is very unlikely. We would like to support in ways we can, eg through our statutory duty, eg 'Enter and View'.

Page 81 – CQC inspection

- We recognise the 'outstanding' mark from CQC for 'caring services' and would like to offer our support to understand the patients' experience.

Page 88 – Patient recommendation to friends and family

- We acknowledge the response rate in A&E has consistently increased. However, this is not the case for inpatient. Could you kindly explain the reasons behind it, just so we can determine ways to help address it.

Healthwatch Lambeth

May 2018



We are proud to be celebrating the 70th birthday of the NHS in 2018. This image shows a children's ward at Guy's in the 1950s.

Foreword to the accounts

These accounts, for the year ended 31 March 2018, have been prepared by Guy's and St Thomas' NHS Foundation Trust in accordance with paragraphs 24 & 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.



Amanda Pritchard
Chief Executive and Accounting Officer

23 May 2018

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

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Guy's and St Thomas' NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2018 which comprise the Consolidated Statement of Comprehensive Income, the Statement of Financial Position, the Group and Trust Statement of Changes in Taxpayers' Equity, the Consolidated Cash Flow Statement and notes to the financial statements, including Accounting Policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

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 2018 and of the group's expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; 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. 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.

Who we are reporting to

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.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Trust's ability to continue to adopt the going

concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.



Overview of our audit approach

- Overall materiality: £27,000,000, which represents 1.91% of the group's gross revenue expenditure (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
 - Additional NHS contract income from healthcare activities
 - Valuation of property
- This was our first year as auditor of the Trust. We performed a full scope audit of Guy's and St Thomas' NHS Foundation Trust and analytical audit procedures on the non-significant group components.

Key audit matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter – Group and Trust	How the matter was addressed in the audit – Group and Trust
<p>Risk 1 - Additional NHS contract income from healthcare activities</p> <p>Approximately 78% of the group's income is in relation to NHS contract income from healthcare activities. Healthcare activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners.</p> <p>We therefore identified the occurrence and accuracy of additional NHS contract income from healthcare activities as a significant risk, which was one of the most significant assessed risks of material misstatement.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none">• evaluating the group's accounting policy for recognition of income from healthcare activities for appropriateness and compliance with the Department of Health and Social Care Group Accounting Manual (GAM);• gaining an understanding of the group's system for accounting for income from healthcare activities and evaluating the design of the associated controls;• agreeing significant contract variations to correspondence with commissioners and NHS England,• where significant, agreeing contract [or contract variation?] values with commissioners to notifications received by the Trust from those entities; and• testing a sample of income from additional healthcare activity to signed contract variations, invoices, and other supporting documentation, such as correspondence from the Trust's commissioners confirming their agreement to pay for the additional activity.

Key Audit Matter – Group and Trust	How the matter was addressed in the audit – Group and Trust
	<p>The group's accounting policy on income from healthcare activities is shown in note 1.3 to the financial statements and related disclosures are included in note 3.</p> <p>Key observations We obtained sufficient, appropriate audit evidence to conclude that:</p> <ul style="list-style-type: none"> - the Trust's accounting policy for recognition of additional NHS contract income from healthcare activities complies with the GAM 2017/18 and has been properly applied; and - additional NHS contract income from healthcare activities is not materially misstated.
<p>Risk 2 - Valuation of property The Trust revalues its property on a quinquennial basis with interim targeted valuations between to ensure that carrying value is not materially different from fair value. 2017/18 was valued under the targeted valuation method. This represents a significant estimate by management in the financial statements.</p> <p>We therefore identified valuation of property as a significant risk, which was one of the most significant assessed risks of material misstatement.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> • evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work; • evaluating the competence, capabilities and objectivity of the valuation expert; and • challenging the information and assumptions used by the valuation expert to assess completeness and consistency with our understanding. • testing a sample of valuation movements and associated reserve impacts. <p>The group's accounting policy on the valuation of property, plant and equipment is shown in note 1.7 to the financial statements and related disclosures are included in note 13.</p> <p>Key observations We obtained sufficient, appropriate audit evidence to conclude that:</p> <ul style="list-style-type: none"> - the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimate were reasonable; and - the valuation of property disclosed in the financial statements is reasonable.

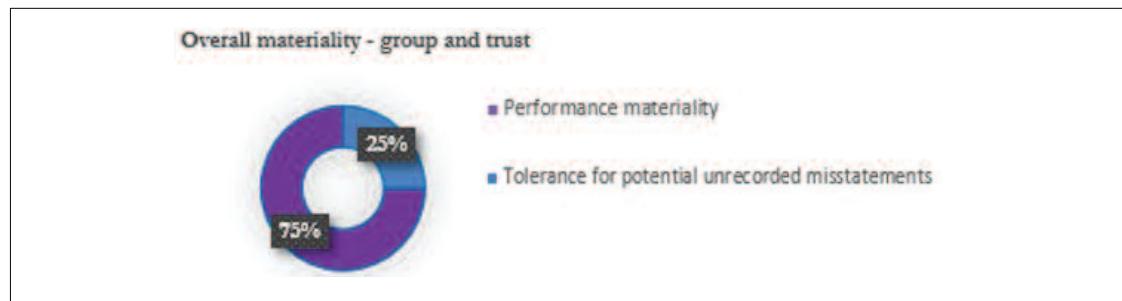
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Group and Trust
Financial statements as a whole	£27,000,000 which is 1.91% of the group's gross revenue expenditure. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
The level below which items are clearly trivial.	£300,000 per the NAO maximum triviality value

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the group's business, its environment and risk profile and in particular included:

- Evaluation of identified components to assess the significance of that component and to determine the planned audit response based on a measure of materiality and significance of the component as a

percentage of the group's total gross revenue expenditure. A full scope, targeted or analytical approach was taken for each component based on their relative materiality to the group and our assessment of audit risk;

- Full scope audit procedures on Guy's and St Thomas' NHS Foundation Trust. The Trust's transactions represents more than 99% of the group's total income, more than 99% of its total expenditure and more than 99% of its total net assets;
- Gaining an understanding of and evaluating the group's internal control environment including its financial and IT systems and controls; and
- Analytical audit procedures on the group components:
 - Essentia Trading Ltd;
 - Guys' and St Thomas' Enterprises Ltd;
 - GTI Forces Healthcare Ltd; and
 - Pathology Services Ltd

which together represent 0.3% of the group's total net assets.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report other than the financial statements and our auditor's report thereon. 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.

In connection with our audit of the financial statements, 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 of the group and Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group and Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit

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 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 meet the disclosure requirements set out in the NHS foundation trust annual reporting

manual 2017/18. 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.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources 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 have reported a matter 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 have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken 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 and Those Charged with Governance for the financial statements

As explained more fully in the Statement of 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 2017/18, 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 group or the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the group or the Trust.

The Audit Committee is Those Charged with Governance.

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.

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 – Conclusion on 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 - 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 2018.

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

Responsibilities of the Accounting Officer

The 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 and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code

of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Guy's and St Thomas' NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Paul Dossett
Senior Statutory Auditor
for and on behalf of Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG

24 May 2018

Consolidated statement of comprehensive income for the year ended March 31 2018

	March 31 2018 NOTE	March 31 2017 £000
Patient care income	3 1,185,469	1,133,049
Non-patient care income	4 293,569	313,461
TOTAL INCOME	1,479,038	1,446,510
Operating expenses	5.1 (1,412,553)	(1,380,074)
OPERATING SURPLUS	66,485	66,436
FINANCE COSTS		
Finance income	9 1,577	388
Finance expenses	10 (5,685)	(5,695)
Public Dividend Capital dividend payable	29 (20,631)	(19,552)
Net finance costs	(24,739)	(24,859)
(Losses) in disposal of assets	8 (884)	(98)
Movement in fair value of Investment Property	8 –	1,090
Corporation tax	11 (38)	93
SURPLUS FOR THE YEAR	40,824	42,662
Other comprehensive Income/(Expense)		
Impairments	15 (208)	(10,161)
Revaluations	18 55,265	35,790
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	95,881	68,291

The notes on pages 112 to 137 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

	March 31 2018 £000	March 31 2017 £000
Total comprehensive income as above	95,881	68,291
Less reserve movements in other comprehensive (expense)	a (55,057)	(25,629)
Total comprehensive income before reserve movements	40,824	42,662
Add back in year impairments and reversals of impairments included in surplus/(deficit) above (see note 15)	b (10,758)	25,369
Other non-operating items	–	98
Less capital donations	(12,399)	(32,353)
NET UNDERLYING SURPLUS EXCLUDING ITEMS ABOVE	c 17,667	35,776

- a. This is the total of the two items shown in Other Comprehensive Income.
- b. This is the total net impairments charged to expenditure (Note 15).
- c. Represents the primary view used by the Board of Directors to monitor the Trust's financial performance.

Statement of financial position as at March 31 2018

	GROUP		TRUST		
	NOTE	MARCH 31 2018 £000	MARCH 31 2017 £000	MARCH 31 2018 £000	MARCH 31 2017 £000
NON-CURRENT ASSETS					
Property plant and equipment	13	1,198,070	1,107,297	1,198,020	1,107,289
Intangible assets	14	44,857	42,146	44,857	42,144
Investment property	17	1,169	1,169	1,169	1,169
Investments in associates (joint controlled operations)	19.1	71	71	2,050	1,450
Other investments/financial assets	22	1,368	2,574	4,898	5,595
Other financial assets	21.2	2,107	2,152	2,107	2,152
TOTAL NON-CURRENT ASSETS		1,247,642	1,155,409	1,253,101	1,159,799
CURRENT ASSETS					
Inventories	20	25,075	21,697	25,075	21,697
Trade and other receivables	21.1	158,294	149,095	157,715	149,295
Other financial assets	22	1,270	1,006	1,270	1,531
Assets for sale and assets in disposal groups	16	–	418	–	418
Cash and cash equivalents	25	134,783	140,391	133,454	138,565
TOTAL CURRENT ASSETS		319,422	312,697	317,514	311,506
CURRENT LIABILITIES					
Trade and other payables	23.1	(156,820)	(159,640)	(157,198)	(160,269)
Other liabilities	23.2	(28,702)	(22,308)	(28,702)	(22,308)
Provisions	24.1	(698)	(1,124)	(698)	(1,124)
Borrowings	23.3	(12,085)	(10,485)	(12,085)	(10,485)
TOTAL CURRENT LIABILITIES		(198,305)	(193,557)	(198,683)	(194,186)
NON-CURRENT LIABILITIES					
Provisions	24.1	(6,227)	(11,072)	(6,227)	(11,072)
Borrowings	23.3	(211,290)	(210,687)	(211,290)	(210,687)
TOTAL NON-CURRENT LIABILITIES		(217,517)	(221,759)	(217,517)	(221,759)
TOTAL ASSETS EMPLOYED		1,151,242	1,052,700	1,154,415	1,055,360
TAXPAYERS' EQUITY					
Public Dividend Capital		367,328	364,667	367,328	364,667
Revaluation reserve		372,671	317,614	372,671	317,614
Other reserves		743	743	743	743
Income and expenditure reserve		410,500	369,676	413,673	372,336
TOTAL TAXPAYERS' EQUITY		1,151,242	1,052,700	1,154,415	1,055,360

Amanda Pritchard
Chief Executive and Accounting Officer
23 May 2018

Statement of changes in taxpayers' equity

GROUP 2017/18

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2017	364,667	317,614	743	369,676	1,052,700
Surplus for the year	–	–	–	40,824	40,824
Impairments	–	(208)	–	–	(208)
Revaluations	–	55,265	–	–	55,265
Public Dividend Capital received	2,661	–	–	–	2,661
Taxpayers' equity as at March 31 2018	367,328	372,671	743	410,500	1,151,242

GROUP 2016/17

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2016	364,273	292,785	743	326,214	984,015
Surplus for the year	–	–	–	42,662	42,662
Transfers to retained earnings on disposal of assets	–	(800)	–	800	–
Impairments	–	(10,161)	–	–	(10,161)
Revaluations	–	35,790	–	–	35,790
Public Dividend Capital received	394	–	–	–	394
Taxpayers' equity as at March 31 2017	364,667	317,614	743	369,676	1,052,700

TRUST 2017/18

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2017	364,667	317,614	743	372,336	1,055,360
Surplus for the year	–	–	–	41,337	41,337
Impairments	–	(208)	–	–	(208)
Revaluations	–	55,265	–	–	55,265
Public Dividend Capital received	2,661	–	–	–	2,661
Taxpayers' equity as at March 31 2018	367,328	372,671	743	413,673	1,154,415

TRUST 2016/17

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2016	364,273	292,785	743	328,791	986,592
Surplus for the year	–	–	–	42,745	42,745
Transfer to retained earnings on disposal of assets	–	(800)	–	800	–
Impairments	–	(10,161)	–	–	(10,161)
Revaluations	–	35,790	–	–	35,790
Public Dividend Capital repaid	394	–	–	–	394
Taxpayers' equity as at March 31 2017	364,667	317,614	743	372,336	1,055,360

Consolidated cash flow statement for the year ended March 31 2018

NOTE	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	*Restated*	March 31 2017 £000
			March 31 2018 £000	
Cash flows from operating activities				
Operating surplus from continuing operations	66,485	66,436	66,854	66,493
Non-cash income and expense				
Depreciation and amortisation	5.1	53,047	47,071	53,042
Impairments and reversal of impairments	15	(10,143)	25,369	(10,143)
Income recognised in respect of capital donations (cash and non-cash)		(12,399)	(32,353)	(12,399)
(Increase) in trade and other receivables		(11,234)	(40,802)	(10,503)
(Increase)/Decrease in other assets		—	(6)	—
(Increase) in inventories		(3,378)	(371)	(3,378)
(Decrease)/Increase in other liabilities		6,394	(7,750)	6,394
Increase in trade and other payables		(2,809)	2,297	(3,066)
(Decrease) in provisions		(5,273)	(41)	(5,273)
Tax paid	11	(73)	(107)	0
Other movements in operating cash flows		36	196	9
NET CASH GENERATED FROM OPERATING ACTIVITIES		80,653	59,939	81,536
				59,715
Cash flows from investing activities				
Interest received	9	1,577	388	1,681
Purchase of financial assets		(64)	—	(600)
Proceeds from settlements of financial assets		1,000	—	1,000
Purchase of intangible assets		(8,643)	(11,036)	(8,643)
Purchase of property, plant and equipment		(73,191)	(95,095)	(73,146)
Proceeds from sale of property, plant and equipment		34	1,169	34
Receipt of cash donations to purchase capital assets		12,399	32,353	12,399
NET CASH USED IN INVESTING ACTIVITIES		(66,888)	(72,221)	(67,275)
				(73,058)
Cash flows from financing activities				
Movement in loans from the Department of Health and Social Care		2,203	62,269	2,203
Public Dividend Capital received		2,661	394	2,661
Interest paid		(5,686)	(5,475)	(5,686)
Public Dividend capital paid		(18,551)	(21,993)	(18,551)
NET CASH GENERATED FROM FINANCING ACTIVITIES		(19,373)	35,195	(19,373)
				35,195
Net increase/(decrease) in cash and cash equivalents		(5,608)	22,913	(5,111)
Cash and cash equivalents at April 1		140,391	117,478	138,565
Cash and cash equivalents at March 31	25	134,783	140,391	133,455
				138,565

*Restated – the prior year comparator has been disclosed to reflect updates to presentational requirements of the Department of Health and Social Care Group Accounting Manual.

Notes to the accounts

1 Accounting policies

1.1 Basis of preparation of the financial statements

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts all meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in that manual follow IFRS and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Going concern

The directors have a reasonable expectation that the NHS Foundation Trust will continue to provide the current service for the foreseeable future, as although contract negotiations are not yet complete in all cases they are confident the Trust will receive broadly the same level of funding for the next year as in the previous year (as evidenced by ongoing payments received in April and May) and the Trust starts the new financial year with a healthy cash balance. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.2 Basis of consolidation

The group financial statements consolidate the financial statements of the Trust and entities controlled by the Trust (its subsidiaries) and incorporate its share of the results of joint ventures and associates using the equity method of accounting. The financial statements of the subsidiaries are prepared for the same reporting year as the Trust.

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 are consolidated in full into the appropriate financial statement lines.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where differences are material.

All intragroup balances and transactions, including unrealised profits arising from intragroup transactions, have been eliminated in full on consolidation. 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.

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 (eg revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, eg 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 it 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. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The exemption to include the Trust's Statement of Comprehensive Income (SOCI) as allowed by DHSC GAM 2017/18 has been applied by the directors.

All notes in the accounts refer to the group and the trust notes are included only where materially different.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Revenue relating to spells that are partially completed at year-end are apportioned across the financial years on a pro rata basis. This basis is based on the costs incurred over the length of the treatment and the expected or actual length of stay.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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

1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments 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

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and these are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018, is based on valuation data as at 31 March 2017, updated to 31 March 2018 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health and Social Care, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

In addition the Trust also operates a NEST scheme for staff not eligible for the NHS pension scheme. This is a defined contribution, off Statement Of Financial Position scheme and the number of employees opting in and the value of the contributions has been negligible.

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.

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. All assets are measured subsequently at fair value.

Land and buildings 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 2018 the land and building assets were revalued.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury adopts a standard approach to depreciated replacement cost valuations using a modern equivalent asset basis, and, where it would meet the location requirements of the service being provided, an alternative site can be valued. As at 31 March 2016 a valuation using an alternative site basis was carried out for the first time.

Properties in the course of construction are carried at cost. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value.

New fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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.

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.

The Trust depreciates assets over the following ranges:

- Buildings, 2 - 62 years
- Plant and machinery, 2 - 20 years
- Transport equipment, 2 - 7 years
- IT hardware, 2 - 10 years
- Furniture and fittings, 5 -15 years.

Buildings and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the NHS Foundation Trust's professional valuer. The Trust adopts a policy of revaluing its estates on an annual basis. This has the impact that the useful life for buildings may vary subtly year on year.

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

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

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

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

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria 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 or significant changes made to it.

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. 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 economic 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 majority of donated assets have funding received retrospectively, so that restrictions imposed by the donor are met upon the receipt of the donated cash. If donated assets were no longer used for the purpose intended, for treating patients, and they still had a net book value, the donor would be notified. There were no restrictions placed on the donations received in the year.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8 Intangible fixed assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets are capitalised when: they are capable of being used in the Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

They are recognised only where it is probable that the future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits, eg the presence of a market for it or its

output, or, where it is to be used for internal use, the usefulness of the asset can be shown;

- adequate financial, technical and other resources are available to the Trust to complete the development and sale or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at fair value which is typically amortised cost. Revaluation gains and losses and impairments are treated in the same manner as property, plant and equipment.

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

Amortisation

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

The Trust depreciates intangible assets over the following ranges:

- Information technology, 3 – 15 years
- Software licences and trademarks, 5 – 10 years.

1.9 Investment property

Investment property, which is property held to earn rentals, is stated at its fair value at the balance sheet date, determined annually by independent professional valuers. Gains or losses arising from changes in the fair value of investment property are included in the Statement of Comprehensive Income for the period in which they arise. The cost of major renovations and improvements are capitalised and the cost of maintenance, repairs and minor improvements are recognised in the Statement of Comprehensive Income when incurred. On disposal of an investment property, the difference between the disposal proceeds and the carrying amount is recognised in profit or loss.

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 GSTT's heritage asset as required by FRS 102 can be found in Note 34.

1.11 Government and other revenue grants

Government grants are grants from Government bodies other than income from commissioners or NHS 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.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the FIFO method.

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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid over as Public Dividend Capital. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value for all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of 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

Current tax assets and liabilities are measured at the amount expected to be recovered from or paid to the taxation authorities, based on tax rates and laws that are enacted or substantively enacted by the Statement of Financial Position date.

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 which arise from contracts for 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, are recognised when, and to the extent that, performance occurs, ie when receipt or delivery of the goods or services is made.

Regular purchases or sales are recognised and de-recognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: a loan to Viapath, current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health and Social Care are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets

Non-derivative financial assets classified as available-for-sale are either specifically designated in this category or not classified in any of the other categories. Available-for-sale financial assets are initially recognised at fair value, including transaction costs, and measured subsequently at fair value, with gains and losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are not sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts estimated future cash payments through the

expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

Financial liabilities are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

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

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure', are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.19 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The assets and liabilities are recognised at the commencement of the lease. Thereafter the assets are accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.20 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate, except for early retirement provisions which uses the HM Treasury's pension discount rate of 0.10% (2016/17: 0.24%) in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS resolution which in return settles all

clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the notes to the Statement of Comprehensive Income.

Non-clinical risk pooling

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

Commercial insurance

In addition to NHS Resolution Property Expenses and Liabilities to Third Parties Schemes, the Trust also holds commercial insurance. The annual premium is charged to operating expenses.

Contingencies

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

Contingent liabilities are not recognised, but are disclosed in the Contingencies note, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in 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.

However, 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 Critical accounting judgements and key 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. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

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

Provisions

A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities. The following discount rates as published by HM Treasury have been used in calculating the injury benefit provision: Short-term -2.42%, Medium-term -1.95% and Long-term -1.56%. Early voluntary retirement pension provision has been calculated by applying a 0.10% discount rate as advised by HM Treasury.

Provision for impairment of receivables

Management will use their judgement to decide when to write-off revenue or to provide against the probability of not being able to collect debt.

Impairments and estimated asset lives

The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives.

Valuations of land and buildings

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See Note 1.7 for further details.

Key sources of estimation uncertainty

Management has made the following critical judgements in the process of applying the entity's accounting policies and this has had a significant effect on the amounts recognised in the accounts:

- 1) The use of estimated asset lives in calculating depreciation (See Note 1.7 and Note 1.8).
- 2) Provisions for early voluntary retirement pension contributions and injury benefit obligations are estimated using expected life tables and discounted at the pensions rate of 0.10% (0.24% 2016/17) (See Note 1.20).

1.24 Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the Government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2 Segmental reporting

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive, is the chief operating decision maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed.

Day-to-day financial control is devolved to:

- Sixteen Clinical Directorates are accountable to the Board of Directors via the Chief Operating Officer;
- Corporate and other support services accountable to the Board of Directors via the appropriate Executive Directors;
- Evelina London Strategic Business Unit is accountable to the Board of Directors via the Chief Executive Officer.

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 Director of Finance to the Board of Directors at each meeting. This report is made available to the public at the meeting and via the public website of the Trust.

3 Patient care income

3.1 Income from activities by source

	Year ended March 31 2018 £000	*Restated* Year ended March 31 2017 £000
NHS England	538,493	477,061
Clinical Commissioning Groups (CCGs)	601,513	605,134
Department of Health and Social Care	10	–
NHS Foundation Trusts	264	114
NHS Trusts	98	14
Local authorities	11,689	20,320
NHS other (including Public Health England)	6,019	4,994
Non NHS: private patients	21,485	18,139
Non NHS: overseas patients (non reciprocal, chargeable to patient)	3,767	3,964
Injury cost recovery scheme	687	1,503
Non NHS: other	1,444	1,806
Total income from patient care activities	1,185,469	1,133,049
Of which:		
Related to continuing operations	1,185,469	1,133,049
Related to discontinued operations	–	–

3.2 Income from patient care (by nature)

	Year ended March 31 2018 £000	Year ended March 31 2017 £000
Elective income	203,374	183,650
Non-elective income	131,031	118,674
Outpatient income	61,897	62,275
Follow up outpatient income	89,115	94,639
Accident and Emergency income	26,805	24,474
High cost drugs income from commissioners (excluding pass-through drugs)	113,344	112,054
Other NHS clinical income	401,116	380,172
Private patient income	21,581	22,339
Community services:		
– Income from CCGs and NHS England	98,898	95,342
– Income from other sources (eg local authorities)	12,944	11,107
Other income**	25,364	28,323
	1,185,469	1,133,049

Restated – the prior year comparator has been restated to reflect updates to presentational requirements of the Department of Health and Social Care Group Accounting Manual.

**Other income includes income from commercial activities, staff accommodation rentals, clinical excellence awards, catering, and other direct credits.

3.3 Patient care income

	Year ended March 31 2018 £000	Year ended March 31 2017 £000
Commissioner requested services	1,163,888	1,110,710
Non Commissioner requested services	21,581	22,339
	1,185,469	1,133,049

Commissioner requested services are largely funded by CCGs and NHS England.

3.4 Overseas visitor income

	Year ended March 31 2018 £000	Year ended March 31 2017 £000
Income recognised this year	3,767	3,964
Cash payments received in-year (relating to invoices raised in current and previous years)	975	975
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	2,955	3,059
Amounts written-off in-year (relating to invoices raised in current and previous years)	5,063	926

4 Non-patient care income

	Year ended March 31 2018 £000	Year ended March 31 2017 £000
Research and development	54,317	52,571
Education, training and research	73,785	79,084
Education and training – notional income from apprenticeship fund	190	–
Charitable and other contributions to expenditure and capital assets	17,663	37,688
Non-patient care services to other bodies	25,979	24,198
Sustainability and Transformation Fund income	28,370	37,958
*Other income	80,928	74,663
Rental revenue from operating leases – minimum lease payments	7,373	3,248
Income in respect of staff recharges	4,964	4,051
	293,569	313,461

*Other income includes: £16m from clinical tests, £11m from external estate recharges and the remaining from catering, staff accommodation rentals, income from commercial activities, clinical excellence awards and other direct credits.

5 Operating expenses

5.1 Operating expenses comprise:

	Note	Year ended March 31 2018 £'000	*Restated* Year ended March 31 2017 £'000
Purchase of healthcare from NHS and DHSC bodies		23,660	26,949
Purchase of healthcare from non-NHS and non-DHSC bodies		19,532	18,779
Staff and executive directors costs		819,219	771,091
Non-executive directors		221	197
Supplies and services – clinical (excluding drugs costs)		174,563	167,519
Supplies and services – general		8,945	8,408
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		132,271	130,392
Inventories written down (net including drugs)		404	284
Consultancy		1,410	967
Establishment		25,002	22,103
Premises – business rates collected by local authorities		10,576	7,349
Premises – other		73,529	70,588
Transport – other (including patient travel)		14,787	16,541
Depreciation		44,139	38,616
Amortisation		8,908	8,455
Impairments net of (reversals)		(10,143)	25,369
Increase in impairment of receivables		6,683	2,176
Change in provisions discount rate		18	533
Audit services – statutory audit		128	120
Other auditor remuneration	5.2	10	551
Internal audit – staff costs		459	375
Clinical negligence – amounts payable to NHS Resolution (premium)		21,487	19,533
Legal fees		774	1,777
Insurance		651	1,550
Research and development – non-staff		269	235
Education and training – non-staff		6,032	7,114
Education and training – notional expenditure funded from apprenticeship fund		190	–
Operating lease expenditure		16,828	17,890
Early retirements – non-staff		582	26
Redundancy costs – staff costs		342	732
Hospitality		145	169
Other**		10,932	13,686
		1,412,553	1,380,074

Restated – the prior year comparator has been restated to reflect updates to presentational requirements of the Department of Health and Social Care Group Accounting Manual.

**Other operating expenses includes expenditure on commercial activities, training and legal fees.

5.2 Other auditor remuneration

	Year ended March 31 2018 £'000	Year ended March 31 2017 £'000
Other auditor remuneration paid to the external auditor		
Audit-related assurance services	10	18
Taxation and advisory services	–	533
	10	551

Payments made to our auditor for non-audit work in 2017/18 were £nil relating to taxation and advisory services (2016/17 £533k). In 2016/17 KPMG, who were the External Auditors were paid for the Fleming Latent VAT claim where the work was completed by their tax team between 2009 to 2014. The value of the work was agreed on a contingent basis as a percentage of the savings achieved for the Trust, resulting in a HMRC repayment of £1.6m including Interest. The £1.6m was received from HMRC in 2017/18.

5.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2017-18 is £2million (2016-17 £2million).

5.4 Operating leases

5.4.1 Operating lease expenditure:

	Year ended March 31 2018 £'000	Year ended March 31 2017 £'000
Minimum lease payments under operating leases recognised as an expense in the year	16,828	17,890

5.4.2 Future minimum lease payments:

Future minimum lease payments due:	Year ended March 31 2018 £'000	Year ended March 31 2017 £'000
Within 1 year	17,597	18,186
Between 1 and 5 years inclusive	31,184	31,653
After 5 years	32,817	22,182
	81,597	72,021

5.4.3 Operating lease income:

	Year ended March 31 2018 £'000	Year ended March 31 2017 £'000
Rental revenue from operating leases – minimum lease receipts	7,373	3,248
	7,373	3,248

5.4.4 Future minimum lease receipts:

Future minimum lease receipts due:	Year ended March 31 2018 £'000	Year ended March 31 2017 £'000
Within 1 year	6,786	5,808
Between 1 and 5 years inclusive	24,904	20,909
After 5 years	99,661	81,192
	131,350	107,909

6 Employee costs and numbers

6.1 Employee costs (including executive directors)

	Year ended March 31 2018 Permanently employed £000	Year ended March 31 2018 Other £000	Year ended March 31 2018 Total £000	Year ended March 31 2017 Total £000
Salaries and wages	602,753	52,828	655,581	612,047
Social security costs	66,782	3,350	70,132	64,409
Apprenticeship levy	3,237	–	3,237	–
Employer contributions to NHSPA	74,148	1,941	76,089	71,299
Termination benefits	342	–	342	732
Temporary staff – external bank	–	6,573	6,573	4,643
Temporary staff – agency and contract staff	–	28,762	28,762	38,820
Total gross staff costs	747,262	93,454	840,716	791,950
Recoveries in respect of seconded staff	(6,960)	–	(6,690)	(6,046)
Total staff costs	740,302	93,454	833,756	785,904
Of which:				
Costs capitalised as part of assets	12,422	1,314	13,736	13,706
Analysed into Operating Expenditure (note 5.1)				
Employee expenses – staff & executive directors	727,081	92,138	819,219	771,091
Redundancy	342	–	342	732
Internal audit costs	457	2	459	375
Total employee benefits excluding capitalised costs	727,880	92,140	820,020	772,198

6.2 Retirements due to ill-health

During 2017-18 there were 8 early retirements from the Trust agreed on the grounds of ill-health (12 in the year ended March 31 2017). The estimated additional pension liabilities of these ill-health retirements is £197k (£598k in 2016-17). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

6.3 Analysis of termination benefits

	Year ended March 31 2018	Year ended March 31 2017
Number of cases	16	12
Cost of cases (£000)	687	405

7 Exit packages

7.1 Other compensation schemes – exit packages 2017-18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000
	Number	£000	Number	£000	Number	£000
<£10,000	4	28	–	–	4	28
£10,001 – £25,000	4	77	1	17	5	94
£25,001 – £50,000	2	65	–	–	2	65
£50,001 – £100,000	2	143	1	81	3	224
£100,001 – £150,000	1	116	–	–	1	116
£150,001 – £200,000	1	160	–	–	1	160
Total	14	589	2	98	16	687

7.2 Other compensation schemes – exit packages 2016-17

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000
	Number	£000	Number	£000	Number	£000
<£10,000	3	19	1	4	4	23
£10,001 – £25,000	5	99	–	–	5	99
£50,001 – £100,000	2	123	–	–	2	123
£150,001 – £200,000	1	160	–	–	1	160
Total	11	401	1	4	12	405

7.3 Exit packages: other (non-compulsory) departure payments

	2017-18		2016-17	
	Payments agreed	Total value of agreements £000	Payments agreed	Total value of agreements £000
	Number	£000	Number	£000
Exit payments following Employment Tribunals or court orders	1	17	–	–
Contractual payments in lieu of notice	1	81	1	4
Total	2	98	1	4

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

8 Other gains and losses

	Year ended March 31 2018 £000	Year ended March 31 2017 £000
Profit on disposal of fixed assets held for sale	–	105
Loss on disposal of other property, plant and equipment	(884)	(455)
Profit on disposal of other property, plant and equipment	–	252
	<u>(884)</u>	<u>(98)</u>
Fair value gain on investment properties	–	1,090
	<u>(884)</u>	<u>992</u>

9 Finance income

	Year ended March 31 2018 £000	Year ended March 31 2017 £000
Interest on bank accounts	390	300
Interest on loans and receivables	74	88
*Other	1,113	–
	<u>1,577</u>	<u>388</u>

*Other: This relates to Interest received from HMRC for an historic VAT reclaim.

10 Finance expenses

	Year ended March 31 2018 £000	Year ended March 31 2017 £000
Capital loans for the Department of Health and Social Care	(5,680)	(5,590)
Unwinding of discounts on provisions	(2)	(103)
Other	(3)	(2)
	<u>(5,685)</u>	<u>(5,695)</u>

11 Taxation

	Year ended March 31 2018 £000	Year ended March 31 2017 £000
UK corporation tax		
Adjustments in respect of prior years	(35)	(197)
Current tax payable on income at 20%	73	104
	<u>38</u>	<u>(93)</u>

None of the Trust's activities are subject to corporation tax. However, the Trust's commercial subsidiaries are subject to corporation tax, the totals of which are recorded above.

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of the Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private subject will be subject;
- Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

12 Surplus attributable to the Trust

The Consolidated Statement of Comprehensive Income shows a surplus of £40,824k (16/17 Surplus £42,662k) for the Group.

The operating surplus for the Trust was £41,337k (2016-17 operating surplus of £42,745k), and is included within the Statement of Comprehensive Income for the Group. As permitted by DHSC GAM, no separate Statement of Comprehensive Income is presented in respect of the parent.

13 Property, plant and equipment – March 31 2018

13.1 Property, plant and equipment at the statement of financial position date comprises the following elements:

Group and Trust	Assets under construction								Total £'000
	Land £'000	Buildings excluding dwellings £'000	Payments on account £'000	Plant and machinery £'000	Transport equipment £'000	IT hardware £'000	Furniture and fittings £'000		
Cost or valuation									
At April 1 2017	218,262	739,568	79,112	169,638	176	39,759	3,660	1,250,175	
Additions purchased	–	3,133	56,023	22	–	2,013	9	61,200	
Additions – assets purchased from cash donations/grants	–	142	11,585	141	–	118	1	11,987	
Impairments – charged to operating expenses	–	(5,417)	(384)	–	–	–	–	(5,801)	
Impairments – charged to the revaluation reserve	(208)	–	–	–	–	–	–	(208)	
Revaluation	10,770	42,648	–	–	–	–	–	53,418	
Reclassifications	–	35,396	(50,741)	9,942	–	2,032	79	(3,292)	
Transfers to/from assets held for sale and assets in disposal groups	418	–	–	–	–	–	–	418	
Disposal	–	–	–	(21,536)	(12)	(2,109)	–	(23,657)	
Cost or valuation	229,242	815,470	95,595	158,207	164	41,813	3,749	1,344,240	
Accumulated depreciation									
At April 1 2017	–	12,379	–	105,510	176	23,106	1,707	142,878	
Provided during the year	–	20,663	–	16,876	–	6,234	366	44,139	
Reversal of impairments credited to operating income	–	(16,175)	–	–	–	–	–	(16,175)	
Reclassification	–	–	–	–	–	(85)	–	(85)	
Revaluation	–	(1,847)	–	–	–	–	–	(1,847)	
Disposals	–	–	–	(21,226)	(12)	(1,502)	–	(22,740)	
At March 31 2018	–	15,020	–	101,160	164	27,753	2,073	146,170	
Net book value March 31 2018									
Purchased assets	148,599	588,846	81,887	35,213	–	9,764	353	864,662	
Government granted assets	–	175	–	214	–	51	–	440	
Donated assets	80,643	211,429	13,708	21,620	–	4,245	1,323	332,968	
Total at March 31 2018	229,242	800,450	95,595	57,047	–	14,060	1,676	1,198,070	

The reclassification line of Property, Plant and Equipment and Intangible Assets nets to zero across both 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 both 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.

In the year ended 31 March 2018 a valuation exercise was carried out on the Trust's properties by Gerald Eve, a firm specialising in property valuations. The purpose of this exercise was to determine a fair value for Trust land and buildings as at 31 March 2018. The valuation was conducted in accordance with the terms of the Royal Institution of Chartered Surveyors' (RICS) Valuation Standards.

a) Depreciated Replacement Cost (DRC)

The basis used for the valuation of specialised operational property for financial accounting purposes is Depreciated Replacement Cost (DRC). The RICS Standards at Appendix 4.1, restating International Valuation Application 1 (IVA 1) provides the following definition:

"The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."

Those buildings which qualify as specialised operational assets, and therefore fall to be assessed using the Depreciated Replacement Cost approach, have been valued on a modern equivalent asset basis.

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for the financial accounting purposes under IAS16 is fair

value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS 1.3 as:

"The estimated amount for which a property should exchange on the date of the valuation between a willing buyer and a willing seller in an arm's length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

c) Market Value (MV)

Market Value is the basis of valuation adopted for the reporting of non-operational properties, including surplus land, for financial accounting purposes. The RICS Standards at PS3.2 defined MV as:

"The estimated amount for which a property should exchange on the date of the valuation between a willing buyer and a willing seller in an arm's length transaction after proper marketing wherein the parties had each acted knowledgeably, prudently and without compulsion."

d) 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 2017/18 had an impairment charge to income and expenditure in prior years. In 2017/18 the increase in value of these assets resulted in a reversal of the impairments and resulted in credit to income and expenditure.

13 Property, plant and equipment – March 31 2017

13.2 Property, plant and equipment at the statement of financial position date comprises the following elements:

Group and Trust	Assets under construction								Total £000
	Land £000	Buildings excluding dwellings £000	Payments on account £000	Plant and machinery £000	Transport equipment £000	IT hardware £000	Furniture and fittings £000		
Cost or valuation									
At April 1 2016	186,712	630,169	180,971	168,356	176	37,192	2,591	1,206,167	
Additions purchased	–	–	56,310	156	–	1,198	–	57,664	
Additions – grants/donations	–	7,109	22,040	1,289	–	555	–	30,993	
Impairments – charged to operating expenses	–	(24,780)	(548)	–	–	–	–	(25,328)	
Impairments – charged to the revaluation reserve	–	(10,161)	–	–	–	–	–	(10,161)	
Reclassifications	–	149,736	(179,656)	26,336	–	2,758	1,069	243	
Revaluation	31,968	(12,505)	–	–	–	–	–	19,463	
Transfers to assets held for sale	(418)	–	–	–	–	–	–	(418)	
Disposal	–	–	(5)	(26,499)	–	(1,944)	–	(28,448)	
Cost or valuation	218,262	739,568	79,112	169,638	176	39,759	3,660	1,250,175	
Accumulated depreciation									
At April 1 2016	–	9,866	–	117,736	176	19,425	1,464	148,667	
Provided during the year	–	18,937	–	14,260	–	5,201	218	38,616	
Reversal of impairments credited to operating income	–	(97)	–	–	–	–	–	(97)	
Revaluation	–	(16,327)	–	–	–	–	–	(16,327)	
Disposals	–	–	–	(24,461)	–	(1,520)	–	(27,981)	
Reclassifications	–	–	–	(25)	–	–	25	–	
At March 31 2017	–	12,379	–	105,510	176	23,106	1707	142,878	
Net book value March 31 2017									
Purchased assets	142,165	536,753	72,944	36,754	–	13,616	473	802,705	
Government granted assets	–	185	–	363	–	70	–	618	
Donated assets	76,097	190,251	6,168	27,011	–	2,967	1,480	303,974	
Total at March 31 2017	218,262	727,189	79,112	64,128	–	16,653	1,953	1,107,297	

14 Intangible assets

14.1 As at March 31 2018

Group and Trust	Software licences £'000	Information technology £'000	Assets under construction £'000	Total £'000
Cost April 1 2017	5,622	67,693	11,874	85,189
Additions purchased/internally generated	118	1,931	6,182	8,231
Additions – grants/donations of cash	5	24	383	412
Impairments charged to operating expenses	–	–	(231)	(231)
Reclassification	356	7,649	(4,713)	3,292
Disposals	–	(2,409)	–	(2,409)
Gross cost at March 31 2018	6,101	74,888	13,495	94,484
Amortisation April 1 2018	2,817	40,226	–	43,043
Provided during the year	773	8,135	–	8,908
Reclassifications	–	85	–	85
Disposals	–	(2,409)	–	(2,409)
Amortisation at March 31 2018	3,590	46,037	–	49,627
Net book value March 31 2018	2,511	28,851	13,495	44,857
Purchased assets	2,160	27,334	12,582	42,076
Government granted assets	156	530	–	686
Donated assets	195	987	913	2,095
Total at March 31 2018	2,511	28,851	13,495	44,857

The reclassification line of Property, Plant and Equipment and Intangible Assets nets to zero across both 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 both notes are viewed together.

14.2 As at March 31 2017

Group and Trust	Software licences £'000	Information technology £'000	Assets under construction £'000	Total £'000
Cost April 1 2016	4,820	60,489	11,113	76,422
Additions purchased/internally generated	328	1,991	5,595	7,914
Additions – grants donations of cash	6	15	1,339	1,360
Reclassification	510	5,203	(6,035)	(322)
Impairments charged to operating expenses	–	–	(138)	(138)
Impairments charged to the revaluation reserve	–	–	–	–
Disposals	(42)	(5)	–	(47)
Gross cost at March 31 2017	5,622	67,693	11,874	85,189
Amortisation April 1 2016	2,082	32,553	–	34,635
Provided during the year	777	7,678	–	8,455
Disposals	(42)	(5)	–	(47)
Amortisation at March 31 2017	2,817	40,226	–	43,043
Net book value March 31 2017	2,548	25,509	11,152	39,209
Purchased assets	257	722	–	979
Government granted assets	–	1,236	722	1,958
Donated assets	–	–	–	–
Total at March 31 2017	2,805	27,467	11,874	42,146

15 Impairments

	March 31 2018 £000	March 31 2017 £000
Charged to Statement of Comprehensive Income (SOCl):		
Net impairments arising from professional valuation including reversals	10,758	(24,683)
Other impairments of property, plant and equipment	(384)	(548)
Total impairments of property, plant and equipment charged to I&E	10,374	(25,231)
Impairment of intangibles	(231)	(138)
Net impairment impact on SOCI	10,143	(25,369)
Charged to Revaluation Reserve:		
Professional valuation impairments of building value	(208)	(10,161)
Total impairments charged to Other Comprehensive Income	(208)	(10,161)

The majority of the 2017/18 impairment reversal and charge relates to the property valuation.

Land and buildings were valued independently by Gerald Eve as at 31 March 2018 in line with the accounting policies. 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 (SOCl).

The movement arising from the professional valuation can be summarised as follows:

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 movement in impairment and Revaluation Reserve is summarised below.

	March 31 2018 £000	March 31 2017 £000
Impairments:		
Abandonment of assets in the course of construction	615	686
Other	(10,758)	24,683
Total impairments and (reversals) charged to operating surplus	(10,143)	25,369
Total net impairments charged to revaluation reserve	208	10,161
Total impairments and (reversals)	(9,935)	35,530
Impairments charged to operating expenses:		
Of which Departmental Expenditure Limit (DEL)	615	686
Of which Annually Managed Expenditure (AME)	(10,758)	24,683

	March 31 2018 £000	March 31 2018 £000	March 31 2018 £000	March 31 2017 £000	March 31 2017 £000	March 31 2017 £000
From professional valuation of land and buildings:						
Revaluation Reserve	—	—	Total	Revaluation Reserve	SOCl	Total
Increase in land value	10,770	—	10,770	31,968	—	31,968
Increase in building value	44,495	—	44,495	4,910	—	4,910
Impairments in land value	(208)	—	(208)	—	—	—
Impairments in building value	—	(5,417)	(5,417)	(10,161)	(24,780)	(34,941)
Reversal of previous impairments	—	16,175	16,175	—	97	97
Total movement	55,057	10,758	65,815	26,717	(24,683)	2,034
Other valuation movements:						
Other revaluation movements (Investment Property)	—	—	—	(1,088)	—	(1,088)
Other impairments of property, plant and equipment	—	(384)	384	—	(548)	(548)
Increase in intangible value	—	—	—	—	—	—
Intangible impairment	—	(231)	(231)	—	(138)	(138)
	55,057	10,143	65,200	25,629	(25,369)	260

16 Assets for sale

	March 31 2018 £000	March 31 2017 £000
Carrying value at April 1	418	800
Assets classified as available for sale in the year	–	418
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(418)	–
Assets sold in year	–	(800)
Carrying value at March 31	–	418

Land for Bowley Close car park was re-classified from an asset held for sale to property, plant and equipment during 2017-18 as it was no longer being actively marketed for sale.

17 Investment property

Investment property carrying values

	March 31 2018 £000	March 31 2017 £000
Carrying value at April 1	1,169	–
Fair value gains to Statement of Comprehensive Income	–	1,090
Reclassifications from Property, Plant and Equipment (PPE)	–	79
Carrying value at March 31	1,169	1,169

18 Revaluation reserve movements

Property, plant and equipment

	March 31 2018 £000	March 31 2017 £000
Revaluation reserve at April 1	317,614	292,785
Net impairments	(208)	(10,161)
Revaluations	55,265	35,790
Transfers to other reserves	–	(800)
Revaluation reserve at March 31	372,671	317,614

19 Subsidiaries and interests in associates and joint ventures

The Guy's and St Thomas' principal subsidiary undertakings, associates and joint ventures as included in the consolidation at March 31 2018 are set out below. The accounting date of the financial statements for the subsidiaries is March 31 2018 and for the joint ventures December 31 2017. For the joint venture undertakings that have different accounting year-end dates, interim accounts to March 31 have been consolidated.

	Country of incorporation	Beneficial interest	Principal activity
Subsidiary undertakings			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
GTI Forces Healthcare Ltd ¹	UK	100%	Healthcare services
Pathology Services Ltd ¹	UK	100%	Healthcare services
Essentia Trading Ltd ¹	UK	100%	Healthcare services
Associates and joint ventures			
SSAFA GSTT Care LLP	UK	50%	Healthcare services
Viapath Group LLP ¹	UK	33%	Healthcare services
Viapath Services LLP ¹	UK	33%	Healthcare services
Viapath Analytics LLP ¹	UK	33%	Healthcare services
Spot on Diagnostics Ltd ¹	UK	30%	Healthcare services
Precision Diagnostic Analytics Ltd ¹	UK	25%	Healthcare services
King's Health Partners Ltd ²	UK	25%	Healthcare services
Collaborative Procurement Partnership LLP	UK	25%	Healthcare services

¹ Not directly owned by Guy's and St Thomas' NHS Foundation Trust

² Limited by guarantee – no cash investment has been made, Guy's and St Thomas' NHS Foundation Trust holds 25% voting rights.

19.1 Investments

	Investments joint ventures and associates March 31 2018	Investments joint ventures and associates March 31 2017
	£000	£000
Carrying value at April 1	71	71
Carrying value at March 31	71	71

20 Inventories

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Raw materials and consumables	25,075	21,697	25,075	21,697
	<u>25,075</u>	<u>21,697</u>	<u>25,075</u>	<u>21,697</u>

21 Trade and other receivables

21.1 Current

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Trade receivables	87,635	77,348	87,370	77,708
Accrued income	80,545	76,975	80,077	76,719
Provision for impaired receivables	(27,056)	(25,812)	(27,056)	(25,808)
Prepayments	9,287	10,610	9,238	10,608
PDC dividend receivable	13	2,093	13	2,093
VAT and other tax receivable	2,097	2,970	2,370	3,135
Other receivables	5,773	4,911	5,703	4,840
	<u>158,294</u>	<u>149,095</u>	<u>157,715</u>	<u>149,295</u>

Restated – the prior year comparator has been restated to reflect updates to presentational requirements of the Department of Health and Social Care Group Accounting Manual.

21.2 Non-current

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Other receivables	2,107	2,152	2,107	2,152
	<u>2,107</u>	<u>2,152</u>	<u>2,107</u>	<u>2,152</u>

21.3 Provision for impaired receivables

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
At April 1	25,812	25,617	25,808	25,617
Increase in provision	6,683	2,176	6,683	2,172
Amounts utilised	(5,439)	(1,981)	(5,435)	(1,981)
At March 31	<u>27,056</u>	<u>25,812</u>	<u>27,056</u>	<u>25,808</u>

21.4 Analysis of aged group trade and other receivables

GROUP	Impaired		Non-impaired	
	March 31 2018 £000	March 31 2018 £000	March 31 2017 £000	March 31 2017 £000
0 – 30 days	2,256	44,443	3,781	46,595
30 – 60 days	2,520	9,473	560	8,428
60 – 90 days	2,476	4,872	2,822	1,126
90 – 180 days	3,813	4,727	3,631	5,738
Over 180 days	15,991	4,943	15,018	7,947
	<u>27,056</u>	<u>68,458</u>	<u>25,812</u>	<u>69,834</u>
TRUST	£000	£000	£000	£000
0 – 30 days	2,256	44,109	3,777	44,907
30 – 60 days	2,520	9,473	560	8,428
60 – 90 days	2,476	4,872	2,822	1,126
90 – 180 days	3,813	4,727	3,631	5,738
Over 180 days	15,991	4,943	15,018	7,947
	<u>27,056</u>	<u>68,124</u>	<u>25,808</u>	<u>68,146</u>

22 Other investments/financial assets

Non-current	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Carrying value at April 1	2,574	74	5,595	6,686
Additions	64	2,500	48	–
Current re-classified as non-current	–	–	525	–
Current portion of loans receivable transferred to current financial assets	(1,270)	–	(1,270)	(1,525)
Carrying value at March 31	1,368	2,574	4,898	5,595
Current	March 31 2018	March 31 2017	March 31 2017	March 31 2017
Loans receivable within 12 months transferred to current financial status	1,270	–	1,270	1,525
Other current financial assets	–	1,006	–	6
	1,270	1,006	1,270	1,531

2017-18 Group other investments/financial assets

Organisation	Current £000	Non-current £000	Interest rate	Maturity date
Viapath Group	1,270	1,230	Libor +2%	Dec 2019
Convertible loan notes	–	64		
Other investments	–	74		
	1,270	1,368		

2017-18 Trust other investments/financial assets

Organisation	Current £000	Non-current £000	Interest rate	Maturity date
Viapath Group	1,270	1,230	Libor +2%	Dec 2019
Pathology Services Ltd (loan + accumulated interest)	–	2,068	Libor +2%	Mar 2022
Essentia Trading Ltd	–	1,600	3.50%	Mar 2024
	1,270	4,898		

Loans with Pathology Services Ltd and Essentia Trading Limited are removed from the Group Accounts following consolidation adjustments.

23 Trade and other payables

23.1 Current

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Trade payables	49,966	50,334	50,686	50,934
Capital payables	15,733	15,737	15,733	15,737
Accruals	67,624	72,419	67,532	72,707
Receipts in advance	1,137	1,025	1,137	1,025
Other taxes payable	19,423	17,493	19,204	17,257
Accrued interest on other loans	886	893	886	893
Other payables	2,051	1,739	2,020	1,716
	156,820	159,640	157,198	160,269

23.2 Other liabilities

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Deferred income	28,657	22,260	28,657	22,260
Deferred grants income	45	48	45	48
	28,702	22,308	28,702	22,308

23.3 Borrowings

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Current				
Capital loans from Department of Health and Social Care	12,085	10,485	12,085	10,485
	12,085	10,485	12,085	10,485
Non-current				
Capital loans from Department of Health and Social Care	211,290	210,687	211,290	210,687
	211,290	210,687	211,290	210,687

Schedule of borrowing from the Department of Health and Social Care

Date loan started	Date to be completed	Interest rate %	Amount of loan agreed March 31 2018 £000	Total repaid March 31 2018 £000	Amounts left to draw down March 31 2018 £000	Amounts outstanding March 31 2018 £000
Mar 2012	Mar 2037	2.85	80,000	9,320	–	70,680
Jun 2011	Jun 2036	3.27	75,000	11,918	–	63,082
Jun 2011	Jun 2017	1.05	5,000	5,000	–	–
Sep 2013	Nov 2023	1.95	9,000	2,250	–	6,750
Feb 2016	Feb 2041	1.9	25,000	1,530	–	23,470
Feb 2016	Feb 2041	1.9	14,000	582	–	13,418
Feb 2016	Feb 2041	1.9	33,768	–	10,668	23,100
Feb 2016	Feb 2031	1.38	27,232	–	11,357	15,875
Nov 2017	Nov 2042	1.76	10,000	–	3,000	7,000
			279,000	30,600	25,025	223,375

No security has been pledged against these loans.

All borrowing relates to capital loans have been secured to support the Trust's ongoing plans to redevelop its two hospital sites and upgrade IT and other infrastructure.

A further £90m has been agreed by the Independent Trust Financing Facility committee. This is currently awaiting clearance at the Department of Health and Social Care.

24 Provisions for liabilities

Group and Trust

24.1 Overall provisions

	Current		Non-current		Total Provisions	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Pensions relating to other staff	—	792	—	7,275	—	8,067
Legal claims	246	257	—	—	246	257
Redundancy	—	32	—	—	—	32
Other	452	43	6,227	3,797	6,679	3,840
	698	1,124	6,227	11,072	6,925	12,196

24.2 Changes in provisions

	Pensions relating to other staff £000	Legal claims £000	Redundancy £000	Other £000	Total £000
As at April 1 2017	8,067	257	32	3,840	12,196
Change in discount rate	—	—	—	18	18
Arising during the year	1,324	112	—	2,868	4,304
Utilised during the year	(9,106)	(42)	(32)	(33)	(9,213)
Reversed unused	(301)	(81)	—	—	(382)
Unwinding of discount	16	—	—	(14)	2
As at March 31 2018	—	246	—	6,679	6,925

24.3 Expected timing of cash flows

	Pensions relating to other staff £000	Legal claims £000	Redundancy £000	Other £000	Total £000
Within 1 year	—	246	—	452	698
Between 1 and 5 years	—	—	—	2,560	2,560
After 5 years	—	—	—	3,667	3,667
	—	246	—	6,679	6,925

The provision relating to pensions of former staff consists of provisions for pre-1995 early retirements and was calculated using information provided by the NHS Pensions Agency. In December 2017 the Trust was asked by NHS Business Service Authority to buy out the pre-1995 early retirements pension provisions at a cost of £8,721k This was agreed by the Trust Board.

Other provisions consist of provisions for injury benefits and dilapidations.

£332m is included in the provision of the NHS Litigation Authority under legal claims at March 31 2018 in respect of clinical negligence liabilities of the Foundation Trust (£314m at March 31 2017).

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

25 Analysis in changes of net cash

GROUP	At April 1 2016 £000	Cash changes in period £000	At March 31 2017 £000	Cash changes in period £000	At March 31 2018 £000
Cash with the Government Banking Service	116,498	21,906	138,404	(5,147)	133,257
Cash at bank and in hand – commercial bank	980	1,007	1,987	(461)	1,526
	117,478	22,913	140,391	(5,608)	134,783
TRUST	At April 1 2016 £000	Cash changes in year £000	At March 31 2017 £000	Cash changes in year £000	At March 31 2018 £000
Cash with the Government Banking Service	116,331	22,073	138,404	(5,146)	133,258
Cash at bank and in hand – commercial bank	383	(222)	161	35	196
	116,714	21,851	138,565	(5,111)	133,454

26 Capital commitments

Commitments under capital expenditure contracts at March 31 2018 for the Group and the Trust were £28.8m (£33.7m at March 31 2017).

26.1 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made:

	March 31 2018 2017/18	March 31 2017 2016/17
	£000	£000
Not later than 1 year	304	–
After 1 year and not later than 5 years	3,068	–
Paid thereafter	46,835	–
Total	50,207	–

Guy's and St Thomas' NHS Foundation Trust has entered into a Managed Service Agreement with Johnson & Johnson Finance Ltd relating to the provision of managed orthopaedic theatre facilities. The contract commenced on 16 April 2018 and will last for 15 years.

27 Events after the reporting date

There were no events after the reporting date.

28 Contingencies

28.1 Contingent liabilities

	At March 31 2018	At March 31 2017
	£000	£000
Contingent liabilities for claims against the group and Trust	(88)	(104)
Net contingent liability	(88)	(104)

Contingent liabilities recorded are in respect of Public and Employee liability cases and the Property Expenses Scheme as advised by the NHS Litigation Authority. This represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

29 Public Dividend Capital (PDC) dividend

The Trust is required to demonstrate that the PDC dividend payable is in line with the actual rate of 3.5% of average relevant net assets. The dividend payable relating to the period to March 31 2018 was £20,631k (2016-17 £19,552k), based on the average relevant net assets of £764,207k.

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' NHS 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
- CCGs and NHS England
- Special Health Authorities
- Non-Departmental Public Bodies
- Other Department of Health and Social Care bodies

The Trust has taken advantage of the exemption provided by IAS 24 'Related Party Disclosures', where the parent's own financial statements are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation.

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.

	Amounts due from related parties		Amounts owed to related parties	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Non-NHS related party transactions				
Guy's and St Thomas' Charity	1,842	2,377	—	—
King's College London	5,809	8,255	5,216	4,878
Viapath*	2,888	2,864	2,434	3,188
SSAFA GSTT Care LLP	1,380	1,245	1	1

	Receipts from related parties		Payments to related parties	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Non-NHS related party transactions				
Guy's and St Thomas' Charity	13,843	28,085	70	1,202
King's College London	18,553	15,484	11,873	14,483

* Includes transactions with Viapath Group LLP, Viapath Services LLP, Viapath Analytics LLP

	31 March 2018 £000	31 March 2017 £000
Trust debtor with wholly owned subsidiaries		
Essentia Trading Ltd	879	1,354
GTI Forces Healthcare Ltd	—	—
GSTT Enterprises Ltd	106	87
Pathology Services Ltd	1	1
Trust creditor with wholly owned subsidiaries		
Essentia Trading Ltd	1,347	1,424
GTI Forces Healthcare Ltd	—	—
GSTT Enterprises Ltd	—	—
Pathology Services Ltd	—	—
Trust income from wholly owned subsidiaries		
Essentia Trading Ltd	703	734
GTI Forces Healthcare Ltd	—	—
GSTT Enterprises Ltd	100	67
Pathology Services Ltd	50	44
Trust expenditure with wholly owned subsidiaries		
Essentia Trading Ltd	3,303	2,958
GTI Forces Healthcare Ltd	—	—
GSTT Enterprises Ltd	—	—
Pathology Services Ltd	—	—

The subsidiaries are wholly owned by the Trust and the transactions are eliminated on consolidation.

Sir Ron Kerr rented accommodation from the Trust at a commercial market rate until 30 April 2017.

Sir Hugh Taylor (Chairman) is a Trustee of Macmillan Cancer Support, the Nuffield Trust, Cicely Saunders International, and the National Skills Academy for Health, all bodies which interact with the Trust from time to time.

Dr Ian Abbs sits on the Governing Bodies of Lambeth CCG and Southwark CCG representing King's Health Partners.

Eileen Sills is a Trustee of the Burdett Trust and chairs their grants committee, during 17/18 we have received no grants from the Burdett Trust. Eileen also holds the following positions: visiting Professor at King's College London and London Southbank Universities; and Clinical Director for Dementia for NHSE (London).

Neil Wigglesworth, Deputy Director for Infection Prevention and Control, is currently President of the IPS and a director/trustee (IPS is a company limited by guarantee and a registered charity).

The Council of Governors includes representatives from organisations that work closely with the Trust including Lambeth Council, Southwark Council, Lambeth CCG, Southwark CCG, NHS England, London South Bank University, King's College London, King's College Hospital NHS Foundation Trust and South London and Maudsley NHS Foundation Trust.

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		TRUST	
	Loans and receivables	March 31 2018 £000	Loans and receivables	March 31 2018 £000
		March 31 2017 £000		March 31 2017 £000
Trade and other receivables (excluding non financial assets) – with NHS and DHSC bodies	102,088	100,506	101,286	137,704
Trade and other receivables (excluding non financial assets) – with other bodies	46,929	36,963	46,929	–
Other investments/financial assets	2,709	3,651	6,168	7,126
Cash and cash equivalents	134,783	140,391	133,454	138,565
	286,509	281,511	287,837	283,395

31.2 Carrying value and fair value of financial liabilities

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Borrowings excluding finance lease and PFI liabilities	223,375	221,172	223,375	221,172
Trade and other payables (excluding non financial liabilities) – with NHS and DHSC bodies	11,789	9,946	12,386	10,810
Trade and other payables (excluding non financial liabilities) – with other bodies	124,471	131,177	124,471	131,177
Provisions under contract	6,925	12,196	6,925	12,196
Total at March 31	366,560	374,491	367,157	375,355

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

31.3 Maturity of financial liabilities

	GROUP		TRUST	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
In one year or less	149,043	152,732	149,640	153,596
In more than one year but not more than two years	12,376	11,684	12,376	11,684
In more than two years but not more than five years	39,688	38,372	39,688	38,372
In more than five years	165,453	171,703	165,453	171,703
	366,560	374,491	367,157	375,355

31.4 Loan disclosure

	Current £000	Non Current £000	Weighted average interest rate %	
			Total £000	
March 31 2018				
Fixed interest rate instruments	12,085	211,290	223,375	2.57%
March 31 2017				
Fixed interest rate instruments	10,485	210,687	221,172	2.60%

31.5 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with the Clinical Commissioning Groups (CCGs), and the way those CCGs are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS 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 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 has an operation overseas with British Forces in Germany and consequently makes Euro transactions. Overall the Trust deems that it is not exposed to significant exchange rate risk. However, to provide some certainty over Euro exchange rate gains and losses, the Trust has taken out Forward Currency contracts during 2017-18. All contracts matured during 2017-18.

Interest rate risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has limited exposure to credit risk. The maximum exposures as at March 31 2018 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds generated from free cash flow and donations. The details of our borrowing to fund capital expenditure is detailed in the Borrowings note.

32 Third party assets

The Trust held £216k cash and cash equivalents at March 31 2018 (£198k at March 31 2017) which relates to monies held by the Trust on behalf of patients. This has been excluded in the cash at bank and in hand figure reported in the accounts. £2,792k is held as client monies on behalf of tenants as a result of assurities (£149k at March 31 2017).

33 Losses and special payments

Losses	Year ended	Year ended	Year ended	Year ended
	March 31 2018	March 31 2018	March 31 2017	March 31 2017
	Cases	£000	Cases	£000
Cash losses	15	162	16	51
Stores losses and theft	87	414	88	314
Bad debts and claims abandoned	1,022	5,391	725	2,023
Total losses	1,124	5,967	829	2,388

Special payments	Year ended	Year ended	Year ended	Year ended
	March 31 2018	March 31 2018	March 31 2017	March 31 2017
	Cases	£000	Cases	£000
Ex gratia payments	32	12	22	7
Total special payments	32	12	22	7

Total losses and special payments	1,156	5,979	851	2,395
--	--------------	--------------	------------	--------------

Old debt of £5.1m for overseas visitors was written off in 2017/18. The amounts quoted above are reported on an accruals basis but exclude provision for future losses.

34 Heritage assets note

Historic artefacts

The remains of a Roman boat lie in the Guy's Hospital site, beneath the Cancer 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 (2016-17: nil). There were no disposals of artefacts during either year.

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

The Trust incurred £nil (£3k 2016-17) in charges relating to the late payment of commercial debts.

36 Accounting standards that have been issued but have not yet been adopted

IAS 8 requires entities to disclose an estimate of the impact of future accounting standards not yet adopted.

36.1 Impact of future accounting standards: IFRS 9

The Trust cannot yet assess whether the changes in the classification and measurement of financial assets and liabilities, changes in the impairment module for Financial Assets and the option of hedge accounting will have a material impact on the Trust's 2018/19 accounts.

36.2 Impact of future accounting standards: IFRS 15

The Trust cannot yet assess whether the implementation of IFRS 15 will have a material impact on the recognition of NHS contract and other contract income in 2018/19.

contacts

Chief Executive

If you have a comment for the Chief Executive,
contact:
Amanda Pritchard, Chief Executive
Tel: 020 7188 0001
Email: chief.executive@gstt.nhs.uk

Patient Advice and Liaison Service (PALS)

If you require information, support or advice about our services,
contact:
PALS
Tel: 020 7188 8801 (St Thomas')
or 020 7188 8803 (Guy's)
Email: pals@gstt.nhs.uk

Membership

If you are interested in becoming a member of our NHS Foundation Trust,
contact:
Tel: 0800 731 0319
Email: members@gstt.nhs.uk

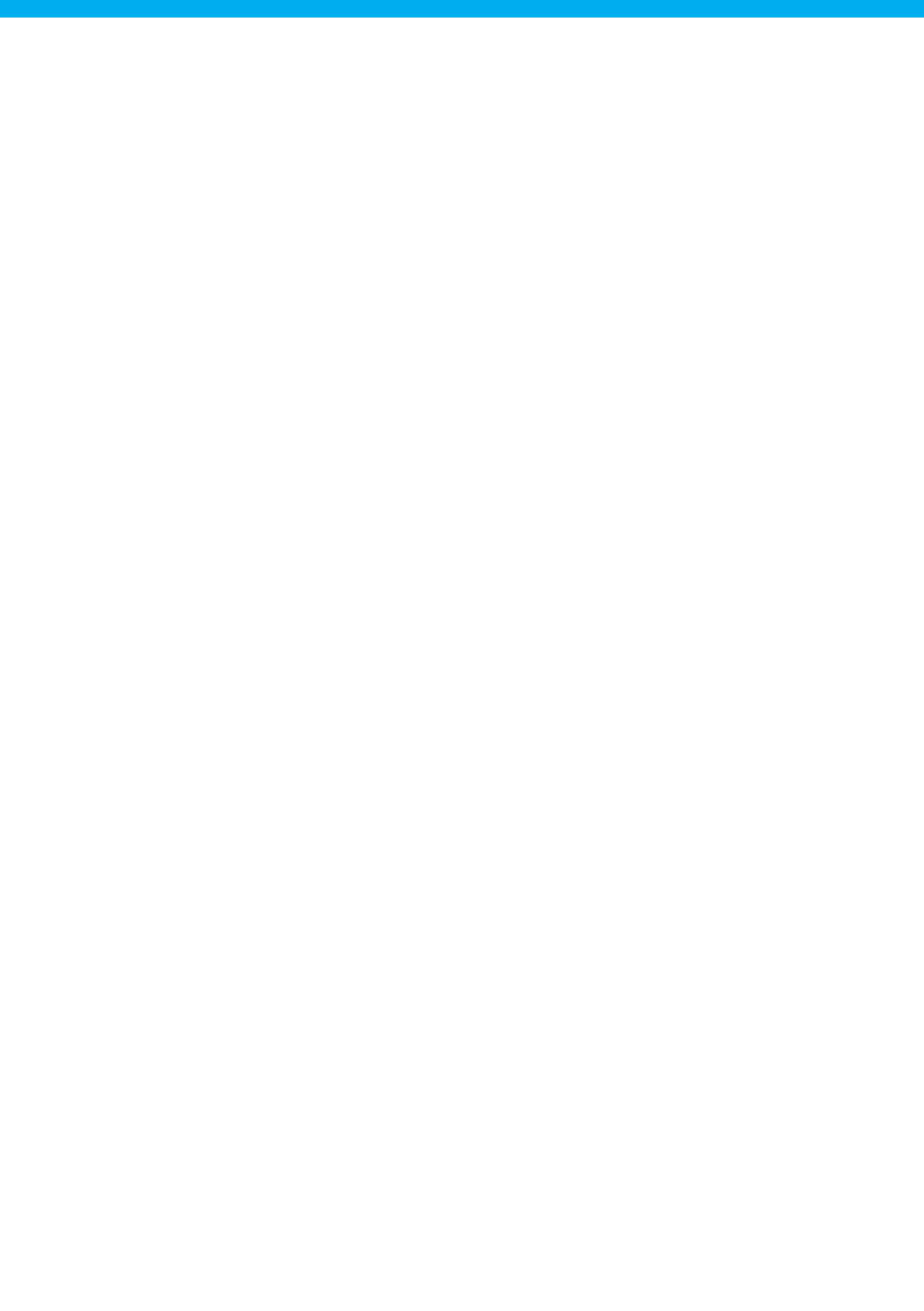
Recruitment

If you are interested in applying for a job at Guy's and St Thomas',
contact:
The Recruitment Centre
Tel: 020 7188 0044
<http://jobs.gstt.nhs.uk>

Further information

If you have a media enquiry or require further information,
contact:
Anita Knowles, Director of Communications
Tel: 020 7188 5577
Email: communications@gstt.nhs.uk

www.guysandstthomas.nhs.uk



Guy's and St Thomas' NHS Foundation Trust
Guy's Hospital Great Maze Pond London SE1 9RT
St Thomas' Hospital Westminster Bridge Road London SE1 7EH
Tel: 020 7188 7188

www.guysandstthomas.nhs.uk