

**ANNUAL
REPORT
AND
ACCOUNTS
2010|11**



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

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

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Guy's and St Thomas' NHS Foundation Trust is part of King's Health Partners Academic Health Sciences Centre (AHSC), a pioneering collaboration between King's College London, and Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts.

King's Health Partners is one of only five AHSCs in the UK and brings together an unrivalled range and depth of clinical and research expertise, spanning both physical and mental health. Our combined strengths will 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



Pioneering better health for all



Guy's and St Thomas' NHS Foundation Trust comprises two of London's best known teaching hospitals with longstanding reputations for quality and innovation.

As well as being one of the most successful Foundation Trusts, we are one of the busiest, with a million patient contacts a year. We provide a full range of services for local residents, including community services, and also specialist services for patients from further afield, including cancer, cardiothoracic and renal services. The Evelina Children's Hospital at St Thomas' – designed with the help of its young patients – is home to many specialist children's services, while Guy's is the site of the largest dental school in Europe.

As part of King's Health Partners, we are now one of the UK's first Academic Health Sciences Centres and, together with King's College Hospital and South London and Maudsley NHS Foundation Trusts and our academic partner King's College London, we bring together world-class teaching, research and clinical services.

We have a long history of clinical and scientific excellence. Our National Institute for Health Research funded comprehensive Biomedical Research Centre, established with King's College London, is already ensuring that translational research drives better treatment for our patients.

Guy's and St Thomas' is one of the largest employers in Lambeth and Southwark, with around 12,000 staff following the integration of community services. We work hard to reflect the cultural and ethnic diversity of the communities we serve and we are strengthening our partnerships with patients and local people, as well as neighbouring NHS organisations, local authorities, GPs and voluntary organisations.

We strive to recruit and retain the best doctors, nurses, therapists and other staff and the dedication of our employees is key to our hospitals' success.



We were proud that our specialist children's heart services were the most highly ranked in a national report as part of the Safe and Sustainable Review

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Chairman's statement

The Trust's activity during 2010/11 has taken place against the backdrop of significant change across the health service, the continued development of King's Health Partners, our Academic Health Sciences Centre and the successful integration of community services in Lambeth and Southwark.

Colleagues from across the Trust and the local community have worked tirelessly to bring together services and management structures to ensure that we integrate community health services with Trust activity, and we move towards providing seamless services, in the right place at the right time for our patients.

This year, we have also continued to work with our NHS and academic partners to develop King's Health Partners aligning our own clinical, academic and research activities with the Clinical Academic Groups which lie at the heart of the Academic Health Sciences Centre. In doing so, we have also continued work to improve the fabric of our hospitals and arrange services to improve access and the pathway for patients.

Sir Ron Kerr and the Trust Board continue to lead and inspire the organisation to embrace the changes both locally and nationally and seize the opportunities they present. In a challenging financial environment, the Trust Board takes seriously its responsibility to provide firm financial foundations on which to build, enabling us to develop services and facilities to meet the needs of our local population and those who come from further afield to access our specialist services. This year, the Executive Directors have been joined by Dr Ian Abbs, who brings a wealth of experience in clinical leadership to the role of Medical Director.


The Council of Governors has continued to provide a valuable contribution to the development of Trust strategy. Governors have a wide range of interests and expertise, and have contributed to discussions around patient experience and our estates and service strategies. They have participated in ward visits, as well as contributed to the development of our quality accounts. The Trust remains grateful to those who contribute as Foundation Trust members and governors for their support, insight and enthusiasm.

The Trust is indebted to numerous generous partners for their ongoing support, notably Guy's and St Thomas' Charity under the leadership of Sir William Wells and Peter Hewitt as Chairman and Chief Executive respectively. We continue to work closely with local authority leaders, the Metropolitan Police, the Greater London Authority, our Members of Parliament and other South Bank leaders to ensure that we listen to and serve the local community of which we are so proud to be a part.

This year, the Trust has said a fond farewell to Patricia Moberly who served as Chairman for over 12 years. Patricia's commitment to equality of access, service to the local community and excellence of care have been an inspiration to colleagues across the Trust and we are indebted to her for her hard work and dedication throughout her tenure.



Sir Hugh Taylor, Chairman

A woman with short dark hair and glasses, wearing a blue NHS uniform with white piping, stands next to a white car. She is smiling and looking towards the camera. Her uniform has a small circular NHS logo on the left chest and a lanyard with an ID badge around her neck. Two pens are tucked into her pocket. The background shows a residential street with brick buildings and parked cars.

In April, local community services in Southwark and Lambeth transferred to the Trust, marking a new era and exciting opportunities to enhance patient care

2

Directors' report 2010/11

Guy's and St Thomas' has performed well once again – both operationally and financially – although it has been a particularly demanding year as we have sought to balance quality with achieving our performance targets.

Guy's and St Thomas' continues to deliver excellent patient care, whilst seeking to maintain a strong financial position that will allow us to drive forward quality and service improvements for our patients in future years. That said, striking a balance between quality and service delivery and a healthy financial position, with surpluses to reinvest, has proved increasingly difficult in the tightening financial environment.

We have worked hard to achieve our CQUIN (Commissioning for Quality and Innovation) targets, and are now preparing for the new QIPP (Quality, Innovation, Productivity and Prevention) requirements and Monitor's new compliance framework. We are also preparing for the wider changes proposed in the Health and Social Care Bill, and have been building strong and productive relationships with the emerging GP commissioning consortia in Lambeth and Southwark.

King's Health Partners

The Trust remains firmly committed to the development and success of our Academic Health Sciences Centre, King's Health Partners, which underpins all that we do and represents our ambitious vision to be truly world-class, benefitting both the local communities we serve, and patients nationally and internationally.

Over the past year, King's Health Partners has continued to develop in partnership with King's College Hospital and South London and Maudsley NHS Foundation Trusts and our shared academic partner King's College London. We have now appointed a leadership team to all of

the King's Health Partners' Clinical Academic Groups which bring together clinical services, research and education activities within a series of single managerial units.

During the year, each Clinical Academic Group has been progressing through an 'accreditation' process, which requires them to develop a strategic overview and vision for the added value they will bring through the integration of these activities.

Work to develop an overarching clinical strategy is also progressing and has identified clinical areas where we expect to be world-class and areas where we want to grow our collective research strength. To achieve this, we have been reviewing how we configure our services across the three acute hospital sites so that we continue to drive up quality, increase efficiency and respond to commissioner reviews.

Priority areas include: consolidating surgery for certain cancer tumours such as lung and urological cancer; becoming the network lead for specialist children's services in south London, including securing national designation for specialist paediatric cardiac surgery and paediatric neuro-surgery; centralising hyper acute stroke services at King's College Hospital; and developing an implementation plan to bring together cardiovascular services.

In January 2011, the Board of Directors, and that of King's College Hospital, agreed that vascular inpatient services should be centralised at St Thomas' to deliver better patient outcomes, higher quality care and improved efficiency. This transfer will be completed by Spring 2012. Together, we will

be the only comprehensive vascular surgical service in the UK, and the largest vascular service in London.

Detailed planning to move bone marrow transplant services from Guy's Hospital to King's College Hospital also commenced during the year, and the Board will be considering a business case to approve the transfer of this service from September 2011.

The launch of the Experimental Medicine Hub at Guy's is a significant step forward in our commitment to provide state-of-the-art facilities to enable transitional research. For more information about the Experimental Medicine Hub, please see page 39.

The education agenda has also been moving forward, building on our success in becoming the Health, Innovation and Education Cluster (HIEC) for south London. Key developments include the use of simulation technology, as well as the development of a wide ranging apprenticeship scheme and work with local schools to increase access to medicine and other health-related career opportunities.

On the partnership front there has also been plenty to celebrate, including a revived exchange programme with Johns Hopkins in Baltimore; a new partnership with the University of California in San Francisco; and work in both Zambia and Somaliland that is being driven forward in collaboration with the Tropical Health Education Trust.

We have also integrated our fundraising efforts across King's Health Partners, creating a single team which we believe will provide unrivalled opportunities to increase

philanthropic support for services, teaching and research.

Community services integration

From 1 April 2011, the provision of community health services in Lambeth and Southwark successfully transferred to Guy's and St Thomas', acting on behalf of King's Health Partners. We are delighted to welcome 1,600 community health care colleagues as this provides significant opportunities for us to improve patient care by working in a truly integrated way.

Bringing together the services and management structures has been a lengthy and complex process, which has taken place at a time of major change and uncertainty for staff working in primary and community care. Having achieved formal integration, we now look forward to focusing our attention on the service transformation to ensure that both community and hospital services are better tailored to meet patients' needs.

In a separate, but closely linked initiative, we are working with our local authorities and primary care colleagues to develop an Integrated Care Pilot for Lambeth and Southwark, which will have a strong focus on improving care for frail elderly people and people with long term conditions.

Our wider role

As a Trust, we provide a full range of local hospital services to people living in Lambeth, Southwark and Lewisham, as well as a wide range of specialist services for local people and patients from further afield. We

continue to collaborate through King's Health Partners with organisations across south east London and the capital, as well as nationally and internationally, to support and enhance service delivery, research and education.

We play an active role in the south east London cancer and cardiac networks, and we continue to work with both specialist commissioning groups and NHS London to support change which is being driven by the need to maintain quality and excellence and to develop sustainable service models for the future.

Last September saw the move of complex and emergency paediatric surgery to the Evelina Children's Hospital from University Hospital Lewisham, improving care for younger patients locally.

As part of the national *Safe and Sustainable Review of Children's Congenital Cardiac Services*, Sir Ian Kennedy provided an assessment of all the current centres providing specialist services for children with serious heart conditions to the Joint Committee of Primary Care Trusts. We were delighted that the Evelina was the most highly ranked service nationally against a range of criteria. The options being consulted on include a recommendation that there should be two centres in London – one at the Evelina Children's Hospital and the other at Great Ormond Street Hospital for Children. We await the final review.

St Thomas' provides a wide range of very specialist services and sub-specialties, 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 cardiac centre, vascular services and a comprehensive range of women's and children's services, many of which benefit from being co-located on a single site.

Our services at Guy's also serve a wide population across south east England, either from central London or through a growing network of outreach clinics and satellite centres. As well as renal services and complex surgery, cancer services at Guy's are a key strategic priority for the Trust and Academic Health Sciences Centres through the Integrated Cancer Centre.

In November, the Board approved an outline business case for a £145 million Cancer Treatment Centre at Guy's and in April 2011 we were delighted to formally open a new Cancer Day Unit which is a key milestone in our commitment to the delivery of world-class care. We are also developing exciting plans, with King's College Hospital, to create a joint elective orthopaedic centre at Guy's.

Many of our services have a fundamental interdependency with the health schools and biomedical sciences at King's College London and this underpins our longstanding reputation for world-class clinical and biomedical research. This continues to be enhanced by our National Institute for Health Research funded comprehensive Biomedical Research Centre which is currently engaged in a process of reapplication for future funding and is described further on page 40.

Working with commercial partners

The Trust has a long tradition of innovation, ranging from medical breakthroughs and translational research to a commitment to broader commercial opportunities that will generate additional income to support the delivery of NHS services.

This year, a number of initiatives reflect this, including:

- the opening of our Experimental Medicine Hub, which brings together academic, NHS and commercial partners, including leading international trials company, Quintiles;
- the continued success of our pathology joint venture, GSTS Pathology, with Serco Group plc;
- our longstanding contract with the Ministry of Defence to provide healthcare to British Forces and their families in northern Europe;
- and, in October 2010 we were the successful bidder to provide non-clinical support services to Primary Care Trusts in south west London via the Support Services Partnership which has now been integrated into the Trust.

Business review

Guy's and St Thomas' performed well in 2010/11, despite an increasingly challenging financial environment. The Trust has declared a surplus of £17.9 million for the financial year after accounting for an impairment of £4.6 million due to the revaluation of the Trust's buildings, equivalent to a £22.5 million surplus excluding the

impairment. Although slightly less than the surplus we originally planned for, we believe this is a good performance at a time when efficiency savings have proved increasingly difficult to achieve without impacting adversely on patient care.

Pressures such as adverse weather conditions, increasing demand for emergency services and the seasonal flu outbreak have added to operational challenges during the year, although staff responded exceptionally and patient care was maintained to a high standard throughout.

This year's surplus will add to those achieved in previous years, and we are currently undertaking a review to identify prudent levels of investment in service development and capital schemes in support of our strategic vision over the coming years.

We have identified a number of drivers of change which we believe present both challenges and opportunities. These are:

- emerging health policy and legislation;
- the changing economic environment;
- the ongoing development of King's Health Partners, including Clinical Academic Groups;
- changes to commissioning arrangements for clinical services;
- the integration of community services in Lambeth and Southwark;
- the new Monitor compliance framework;

- the need to continue to focus on improving productivity to make savings;
- our transformation programme;
- commercial opportunities.

The Trust continues to focus on managing the risks associated with the drivers of change which are potential challenges, and on ensuring that it is in a strong position to take advantage of any potential opportunities.

We have a well established financial and performance reporting model that includes detailed monthly scorecard reporting of national and Trust performance targets to both the Board of Directors and the Trust Management Executive. In addition, Board sub-committees have developed a range of key performance indicators, and local performance indicators are well developed throughout the organisation. During the past year, we have made considerable progress in embedding service line management across the organisation, and we will build on this in 2011/12.

The Board has paid close attention to the areas where performance has proved challenging, including achieving the waiting times target in A&E, maximum waiting times in particular specialties such as orthopaedics, and in delivering the 62 day cancer target.

Performance and inspections

In 2010, under the Care Quality Commission's (CQC) new system for regulating health and social care organisations, Guy's and St Thomas'

was granted its licence to provide services with no conditions or improvement notices, having complied with 16 essential standards for quality and safety.

Sustaining operational performance against a wide range of national and local targets and measures and Monitor's new compliance framework, as well as ensuring the delivery of high quality and clinically safe care to a million patient contacts a year remains an enormous challenge. It requires sustained effort from frontline staff and managers, and we work hard to support them, for example through our successful 'Clinical Fridays' and weekly managers' forum.

We continue to have considerable success in reducing hospital infections and retain a sharp focus on quality, safety and clinical effectiveness through the objectives we agree with our local stakeholders for our quality accounts. We were delighted to receive very positive feedback following an inspection by the Patient Environment Action Team in summer 2010, which rated the Trust as one of the best in London for key areas such as food, cleanliness, and privacy and dignity. We also had a positive unannounced CQC inspection in April 2011, and are currently awaiting formal feedback.

We are aware that there is more that we can do to improve the quality and timeliness of care for our patients and a major programme of work to support improvements to the patient experience has been initiated with close involvement from the Board of Directors and Council of Governors. This will have

a particular focus on outpatient services and supporting administrative processes where we have identified a need for urgent changes.

Corporate social responsibility

The Trust has a strong track record for acting responsibly in terms of the environment, staff, the local community and wider population.

We have won many awards nationally for our commitment to sustainability and tackling climate change, and we consider ourselves to be at the forefront of these initiatives in the NHS. In February 2011 we held a major event to share best practice across London. See page 17 for further details.

We are also committed to buying goods and services locally wherever possible, and have a number of employment initiatives to enable us to employ local people, including by increasing access to employment via schemes such as apprenticeships and Project SEARCH – see page 30 for further details.

As part of King's Health Partners, we have made a strong commitment to improving the health and wellbeing of the ethnically and socially diverse communities we serve locally. We also are proud to have developed formal links with health organisations overseas, including in Tanzania and Zambia so that our support and expertise will develop communities in other parts of the world.

Board of Directors

The Board of Directors brings a wide range of experience and expertise to their stewardship of the Trust and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive. In the past year, the Trust paid tribute to outgoing chairman Patricia Moberly, for her tireless hard work and commitment on behalf of the Trust and its patients and staff. We also welcomed a most worthy successor in Sir Hugh Taylor, who brings exceptional skills and expertise to the organisation at a crucial time.

In 2010/11, Board membership consisted of the following Executive Directors:

Chief Executive, Ron Kerr; Director of Finance, Martin Shaw; Medical Director to October 2010, Edward Baker; Acting Medical Director from October 2010 to January 2011, Diana Hamilton-Fairley; Medical Director from January 2011, Ian Abbs; Chief Nurse, Eileen Sills; Director of Capital, Estates and Facilities, Steve McGuire; Director of Workforce and Organisational Development, Ann Macintyre; and Commercial Director, Hugh Risebrow.

And seven Non-Executive Directors:

Chairman to January 2011, Patricia Moberly; Chairman from February 2011, Sir Hugh Taylor; and Non-Executive Directors: David Dean, Mike Franklin, Rory Maw, Frank Nestle, Jan Oliver and Diane Summers. In February 2011 the Council of Governors reappointed David Dean for a further term from June and Mike Franklin for a further

term from November. We are currently recruiting a further non-executive director to replace Jan Oliver when she steps down in December 2011.

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

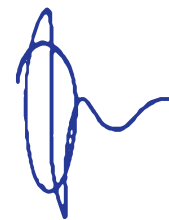
The Board considers the Trust to be compliant with the principles of the NHS Foundation Trust Code of Governance, as well as with the provisions of the Code in all but the following areas where we have alternative arrangements in place: appraisal of the Chairman; the designation of independent directors and a senior independent director; Chief Executive and Executive Director terms of appointment; information about elected governors standing for re-election; and independent professional advice for Non-Executive Directors. Further details can be found in the full compliance statement which is available on the Trust website.

Looking ahead

Guy's and St Thomas', in common with the health service and public sector as a whole, is operating in a fast changing and demanding external environment, particularly as we understand and respond to the new Monitor compliance framework. We recognise the need to significantly increase efficiency whilst maintaining high quality care at a time when budgets will be

tight, and we will continue to use our strong financial track record and exceptional staff to respond to these challenges. We believe the greater freedoms we are afforded as an NHS Foundation Trust will enable us to thrive and set our own strategic direction for the benefit of the patients and communities we serve, as well as our staff.

It remains to thank the people who have helped us to achieve so much in 2010/11 including our staff; our new community colleagues; our Council of Governors and our wider membership; Guy's and St Thomas' Charity for their ongoing and generous investment; our King's Health Partners collaborators; and our many external stakeholders and supporters, in particular our local Primary Care Trusts and other NHS organisations in south east London with whom we work closely.



Ron Kerr

Chief Executive

On behalf of the Board of Directors

A photograph of two men in a workshop setting. The man in the foreground, wearing a blue polo shirt, is focused on a task, using a red-handled screwdriver to work on a component of a large blue industrial machine. A bright blue light source, possibly a flashlight, is visible near his hand, creating a lens flare. The second man, wearing a dark blue hoodie, stands behind him, observing the work. The background shows more of the industrial environment with various pipes and machinery.

Our successful apprenticeship programme provides training for local people and regularly results in long term employment

3 Operational and financial review

Guy's and St Thomas' is one of the largest and busiest Trusts in the country. During 2010/11, we saw 620,000 outpatients, 81,000 inpatients, 67,000 day case patients and 168,000 accident and emergency attendances. This will increase to a million patient contacts a year following the integration of community services.

Our performance

The Trust is subject to a range of external assessments each year to monitor our performance against national standards and targets. 2010/11 has been a particularly demanding year as we have sought to balance quality with savings plans and maintaining good outcomes against these assessments. Our achievements during the year are due to the hard work of our staff and the robust policies and structures we have in place.

The Trust is granted its licence to provide services by the Care Quality Commission (CQC). In 2010, the CQC introduced significant changes to the way in which health and social care organisations such as Guy's and St Thomas' are regulated. The Annual Health Check has been replaced with 16 essential standards of quality and safety, covering everything from medicines management and safeguarding vulnerable people to infection control and effective records management. The Trust has been granted its licence to provide services with no conditions or improvement notices, against these essential standards.

Meeting national targets

We have continued to reduce cases of MRSA and are proud to have achieved the very demanding national targets set for the Trust in 2010/11. We place great importance on reducing hospital acquired infections through a continued drive on cleanliness and a zero tolerance approach to poor hand hygiene. Last year, the Trust had only four attributable

MRSA blood infections, against a target of no more than nine cases for the whole year, and we had more than six months with no adult infections at all.

This year we were also one of the first Trusts to introduce a new test for *C.difficile*, which is significantly more sensitive than the previous test. This has resulted in a rise in the number of cases detected at our hospitals, enabling us to treat patients more promptly and effectively. However, we have had to seek a revised target for 2011/12 – agreed with our lead Primary Care Trust Commissioners – to reflect this.

The Trust has continued to work hard to ensure prompt access to cancer diagnosis and treatment, and we have achieved the national targets for those patients referred urgently by their GP to be seen within two weeks. We have also met the requirement to extend the maximum waiting time for breast cancer patients to all referrals, not just urgent cases, ensuring all patients are seen within two weeks. In January 2011, a new national waiting time standard for radiotherapy was introduced, which we have also achieved.

However, in common with many centres providing specialist cancer services and receiving 'tertiary' referrals from other hospitals, we have struggled to meet the 62 day maximum referral to treatment target, particularly where patients are referred to us late in their pathway. We are working closely with colleagues in primary care and external referral centres, as well as reviewing internal processes to ensure that we eliminate any

avoidable delays for these patients. In addition, last year we faced some problems in urology with the target that patients diagnosed with cancer should be treated within 31 days. These issues were resolved by the end of the year.

For patients with heart conditions, we continue to ensure that no patient waits longer than three months for a cardiac revascularisation operation, and that all patients referred to the rapid access chest pain clinic are seen within two weeks.

We have continued to work hard to meet the maximum 18 week waiting time target, and have achieved this for the year as a whole. We have not succeeded in meeting this standard for orthopaedics, where demand has exceeded our capacity. We are working with our Primary Care Trusts and NHS London to address this. Performance during the winter months was affected by severe weather conditions and the Trust's designation as one of only four centres nationally to offer advanced critical care support, including extracorporeal membrane oxygenation (ECMO), to flu patients.

We continue to experience unprecedented demand for our accident and emergency service, although we did achieve the national target, with over 95 per cent of patients diagnosed, treated, discharged or admitted within four hours. We continue to work hard to address the challenges we face in handling emergency attendances, with help from the Department of Health's intensive support team, and a range of measures were

introduced during the year to improve our performance.

CQUIN targets

The Trust agreed a number of quality improvement targets with our local Primary Care Trusts under the Commissioning for Quality and Innovation (CQUIN) scheme. The Trust programme consisted of 21 areas for improvement, through which we could earn an additional 1.5 per cent of contract income, equivalent to approximately £10 million.

Our performance against these targets has been strong, and we secured over 90 per cent of the available funding. This is especially welcome given the targets included many new measures which aim to improve the quality of our services.

Full details of the Trust's performance against a range of quality measures can be found in the quality report on page 43 and the Statement of Internal Control on page 72. The Trust's Annual Quality Accounts are published separately and are available online at NHS Choices (www.nhs.uk). In future years, we will replace the Statement of Internal Control with a new Annual Governance Statement, and we are working towards this during 2011/12.

NHS Litigation Authority

In June 2010 we were assessed by the NHS Litigation Authority against their Risk Management Standards for Acute Trusts and Maternity Services, and achieved level 3 (the highest level possible) in both assessments. The assessments, which measure our effectiveness in managing risk, look

at standards covering a wide range of activities from information for patients to mandatory training for staff. Level 3 accreditation is a considerable achievement and a testament to our staff's commitment to quality and safety.

Sustainability and climate change

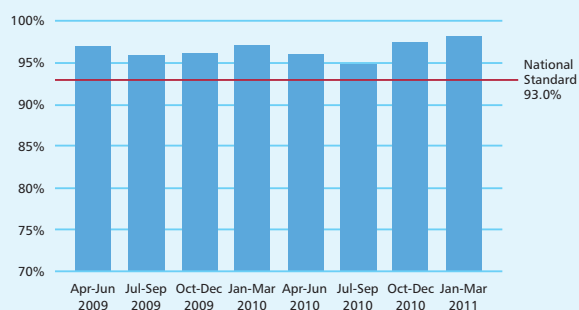
The Trust continues to implement its award winning environmental sustainability strategy, and to actively engage patients, staff, visitors and other stakeholders in this process. As a result of our proactive approach to carbon and resource reduction, as well as sustainable procurement, we were awarded the Sustainable Hospital Award at the Health Business Awards in December 2010. We have also managed to reduce our environmental impact, whilst simultaneously growing our clinical and facilities management operations.

Combined Heat and Power units on both sites have been fully operational since early 2010 and have dramatically reduced our dependency on the National Grid for electricity. 'Waste' heat is used to its full capacity, for example by providing hot water to the hospitals. We continue to invest in energy saving technologies and to upgrade our infrastructure; for example, by introducing LED lighting and highly efficient chillers to support clinical services and provide a comfortable environment for our patients and staff.

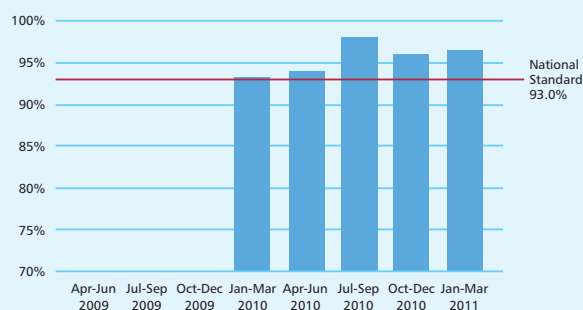
Everyone is encouraged to take responsibility for saving energy and water, and for reducing waste, and we have more than 125 staff

Performance against cancer access targets

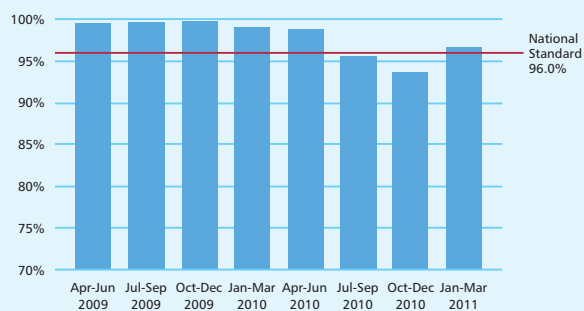
Urgent GP referrals seen within 2 weeks



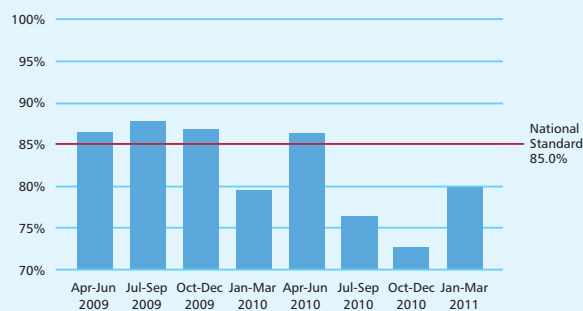
Breast symptomatic referrals seen within 2 weeks



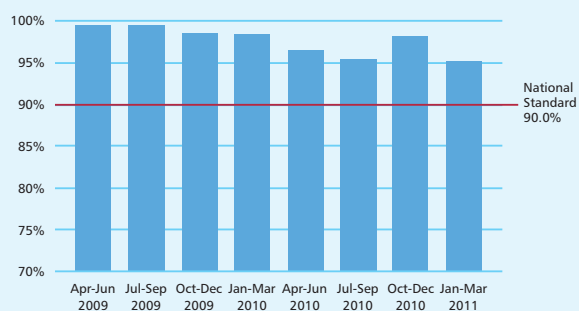
First treatment within 31 days



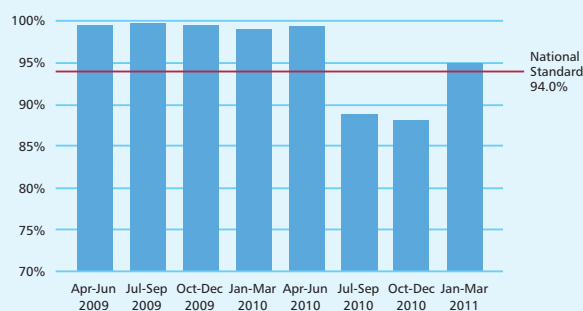
Treatment within 62 days of an urgent GP referral



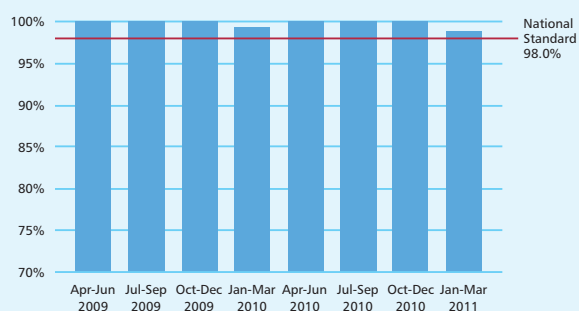
Treatment within 62 days of referral from screening



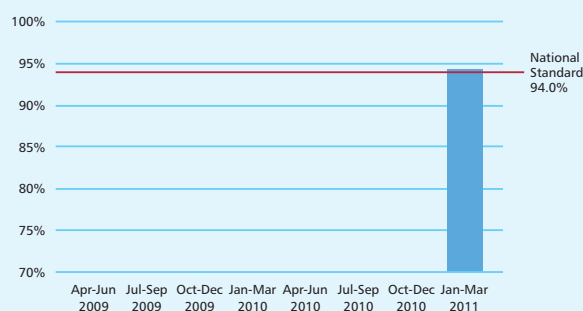
Subsequent treatment (surgery) within 31 days



Subsequent treatment (chemotherapy) within 31 days

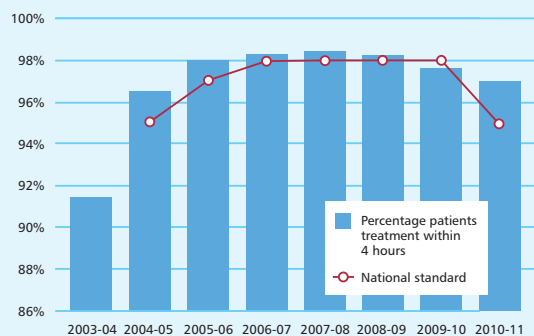


Subsequent treatment (radiotherapy) within 31 days

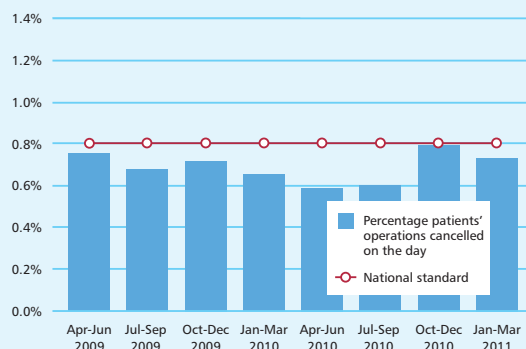


Performance against national targets

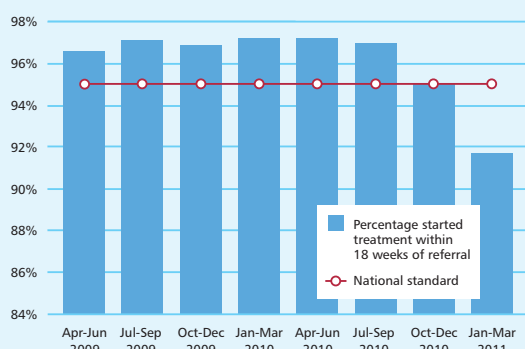
Percentage of patients treated within four hours in A&E



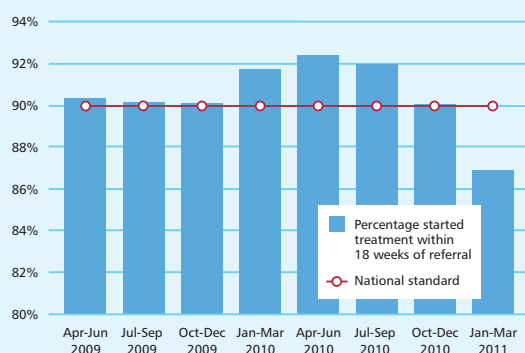
Percentage of patients' operations cancelled on the day



Percentage of patients starting outpatient treatment within 18 weeks of referral



Percentage of patients starting day case or inpatient treatment within 18 weeks of referral



Operational and financial review

Environmental impact performance indicators 2010/11

Area		Non-financial metric 2010/11	Non-financial metric 2009/10		Financial data (£000k) 2010/11	Financial data (£000k) 2009/10
Waste minimisation and management	High temperature disposal	268 tonnes	678 tonnes	Total waste cost	£802	£1,318
	Landfill disposal	2,055 tonnes	2,524 tonnes			
	Non-burn treatment	1,359 tonnes	878 tonnes			
	Waste recovery/recycling	22.3%	15.6%			
Finite resources	Water	508,932 m3	364,219 m3	Water	£673	£520
	Electricity	146,097 GJ	162,016 GJ	Energy	£7,345	£7,496
	Gas	672,095 GJ	534,177 GJ			
	Oil	412 GJ	1,048 GJ			

environment representatives who support us in this work.

We actively monitor and report on carbon consumption and other key performance indicators to ensure that we are consistently reducing our environmental impact. For example the Trust has committed to at least halving its waste to landfill from construction projects in cooperation with the Waste Reduction Action Programme (WRAP).

In the last year, the Trust has reduced its electricity use by 10 per cent, reduced waste to landfill by 18 per cent and increased recycling by 54 per cent. This was achieved through the introduction of alternative waste treatment, as well as increased awareness of recycling across the organisations.

The Trust also leads the London Procurement Programme which has delivered £6.3 million savings to London Trusts in the past year, mainly through renegotiating patient transport and waste service contracts.

Corporate social responsibility

We provide work experience and placements for local students, which offer insight into specific careers and gives targeted groups a greater opportunity to get into work. This supplements our successful apprenticeship programme, which regularly results in long term employment opportunities for local people.

We are also proud of Project SEARCH, an employment-focused education programme designed to give students with learning difficulties or disabilities the opportunity to develop employability skills and gain real work experience.

The Trust hosted its third annual Diversity Conference in February 2011, introduced by Trust Chairman Sir Hugh Taylor and led by inspirational speakers, including: David Congdon, head of campaigns and policy at Mencap, who spoke about the experiences of people with learning disabilities accessing public services such as health care; Phillippa Drew, who spoke of her experiences as an openly gay

woman in a senior leadership role in the civil service; and Trust staff including part-time assistant Muslim chaplain Shahir Muir.

The Trust's links with Tanzania and Zambia continue. The first projects are now underway with the Ndola Central Hospital in Zambia focusing on medical equipment, infection control and women's health. A team from Zambia visited Guy's and St Thomas' in October 2010 and a team from their Children's Hospital will be visiting the Trust in May 2011. We are also contributing to the King's Health Partners' Global Health initiatives which are supporting projects in Sierre Leone, Zimbabwe, Somaliland, Zambia and Tanzania.

The Trust continues to support clinical teams undertaking voluntary work internationally, such as the paediatric cardiac team who will be visiting Kenya in May 2011.

Operational and financial review

Our performance against national and core quality standards

- Target fully achieved
- Target partially achieved
- Target not met

Existing commitments		National standard	2010/11	2009/10	2008/09
A&E access	% patients discharged within 4 hours in A&E and MIU	>95%	*95.9% ●	97.6% ●	98.2%
Cardiac access	Patients seen within 2 weeks for rapid access chest pain	>99%	100.0% ●	100.0% ●	99.7%
	Patients waiting more than 3 months for revascularisation	<1%	0.3% ●	0.0% ●	0.0%
Cancelled operations	% elective operations cancelled on day of operation	<0.8%	0.67% ●	0.70% ●	1.17%
	% cancellations not re-admitted within 28 days	<5%	0.0% ●	0.9% ●	1.2%
Transfers of care	Inpatients with delayed transfer of care (monthly average)	<2%	0.5% ●	0.5% ●	0.3%
Health and well-being	Patients seen within 48 hours of referral to GUM clinic	>99%	100.0% ●	100.0% ●	99.8%
	Ethnic coding of inpatients	>90%	91.7% ●	91.9% ●	91.2%
Clinical quality	Call to balloon time for primary angioplasty – % under 150 minutes	>80%	87.2% ●	58.1% ●	n/a
MRSA screening	% compliance with MRSA screening for elective admissions (Jan-Mar)	100.0%	99.0% ●	93.4% ●	n/a

National priorities		National standard	2010/11	2009/10	2008/09
Infection control	MRSA bacteraemia reduction (to 9 for 2010-11)	<9	4 ●	16 ●	24
	C. difficile acquisitions in over 2s reduction (to 91 for 2010-11)	<91	118 ●	73 ●	84
18 week referral to treatment times	% admissions within 18 weeks	>90%	90.4% ●	90.6% ●	90.2%
	% non-admissions within 18 weeks	>95%	95.6% ●	96.2% ●	96.1%
Cancer access	Urgent GP referrals seen within 2 weeks	>93%	96.6% ●	97.0% ●	n/a
	Breast symptomatic referrals seen within 2 weeks	>93%	96.2% ●	93.2% ●	n/a
	Cancer treatments started within 1 month of decision to treat	>96%	96.1% ●	99.4% ●	99.5%
	Cancer treatments started within 2 months of urgent GP referral	>85%	79.2% ●	85.2% ●	n/a
	Treatments started within 2 months of screening programme referrals	>90%	96.5% ●	99.0% ●	n/a
	Subsequent surgical treatment within 1 month	>94%	93.3% ●	97.8% ●	n/a
	Subsequent chemotherapy treatment within 1 month	>98%	99.9% ●	99.6% ●	n/a
	Subsequent radiotherapy treatment within 1 month (Jan-Mar)	>94%	*94.3% ●	n/a	n/a
Infant health	Smoking during pregnancy	<5%	3.8% ●	4.8% ●	5.0%
	Breastfeeding initiation	>90%	90.6% ●	87.0% ●	90.8%
Clinical quality	Stroke care – patients with more than 90% of their stay in a stroke unit	>90%	94.5% ●	82.1% ●	n/a

* New targets in 2010/11

- Target fully achieved
- Target partially achieved
- Target not met

Our performance against local targets

Clinical quality		Local target	2010/11	2009/10	2008/09
Infection control	% clinical staff compliant with hand hygiene (monthly audit)	>98%	97.7% ●	97.5% ●	99.0%
	MRSA screening of non-elective admissions (Jan-Mar)	>97%	*95.7% ●	n/a	n/a
	MRSA acquisitions from clinical specimens	<80	27 ●	28 ●	67
	GRE bacteraemias (per month)	<2 / mth	0.0 ●	0.4 ●	0.8
Clinical indicators	Hospital mortality – unadjusted counts of deaths (monthly average)	<100	91 ●	93 ●	99.8
	Standardised mortality ratio	<85	81.0 ●	82.6 ●	79.6
	Readmission rate (all emergency readmissions within 28 days)	<4.5%	5.4% ●	4.7% ●	4.6%
	Venous thromboembolisms – % patients screened (Jan-Mar)	>90%	*92.7% ●	n/a	n/a
	10% reduction in patient slips trips and falls with harm (per month)	<5	*3.1 ●	n/a	n/a
	Pressure ulcer acquisitions – 10% reduction (per month)	<22.5	*13.0 ●	n/a	n/a
	Smoking cessation referrals per month	>150	150.4 ●	120.0 ●	n/a
Maternity	% Caesarean births	<27%	27.6% ●	28.4% ●	n/a
	Health assessments completed within 12 weeks	>80%	93.0% ●	87.0% ●	n/a
	Dedicated midwife during labour	>90%	98.0% ●	99.0% ●	n/a

* New targets in 2010/11

Our strategic vision

King's Health Partners is pioneering better health and well-being locally and globally, through integrating excellence in research, in education and training and in patient care. As part of our commitment to this, over the next few years we will focus on:

- delivering high quality sustainable services;
- progressing a limited number of clinical and academic developments.

To achieve this we will:

- continue to develop the Academic Health Sciences Centre;
- transform major pathways of care;
- improve our systems where this supports the above.

Information risks

The Trust is required to assess and report information risks and data losses in a standard format. We are pleased to report that we have had no such losses in 2010/11.

We take all incidents very seriously and these are investigated in the same way as clinical incidents so that we learn lessons and take action to prevent similar issues occurring.

Sickness absence

The Trust is required by the regulator to report the sickness absence rate of staff. In 2010/11, the sickness absence was 3.8 per cent.

Guy's and St Thomas' has again performed well financially in 2010/11, despite the continued difficult economic environment. The Trust declared a surplus of £22.5 million for the financial year, before accounting for an impairment of £4.6 million due to the revaluation of the Trust's buildings, which reduced the reported surplus to £17.9 million.

Our financial performance

In 2010/11, recognising the scale of financial challenge the Trust faced, the Board of Directors initially planned for a surplus of £5 million, but developed plans during the year to increase this to £25 million in order to deliver our ambitious plans for capital investment which underpin our estates strategy. Although the Trust did not quite achieve the revised target we believe

Table 1	Plan 2010/11 £ millions	Actual 2010/11 £ millions	Variance £ millions
Total income	951.9	992.3	40.4
Expenses	(881.8)	(914.6)	(32.8)
Depreciation	(44.3)	(39.1)	5.2
Operating surplus	25.8	38.6	2.4
Public Dividend Capital dividend	(21.6)	(20.9)	0.7
Finance income	0.8	0.8	0
Other	–	(0.6)	(0.6)
Surplus for the year	5.0	17.9	12.9

this is a good performance at a time when efficiency savings have proved increasingly difficult to achieve without impacting adversely on patient care. The Trust had identified the requirement for a £78 million efficiency improvement, which would have delivered a £25 million surplus in 2011 and at the end of the year we had achieved £55.9 million of these savings.

The annual accounts reflect not only the performance of the Trust, but also the consolidated results of its wholly owned subsidiaries, GST Enterprises, GTI Forces Healthcare Limited, Pathology Services Limited, an associate company SSAFA GSTT Care Limited Liability Partnership, and joint venture GSTS Pathology Limited Liability Partnership.

In October 2010 the Trust was the successful bidder to provide non-clinical support services to Primary Care Trusts within south west London including contracting services, operational services, projects and partnering, technical services and strategic estates advice. The South West London Support Services Partnership's integrated facilities and property services are now part of the Trust's capital, estates and facilities directorate.

In line with Government accounting policy, the income and expenditure for the Support Services Partnership for all of 2010/11 is included in the Trust's annual accounts.

The year end surplus reflects that the Trust delivered a significant programme of cost reduction and increased efficiency. The Trust's income position exceeded our planned income for this period by £40.4 million, whilst expenditure was £32.8 million above plan – reflecting the additional costs of delivering these higher levels of activity, the transfer of the South West London Support Service Partnership, and the £4.6 million impairment on our fixed assets.

The Trust's depreciation charge and dividend on Public Dividend Capital costs were £5.2 million and

£0.7 million below plan respectively.

Table 1 compares the 2010/11 outturn to the 2010/11 plan.

The increase in actual income, compared with the levels set out in our plan, was primarily a result of the Trust undertaking additional activity for a number of Primary Care Trusts, over and above the original contracted levels. This resulted in increased income and expenditure associated with delivering this additional work.

The integration of the South West London Support Services Partnership increased both income and expenditure by £10.9 million. The 2009/10 accounts have been restated to include the Support Services Partnership income and costs of £13.3 million.

Financial performance 2009/10 and 2010/11

Guy's and St Thomas' has performed well financially in 2010/11 and the Trust has declared a surplus of £17.9 million for the year. The Trust had planned to achieve a surplus of £5 million at the start of 2010/11, but developed plans during the year to increase this to £25 million to deliver our ambitious target for capital investment to deliver our estates strategy.

Table 2 shows the Trust's financial performance for 2009/10 and 2010/11.

The Trust made a £1.8 million surplus in 2009/10 and achieved a surplus of £17.9 million in 2010/11 after accounting for the £4.6 million fixed asset impairment equivalent to a £22.5 million surplus excluding the fixed asset impairment. These surpluses have been allocated to

develop services and to implement our ambitious estates strategy.

The surpluses were primarily due to the following positive factors:

- additional activity which has resulted in increased income from Primary Care Trusts;
- the successful delivery of a significant cost improvement programme;
- continued benefits of supply stock cabinets; and
- the recovery of prior year income.

These 'gains' have been partially offset by:

- the increase in costs associated with increased activity for Primary Care Trusts; and
- the cost of meeting national waiting time targets.

The Trust delivered efficiency savings of £55.9 million in 2010/11, and will continue to drive down costs in future years as part of the plan to meet anticipated financial risks and to deliver surpluses which can be reinvested in service developments and our estate.

Trends in activity, income and expenditure

Charts 1 to 5 on page 23 show activity and income and expenditure growth over a five year period from 2006/07 to 2010/11.

Activity trends

Charts 1 to 3 show the growth in inpatient and day case activity (measured as completed patient spells) – up by 20 per cent, and growth in outpatient attendances – up by 17 per cent.

The growth in inpatient and day case activity relates to increased demand for specialist (tertiary) services, including the transfer of complex and emergency paediatric surgery from University Hospital Lewisham to the Evelina Children's Hospital in September, and the increased activity purchased by Primary Care Trusts to achieve national waiting times targets. The majority of the activity growth over the period relates to day case activity.

Total outpatient activity has grown by 17 per cent (new outpatient referrals increased by 31 per cent and follow-up referrals increased by 11 per cent) over the period.

Accident and emergency attendances increased by two per cent in 2010/11, compared to 2009/10, and total attendances are up by four per cent over the five year period.

Table 2	Actual 2010/11 £millions	Actual 2009/10 £millions
Total income	992.3	943.3
Expenditure including depreciation	(953.7)	(921.8)
Operating surplus	38.6	21.5
Public Dividend Capital	(20.9)	(20.2)
Interest on loans & receivables/other	0.2	0.5
Surplus for the year	17.9	1.8

2009/10 figures restated

Chart 4 shows the growth in income over the five year period from April 2006 to March 2011. Income has grown at approximately 10 per cent a year. The increase in income, above inflation, is mainly as a result of Primary Care Trusts purchasing additional activity and also specific funding for quality improvements in some areas.

Chart 5 shows the growth in expenditure over the five year period. Expenditure has also grown at an average rate of 10 per cent a year. This is primarily as a result of the additional staff and non-pay costs associated with delivering additional activity.

The Trust delivered efficiency savings of £55.9 million in 2010/11, and will continue to drive down costs in future years.

However, it should be noted that the change in income and expenditure between 2009/10 and 2010/11 is significantly below the five year average, with income growing at five percent and expenditure by four per cent. This reflects the changing economic climate and the increased efficiency savings delivered by the Trust in 2010/11. It is expected that reduced income growth and the need for increasing efficiency and productivity improvements will continue in 2011/12 and future years.

Cash flow and balance sheet

There have been a number of significant changes in the Trust's balance sheet and working capital during the year.

The Trust ended the year with £100.1 million cash in the bank, against a plan of £68.1 million. This was an increase in cash of £32 million compared to plan, and a reduction of £11.8 million when compared with the £111.9 million position at the end of 2009/10. The increase in cash against plan is largely due to the Trust's higher than planned surplus of £17.9 million, prior to the impairment charge, a lower than planned capital spend of £12.2 million on NHS funded assets, and an improvement in working balances of £4 million.

The Trust had a planned capital spend of £86.2 million for the year. The actual capital expenditure during the year was £76.4 million, including £10.1 million from charitable funds.

The Trust's land and buildings were valued independently by the Valuation Office as at March 2011, in line with the accounting policies. The valuation included positive and negative movements. All valuation movements were the result of changes in the market price. There was an overall net impairment of £7.5 million, of which £4.6 million was charged to the income and expenditure account as the buildings had insufficient revaluation reserves to fund the valuation movement.

The valuation included negative valuations of £33.8 million and £0.9 million on buildings and land respectively. There were positive valuation movements on other Trust buildings and land of £12.1 million and £15.1 million respectively.

Trends in activity, income and expenditure

Chart 1: Completed patient spells

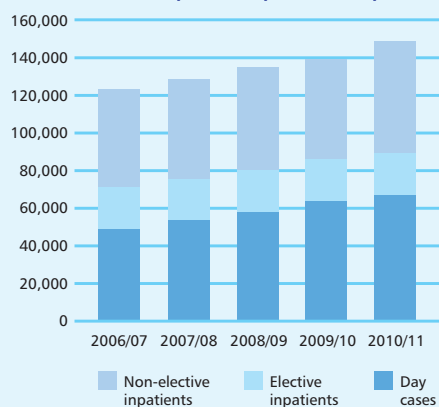


Chart 2: Outpatient attendances

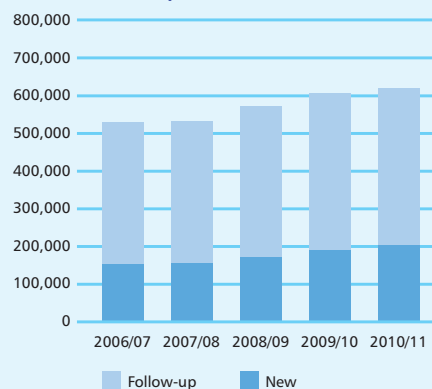


Chart 3: A&E attendances

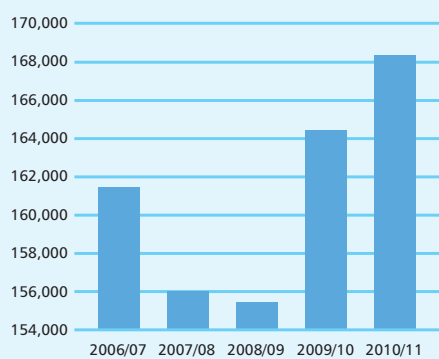


Chart 4: Income £000s

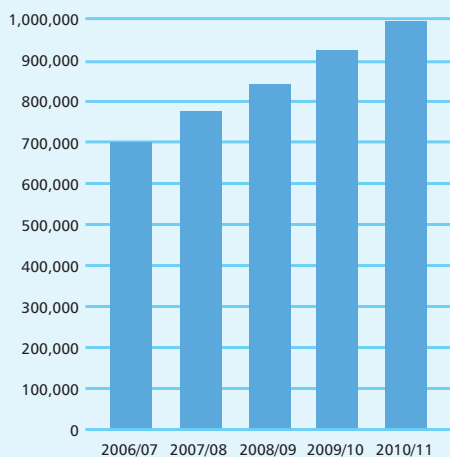
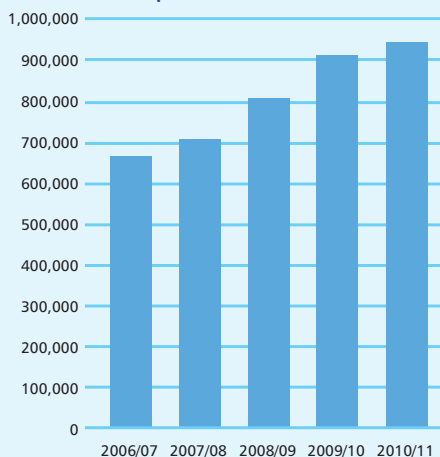


Chart 5: Expenditure £000s



There has been no change to the Trust's schedule of protected and non-protected assets during the year. In 2009/10 the Trust relinquished its lease with Lewisham Primary Care Trust for the remaining parts of the New Cross Hospital site, and Trust services occupying the site were relocated to other parts of the estate. The Trust received £800,000 in 2010/11 from Lewisham Primary Care Trust following the sale of New Cross Hospital.

Capital expenditure

Capital expenditure during 2010/11 was focused on protected assets and included backlog maintenance, the provision of medical equipment and investment in IT projects. Table 3 below shows a breakdown of the different sources of the capital and how this has been spent.

Table 3	NHS Funded £ millions	Donated £ millions
Buildings	20.3	1.8
Assets under construction	22.9	4.9
Plant and machinery	16.8	2.7
Information technology (IT)	6.3	0
Furniture and fittings	0	0
Software licenses etc	0	0.7
Total	66.3	10.1

Commercial income and private patient cap

The Trust has a large commercial portfolio, and much of this income is subject to long term contracts.

In accordance with Foundation Trust legislation, the Trust's private patient income is capped at 3.04 per cent of income from patient care activities based on the Trust's 2002/03 financial outturn. The Trust remained within the private patient

cap for 2010/11 (see note 4.3 on page 86 of the annual accounts). Our future plans assume that private income will remain constant in real terms, and that we will therefore remain within the required limit.

Prudential Borrowing Limit

A Prudential Borrowing Limit (PBL) is set by Monitor and is reviewed at least annually. The total amount that the Trust borrows must be within this limit. Monitor sets the Prudential Borrowing Limit for each Foundation Trust with reference to financial ratios and the individual Trust's working capital facility. In 2010/11 the Trust arranged a working capital facility of £30 million but did not need to draw on these funds.

The Trust had no borrowing against the Prudential Borrowing Limit during 2010/11, and this was in line with expectation. The Trust's performance against the Prudential Borrowing Limit indicators is described in note 24 on page 96 of the annual accounts.

External audit services

Following a recommendation from the Board, the Council of Governors agreed that Deloitte LLP should be the Trust's external auditor for 2010/11. The Trust incurred £125,786 in audit services fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries' to March 31 2011. A further £67,560 was incurred for auditing the Trust's Quality Accounts for 2009/10 and 2010/11 and other audit services.

Monitoring Trust performance

The Trust has developed a 'balanced

score card' to review and monitor performance at a Trustwide and directorate level. Incorporated within the Trust level score card, which is reported monthly to the Board of Directors, are the metrics used by Monitor to assess the financial risk rating of the Trust.

Monitor uses four criteria to assess the Trust's financial risk rating: underlying financial performance; achievement of the financial plan; financial efficiency; and liquidity. At the end of the financial year the Trust achieved a risk rating of four, in a range of one to five where five is the best performance.

Identifying potential financial risks and opportunities

In assessing the financial risks faced by the Trust, we have assessed the external factors which are likely to impact on the organisation. We have identified the key drivers of change which we believe present both challenges and opportunities to our future operation. These are:

- our transformation programme;
- commercial opportunities.

The Trust continues to focus on managing the risks associated with the drivers of change which are potential challenges, and on ensuring that it is in a position to take advantage of the potential opportunities.

The Academic Health Sciences Centre and extending our commercial income are primarily viewed as opportunities. The changed economic climate, the volatility of the national tariff and Market Forces Factor under Payment by Results and our purchasers' commissioning intentions, as well as changes to the levy funding we receive for teaching, are major uncertainties and viewed as threats which make future planning difficult.

Responding to potential financial risks and opportunities

In responding to these potential risks and opportunities, in particular the change and uncertainty we face in terms of the external environment, the Trust continues to set itself challenging financial targets.

The Trust is planning to achieve a further £53.2 million savings in 2011/12 and also aims to deliver a surplus of £30 million, which will be in addition to the surpluses achieved in prior years. These surpluses will then be available to reinvest in service developments and our estate in support of the Trust's strategic vision.

The degree to which these targets are achieved will determine

the levels of investment that the Trust is able to undertake in future years, and will also provide a financial buffer should the financial risks we have identified materialise.

The following section sets out the key challenges and opportunities we have identified in achieving the financial targets that we have set ourselves, and how these will be managed.

Emerging health policy and legislation

The Health and Social Care Bill currently passing through Parliament heralds significant changes in the NHS. It may change in form as it passes through the legislative process, and it is therefore difficult to assess the impact of the change proposed at this stage. The commissioning and financial risks set out below are those we are currently aware of.

The economic environment

The global economic downturn has impacted significantly on future funding likely to be available to the NHS. This will require increased efficiency savings for NHS Trusts of four per cent a year or more.

In addition, changes to funding arrangements for education being considered by the Department of Health could reduce the funding available to teaching hospitals. The Trust will ensure programmes are developed to respond to the financial challenges and will focus on further improvements in productivity and efficiency, whilst also improving the quality of patient care and the patient experience.

Development of King's Health Partners

Together with King's College Hospital and South London and Maudsley NHS Foundation Trusts, and our shared academic partner King's College London, we are an Academic Health Sciences Centre, King's Health Partners. Through our complementary skills and activities we provide a full range of world-class clinical services, combined with excellence in teaching and research, for the benefit of the populations we serve.

Opportunities to improve the effectiveness and quality of our services, and to reduce unnecessary duplication continue to be actively explored. The Academic Health Sciences Centre continues to present exciting opportunities for service development and income growth and diversification, as well as greater efficiency.

The development of Clinical Academic Groups is at the heart of our efforts to bring clinical services, research and education activities together through a series of combined management units.

Changes to commissioning arrangements

The Trust is working closely with commissioners as they develop and organisational structures change. The commissioning intentions for 2011/12 have focused on referral management and productivity improvements via locally agreed quality, innovation, productivity and prevention initiatives.

National changes relating to payments for emergency re-

admissions within 30 days of discharge following a previous admission have placed significant financial risk on provider organisations. We continue to monitor the impact on the Trust of these new arrangements having concluded contract negotiations with commissioners.

Plans to rationalise specialist services may be reflected in the future commissioning intentions. We are well placed to assist in the consolidation of specialist services and, if asked, would provide services to an agreed population as part of networked pathways of care.

Integration of community services

Guy's and St Thomas', on behalf of King's Health Partners, is contracted to manage the community services in Lambeth and Southwark with effect from April 2011. This presents a major opportunity to ensure closer working with GPs and a range of other health and social care professionals.

New Monitor compliance framework

Monitor has introduced a new compliance framework with effect from 1 April 2011. The Trust may be at risk of incurring additional costs to deliver the additional activity required to meet the compliance targets, and this may be unaffordable to purchasers in the current financial climate. The Trust does not believe this to be a significant financial risk, although it will present significant operational challenges.

Savings and activity plans

The Trust has set itself challenging financial targets over the next three years to deliver the financial savings required by the NHS and the surpluses needed to invest in our estate. The Trust is developing plans to reduce cost whilst continuing to provide high quality effective clinical services.

We are also working with local Primary Care Trusts on a number of key productivity improvements and demand management protocols to deliver overall system sustainability so that the activity delivered by the Trust is both affordable and can be delivered within the funding available.

The risk of not meeting these targets would be that the Trust and local Primary Care Trusts were in financial deficit, potentially leading to additional reductions in activity and available funding in future years. This would also adversely impact on our estates strategy.

We have a good history of working with local Primary Care Trusts to deliver system change within the funding available to all parties. The Trust's transformation programme, potential cost savings from King's Health Partners and the integration of community services give us a firm basis from which to deliver significant service redesign and cost reduction.

Transformation programme

The Trust recognises that real efficiency gains and service improvements can only be achieved by changing our business processes. The Trust has a dedicated change team which leads on transformation

work, overseen by a Transformation Board.

From April 2011 the Transformation Board will work closely with Executive Directors on a number of corporate initiatives to improve productivity and reduce costs. These include improving bed and theatre productivity; reductions in corporate costs through the rationalisation of corporate functions with King's Health Partners; and savings in non-pay costs through product rationalisation, the negotiation of better prices from suppliers and through joint purchasing initiatives with other NHS organisations.

Commercial opportunities

The Trust benefits from having one of the largest and most successful enterprise units in the NHS. The commercial directorate supports and develops a range of initiatives to diversify our income base and create additional financial surpluses, which are used to invest in NHS patient care and our facilities and equipment.

Commercial opportunities and activities are subject to scrutiny by the Board, and aim to create commercial gain from the physical and intellectual assets of the Trust, without incurring significant financial or reputational risk.

These include treating private and international patients at private patient facilities; commercial research and trials; commercialisation of intellectual property; consultancy services in the UK and internationally, both independently and in conjunction with leading consultancies; management of healthcare facilities for governments, military

organisations and other healthcare organisations internationally; provision of support services to other NHS organisations; and partnering with commercial organisations who have innovative products and services.



Our 12,000 staff work closely with patients and our partners to ensure care meets the needs of the diverse population we serve

4 Our staff, patients and partners

The Trust strives to improve the quality of care and the hospital environment through consultation with our patients, the commitment and hard work of our staff, and the support of our partners. This enables us to deliver services that meet the needs of the diverse local communities we serve.

Our staff

Last year, we employed over 10,500 staff, clinical and non-clinical, who are integral to the success of the organisation. They continue to provide high quality care and work hard to meet national and local targets, and to improve efficiency.

Communicating with our staff

The Trust is committed to involving staff in decision-making and keeping them informed of changes and developments across the organisation. The Trust's two-day corporate induction programme is a valuable source of information for new recruits and the Knowledge and Information Centre at St Thomas' provides email and computer access for staff, as well as regular information and training sessions.

We do our best to ensure staff are aware of the key priorities and issues affecting the organisation, including the changing financial and regulatory environment. Our range of well-established communications channels include a monthly team briefing, a daily email bulletin and our intranet, GTi, which is a central source for policies, guidance and online tools. We also produce a regular magazine for staff and hold regular face to face briefings on both clinical and management issues.

We work with staff representatives to ensure employees' voices are heard. The Joint Staff Committee meets bimonthly, acting as a valuable consultative forum. In addition, sub-groups have been established to look at policy and pay issues, and topics such as financial

performance are regularly discussed.

Staff throughout the organisation are encouraged to voice opinions and get involved in developing local services to drive continuous improvement.

Staff survey

We participate in the annual NHS national staff survey which provides a valuable insight into the views of our staff. Based on the latest results from the 2010 survey, Guy's and St Thomas' is among the top 20 per cent of acute Trusts in England for 21 out of the 38 key scores; a similar performance to that in 2009 (top 20 per cent for 22 out of 40).

In 2010, we surveyed a sample of staff, in accordance with the requirements of the Care Quality Commission (CQC), and 386 members of staff responded to the survey, a response rate of 49%. We also included additional questions to help us understand the areas where we didn't score as well. The areas of best and weakest performance can be seen in the table on page 35.

The Trust uses the results of the national survey and other staff feedback in a variety of ways to address any areas of concern. We have worked with staff side representatives to develop an action plan which addresses issues raised through the staff surveys at Trustwide and local level. This action plan has enabled us to focus on improved training for staff as well as better incident reporting in key areas to ensure that we learn from mistakes.

The Trust continues to recognise and honour staff for their outstanding contributions to the

care of patients and the running of our hospitals. Our monthly CARE awards, as well as an annual Trustwide awards ceremony provides us with an opportunity to acknowledge and thank staff. In addition, senior clinical leaders and managers devote significant time, on Fridays or through our *In Your Shoes* initiative, to spending time on the shop floor, understanding the work of frontline staff and the experience of our patients.

In 2010, the Trust opened a purpose designed Education Centre at York Road, close to St Thomas' to provide high quality teaching and learning facilities.

Equality and diversity

The Trust takes an inclusive approach to the six strands of equality – age, disability, ethnicity and race, religion and belief, gender, and sexual orientation. The organisation has in place an Equality and Human Rights Scheme 2010-2013 that proactively promotes diversity through key priorities including:

- robustly addressing discrimination, bullying and harassment at all levels of the organisation;
 - ensuring that clinical services are fair and fully accessible;
 - providing equality of opportunity for all our workforce; and
 - ensuring that our staff reflects the communities we serve.
- The Trust's Associate Director of Equality and Diversity takes overall responsibility for monitoring our operations against these priorities and publishes details of our performance.
- Over the past year, the Trust's learning disability co-ordinator has supported clinical directorates in meeting the needs of patients with learning disabilities by providing accessible information and making reasonable adjustments. We will continue this work to ensure that we meet the recommendations of *Healthcare for all* – the independent inquiry led by the Trust's former Chief Executive Sir Jonathan Michael to consider how hospitals meet the needs of people with learning disabilities.
- In 2010/11, the Trust has also strengthened the Equality Impact Assessment process to ensure new service developments and building projects, as well as Trust policies and decisions, support our commitment to diversity.
- The Trust continues to develop equitable and fair recruitment practices to ensure equal access to employment opportunities for all. We use the 'two tick' disability symbol on recruitment materials, signifying our positive attitude towards the recruitment of disabled people, and we continue to support disabled staff, including anyone who becomes disabled during their employment.
- The Trust has successfully implemented Project SEARCH, an education programme designed to

give students with learning difficulties or disabilities the opportunity to develop employability skills and gain real work experience. Through the Southwark Partnership, the Trust works closely with a number of specialist organisations including Remploy and Prospects – a partnership between the National Autistic Society and Southwark College to provide work placements which is the only project in the UK providing opportunities specifically aimed at young people with autistic spectrum disorders.

Aspire, the Trust's equality and diversity network, brings together staff, Non-Executive Directors and members of the local community to actively support our diverse workforce at all levels.

Training and development

The Trust is committed to the training, career development and promotion of all staff and offers a range of opportunities to support this, including short courses, management development programmes, mandatory training, mentoring schemes and access to university programmes.

In addition to the well-developed programme of mandatory training and developmental courses, the Trust has introduced a number of new initiatives during 2010/11 to enable staff to develop and learn. These include:

- *The difference is you* – a programme to support frontline staff to communicate effectively and develop a customer relationship approach;
- *The frontline leadership programme* – aimed at ward

sisters and service managers to develop leadership and coaching skills and to support improvements in patient care.

The Trust runs an apprenticeship scheme to provide work-based training for staff seeking to gain the knowledge and skills required to undertake their role and tasks more effectively. Over 200 apprenticeships have been identified covering a diverse range of areas and these include roles in nursing, maternity and administration, as well as in pharmacy and housekeeping. At the NHS London Apprentice of the Year Awards, our apprenticeship team was awarded 'Team of the Year' for their success in developing new and existing staff.

The Trust also offers a cadet scheme to raise awareness of apprenticeships and work experience opportunities in local schools and colleges, and with job seekers. Cadets are able to spend time in key services relating to their areas of interest and will be able to undertake accredited learning under the guidance of a coach.

In 2010, the Trust opened a purpose designed Education Centre at York Road, close to St Thomas' to provide high quality teaching and learning facilities, enabling valuable space on both hospital sites to be redeveloped for patient facilities.

Volunteers

Our patients and staff benefit greatly from the support of a team of almost 400 volunteers who contribute an estimated 1,200 hours a week to the Trust. One

hundred new volunteers have joined the team this year, providing a range of services including welcoming and guiding patients and visitors, and they now work from distinctive new information pods funded by Guy's and St Thomas' Charity. They also work with the spiritual care team and escort patients to the MediCinema to watch the latest films, often in wheelchairs or even in their beds. This year, the volunteers have taken on a number of new roles, including assisting patients at meal times and helping new mothers to breast feed.

Safe working environment

We place a strong focus on health and safety to maintain an environment that is safe for staff, patients and visitors. Our health and safety strategy sets out a three year vision for improving performance. This year significant progress has been made in providing training and information for staff and in improving the documentation used across the organisation.

The Trust welcomes the publication of Dr Steve Boorman's independent review of NHS staff health and wellbeing, and has convened a health and wellbeing group to develop initiatives to encourage healthy working lives for all of our staff.

Our occupational health service remains one of the largest in the country, employing a team of doctors, nurses, counsellors and support staff, who not only serve our staff, but also have contracts to provide services for a number of local businesses. Now based at the

Education Centre, the occupational health service has improved facilities to offer services such as pre-employment screening, work-related health checks and a vaccination and immunisation programme. There is also a new rehabilitation centre where disabled employees can test adapted office equipment to support their individual needs.

This year, following an extremely successful awareness campaign, an unprecedented number of staff – more than 4,000 – were vaccinated against seasonal flu.

The Trust is committed to involving patients and the public in the development and improvement of services.

Patients

A million patients now walk through our doors or are seen by our staff in the community each year, and it is their experience which is at the heart of everything we do. It is only through listening to our patients, their relatives, carers and visitors that we can provide the best possible services.

Listening to patients

We value patient feedback which helps us monitor and improve services. The independent research organisation Ipsos MORI conducts a telephone survey of around 4,000 patients on behalf of the Trust twice a year.

We continue to see high levels of satisfaction with the services we provide, with over 90 per cent of those surveyed reporting they were very or fairly satisfied with their visit to our hospitals and the quality of care they received.

We also participate in the Care Quality Commission's annual inpatient survey and this showed that 94 per cent of our inpatients rated their care as good or excellent. We saw high levels of satisfaction with those aspects of care that we know are important to patients – 91 per cent of patients and visitors told us that hand-wash gels were visible and available for them to use, whilst 95 per cent of patients rated the room or ward they stayed in as very or fairly clean. The survey also showed that 80 per cent of patients felt that they were treated with dignity and respect at all times.

The Trust now offers a comment card scheme which gives patients the opportunity to complete surveys online, or by using handheld devices and kiosks on both hospital sites.

These survey and feedback mechanisms ensure that we continue to make changes that patients and visitors want. The results and observations are fed back to the relevant local teams for action and reported to the Board of Directors and Council of Governors' patient experience working group.

Over the last year the Trust's environmental improvement programme has included work to ensure that patients do not share sleeping accommodation and bathroom facilities with patients of the opposite sex, except where there is an exceptional clinical

need. Our telephone survey shows a 10 per cent improvement (from 83 per cent in 2009 to 93 per cent in 2010) in the number of patients who tell us they did not share a bay on a ward with members of the opposite sex. Patients also wanted more information about their treatment and we have been working hard to ensure patients see the letters we send to their GP.

The Trust is committed to actively listening to our older and more vulnerable patients. To continue to support communication and to improve the care of older patients living in our local community, we ensure that a named senior nurse acts as a first contact point for any queries or concerns about their care and treatment.

The Trust takes complaints very seriously and we strive to learn lessons so we improve services and better meet the needs of patients. We have fully implemented the national complaints framework which aims to deliver a more complainant-focused approach and encourages open communication between patients and service providers. We have worked to promote an atmosphere of openness and respect so that patients or visitors feel comfortable raising any concerns with staff directly.

Patient involvement

The Trust is committed to involving patients and the public in the development and improvement of services. This year, we have continued to implement our patient and public involvement

strategy – a three year plan to embed a positive approach to involvement across the Trust.

This has included involving patients in thinking about the future redevelopment of our accident and emergency department at St Thomas', and in the development of a new outpatient centre, through a workshop and focus groups. A user reference group, made up of governors, patients and members of local community groups has been established to take this work forward. Patients have also been at the heart of the design of our new Cancer Day Unit at Guy's.

Patient involvement has been a key feature of the integration of community services, with a range of local partners and community representatives participating in a stakeholder reference group. This group will continue to provide a valuable contribution following integration.

As part of the patient and public involvement strategy, we continue to support staff to develop the necessary skills to involve patients in the development of services. This year, we have worked with Participate and the Consultation Institute to develop and deliver four specialist training courses for staff, with funding from Guy's and St Thomas' Charity.

Patient information

The Trust is committed to providing patients with clear, informative, clinically accurate information on conditions and treatments to enable them to make informed decisions about their care. All information produced by the Trust

is monitored and approved using a rigorous process to ensure that it is evidence-based, meets national standards and has been reviewed by patients. In June 2010, the Trust received the highest possible accreditation level (3) from the Clinical Negligence Scheme for Trusts (CNST) for the quality of its patient information.

During the year, the Trust produced over 100 new patient publications, and reviewed existing publications to ensure accuracy. This year we launched a new ward welcome pack for every new inpatient in our hospitals to help them feel familiar with the hospital environment and the team caring for them. In October, our booklet *Taking part in medical research studies* won the NHS Trust category for best patient information at the British Medical Association Patient Information Awards. The judges praised its 'Clear informative description of medical research to aid decision making'.

In November, our radiographers and patient publications team won the Bupa Foundation's Communication Award. This prize recognised the excellence of the resources we provide to prepare children coming in to hospital for an MRI scan. A dvd, picture books and sessions with a play specialist have helped over 200 children so far.

The Knowledge and Information Centre at St Thomas' continues to provide a welcoming and accessible location for patients and their families to enquire about health services, use computers and search the internet, as well as visit the PALS walk-in service if they need help or

advice. Staff also work with partners to provide a wide range of services including: smoking cessation sessions and careers advice. Last year nearly 70,000 people visited the centre and staff also responded to queries by email and telephone.

During the year, PALS received 5,000 enquiries and staff work closely with Trust colleagues to resolve concerns at an early stage whenever possible and also advise patients on how to make a formal complaint. Themes identified through PALS cases are reported quarterly to senior colleagues and contribute to the patient experience data used to improve our services.

The Trust provides a comprehensive language support service to meet the needs of our diverse population and can provide interpreters for patients and their carers. We provide telephone interpreting services in most common languages and facilities exist to translate information, including into formats such as audio or Braille.

Partnerships to improve healthcare

King's Health Partners has made much progress over the last year.

Leaders have been appointed to the Clinical Academic Groups, 14 of which include Trust services. These are the building blocks for the delivery of the Academic Health Sciences vision, enabling integrated leadership across the partner organisations and bringing together clinical services, research and teaching.

Lambeth and Southwark

community services were successfully transferred into the Trust on April 1 2011, on behalf of King's Health Partners, following lengthy planning for integration during 2010/11. This will enable the transformation of major pathways of care across hospital and community services.

Working across King's Health Partners, and with local GPs and our local authorities, we are developing an Integrated Care Pilot in Lambeth and Southwark to improve urgent care services and care for frail older people and people with long term conditions.

We continue to work closely with the South Bank Employers Group and last year we provided around 80 work placements for local school children and adults living in Lambeth and Southwark who have been out of the job market for some time. These covered a wide range of roles in the Trust and reflect our commitment to supporting the local community.

Consultations

As part of the *National Safe and Sustainable Review of Children's Congenital Cardiac Services*, the Evelina Children's Hospital has been identified as one of the recommended centres to provide specialist heart surgery, and this supports our ambition to address childhood diseases for our local community and nationally. These proposals are subject to public consultation which takes place until 1 July 2011.

Commissioning Support for London has acted on behalf of the Joint Committee of Primary Care

Trusts to develop new models of care for cardiovascular, cancer and specialist children's services. The objective of these reviews is to develop centres of excellence that improve clinical outcomes and the patient pathway. These reviews will provide King's Health Partners with evidence to help review and configure services in ways that will allow us to develop excellent care.

The Trust works closely with local agencies to ensure there is good engagement and communication.

The Trust seeks to engage with the local authority through the Overview and Scrutiny Committee when deciding on the priorities for the Trust's Quality Accounts and also where there are potential changes to the provision of services, for example our proposals for urgent care and vascular services.

Guy's and St Thomas' Charity

The Trust is fortunate to benefit from the support of Guy's and St Thomas' Charity which provides grants, loans and investment finance to support innovation across the Trust.

As the principal beneficiary of the Charity, the Trust received a total of more than £3.5 million for 59 projects last year ranging from research projects to assess the psychological and emotional benefits of living kidney donation to the use of teleconsultation for paediatric neurosciences and the development of a smartphone application to support the training of junior doctors. A number of staff development, arts and cultural projects were also supported, including an innovative performing arts programme which provides

Staff survey

	2010/2011		2009/2010		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
Response Rate	49%	54%	41%	55%	Improvement
Areas of best performance					
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months*	9%	15%	n/a	n/a	Comparison not possible due to change in question format
Percentage of staff feeling valued by their work colleagues	84%	76%	80%	76%	Improvement
Effective team working (average score out of 5)	3.82	3.69	n/a	n/a	New score in 2010
Staff recommendation of the Trust as a place to work or receive treatment (average score out of 5)	3.95	3.52	3.93	3.5	Improvement
Areas of weakest performance					
Percentage of staff experiencing physical violence from staff in the last 12 months*	3%	1%	n/a	n/a	Comparison not possible due to change in question format
Percentage of staff working extra hours*	72%	66%	70%	65%	Deterioration
Percentage of staff using flexible working options	59%	63%	58%	70%	Improvement
Percentage of staff saying hand washing materials are always available	56%	67%	57%	69%	Deterioration

* the lower the score the better

therapeutic benefit to patients and enhances the hospital environment for all. For more information visit www.gsttcharity.org.uk

In 2011 the Charity's fundraising function became part of a new team serving all the organisations within King's Health Partners. The Trust is very grateful for the support of patients and their families, the local community, businesses and individuals who support the hospitals through donations or fundraising activities.



Clinical teams and research staff work closely together to drive medical breakthroughs and develop new treatments

5 Teaching and research and development

As leading teaching hospitals and a major academic centre, Guy's and St Thomas' is committed to developing first-class healthcare professionals and delivering ground-breaking advances in medical treatment for the benefit of our patients.

Teaching

The Trust plays an important role in the clinical education and training of a wide range of health professionals, including doctors, dentists, nurses, allied health professionals and many other laboratory and technical staff who are vital to the delivery of first class health care.

Education and research are central to our responsibilities as leading teaching hospitals and a major academic centre, and underpin our vision for our Academic Health Sciences Centre, King's Health Partners. They are also fundamental to King's Health Partners' role in the Health, Innovation and Education Cluster for South London (HIEC) which aims to deliver high quality patient care through a better trained workforce and the more rapid dissemination of research findings. Our HIEC is focusing on four areas initially: mental health; infection prevention and control; diabetes; and stroke.

During the year, the Trust has strengthened educational leadership by appointing new directors of undergraduate and postgraduate education to ensure that we continue to provide the best possible learning opportunities for the doctors of the future.

The Simulation and Interactive Learning (SaIL) Centre

The Simulation and Interactive Learning (SaIL) Centre at St Thomas' opened in June 2010. The centre provides clinical staff and students with the opportunity to learn using life-sized, high-fidelity manikins to simulate real-life scenarios. The manikins are programmed to

convey typical patient responses, respond to drugs and have measurable blood pressures and pulse rates.

Real clinical incidents are played out and the root causes of situations are analysed. The environment allows students to practise dealing with uncertainty, breaking bad news and end of life decision making in a realistic, but safe environment.

This is the latest addition to the simulation facilities across King's Health Partners and hosts a mock GP consulting room and a home environment, as well as more traditional hospital settings including a six-bedded ward, an operating theatre/2-bedded intensive care ward and a surgical simulation room.

Since opening, over 1,000 undergraduate and postgraduate doctors, nurses and allied health professionals have undertaken training at the SaIL Centre in a wide range of specialties including obstetrics, paediatrics, emergency medicine and general practice. We have also hosted visits from local school children as part of our commitment to widening access to medical careers in the local community.

Undergraduate education

Each year, more than 300 consultants and many administrative and other medical staff make a significant contribution to the education and development of over 800 undergraduate medical students from our academic partner, King's College London.

The Trust continues to engage newly appointed consultants in the education

programme, ensuring they have dedicated time for teaching, hosting students and providing lectures, particularly in the September introductory week and by assessing competency in July's final clinical exams. These staff also support students throughout the academic year, and we are currently developing a programme to recognise and reward consultants who make a significant contribution to undergraduate teaching.

We continue to work closely with our academic partners to recruit and retain nurses we have supported during their training.

We have two unique systems in place at the Trust to monitor undergraduate teaching and to ensure that we deliver well-rounded education experiences for students, including a comprehensive induction programme that encompasses ward-based and bedside teaching; lectures and tutorials; access to specialty clinics; and theatre sessions.

An undergraduate education committee meets bimonthly with representatives from each of the Trust's clinical directorates and from King's College London, to ensure that the quality of teaching and the student experience is continuously scrutinised. In addition, an undergraduate education coordinator sits on a number of College committees to facilitate effective two-way communication between the

hospitals and university. Education leads within each of our clinical directorates also work closely with College colleagues to develop the undergraduate curriculum.

Postgraduate education

In April 2010, the Postgraduate Medical Education Department moved to new facilities within the Education Centre at York Road and this has provided the team and the postgraduate students with improved teaching facilities.

This year, the department was successful in securing £7,500 of funding from the London Deanery for faculty development to run education courses for specialist trainees in their last two years of training before they become consultants. The education and training team is also responsible for delivering a wide range of courses for consultants, junior doctors and other healthcare professionals, including Teaching for Teachers, Clinical Supervision and Education Supervisor courses.

The department's foundation programme team continues to lead successful induction programmes for all incoming junior doctors, which include a robust online induction programme and a number of smaller, specialist inductions throughout the year.

Nursing training

We continue to work closely with our academic partners to recruit and retain nurses we have supported during their training. This year, we have also continued to develop strong mentorship support for undergraduate nurses

to enhance their learning in clinical settings. For example, we have developed robust foundation programmes for newly qualified nurses to ensure that they continue to enjoy the support they need as they enter their first year of clinical practice.

We have introduced clinical assistant practitioners, who are trained at degree level to perform specific practical tasks under the supervision of a registered nurse or doctor. A Band 7 multi-professional leadership course was also introduced across King's Health Partners, bringing together leaders from a variety of professions on a single course, to enhance leadership and team building skills, as well as confidence amongst this important group of front line staff.

A new recruitment strategy has been introduced to enable us to recruit and retain the best nurses, offering exciting opportunities for staff to work across hospital and community settings. The first of these career pathways has been established within elderly care.

Research and development

Our hospitals have a long tradition of making significant medical breakthroughs and developing new treatments. With our university partner, King's College London, we are a major centre for NHS-funded research.

We are one of only five National Institute for Health Research (NIHR) funded comprehensive Biomedical Research Centres. As such, we are committed to driving forward research and innovation which will benefit our local population and

have a positive impact on healthcare nationally and internationally.

Our research and development portfolio is constantly increasing. Almost 350 non-commercial projects involving patients and volunteers were approved during the year, while over 850 active non-commercial research studies have been taking place across the Trust and King's College this year.

We recruited over 17,300 patients into non-commercial clinical trials and other patient-focused studies, making us the most successful Trust in terms of recruitment in the London (South) Comprehensive Local Research Network, which we also host.

Studies taking place across the Trust are diverse, ranging from projects looking at the causes of diseases to the use of robotics in health care, the viability of new treatments and the detailed analysis of patient samples to further understand how various diseases progress. A particular highlight this year, was the first 'in man' study to widen the heart valve of a six year old boy using an MRI scan rather than x-ray imaging. This groundbreaking technique has been developed by a team of clinicians and scientists from across King's Health Partners, led by Professor Reza Razavi.

It is vital that we continue to increase our capacity to undertake research, so that we can continue to expand the opportunities for our patients to take part in and benefit from research. In March 2011, Health Minister Lord Howe opened the King's Health Partners

Experimental Medicine Hub at Guy's. This pioneering collaboration between our hospitals, King's College London, King's College Hospital and South London and Maudsley NHS Foundation Trusts, together with Quintiles, brings an important critical mass of research activity together in one location. With state of the art facilities, we hope that this leading edge research facility will encourage more patients and healthy volunteers to participate in clinical studies.

During the year, a number of successful initiatives have enabled us to increase capacity, including the recruitment of five full-time clinical research fellows and a pool of research nurses to support the studies within the Comprehensive Local Research Network and our Biomedical Research Centre. We continue to award protected time to consultant staff to carry out research and have also introduced a scheme to offer GPs the opportunity to undertake research. This has fostered a new generation of investigative talent and seen the launch of many new studies, with staff publishing over 200 articles in peer-reviewed journals as a direct result of involvement in NIHR funded research.

Biomedical Research Centre

During the year, the highly successful training schemes run by the NIHR-funded comprehensive Biomedical Research Centre continued to flourish, with additional opportunities for consultants, junior doctors, allied health professionals, nurses and midwives and PhD students to secure funding for their work.

Five junior consultants were awarded clinical research consultant posts. This is enabling them to dedicate half their time to research and to establish independent research programmes, while seven

over 500 members who are able to interact, collaborate and access leading edge technologies and facilities, as well as advice and consultancy services in a unique faculty space. The faculty is housed in state-of-the-art accommodation on the 16th floor of Guy's Tower, which is also home to the research and development department, the Joint Clinical Trials Office and the London (South) Comprehensive Local Research Network. This centre is a one-stop-shop for all research related matters, co-located with Guy's clinical research facility and a commercial clinical trials unit run by Quintiles, a leading provider of first-in-man trials.

Members of the faculty and colleagues from our partner organisations come together every month for our Biomedical Forum which allows them to find out about the latest advances in translational medicine. This flagship event has now expanded and audiences and speakers participate across the King's Health Partners, and are also video-linked to Queen Mary University of London and the Karolinska Institute in Sweden.

Clinical research facilities

The new clinical research facility at Guy's opened in June 2010, housing a Good Manufacturing Practice cell therapy unit, enabling researchers to safely control and manage the manufacture and testing of novel cell and protein therapies. This complements the facility at St Thomas' which opened in 2008. Over 80 studies involving patients and healthy volunteers

Over 80 studies involving patients and healthy volunteers have taken place during the year in our clinical research facilities, helping us to find more effective ways to tackle major health problems such as obesity and heart disease.

medical and dental clinical trainees were awarded one year clinical training fellowships, enabling the Biomedical Research Centre to continue its drive to build capacity in translational medicine.

2010/11 saw the first full year of operation of the centre's Faculty of Translational Medicine, which brings together clinicians, scientists, nurses, midwives, allied health professionals and managers in the search for new treatments and diagnostic tests for a wide range of diseases and conditions. The faculty now has

have taken place during the year in our clinical research facilities, helping us to find more effective ways to tackle major health problems such as obesity and heart disease.

The Trust continues to provide learning and development opportunities for staff involved in research. During the year, the Clinical Research Facilities nursing team has established a clinical research nurse and midwife forum and development programme and, in December 2010, they hosted the first open day for these key research staff.

The Trust's clinical research facilities work closely with a number of partners, including commercial partner Quintiles, for whom we hosted their first bronchoscopy study during 2010.

Involving patients

The Trust is committed to undertaking research which involves and benefits our local population. We have worked hard to develop ways for patients, carers and family members, as well as members of the public and representatives from patient and charitable organisations to have their say about the research taking place within our hospitals. One example of this involvement is the recently established Consumer Research Panel for Cancer. Panel members are patients and carers with experience of living with cancer who advise researchers on research design, recruitment to studies and what is important to patients who participate in trials.

In 2010, we launched Café

Research, a quarterly community event at which local people can hear a researcher talk about their work, ask questions and discuss research topics of interest. Events so far have covered subjects as diverse as the future of dentistry and the health implications of taking legal highs. Local secondary school students can also learn more about the science behind research by participating in a one day laboratory based education event, Demonstrating Science, led by trainees from the Biomedical Research Centre.

We are working to demystify the research process for patients and have developed patient information to explain the benefits of taking part in medical research studies. In October, the booklet *Taking part in medical research studies* won the NHS Trust category for best patient information at the British Medical Association Patient Information Awards.

We also provide research staff with a detailed guide, *Developing information materials for research studies* to ensure that information given to patients participating in research is clear and unambiguous. This guide has been made available to all staff throughout King's Health Partners.



By signing pledge cards, thousands of staff renewed their commitment to best practice as part of this year's infection control campaign

6

Quality report

Chief Executive's statement

For me, quality is about making sure that every member of staff at the Trust is equipped to provide excellent care that delivers the best possible outcomes for our patients, whether that is around patient safety, the effectiveness of the treatments we provide, or the individual experience a patient has when using our services.

I hope that this Quality Report demonstrates our real commitment to quality, as well as explains clearly how we have progressed with our priorities to date and shows where we feel we still have work to do. A more comprehensive picture of our approach to quality can be found in the Trust's full Quality Accounts, which are available on our website.

The effort to achieve quality takes place across the Trust throughout the year – not just at reporting time. We try to make quality relevant to all our staff with a vision that means something to everyone, leadership that ensures a focus on quality from 'ward to Board', quality improvement plans, and learning and development opportunities. We are continually working to improve. There is always more to do and the focus on quality helps us to identify and work on the gaps between the level of care we want to provide, and what some of our patients may actually experience.

Both the Board of Directors and Council of Governors are involved in this work, and I can personally assure you that the contents of this Quality Report meet our rigorous data quality standards. We are all committed to continually improving quality within the organisation and look forward to building on our achievements and making progress in areas where we still need to improve.



Ron Kerr, Chief Executive

Our quality priorities for 2011/12

We have combined our hospital and community services priorities for the coming year, choosing 17 areas to focus on which span the three domains of patient safety, clinical effectiveness and patient experience.

The areas we have chosen are priorities for the Trust and areas where we know our performance should be improved. Throughout the year we will report on our progress to the Board of Directors.

To help us choose our priorities, we held two staff workshops and distributed 200 questionnaires to doctors, nurses and therapists across the Trust. The resulting long-list of priorities was used as the basis for discussions with our Council of Governors, Local

Involvement Networks (LINKs), commissioners, Scrutiny Committees and local GPs.

At two public events, we asked local stakeholders, including our commissioners, to add to and rank the long-list in order of priority. This helped the Chief Nurse and Medical Director inform the Board on our priorities, and these were signed off in April 2011.

In each of the three domains we have included at least the top three priorities chosen by our public stakeholders. In some cases we have aligned our priorities with targets that are still under negotiation with our commissioners. This explains why some priorities do not yet have an agreed target.

Patient safety

Our quality priorities and why we chose them	What success will look like	How did our public stakeholders rank this initiative?
Pressure sore reduction Pressure sores are debilitating and largely avoidable injuries which cost the NHS millions of pounds every year. By working together across King's Health Partners we want to considerably reduce avoidable pressure sores for our patients.	<ul style="list-style-type: none"> - Have no avoidable grade 4 pressure sores this year, as these are the most debilitating and can lead to weeks or months of treatment - Also reduce grade 2 and 3 pressure sores by at least 10 per cent in our hospitals and 80 per cent over two years in the community. 	This was ranked number 1
Infection control We have made great progress tackling MRSA infection and want to build on this success by reducing the incidence of <i>C.difficile</i> .	<ul style="list-style-type: none"> - Also reduce <i>C.difficile</i> cases that originate in our acute hospitals to no more than 155 this year. 	This was ranked number 2
Reducing falls Some falls are avoidable. We want to reduce the most serious falls that cause an injury in the community.	<ul style="list-style-type: none"> - Reduce the number of patients who suffer a fracture as a result of a fall in the community by at least 50 per cent in line with our CQUIN target. 	This was ranked number 3
Reducing falls Although the Trust has done a lot of work on falls this year, we want to maintain this momentum and improve communication and collaboration between hospital and community services.	<ul style="list-style-type: none"> - Ensure we maintain at least 95 per cent compliance with our falls policy, which sets standards for reducing falls in the Trust - Establish a joint community/acute falls quality improvement group. 	This was ranked number 3
High risk medicine safety Overall reporting and sharing of learning following a medicines error is good. However, we have identified that our doctors report fewer errors than other staff. We want to improve this by encouraging this critical group of staff to report more. Based on the success of our medicines safety forum, a group that leads the drive for medicines safety and works on a programme of best practice for specific medicines, we want to roll the programme out to include additional high risk medicines.	<ul style="list-style-type: none"> - Increase the number of medical staff reporting medicine related errors by at least 10 per cent - Establish dedicated quality improvement groups for intravenous sedation and allergy medicines - Based on this year's national patient survey, improve satisfaction with the medicines information provided when patients leave hospital by at least three per cent. 	This was ranked number 4
Venous thromboembolism (VTE) VTE (a blood clot) is a major contributor to severe illness or death in the UK, accounting for up to 25,000 deaths a year. We have improved our patient assessment for VTE, and following this we want to ensure that the right patients are on the right treatment at the right time.	<ul style="list-style-type: none"> - Ensure at least 90% of adult inpatients have a documented VTE assessment and appropriate treatment in line with our CQUIN target. 	This was ranked number 5
Childhood immunisations We can improve our current levels of childhood vaccination locally. Poor vaccination levels can lead to an increase in preventable illness, which has a devastating effect on children and families.	<ul style="list-style-type: none"> - Increase the number of children aged five years and under receiving vaccination, in line with our CQUIN targets. 	This was ranked number 6

Our quality priorities for 2011/12

	Community and Hospital
	Hospital
	Community

Clinical efficiency

Our quality priorities and why we chose them	What success will look like	How did our public stakeholders rank this initiative?
Nutrition and hydration We want to get the essentials of nutrition right for all of our patients, all of the time. This priority was ranked number one by our stakeholders and commissioners and is an area where we believe we can, and should, improve our performance.	Conduct a Trustwide review and develop an action plan to ensure that we are at the forefront of best practice when: <ul style="list-style-type: none"> - assessing our patients - assisting them with eating - weighing them appropriately - providing access to snacks 24 hours a day - documenting and communicating care. 	This was ranked number 1
Improve communication between district nurses and GPs As a result of the community/hospital integration, we have already begun significant work to improve communication between our hospital and community teams. Following GP and commissioner feedback, we have changed the focus of this priority to improve communication between district nurses and GPs.	<ul style="list-style-type: none"> - Community teams will confirm receipt of GP referrals - Community teams will communicate with a patient's GP after initial assessment and at discharge in line with our CQUIN targets. 	This was ranked number 2
The Productive Series, also known as 'Releasing Time to Care' This aims to equip teams with methods to improve their environment, systems and processes. It helps clinicians to make decisions about using resources more efficiently. We have had considerable success with the 'Productive Ward' and now want to roll this national improvement scheme out to other areas such as operating theatres and community services.	<ul style="list-style-type: none"> - Roll out the 'Productive Operating Theatre' across selected specialities - Start the 'Productive Community' programme - Both programmes will have bespoke performance measures, such as increasing the number of operations that start on time. 	This was ranked number 3
Establish a dedicated hospital readmissions review group With many changes taking place in health and social care comes the potential risk of increased hospital readmissions. This can be a sign of poor quality care and we want to act early when we see subtle changes in readmission patterns across our specialities.	<ul style="list-style-type: none"> - Identify directorate leads - Review in detail emergency readmission trends across our hospitals, developing local and Trust/community wide action plans where necessary - Embed this process in monthly directorate performance reviews. 	This was ranked number 4
Develop an individual ward accreditation scheme We want to have the safest wards in the NHS. With our governors and other stakeholders we will independently review and score our wards for safety, and patient and staff experience.	<ul style="list-style-type: none"> - Develop an individual ward accreditation scheme based on Care Quality Commission assessment and rankings. 	This was ranked number 5
Increasing new birth visits Picking up issues early, and assisting mothers with newborn babies, is a crucial element of good healthcare in the community. We can improve in this area.	<ul style="list-style-type: none"> - Increase the percentage of new born babies who receive a new birth visit (or attempted visit) between 10 and 14 days after they are born. 	Not included in ranking exercise

Patient experience

Our quality priorities and why we chose them	What success will look like	How did our public stakeholders rank this initiative?
Improving end of life care We can do more to improve care in the community and our hospitals for patients nearing the end of their life. Better communication between hospitals, GPs and district nurses, along with the latest evidence-based care, can have a positive impact on patients and carers.	<ul style="list-style-type: none"> - Increase the number of patients with an advance care plan in place that includes details of their wishes - Increase the number of patients who, following referral to palliative care, are cared for on the Liverpool Care Pathway (national best practice) in the final stages of their illness, in line with our CQUIN targets. 	This was ranked number 1
A renewed focus on dementia care We have done some good work on dementia care in the past 12 months. We want to maintain the momentum and focus on this potentially devastating illness which is becoming increasingly common as the population ages.	<ul style="list-style-type: none"> - Embed the year one Healthcare for London dementia goals, which aim to improve quality of life for people with dementia and their carers - Review and roll out a work plan to deliver the year two goals. 	This was ranked number 2
Improve patient experience responses to the national survey These questions have been chosen by the Department of Health as key areas for all NHS Trusts in England to focus on.	<p>Improve percentage patient satisfaction scores by three per cent on questions covering the following areas:</p> <ul style="list-style-type: none"> - Privacy and dignity - Medicines information - Involvement in care - Information about concerns - Someone to talk to if worried <p>in line with our CQUIN targets.</p>	This was ranked number 3
Improve women's satisfaction with maternity care Our maternity survey results came out after the public engagement on our priorities for 2011/12. However, our results show that we need to improve satisfaction with our maternity service.	<ul style="list-style-type: none"> - Improve patient satisfaction scores across a number of key questions, in line with our CQUIN targets. 	Not included in the ranking exercise
Improve patient information leaflets Following the integration of hospital and community services we could have up to three different types of patient information leaflet. This could be confusing for our patients. We will rapidly review the current position and draw up a plan to standardise patient information leaflets across all our services.	<ul style="list-style-type: none"> - Review current position across Lambeth and Southwark - Update community information leaflets to reflect integration. 	Not included in the ranking exercise

Statements of assurance from the Board

A review of our services

As well as providing care to patients at Guy's and St Thomas', we also provided NHS clinical services in 11 locations outside the Trust estate last year. These were:

- five satellite dialysis units at Camberwell, Lewisham, New Cross, Tunbridge Wells, and Sidcup;
- four chemotherapy day units at Dartford, Sidcup, Bromley, and King's;
- plastic surgery services at Princess Royal University Hospital Bromley and;
- a urology service at Lewisham Hospital.

We continue to regularly review, all the data available on the quality of care for these services. The total income for these activities in 2010/11 was £16.2 million, which represents 1.7 per cent of our total income.

Clinical audits and national confidential enquiries

Last year we undertook 50 national clinical audits and four national confidential enquiries.

By doing so, we participated in 70 per cent of the national clinical audits and 100 per cent of the national confidential enquiries that we were eligible to participate in. There were a small number of national audits that we chose not to undertake for various reasons, for example, because we were performing other audit or research work in that area, or our patient case

mix didn't meet the audit criteria.

The clinical audits and confidential enquiries that we were eligible to participate in, participated in, and for which data was collected last year are listed overleaf, along with the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required.

The Trust's clinical governance department continually reviews the quality of both national and local audit submissions.

The reports of 27 national clinical audits were reviewed last year and the following examples were identified as having improved the quality of our services.

In 2009/10, the Trust was one of the pilot sites for the World Health Organisation's Surgical Site Safety Checklist. This work has continued into 2010/11, with regular observations and monthly feedback sessions. In December 2010, the Trust was made one of only four sites in England to offer extracorporeal membrane oxygenation (ECMO) to the most severely ill flu patients. This allowed us to provide invaluable audit information to the Intensive Care National Audit Research Centre, and other audits, which will help to inform the treatment of patients in future flu outbreaks. We also contribute regularly to the National Joint Registry, where information is collected on all hip, knee and ankle replacements, and the National Sentinel Stroke Audit, which monitors improvements in stroke care services.

Audit played a key role in the Trust's achievement of NHSLA level 3 in June 2010 and this work now

underpins a strong rolling programme of effective monitoring for key patient safety policies throughout the hospitals. Particular attention was given to patient identification, patient transfers, discharge arrangements, falls, safeguarding vulnerable patients and oxygen administration.

All six of these audits are on the Trust-wide forward audit plan which is monitored on a regular basis. Detailed feedback is provided to relevant teams and services. Trust-wide figures are routinely broken down to directorate, specialty and ward level to maximise awareness of the good work that is being undertaken, and of the improvements still to be made.

Last year, the reports of 128 local clinical audits were also reviewed and actions taken to improve the quality of our services. Examples include:

- audits in the genitourinary medicine (GUM) clinic have helped reduce the time a new HIV patient has to wait for their results by an average of seven days;
- allied health professionals now use a simple electronic referral system, which has decreased referral time and cut the amount of paperwork for clinical staff;
- a review of 'front-end' processes has led to a major piece of work to improve the experiences of patients using our hospitals. For example we have improved the telephone service for patients needing to

Quality report

National clinical audits 2010-11

Audit title	Audit source	Compliance with audit terms
1. Peri and neonatal		
Perinatal mortality	Centre for Maternal and Child Enquiries	100%
Neonatal intensive and special care	National Neonatal Audit Programme	100%
2. Children		
Paediatric pneumonia	British Thoracic Society	Did not participate
Paediatric asthma	British Thoracic Society	Did not participate
Paediatric fever	College of Emergency Medicine	Did not participate
Childhood epilepsy	Royal College of Paediatrics and Child Health (RCPCH) National Childhood Epilepsy Audit	March 2011
Paediatric intensive care	Paediatric Intensive Care Audit Network (PICANet)	100%
Paediatric cardiac surgery	National Institute for Clinical Outcome Research (NICOR) Congenital Heart Disease Audit	99%
Diabetes	RCPCH National Paediatric Diabetes Audit	Did not participate
3. Acute care		
Emergency use of oxygen	British Thoracic Society	Did not participate
Adult community-acquired pneumonia	British Thoracic Society	100%
Non-invasive ventilation	British Thoracic Society	100%
Pleural procedures	British Thoracic Society	100%
Cardiac arrest	National Cardiac Arrest Audit	100%
Vital signs in majors	College of Emergency Medicine	Did not participate
Adult critical care	Case Mix Programme	Did not participate
Potential donor audit	NHS Blood and Transplant (NHSBT)	100%
4. Long term conditions		
Diabetes	National Adult Diabetes Audit	100%
Heavy menstrual bleeding	Royal College of Obstetricians and Gynaecologists National Audit of Heavy Menstrual Bleeding	100%
Chronic pain	National Pain Audit	Did not participate
Ulcerative colitis and Crohn's Disease	National Inflammatory Bowel Disease Audit	Awaiting final compliance figure
Parkinson's Disease	National Parkinson's Audit	Did not participate
Chronic Obstructive Pulmonary Disease	British Thoracic Society/European Audit	2013
Adult asthma	British Thoracic Society	Did not participate
Bronchiectasis	British Thoracic Society	Did not participate
5. Elective procedures		
Hip, knee and ankle replacements	National Joint Registry	100%
Elective surgery	National Patient Reported Outcome Measures (PROMs) Programme	100%
Coronary angioplasty	NICOR Adult Cardiac Interventions Audit	100%
Peripheral vascular surgery	Vascular Society of Great Britain and Ireland Vascular Surgery Database	30%
Carotid interventions	Carotid Intervention Audit	50%
Coronary Artery Bypass Surgery (CABG) and valvular surgery	Adult Cardiac Surgery Audit	100%

Audit title	Audit source	Compliance with audit terms
6. Cardiovascular disease		
Familial hypercholesterolaemia	National Clinical Audit of Management of Familial Hypercholesterolaemia	100%
Acute Myocardial Infarction and other Acute Coronary Syndrome	Myocardial Infarction Audit Programme	100%
Heart failure	Heart Failure Audit	100%
Pulmonary hypertension	Pulmonary Hypertension Audit	Awaiting final compliance figure
Acute stroke	Stroke Improvement National Audit Programme	100%
Stroke care	National Sentinel Stroke Audit	100%
7. Renal disease		
Renal replacement therapy	Renal Registry	100%
Renal transplantation	NHSBT UK Transplant Registry	100%
Patient transport	National Kidney Care Audit	100%
Renal colic	College of Emergency Medicine	Did not participate
8. Cancer		
Lung cancer	National Lung Cancer Audit	56%
Bowel cancer	National Bowel Cancer Audit Programme	Did not participate
Head and neck cancer	Data for Head and Neck Oncology	34%
9. Trauma		
Hip fracture	National Hip Fracture Database	100%
Severe trauma	Trauma Audit and Research Network	Did not participate
Falls and non-hip fractures	National Falls and Bone Health Audit	100%
10. Blood transfusion		
O-negative blood use	National Comparative Audit of Blood Transfusion	Did not participate
Platelet use	National Comparative Audit of Blood Transfusion	100%
National Confidential Enquiries		
NCEPOD Enquiries:		
• Surgery in Children Study	100%	
• Peri-Operative Care Study	100%	
• Cardiac Arrest Procedures Study	100%	
Confidential Enquiry into Maternal and Child Health (CEMACH) (Peri-Operative Care Study)		

change their appointments and reduced waiting times in clinics. We recognise we have more to do;

- the process of launching and promoting evidence-based clinical guidelines has been streamlined, making it easier for clinical staff to amend, review and update guidelines;
- a new guidelines database has been established to allow doctors and nurses to rapidly access the most up to date clinical information directly from computers on every ward, as close to where they are delivering patient care as possible;

We have improved the telephone service for patients needing to change their appointment.

- The Trust's Simulation Centre uses simulated scenarios based upon real life incidents and outputs from safety audits to help clinical teams to improve their response;
- Root Cause Analysis training is enabling staff to rapidly review, learn and share Trust-wide actions should a mistake occur;
- we have started to roll out specialist communication training and de-escalation training to help staff manage challenging situations;

- we have a rolling clinical programme of re-audit and follow-up. Topics include: blood transfusion, compliance with our falls policy, the quality of medicines prescribing and administration, patient identification and use of oxygen therapy;
- in light of the Human Tissue Act, we have also reviewed our consent procedure for the donation and transplantation of organs.

Clinical research

Last year 17,300 patients were recruited to participate in research studies approved by a research ethics committee (NRES).

CQUIN targets

In 2010/11, 1.5 per cent of Trust income was dependent upon achieving quality improvement and innovation goals agreed with Lambeth, Southwark and Lewisham Primary Care Trusts through the CQUIN payment framework. This equated to around £10 million last year. At the end of the year, the Trust was set to receive over 90 per cent of this figure.

In 2011/12, 1.5 per cent of Trust income is again conditional on achieving similar goals negotiated with our commissioners. Further details are available online at www.monitor-nhsft.gov.uk.

Care Quality Commission

We are required to register with the CQC and our current registration status is 'registered without conditions or restrictions'. The CQC

did not take any enforcement action against the Trust and we did not participate in any special reviews by the CQC during the year.

Data quality

The Trust submitted records to the Secondary Users Service (SUS) for inclusion in the Hospital Episode Statistics (HES). The percentage of records in the published data which included the patient's valid NHS number was 96.3 per cent for admitted patients, 96.3 per cent for outpatients, and 76.1 per cent for accident and emergency patients. This included the patient's valid General Practitioner Registration Code for 98.1 per cent of admitted patients, 94.7 per cent of outpatients and 89.1 per cent of accident and emergency patients.

This year, our Information Governance Assessment Report overall score was 80 per cent. We did not achieve one of the forty-five requirements and, using the new scoring system, the Trust received a 'not satisfactory' rating. We are working hard to correct the area where we were not compliant and will be taking actions to improve data quality, including compulsory staff training on information governance, regular data quality audits, clinical audits of case note quality and establishing an NHS number quality improvement project group.

We were subject to the Payment by Results clinical coding audit by the Audit Commission. The error rate reported in the latest published audit for diagnoses and treatment coding (clinical coding) was nine per cent. This is a two per

cent improvement on the same audit last year. The services audited this year were general medicine, maternity care, thoracic disorders and procedures, and gynaecological malignancies. Because of the nature of the sampling, the results should not be extrapolated further than the actual sample audited.

Our progress against 2010/11 priorities

The process of consultation to select our priorities began in summer 2009 and involved governors and staff, feedback from outside the Trust, particularly from our Local Involvement Networks (LiNs) and commissioners, as well as discussions with one of our local elderly residents' associations. We also used more traditional methods to gather intelligence such as NHS Litigation Authority audits, national drivers such as performance on blood clot prevention, and patient feedback and complaints.

We are pleased that of 15 priorities set, we have fully achieved ten and partially achieved one (infection).

Although we are disappointed with our responses against four out of the five nationally chosen patient experience questions, it is important to recognise that our overall position in the national patient survey remains favourable, and represents an improvement on our position last year. We continue to work hard across the Trust to improve the experience of our patients.

Information about performance against national and core quality standards can be found in the

operational and financial review on page 13 or in more detail in the Trust's full Quality Accounts, which are available on the Trust's website at www.guysandstthomas.nhs.uk, or the NHS Choices website at www.nhs.uk. Alternatively, please contact the Trust's communications department – see page 101 for details.

Summary of our 2010-11 quality achievements

Patient safety

Quality indicator	We said we would...	How did we do?
Screen adult inpatients for venous-thromboembolism (VTE).	Establish a new system to ensure that at least 90 per cent of our inpatients receive an assessment by March 2011, in accordance with NICE guidance.	We achieved this and screened more than 90 per cent of inpatients at year end. We implemented a Trustwide education programme for junior doctors, and were one of the first Trusts in the UK to develop a bespoke online assessment tool for ward staff.
Review unexpected deaths across our hospitals by using the <i>Global Trigger Assessment Tool</i> .	In addition to the current 100 per cent review of all patients who die unexpectedly, introduce a review by an independent team who will, in the first year, be capable of reviewing at least 75 per cent of all unexpected deaths at the Trust.	We achieved this, and exceeded the separate CQUIN target by over 30 per cent.
Reduce the number of MRSA blood infections and <i>C.difficile</i> episodes at our hospitals.	Aim not to exceed nine cases of Trust-attributable MRSA bacteraemias and to have no more than 91 cases of <i>C.difficile</i> in 2010/11.	Partially achieved. We achieved the MRSA target and had just four cases in the year. We were the only acute Trust in London to achieve this target. We did not achieve our <i>C.difficile</i> target and had 118 cases in the year. This was due to the introduction of a new, more sensitive test during the year. <i>Further information can be found in the Trust's full Quality Accounts.</i>
Reduce the number of patients who come to harm following a fall.	Increase compliance with the Falls Policy from 85 to 95 per cent and reduce the number of falls that result in harm by 10 per cent.	We achieved this and reduced the number of fractures in the last six months of the year by 19 per cent compared to the first six months. We maintained 95 per cent compliance with the Falls Policy.
Expand our successful 2009-10 Quality Accounts Medicine Safety Programme to include high risk medicines, strong opiates (strong analgesics like morphine) and insulin (a medicine for reducing blood sugar).	Establish high-level multi-professional groups to benchmark our current performance. Implement the recommendations of these groups and where appropriate set targets for reducing harm from these medicines.	We achieved this and while reporting of incidents remained high, we did not see an increase in harm events associated with these medicines in the year. We established quality improvement groups for both programmes who reviewed practice and launched high profile communications initiatives.

Patient experience

Quality indicator	We said we would...	How did we do?
Question 1 Were you as involved as much as you wanted to be in decisions about your care?	Achieve 74.2 per cent based on the national inpatient postal survey.	We did not achieve this and scored 70.2 per cent. Score last year: 74 per cent.
Question 2 Did you find someone to talk to about worries and fears?	Achieve 62.4 per cent based on the national inpatient postal survey.	We did not achieve this and scored 56.9 per cent. Score last year: 59 per cent.
Question 3 Were you given enough privacy when discussing your condition or treatment?	Achieve 83.1 per cent based on the national inpatient postal survey.	We did not achieve this and scored 81.1 per cent. Score last year: 81 per cent.
Question 4 Were you told about the side effects to watch out for when you went home?	Achieve 53.3 per cent based on the national inpatient postal survey.	We did not achieve this and scored 45.1 per cent. Score last year: 47 per cent.
Question 5 Were you told who to contact if you were worried about your condition after you left hospital?	Achieve 73.6 per cent based on the national inpatient postal survey.	We achieved this and exceeded the target, scoring 74 per cent. Score last year: 71 per cent.

Summary of our 2010-11 quality achievements

Clinical effectiveness

Quality indicator	We said we would...	How did we do?
Improve the discharge care of our older and more vulnerable patients	Perform a thorough and independent review of older people's nursing care, including discharge. Establish an older persons discharge group to ensure that the highest standards are maintained at all times. We will monitor progress through patient feedback, PALs and complaints.	We achieved this. Our external independent review reported to the Trust Board in the summer of 2010 and providing the best possible care for older people remains a Trust priority. Our discharge group is well established and highlights areas for quality improvement to senior staff.
Establish a Trustwide Clinical Outcomes Group	Establish a Clinical Outcomes Group, chaired by an Associate Medical Director who oversees mortality trends in detail across the Trust. The group will highlight any issues or concerns at the earliest opportunity and report to the Medical Director/Chief Nurse. The group will report to the Trust Clinical Governance Committee and to the Board via the Quarterly Patient Quality and Safety Report.	We achieved this. This group is now well established and consists of senior respected clinicians from across the Trust. This independent group raises alerts to clinical directors based on any subtle changes in mortality trends and commissions reviews based on Care Quality Commission or Dr Foster alerts.
Develop ward level quality and safety information	Develop new ward level safety and quality information which aims to provide frontline staff with the tools they need to drive quality and patient safety and to enhance our patients' experience where it matters most – on the ward and in the outpatient department.	We achieved this. Ward-level scorecards went live in late 2010 and are now embedded in the performance monitoring of wards and directorates in the Trust.
Roll out <i>Releasing Time to Care</i>	Roll out this comprehensive programme to all eligible wards by March 2011. Establish a monitoring system to review progress and the time freed up for nurses to spend on direct care.	We achieved this, as part of our CQUIN target. Based on this success we are rolling out the programme to our operating theatres and the community.
Implement the year one goals in the Healthcare for London Dementia Care Pathway	Implement the year one goals for the London Dementia Care Pathway. These include: <ul style="list-style-type: none"> identifying a dedicated lead at consultant physician level implementing training and induction packages for staff in high-risk areas implementing a patient assessment tool. 	We achieved this. Amongst the achievements are a dedicated named dementia consultant and specialist nurse, and a training package for high-risk areas. We have greatly enhanced the collaboration between hospital and community dementia services.

Annex: 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 2010 to prepare Quality Accounts for each financial year.

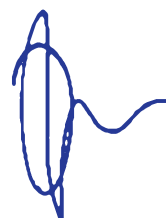
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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 2010-11;
- 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 2010 to June 2011
 - Papers relating to quality reported to the Board over the period April 2010 to June 2011
 - Feedback from the commissioners dated 19/05/2011
 - Feedback from governors dated 11 and 15/05/2011
- Feedback from Lambeth LINKs dated 16/05/2011
- Feedback from Southwark LINKs dated 12/05/2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 19/05/2011;
- The latest national patient survey 21/04/2011
- The latest national staff survey 03/2011
- The Head of Internal Audit's annual opinion over the trust's control environment dated 04/2011
- CQC quality and risk profiles dated 06/04/2011;
- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual).

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



Ron Kerr

Chief Executive

On behalf of the Board of Directors
June 3 2011

Independent Auditor's 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 Board of Governors of Guy's and St Thomas' NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Guy's and St Thomas' NHS Foundation Trust's Quality Report for the year ended March 31 2011 (the "Quality Report").

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 March 31 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. 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 save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we become aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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 content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual* or is inconsistent with the documents.

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

- Board minutes for the period April 2010 to June 2011
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011
- Feedback from the Commissioners dated 19/05/2011
- Feedback from Governors received in April 2011
- Feedback from LINKS received in April and May 2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for 2010/11
- The national patient survey for 2010/11
- The national staff survey for 2010/11
- The Head of Internal Audit's annual opinion over the Trust's control environment for 2010/11
- CQC quality and risk profiles for 2010/11.

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

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:

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and

- Reading the documents.

A limited assurance engagement is less 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

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended March 31 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.



Deloitte LLP

Chartered Accountants
St Albans

June 3 2011

Feedback on our 2011/12 Quality Accounts

Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees

This section contains the actual feedback on an earlier Quality Accounts draft from our local Scrutiny Committees, Commissioners and LINKs.

Southwark LINK response

1. Acknowledgment of LINK involvement

LINK Southwark would like to thank Guy's and St Thomas' Hospital Foundation Trust (GSTFT) for inviting the LINK to the two Stakeholder Events in November 2010 and January 2011. We can confirm that via year long engagement with GSTFT regarding other areas of work including the QA that the organisation is committed to improving quality.

2. Data provided in the Quality Account

The LINK realises that the production of a Quality Account takes much time and effort from a wide range of people working within GSTFT and externally. Having engaged and worked with GSTFT, we believe the information contained within the QA accounts to be accurate.

However, LINK Members did comment on the fact that substantial data was missing from the draft report. Several pieces of data, information and policy decisions on specific targets were yet to be confirmed which made it difficult for the LINK to be fully informed and ascertain its accuracy, as our role as an independent monitoring and scrutiny body.

It is noted that statistics without a context, i.e. a comparison from last year's targets or relative to something, are commonly referred to throughout the report. Use of statistics in an abstract way will not allow us to be fully informed of its impact or meaning, diminishing the use and appreciation of these statistics in this context.

3. Format of Quality Accounts

As the Department of Health has stated that QAs are public facing documents, LINK Southwark recommends that the report should be produced in different formats including a brief "easy-to-read" booklet which

summarises the contents of the larger QA. This would increase the readership accessibility to all local residents.

4. Quality Account priorities 2011-12

The LINK would like to state that it agrees with the priorities and would like to make the following comments:

- Staff involvement and training is essential when increasing patient safety and we assume/hope that there are mechanisms and procedures in place that will reflect this as a top priority. While this is not mentioned in the QA, perhaps this could be a future consideration.
- We appreciate the focus on improving patient satisfaction regarding medical information provided to the patients, however we would like clarification as to how you intend to carry this out.

5. Previous Targets 2010-2011 / additional comments

- a) We would welcome the GSTFT taking part in the Royal College of Paediatrics and Child Health (RCPH) National Paediatric Diabetes Audit especially in light of the presence of the Diabetes Modernisation Initiative in Lambeth and Southwark.
- b) From data collected by the LINK, discharge issues with coordinated community follow-up are of local concern. Patients who have been discharged from hospital sometimes find it difficult to liaise with Adult Social Care at the London Borough of Southwark. The LINK would welcome that this issue undergo a system review in collaboration with LINKs and other service-user groups.
- c) We appreciate the shift towards community services/hospital integration to streamline patient care pathways, however strict monitoring is needed during the integration process to ensure that existing high standards that have been achieved (or recently achieved), in certain areas (i.e. Safeguarding), do not decrease. As well as increasing efforts to work at streamlining integration that will have an impact, especially on cancer targets, partly attributed to referrals delays between GPs and Trusts.

Note: GSTFT has involved the LINK in the Community Services Stakeholder Reference Group.

d) From data collected by LINK, issues have been raised repeatedly by staff and patients on the 'muddles' and 'delays' over appointments, notes or letters being on the wrong site/obtainable. We welcome the review on front end services that should improve these frontline services, and look forward to seeing the effects of these.

Lambeth LINK response

1. Improved involvement of LINK and joint work with governors

Lambeth LINK would like to thank Guy's and St Thomas' Hospital Foundation Trust (GSTFT) for inviting the LINK to the Stakeholder Events in November 2010 and January 2011.

These were useful events, where we were given more detailed information about comparative performance than in the previous year, and it is clear that there is an ongoing commitment to improving quality.

We would like this improvement and increased information sharing to continue and build in the forthcoming year too.

2. Data provided in the Quality Account

The LINK realises that the production of a Quality Account takes much time and effort from a wide range of people working within GSTFT and externally. However, LINK Members in both Lambeth and Southwark commented on the fact that some data was very thorough and well presented, while other substantial data was missing from the consultation report which made it difficult for the LINK to carry out its role as an independent monitoring and scrutiny body.

We do also point out that the datasets submitted are not audited. The LINK would like more substantial data on outpatient areas.

We appreciate the listing this year of clinical audits to which the Trust did not submit data. It is an improvement to include enough information to allow these to be identified.

3. Format of Quality Accounts

As the Department of Health has stated that QAs are public facing documents, LINK Lambeth recommends that some of the narrative could be prepared in a more accessible format, and the opportunity could be taken to align these to include information which includes equalities targets.

4. Quality Account priorities 2011-12

The LINK would like to state that it was involved in the priority setting process, and agrees with the priorities set out.

5. Additional comments

- a) GSTFT should plan to take part in the National Paediatric Diabetes Audit and other paediatric audits in future years.
- b) Discharge from hospital remains an area of concern for Lambeth LINK and we would hope to see improvements in this area due to the integration of community services.
- c) We would recommend that there is quality monitoring of community services to ensure that standards are maintained or improved following integration,
- d) There are basic issues over outpatient appointments, waiting times and telephone problems, together with problems with notes not being available across sites, which we would wish to see addressed in future years.

Lambeth Overview and Scrutiny Committee response

Thank you for inviting Lambeth Council's Health and Adult Services Scrutiny Sub Committee to provide a statement on the (draft) Guy's and St Thomas' Quality Account 2010/11. Unfortunately the timeline for submission of comments has meant that the committee has not been able to formally consider the QA. However the committee was represented at one of the stakeholder events and welcomed the opportunity to participate in discussions and appreciates the effort the trust has made to engage on the development of the QA this year.

As a general point the committee would wish to emphasise the importance of early and ongoing public engagement if scrutiny and other stakeholders are to have real influence about service priorities and the design and delivery of services

Elaine Carter

Lead Scrutiny Officer

London Borough of Lambeth

NHS South East London response

The draft Guy's and St Thomas' Hospitals NHS Foundation Trust (GSTT) Quality Report 2010/11 was reviewed by a number of local commissioning stakeholders, including representatives from NHS Lambeth, NHS Southwark and NHS SE London. The coordination of feedback has been undertaken by NHS SE London, which welcomes the opportunity to respond to this document.

Local commissioning organisations have excellent relationships with GSTT and are committed to working closely to ensure the ongoing delivery of high quality services. NHS SE London has processes for regularly reviewing quality issues with GSTT, via regular Clinical Review Meetings (GSTT 'Quality' meetings), as well as a number of other quality review mechanisms.

NHS SE London believes the content of this draft document is accurate. The document clearly sets out how the Trust prioritised its key delivery areas and this includes good stakeholder engagement.

GSTT has made good progress against last years' targets and quality priorities and is to be congratulated on progress, particularly in the area of MRSA infections and screening for blood clots, which are national priorities. Accident and Emergency and 18-week targets were — and continue to be — particularly challenging. The implementation of action plans is ongoing.

The Trust is to be commended for clearly identifying priorities for both the acute and community services and the integration of Lambeth and Southwark community and acute services from April 2011 will support delivery. Trust plans for 2011/12 include areas of concern to commissioners including End of Life Care, falls and pressure ulcer reduction and we would strongly support this plan.

Jane Fryer

Medical Director

NHS Sout East London



Our monthly CARE awards enable us to acknowledge and thank outstanding staff from all parts of the organisation

7 Our organisational structure

Our governors continue to play an active and important part in the work of the Trust. We are also fortunate to benefit from a strong Board of Directors, whose wide-ranging experience underpins our continuing success.

Council of Governors

The Council of Governors (our equivalent of the Board of Governors described in Foundation Trust legislation) advises us on how best to meet the needs of our patients and wider communities.

It has a number of statutory duties, including appointing the Chairman and Non-Executive Directors, deciding on their remuneration and ratifying the appointment of the Chief Executive. The Council of Governors also receives the Trust's Annual Report and Accounts, and the Auditor's Report, and this year agreed the appointment of our external auditor.

The patient, public and staff members of the Council are elected from and by the Foundation Trust membership to serve for three years. Elections have taken place this year. Some of the organisations we work most closely with nominate a stakeholder governor. See the following page for a full list of who's who.

Constitution

During 2010/11 the Council of Governors made a change to our Foundation Trust Constitution to create an additional staff constituency for members of the newly created community services directorates.

Our Constitution is on the website of our regulator, Monitor: www.monitor-nhsft.gov.uk

Working groups

The Council of Governors has three working groups which met outside the formal meetings of the full Council to focus on specific issues. They were:

Service strategy – contributing to the Trust's strategy, including service developments. This year the group took a particular interest in community services integration, the national *Safe and Sustainable Review of Children's Congenital Cardiac Services* and the ongoing development of King's Health Partners.

Patient experience – reviewing the results of the annual postal survey of inpatients and the quarterly patient experience telephone surveys. The group was involved in the patient environment action team inspections to help assess and improve the hospital environment and advised on inpatients' menus.

Membership development, involvement and communications – improving communications and increasing members' involvement, as well as supporting recruitment from under-represented groups.

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 it has successfully nominated a single candidate to the full Council of Governors for the post of Chairman, and the Trust is delighted to have secured a candidate of the exceptional calibre of Sir Hugh Taylor.

The committee has also recommended a freeze on non-executive director's remuneration until 2012.

Membership and attendance

Name	Actual/possible
Mrs Pauline Anderson	3/3
Prof Judith Ellis	1/1
Mrs Dawn Hill	1/1
Ms Madeliene Long	2/2
Dr David Treacher	3/3
Ms Jane Wardle	2/2

Our membership

The Trust 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 or 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 18,059 members, of whom 3,493 are patient members, 4,347 are public members and 10,219 are staff members. We aim for a membership that represents the diverse communities we serve. However recent analysis shows that during 2011/12 we still have further work to do to ensure our membership is fully representative.

Members receive regular mailings and are invited to events including our Annual Public Meeting, Council of Governors' meetings and other events such as our regular health seminars. The seminars are extremely popular, and recent topics include healthy hearts and speech and hearing.

We are keen to hear members' views. Members wishing to get in touch with governors or executive directors, or anyone wanting to know more about membership, should contact:

Membership Office

Ground Floor, West Wing
Guy's Hospital
Great Maze Pond
London SE1 9RT

Tel: 020 7188 0012

Email: members@gstt.nhs.uk

Board of Directors

Our Board of Directors is made up of our Chairman, Sir Hugh Taylor, six other Non-Executive Directors and seven Executive Board Directors, including the Chief Executive, Sir Ron Kerr. 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 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 all the Non-Executive Directors are independent in character, and there are no relationships or circumstances which are likely to affect, or could appear to

Council of Governors

Patient governors	Elected from	Actual/possible attendance
Mr Michael Craft	July 1 2009	3/5
Ms Susan Hardy	Feb 1 2008	2/2
Ms Dawn Hill	July 1 2009	4/5
Mr Brian Lymbery	July 1 2009	4/5
Mr Jeremy Marsh	July 1 2009	4/5
Dr John Mathews	July 1 2007	2/2
Ms Niamh O'Sullivan	July 1 2007	4/5
Mr John Taylor	July 1 2007	2/2
Sir Richard Thompson	July 1 2007	3/5
Ms Jane Wardle	July 1 2009	4/5
Mrs Paula Young	July 1 2010	3/3

Staff governors	Constituency	Elected from	Actual/possible attendance
Ms Liz Dunn	Nursing and midwifery	July 1 2009	3/5
Mrs Margaret Evison	Other health professionals	July 1 2009	1/5
Mrs Mia Hilborn	Other	July 1 2010	3/3
Mr Brian Johnson	Other	July 1 2009	5/5
Mr Shamim Khan	Medical and dental practitioners	July 1 2009	2/5
Ms Jacky Lewis	Other	July 1 2007	2/2
Dr David Treacher	Medical and dental practitioners	July 1 2009	4/5

Public governors	Elected from	Actual/possible attendance
Mrs Pauline Anderson	July 1 2009	5/5
Mrs Jean Bates	July 1 2009	3/5
Miss Susan Brooks	July 1 2007	1/2
Mrs Jenny Cobley	July 1 2007	5/5
Mr Edward Heckels*	January 1 2011	1/1
Mrs Wendy Mathews	July 1 2007	2/2
Mrs Patricia Prendergast	July 1 2010	3/3
Mrs Victoria Silvester	July 1 2009	4/5
Cllr Peter Truesdale	July 1 2007	4/5
Mr Philip Turner	July 1 2009	1/4
Mr Simon Wallace	July 1 2009	5/5

*Mr Edward Heckels replaced a previous governor mid-term and will therefore serve until July 1 2012.

Stakeholder governors	Organisation	Actual/possible attendance
Dora Dixon-Fyle	Southwark Council	1/3
Professor Judith Ellis	London South Bank University	3/5
Mr Robert Foster	King's College Hospital	1/2
Ms Sue Gallagher	Lambeth PCT	1/1
Ms Caroline Hewitt	Lambeth PCT	3/4
Professor Denise Lievesley	King's College London	4/5
Ms Madeliene Long	South London and the Maudsley	2/5
Mr Michael Parker	King's College Hospital	2/3
Dr Neeraj Patil	Lambeth Council	0/1
Cllr Jane Pickard	Lambeth Council	2/4
Cllr Nick Stanton	Southwark Council	0/1
Mr Stephen Webb	NHS London	0/5
Ms Susanna White	Southwark PCT	3/5
Mr Martin Wilkinson	Lewisham PCT	0/5

To view the register of interests of our Council of Governors, please contact:
 Head of Corporate Affairs
 Gassiot House
 St Thomas' Hospital
 Westminster Bridge Road
 London SE1 7EH
 Tel: 020 7188 0007

Our organisational structure

affect, their judgment. We therefore have not appointed a senior independent director. Rory Maw, Chief Financial Officer of Bridges Community Ventures, has been Vice Chairman since May 2009.

In September 2010, around 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 and had an opportunity to meet and ask questions of the Board of Directors and the Council of Governors.

Audit Committee

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

It 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 meeting in December, the Council of Governors accepted the Board of Directors' recommendation that, following a re-tendering exercise, Deloitte LLP be reappointed as the Trust's external auditors from 2010-2013.

At its meeting in May 2011, the Committee reviewed the draft Annual Accounts and approved their submission to the auditors. During the year, the Committee also reviewed the Trust's Annual Plan and its Quality Accounts, and received reports on a number of topics including community services integration and matters relating to King's Health Partners.

Board meeting attendance	
Name	Actual/possible
Ian Abbs	3/3
Edward Baker	4/4
David Dean	11/11
Diana Hamilton-Fairley	3/4
Mike Franklin	8/11
Ron Kerr	11/11
Ann Macintyre	9/11
Rory Maw	11/11
Steve McGuire	10/11
Patricia Moberly	9/9
Frank Nestle	9/11
Jan Oliver	10/11
Hugh Risebrow	10/11
Martin Shaw	11/11
Eileen Sills	10/11
Diane Summers	11/11
Hugh Taylor	2/2

Committee	Membership
Assurance & Risk	Mike Franklin (Chair) Ian Abbs (from 1 Jan '11) Edward Baker (to 31 Aug '10), David Dean, Diana Hamilton-Fairley (10 Jan to 31 Dec '10) Ron Kerr, Steve McGuire Jan Oliver, Eileen Sills
Audit	David Dean (Chair) Rory Maw Diane Summers
Finance & Investment	Rory Maw (Chair) David Dean, Ron Kerr Steve McGuire Frank Nestle Hugh Risebrow Martin Shaw Diane Summers
Workforce	Jan Oliver (Chair) Mike Franklin Ron Kerr Ann Macintyre Steve McGuire Eileen Sills Diane Summers
Remuneration	Patricia Moberly (Chair to 31 Jan '11) Hugh Taylor (from 12 Feb 11) All Non-Executive Directors

Audit Committee attendance

Name	Actual/possible
David Dean (Chair)	4/4
Rory Maw	4/4
Diane Summers	4/4

Remuneration Committee

The Remuneration Committee decides the pay and allowances, and other terms and conditions, of the Executive Directors.

Working with the Council of Governors

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

Governors may attend Board Meetings and they present a formal report of the activities of the Council and its working groups, while Board members do the same at Council of Governors' meetings.

Meetings of the Council of Governors' working groups are also attended by a Non-Executive and Executive Director of the Board.

Remuneration Committee attendance

Name	Actual/possible
Patricia Moberly (Chair)	2/2
David Dean	2/2
Mike Franklin	2/2
Rory Maw	2/2
Frank Nestle	1/2
Jan Oliver	1/2
Diane Summers	2/2

Trust Management Executive

The membership of the Trust's Management Executive brings together Executive Board Directors, Trust Directors, Clinical Directors and other senior managers. Its role is to:

- monitor the management of risk and agree any action plans or resources;
- contribute to the development of our service strategy;
- review and agree detailed business plans and performance contracts;
- monitor the delivery of our service activity and financial objectives;
- agree policies and procedures to ensure the delivery of external and internal governance;
- develop and monitor the implementation of plans to improve the efficiency, effectiveness and quality of our services.

The Management Executive has the following sub-committees:

- Capital Investment;
- Clinical Governance and Risk Management;
- Clinical Programme Board;
- General Managers' Group;
- Medical Workforce;
- Research and Development.

Board of Directors – Executive Directors



Sir Ron Kerr CBE

Chief Executive

Ron Kerr took up the position of Chief Executive in October 2007. He brings a wealth of experience from his extremely successful and wide-ranging NHS career, including roles at a local, regional and national level. He was most recently the Chief Executive of United Bristol Healthcare NHS Trust.

Previous roles include Director of Operations for the NHS Executive, Regional Director for North Thames Regional Office, and Chief Executive of the South East London Commissioning Agency. His early career also included work at several central London teaching hospitals and, prior to moving to Bristol, he was Chief Executive of the National Care Standards Commission. He is currently chair of the Association of UK University Hospitals.

We are delighted that he was recognised with a Knighthood in the 2011 New Year's honours.



Dr Ian Abbs

Medical Director

Ian Abbs became Medical Director on 1st January 2011. 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.

More recently, in addition to his clinical work, Ian has played a key role in the development of Clinical Academic Groups – the management units of King's Health Partners – and was closely involved in our bid to integrate with community services in Lambeth and Southwark. For much of 2010, he was seconded to Barking, Havering and Redbridge Hospitals, where he was the Trust's Medical Director.



Ann Macintyre

Director of Workforce

Ann Macintyre came to the Trust from Barts and The London NHS Trust, where she was Director of Human Resources.

She has over 30 years of NHS experience working at national, regional and local level. Ann is the current joint Chair of the national JCC (seniors), which is the negotiating committee for consultant medical staff in England. She is also a member of the national and regional Social Partnership Forums working with Health Ministers and Trade Unions on workforce policy implementation. Ann is also a member of the Department of Health's revalidation delivery board.



Steve McGuire

Director of Capital, Estates and Facilities Management

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

Steve joined the NHS in 1992 and has been Director of Facilities at both Leeds Health Authority and St James and Seacroft NHS Teaching Trust. Previously Steve worked for the British Coal Corporation where he held a variety of posts. He is a Chartered Engineer. Steve represents the Trust on the South Bank Employers Group.



Hugh Risebrow

Commercial Director

Hugh Risebrow joined the Trust in October 2009 from Interhealth Canada (UK) where he was Chief Executive. He has held leadership positions with United Health Europe, BUPA and Aid-Call plc. He also spent two years with the NHS Modernisation Agency.

Hugh's early career was in strategic consultancy with Bain & Co and he holds an engineering degree from Cambridge University. Until he joined the Trust, he chaired the CBI's health panel and was a member of the CBI's public services strategy board.



Martin Shaw

Director of Finance

Martin Shaw 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 there until 1993 when he joined Guy's and St Thomas' as Business and Financial Planning Manager, before becoming Strategy Director and Projects Director. Since 1998, he has been Finance Director of the Trust.

Martin chairs the Healthcare Financial Management Association's Finance Directors' Group and is a member of the Foundation Trust Network's Finance Directors' Group.



Eileen Sills CBE

Chief Nurse and Director of Infection Prevention and Control

Eileen Sills 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 holds two visiting professorships, at King's College London and London South Bank Universities. She is a member of the NHS Employers policy board, a trustee of the Burdett Trust for Nursing, and advised Gordon Brown as a member of his Commission on the Future of Nursing and Midwifery. She was awarded a CBE in 2003 for services to nursing.

Dr Edward Baker

Medical Director

Ted Baker was Medical Director from 2003 to September 2010. He is a consultant paediatric cardiologist and was a senior lecturer at King's College London. He held a number of Trust positions, including Clinical Director of Children's Services.

Board of Directors – Non-Executive Directors



Sir Hugh Taylor

Chairman

Sir Hugh was appointed as Chairman of Guy's and St Thomas' in February 2011. He has a long and distinguished career in the civil service which has 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.



David Dean

Non-Executive Director

David Dean enjoyed a long and successful career in investment banking, working for Nomura International in London and Hong Kong, and New Japan Securities Europe, with extensive experience in corporate finance and capital markets. He is a part-time concert pianist and Licentiate of the Royal Schools of Music. He has lived in Dulwich for 17 years and is a Trustee and organiser of the Dulwich Festival.

David joined the Board in June 2007 and chairs the Audit Committee.



Mike Franklin

Non-Executive Director

Mike Franklin is a Commissioner and board member of the National Independent Police Complaints Commission. He was previously a member of the TUC race relations committee and a member of the Metropolitan Police Service Independent Advisory Group set up following the Stephen Lawrence Inquiry.

He has extensive legal experience, as an employment specialist in both the statutory and voluntary sector. He has a long association with Lambeth, as former Chairman of the Community Police Consultative Group for Lambeth (CPCG) and Vice Chair of the Brixton Circle Projects Mental Health organisation.

Mike joined the Board in November 2007 and chairs the Assurance and Risk Committee.



Rory Maw

Non-Executive Director and Vice Chairman

Rory Maw is Chief Financial Officer of Bridges Ventures, a venture capital firm which delivers positive social and environmental impacts as well as financial return for investors.

He read economics at Trinity College, Cambridge before qualifying as a Chartered Accountant and joined Schroders' Investment Banking division in 1989. In 2000 he moved to Morgan Stanley, becoming Head of its European Consumer Products Group.

Rory joined the Board in March 2005 and was reappointed in March 2009. He was appointed Vice Chairman in May 2009 and also chairs the Finance and Investment Committee.



Professor Frank Nestle

Non-Executive Director

Professor Frank Nestle holds the Mary Dunhill Chair of Cutaneous Medicine and Immunotherapy at St John's Institute of Dermatology, King's College London. He is Director of the Clinical Research Facilities, which form part of our comprehensive Biomedical Research Centre.

His academic interests focus on common skin diseases, such as psoriasis and melanoma, and the development of novel therapies. Frank joined the Board in May 2009.



Jan Oliver

Non-Executive Director

Jan Oliver has considerable experience in Equality and Human Rights. Her previous roles include Diversity Manager at the BBC and Chair of the Black and Asian Forum. She was also a Trustee of the Stephen Lawrence Charitable Trust and worked as a coach and mentor at Imperial College London.

Jan now works for Fanon Southside Partnership providing recovery focused services for people with complex mental health needs.

Jan joined the Board in January 2004 and was reappointed in 2007. She chairs the Personnel and Workforce Committee.



Diane Summers

Non-Executive Director

Diane is a former managing editor of the Financial Times, where she worked for 19 years as a writer, editor and executive. Her experience before that spanned the voluntary and private sectors and included senior positions at the consumers' organisation Which? and the homelessness charity Shelter.

Since 2006, Diane has been a freelance writer, editor and consultant. She is a trustee of The Guinness Partnership, a major social housing provider, and is an independent adviser to the BBC Trust.

Diane joined the Board in June 2008 and chairs the recently formed Community Services Committee.

Patricia Moberly

Chairman

Patricia Moberly was Chairman from 1999 to January 31 2011. She joined the Trust Board in December 1997 as a Non Executive Director and was previously Chairman of Lambeth Community Health and a member of West Lambeth Community Health Council.

We provide many innovative treatments for our patients, including Transcatheter Aortic Valve Implantation (TAVI) for those considered too high risk for open heart surgery



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Remuneration report

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 Appointments Commission. 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 the Non-Executive Directors.


The Remuneration Committee took a decision to freeze pay for executives for the period 2010/11, in line with recommendations on national agreements. Details of remuneration, including the salaries and pension entitlements of the Board of Directors, are published on page 88 of the annual accounts.

The only non-cash element of senior managers' remuneration packages are pension related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff in the scheme.

Pay levels are informed by executive salary surveys conducted by independent management consultants and by the salary levels in the wider market place. Affordability, determined by corporate performance and individual performance, are also taken into account. Where appropriate, terms and conditions are consistent with the new NHS pay arrangements such as *Agenda for Change*.

The Trust's strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and ongoing appraisal process. All senior managers' remuneration is subject to performance.

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by either party with six months notice, or 12 months in the case of the Chief Executive. 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.



Ron Kerr, Chief Executive, June 3 2011



9

Annual accounts

Foreword to the accounts

These accounts, for the year to March 31 2011, have been prepared by the Guy's and St Thomas' NHS Foundation Trust in accordance with the NHS Act 2006.



Ron Kerr, Chief Executive and Accounting Officer, June 3 2011

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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

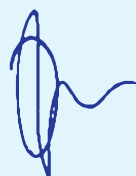
Under the NHS Act 2006, Monitor has directed Guy's and St Thomas' NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state 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 NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 Financial Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; 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 him 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 Monitor's NHS Foundation Trust Accounting Officer Memorandum.



Ron Kerr, Chief Executive and Accounting Officer, June 3 2011

Statement on internal control 2010/11

1. Scope of responsibility

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

2. 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 March 31 2011 and up to the date of approval of the Annual Report and Accounts.

3. 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 in place which describe the roles and responsibilities in relation to the identification, management and control of risk. 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, performance management, continuing professional development, clinical audit and application of evidence based practice.

4. 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 the risk is identified, evaluated and controlled.

A risk management matrix is used to ensure a consistent approach is taken to assessing and responding to clinical and non-clinical risks and incidents. This determines the Trust's appetite for risk with clear processes for the management and monitoring of proactive risk assessments defined within the Risk Management Policy and supporting procedures. All serious untoward incidents and serious risks are reported to the Board of Directors via the established governance committee structures.

All new staff are given information governance training through corporate induction. They are informed of the law, NHS guidance and the Trust's policies with regards to the safe and appropriate processing of data.

In line with the requirements of the Information Governance Toolkit, there is a mandatory requirement for all existing staff to have annual information training. This is done via a series of modules on Connecting for Health's Information Governance Training Toolkit, and an online training package developed by the King's Health Partners. Additionally, there is a wealth of policies, guidance, and best practice information on the Trust's intranet.

The Executive Directors have appointed an Information Asset Owner (IAO) for each department/specialty, who is responsible for monitoring

and managing information security risks. A quarterly report from each department/specialty is generated and included in the quarterly information governance report which is submitted to the Trust Board of Directors.

All data security incidents are reported via the Trust's incident database – DATIX. Incidents are reviewed at the monthly Information Governance Committee chaired by the Senior Information Risk Owner. Where an ongoing risk is identified it is recorded on the trust wide risk register.

Risks to the achievement of performance targets have been identified on the Board Assurance Framework. Looking to the forthcoming year, risks remain to the achievement of two targets – the referral to treatment and the 62 day cancer waiting time targets. The Trust will not meet the referral to treatment target for quarter one but has plans in place to do so in subsequent quarters for all pathways except orthopaedics, where local arrangements with commissioners are in place. With the 62 day cancer waiting time target we have still to resolve some of the issues relating to late referrals from other Trusts, particularly those outside the South East Cancer Network. We are currently in discussions with the Department of Health and the National Cancer Director about this target and our particular case mix, and whether there can be a more standardised approach across the country to the issue of cases referred after the breach date counting against our performance targets.

In 2010/11 the Trust was assured on the effectiveness of control of risks to the prevention of infection by excellent performance against the MRSA target. However in 2011/12 a target of no more than seven cases remains a challenge for a Trust of this size and complexity.

Risk management is embedded in the organisation in a variety of ways. All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. The Trust receives assurance from the National Patient Safety Agency on how incident reporting rates compare with other similar organisations. The Trust is in the top 10 per cent for the rate of incident reporting and is assured that this risk management activity is embedded in the activity of the organisation. Local management teams, via clinical governance groups are responsible for developing and maintaining local risk registers and overseeing the management of adverse incidents. Management teams are responsible for review risk action plans and ensuring they are implemented through business planning and other established routes.

Further assurance on the effectiveness of risk management has been received with the achievement of compliance with the Risk Management Standards of the NHS Litigation Authority at level 3 for both acute and maternity services in June 2010. Risk processes are monitored and reviewed by the Clinical Governance and Risk Management Committee, the Assurance and Risk Committee and the Audit Committee.

The Trust's public involvement and consultation process ensures compliance with relevant legislation, it 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 (PPI) initiatives. The process for engaging with our key stakeholders includes exploring risks that may have an impact on them and varies according to the nature of the development or change.

In 2010/11 the Trust has invited the Local Involvement Network (LINKs) to participate in a steering group overseeing the development of the Trust's patient information strategy; to join a user reference group to support the development of capital schemes for A&E and a new outpatient centre; to take part in the stakeholder reference group for the integration of community services in Lambeth and Southwark with the Trust; and to participate in workshops to develop the priorities for the Quality Accounts for 2011/12.

The views of patients have been sought in a variety of ways, including the quarterly Trust (Ipsos MORI) telephone survey, nationally mandated surveys, and comment cards and through other patient involvement activities. As part of the business planning and investment

process departments must demonstrate how stakeholders might be affected and the engagement plans they will follow to ensure patients and others are consulted and their views are considered before any investment is approved.

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

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. These obligations are set out within the Trust's Equality and Human Rights Scheme 2010-2013. The associated action plan is monitored by the Equality and Human Rights Governance Committee which reports through the Trust Management Executive to the Trust Board of Directors and provides the Board with an annual report. The Trust has adopted the Equality Delivery System to ensure that our public sector equality duties will be met.

Control measures are in place to ensure patients, the public and staff with physical and sensory impairments are able to access buildings on both sites. The Trust commissioned an independent Trust wide access audit, to set out recommendations to improve access and ensure compliance with the Equality Act 2010. The Trust's access steering group meets quarterly to assure that estates are compliant with the Equality Act 2010, by systematically working through the independent auditors recommendations, and by monitoring and responding to PALS and complaints reports.

The Trust has reviewed and continues to monitor the systems in place to care for people with learning disabilities. The Board of Directors, through the Assurance and Risk Committee, received a report on the effectiveness of the systems that the Trust currently has in place to enable it to understand and plan to meet the full range of needs of people with learning disabilities; and the capacity and capability of the services that the Trust provides to meet the additional and often complex needs of people with learning disabilities.

The Trust developed an action plan to ensure it is compliant with the various recommendations. The Trust also responded by recruiting a Learning Disability Coordinator, to oversee and further improve the systems to effectively care for people with learning disabilities. The Trust's Protecting Adults at Risk Assurance and Governance Committee reviews the effectiveness of systems to protect people with learning disabilities, and reports directly to the Board of Directors.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

As part of their annual audit, our external auditor is required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They do this by examining documentary evidence and through discussions with senior managers. The audit working papers in relation to this work are made available to the Trust and presented to the Audit Committee. These confirm that they have drawn positive conclusions from their work.

The key processes to ensure that resources are used economically, efficiently and effectively across clinical services include directorate performance reviews, the Trust's transformation programme, and regular monitoring of clinical indicators on quality and safety.

The emphasis of internal audit work is on risk management, 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.

The Board Assurance Framework sets out the principal risks to delivery of key priorities and overarching strategic priorities (corporate objectives). The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The Board Assurance Framework identifies the assurances available to the Board of Directors in relation to the achievement of the Trust's key objectives. The principal risks to the delivery of these objectives are mapped to key controls. The Board Assurance Framework supports the process for monitoring ongoing compliance with the requirements for registration with the Care Quality Commission with mapping of the regulations to strategic priorities. The Board of Directors plays a role in procurement as part of compliance with the Trust's policies and procedures to ensure that resources are used efficiently and effectively.

6. Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Chief Nurse is the nominated Trust Executive for the Quality Account. Two clinical leads have been put in place, the Deputy Chief Nurse and Associate Medical Director. An Executive Group was established and charged with reviewing current Trust quality work streams and establishing the priorities for the 2010/11 Quality Account.

To inform our priorities for the coming year the Trust reviewed key regulation, staff and patient surveys and external reviews such as Age UK *Hungry to be Heard* and the Ombudsman's report *Care and Compassion*. Staff and public consultation began in September and the Trust held two staff workshops and distributed 200 questionnaires to doctors, nurses and therapists across the organisation. These events and reviews led to the development of a long-list of priorities which was used as the basis for public discussions with our governors, LINKs, commissioners, Scrutiny Committees and local GPs. At two public events local stakeholders (including commissioners) were asked to add to and rank the long-list in order of priority. This was an invaluable exercise which helped the Chief Nurse and Medical Director inform the Board of Directors on our priorities moving forward.

Under each of the three mandated domains we are pleased that we have selected as a minimum the top three priorities chosen by our public stakeholders. Throughout the process our Trust governors were actively engaged, offering essential guidance and critical advice on the process.

For the Annual Quality Report, the Trust employs the same information assurance processes as used for other aspects of performance. These aim to identify and correct errors in data recording or data processing, and to give greater certainty that what is reported is an accurate reflection of what has actually happened. This provides a truer assessment of performance; allows better decision-making; and aids the understanding of changes in the pattern of service provision. In terms of monitoring, key elements of the CQUIN programme and Quality Report are reported monthly to the Board of Directors and directorate management teams. A quarterly update summary is submitted to the Board via the Trust quality and safety report, produced jointly by the Chief Nurse and Medical Director. External assurance on aspects of our Quality Accounts has been provided by the Trusts external auditors.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Assurance and Risk Committee and 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. The Board reviews a monthly 'dashboard' covering a wide range of performance metrics – these show the key relevant national priority and regulatory indicators, including CQUIN targets; with additional sections devoted to safety, clinical effectiveness and patient experience. A monthly qualitative summary is supplemented by more detailed briefings on any areas of adverse performance.

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection. The Board's dashboard is backed up by a cascade of more granular reports reviewed by Board sub-committees, directorates and individual services, with analysis at individual practitioner level.

The internal audit plan includes a programme of reviews of key indicators and responds to the identification of any risks associated with information assurance. There is clear evidence of action taken to resolve audit concerns with re-audits taken to assess performance improvement. An assessment of the controls applicable to the key indicators is included as part of the monthly dashboard.

Wherever possible, electronic systems are used to capture data, allowing reports to be generated with minimal effort. This allows information to be traced to source and the information asset owners are held accountable for the validity of their information.

Risks associated with pathway measurement have been identified during 2010/11 reflecting the possible variation in the interpretation of definitions. Controls have been strengthened and an expert sub-group of the Trust's Data Quality Executive has been established and has required each responsible department to complete a standardised Trust template for recording and reporting against national targets. This sets out the relevant definitions; the information-gathering steps with clearly defined responsibilities; the reporting process; and the assurance of the reporting. Each protocol has been critically appraised by the sub-group. Training has also been delivered on pathway measurement.

Information relating to quality performance is displayed clearly and consistently with comparisons to expected standards and with trends over time. Information being reviewed is the most recent available, allowing rapid response to any apparent anomalies. Drill-down capability is available for all metrics, and the Trust uses triangulation to ensure the best possible interpretation of potentially complex data, for example reporting

absolute numbers of deaths in addition to a standardised mortality ratio.

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 sub-committee has received reports from external and internal audit including reports relating to the Trust's counter fraud arrangements.

The Trust's Executive Directors and senior managers have provided the Board of Directors with reports on risk management, performance management and clinical governance through the Assurance and Risk Committee.


Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

The Board Assurance Framework has been updated throughout the year to reflect the risks associated with failing to achieve the Trust's strategic objectives. Throughout the year the Trust has monitored its ongoing compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 against the 16 CQC essential standards of quality and safety. Each standard has been given an Executive lead and an outcome lead. The outcome leads are individuals with responsibility for a particular area of service. Each lead has completed a 'provider compliance assessment', these set out the Trust position and evidence for the outcomes that support the assessment. Where there are gaps in compliance, a detailed action plan is submitted setting out what needs to be undertaken in order to be compliant, and timescales for completion. The Trust's position against the 16 essential standards of quality and safety is monitored by the Clinical Governance and Risk Management Committee and the Assurance and Risk Committee.

In 2010/11 the Trust has achieved compliance at level 3 of the NHS Litigation Authority's Risk Management Standards for both maternity services and acute services. This has provided a high level of assurance on the effectiveness of the Trust's risk management systems.

Conclusion

In 2010/11, weaknesses in control were identified with the Trust's information assurance arrangements, action has been taken to strengthen controls as described above. Immediate improvements were made to processes and an ongoing improvement plan continues to be delivered. With the exception of the internal control issues that I have outlined in this statement, my review confirms that Guy's and St Thomas' NHS Foundation Trust has a generally sound system of internal controls that supports the achievement of its objectives, and that identified control issues have been or are being addressed.



Ron Kerr, Chief Executive and Accounting Officer, June 3 2011

Independent Auditor's Report to the Council of Governors and Board of Directors of Guy's and St Thomas' NHS Foundation Trust

We have audited the financial statements of Guy's and St Thomas' NHS Foundation Trust for the year ended March 31 2011 which comprise the Consolidated Statement of Comprehensive Income, the Group and Trust Statement of Financial Position, the Group and Trust Statement of Changes in Taxpayers Equity, the Consolidated Cash Flow Statement and the related notes 1 to 34. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Guy's and St Thomas' NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the trust's affairs as at March 31 2011 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matter prescribed by the National Health Service Act 2006 Basis of audit opinion

In our opinion:

- the information given in the Directors' 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

We have nothing to report in respect of the following matters where the National Health Service Act 2006 requires us to report to you if, in our opinion:

- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.



Nigel Johnson (Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans

June 3 2011

Consolidated statement of comprehensive income for the year ended March 31 2011

		March 31 2011	March 31 2010
			Restated*
	NOTE	£000	£000
Operating income	4.1	715,481	676,008
Other operating income	5	276,857	267,293
Operating expenses	6.1	(953,767)	(921,809)
OPERATING SURPLUS		38,571	21,492
FINANCE COSTS			
Finance income	11	838	782
Finance expenses – unwinding of discount on provision	12	(293)	(211)
Public Dividend Capital dividend payable		(20,905)	(20,215)
Net finance costs		(20,360)	(19,644)
Share of operating loss in joint ventures	9	(329)	–
Corporation Tax	13	(2)	(1)
SURPLUS FOR THE YEAR		17,880	1,847
Other comprehensive income			
Revaluation gains and impairment losses on intangible assets		–	78
Revaluation losses and impairment losses on property, plant and equipment		(4,296)	(17,008)
Increase in the donated asset reserve due to receipt of donated assets		10,038	4,146
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		(5,135)	(9,304)
Movement between reserves		(136)	(323)
Transfers to income in respect of assets disposed			(480)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		18,351	(21,044)

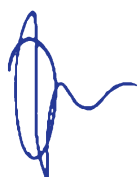
The notes on pages 80 to 100 form part of these accounts.

* The prior year has been restated to reflect merger accounting. See notes 2, 3, 4, 5, 6 and 7

Statement of financial position as at March 31 2011

		GROUP		TRUST	
			Restated*		Restated*
		March 31 2011	March 31 2010	March 31 2011	March 31 2010
NOTE		£000	£000	£000	£000
NON CURRENT ASSETS					
Property plant and equipment	15	861,209	838,854	861,209	838,854
Intangible assets	16	27,286	20,000	27,074	19,959
Trade and other receivables	21.2	2,360	2,093	3,605	3,245
TOTAL NON-CURRENT ASSETS		890,855	860,947	891,888	862,058
CURRENT ASSETS					
Inventories	20	14,595	14,252	14,595	14,252
Trade and other receivables	21.1	68,546	56,359	68,620	56,411
Tax receivable		589	2,328	589	2,328
Cash and other equivalents	25	100,139	111,911	100,001	111,825
TOTAL CURRENT ASSETS		183,869	184,850	183,805	184,816
CURRENT LIABILITIES					
Trade and other payables	22.1	(98,183)	(88,482)	(97,959)	(88,403)
Tax payable	22.2	(11,492)	(11,192)	(11,490)	(11,190)
Other liabilities	22.3	(21,624)	(17,444)	(21,624)	(17,444)
Provisions	23.1	(2,475)	(2,254)	(2,475)	(2,254)
TOTAL CURRENT LIABILITIES		(133,774)	(119,372)	(133,548)	(119,291)
NON-CURRENT LIABILITIES					
Other liabilities	22.3	(3,053)	(6,225)	(3,053)	(6,225)
Provisions	23.1	(8,301)	(8,955)	(8,301)	(8,955)
TOTAL NON-CURRENT LIABILITIES		(11,354)	(15,180)	(11,354)	(15,180)
TOTAL ASSETS EMPLOYED		929,596	911,245	930,791	912,403
TAX PAYERS' EQUITY					
Public Dividend Capital		355,766	355,766	355,766	355,766
Revaluation reserve		210,714	220,326	210,714	220,326
Donated asset reserve		221,285	216,505	221,285	216,505
Other reserves		743	743	743	743
Income and expenditure reserve		141,042	117,936	142,237	119,094
Merger Reserve surplus/(deficit)		46	(31)	46	(31)
TOTAL TAXPAYERS' EQUITY		929,596	911,245	930,791	912,403

The prior year has been restated to reflect merger accounting. See notes 15 and 22.



Ron Kerr

Chief Executive and Accounting Officer, June 3 2011

Statement of changes in Taxpayers' equity

GROUP	Public Dividend Capital £000	Revaluation reserve £000	Donated asset reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2010	355,766	220,326	216,505	743	(31)	117,936	911,245
Surplus for the year	–	–	–	–	–	17,880	17,880
Impairments	–	(22,373)	(7,655)	–	–	–	(30,038)
Revaluations	–	18,077	2,530	–	–	–	20,607
Receipt of donated assets	–	–	10,038	–	–	–	10,038
Other reserve movements	–	(5,316)	(123)	–	77	5,226	(136)
Taxpayers' equity as at March 31 2011	355,766	210,714	221,285	743	46	141,042	929,596

TRUST	Public Dividend Capital £000	Revaluation reserve £000	Donated asset reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2010	355,766	220,326	216,505	743	(31)	119,094	912,403
Surplus for the year	–	–	–	–	–	17,920	17,920
Impairments	–	(22,373)	(7,665)	–	–	–	(30,038)
Revaluations	–	18,077	2,530	–	–	–	20,607
Receipt of donated assets	–	–	10,038	–	–	–	10,038
Other reserve movements	–	(5,316)	(123)	–	77	5,223	(139)
Taxpayers' equity as at March 31 2011	355,766	210,714	221,285	743	46	142,237	930,791

Consolidated cash flow statement for the year ended March 31 2011

	NOTE	March 31 2011 £000	March 31 2010 £000
Cash flows from operating activities			
Operating surplus from continuing operations		38,571	21,492
Non-cash income and expenses			
Depreciation and amortisation		39,073	39,856
Impairments and reversals		4,538	5,104
Transfer from donated asset reserve		(6,810)	(9,304)
Transfer from government grants reserve		(354)	(563)
(Increase)/decrease in trade and other receivables		(12,553)	2,562
Increase in inventories		(343)	(6,723)
Increase/(decrease) in other liabilities		3,860	(2,645)
Increase in trade and other payables		10,677	3,837
(Decrease)/increase in provisions		(1,284)	634
Tax received		2,037	1,112
Other movements in operating cash flows		(641)	–
NET CASH GENERATED FROM OPERATING ACTIVITIES		76,711	55,362
Cash flows from investing activities			
Interest received		829	806
Purchase of financial assets		–	(60,000)
Sale of financial assets		–	60,000
Purchase of intangible assets		(10,281)	–
Proceeds from sale of intangible assets		–	24
Purchase of property, plant and equipment		(66,227)	(88,127)
Proceeds from sale of property, plant and equipment		608	–
Net cash generated used in investing activities		(75,071)	(87,297)
Cash flows from financing activities			
Public Dividend Capital dividend paid		(20,478)	(20,445)
Donated capital receipts		7,006	5,545
Public Dividend Capital received		–	3,699
NET CASH GENERATED USED IN INVESTING ACTIVITIES		(13,472)	(11,201)
Decrease in cash and cash equivalents		(11,772)	(43,136)
Cash and cash equivalents at April 1		111,911	155,047
Cash and cash equivalents at March 31	25	100,139	111,911

Notes to the accounts

1 Accounting policies

1.1 Basis of preparation of the financial statements

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/2011 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FRM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

The financial statements have been prepared under the historical cost convention, modified for the revaluation of certain financial assets and liabilities at fair value.

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 jointly controlled entities (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 has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves 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. Subsidiaries are consolidated from the date on which control is obtained by the Group and cease to be consolidated from the date on which control is no longer held by the Group. Where the Group ceases to hold control of a subsidiary, the consolidated financial statements include the results for the part of the reporting year during which the Group held control.

Joint ventures are contractual arrangements whereby two or more parties undertake an economic activity subject to joint control. Joint ventures 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 or losses (eg revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, eg share dividends, is received by the Trust from the associate.

In the Group's financial statements investments in joint ventures are initially recognised at cost. Subsequent to acquisition, the carrying value of the Group's investment in associates and joint ventures includes the Group's share of post-acquisition reserves, less any impairment in the value of individual assets. The Statement of Comprehensive Income reflects the Group's share of the results of operations of the associate or joint venture after tax.

A separate income statement for the parent organisation has not been presented in accordance with the guidelines in the Annual Reporting Manual.

1.3 Acquisitions and mergers

During 2010/11 Guy's and St Thomas' NHS Foundation Trust merged with the South West London Support Services Partnership (SSP), previously a division of Wandsworth Primary Care Trust. This transaction represents the transfer of services between public sector bodies which are under common control and therefore is a 'machinery of government change'. This transaction meets the definition of a 'Group Reconstruction' under IFRS 3 'Business Combinations' and therefore falls outside the scope of that standard. Consequently, in accordance with the FT ARM the principles of merger accounting have been applied to this transaction, as set out in Financial Reporting Standard 6 'Acquisitions and mergers' issued by the United Kingdom Accounting Standards Board. This is detailed in Note 2.

1.4 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 health care services.

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.

1.5 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates, was undertaken as at March 31 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at March 31 2004, and after consideration of changes to the NHS Pension Scheme taking effect from April 1 2008, his

valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from April 1 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

The valuation of the scheme liability as at March 31 2010 is based on detailed membership data as at March 31 2008 (the latest midpoint) updated to March 31 2010 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

1.6 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to the Statement of Comprehensive Income.

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. Benefits received and receivable as an incentive to sign an operating lease are similarly spread on a straight-line basis over the lease term.

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.

1.7 Expenditure on other goods and services

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

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and,
- individually it costs at least £5,000; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250;

- the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; 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.

Valuation

Land and buildings will be valued by an independent registered chartered surveyor on a regular basis as required under IAS16 to reflect fair value. As at March 31 2011 the land and buildings assets were revalued.

All property, plant and equipment are measured initially at cost, representing the cost 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.

Fair values 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.

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.

Fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost.

Assets with a life under 15 years are shown at a historical cost basis. From 1 April 2009 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives. New fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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 income.

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 FT ARM, impairments that are due to a loss 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.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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:

- Buildings, 10 - 49 years
- Plant and machinery, 5 - 10 years
- Transport equipment, 2 - 7 years
- IT hardware, 5 - 10 years
- Furniture and fittings, 10 years.

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.

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 ie:
 - 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';
 - 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Non property assets

We have adopted historical cost as a proxy for fair value for non-volatile, short-life assets. We deem an asset life under 15 years to be short.

We individually review non-property assets with a useful life of 15 years and over on an annual basis, to ensure that these are being carried at fair value.

Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure reserve. Similarly, any impairment on donated assets charged to income and expenditure is matched by a transfer from the donated asset reserve. On the sale of a donated asset, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

1.9 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;
- 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;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset;
- 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. 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.

Assets under construction are not amortised until they are complete and available for use in the Trust's business.

1.10 Government grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants, as are grants from the Big Lottery Fund. Funding received as Public Dividend Capital is accounted for as NHS capital. Where the Government grant is used to fund revenue expenditure, it is recorded as revenue income. Where the grant is used to fund capital expenditure, the grant is held as deferred income and released to operating income over the life of the asset on a basis consistent with the depreciation charge for that asset.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.12 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure 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 of 2.9% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed in the notes to the Statement of Comprehensive Income.

Non-clinical risk pooling

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

Commercial insurance

In addition to the NHSLA Property Expenses and Liabilities to Third Parties Schemes the Trust also holds commercial insurance. The annual premium is charged to operating expenses.

EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from the government grant reserve. The provision is settled on surrender of the allowances. The asset, provision and government grant reserve are valued at fair value at the end of the reporting period.

1.13 Contingencies

Contingent assets are defined as assets arising from past events the existence of which will only be confirmed by one or more future events not wholly within the entity's control. These assets are not recognised as assets, but are disclosed in the note Contingencies, where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the note Contingencies, 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.

1.14 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 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 real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held within the Government Banking System. Average relevant net assets are calculated as a simple means of opening and closing relevant net assets.

1.17 Other reserves

The other reserves balance of £743,000 was created by a technical accounting adjustment when the original NHS Trust was created in 1993.

1.18 Merger reserve

The merger reserve balance of £46,000 was created due to the merger of the South West London Support Services Partnership, previously a division of Wandsworth Primary Care Trust.

1.19 Foreign exchange

The functional and presentational currencies of the Trust are 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;
- 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.

1.20 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 which, 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

Financial assets are no longer recognised (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.

1.21 Financial assets and financial liabilities

Classification and measurement

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 GSTS Pathology LLP, current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

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 plus direct transaction costs and then re-measured at subsequent reporting dates to fair value, with unrealised gains and losses (except for changes in exchange rates for monetary items, interest, dividends and impairment losses, which are recognised in the Statement of Comprehensive Income) recognised in equity until the financial asset is de-recognised, at which time the cumulative gain or loss previously recognised in equity is taken to the Statement of Comprehensive Income in the line that most appropriately reflects the nature of the item or transaction.

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 independent valuations.

1.22 Financial assets and financial liabilities

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.

1.23 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.24 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. Details of third party assets are given in Note 33 to the accounts.

1.25 Losses and special payments

Losses and special payments are divided into different categories. Losses and special payments are charged to the Statement of Comprehensive Income, including losses which would have been made good through insurance cover had the Trust not been bearing their own risk (with insurance premiums then being included as normal revenue expenditure).

2 Acquisitions and mergers

On October 1 2010 the Guy's and St Thomas' NHS Foundation Trust acquired the South West London Support Services Partnership, which was previously a division of Wandsworth Primary Care Trust and not a separate legal entity. The transaction involved the purchase of property plant and equipment of South West London Support Services Partnership, with a value of £46k. The consideration given by the NHS Foundation Trust was £46k in cash. Working capital balances also transferred, with a net value of £400k which was funded by a payment from South West London Support Services Partnership to Guy's and St Thomas' NHS Foundation Trust. Therefore a net consideration of £354k was received by Guy's and St Thomas' NHS Trust.

	April 1 2010 to September 30 2010	October 1 2010 to March 31 2011	Full Year	
2010/11	South West London Support Services Partnership £000	NHS Foundation Trust £000	Combined Results £000	Total £000
Statement of comprehensive income				
Income from activities	–	354,323	361,158	715,481
Other income	5,774	128,243	142,840	276,857
Operating expenses	(5774)	(468,705)	(479,288)	(953,767)
Finance costs	–	(10,549)	(10,142)	(20,691)
Surplus for the period	–	3,312	14,568	17,880
Other comprehensive income	–	–	471	471
Total comprehensive income for the period	–	3,312	15,039	18,351
2009/10	South West London Support Services Partnership £000	NHS Foundation Trust £000	Combined Results £000	Total £000
Statement of comprehensive income				
Income from activities	–	676,008	676,008	676,008
Other income	13,335	253,958	267,293	267,293
Operating expenses	(13,335)	(908,474)	(921,809)	(921,809)
Finance costs	–	(19,645)	(19,645)	(19,645)
Surplus for the period	–	1,847	1,847	1,847
Other comprehensive income	–	(22,829)	(22,829)	(22,829)
Total comprehensive income for the period	–	(20,982)	(20,982)	(20,982)

3 Segmental reporting

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
INCOME		
Patient care income	715,481	676,008
Non patient care income	276,857	267,293
Total income	992,338	943,301
EXPENDITURE		
Clinical divisions	(650,905)	(627,656)
Corporate	(323,553)	(313,798)
Total expenditure	(974,458)	(941,454)
SURPLUS	17,880	1,847

Day-to-day financial control is devolved to:

- fourteen Clinical Directorates accountable to the Board of Directors via the Chief Nurse/Director of Infection, Prevention and Control and Medical Director; and
- corporate and other support services accountable to the Board of Directors via the appropriate Executive Directors.

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 and forecast report 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 web site www.guysandstthomas.nhs.uk – see the Board of Directors page.

For the purposes of internal financial reporting, the majority of contractual and other income is accounted for centrally; income from activity that differs to planned and budgeted levels is allocated to clinical directorate, usually at the marginal cost of that income.

Prior year has been restated to reflect merger accounting. Income and expenditure have both increased by £13,334k.

4 Operating income

4.1 Income from activities by source

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Strategic Health Authorities	–	3,334
Primary Care Trusts	688,516	649,160
NHS other	2,230	2,037
Non NHS:		
– Private patients	19,033	16,985
– Overseas patients (non-reciprocal)	1,954	2,147
– NHS injury scheme	991	1,056
– Other	2,757	1,289
	715,481	676,008

4.2 Income from activities by type

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Elective income	161,228	148,156
Non-elective income	115,163	114,140
Outpatient income	132,059	129,819
Other type of activity income	268,247	248,417
Accident and Emergency income	17,797	16,344
Private patient income	20,987	19,132
	715,481	676,008

Prior year has been restated to reflect merger accounting. Income and expenditure have both been increased by £13,334k.

4.3 Private patient income

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Private patient income	20,987	19,132
Total patient related income	715,481	676,008
Proportion as a percentage	2.93%	2.83%

Under the revised definition agreed in 2009/10, Section 15 of the 2003 Act requires that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed 3.04%, its revised proportion whilst the body was an NHS Trust in 2002/03.

Income from overseas visitors not covered by reciprocal agreements is included within private patient income.

5 Other operating income

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Research and development	51,514	41,196
Education, training and research	77,404	77,659
Charitable and other contributions to expenditure	6,004	5,184
Transfers from donated asset reserve	6,810	9,304
Non-patient care services to other bodies	14,242	16,307
Other income	120,446	117,638
Reversal of impairments of property, plant and equipment	45	–
Profits on disposal of fixed assets	392	–
Profits on disposal of tangible fixed assets	–	5
	276,857	267,293

Other income includes income from commercial activities, staff accommodation rentals, clinical excellence awards, catering, foreign currency gains of £661k (gains of £1,623k in 2010/2011 included in other operating expenses) and other direct credits.

Revenue is almost totally from supply of services. Revenue from supply of goods is immaterial.

Prior year has been restated to reflect merger accounting. Non-patient care services to other bodies has increased by £13,334k.

6 Operating expenses

6.1 Operating expenses comprise:

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Services from other NHS Trusts	3,052	3,013
Services from other NHS bodies	4,964	5,435
Services from NHS Foundation Trusts	925	–
Purchase of healthcare from non-NHS bodies	1,780	5,033
Executive Directors' costs	1,442	1,390
Non-Executive Directors' costs	181	182
Staff costs	531,433	510,306
Drugs	83,579	84,343
Supplies and services – clinical	130,926	114,473
Supplies and services – general	7,289	8,215
Establishment	24,752	24,065
Research and development	95	35
Transport	7,759	6,538
Premises	52,196	48,169
Bad debts	(469)	7,892
Depreciation and amortisation	39,073	39,856
Impairments of property, plant and equipment	4,583	5,104
Audit fees – statutory audit	126	168
Other auditor's remuneration	67	20
Clinical negligence	6,935	6,311
Other*	53,079	51,261
	953,767	921,809

*Other operating expenses includes expenditure on commercial activities, training and legal fees.

Prior year has been restated to reflect merger accounting. Expenditure has been increased by £13,334k.

6.2 Audit fees

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Audit services for statutory audit	117	159
Audit fee for subsidiary companies	9	9
Other audit related services	67	20
	193	188

6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2010/2011 or 2009/2010.

6.4 Operating leases

As Lessee

6.4.1 Payments recognised as an expense:

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Minimum lease payments under operating leases recognised as an expense in the year	6,649	6,674

At the Statement of Financial Position date, the Group had outstanding commitments for future minimum lease payments under non-cancellable operating leases which fall due as follows:

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Within 1 year	6,527	5,221
Between 1 and 5 years inclusive	17,154	12,007
After 5 years	13,182	12,947
	36,863	30,175

As Lessor

6.4.2 Rental revenue:

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Income	4,130	2,872

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Within 1 year	3,354	2,752
Between 1 and 5 years inclusive	12,752	10,655
After 5 years	9,249	9,873
	25,355	23,280

6.5 2010/11 Salary and pension entitlements of senior managers

A) Remuneration

Name	Title	Executive remuneration £000	Other remuneration £000	Year ended March 31 2011	Year ended March 31 2010
				Total remuneration £000	Total remuneration £000
Executive Directors					
I. Abbs	Medical Director (appointed January 2011)	49	–	49	–
E. Baker	Joint Director of Clinical Leadership and Medical Director (resigned September 2010)	60	43	103	217
D. Hamilton Fairley	Acting Medical Director (for the period September 2010 to December 2010)	57	–	57	–
R. Kerr	Chief Executive	254	–	254	274
A. Macintyre	Director of Workforce	146	–	146	155
S. McGuire	Director of Capital, Estates & Facilities Management	157	–	157	157
H. Risebrow	Commercial Director	150	–	150	71
M. Shaw	Director of Finance	157	–	157	157
E. Sills	Chief Nurse/Director of Infection Prevention and Control	173	–	173	173
		1,203	43	1,246	1,204
Non-Executive Directors					
D. Dean	Non-Executive Director and Chairman Audit Committee	20	–	20	20
M. Franklin	Non-Executive Director	17	–	17	17
R. Maw	Non-Executive Director	17	–	17	17
P. Moberly	Chairman (until January 2011)	51	–	51	61
F. Nestle	Non-Executive Director	17	–	17	16
J. Oliver	Non-Executive Director	17	–	17	17
D. Summers	Non-Executive Director	17	–	17	17
H. Taylor	Chairman (appointed February 2011)	10	–	10	–
		1,369	43	1,412	1,369

B) Pension benefits

Name	Title	Real increase in pension and related lump sum at age 60 £000	Total accrued pension and related lump sum at age 60 at March 31 2011 £000	Cash equivalent transfer value at March 31 2011 £000	Real increase in cash equivalent transfer value at March 31 2011 £000
I. Abbs	Medical Director (appointed January 2011)	5	252	1,146	(6)
E. Baker *	Joint Director of Clinical Leadership and Medical Director (resigned September 2010)	–	–	–	–
D. Hamilton Fairley	Acting Medical Director (for the period September 2010 to December 2010)	3	211	1,032	(9)
R. Kerr**	Chief Executive	–	–	–	–
A. Macintyre	Director of Workforce	13	195	819	(37)
S. McGuire	Director of Capital, Estates and Facilities Management	8	119	527	(24)
H. Risebrow	Commercial Director	13	34	135	10
M. Shaw	Director of Finance	8	240	1,179	(65)
E. Sills	Chief Nurse/Director of Infection Prevention and Control	7	223	862	(22)

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

* The Medical Directors costs were recharged to the Trust from King's College Medical School.

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

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

In the budget of July 22 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI). As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in the calculations and are lower than the previous factors used therefore the value of the CETVs for some members has fallen since March 31 2010.

7 Employee costs and numbers

7.1 Employee costs

	Permanently employed £000	Other £000	Year ended March 31 2011 Total £000	Year ended March 31 2010 Total £000
Salaries and wages	419,598	–	419,598	399,167
Social security costs	34,430	–	34,430	32,613
Employer contributions to NHSPA	47,118	–	47,118	44,092
Termination benefits	604	–	604	113
Agency and contract staff	–	30,779	30,779	35,488
Seconded staff	–	346	346	337
	501,750	31,125	532,875	511,810

Prior year has been restated to reflect merger accounting. Employee costs have increased by £6,251k. Termination benefits incurred during 2010/2011 were not material and no further disclosure shall be presented.

7.2 Average number of people employed

	Permanently employed number	Other number	Year ended March 31 2011 Total number	Year ended March 31 2010 Total number
Medical and dental	1,423	–	1,423	1,367
Administration and estates	2,238	–	2,238	2,281
Healthcare assistants and other support staff	794	–	794	774
Nursing, midwifery and health visiting staff	3,083	–	3,083	3,486
Nursing, midwifery and health visiting learners	492	–	492	429
Scientific, therapeutic and technical staff	1,752	–	1,752	1,743
Bank and agency staff	–	914	914	730
Social care staff	1	–	1	–
	9,783	914	10,697	10,810

7.3 Management costs

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Management costs	36,981	34,901
Income	992,338	929,966
Management costs as a percentage	3.73%	3.75%

Management costs are defined as those on the management cost website at:
[www.dhl.gov.uk/Policy and Guidance/OrganisationPolicy/Finance and Planning/NHSMangement Costs/fs/en](http://www.dhl.gov.uk/Policy%20and%20Guidance/OrganisationPolicy/Finance%20and%20Planning/NHSMangement%20Costs/fs/en)

7.4 Retirements due to ill-health

During 2010/11 there were 4 early retirements from the Trust agreed on the grounds of ill-health (7 in the year ended March 31 2010). The estimated additional pension liabilities of these ill-health retirements is £166k (£571k in 2009/10). These retirements represented 0.38 per 1,000 active scheme members. The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

8 Better Payment Practice Code

8.1 Measure of compliance

	Number	Year ended March 31 2011 £000	Number	Year ended March 31 2010 £000
Total bills paid in the year	268,188	521,135	220,410	508,138
Total bills paid within target	216,897	352,555	159,638	350,728
Percentage of bills paid within target	81%	68%	72%	69%

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

8.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust did not incur any expenditure relating to the late payment of commercial debt.

9 Share of operating loss in joint ventures

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
GSTS Pathology LLP	(329)	—
	<u>(329)</u>	<u>—</u>

10 Profit/(loss) on disposal of non-current assets

Profit/(loss) on the disposal of non-current assets is made up as follows:	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Profit on disposal of intangible assets	—	5
Profit/(loss) on disposal of plant and equipment	392	(20)
	<u>392</u>	<u>(15)</u>

11 Finance income

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Interest on loans and receivables (including cash and bank balances)	838	782
	<u>838</u>	<u>782</u>

12 Finance expenses

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
Unwinding of discounts on provision	(293)	(211)
	<u>(293)</u>	<u>(211)</u>

13 Taxation

	Year ended March 31 2011 £000	Year ended March 31 2010 £000
UK corporation tax		
Current tax payable on income at 21%	(2)	(1)
	<u>(2)</u>	<u>(1)</u>

Corporation tax is applicable to the profits of GTI Forces Healthcare Limited and the profits of the joint ventures.

As of April 6 2011 the applicable corporation tax rate reduced to 20%.

14 Surplus attributable to the Trust

The surplus for the Trust was £17,920k (2009/10 surplus of £1,884k), and is included within the Statement of Comprehensive Income for the Group. As permitted by Monitor's FT ARM, no separate Statement of Comprehensive Income is presented in respect of the parent.

15 Property, plant and equipment

15.1 Property, plant and equipment for 2009/2010 comprised of the following elements:

Group		Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
Cost or valuation	Land £000	£000	£000	£000	£000	£000	£000	£000
at April 1 2009	166,950	548,674	37,826	127,163	130	30,417	2,199	913,359
Additions purchased	–	35,522	25,071	15,682	–	3,631	–	79,906
Additions donated	–	373	1,864	1,582	–	–	–	3,819
Impairments	–	(45,165)	–	–	–	–	–	(45,165)
Reclassifications	–	9,853	(20,014)	2,487	56	3,560	–	(4,058)
Revaluation	–	–	–	–	–	–	–	–
Disposals	–	–	–	(793)	–	–	–	(793)
At March 31 2010	166,950	549,257	44,747	146,121	186	37,608	2,199	947,068
Accumulated depreciation								
at April 1 2009	–	–	–	78,771	130	13,523	1,431	93,855
Provided during the year	–	23,687	–	7,472	–	6,917	110	38,186
Impairments	–	(23,053)	–	–	–	–	–	(23,053)
Reclassifications	–	–	–	–	–	–	–	–
Revaluation surpluses	–	–	–	–	–	–	–	–
Disposals	–	–	–	(774)	–	–	–	(774)
At March 31 2010	–	634	–	85,469	130	20,440	1,541	108,214
Net book value								
Purchased assets	99,200	411,065	37,826	37,583	–	15,906	245	601,825
Donated assets	67,750	137,609	–	10,809	–	988	523	217,679
Total at April 1 2009	166,950	548,674	37,826	48,392	–	16,894	768	819,504
Purchased assets	99,200	412,110	42,883	51,685	56	16,579	211	622,724
Donated assets	67,750	136,513	1,864	8,967	–	589	447	216,130
Total at March 31 2010	166,950	548,623	44,747	60,652	56	17,168	658	838,854

Prior year has been restated to reflect merger accounting. Property, plant and equipment has increased by £56k.

15.2 Property, plant and equipment at the statement of financial position date comprises the following elements:

Group		Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
Cost or valuation	Land £000	£000	£000	£000	£000	£000	£000	£000
At April 1 2010	166,950	549,257	44,747	146,121	186	37,608	2,199	947,068
Additions purchased	–	20,302	15,291	16,774	46	3,802	–	56,215
Additions donated	–	1,802	4,452	2,737	–	–	–	8,991
Impairments	(850)	(53,318)	–	–	–	–	–	(54,168)
Reclassifications	–	38,582	(37,673)	2,738	–	(2,612)	(1,035)	–
Revaluations	15,095	12,058	–	–	–	–	–	27,153
Disposals	–	–	–	(5,807)	–	(3,632)	–	(9,439)
At March 31 2011	181,195	568,683	26,817	162,563	232	35,166	1,164	975,820
Accumulated depreciation								
At April 1 2010	–	634	–	85,469	130	20,440	1,541	108,214
Provided during the year	–	19,865	–	9,916	14	5,267	105	35,167
Impairments	–	4,583	–	–	–	–	–	4,583
Reclassifications	–	–	–	1,907	–	(872)	(1,035)	–
Revaluations	–	(24,130)	–	–	–	–	–	(24,130)
Disposals	–	–	–	(5,591)	–	(3,632)	–	(9,223)
At March 31 2011	–	952	–	91,701	144	21,203	611	114,611
Net book value								
Purchased assets	99,200	412,110	42,883	51,685	56	16,579	211	622,724
Donated assets	67,750	136,513	1,864	8,967	–	589	447	216,130
Total at April 1 2010	166,950	548,623	44,747	60,652	56	17,168	658	838,854
Purchased assets	107,195	435,708	23,722	59,857	88	13,905	199	640,674
Donated assets	74,000	132,023	3,095	11,005	–	58	354	220,535
Total at March 31 2011	181,195	567,731	26,817	70,862	88	13,963	553	861,209

A separate schedule for the Trust's tangible assets has not been produced as the subsidiaries' have no tangible fixed assets.

15.3 The net book value of property, plant and equipment at March 31 2011 comprises:

	Land £000	Buildings £000	Other assets £000	Total property, plant and machinery £000
Protected	181,195	557,726	–	738,921
Unprotected	–	10,005	112,283	122,288
Net book value	181,195	567,731	112,283	861,209

16 Intangible assets

16.1 As at March 31 2010

Group	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
Cost April 1 2009	362	20,458	–	663	21,483
Reclassification	–	4,118	–	–	4,118
Other revaluation	–	–	–	78	78
Additions purchased	38	4,502	2,188	201	6,929
Additions donated	–	–	327	–	327
Disposals	–	–	–	(20)	(20)
Gross cost at March 31 2010	400	29,078	2,515	922	32,915
Amortisation 1 April 2009	80	11,166	–	–	11,246
Provided during the year	63	1,606	–	–	1,669
Amortisation at March 31 2010	143	12,772	–	–	12,915
Net book value					
Purchased assets April 1 2009	282	9,213	–	–	9,495
Donated assets April 1 2009	–	79	–	663	742
Total at April 1 2009	282	9,292	–	663	10,237
Purchased assets at March 31 2010	257	16,258	2,188	922	19,625
Donated assets at March 31 2010	–	48	327	–	375
Total at March 31 2010	257	16,306	2,515	922	20,000

16.2 As at March 31 2011

Group	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
Cost April 1 2010	400	29,078	2,515	922	32,915
Reclassification	340	(174)	(165)	(1)	–
Other revaluation	–	–	–	–	–
Additions purchased	2	2,519	7,624	–	10,145
Additions donated	–	(14)	397	664	1,047
Disposals	–	(578)	–	–	(578)
Gross cost at March 31 2011	742	30,831	10,371	1,585	43,529
Amortisation April 1 2010	143	12,772	–	–	12,915
Provided during the year	96	3,810	–	–	3,906
Reclassification	169	(169)	–	–	–
Disposals	–	(578)	–	–	(578)
Amortisation at March 31 2011	408	15,835	–	–	16,243
Net book value					
Purchased assets April 1 2010	257	16,258	2,188	922	19,625
Donated assets April 1 2010	–	48	327	–	375
Total at April 1 2010	257	16,306	2,515	922	20,000
Purchased assets at March 31 2011	333	14,972	9,646	1,585	26,536
Donated assets at March 31 2011	1	24	725	–	750
Total at March 31 2011	334	14,996	10,371	1,585	27,286

A separate schedule for the Trust's intangible assets has not been produced as the subsidiaries' fixed assets represent just £210k of intangible assets held by the Group. The subsidiary assets are split accordingly: £85k are information technology assets and £125k are intangible assets under construction.

17 Impairments

Land and buildings were valued independently by the Valuation Office as at March 31 2011 in line with the accounting policies. The valuation included positive and negative valuation movements. All valuation movements were a result of changes in the market price.

Altogether there was a net impairment charge of £7,467k, of which £4,583k was charged to the Statement of Comprehensive Income as the buildings had insufficient revaluation reserves to fund the valuation movement. The valuation included negative valuations of £33,770k and £850k on buildings and land respectively. There were positive valuation movements on other Trust buildings and land of £12,058k and £15,095k respectively. £45k on the positive valuation was charged to the Statement of Comprehensive Income to reverse impairments recognised in prior periods.

18 Subsidiaries and interest in associates and joint ventures

The NHS Foundation Trust's principal subsidiary undertakings, associates and joint ventures as included in the consolidation at March 31 2011 are set out below. The accounting date of the financial statements for the subsidiaries is March 31 2011 and for the joint ventures December 31. For the joint venture undertakings that have different accounting year end dates, interim accounts to March 31 2011 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
Spot on Diagnostics Ltd ²	UK	100%	Healthcare services
Joint ventures			
GSTS Pathology LLP ¹	UK	33% ⁴	Healthcare services
SSAFA GSTT Care LLP ¹	UK	50%	Healthcare services
King's Health Partners Ltd ³	UK	25%	Healthcare services

¹ Not directly owned by Guy's and St Thomas' NHS Foundation Trust

² Nominal £1 share issued – company dormant as at March 31 2011

³ Limited by guarantee – no cash investment has been made, GSTT holds 25% voting rights

⁴ During 2010/11 King's College Hospital became a third partner in the GSTS Pathology partnership. This reduced our share from 50% to 33% and is reflected in the group share of net assets in note 19. The group share of net losses will remain at 50% until profit is sufficient to cover cumulative losses at the partnership change date.

19 Aggregated amounts relating to associates and joint ventures

	March 31 2011 £000	March 31 2010 £000
Non current assets	5,128	4,645
Current assets	9,937	9,155
Non current liabilities	(4,054)	(2,500)
Current liabilities	(10,933)	(11,636)
Group share net assets (liabilities)	78	(336)
Revenue	42,530	31,955
Expenditure	(42,637)	(32,546)
Group share net (loss)	(107)	(591)

As per accounting policy note 1.2 the Group accounts for associates and joint ventures on an equity basis. The Group has not recognised its share of losses exceeding Group interest. The Group share of unrecognised losses is disclosed below.

	March 31 2011 £000	March 31 2010 £000
Group share of unrecognised losses	1,098	1,321

All figures are based on unaudited figures.

20 Inventories

	GROUP		TRUST	
	March 31 2011 £000	March 31 2010 £000	March 31 2011 £000	March 31 2010 £000
Raw materials and consumables	14,595	14,252	14,595	14,252
	<u>14,595</u>	<u>14,252</u>	<u>14,595</u>	<u>14,252</u>

21 Trade and other receivables

21.1 Current

	GROUP		TRUST	
	March 31 2011	March 31 2010	March 31 2011	March 31 2010
	£000	£000	£000	£000
NHS receivables	17,088	12,374	17,088	12,374
Provision for impaired receivables	(10,526)	(16,907)	(10,526)	(16,907)
Prepayments	2,574	7,071	2,574	7,071
Accrued income	13,643	21,333	13,643	21,333
Other receivables	45,767	32,488	45,841	32,540
	<u>68,546</u>	<u>56,359</u>	<u>68,620</u>	<u>56,411</u>

Other receivables include an amount of £14,903k which relates to a balance with GSTS Pathology LLP and £190k which relates to SSAFA GSTT Care LLP.

Included within the GSTS Pathology LLP balance is an amount of £3,500k which relates to a loan to the joint venture GSTS Pathology LLP, with a maturity date of January 29 2012 and a variable rate of interest (Libor + 2%). Prior year has been restated to more accurately reflect accrued income. Accrued income has increased by £13,652k, which was previously shown in NHS receivables.

21.2 Non current

	GROUP		TRUST	
	March 31 2011	March 31 2010	March 31 2011	March 31 2010
	£000	£000	£000	£000
NHS receivables	564	563	564	563
Other receivables with related parties	–	–	1,244	1,152
Other receivables	1,796	1,530	1,797	1,530
	<u>2,360</u>	<u>2,093</u>	<u>3,605</u>	<u>3,245</u>

21.3 Ageing of trade and other receivables

	GROUP		TRUST	
	March 31 2011	March 31 2010	March 31 2011	March 31 2010
	£000	£000	£000	£000
Not past due date	55,822	54,013	55,896	54,065
Up to three months	7,149	831	7,149	831
In three to six months	5,151	2,216	5,151	2,216
Over six months	2,784	1,392	4,028	2,544
	<u>70,906</u>	<u>58,452</u>	<u>72,224</u>	<u>59,656</u>

22 Trade and other payables

22.1 Current

	GROUP		TRUST	
	March 31 2011	March 31 2010	March 31 2011	March 31 2010
	£000	£000	£000	£000
Receipts in advance	698	537	698	537
NHS payables	14,748	12,285	14,748	12,285
Trade payables – capital	2,400	3,576	2,400	3,576
Other trade payables	36,861	37,613	36,861	37,612
Other payables	3,052	2,273	3,051	2,273
Accruals	40,424	32,198	40,201	32,120
	<u>98,183</u>	<u>88,482</u>	<u>97,959</u>	<u>88,403</u>

NHS payables includes £5,911k outstanding pension contributions at March 31 2011 (£5,891k at March 31 2010).

Trade and other payables includes amounts owed to GSTS Pathology LLP, £4,522k in other trade payables and £7,114k is included in accruals.

Prior year has been restated to more accurately reflect accruals and to include the effects of merger accounting. Accruals have increased by £1,830k, which was previously shown in NHS payables, and other payables have increased by £91k as a result of merger accounting.

22.2 Current taxes payable

	GROUP		TRUST	
	March 31 2011	March 31 2010	March 31 2011	March 31 2010
	£000	£000	£000	£000
Taxes payable	11,492	11,192	11,490	11,190
	<u>11,492</u>	<u>11,192</u>	<u>11,490</u>	<u>11,190</u>

22.3 Other liabilities

	GROUP		TRUST	
	March 31 2011	March 31 2010	March 31 2011	March 31 2010
Current	£000	£000	£000	£000
Deferred income	21,293	17,079	21,293	17,079
Deferred Government grant	331	365	331	365
	<u>21,624</u>	<u>17,444</u>	<u>21,624</u>	<u>17,444</u>
Non-current				
Deferred income	1,174	4,635	1,174	4,635
Deferred Government grant	1,879	1,590	1,879	1,590
	<u>3,053</u>	<u>6,225</u>	<u>3,053</u>	<u>6,225</u>

23 Provisions for liabilities and charges

23.1 Overall provisions

Group and Trust	Current		Non Current		Total Provisions	
	March 31 2011	March 31 2010	March 31 2011	March 31 2010	March 31 2011	March 31 2010
	£000	£000	£000	£000	£000	£000
Pensions relating to former staff	780	784	7,122	7,729	7,902	8,514
Legal claims	403	777	–	–	401	777
Other	1,292	693	1,179	1,226	2,473	1,918
	<u>2,475</u>	<u>2,254</u>	<u>8,301</u>	<u>8,955</u>	<u>10,776</u>	<u>11,209</u>

23.2 Changes in provisions

	Pensions relating to former staff	Legal claims	Other	Total
	£000	£000	£000	£000
As at April 1 2010	8,514	777	1,918	11,209
Change in the discount rate*	(390)	–	(41)	(431)
Arising during the year	463	215	612	1,290
Utilised during the year	(792)	(49)	(32)	(873)
Reversed unused	(129)	(542)	–	(671)
Unwinding of discount	236	–	16	252
As at March 31 2011	<u>7,902</u>	<u>401</u>	<u>2,473</u>	<u>10,776</u>

*The discount rate changed from 2.2% to 2.9% at March 31 2011.

23.3 Expected timing of cash flows

Timing of Provisions	Pensions relating to former staff	Legal claims	Other	Total
	£000	£000	£000	£000
Within one year	780	401	1,292	2,473
Between one and five years	2901	–	762	3,663
After five years	4,221	–	419	4,640
	<u>7,902</u>	<u>401</u>	<u>2,473</u>	<u>10,776</u>

The provision relating to pensions to former staff consists of provisions for pre 1995 early retirements and has been calculated using information provided by the NHS Pensions Agency. Other provisions consists of provisions for EU emissions, injury benefits and delapidations.

£88,904k is included in the provision of the NHS Litigation Authority under legal claims at March 31 2011 in respect of clinical negligence liabilities of the Foundation Trust (£68,920k at March 31 2010).

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.

24 Prudential borrowing limit

	March 31 2011 £000	March 31 2010 £000
Long term borrowing limit set by Monitor	186,500	182,700
Working capital facility agreed by Monitor	60,000	30,000
	<u>246,500</u>	<u>212,700</u>

25 Analysis in changes of net cash

GROUP	At April 1 2009 £000	Cash changes in period £000	At March 31 2010 £000	Cash changes in period £000	At March 31 2011 £000
Cash with the Government Banking Service	139,909	(28,546)	111,363	(11,804)	99,559
Cash at bank and in hand – commercial bank accounts	15,138	(14,590)	548	32	580
	<u>155,047</u>	<u>(43,136)</u>	<u>111,911</u>	<u>(11,772)</u>	<u>100,139</u>
TRUST					
Cash with the Government Banking Service	139,909	(28,546)	111,363	(11,804)	99,559
Cash at bank and in hand – commercial bank accounts	14,994	(14,532)	462	(20)	442
	<u>154,903</u>	<u>(43,078)</u>	<u>111,825</u>	<u>(11,824)</u>	<u>100,001</u>

26 Capital commitments

Commitments under capital expenditure contracts at the balance sheet date were £3,116k (£6,529k at March 31 2010) for the Group and the Trust.

27 Events after the balance sheet date

As at April 1 2011 the Trust acquired the community health services functions from Lambeth PCT and Southwark PCT. The transaction involved the purchase of property, plant and equipment and the transfer of net assets from Lambeth PCT and Southwark PCT. In addition there was a transfer of retained earnings from Lambeth PCT. As part of this change, approximately 1,500 additional staff were transferred to the Trust. The unaudited results for 2010/11 are: Lambeth PCT £52,702k income and £52,061k expenditure and Southwark PCT £47,704k income and £47,648k expenditure. An approximate £90,000k income and expenditure is expected in 2011/12 and this will be accounted for under merger accounting.

28 Contingencies

	March 31 2011 £000	March 31 2010 £000
Contingent liability for other claims against the Group and the Trust	76	68
Net contingent liability	<u>76</u>	<u>68</u>

All contingent liabilities recorded are in respect of Public and Employee liability cases 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 dividend

The Trust is required to demonstrate that the PDC dividend paid is in line with the actual rate of 3.5% of average relevant net assets. The dividend payable to the March 2011 period of account was £20,905k and, based on the average relevant net assets of £597,299k, the Trust's performance on an annualised basis was 3.51% (3.5% to March 2010).

30 Financial performance targets

The following information relates to the Prudential Borrowing Limit (PBL) with which Guy's and St Thomas' NHS Foundation Trust is required to comply.

- A) The Foundation Trust had no long-term borrowing at March 31 2011.
- B) The Dividend Cover ratio is 3.791 compared to a minimum cover required of 1 (3.039 in the year ended March 31 2010, restated to include interest received).

31 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.

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 debtor and creditor trading balances with the Group's joint ventures are presented in notes 21 and 22 respectively.

The Board members of SSAFA GSTT Care LLP include the following directors from the Trust: Ron Kerr as Non-Executive Director and Chairman, Martin Shaw as Non-Executive Director, Robert O'Leary as Deputy Managing Director, Alistair Scarborough as Commercial Director and Michael Powell as Director of Secondary Health Care.

The Board members of GSTS Pathology LLP include the following directors from the Trust: Ron Kerr, Martin Shaw, Robert O' Leary and Dr Jonathan Edgeworth.

The Department of Health is regarded as a related party. During the year Guy's and St Thomas' NHS Foundation Trust has had a significant number

of material transactions with entities for which the department is regarded as the parent. The main local commissioners are Lambeth Primary Care Trust, Southwark Primary Care Trust, Croydon Primary Care Trust and Lewisham Primary Care Trust from whom the Trust received £396,884k for health care contracts (£344,050k at March 31 2010). Additionally the Trust has transacted with a large number of other Primary Care Trusts and NHS Trusts including West Kent, Bromley, Greenwich and Bexley Primary Care Trusts, as well as the NHS Litigation Authority and NHS Logistics.

The debtors balance for NHS bodies at £17,088k (£12,374k at March 31 2010).

In addition, the Trust has had a number of material transactions with other Government departments and other central and local Government bodies. £38,371k (£37,513k at March 31 2010) has been received from the Ministry of Defence for health services supplied. There were also many transactions with King's College London totalling £7,619k (£8,441k at March 31 2010).

The Trust has also received revenue and capital payments from a number of charitable funds, principally Guy's and St Thomas' Charity to the amount of £20,732k (£11,662k at March 31 2010). The balance for Guy's and St Thomas' Charity debtors was £4,183k (£1,632k at March 31 2010) and for creditors £532k (£280k for March 31 2010). Guy's and St Thomas' Charity is regarded as a related party.

The Trust works closely with its partners in the Kings Health Partners: King's College Hospital NHS Foundation Trust, King's College London and South London and Maudsley NHS Foundation Trust.

Ron Kerr, Chief Executive, and Eileen Walsh, Director of Assurance, rent accommodation from the Trust at a commercial market rate.

Rory Maw (Non-Executive Director) is a trustee of Guy's and St Thomas' Charity.

Tony West (Chief Pharmacist and Clinical Director) is chair of an Advisory Board for GlaxoSmithKline UK (GSK).

The Council of Governors includes representatives from organisations that work closely with the Trust including Lambeth Council, Southwark Council, Lambeth Primary Care Trust, Southwark and Lewisham Primary Care Trusts, London South Bank University, South Bank Employees Group, NHS London, King's College London 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.

32 Financial assets and liabilities

32.1 Financial assets

Floating rate	GROUP		TRUST	
	March 31 2011 £000	March 31 2010 £000	March 31 2011 £000	March 31 2010 £000
Denominated in £ Sterling	166,335	161,540	167,516	162,656
In other currencies, restated in £ Sterling	2,137	1,524	2,137	1,524
Gross financial assets at March 31	168,472	163,064	169,653	164,180

32.2 Analysis of financial liabilities

Floating rate	GROUP		TRUST	
	March 31 2011 £000	March 31 2010 £000	March 31 2011 £000	March 31 2010 £000
Denominated in £ Sterling	108,261	99,154	108,038	99,075
Gross financial liabilities at March 31	108,261	99,154	108,038	99,075

32.3a Financial assets by category

GROUP	Loans and receivables £000	TRUST	Loans and receivables £000
At March 31 2011		At March 31 2011	
Assets as per balance sheet		Assets as per balance sheet	
NHS debtors	17,652	NHS debtors	17,652
Accrued income	13,643	Accrued income	13,643
Other debtors with related parties	–	Other debtors with related parties	1,244
Other debtors	47,564	Other debtors	47,639
Provision for doubtful debts	(10,526)	Provision for doubtful debts	(10,526)
Cash at bank and in hand	100,139	Cash at bank and in hand	100,001
At March 31 2011	168,472	At March 31 2011	169,653
At March 31 2010		At March 31 2010	
NHS debtors	12,707	NHS debtors	12,707
Accrued income	21,333	Accrued income	21,333
Other debtors with related parties	–	Other debtors with related parties	1,152
Other debtors	34,019	Other debtors	34,070
Provision for doubtful debts	(16,907)	Provision for doubtful debts	(16,907)
Cash at bank and in hand	111,912	Cash at bank and in hand	111,825
Total at March 31 2010	163,064	Total at March 31 2010	164,180

32.3b Financial liabilities by category

Other financial liabilities	GROUP £000	TRUST £000
At March 31 2011		
NHS creditors	14,748	14,748
Other creditors	42,312	42,312
Accruals	40,423	40,200
Provisions under contract	10,778	10,778
Total at March 31 2011	108,261	108,038
At March 31 2010		
NHS creditors	12,285	12,285
Other creditors	43,462	43,461
Accruals	32,198	32,120
Provisions under contract	11,209	11,209
Total at March 31 2010	99,154	99,075

32.4 Fair values of financial assets at March 31 2011

	GROUP		TRUST	
	Book value £000	Fair value £000	Book value £000	Fair value £000
Debtors over one year – Agreements with commissioners to cover creditors and provisions	2,360	2,360	3,245	3,245
Other	100,139	100,139	100,001	100,001
	102,499	102,499	103,246	103,246

As allowed by IFRS 7, short-term trade debtors and creditors measured at amortised cost may be excluded from the above disclosure as their book values reasonably approximate their fair values.

32.5 Maturity of financial liabilities

	GROUP		TRUST	
	March 31 2011 £000	March 31 2010 £000	March 31 2011 £000	March 31 2010 £000
Less than one year	108,261	99,154	108,038	99,075
	108,261	99,154	108,038	99,075

32.6 Financial assets interest risk

GROUP					
Currency	Total £000	Floating rate £000	Fixed rate £000	Non- interest bearing £000	Weighted average interest rate %
At March 31 2011					
Sterling	98,552	97,560	550	442	0.3
Other	2,137	61	–	2,076	0.4
Gross financial assets	100,689	97,621	550	2,518	
At March 31 2010					
Sterling	110,957	110,058	569	330	0.2
Other	1,502	–	–	1,502	0.0
Gross financial assets	112,459	110,058	569	1,832	
TRUST					
Currency	Total £000	Floating rate £000	Fixed rate £000	Non- interest bearing £000	Weighted average interest rate %
At March 31 2011					
Sterling	98,552	97,560	550	442	0.3
Other	2,137	61	–	2,076	0.4
Gross financial assets	100,689	97,621	550	2,518	
At March 31 2010					
Sterling	110,870	110,058	569	243	0.2
Other	1,502	–	–	1,502	0.0
Gross financial assets	112,372	110,058	569	1,745	

32.7 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 primary care trusts and the way those primary care trusts 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 but has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. 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 low exposure to credit risk. The maximum exposures as at March 31 2011 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 primary care trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

33 Third party assets

The Trust held £7,274 cash and cash equivalents at March 31 2011 (£20,694 at March 31 2010) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

34 Losses and special payments

There were 1,827 cases of losses and special payments totalling £6,722k (1905 cases totalling £2,112k at March 31 2010) approved during the year to March 31 2011. This includes cash payments during the year. These are not calculated on an accruals basis.



Contact information

Chief Executive

If you have a comment for the Chief Executive, contact:

Ron Kerr, 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: 020 7188 0012

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:

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