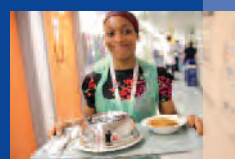
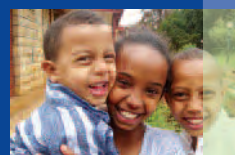


Annual Report and Accounts 2011-12



Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2011-12

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

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

We are among the UK's busiest, most successful foundation trusts. We provide a full range of local hospital and community services for people in Lambeth and Southwark, as well as specialist care for patients from further afield, including cancer, renal and cardiothoracic services. The architecturally award-winning Evelina Children's Hospital at St Thomas' provides many specialist services, including treatment for complex heart conditions, as well as general services for local children. Guy's is home to the largest dental school in Europe.

We have a long tradition of clinical and scientific achievement, including the development of one of the UK's first Academic Health Sciences Centres through which we create world-class teaching, research and clinical services.

We are developing this important academic healthcare organisation, King's Health Partners, with King's College Hospital NHS Foundation Trust,

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

We also have one of the National Institute for Health Research's original five comprehensive Biomedical Research Centres, established with King's College London in 2007. Last year, we were successful in securing £58.7 million to run our NIHR Biomedical Research Centre for a further five years.

We have around 12,500 employees, making us one of the biggest employers locally. We aim to reflect the diversity of local communities and have spent time over the year developing new and existing partnerships with local people, patients, neighbouring NHS organisations, local authority and charitable bodies and GPs.

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

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



KING'S HEALTH PARTNERS

Pioneering better health for all



During the year we relaunched our corporate social responsibility vision. The pictures in this report are taken from a short film that aims to encourage our staff to get involved. To see the DVD which highlights some of the exciting things that we are doing, visit our website: www.guysandstthomas.nhs.uk

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Chairman's statement

2011/12 was on any view a challenging year for the Trust. We were operating in a turbulent environment. There was a national debate about the future of the health services, alongside the introduction of new legislation.

Changes were being made to the way our services are commissioned, in the transition to the new Clinical Commissioning Groups. We were operating in what the NHS Chief Executive has described as "the toughest financial climate [the NHS] has ever known"; and of course the impact of the current economic climate was felt personally by every member of staff as the cost of transport and utilities rose, while pay was held back.

The staff of the Trust rose magnificently to this challenge under the leadership of the Chief Executive, Sir Ron Kerr, and the Board. Thanks to the professionalism and dedication of our staff, we continued to provide high quality services to our patients in our hospitals and in the community. We reinforced our commitment to sustaining and improving our performance with the publication of a new quality strategy. We continued to improve our efficiency and productivity, enabling us to invest in the future of our organisation through the capital programme.


Having welcomed to the Trust our colleagues in community services, we are already seeing benefits both from integrating community services across Lambeth and Southwark and from closer working between hospital and community services.

There were difficulties, of course. Our A&E department was under huge pressure throughout the year as the number of attendances continued to rise to unprecedented levels. We also had more patients waiting longer than 18 weeks for inpatient services than we should have done – and had to increase our workload to get ourselves back on track.

The Council of Governors continued to support the development of the Trust's strategy, providing challenge and support. Notably, they focused attention on the quality of our outpatient services and in particular 'front-end' processes such as appointments, phone services and welcome desks and the governors worked collaboratively with the Trust as we implemented improvements.

The Trust was indebted, as ever, to the partners with whom we work and on whom we rely for support, notably Guy's and St Thomas' Charity, and we continue to work closely with the Metropolitan Police, our colleagues in the Lambeth and Southwark local authorities, our Members of Parliament and other South Bank leaders to ensure that we listen to and serve our local community.

During the course of the year, the four organisations which form King's Health Partners agreed to prepare a Strategic Outline Case to assess the benefits, costs and risks of bringing the three Foundation Trusts together into a single organisation working even more closely with our shared university partner. This is, of course, a development of huge strategic importance to the Trust; and both the Board and the Council of Governors are deeply conscious of our responsibility and to weigh the outcome of the process with great care.



Sir Hugh Taylor, Chairman



As one of the largest employers in South East London, we work hard to create employment opportunities for our diverse local community. Project Search gives local people with autism work experience, and some have gone on to secure a job with the Trust.

Directors' report 2011/12

Guy's and St Thomas' NHS Foundation Trust has had another successful year operationally and financially, although this has not been without its challenges. Throughout the year, we have worked hard to balance patient safety, quality and efficiency while also maintaining good outcomes against national standards and targets.

Guy's and St Thomas' continues to deliver excellent care for patients while seeking to maintain a strong financial position that will allow us to invest in quality and service improvements that benefit our patients and help to deliver the ambitious vision that we have for both our Foundation Trust and our Academic Health Sciences Centre, King's Health Partners.

The Trust is not only one of the largest and busiest in the UK, but we also have one of the most ambitious capital investment programmes in the country. In striving for excellence, we recognise the need to generate surpluses to enable us to invest in services, new equipment and technology and the buildings, infrastructure and information technology that we believe will provide the cornerstone of world-class health care in the future.

We are determined that local people, as well as patients from further afield – including nationally and internationally – will benefit from the services, teaching and research that lie at the heart of what we do.

We strive to achieve this despite the increasingly difficult financial position facing the NHS and the public sector more widely. We continue to work hard to achieve our CQUIN (Commissioning for Quality and Innovation), QIPP (Quality, Innovation, Productivity and Prevention) and Monitor targets, as well as the many other national and local standards expected of us.

We also seek to play an active and positive role in the wider health economy in south east London and beyond. This includes forging

strong relationships with the new clinical commissioning groups and maintaining those we have with primary care trusts, other hospital trusts and clinical networks.

All that we do depends upon the dedication and hard work of our staff and we are delighted with the progress we have made in integrating community health services in Lambeth and Southwark into the Trust on behalf of King's Health Partners. While there is more to do to achieve all the benefits this offers our patients, we are now working from firm foundations that we have established over the past year.

King's Health Partners

The success of King's Health Partners Academic Health Sciences Centre (AHSC) is fundamental to our vision of world-class health care, underpinned by excellence in teaching, training and translational medicine that will bring new treatments to our patients at the earliest opportunity.

With our partner organisations – King's College Hospital and South London and Maudsley NHS Foundation Trusts and our shared academic partner, King's College London – we are committed to developing our Academic Health Sciences Centre faster and to a greater extent than we have to date.

In support of this, in February, the King's Health Partners Board, with the full support of the Boards of the three NHS Foundation Trusts and their equivalent in King's College London, agreed to support the development of a Strategic Outline Case to explore the creation

of a single academic healthcare organisation. This process will assess the benefits, costs and risks, as well as the opportunities this would bring and is expected to report back in summer 2012.

The development of the 21 Clinical Academic Groups, which lie at the heart of King's Health Partners and bring together the tripartite mission of clinical care, teaching and research, has continued during the year.

A number of service changes are being planned or have taken place in support of this: notably, major investment is under way at St Thomas' to centralise inpatient vascular services, complete with a new state-of-the-art hybrid theatre. This will create London's largest vascular service, benefiting patient care and research.

Meanwhile, bone marrow transplant services have integrated into a single service, with patients transferring from Guy's to King's College Hospital. A single hyper-acute stroke service (HASU) has also been created at King's to treat the most seriously ill stroke patients, working closely with the stroke unit at St Thomas'.

King's Health Partners is delighted to have joined the partnership to create the Francis Crick Institute. Due to open in 2015, this £650 million world-class biomedical research institute will bring together clinicians and researchers from London's three Academic Health Science Centres, the Medical Research Council, Cancer Research UK and the Wellcome Trust.

In a further development, the

fundraising teams across King's Health Partners have come together as a single team under a new brand, *Together we can...* This is already increasing philanthropic donations across the partner organisations to support our services and research.

Achievements

The past year has been one of many achievements, despite a number of operational performance issues that we have worked hard to address. The highlights include:

- the successful integration of Lambeth and Southwark community services in April 2011, with around 1,500 new staff joining the Trust;
- favourable inspection reports from the Care Quality Commission, confirming that the Trust meets essential standards of quality and safety;
- recognition that we are among the best performing London hospitals according to the latest national inspection of patient food, hospital environment, cleanliness, privacy and dignity;
- the launch of our first equality objectives and a new and engaging vision for corporate social responsibility;
- the award in August of £58.7 million from the National Institute for Health Research (NIHR) for our Biomedical Research Centre over the next five years to support an ambitious programme of translational research, complemented by £5.6 million

for our Clinical Research Facility awarded in February;

- the delivery of a surplus of £11.4 million, following an impairment of £6.2 million due to the revaluation of the Trust's buildings.

As part of our focus on avoiding unnecessary hospital admissions, in January our community services teams launched Home ward to care for more patients at home rather than in hospital, as well as an enhanced rapid response service that provides home based re-ablement and support so that vulnerable people can remain at home.

In addition, we are delighted that Guy's and St Thomas' Charity confirmed funding of £10.6 million to support the integrated care programme that we have developed with mental health, local authority and primary care colleagues. Building on a pilot project, this programme will focus initially on improving the older persons pathway, as well as people with long-term conditions, in Lambeth and Southwark.

St Thomas' continues to provide a wide range of highly specialised 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.

Among the many services that celebrated milestones last year were our Assisted Conception Unit at Guy's, which marked the birth of more than 300 healthy babies with a party for children and their families who have benefited from pioneering pre-implantation genetic diagnosis (PGD) for serious genetic

conditions, and the Three Boroughs team, which celebrated 20 years of supporting some of the most vulnerable people in Lambeth, Southwark and Lewisham and making a real difference to their lives in times of crisis.

We were delighted that, as part of the national Safe and Sustainable Review of specialist services for children with serious heart conditions, the Evelina Children's Hospital came out as the most highly ranked service in England in a report by Sir Ian Kennedy.

We are committed to providing the best possible services to young patients and their families and are proud of our ability to support patients as they move from the Evelina Children's Hospital into our adult services. Subject to the outcome of the current judicial process, we are committed to working collaboratively to implement the recommendations of the review and manage the transition process in the best interest of patients.

As part of our significant capital investment programme, one of the most exciting developments is the King's Health Partners Cancer Treatment Centre at Guy's. During the year, we have made great progress with the detailed design work, involving patients and staff at every step of the way. Having secured a loan from the NHS Foundation Trust financing facility, we expect to submit a planning application later this year.

In other developments, a new outpatient facility will open at St Thomas' in June, building on considerable work during the year

to improve the experience of the 647,500 patients who attend an outpatient appointment at our hospitals each year.

We also began to implement our ambitious estates strategy, with more than £433 million being invested over four years on hospital sites. Work began on a £40 million recladding of Guy's Tower and we are planning investment in the East Wing at St Thomas' and an ambitious IT strategy. The former includes energy efficient cladding and windows and repairs to deteriorating concrete, as well as dramatic artwork. The result will be a landmark worthy of the world's tallest hospital tower.

Business and review

Guy's and St Thomas' has again performed well financially in 2011/12, despite the continued difficult economic environment. The Trust declared a surplus of £17.6 million for the financial year, before accounting for an impairment of £6.2 million due to the revaluation of the Trust's buildings, which reduced the reported surplus to £11.4 million.

Although, we did not achieve our target surplus, 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.

This year's surplus will add to those achieved in previous years and allocated to develop services and to implement our ambitious estates strategy.

We have identified the key drivers of change which we believe present

both challenges and opportunities to our future operation. These are:

- health policy and legislation, including the implementation of the Health and Social Care Act;
- the changing economic environment;
- the ongoing development of King's Health Partners, including Clinical Academic Groups;
- changes to commissioning arrangements for clinical services;
- savings and activity plans;
- Commissioning for Quality and Innovation targets (CQUIN)
- commercial opportunities.

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

The Trust has developed a 'balanced score card' to review and monitor performance at both a Trust-wide 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 three, in a range of one to five where five is the best performance.

Performance and inspections

Last year saw a significant improvement in our performance against the national cancer targets, but it was also a difficult year with respect to performance against the new 'referral to treatment' measures. Overall, we believe we have ended the year in a stronger position, with a better understanding and ability to address the issues that have an impact on our performance in these areas.

Not only did we treat around 10 per cent more inpatient and day cases last year, but we also have robust plans in place to treat significantly more elective patients in 2012-13, enabling us to tackle our longest waits by the end of September. We have also increased diagnostic capacity, particularly in endoscopy and radiotherapy.

In 2011-12 the Trust identified weaknesses in control with the Trust's information assurance arrangements; we have therefore implemented a 12-month action plan. The Trust is not complacent and we have commissioned independent external reviews of our information assurance processes. This remains an ongoing area of risk, which will continue to be monitored externally and through our committee structure.

In 2011, under the Care Quality Commission's (CQC) 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. During the year, we were also subject to a

number of unannounced CQC inspections and, while some areas for improvement were identified, all the visits were very positive.

Throughout the year, we have worked hard to balance patient safety, quality and efficiency, while also maintaining good outcomes against national standards and targets, including Monitor's compliance framework. This requires sustained effort from frontline staff and managers and we work hard to support them, for example, through our 'Clinical Fridays' and weekly managers' forum.

In November, we launched a quality strategy for the Trust which draws together our many quality initiatives, focused on patient safety and patient experience, and we have also introduced a number of ways in which we can listen and respond to the views of our patients. Further details can be found in our full Quality Accounts, and also in chapter 6 and the Annual Governance Statement in this report.

We recognise that there is always more that we can do to improve the quality and timeliness of care for our patients; this work has been driven forward with the strong support and involvement of both our Council of Governors and Board of Directors. We have introduced a new style quality report which aims to improve and make our reporting of quality issues more accessible and engaging.

Corporate social responsibility

We have a strong track record and commitment to corporate social responsibility. We continue to buy goods and services locally wherever

possible, and have a number of employment initiatives to help local people into employment. We are proud to be the first hospital in England to collaborate with the Prince's Trust to reduce youth unemployment by offering placements to local 16- to 25-year-olds who do not have a job.

We have made a strong commitment to improving the health and well-being of our staff and local population, and also internationally through the King's Health Partners' Centre for Global Health.

Commercial activities

The Trust has a long tradition of innovation, ranging from medical breakthroughs and translational research to capitalising on commercial opportunities which allow us to generate additional income that supports the delivery of our NHS services.

Major initiatives this year have included:

- securing a preferred bidder to work with us to deliver enhanced private patients services in a partnership that will form a key part of the new Cancer Treatment Centre at Guy's;
- agreement with a commercial partner to provide home healthcare, outpatient dispensing, and associated retail services that will improve services for patients, visitors and staff;
- plans for new satellite renal and radiotherapy services;
- continuing to provide healthcare services for British Forces based in Germany.

Board of Directors

The Board of Directors brings a wide range of experience and expertise to its stewardship of the Trust and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive. Sir Hugh Taylor, who brings exceptional skills and expertise to the organisation at a crucial time, completed his first full year as Chairman in February.

In 2011-12, the Board comprised the following Executive Directors: Chief Executive Sir Ron Kerr, Director of Finance Martin Shaw, Medical Director Dr Ian Abbs, Chief Nurse Eileen Sills, Director of Capital, Estates, Facilities and IT&T Steve McGuire, Director of Workforce and Organisational Development Ann Macintyre and Commercial Director Hugh Risebrow.

Hugh Risebrow left at the end of March 2012 after three years at Guy's and St Thomas', during which time he helped to improve the profitability of our commercial services and broaden our approach to commercial ventures in general. His deputy, Vicki Cheston, took over his post in an acting capacity. Amanda Pritchard joined the Trust as Chief Operating Officer in April 2012, taking on the responsibility for operational management which has previously been shared by Ian Abbs and Eileen Sills.

The Board, chaired by Sir Hugh Taylor, also includes the following Non-Executive Directors: David Dean, Mike Franklin, Rory Maw, Frank Nestle, Jan Oliver and Diane Summers, with Girda Niles being appointed as a Non-Executive Director in September 2011 and

taking up her appointment in January 2012. Jan Oliver's appointment was extended for a year, until December 31st 2012, following the appointment of Amanda Pritchard as an additional Executive Director. The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditors. Board members 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.

Accounting policies for pensions and other retirement benefits are set out in note 1.6 to the accounts and details of senior employees' remuneration can be found on page 96 in note 6.5.

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 our website (www.guysandstthomas.nhs.uk).

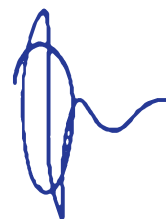
Looking ahead

In common with the health service and public sector as a whole, we are

operating in a fast changing and demanding external environment. We recognise the need to increase efficiency significantly whilst maintaining high quality care at a time when budgets are tight. We will continue to use our strong financial track record and exceptional staff to respond to these challenges, including the further changes that will be implemented as a result of the passing into statute of the Health and Social Care Act.

We believe the greater freedoms we are afforded as an NHS foundation trust, combined with the opportunities we have as part of King's Health Partners, 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.

We wish to thank all those who have helped us to achieve so much in 2011-12, including our staff, governors and wider membership, Guy's and St Thomas' Charity for its ongoing support, our King's Health Partners collaborators and our many external stakeholders and supporters, in particular the new GP commissioning groups, local primary care trusts and the many other NHS organisations in south east London with which we have worked closely over the past year.



Sir Ron Kerr

Chief Executive

On behalf of the Board of Directors



We are proud to have developed links with overseas health organisations, and many of our staff also volunteer abroad. We provide clinical and management expertise, for example, to support the Children's Hospital in Ndola, Zambia and to help train ophthalmology staff in Tanzania. Our staff volunteer in many countries, including in Ethiopia, Nigeria, Kenya and Sri Lanka.

3

Operational and financial review

Guy's and St Thomas' is one of the largest and busiest trusts in the country; over the past year, we have seen and treated 647,500 outpatients, 83,500 inpatients, 74,000 day case patients and 171,500 accident and emergency attendances. We have also had 672,701 contacts with community patients.

Our performance

Our performance is externally assessed against a range of national targets and standards. Last year was a particularly challenging one for the NHS with all trusts expected to provide the highest standards of care while achieving demanding efficiency savings.

Throughout the year, we worked hard to balance patient safety, quality and efficiency with achieving excellent patient outcomes and maintaining performance against these targets.

We saw significant improvements against national cancer targets but it was a difficult year in respect of our performance against the new referral to treatment measures. Overall, we believe that we have ended the year in a stronger position, with a better understanding and ability to address the issues that affected our performance in these areas.

Activity levels increased significantly last year. Not only did we treat around 10 per cent more inpatient and day cases, but we also have robust plans in place to treat significantly more elective patients in 2012-13, enabling us to tackle our longest waits by the end of September. We have also increased diagnostic capacity, particularly in endoscopy and radiotherapy.

All our achievements during the year are a testament to our robust policies and hard working staff.

The CQC granted Guy's and St Thomas' a licence to practice as an NHS foundation trust in 2011-12. The CQC requires trusts to meet 16 standards that cover aspects of care including patient involvement and information,

personalised care and treatment, and safety and safeguarding.

National targets

We have continued to work hard so that most of our patients are seen within 18 weeks. Midway through the year, we identified that we had more people on our referral to treatment pathway for patients requiring admission – the target that measures maximum waiting times – than previously reported. This resulted in the Trust undertaking a detailed internal review with expert advice.

A comprehensive action plan was urgently developed to tackle the longest waits, which are concentrated in a small number of specialist areas. We remain on track with this plan and treat around 500 extra patients a month.

As a result of the way that this target is measured – and while we are treating more patients who have waited over 18 weeks each month – we do not expect to achieve the referral to treatment target by the end of September 2012. Over half our admitted patients waited seven weeks or less, against a comparable national average of eight weeks. We are currently treating about 85 per cent of our admitted patients within 18 weeks, against a target of 90 per cent.

It is highly regrettable when someone has a long wait for treatment. We are working hard to ensure that all our patients are seen in a timely way by our highly skilled and often very specialist staff.

Last year saw significant improvements in our performance against the national cancer

targets, with our achieving the target of seeing patients within two weeks after urgent GP referral.

Common with trusts receiving tertiary referrals from other hospitals, we continue to find it difficult to achieve the target of a maximum of 62-day referral to treatment target. We met this target for patients already registered at Guy's and St Thomas', but we didn't meet this for patients referred to us later in their pathway from other hospitals. We are working with external referral centres to ensure that delays are minimised for these patients.

As part of our drive to reduce cancer waiting times further, we are investing in a new four-bed endoscopy suite to increase our diagnostic capacity. We have also invested in a state of the art Tomotherapy machine to provide additional radiotherapy. We are also investing in our cancer day unit, which will see capacity for chemotherapy doubled.

We continue to have very low levels of hospital acquired infections, including MRSA, clostridium difficile, norovirus and surgical site infections. We are committed to reducing the levels of hospital acquired infections through a drive for cleanliness and zero tolerance of poor hand hygiene.

Reducing the rate of MRSA infections is a key national target and is indicative of the degree to which hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by staff.

We are disappointed that we exceeded our MRSA target of no more than seven cases in a year. We

had a total of eight cases: two were considered unavoidable. In the other six cases, the patients had complex medical conditions which contributed to their infections.

We were also set a target of no more than 155 cases of *C.difficile* by our commissioners. We had 121 cases in 2011-12; the number reflects the introduction of a new and significantly more sensitive test, which identifies more cases and so is better for patients.

We continue to see significantly increasing demand for our accident and emergency department at St Thomas'. Despite this, we met the national target for diagnosing, treating and discharging or admitting 95 per cent of patients within four hours.

We are currently reviewing in detail how patients move through our emergency services in A&E to allow us to meet future patient demands and to improve services for our patients. This includes opening a new Urgent Care Centre at Guy's in summer 2012.

During the year, we began detailed preparations for the Olympics and Paralympics so that we can operate as usual during the London 2012 Games, while addressing staff and patients' travel difficulties and creating an Olympic legacy that celebrates health and well-being.

Commissioners hold the NHS budget for their area and decide how to spend it on hospitals and other health services. Our commissioners set us goals based on quality and innovation: a proportion of our income is conditional on achieving these goals. This system is

called the Commissioning for Quality and Innovation or the CQUIN payment framework.

Last year, 1.5 per cent of our clinical income was conditional upon achieving quality improvement and innovation goals agreed with Lambeth, Southwark and Lewisham primary care trusts through CQUIN. This equates to more than £10 million of our total income and we are pleased to have achieved virtually all the targets and secured more than 90 per cent of this income.

For further details of the Trust's performance see tables on page 15, chapter 6 and the Annual Governance Statement on page 79. The Trust's annual Quality Accounts are published separately and are available online at NHS Choices (www.nhs.uk).

NHS Litigation Authority

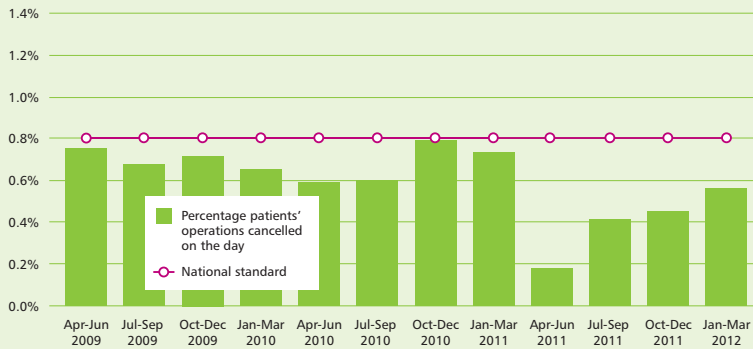
We were assessed by the NHS Litigation Authority against their risk management standards for acute trusts and maternity services in June 2010, when we achieved level three (the highest level possible) in both assessments.

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 three accreditation is a considerable achievement and a testament to our employees' commitment to quality and safety.

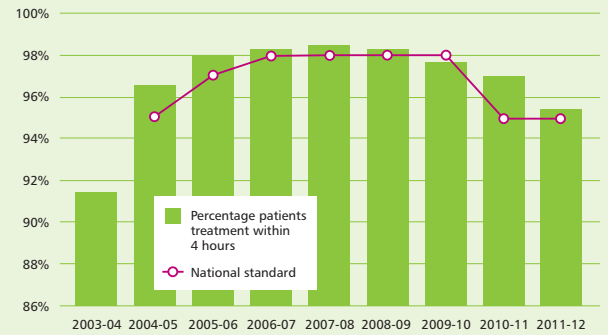
We are currently preparing for our assessment against level three standards for acute services in March 2013, with an assessment for level three maternity standards in June 2013.

Performance against national targets

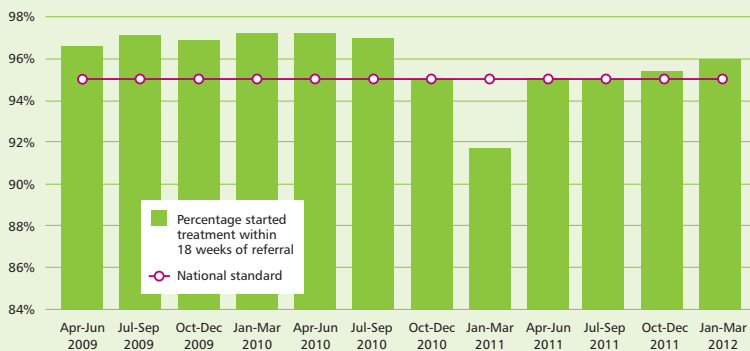
Percentage of patients' operations cancelled on the day



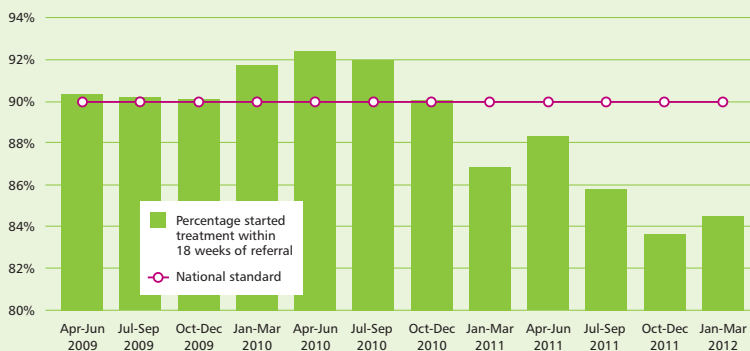
Percentage of patients treated within four hours in A&E



Percentage of patients starting non-admitted treatment within 18 weeks of referral

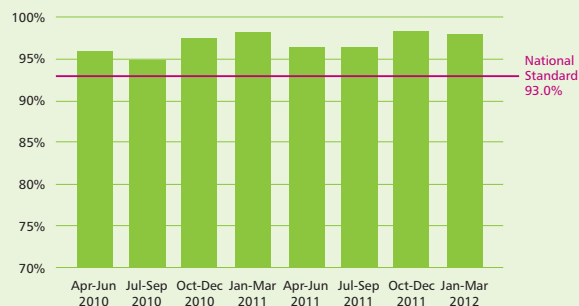


Percentage of patients starting admitted treatment within 18 weeks of referral

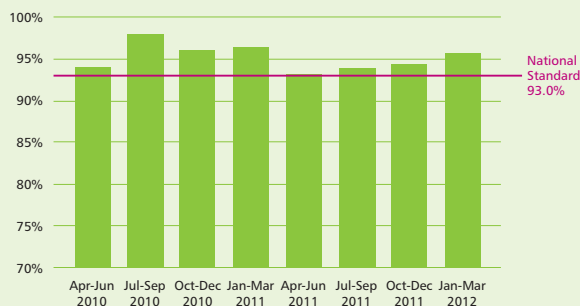


Performance against cancer access targets

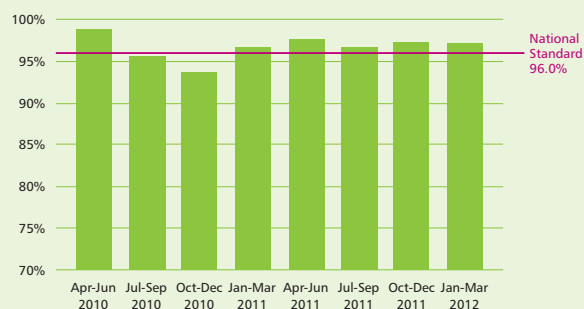
Urgent GP referrals seen within 2 weeks



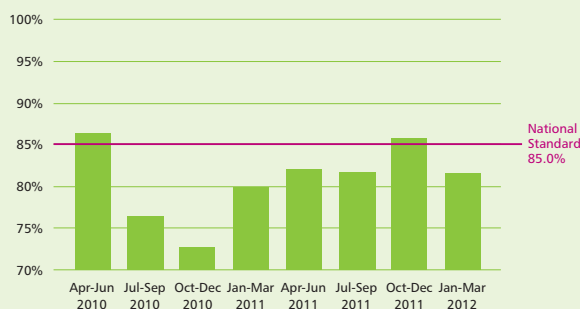
Breast symptomatic referrals seen within 2 weeks



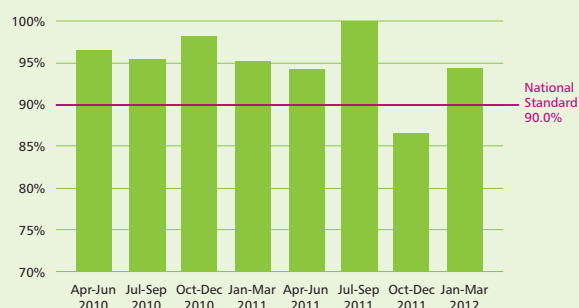
First treatment within 31 days



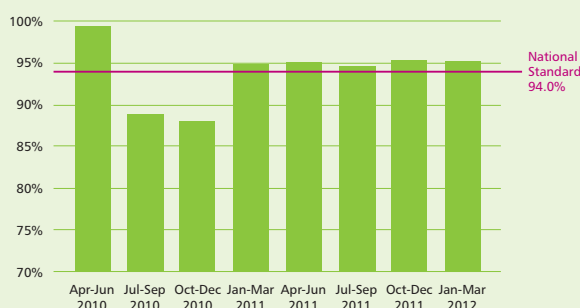
Treatment within 62 days of an urgent GP referral



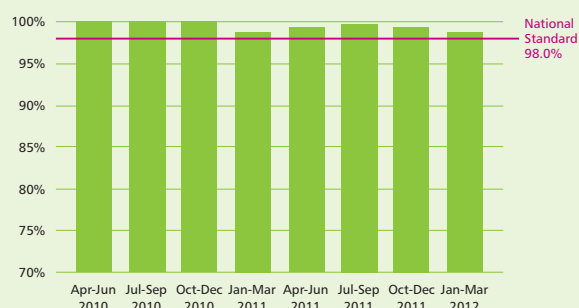
Treatment within 62 days of referral from screening



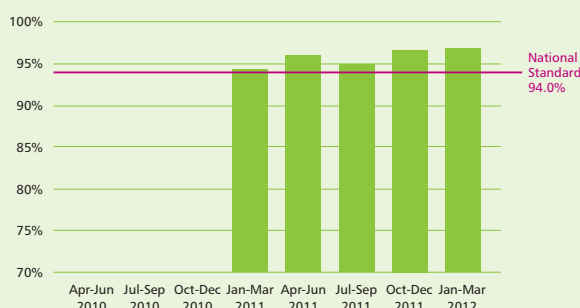
Subsequent treatment (surgery) within 31 days



Subsequent treatment (chemotherapy) within 31 days



Subsequent treatment (radiotherapy) within 31 days



Environmental impact performance indicators 2011/12

Area		Non-financial metric	Non-financial metric		Financial data (£000k)	Financial data (£000k)
		2011/12	2010/11		2011/12	2010/11
Waste minimisation and management	High temperature disposal	271 tonnes	268 tonnes	Total waste cost	£1,365*	£802
	Landfill disposal	1,370 tonnes	2,055 tonnes			
	Non-burn treatment	1,339 tonnes	1,359 tonnes			
	Waste recovery/recycling	32%	22.3%			
Finite resources	Water	437,166 m3	508,932 m3	Water	£606	£673
	Electricity	152,904 GJ	146,097 GJ	Energy	£9,064	£7,345
	Gas	647,878 GJ	672,095 GJ			
	Oil	685 GJ	412 GJ			

*The figures for 2011/12 include two waste streams that were not part of the 2010/11 return – this explains the increase in the 2011/12 figure.

Sustainability and climate change

The Trust continues to implement its award-winning sustainability strategy, in line with the NHS carbon reduction strategy. We are on target to cut our carbon emissions by 20 per cent by 2015, 34 per cent by 2020 and by 80 per cent by 2050.

The combined heat and power engines, on both sites reduce carbon emissions and save us nearly £2 million a year. We also invested in energy savings when upgrading our infrastructure: for example, installing LED lighting, computer power management and highly efficient chillers.

Our network of over 100 local environment representatives helped save energy, water and waste, engage staff and act as the eyes and ears of our sustainability campaign. We also engaged staff and patients by taking part in the NHS Forest initiative and by running environmental awareness events during Climate Week and on the NHS sustainability day of action.

We buy 100 per cent recycled paper and other stationery products, and have reduced the use of paper through double-sided printing and

by introducing paperless working. We are committed to reducing our construction waste to landfill by 80 per cent, exceeding the government target of 50 per cent.

We reduced our gas consumption by 6 per cent when compared to last year, and water usage is down by 14 per cent. There was a slight increase in overall waste of some 15 tonnes, or 0.35 per cent; however our clinical waste for incineration was reduced by 12 per cent and the percentage of our overall waste recycled increased from 22 per cent in 2010-11 to 32 per cent in 2011-12. These achievements happened while increasing our clinical and facilities management activities, which makes them all the more impressive.

Future improvements will include: further water efficiency, waste reduction and recycling; active and sustainable travel; improving the environmental impact of our supply chain and adapting models of care to improve efficiency.

Corporate social responsibility

As the largest employer in south London with around 12,500 staff,

the Trust has a significant impact on the environment and on local residents and businesses, as well as on the health and well-being of our patients and staff.

Corporate social responsibility embodies the best of Guy's and St Thomas' and our values. Last year, the Board renewed our vision to support and enhance the communities we serve, and help protect the environment by:

- seeking to deliver the best and most ethical health care;
- publicly reporting on our environmental impact;
- fostering positive relationships with our diverse local communities;
- teaming up with suppliers to minimise our environmental impact;
- raising staff awareness of their impact on the planet both at work and at home;
- creating partnerships with local businesses to positive effect;
- supporting global health initiatives and share learning;
- promoting healthy and sustainable lifestyles.

We are proud to be one of the first

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

Our performance against national and core quality standards

Existing indicators		National standard	2011/12 Final	2010/11 Final	2009/10 Final
A&E access	% patients discharged within 4 hours in A&E and MIU	>95%	95.6% ●	95.9% ●	97.6% ●
Cancelled operations	% elective operations cancelled on day of operation	<0.8%	0.50% ●	0.67% ●	0.70% ●
	% cancellations not re-admitted within 28 days	<5%	4.1% ●	0.0% ●	0.9% ●
Health and well-being	Patients seen within 48 hours of referral to GUM clinic	>99%	100.0% ●	100% ●	100.0% ●
	Ethnic coding of inpatients	>90%	92.2% ●	91.7% ●	91.9% ●
Clinical quality	Call to balloon time for primary angioplasty – % under 150 minutes	>80%	92.2% ●	87.2% ●	58.1% ●
MRSA screening	% compliance with MRSA screening for elective admissions		98.7% ●	99.0% ●	93.4% ●
Infection control	MRSA bacteraemia reduction	<7	8 ●	4 ●	16 ●
	C.difficile acquisitions in over 2's	<155	121 ●	118 ●	73 ●
	% clinical staff compliant with hand hygiene (monthly audit)	>98%	98.9% ●	97.7% ●	97.5% ●
	MRSA screening of non-elective admissions		94.8% ●	95.7% ●	
18 week referral to treatment times	% admissions within 18 weeks	>90%	85.4% ●	90.4% ●	90.6% ●
	% non-admissions within 18 weeks	>95%	95.4% ●	95.6% ●	96.2% ●
Cancer access	Urgent GP referrals seen within 2 weeks	>93%	97.4% ●	96.6% ●	97.0% ●
	Breast symptomatic referrals seen within 2 weeks	>93%	94.5% ●	96.2% ●	93.2% ●
	Cancer treatments started within 1 month of decision to treat	>96%	97.2% ●	96.2% ●	99.4% ●
	Cancer treatments started within 2 months of urgent GP referral	>85%	83.5% ●	79.2% ●	85.2% ●
	Treatments started within 2 months of screening programme referrals	>90%	94.1% ●	97.0% ●	99.0% ●
	Subsequent surgical treatment within 1 month	>94%	95.5% ●	93.2% ●	97.8% ●
	Subsequent chemotherapy treatment within 1 month	>98%	99.2% ●	99.6% ●	99.6% ●
	Subsequent radiotherapy treatment within 1 month	>94%	96.2% ●	94.3% ●	
Infant health	Smoking during pregnancy	<5%	3.7% ●	3.8% ●	4.8% ●
	Breastfeeding initiation	>90%	93.7% ●	90.6% ●	87.0% ●
Clinical indicators	Hospital mortality – unadjusted counts of deaths (monthly average)	<90	81 ●	91 ●	93 ●
	Standardised mortality ratio (earlier years re-based)	<85	79.1 ●	72.3 ●	93.6 ●
	Readmission rate (emergency readmissions within 28 days)	<4.5%	5.3% ●	5.4% ●	4.7% ●
	Quality of stroke care – % patients with >90% stay in stroke unit	>90%	91.7% ●	94.5% ●	82.1% ●
	Venous thromboembolisms – % patients screened	>90%	92.0% ●	92.7% ●	
	10% reduction in patient slips trips and falls with harm (per month)	<5	2.1 ●	3.1 ●	
	Pressure ulcer acquisitions – 10% reduction (per month)	<12.7	6.5 ●	13.0 ●	
	Smoking cessation referrals per month	>150	184 ●	150 ●	120 ●
Maternity	% Caesarean births	<27%	27.4% ●	27.6% ●	28.4% ●
	Health assessments completed within 12 weeks	>80%	93.4% ●	93.0% ●	87.0% ●
	Dedicated midwife during labour	>90%	98.0% ●	98.0% ●	99.0% ●

Community indicator.

Following integration, this is the first year of combined Lambeth and Southwark data.

Indicator	Target	Q1	Q2	Q3	Q4
District nurse: referral to patient contact (<24hrs)	>95%	60%	58%	82%	86%
Health visitor – % infants breastfeeding at 6 – 8 weeks	>75%	65%	72%	72%	76%
Health visitor new birth visits within 14 days*	>95%	80%	85%	89%	91%

* figure excludes where receipt of birth notification is greater than five days.

hospitals in England to work with the Prince's Trust to reduce youth unemployment by offering three-week work placements, with mentors, to unemployed local people aged 16 to 25. Once they had finished, almost half of the participants found employment with the Trust. We will continue to work alongside the Prince's Trust to widen access to employment and skills.

Internationally, we contribute to the King's Health Partners Centre for Global Health, which leads the development of education, training and capacity building in a number of African countries including Sierra Leone, Somaliland, Tanzania, Zambia and Zimbabwe.

We have links with Ndola Central Hospital and the Arthur Davison Children's Hospital in north-west Zambia. The children's hospital management team visited last May and their Chief Nursing Officer worked with us last autumn to develop a paediatric nursing curriculum. One of our paediatric haematology consultants and an ENT consultant went to Zambia in November, while other clinical staff from the Trust worked with their counterparts in Tanzania to identify and treat retinal diseases.

Separate from corporate initiatives, many staff give up their own time and money by donating their expertise at home and abroad to worthwhile causes. A cardiac team from the Evelina Children's Hospital travelled to Kenya last May and again during February 2012 to carry out surgery and teach the principles of managing sick children. Another cardiac team visited Sri Lanka as part of a continuing programme of annual visits.

To support individual volunteers, we are launching an online social networking platform for staff to promote corporate social responsibility, encourage staff participation and help to connect individuals and teams with charitable and volunteering activities.

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, we have two main strategic priorities over the next few years:

- to deliver services of increasing productivity and excellence which ensure financial sustainability for the Trust;
- to progress a limited number of vital clinical service and academic developments.

To achieve this, it will be important to develop the King's Health Partners Academic Health Sciences Centre, enhancing the strong reputation for clinical excellence and high quality care.

Information risks

The Trust is required to assess and report information risks and data losses in a standard format. Unfortunately, in 2011-12 we had one serious incident involving the destruction of a set of clinical records held in a local school. This was reported to the Information Commissioner's Office. Although the incident did not result in the permanent loss of information – as there were duplicate records – and no confidential information entered

the public domain, it did highlight our need for more robust records management processes. These have now been implemented.

We take all information security 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.

Quality

Delivery of the quality strategy is underpinned by our quality governance framework which is built on the principles of: strategy; capability and culture; structures; and measurement, described in the Monitor quality governance framework.

The strategy focuses on patient safety and patient experience. Our priorities were developed with our stakeholders and are described in chapter 6. Delivery is monitored against specific and measurable objectives by the Board's Quality Committee. The Annual Governance Statement on page 79 describes the structures and information used to provide assurances to the Board of Directors. It also describes the significant risks managed during the year and those identified for 2012/13.

The Trust is implementing a system to provide clinical outcome information at a level where it can be used across the organisation to give a richer understanding of clinical quality and outcomes. This is part of wider improvements to the quality and use of data.

Sickness absence

Monitor requires us report our staff sickness absence rate. In 2011-12, this was 3.7 per cent.

Guy's and St Thomas' has again performed well financially in 2011/12, despite the continued difficult economic environment. The Trust declared a surplus of £17.6 million for the financial year, before accounting for an impairment of £6.2 million due to the revaluation of the Trust's buildings, which reduced the reported surplus to £11.4 million.

Our financial performance

In 2011/12, the Trust planned for a surplus of £30 million to deliver our ambitious plans for capital investment which underpin our estates strategy. Due to changes in the way in which Monitor requires Foundation Trusts to account for donations for capital expenditure, from April 2011 the plan was restated with a planned surplus of £25.8 million.

Table 1	2011/12 Plan £ millions	2011/12 Actual £ millions	Variance £ millions
Total income	1,068.2	1,136.4	68.2
Expenses excluding depreciation	-978.8	-1,063.2	-84.4
Depreciation	-42.3	-41.3	1
Operating surplus	47.1	31.9	-15.2
Public Dividend Capital dividend	-21.7	-20.8	0.9
Finance income	0.4	0.6	0.2
Other	0.0	-0.3	-0.3
Surplus for the year	25.8	11.4	-14.4

This restatement does not alter the Trust's planned funding for capital investment. It is against this revised plan that the £17.6 million surplus (prior to impairment) should be compared. This change has also led to the 2010/11 financial performance being restated for comparative purposes.

Although, the Trust did not achieve the target surplus, 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. The Trust had identified the requirement for a £60.7 million efficiency improvement, which would have delivered the £25.8 million surplus in 2011/12 and, at the end of the year, we had achieved £30 million of these savings and delivered increased activity and productivity improvements in addition to the efficiency savings.

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

In April 2011 the Trust was the successful bidder to provide community services in Lambeth and Southwark on behalf of King's Health Partners. These contracts increased the income of the Trust by £92.8 million in 2011/12.

Treasury accounting policy would normally require that these transactions be accounted for under the transfer of government function rule which requires the use of 'merger accounting'. Merger accounting requires prior period comparator figures to be restated to consolidate the financial performance and assets of the merged organisations as if they had been merged in the

comparator period. The Treasury has specifically exempted transactions which fall under the heading 'Transfer of Community Services' for 2011/12. Therefore the 2010/11 accounts have not been restated for these transactions.

The year end surplus reflects that the Trust successfully delivered a significant programme of cost reduction and increased efficiency. The Trust's income position exceeded our planned income for this period by £68.2 million, whilst expenditure was £84.4 million above plan – reflecting the additional costs of delivering higher levels of activity, the in-year transfer of the NHS Revalidation Support Team and a net £6.2 million impairment on our fixed assets.

The Trust's depreciation charge and dividend on Public Dividend Capital costs were £1 million and £0.9 million below plan respectively.

Table 1 compares the 2011/12 outturn to the 2011/12 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 to deliver the 18 week referral to treatment times, over and above the original contracted levels. This resulted in increased income and expenditure associated with delivering the additional work.

Financial performance 2010/11 and 2011/12

Guy's and St Thomas' has performed well financially in 2011/12 and the Trust has declared

a surplus of £17.6 million, prior to the £6.2 million impairment, leaving a net surplus of £11.4 million for the year. The Trust had planned to achieve a surplus of £25.8 million to deliver our ambitious target for capital investment to deliver our estates strategy.

Table 2 shows the Trust's financial performance for 2010/11 and 2011/12.

The Trust made a £20.8 million surplus in 2010/11 (restated from £17.9 million due to the Treasury requirement relating to accounting for capital donations) and achieved a surplus of £11.4 million in 2011/12, after accounting for the £6.2 million fixed asset impairment.

Table 2	2011/12 Actual £ millions	2010/11 Actual £ millions
Total income	1,136.4	995.3
Expenditure including depreciation	-1,104.5	-953.8
Operating surplus	31.9	41.5
Public Dividend Capital dividend	-20.8	-20.9
Interest on loans & receivables/other	0.3	0.2
Surplus for the year	11.4	20.8

2010/11 figures restated

This is equivalent to a £17.6 million surplus, excluding the fixed asset impairment. These surpluses have been allocated to develop services and to implement our ambitious estates strategy.

The surplus was primarily due to the following positive factors:

- additional activity which has resulted in increased income from Primary Care Trusts;
- additional funding from the Department of Health to recognise the specialist activity undertaken by the Trust funded at national tariffs;
- the successful delivery of a significant cost improvement programme;
- continued benefits of supply stock cabinets.

These 'gains' have been partially offset by:

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

The Trust delivered efficiency savings of £30 million in 2011/12, and will continue to drive down costs in future years as part of its plan to meet anticipated financial risks and to deliver surpluses that can be reinvested in service developments and our estate in support of the Trust's strategic vision.

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 2007/08 to 2011/12.

Activity trends

Charts 1 to 3 show the growth in inpatient and day case activity (measured as completed patient spells) – up by 22 per cent, and growth in outpatient attendances – up by 21 per cent.

outpatient referrals increased by 37 per cent and follow-up referrals increased by 15 per cent) over the period.

Accident and emergency attendances increased by two per cent in 2011/12, compared to 2010/11, and total attendances are up by ten per cent over the five year period.

Chart 4 shows the growth in income over the five year period from April 2007 to March 2012. Income has grown at approximately 12 per cent a year. However this includes the acquisition of Lambeth and Southwark Community Services and NHS Revalidation Team in 2011/12, and South East London and South West London Shared Service Partnership in previous years.

After adjusting for these acquisitions, the underlying growth in income is eight per cent a year over the five year period. The increase in income, above inflation, is mainly as a result of the 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 significantly at an average rate of 14 per cent a year, adjusted to 10 per cent after accounting for the recent acquisitions in 2010/11 and 2011/12. The growth in expenditure is primarily as a result of inflationary costs, additional staff and non-pay costs associated with delivering additional activity, and quality improvements.

However, it should be noted that the change in income and

The combined heat and power engines, on both sites reduce carbon emissions and save us nearly £2 million a year.

The growth in inpatient and day case activity relates to increased demand for specialist (tertiary) services 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 21 per cent (new

Trends in activity, income and expenditure

Chart 1: Completed patient spells

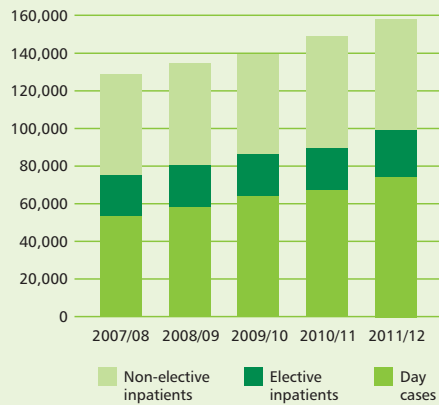


Chart 2: Outpatient attendances

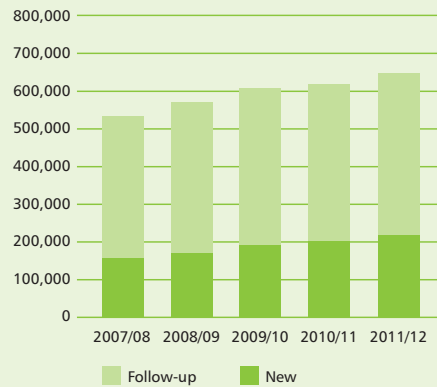


Chart 3: A&E attendances

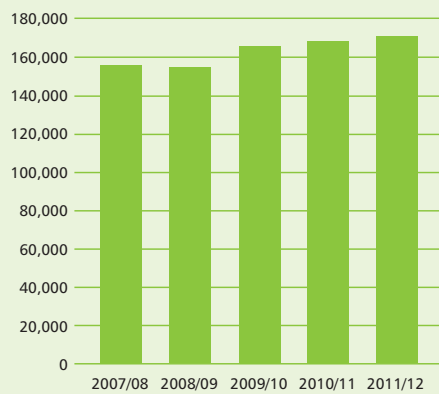


Chart 4: Income £000s

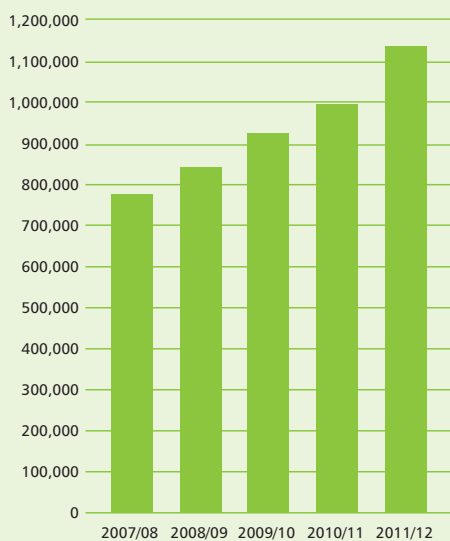
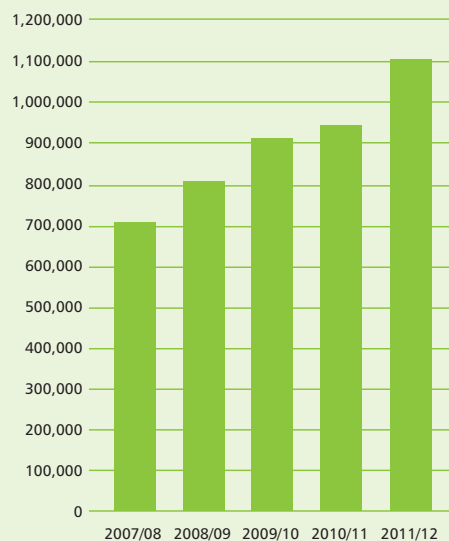


Chart 5: Expenditure £000s



expenditure between financial years 2009/10 and 2011/12 is significantly below the five year average, with both income and expenditure growing at slightly above four per cent a year. This reflects the changing economic climate and the increased efficiency savings delivered by the Trust since 2010/11. It is expected that reduced income growth and the need for further efficiency and productivity improvements will continue in 2012/13 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.

Table 3	NHS Funded £ millions	Donated £ millions
Buildings	3.6	0.8
Assets under construction	29.7	4.9
Plant and machinery	1.2	0.9
Information technology (IT)	3.4	0.0
Furniture and fittings	0.0	0.0
Software licenses etc	0.0	0.0
Total	37.9	6.6

The Trust ended the year with £143.9 million cash in the bank, against a plan of £93.0 million. This was an increase in cash of £50.9 million compared to plan, and an increase of £43.8 million when compared with the £100.1 million position at the end of 2010/11. The increase in cash against plan is mainly due to the Trust under-spending against the capital expenditure plan by £29 million on NHS funded assets, the

draw down of capital loans of £3.7 million, and the variance in working balances against plan of £31.8 million, offset by a shortfall in the income and expenditure cash surplus of £13.6 million.

The Trust had a planned capital spend of £69.9 million for the year, including £3 million of capital donations.

The actual capital expenditure during the year was £44.5 million, including £6.6 million from charitable funds. In addition the Trust drew down £3.7 million from a total of £160 million of loans secured from the Foundation Trust Financing Facility to support five major capital schemes, subject to Full Business Case approval.

The Trust's land and buildings were valued independently by the Valuation Office at March 31 2012, in line with accounting policies. The valuation included positive and negative movements. All valuation movements were the result of changes in market price.

Overall there was a net impairment charge of £13.6 million, of which £6.2 million was charged to the income and expenditure account as the Trust's buildings had insufficient revaluation reserves to fund the valuation movement.

The valuation included negative valuations of £27.9 million on buildings, as well as positive valuation movements on the Trust's land of £14.3 million.

There has been no change to the Trust's schedule of protected and non-protected assets during the year.

Charitable funding

The Trust is fortunate to be supported by Guy's and St Thomas' Charity. All the charitable funds that benefit the Trust are administered by this separate charity. In 2011/12, the Trust spent £6.6 million from charitable grants on capital projects, and also received £6.1 million in charitable contributions towards revenue expenditure.

Capital expenditure

Capital expenditure during 2011/12 was focused on protected assets and included backlog maintenance, the provision of medical equipment and investment in IT projects. Table 3 shows a breakdown of the different sources of the capital and how this has been spent.

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 patients cap for 2011/12 (see note 4.4 on page 94 of the annual accounts). The new Health and Social Care Act gives the Secretary of State the powers to abolish the Private Patient Cap.

Prudential Borrowing Limit

A Prudential Borrowing Limit 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 2011/12 the Trust arranged a working capital facility of £60 million, but did not need to draw on these funds.

The Trust has agreed loans totaling £160 million with the Foundation Trust Financing Facility for five major capital schemes. These loans are contingent upon the Board of Directors agreeing business cases for each scheme. The Board has agreed Full Business Cases to re-clad Guy's Tower and refurbish the sterile services department, totalling £43 million. In 2011/12 the Trust drew down £3.7 million of the agreed loan to cover the expenditure incurred. The Trust's performance against the Prudential Borrowing Limit indicators is described in note 25 on page 105 of the annual accounts.

External audit services

The Council of Governors agreed that Deloitte LLP should be the Trust's external auditor for 2011/12. The Trust incurred £130,440 in audit services fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries' to 31 March 2012. A further £21,000 was incurred in auditing the Trust's Quality Accounts for 2011/12. See note 6.2 on page 95 of the annual accounts.

In addition to the above, a fee was paid to our auditors of £207,000. This non audit work was for a consultation on a business case review for the Cancer Treatment Centre.

Monitoring Trust performance

The Trust has developed a 'balanced score card' to review and monitor performance at both a Trust-wide 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 three, 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:

- health policy and legislation, including the implementation of the Health and Social Care Act;
- the changing economic environment;
- the ongoing development of King's Health Partners, including Clinical Academic Groups;
- changes to commissioning arrangements for clinical services;
- savings and activity plans;

- Commissioning for Quality and Innovation targets (CQUIN)
- commercial opportunities.

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

The development of our Academic Health Sciences Centre, King's Health Partners, 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 £52.3 million savings in 2012/13 and also aims to deliver a surplus of £13 million, which will be in addition to the surpluses achieved in previous 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 that 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.

Health policy and legislation

The Health and Social Care Act recently passed into legislation, heralds significant changes in the NHS. At this time it is difficult to assess the impact of the changes and therefore the commissioning and financial risks set out below are those that 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 of over four per cent a year to be achieved by NHS Trusts. In addition, changes to funding arrangements for education being considered by the Department of Health could further reduce the funding available to teaching hospitals. The Trust will ensure programmes are developed to respond to these financial challenges, and will also focus on further improvements in productivity and efficiency, whilst maintaining and improving the quality of patient care and the overall 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 form King's Health Partners Academic Health Sciences Centre. 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 will continue to be actively explored. This continues to present exciting opportunities for service development, income growth and diversification, as well as greater efficiency.

The development of Clinical Academic Groups are at the heart of our efforts to bring clinical services, research and education activities together through a series of combined management units. We are currently exploring the case for closer integration through the development of a Strategic Outline Case. This process will assess the benefits, costs and risks, as well as opportunities this would bring and is expected to report back in summer 2012.

Changes to commissioning arrangements and for clinical services

The Trust is working closely with commissioners as they develop Clinical Commissioning Groups and as commissioning organisational

structures change. The commissioning intentions for 2012/13 focus on referral management and productivity improvements to be achieved through locally agreed quality, innovation, productivity and prevention initiatives. We continue to monitor the impact on the Trust of these new arrangements, having concluded our contract negotiations with our commissioners.

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

Savings and activity plans

The Trust has set itself challenging financial targets over the next three years in order 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 costs, 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 will be that the Trust and local Primary Care Trusts will be in financial deficit, which may lead to additional reductions in activity and

funding available in future years, and would also adversely impact on our estates strategy.

We have a positive track record of working closely with our 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.

Commissioning for Quality and Innovation targets (CQUIN)

The Trust has agreed with local Primary Care Trusts and our Specialist Commissioners fourteen acute and eight community CQUIN targets across a number of national, regional and local clinical priorities. These initiatives will account for 2.5 per cent of the Trust's income from these commissioners, payable based upon the achievement of these targets. The Trust has robust plans in place to ensure these clinical targets are met in full, so that the full income is received by the Trust.

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 partnerships with commercial organisations that have innovative products and services.



Over 400 volunteers help with a range of tasks, including assisting patients at meal times, reviewing patient leaflets and directing patients around the hospital and on the wards.

4

Our staff, patients and partners

The Trust is committed to improving the quality and safety of our services and the way in which our patients are treated. At the heart of this commitment are our dedicated staff and the support of our partners and stakeholders, including patients, local communities and other health and academic organisations.

Our staff

Our staff are the bedrock of the Trust and crucial to its success. Last year, we had over 12,500 clinical and non-clinical employees providing high quality care and increasing efficiency in a challenging environment.

Communicating with our staff

The Trust involves staff in decision-making, keeps them informed of changes and encourages them to get involved in improving services. Our one and a half day corporate induction is a useful introduction for all new recruits.

We work hard to ensure that staff are aware of priorities and relevant issues, including the changing financial and regulatory environment. Our communications include regular face-to-face briefings on clinical and management issues, a monthly team briefing, a daily email bulletin, our intranet, GTi, which is a central source for policies, guidance and news, and a regular magazine available in our hospitals and community centres.

We work with staff representatives to ensure that employees' voices are heard. The Trust Joint Staff Committee meets bi-monthly, acting as a valuable consultative forum. Sub-groups have worked to ensure we have robust and fair pay and employment policies and topics such as financial performance are regularly discussed. Our policies are assessed for their impact on equality.

Staff survey

We participate in the annual NHS national staff survey, which provides a valuable insight into employees' views. The 2011 survey was the first since Lambeth and Southwark community health services' staff joined the Trust and covered both hospital and community staff. Our response rate this year was 51 per cent, compared with a national average of 53 per cent for acute trusts.

The past year saw the Trust working on improving employees' experiences at work, including creating an action plan with staff side representatives in response to the 2010 results. Last year's action plan focused on appraisals, dignity and respect, infection control, healthy and safety, equality and diversity, and work-life balance. The 2011 survey results showed many improvements in these areas, with perception of the Trust remaining strong: 80 per cent reported that they agreed or strongly agreed that care of patients was the Trust's top priority. Additionally, 77 per cent would recommend the Trust as a place to work. We were among the top 20 per cent of acute trusts for 22 out of 38 key scores: an improvement from Q1 in 2010. The table on page 35 gives further details.

Like most NHS trusts, we are experiencing unprecedented change, including integrating community services, service reconfigurations and increased financial pressure. This level of change looks set to continue, so it is vital to continue to engage staff effectively. The Trust is exploring the option of small-scale, topical surveys, particularly online. The results will

complement the action plans and identify how else we can support staff.

Health and well-being

For the Trust to be successful, staff need to feel valued and we strive to achieve this. Staff benefits are an important part of our employees' overall reward package, and we offer a range of benefits that support organisational objectives, and staff motivation and well-being.

We aim to be one of the healthiest NHS trusts, thereby increasing staff retention and reducing sickness absence, which should in turn improve patient satisfaction.

Last year, we developed a new staff benefits strategy to help communicate benefits more clearly to staff. In February 2012 we held health and well-being roadshows on four sites which proved popular and align with NICE guidance on health and well-being in the public sector. We have been successful in helping staff to quit smoking this year and have exceeded our target. This was through joint working between staff in the acute and community services. We aim to be one of the healthiest NHS trusts, thereby increasing staff retention and reducing sickness absence, which should in turn improve patient satisfaction, quality and other patient outcomes.

We place a strong focus on health and safety to maintain an environment that is safe for staff, patients and visitors, underpinned by our health and safety strategy.

Equality and diversity

The Trust takes an inclusive approach to the nine strands of equality: age, disability, ethnicity and race, religion and belief, gender, sexual orientation, pregnant women, marriage and civil partnership, and gender reassignment.

We set our first equality objectives for 2012-13 in response to changes in legislation. The objectives seek to improve access and the quality of our services, develop our partnerships with local statutory and third sector organisations to tackle health inequalities, ensure that we are a fair and inclusive employer and protect those at the greatest disadvantage and who are most vulnerable.

The Trust's Associate Director of Equality and Diversity takes overall responsibility for monitoring our operations against these priorities and we publish details of our performance.

The Trust has developed fair recruitment practices to ensure equal access to employment opportunities for all. We are proud that we retained the 'two tick' disability symbol on recruitment materials, signifying our positive attitude towards employing disabled people, and we continue to support disabled staff, including anyone who becomes disabled during their employment.

During the past year, we

continued Project Search, which offers work experience to young people with learning disabilities or autism, with some participants moving into full-time employment at the Trust.

Aspire, the Trust's equality and diversity network, brings together staff and Directors to support our diverse workforce at all levels.

The integration of community services gave us a unique opportunity to improve our support for people with learning disabilities. The expertise of the community learning disabilities team, working alongside hospital colleagues, has led to initiatives including a learning disability health passport and more accessible communications, such as mealtime menus that use photo symbols and pictures.

Training and development

We are committed to developing and training our staff to ensure that their skills are up to date and relevant to changing services, and that they progress in their careers. As well as our mandatory training, we offer short courses (many in our purpose-built education centre close to St Thomas'), mentoring schemes, support for university schemes and other opportunities.

The Trust supports clinical and non-clinical apprentices in diverse trades and professions including nursing, pharmacy, housekeeping and engineering, with 184 undertaking an apprenticeship last year.

During 2011-12, the Trust invested significantly in leadership and management capabilities. These skills help key staff at all levels to deal with the increasingly complex

environment in which they work.

Our clinical leadership strategy helps to empower clinical directors, heads of nursing and general managers to lead and manage their services using both clinical and business knowledge. This supports decision making to deliver the best care for patients and consistently drive clinical excellence.

Working with King's College Hospital, the Trust has supported the frontline leadership programme for ward sisters and charge nurses, service managers and equivalent roles. Frontline leadership explores an individual's leadership role and offers coaching to improve performance. Last year, more than 100 quality improvement projects were delivered as part of the programme.

In February 2012, our IT training team received two national awards from the Learning and Performance Institute: training manager of the year and silver award for training department of the year (public sector). These are a benchmark for excellence and were awarded in recognition of our high standards, best practice, innovation and excellence in learning and development.

Essentia

As the scope of the Capital, Estates and Facilities Directorate has expanded it was felt that a new directorate name was needed.

The new name, Essentia, was developed in close consultation with the directorate's staff. It reflects the pride of the teams delivering services to staff within the Trust; to support the vision for

the future; and to reflect the services delivered to existing and potential customers externally.

Volunteers

Patients and staff benefited from almost 400 volunteers. Twice yearly recruitment was supported by in-house training and development to ensure that statutory training requirements, for example, concerning infection control, were met.

Volunteers worked regularly with us in a number of roles, including welcoming and guiding patients around our hospitals and supporting staff in collecting patient feedback. In a new development, 40 staff volunteered to support patients at mealtimes on the elderly care wards. This additional help for nursing staff ensured that their time was available for patients needing help with feeding.

A highlight of the year was a 'thank you' Christmas party, which is funded by Guy's and St Thomas' Charity. For the first time, there was also recognition of volunteers' contribution with the inclusion of a volunteer of the year category in the Trust's annual awards.

Patients

Our patients are why we are here. In 2011-12, we provided almost a million patient contacts in our hospitals, and a further 670,000 patient contacts in our community services. Only by listening to what they have to say about their care, and to the views of relatives, carers and visitors to our hospitals, can we provide excellent services that meet patients' needs.

Good care is not just about clinical quality, it's also about the way we treat our patients. The Care Quality Commission's (CQC) national inpatient and outpatient surveys show that 80 per cent of inpatients and 88 per cent of outpatients report that our staff always treat them with dignity and respect. We are pleased that these are high scores but we are determined to work hard to improve them further.

We are committed to involving patients, community groups and carers in developing our services.

The CQC surveys show that 82 per cent of hospital patients rated their care as good or excellent. We saw high satisfaction levels in many areas that are important to patients. More than nine out of 10 patients rated their room or ward (98 per cent) and toilets and bathrooms (94 per cent) as very or fairly clean. We take infection control very seriously and 89 per cent of inpatients and visitors told us that hand wash gels were visible and available for them to use.

Communicating clearly with patients about their care is important, not least so they have confidence in their treatment. In our national outpatient survey, 85 per cent felt doctors listened, 78 per cent of those with questions understood what they were told and 81 per cent felt were given the

right amount of information about their condition or treatment.

Last year, we introduced near time, electronic patient feedback on the wards and in outpatient departments to get frequent, timely data from the point of care. Results are discussed at our weekly Safe in our Hands clinical briefing. We are now in the process of piloting this in our community health centres across Lambeth and Southwark.

We use feedback to improve patients' experiences. In response to last year's national and local survey results, each directorate developed an action plan covering medication side effects, respecting privacy, involving patients in their care and ensuring they can discuss any worries, and making sure they know whom to contact once they have left hospital. Local activity is monitored through the electronic feedback system and reported at directorate performance review meetings.

A fall in satisfaction levels in the national maternity survey 2010, coupled with disappointing scores for women's services in our patient satisfaction survey, prompted an improvement plan. A '*How can I help?*' philosophy encouraged staff to ask people who looked in need of assistance if they needed help. The clinical directors now produce a weekly newsletter which includes examples of how staff have made a special effort. Poor behaviour or attitude is also discussed.

Community services responded to service level feedback by developing individual action plans for their services, and changes

achieved were publicised to community services staff. Their impact will be assessed in part by the forthcoming community annual survey.

The Board and the Council of Governors regularly review survey findings and other feedback from patients, and monitor their effect on service improvements.

Involving patients

Surveys are useful, but we can also learn by talking directly to patients. We are committed to involving patients, community groups and carers in developing our services.

Patients and the public helped to develop our new outpatient centre at St Thomas'. A group of governors, patients and local community groups commented on the reception's design and highlighted, for example, the needs of people with sensory impairments. Patients also tested the self check in and call forward systems, aimed at reducing delays and improving communication. A similar user group has been helping to develop plans for our accident and emergency department.

A DVD for newly diagnosed cancer patients, *Welcome to our cancer services*, was the brainchild of patients, who said they valued reliable information about what to expect. Short films feature clinical staff explaining treatments and patients talking about their experiences, and the DVD covers everything from clinic appointments and treatments to research trials and includes an introduction by David Dimbleby.

While our national outpatient

survey results were largely very positive, patients rated some aspects of their experiences as poor, including changing appointments and waiting in clinics. As a result, making and rescheduling appointments has been made easier, in part through staff training and implementing call centre technology. We have introduced a 'telephony academy' to help staff deal sensitively with patients, who may be under a great deal of stress, over the phone. Many patients also receive text-message reminders of appointments and further work is under way to reduce clinic waiting times and inform patients about delays.

Patient information

The Trust aims to give patients clear, evidence-based information about conditions and treatments, so that they can make informed decisions about their care. Our patient information goes through a rigorous approval process to ensure that it is evidence based, meets national standards and has been reviewed by patients; it is rated at the highest level by the NHS Litigation Authority.

We produced nearly 400 information leaflets last year, increasing our total to around 750. Three of our leaflets were commended at the 2011 British Medical Association's patient information awards.

In September, we launched a patient information strategy. Its aims include more resources for patients with learning disabilities, working more closely with our King's Health Partners colleagues,

and addressing how best to integrate patient information across the Trust.

Our aim is for consistent, high quality information across our hospitals and in the community, in line with our 2011-12 quality accounts priorities. The first 50 of around 200 Lambeth and Southwark community services leaflets are currently being updated.

Within our hospitals, several innovations to improve the experience of patients also helped us meet legal obligations to support patients with disabilities. We introduced a hospital communications book, a picture-based resource that helps patients with speech and language impairments to communicate with staff, and used more photo symbols to make information accessible to people with learning disabilities.

We also provide detailed access and travel information via our website, aimed at people with disabilities, using Direct Enquiries – the nationwide access register.

Last year, the Knowledge and Information Centre (KIC) welcomed almost 65,000 visitors and recorded over 15,000 requests for help with a wide range of concerns.

The Patient Advice and Liaison Service (PALS) offers support for patients of the Trust. Based in the KIC at St Thomas', and with a new central office at Guy's, PALS dealt with over 6,500 telephone, email and face-to-face enquiries.

The PALS team worked closely with colleagues around the Trust to resolve concerns at an early stage whenever possible and also advise

patients about making formal complaints. Themes identified through PALS cases were reported quarterly to senior colleagues and contributed to the patient experience data used to improve services.

The Trust provides comprehensive language and communication support for our diverse population, including interpreting over the phone or in person for patients and carers. Last year, we offered interpreting in over 200 languages, including British Sign Language, and were able to translate information into easy read, audio and Braille.

always ways in which we can improve further. To this end, we listen to our patients and ideas from staff to make our services more responsive to what patients want.

Safeguarding vulnerable people

CQC inspectors visited in 2011 to ensure that people who use our services were protected from abuse. Visits to adult clinical areas, including an unannounced inspection, and discussions with staff and the Trust's named professionals for protecting children and adults took place. Structures, policies and procedures, training, information and interagency working were reviewed. The CQC gave a positive response and had no concerns.

Following the integration of hospital and community services, the Trust reviewed its safeguarding procedures to ensure cohesive, joint working wherever vulnerable people were in the local NHS system. The Trust already had good relationships with Lambeth and Southwark safeguarding children boards, and worked with partners to introduce multi-agency safeguarding hubs (MASH), which aim to improve support for vulnerable children and families.

A scheme to keep young victims away from gangs was set up with support from Guy's and St Thomas' Charity. A youth worker from the Lambeth-based Oasis charity was based in St Thomas' accident and emergency and works with staff to identify children at risk. Academics from Kingston University will evaluate the project which runs until 2013.

We are proud that the Evelina has been highly rated as part of the national Safe and Sustainable Review.

We launched a new public website, taking into account feedback from patients, staff and other users. The site has a more modern look and is easier to use. It aims to better communicate the Trust's key messages, contribute to business objectives and promote our services and staff, as well as supporting fundraising.

CQC inspections

The Care Quality Commission (CQC) made five unannounced inspections last year, all of which were favourable. Despite these positive inspections, we recognise there are

	2011		2010		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
Response Rate	51%	53%	41%	55%	Improvement
Areas of best performance					
Staff feeling work pressure, (lower score is better)	2.78*	3.12	2.95	3.11	Improvement
Staff recommending Trust as a place to work/get treatment**	4.05*	3.50	3.95	3.52	Improvement
Fairness and effectiveness of incident reporting procedures**	3.65*	3.46	3.60	3.45	Improvement
Percentage of staff satisfied with quality of work and patient care they can deliver**	85%*	74%	80%	75%	Improvement
Areas of weakest performance					
Percentage of staff using flexible working options**	56%	61%	59%	63%	Deterioration
Percentage of staff having equality and diversity training in the last year**	32%	48%	40%	41%	Deterioration
Percentage of staff experiencing physical violence from staff in last year (lower score is better)	2%	1%	3%	1%	Improvement
Percentage of staff working extra hours (lower score is better)	70%	65%	72%	66%	Improvement

* Score was the best for all acute trusts

** Higher the score the better

Partnerships to improve health care

King's Health Partners made good progress over the last year with the continuing development of the 14 hospital and seven mental health clinical Academic Groups that underpin development of the Academic Health Sciences Centre's work.

The Trust is investing in facilities to centralise inpatient vascular services across King's Health Partners at St Thomas' to deliver better patient outcomes, higher quality care and improved efficiency. This will also create London's largest vascular service. The transfer of services is due to be completed in the current financial year.

In response to the London Cancer Review (2010) recommendation that bone marrow transplantation centres carry out at least 100 transplants a year, the service at Guy's was successfully transferred to King's College Hospital in September 2011.

As part of the Healthcare for London Review of Stroke Services, the hyper-acute stroke service was also consolidated at King's College Hospital in September 2011. St Thomas' continues to provide a stroke unit and rehabilitation service to the local community.

Healthcare for London published the cancer case for change document in 2009 and the Department of Health published

Improving outcomes: a strategy for cancer in 2011. As a result, King's Health Partners has worked with Imperial Academic Health Science Centre and the Royal Marsden to create the London Cancer Alliance, an integrated cancer system for north west and south London comprising 16 hospitals. The network aims to improve screening and early diagnosis, eliminate variation in outcomes, improve the delivery of care across pathways and different parts of the system and give patients a better overall experience if they need cancer care.

In response to a review of common cancers by NHS Commissioning Support for London, and subsequent cancer

peer review visits, we have been working with King's College Hospital to develop plans to bring lung and prostate cancer services together at Guy's.

Over the past year, we have been an active member of King's Health Partners integrated care pilot. This brings together the hospital trusts, mental health, community services and the providers of primary and social care in Lambeth and Southwark, and other stakeholders. The focus is on joining up care by concentrating on individual patients' needs, intervening early and working across providers to treat people in the most appropriate settings, particularly during acute crises. We aim to drive up quality and

services also focused on ways to reduce inappropriate admissions and readmissions to hospital and to facilitate earlier discharge from hospital where appropriate. Initiatives included the launch of home ward in Lambeth and Southwark, which supports patients at home with a team of nurses, therapists and primary care colleagues, and also the extension of the enhanced rapid response service providing home-based re-ablement and support for up to six weeks.

The Trust continued to work closely with the Diabetes Modernisation Initiative, funded by Guy's and St Thomas' Charity, which in turn worked with statutory organisations, patients and third sector groups to improve the care of people with diabetes in Lambeth and Southwark. As a result, our community services are implementing a new model of care in Southwark.

Similarly, we worked with the End of Life Care Modernisation Initiative, which completed its work during the year. Achievements include training volunteers to participate in a dementia peer support network and developing the AMBER (Assessment, Management, Best practice, Engagement, Recovery uncertain) 'care bundle', which has been adopted on wards at the Trust and is being extended to community settings. This helps staff to identify patients whose recovery is uncertain and who may die in the next one to two months, so that staff can provide earlier support to patients and their carers and families.

Our patients are why we are here. In 2011-12, we provided almost a million patient contacts in our hospitals, and a further 670,000 patient contacts in our community services.

patients' satisfaction while also reducing costs. The pilot initially focused on frail elderly patients and will be looking at a number of long-term conditions. In March 2012 Guy's and St Thomas' Charity confirmed its contribution of £10.6 million to this project over the next 3 years, building on its previous investment.

During the year, our community

Stakeholders, including local involvement networks (LINks), our governors, commissioners, community public health consultants, local councillors and community services staff, reviewed our Quality Accounts and helped us develop indicators for the following year.

The Trust also liaised with local authority scrutiny committees on potential service changes, such as to bone marrow transplantation and other cancer services.

We took part in workshops to shape the future of Lambeth's health and well-being board, which seeks to improve the health of our local communities, and expect to do the same in Southwark this year.

We maintained our links with the South Bank Employers' Group, helping to improve local access to employment, for example, by offering work experience to the long-term unemployed people through the Waterloo Job Shop.

Consultations

As part of the national Safe and Sustainable Review of children's congenital cardiac services, the Evelina Children's Hospital was recommended as a centre for specialist heart surgery – we are proud that the Evelina has been highly rated as part of this review. This supports our ambition to improve care for childhood diseases both for our local community and more widely. The proposals were subject to public consultation, which concluded on 1 July 2011.

Since the consultation, a judicial review issued by the Royal Brompton and Harefield NHS

Foundation Trust was considered but in April 2012, the Court of Appeal overturned the case and we now expect a decision on the future of specialist children's heart services in July 2012.

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.

As the principal beneficiary of the Charity, the Trust was awarded a total of more than £11.5 million for 10 projects last year, ranging from a programme incorporating magic into rehabilitation for children with hemiplegia to a new state-of-the-art electronic ward safety system.

In 2011, the Charity's fundraising team became part of a new team serving all the organisations in King's Health Partners, and we are confident that this will increase our collective ability to raise funds for all the partner organisations. The Trust is very grateful for the support of patients and their families, the local community, businesses and individuals who support our hospitals and community services through donations or fundraising activities.



Over 400 staff attended our health and well-being roadshows to find out about benefits, including Weight Watcher meetings at work; help with giving up smoking; and the chance to get fit by taking the Global Corporate Challenge.

5

Teaching and research and development

As major teaching hospitals that are part of King's Health Partners Academic Health Sciences Centres, Guy's and St Thomas' NHS Foundation Trust aims to offer the highest quality training to healthcare professionals, as well as undertake research to advance medical science for the benefit of our patients.

Education and training

Educating and training our employees and the NHS professionals of the future are key to our mission as leading teaching hospitals and a major academic centre, working closely across King's Health Partners and with other organisations such as London South Bank University.

The Trust offers extensive education, training and support for staff at all levels so that they can deliver high quality services in a rapidly changing health environment.

Our hospitals are central to the clinical education and training of a wide range of health professionals, including doctors, dentists, nurses, midwives, allied health professionals and many laboratory and technical staff.

Over the past year, we have expanded the types and modes of learning available, making training more accessible and extending the development opportunities available to staff. Financial support and access to training has been extended to all staff groups, underpinned by a new study leave policy to ensure that everyone has an equal opportunity to gain development and support from the organisation.

We have introduced both traditional paper-based and electronic development guides, which provide 90-minute, 'bite size' training sessions in management skills and these have been piloted by staff in our capital, estates and facilities directorate.

Our activities also underpin King's Health Partners' role in the Health, Innovation and

Education Cluster for South London (HIEC). The HIEC aims to support the delivery of high quality patient care through a better trained workforce and the rapid dissemination of research findings.

Simulation and interactive learning

Simulation and interactive learning (SaLL) is part of our commitment to equipping professionals with robust surgical, clinical and communication skills. Our SaLL centres give students the chance to interact with state-of-the-art human patient simulators – lifelike manikins – as well as actors in true-to-life scenarios. The manikins are programmed to convey typical patient responses, for example, in their reactions to drugs, and also have measurable blood pressures and pulse rates.

Real situations are re-enacted, allowing trainees to practise dealing with complex and fast-changing medical situations in a realistic, but safe, environment, enabling them to learn about making swift, accurate decisions about treatment, leading teams, communicating well and breaking bad news.

Patient safety is at the forefront of this training, and simulation training is becoming increasingly popular. Last year, 4,000 undergraduate and postgraduate doctors, nurses and allied health professionals undertook our SaLL training in a wide range of specialties, including obstetrics, paediatrics, emergency medicine and general practice. This marked increase in activity over the past year and the wide variety of courses on offer, with many more specialties having come on

board from both inside and outside the Trust, resulted in our SaLL centres being presented with an educational excellence productivity award by the London Deanery's annual Simulation and Technology enhanced Learning Initiative (STeLI) at their 2011 simulation conference.

In September, the Olympus simulation laboratory was opened at Guy's by Adrian Joyce, president of the British Association of Urological Surgeons (BAUS), and we were delighted to receive a £1 million investment from the Olympus Corporation. The facility focuses on surgical simulation training and houses a da Vinci surgical robot and other training simulators.

the London Deanery for simulation training equipment ranging from wireless, high fidelity manikins, to ultrasound training models and surgical box trainers.

We also run Hands up for Health, well received education sessions funded by Guy's and St Thomas' Charity, which allow local schoolchildren to turn into health professionals in hands-on training sessions using SaLL's lifelike manikins. Increasing educational opportunities and widening access to and understanding of health care careers is part of the Trust's wider commitment to our local communities.

Undergraduate education

More than 300 consultants and supporting administrative staff make a significant contribution to the education, assessment and development of over 1,300 undergraduate medical students from our university partner, King's College London.

The Trust plays a major role in assessing students, providing over 600 examination sessions to evaluate student performance. Trust consultants are crucial to the quality assurance of the examination process in all clinical phases of the course.

We engage newly appointed consultants in the education programme, ensuring that they have dedicated time for teaching students and pastoral care. This year, we provided an additional programme, formally introducing students to clinical medicine with a week of tutorials, lectures and clinical sessions.

Our hospitals have a long tradition of making biomedical breakthroughs and developing new treatments.

On the research front, we appointed an educational research lead, four simulation fellows and one PhD student and have expanded our research portfolio. The centres' staff have attended and presented at both national and international conferences, winning a best oral presentation award at the Association for Simulation Practice in Healthcare 2011 conference.

The centres have successfully bid for more than £500,000 from

We have joined forces with other King's Health Partners organisations to run multi-disciplinary training in our SaL centres for all 470 final year medical students who learn alongside nursing and midwifery students.

We seek feedback from students in regular student liaison sessions to improve the quality of undergraduate teaching.

This year, the Trust has pioneered a scheme linking the skills of its foundation doctors with the clinical learning needs of undergraduates. These 'med ed' courses have now been adopted by other trusts to enhance the learning experience for King's College London's medical students.

Postgraduate education

In 2011, the Trust became a lead provider, managing high quality core surgical training across south east London for the London Deanery. In January 2012, we were awarded lead provider status for six further medical and surgical training specialties across south London, valued at over £11.5million a year. As part of King's Health Partners, we now lead the delivery of 15 training programmes for over 500 trainees on behalf of the London Commissioner for Medical and Dental Education, leading to demonstrable improvements in the quality of medical education in south London.

We pride ourselves on innovation. Simulation and web learning have become an essential part of our training. The education centre at Guy's campus has recently been updated and expanded, and

now includes equipment to allow video links with off-site training and greater flexibility in how and where we train doctors on all our sites.

We also secured £26,100 from the London Deanery to run medical continuing development courses and £3,100 for local leadership training for junior doctors, which is part of the Trust's integrated clinical leadership strategy.

Nursing, midwifery and therapy education

With our university partners, King's College London and London South Bank University, we train the nurses and health therapists of the future. Students from smaller therapy professions also come from other London universities for the wide range of clinical learning opportunities that the Trust has to offer.

All undergraduate students are valued as part of the organisation. Last year, they all completed an induction programme and their experience as students was monitored by our in-house education team as changes in the university curricula were incorporated into their learning. We also trained and supported mentors to undertake their supervisory role.

We provided 575 pre-registration student nurse and midwifery placements in hospital and community settings. All students were supported in practice by mentors and assessed to meet Nursing and Midwifery Council requirements. They also had access to student teaching events at the Trust, which provided

peer support and helped to bridge the theory-practice gap.

All newly qualified clinical staff undertook the Trust's induction programme with additional training specific to their new roles. This training – from statutory and mandatory elements to team working programs – ensures that newly qualified professionals feel confident in embarking on their careers with us. An addition to the newly qualified nurses' and midwives' preceptorship programme was a three-hour coaching session to enable them to reflect and learn from their experience.

Research and development

The Trust is leading a huge amount of health research, aimed at improving patient care, developing better treatments and increasing our understanding of disease. Our hospitals have a long tradition of making biomedical breakthroughs and developing new treatments.

We are passionate about driving forward research and innovation that will benefit our local population and have a positive impact on national and international public health. We have excellent staff, facilities and research capability, as well as one of the most diverse populations in the UK, which enables us to undertake a wide range of health research.

Studies taking place across the Trust are diverse, ranging from developing rehabilitation charts to monitoring recovery after a stroke, and a clinical trial of a drug to treat a form of blood cancer that improves patient quality of life, and which we hope will be fast-tracked

for regulatory approval.

A highlight last year that will benefit future biomedical research was the deposit in the UK Stem Cell Bank (UKSCB) of the first clinical grade human embryonic stem cell lines that are free from animal products, and intended for publicly funded research. The cells have the potential to become the 'gold standard' lines for developing new stem-cell-based therapies. This first batch of cells is the culmination of nearly a decade of collaboration between researchers at Guy's Assisted Conception Unit and King's College London, funded by the Medical Research Council.

Work now being undertaken by doctors and scientists in the Haemostasis Research Unit could soon dramatically improve treatment for people with severe haemophilia A. The breakthrough also has the potential to reduce the cost of treating haemophilia A by a quarter and to improve patients' quality of life by significantly reducing the number of hospital visits they need for treatment.

A hub of NIHR research

With our university partner, King's College London, we are a major hub of National Institute for Health Research (NIHR) funded research. Our research and development department, NIHR Biomedical Research Centre, King's Health Partners Joint Clinical Trials Office, and the NIHR Research Design Service are all located on the 16th floor of Guy's Tower. This is also home to the NIHR Comprehensive Local Research Network (CLRN) for London (South), and the South East

London Cancer Research Network (SELCRN). Additionally, in October 2011 the contract to host the NIHR Primary Care Research Network (PCRN) for Greater London was transferred to Guy's Hospital.

By hosting these networks, which are co-located with the Guy's clinical research facilities and a commercial clinical trials unit run by Quintiles – a leading provider of first-in-man trials world-wide – we are increasing our capability as a 'one stop shop' for research expertise.

Our research and development portfolio is constantly increasing. During the year, 360 non-commercial projects involving patients and healthy volunteers were approved, while 656 active non-commercial research studies have been taking place. During the year, we have generated over 1,000 publications.

We recruited more than 26,600 patients into non-commercial clinical trials and other patient-focused studies. Of these, almost 7,200 were for NIHR portfolio studies. We are proud to have achieved an increase of 23 per cent into NIHR portfolio studies compared with the previous NIHR reporting year. The Trust had the sixth highest number of projects registered with the NIHR's Comprehensive Local Research Network (CLRN).

Over the year we received £13 million of funding for our Biomedical Research Centre, £3.5 million for the Comprehensive Local Research Network, and £4.2 million of flexibility and sustainability funding.

NIHR Biomedical Research Centre

We were one of the National Institute for Health Research's first Biomedical Research Centres established in 2007, and in August this year we were successful in securing £58.7 million of funding for a further five years.

Our original Biomedical Research Centre focused on seven research themes: cancer; cardiovascular disease; cutaneous medicine; asthma and allergy; infection and immunity; transplantation; and oral health. We have made significant progress in translational research relating to important diseases and conditions such as the development of food allergy in children and the identification of gene mutations associated with rare disorders.

Going forward, our NIHR Biomedical Research Centre has a new strategy for translational research and will be organised into four 'clusters' which bring together infrastructure, clinicians, researchers, patients and industry to drive research. For example, our imaging and biomedical engineering research group is one of the largest in Europe. We have over 240 researchers with 50 new faculty appointments in the last four years, as well as £40 million capital and investment. The Centre's new clusters are:

- experimental medicine and therapeutics, which will support the rapid development of novel therapeutic drugs, including 'first in man' trials;
- biomarkers, co-diagnostics and imaging, which will focus on personalising health care by

bringing together our immune monitoring, genetics and imaging facilities;

- population science, which will bring together inter-disciplinary expertise to focus on diseases that are relevant to our local population;
- A new School of Translational and Experimental Medicine, which is being launched jointly with South London and Maudsley NHS Foundation Trust to focus on training and capacity building.

Clinical Research Facilities

We have an excellent Clinical Research Facility. In February, we received an additional £5.6 million of NIHR funding. Our facilities are located across Guy's, St Thomas' and the Evelina Children's Hospitals, with generic and specialist clinical and laboratory space tailored to the research needs of each site and patient group. There are 117 active studies under way, 46 of which were approved in the last year.

This latest NIHR funding award will support and increase research into inflammation, auto-immunity and transplantation, metabolic and cardiac diseases, women's health, nutrition, and clinical pharmacology. It will also help us to improve both recruitment to studies and the patient experience during their participation in research studies.

Translational Research Partnerships

The NIHR's Translational Research Partnerships are a new scheme to

bring the UK's top academic and NHS researchers together with life science companies at the earliest stages of developing new treatments. Research centres were selected based on their proven ability to deliver in experimental medicine and translational research.

Guy's and St Thomas', in collaboration with King's College London, was delighted to receive £80,000 for two years to support partnerships for rheumatology translational research.

Patient and public involvement

We depend on patients enrolling in our clinical studies to ensure that we can push the boundaries of health research and improve treatments and outcomes. It is therefore important that patients, families and carers have a say in the design, management and communication of our studies.

The south east London consumer research panel for cancer is one example of how we achieve this. The panel of eight patients, survivors and carers, supported by our NIHR Biomedical Research Centre, local cancer services, and the South East London Cancer Research Network, works with researchers to review research protocols, patient information sheets and lay summaries.

Our NIHR Biomedical Research Centre is committed to working in partnership with patients, carers and local communities to deliver research that meets the needs of patients. To support researchers and members of the public working together on research studies we

have developed a range of training sessions and implemented new ways to involve and inform the public about our research.

Café Research is an opportunity for our researchers to informally present their work to a public audience and then invite questions and discussion. Last year it covered topics such as how blood works, the importance of circulation in diabetes, and the latest in melanoma research.

Our training sessions for members of the public provide an introduction to patient and public involvement in research, 32 people attended these sessions last year, with 14 of those now working with researchers to develop and manage research studies.

Our local schools programme includes Clinical Research Facility open days, careers information and laboratory-based sessions that give students hands-on experience of research techniques.

The collaboration between research staff and members of the public has led to research being more appropriate for patients. One example of this is a study investigating the psychosocial outcomes after kidney donation from living people. The lack of previous research in this area meant that it was important to discuss the project with a group of former donors. This ensured that it was appropriate and that the issues most important to them around the time of donation were included.



Our 12,500 staff not only provide the best possible care for our patients, but they are also at the heart of our many corporate social responsibility initiatives to support and enhance the communities we serve and help to protect the environment.

Chief Executive's statement

This quality report aims to assure our commissioners, patients and the local population that we continue to provide the highest quality of care.

We have three quality priorities which form the basis of everything that we do: to make sure that our patients are kept safe; to provide the highest quality care; and to find ways to improve the experience for our patients. I hope that this quality report demonstrates this commitment.

Underpinning our ambition is our quality strategy. This sets out our determination to put our patients first; we aim to keep patients safe and ensure that their experience with us is positive.

A more comprehensive picture of our approach to quality and of our quality strategy can be found in the Trust's full Quality Accounts, which are available on our website.

Last year, we again sought to involve our stakeholders in developing our Quality Accounts, particularly our quality priorities. We have held events to seek the views of patients, staff, commissioners and representatives from our local councils, and also held discussions at meetings of our Council of Governors and Board of Directors.

We have made significant progress in some areas, but there is more to do. We have a major investment programme that will see a new outpatient centre open at St Thomas' and improved care for our emergency patients. At Guy's, we are progressing plans for a major new cancer centre.

Quality involves getting the fundamentals right, as well as meeting national targets. Overall, we performed well in most areas, but we found it difficult to meet the demanding targets set for the number of MRSA blood infections last year end and the 62-day cancer wait for patients referred to us from other hospitals. We are working hard to make further improvements in these and other areas, and to make sure that we provide patients with an excellent standard of care.

There are plenty of positives: we are reducing waiting times; we have a low patient mortality rate for hospitals seeing a complex case mix that includes many patients who are seriously ill; and we also had good results in the national patient surveys.

We have successfully integrated community services in Lambeth and Southwark, which is helping us to improve the experience of our patients and to ensure that care is provided in the right place, at the right time.

We have also made changes to improve the experience of outpatients at our hospitals, including areas such as booking appointments and reducing waiting times in clinics. Without invaluable input from our Council of Governors, this would have been much harder to achieve, so I would like to thank them for their continuing support.

Finally, it remains to say that, to the best of my knowledge, the information in this quality report is accurate.



Sir Ron Kerr, Chief Executive

The Trust's quality strategy was launched in November 2011 with the aim of making sure that our patients are kept safe and that their experience with us is a positive one.

Successes in 2011-12

We launched our new quality strategy which focuses on patient safety and improving the patient experience.

We have consistently achieved one of the lowest mortality rates in the NHS in England.

Last year was the first time we had 100 days without a falls-related fracture, with an almost 40 per cent reduction in falls fractures in our hospitals.

We saw our lowest level of cardiac arrests on the wards since 2009, which was when formal records began.

We had no grade 4 pressure ulcers, cases of MRSA blood infections or cases of *C.difficile* in our community inpatient units. We also had no attributable grade 4 pressure ulcers in our hospitals for the first time.

We had one of the highest rates of assessment and one of the lowest rates of readmission to hospital for blood clots (venous thromboembolism) among our London peers.

We were the best performing London teaching hospital in the national outpatient survey, and second best teaching hospital in London in the national inpatient survey.

We saw an increase of 40 per cent in the number of community patients who were cared for on the Liverpool Care Pathway – the 'gold standard' for supporting patients at the end of their lives.

Where we need to improve

Although we are one of the best performing hospitals in London for infection prevention, we want to do even better. We were set a very demanding MRSA target last year and are disappointed that we failed to achieve this.

Despite improvement during the year, some of our patients waited longer for planned procedures than we would have liked. Also, while our performance against the national cancer targets has improved, we did not achieve this target and find it difficult to do so where patients are referred to us late in their pathway from other hospitals, see pages 13-14 for further information.

Though our performance in the national inpatient survey was one of best in London, we believe that there is more that we need to do to improve the experience of our patients.

Our quality strategy

The Trust's quality strategy was launched in November 2011 with the aim of making sure that our patients are kept safe and that their experience with us is a positive one.

The quality strategy sets out our plans in relation to seven major areas of avoidable patient harm. It focuses on:

- safety leadership first;
- safer medicines management;
- preventing healthcare associated infection;
- minimising harm from slips, trips and falls;
- detecting and preventing venous thromboembolism;
- prevention of pressure damage;
- recognising and responding to the acutely unwell patient.

These areas were chosen as they not only span across the organisation, but are locally and nationally regarded as high risks in healthcare. By bringing these seven areas together and focusing on improving outcomes, we aim to achieve our goal as being the UK leader in reducing avoidable patient harm.

Our 'long list' of quality priorities was considered by our governors, Local Involvement Networks (LINKs), commissioners, local GPs, local authority health overview and scrutiny committees and colleagues from King's College Hospital at two stakeholder events. We asked them to review, add to and rank the priorities, and we chose to prioritise at least one of the top three priorities chosen by our stakeholders in each theme.

The Chief Nurse and the Medical Director informed the Board and Trust Management Executive of our priorities in March 2012, and they were agreed in April 2012.

Our quality priorities for 2012-13

We want to demonstrate our commitment to quality and to show where we intend to focus our efforts next year. We have come up with 10 quality priorities that we will focus on from 1 April 2012 to 31 March 2013.

We have selected areas that combine hospital and community priorities. Each priority comes under one of our three quality themes:

Patient safety: having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes.

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

Patient experience: meeting our patients' emotional as well as physical needs. This includes patients being treated with dignity and respect, in a comfortable, clean and safe environment; being given the right information about care and discharge; and being treated without avoidable delays.

The areas we have chosen this year are those that our stakeholders told us were where we needed to improve. Where appropriate, we have aligned our priorities with our 2012-13 Commissioning for Quality and Innovation (CQUIN) targets, a range of local and national quality priorities chosen by our commissioners and by the Department of Health.

Progress against these priorities will be regularly reported to the Trust's Board of Directors.

See our priorities overleaf.

Patient safety

Our quality priorities and why we chose them	What success will look like	How our stakeholders ranked this
Improving staff knowledge of patient safety Our staff are crucial in delivering safe, high-quality care. We want to ensure that they receive appropriate training to keep our patients safe.	<ul style="list-style-type: none"> – In line with our CQUIN targets, we will introduce the national NHS safety thermometer tool¹ in our high risk wards and departments by the end of March 2013. – We will recruit 130 students to assist ward staff in collecting and analysing data for weekly safety reports. 	This was ranked number 1
Reducing severe harm events In line with our quality strategy, we will further reduce the most common and severe harm events in our hospitals and community settings by setting ourselves further targets for falls and pressure ulcers.	<ul style="list-style-type: none"> – We will further reduce fall-related fractures in hospital by 10 per cent. – We will have zero attributable grade 4 pressure ulcers across our hospital and community sites. – In our hospitals, we will reduce hospital acquired grade 2 pressure ulcers by 10 per cent and hospital acquired grade 3 pressure ulcers by 50 per cent. – We will achieve our hospital MRSA and <i>C.difficile</i> targets. 	This was ranked number 2
Increase new birth visits Picking up issues early, and assisting mothers with newborn babies, are important in good community healthcare. There is scope to improve in this area.	<ul style="list-style-type: none"> – We will increase the percentage of newborn babies who receive a visit within 14 days after birth to at least 95 per cent by the end of March 2013. 	Approved by stakeholders to be carried over from 2011-12 to 2012-13

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like	How our stakeholders ranked this
Improve the efficiency of outpatient services Patients tell us that their experience is generally good, but we know that we can do more to improve the experience, especially when it comes to waiting times.	<ul style="list-style-type: none"> – We will reduce how long our patients have to wait for their first appointment. – We will reduce clinic waiting times. – We will reduce the number of patients who 'did not attend' or cancel their appointment. 	This was ranked number 2
Supporting our ward sisters/charge nurses Our ward sisters/charge nurses are the key coordinators of care at our hospitals. We want to equip and empower them to lead efficient and safe services for our patients.	<ul style="list-style-type: none"> – We will support staff and strengthen the voice, role and accountability of the ward sister across our hospitals and in the community. – We will establish a ward leaders expert group to drive quality improvements. – We will further strengthen the links between ward leaders and senior ward doctors (specialist registrars). 	This was ranked number 5
Improving childhood immunisation rates We can increase the number of children we immunise locally. Poor vaccination rates can lead to an increase in preventable illnesses, which can have a devastating effect on families.	<ul style="list-style-type: none"> – In line with our CQUIN targets we will increase the proportion of MMR2 and pre-school booster immunisations. 	Approved by stakeholders to be carried over from 2011/12 to 2012-13
Improve communication between GPs and community nurses. Since community services were integrated to the Trust, we have improved communications between GPs and community nurses, but further improvements can be made.	<ul style="list-style-type: none"> – Our community teams will confirm receipt of GP referrals. – Community teams will also communicate with a patient's GP after an initial assessment and when a patient is discharged from their care. 	Approved by stakeholders to be carried over from 2011-12 to 2012-13

Patient experience

Our quality priorities and why we chose them	What success will look like	How our stakeholders ranked this
Improving staff communication with patients. Communicating with patients is extremely important. We will launch a major staff communications campaign aimed at improving our patients' experiences.	<ul style="list-style-type: none"> – We will introduce a new ward welcome pack for every inpatient. – We will launch an initiative giving patients and their carers direct access to senior staff 24 hours a day, seven days a week. – We will launch a staff training campaign to improve the experience of elderly or vulnerable patients. – We will roll out ward comfort rounds² for all inpatients by the end of March 2013. 	This was ranked number 1
Improving the care of vulnerable patients This will focus on patients with dementia and delirium.	<ul style="list-style-type: none"> – We will achieve our dementia CQUIN objectives, including better assessment and early intervention of patients with dementia or delirium. – We will launch a training initiative so that all staff are equipped to deal with vulnerable patients, including those with dementia. 	This was ranked number 2
Increasing patient satisfaction, as measured by responses to the national patient surveys. We also have our own local systems to get near-time (close to immediate) feedback from patients.	<ul style="list-style-type: none"> – As agreed with our commissioners and reflected in our CQUIN targets, we will improve our hospital and community performance in the national patient experience surveys. – We will roll out our near-time patient feedback to key community services. 	This wasn't included in the ranking exercise, but forms part of our CQUIN targets

(1) The NHS safety thermometer is a national inpatient and community 'safety census' carried out each month. It looks at harm events related to falls, pressure ulcers, infection and blood clots. It observes and calculates a 'snapshot' rate of harm-free care for each department assessed.

(2) Comfort rounds: a member of the ward team reviews each patient on a regular basis to ensure that they are comfortable and that their essential nursing needs are met, checking, for example, that items each patient needs are always within easy reach.

Statements of assurance from the Board of Directors

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

A review of our services

During the reporting period 2011-12, as well as providing care to patients at Guy's and St Thomas' hospitals, we also provide NHS clinical services in other locations:

- five satellite dialysis units (Camberwell, Forest Hill, New Cross Gate, and Tunbridge Wells kidney treatment centres and Queen Mary's Hospital in Sidcup)
- four chemotherapy day units (Dartford, Sidcup, Bromley and King's College Hospital)
- plastic surgery at Princess Royal University Hospital Bromley
- a urology service at University Hospital Lewisham.

We have reviewed and continue to review all the data available on the quality of care in these NHS services. The total forecast income for these activities last year is £15.7 million, which represents 1.4 per cent of our total forecast income.

Our community directorates provide care to patients across Lambeth and Southwark. The income generated by these NHS services received in the last year represents 100 per cent of the total income generated from the provision of community services by the Trust.

Clinical audits and National Confidential Enquiries

Last year, we took part in 47 out of 51 possible national audits. We also participated in four national confidential enquiries. By doing so, we participated in 88 per cent of national clinical audits and 100 per cent of national confidential enquiries in which we were entitled to participate.

The national clinical audits that we participated in and for which we collected data are listed in the table opposite. The information provided also includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Last year, the Trust participated in four National Confidential Enquiries into Patient Outcome and Death (NCEPOD) studies. These included studies into bariatric surgery, cardiac arrest procedures; perioperative care; and children's surgery. We were 100 per cent compliant with the audit terms for each. The Trust also participated in the enquiry into maternal and child health (CEMACH), and again was 100 per cent compliant. We continue to learn and share the lessons from the detailed reports generated from these national studies.

Our clinical audit team reviews findings from the audits and shares best practice. Last year, the team reviewed the findings of 27 national clinical audits. The following examples were identified as having improved the quality of our services:

- Results from the national hip fracture database audit led to investment in additional medical staff to improve medical assessment. The reasons for all hip fracture theatre delays are now tracked, and further audits are carried out on specific delay themes, such as patients taking anti-coagulants. Results, recommendations and implementations from these audits will follow and will be reviewed and monitored by the steering group. There is also an ongoing review of pressure sore acquisition, with rapid cycle audits of pressure relieving equipment use.
- In August 2011, following the national diabetes audit, we launched a pilot campaign, *Think Glucose*, to improve the care of inpatients with diabetes. This multi-professional approach was highly successful in promoting safety and compliance and the programme will be introduced across the Trust in 2012.
- As a result of the Sentinel stroke audit, which every two years looks at the improvements in stroke care, two new assessment tools have been developed to help assess and document patients' mood and cognition (awareness and judgement) following a stroke.

Last year, our clinical audit team also reviewed 84 local clinical audits. The following action was then taken to improve the quality of our services:

National clinical audits 2011-12

Audit title	Participation	% cases submitted
Peri and neonatal		
Perinatal mortality (MBRRACE-UK)	MBRRACE-UK has been discontinued. All our neonatal deaths are reported to NPEU via the badger (SEND) database, hence 100% participation.	
Neonatal intensive and special care (NNAP)	Yes	100%
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	100%
Paediatric asthma (British Thoracic Society)	No	Plan to participate 2012-13
Pain management (College of Emergency Medicine)	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	100%
Paediatric intensive care (PICANet)	Yes	100%
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	100%
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Yes	Data collection ongoing
Non invasive ventilation – adults (British Thoracic Society)	Yes	100%
Pleural procedures (British Thoracic Society)	Yes	6 to 8 patients
Cardiac arrest (National Cardiac Arrest Audit)	Yes	100%
Severe sepsis and septic shock (College of Emergency Medicine)	Yes	100%
Adult critical care (ICNARC CMPD)	Yes	100%
Potential donor audit (NHS Blood and Transplant)	Yes	100%
Seizure management (National Audit of Seizure Management)	No	This being piloted before being rolled out nationally. We are not one of the pilot sites.
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	60-95% (varies by month)
Chronic pain (National Pain Audit)	Yes	50 patients
Ulcerative colitis and Crohn's disease (UK IBD Audit)	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Yes	100%
Adult asthma (British Thoracic Society)	No	
Bronchiectasis (British Thoracic Society)	No	
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	80% Q1, data under review
Elective surgery (National PROMs Programme)	Yes	Data collection ongoing
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	Not applicable to the Trust	
Liver transplantation (NHSBT UK Transplant Registry)	Not applicable to the Trust	
Coronary angioplasty (NICOR adult cardiac interventions audit)	Yes	100%
Peripheral vascular surgery (VSGBI vascular surgery database)	Yes	100%
Carotid interventions (carotid intervention audit)	Yes	100%
CABG and valvular surgery (adult cardiac surgery audit)	Yes	100%

National clinical audits 2011-12		
Audit title	Participation	% cases submitted
Cardiovascular disease		
Acute myocardial infarction and other ACS (MINAP)	Yes	100%
Heart failure (heart failure audit)	Yes	100%
Acute stroke (SINAP)	Yes	100%
Cardiac arrhythmia (cardiac rhythm management audit)	Yes	100%
Renal disease		
Renal replacement therapy (Renal Registry)	Yes	100%
Renal transplantation (NHSBT UK Transplant Registry)	Yes	100%
Cancer		
Lung cancer (national lung cancer audit)	Yes	44%
Bowel cancer (national bowel cancer audit programme)	Participated in 2010-11 and will do so in 2012-13	
Head and neck cancer (DAHNO)	Yes	100%
Oesophago-gastric cancer (national O-G cancer audit)	Yes	Data collection incomplete
Trauma		
Hip fracture (national hip fracture database)	Yes	100%
Severe trauma (trauma audit and research network)	Yes	Limited submission – aim to improve within three months
Psychological conditions		
Prescribing in mental health services (POMH)	Not applicable to the Trust	
Schizophrenia (national schizophrenia audit)	Not applicable to the Trust	
Blood transfusion		
Bedside transfusion (national comparative audit of blood transfusion)	Yes	100%
Medical use of blood (national comparative audit of blood transfusion)	Yes	100%
Health promotion		
Risk factors (national health promotion in hospitals audit)	No	Trust Clinical Audit Committee felt benefits of audit did not outweigh costs of participation
End of life		
Care of dying in hospital (NCDAH)	Yes	100%
National confidential enquiries 2011/12		
Cardiac arrest procedures study	Yes	100%
Bariatric surgery study	Yes	100%
Perioperative care	Yes	100%
Surgery in children	Yes	100%

- An audit by junior doctors of Heparin (a drug used to thin the blood) infusion management recommended changes to the equipment used to deliver the medicine and how its use is documented.
- Each community service has nominated an annual 'quality improvement topic'. This year, a wide range of clinical topics were chosen to improve care for local patients. These included improving wound care, reducing harm from falls and improving the patients' experience.
- Maternity services reported on their work to improve the information given to women who are considering having their baby vaginally after a previous caesarean section. The results of the audit led to changes in practice and patient information, with a subsequent increase in eligible women opting for a vaginal birth after caesarean.
- Medical and pharmacy staff from general medicine and toxicology looked at the quality of intravenous (IV) fluid prescriptions. The results led to changes in junior doctor training and induction and were one of the drivers for changing to a new Trust-wide drug chart.
- Other projects to note include the falls audit, which continues to show improvement in compliance with use of the STRATIFY falls assessment tool. A patient identification audit has led to improvements in ensuring all required information is included on identity bracelets and a new process to improve response times is being introduced following the complaints audit.
- The department of paediatric cardiology at Evelina Children's Hospital conducted an audit using the Health Protection Agency's protocol for surgical site infection (SSI) surveillance. The aims of the audit were to determine the underlying rate of infection, monitor infections and identify their possible causes. The team implemented several changes including: reviewing and updating the wound management guidelines, introducing a new skin wash protocol, trialling and implementing a new type of wound dressing, and improving the education of staff in theatres, paediatric intensive care and on Savannah Ward. The audit and associated changes have significantly reduced the incidence of post-operative infection in paediatric cardiology – from 12 per cent in January 2010 to 4 per cent in November 2011.
- Community services took part in the Trust consent audit and also ran a local project looking at community consent, called 'the consent quality tool'. The records audit helped the teams to demonstrate where there is good practice in recording clinical entries and patients' views and where improvements are needed.
- In July 2011, we held our annual clinical audit celebration day to showcase clinical audit projects that our clinical teams have undertaken and the improvements in patient care and safety that had been achieved. Over 70 hospital and community audit projects were presented by 140 multi-professional staff from across King's Health Partners.

Clinical research

Last year, more than 26,000 patients took part in 1,016 non-commercial clinical trials and other patient-focused studies. Of this, almost 7,200 were for the National Institute for Health Research's (NIHR) portfolio¹ studies, an increase of 23 per cent on the previous year, an achievement we are proud of. The Trust had the sixth highest number of projects registered with the NIHR's Comprehensive Local Research Network (CLRN) approved by our Research Ethics Committee, which ensures that patients are safe and research results are disseminated in a timely way. Over 1,200 clinical staff across our clinical directorates were involved in research.

We were one of the NIHR's original five comprehensive Biomedical Research Centres established in 2007. In August 2011, we were successful in securing £58.7 million for a further five years of operation.

CQUIN performance

Around the country, commissioners hold the NHS budget for their area and decide how to spend it on hospital and other health services. Each year, our commissioners set us goals to improve quality and innovation; a proportion of our income is conditional on achieving these goals. This system is called the Commissioning for Quality and Innovation (CQUIN) payment framework.

Last year, 1.5 per cent of our clinical income depended on achieving quality improvement and innovation goals agreed with Lambeth, Southwark and Lewisham primary care trusts through the CQUIN payment framework. This equates to over £10 million of our total income for 2011-12 and we are pleased to have achieved virtually all the targets and secured more than 90 per cent of this income.

Care Quality Commission

The Care Quality Commission (CQC) is the healthcare regulator responsible for making sure that all services meet the standards set by the Government. It awards licences to care providers and without a licence, Guy's and St Thomas' would not be able to provide NHS services.

The CQC granted Guy's and St Thomas' a licence to practice as an NHS hospital and NHS community services provider in 2011/12. This licence has no conditions or restrictions, allowing us to continue to provide care to our patients across our hospital and community sites. We have had no enforcement action taken against us during the last year.

CQC mortality alerts

The Trust received two Care Quality Commission mortality alerts during the last year. One was for our emergency caesarean rates. We investigated and found that, out of 30 emergency caesarean sections identified, one may possibly have been avoided. The second alert related to coronary artery bypass surgery. Upon investigation, we found no cause for concern. The Care Quality Commission was satisfied with our findings.

The outcomes from these and similar reviews conclude that we are confident that there have been no breaches of our safety system and that no patients have come to harm.

Data quality

It is essential that we produce accurate and reliable data about patient care. For example, how we code a particular procedure or illness is important as it not only allows us to receive the correct income, but also anonymously informs the wider health community about disease trends.

Last year, we identified weaknesses in control in respect of the Trust's information assurance arrangements. The Trust is implementing an action plan to address these issues and commissioned an independent external review of its information assurance processes. This remains an ongoing area of risk which will continue to be monitored rigorously, both internally and externally.

As community sites are not required to upload data, last year only our hospital sites submitted records to the Secondary Uses

¹ The National Institute for Health Research (NIHR) Clinical Research Network (CRN) Portfolio is a database of high-quality clinical research studies that are eligible for support from the NIHR CRN in England.

Service (SUS) for inclusion in the Hospital Episode Statistics.

The percentage of records in the published data that included the patient's valid NHS number was 97.1 per cent of inpatients, 97.1 per cent of outpatients, and 77.6 per cent of accident and emergency patients.

The percentage of records which had the patient's valid GP registration code was 97.3 per cent of inpatients, 95.4 per cent of outpatients, and 89.9 per cent of accident and emergency patients.

The Information governance toolkit is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to *Connecting for Health* in order to assess compliance.

Recently, the Toolkit against which we are measured underwent significant revisions. The latest version is no longer assessed on a percentage basis and is now divided into two broad categories 'satisfactory' and 'non satisfactory'. In 2011-12, our hospital sites were 72 per cent compliant with information governance standards and achieved an overall satisfactory rating.

Our overall information governance assessment report score for 2011-12 was 72 per cent, and was graded compliant/green.

We were subject to the Payment by Results clinical coding audit by the Audit Commission. The error rate reported in the draft audit for diagnosis and treatment coding was 22.6 per cent, higher than the previous year. Because of the

nature of the sampling, the results should not be extrapolated further than the actual sample audited.

The clinical coding error rate of the Payment by Results audit split by category was:

- primary diagnosis incorrect – 22 per cent
- secondary diagnosis incorrect – 24.2 per cent
- primary procedures incorrect – 16.0 per cent
- secondary procedures incorrect – 28.2 per cent.

Progress against 2011-12 priorities

Of the 18 targets we set ourselves in last year's Quality Accounts, we have fully achieved 11 (61%), partially achieved three (16%) and did not achieve four (22%). Details of our progress against priorities are in the tables on pages 56 to 58.

Information about performance against national and core quality standards can be found in the operational and financial review in chapter 3 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.

Patient safety

Our quality priorities and why we chose them	What success will look like	How did we do
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 this year and by 80 per cent over two years in the community. 	<p>There have been no attributable grade four pressure ulcers across our hospital or community directorates. The hospital has reported over 10% reduction in grade 2 and 3 pressure ulcers.</p> <p>At the end of the year, the community directorates were expecting to achieve year one of the two year objective of an 80% reduction in grade 2 and 3 pressure ulcers .</p>
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"> - Reduce <i>C.difficile</i> hospitals acquired cases to no more than 155 this year. 	<p>We have achieved this.</p> <p>We reported a total of 121 cases in year.</p>
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. 	<p>* We have not achieved this. Although considerable progress was made in the first six months, the later part of the year saw an increase in serious falls across the community. We continue to work hard to reduce serious injury from falls in the community.</p>
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 hospital falls quality improvement group. 	<p>We have achieved this. We have maintained greater than 95% compliance with our falls pathway, and have established community/hospital falls quality improvement group.</p>
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. 	<p>We have partially achieved this.</p> <p>We did not increase medical staff reporting by 10%.</p> <p>We did establish a successful high-risk medicine safety group.</p> <p>We did improve our national patient satisfaction score relating to medicines information by 4.1% against a target of 3%.</p>
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. 	<p>* We have achieved this.</p> <p>Across London: we are in the top three performing Trusts for VTE risk assessment and report one of the lowest rates of hospital readmission for VTE.</p>
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. 	<p>*We have not achieved this. Although some localities reported 100% compliance, far above the London average, others did not. For this reason this priority will be carried over into this year's Quality Accounts.</p>

Patient experience

Our quality priorities and why we chose them	What success will look like	How did we do
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. 	*We have achieved this. We have made considerable progress in both community and hospital palliative care in year, this includes an increase in the number of patients cared for on the Liverpool Care Pathway and patients with advanced care plans in place.
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. 	We have achieved this. Although there is more to do, and in line with our CQUIN targets, we have carried this priority over into this year's Quality Accounts.
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.	Improve percentage patient satisfaction scores by three per cent on questions covering the following areas: <ul style="list-style-type: none"> - Privacy and dignity - Medicines information - Involvement in care - Information about concerns - Someone to talk to if worried This is in line with our CQUIN targets.	We have partially achieved this. We have achieved our targets in four out of the five CQUIN questions.
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 showed 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. 	*We have achieved this. We have made demonstrable improvements in women's experience of maternity care at our hospital this year.
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. 	We have partially achieved this. This initiative has changed in year, following a comprehensive review of nearly 200 community patient information leaflets. We therefore are declaring partial compliance this year.

For further information on our quality performance, including benchmarking and data trends, please see our new Patient Safety and Experience Report on our website.

Clinical effectiveness

Our quality priorities and why we chose them

What success will look like

How did we do

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:

- assessing our patients
- assisting them with eating
- weighing them appropriately
- providing access to snacks 24 hours a day
- documenting and communicating care.

We achieved this. We undertook a major multi-professional review of food for patients. Out of this came a large number of interventions, including: new nutrition care plans; new menus, including a multi-cultural menu; and innovative nutrition simulation training for staff.

Early indications are that we have significantly improved our patient experience scores for the quality of our food, as shown by our near-time patient feedback results.

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.

- 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.

*We have not achieved this. We set an ambitious target of a 92% improvement in communication, with our final position being 88%. For this reason this priority will be carried over into next year's priorities.

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.

- 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.

We have achieved this. By year end we have established the 'Productive Operating Theatre' programme across high risk specialities, and made demonstrable improvements in surgical productivity, most notably in orthopaedics'. Further work is underway across other specialities'.

We have commenced the 'Productive Community' series.

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.

- 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.

We have achieved this. We have an established 'Clinical Outcomes Group' which reviews key quality indicators.

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.

- Develop an individual ward accreditation scheme based on Care Quality Commission assessment and rankings.

We have achieved this. In conjunction with our governors, we have developed and piloted an innovative electronic ward accreditation scheme.

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.

- Increase the percentage of new born babies who receive a new birth visit (or attempted visit) within 14 days.

We have not achieved this. Although well above the London average, we have not met our 95% target, and therefore have carried this over into next year's priorities.

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 as amended 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 2011-12;
- 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 2011 to June 2012
 - Papers relating to quality reported to the Board over the period April 2011 to June 2012
 - Feedback from the commissioners dated 18/05/2012
 - Feedback from governors dated 02/05/2012
 - Feedback from LINks dated 04/05/2012
 - Feedback from Lambeth Overview and Scrutiny Committee 08/05/2012
 - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2012;
 - The [latest] national inpatient survey 10/05/2012
 - The [latest] community services survey 04/2012
 - The [latest] national staff survey 03/2012
 - The Head of Internal Audit's annual opinion over the trust's control environment dated 03/2012
 - CQC quality and risk profiles dated 20/04/2012
- 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.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor-nhsft.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.

On behalf of the Board of Directors.

Sir Hugh Taylor

Chairman

30 May 2012

Sir Ron Kerr

Chief Executive

30 May 2012

Appendix 1: 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 Council of Governors of Guy's and St Thomas' NHS Foundation Trust to perform an independent assurance engagement in respect of Guy's and St Thomas' NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Guy's and St Thomas' NHS Foundation Trust as a body, to assist the Council of Governors in reporting Guy's and St Thomas' NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Guy's and St Thomas' NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

1. MRSA
2. Cancer 62 day waits

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual*

Reporting Manual 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:

3. the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
4. the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2011/12; and
5. the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

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 became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

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

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:

6. Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
7. Making enquiries of management;
8. Testing key management controls;
9. Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
10. Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
11. 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

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The nature, form and content required of Quality Reports are determined by DH/Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Guy's and St Thomas' NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

12. the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
13. the Quality Report is not consistent in all material respects with the sources specified in the detailed guidance; and
14. the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.



Deloitte LLP
Chartered Accountants
Reading

30 May 2012

LINK Southwark Response to the Guy's and St Thomas' Hospital Foundation Trust (including Community Services) Quality Account 2011-2012

We appreciate that compilation of a Quality Account (QA) from a complex and large Foundation Trust such as Guy's and St Thomas' requires efforts from many hands at the Trust. On the whole, the report and its achievements is impressive and the LINK appreciates these services available to Southwark residents.

However, two general but key issues that arise from the Quality Account is that the language is not very reader-friendly and data is not provided in some important areas. As a result a conclusion cannot be drawn for the current year because data is not provided as at time of writing.

Generally on the whole, explanation of terms and initiatives are good and simple, however possible considerations to increase accessibility of the QA could be a brief explanation as to how CQC mortality alerts take place, the meaning of 'secondary uses' services and explanation of some of the graphs (with specific reference to Standardised Mortality Relative Risk).

LINK is pleased to see that our responses to your Quality Accounts are considered in future work approaches. We are delighted that Guy's and St Thomas' NHS Foundation Trust has taken part in the Diabetes (RCPH National Paediatric Diabetes Audit) Audit this year amongst other things, as per our suggestion to last years Quality Accounts (2010-2011).

1. Quality Account Priorities 2012-13

Patient safety

- Clarity is needed on how the quality priority of "increasing visits to our new community new birth centre" translates into an increased percentage of new born babies who receive a visit to at least 95% by the end of March 2013.
- While we appreciate and have noted the current/forthcoming priorities, it could be suggested to include other information relating to patient safety that is not covered in the quality priorities. This can be brief and will show to the public (and the more informed public)

consideration of patient safety in the wider sense and that they are keeping abreast of new/best practice. For example there does not seem to be any reference to:

- compliance with the WHO Surgical Safety Check. This has been widely discussed from the Department of Health, the Royal College of Surgeons to being featured in reports from the National Patient Safety Agency. Recent research from Imperial College suggests that compliance may be below rates reported. Will Guy's and St Thomas' be contributing to WHO Surgical Safety Check week?
- Best practice relating to the responsible consultant being present in the operating theatre during surgery even when a junior doctor is authorised to operate. What is Guy's and St Thomas' record?

Clinical effectiveness

- We generally support the clinical effectiveness priorities, including reducing waiting times for outpatients for their first appointment. During our outreach we have received feedback relating to and support this measure.
- More information about how you intend to measure your priority of 'improving our ward sisters'.
- We recognise the importance of this increasing child immunisation rates: It has been suggested that perhaps LINK could work with Guy's and St Thomas' NHS Foundation Trust towards achieving this objective.

Patient experience

- Improving staff communication with patients – how will success rather than process be measured?
- There is lack of detail how Guy's and St Thomas' intend to improve the care of vulnerable patients (dementia related). It could be a possibility to link the priority of *patient experience response to surveys* to this priority.
- Influential factors to patient experience which are not referred to in the report relate to:
 - the quality of the food and whether the food is actually consumed or not, especially relating to older people
 - the widespread problem in London where non-critical patients are kept in ambulances longer than necessary influenced by the 4 hour A&E target. This also has the knock-on effect of fewer ambulances being available. Is this an issue for Guy's and St Thomas'?

2. Previous Targets 2010-2011/ Additional comments

We note that the priorities that have not been achieved have been rolled over to the next year.

Other comments

- At time of LINK receiving the Quality Accounts report there was no statutory statement of assurance from the Board, but we hope that as stated a local context will be provided to this forthcoming information.
- **Consent audit:** while results are not yet available, this issue will become increasingly important especially when loss of capacity is considered and also end of life care.
- We support the use of **Patient Passports** for people with learning disabilities and suggest that this could be valuable to other groups such as patients post operative discharge, as informed by the report of the London Cardiovascular project 'Report of the London Cardiovascular – Patients Perspective'.
- While we note the introduction of **hourly rounds** in response to CQC concern of patient call bells not being answered in a timely manner, these rounds do not necessarily fix this issue. Consideration of wider factors may be needed.
- We are concerned that while the Trust has achieved its CQUIN CQC national patient experience performance target relating to medication side effects, the base level is low at 45% given the importance of knowing potential medication side effects. This should require a higher level of achievement.
- Public and patient involvement is referred to in the report as 'engaging and involving' stakeholders, yet it does not demonstrate involvement in decision making.
- In addition, it is stated that reports to the Trust Boards are referred to in terms of financial performance rather than quality. Quality should be the central component of activity especially in reports to the senior officials.

May 4 2012

Lambeth LINK Response to Guy's and St Thomas' Hospital Quality Accounts for 2011/2012

Lambeth LINK welcomes the opportunity to respond to the Guy's and St Thomas NHS Foundation Trust Quality Accounts 2011/2012.

We have received the above, which now includes its Chief Executive statement. We agree with him that "there's no time to be complacent..", except that we would apply it all hospitals. Guy's and St Thomas' (GSTT) is not being complacent in investing in a new outpatient centre (page 28), when it scored the highest ranking amongst London Acute Teaching Hospitals in the National Outpatient Survey in 2011. Though it was third in 2009 on a higher score.

We are particularly pleased that GSTT has taken our previous comments to heart and began with its successes in 2011-2012 rather than its hopes for 2012-2013. Incidentally, we note that GSTT have selected "Patient Safety" as one, perhaps THE priority for 2012-2013. We approve this but note that the other emergency services always prioritise staff safety as well as public safety. Hospitals need cover during epidemics as well as between them.

Our greatest interest is focussed on "How Did We Do?, progress against 2011-2012 priorities." 12 against the 18 predicted were achieved, i.e. coloured green, is good. However, three predicted "partial compliance" by year end and three "not achieved", i.e. coloured red, are noted. Why are good results described in colours and bad ones only words, not colours (Amber or Red)? We are not sure what number 17 Patient Experience (Maternity) with its green prediction means when the comment in the box is "other results unknown", i.e. all but one of the priorities are predicted and therefore unknown.

The venous thromboembolisms result is very good and we hope your next priority will be to equal the second and in future years the first (University College London). What does UCL do to achieve this result?

Nevertheless we will remember the outpatient survey, with which the comment began. Carry on with the good and try to make North Lambeth and Southwark's hospitals the best in the country.

There are two projects covered in your report that we would highlight that respond to concerns of LINK members and show a positive response which are the patient passports for Adults with Learning Difficulties and the Dementia Forget Me Not initiative.

Format of Quality Accounts

Lambeth LINK made the comment last year that Quality Accounts are public facing documents and the content should therefore be written in a more accessible format.

We are encouraged to note in this year's Quality Accounts that our comments have been taken on board and acronyms are spelt out and NHS speak such as "CQUINS" and "NHS Safety Thermometer Tool" are explained.

May 4 2012

Feedback from Lambeth Overview and Scrutiny

Lambeth Council's Health and Adult Services Scrutiny Sub Committee would like to thank Guy's and St Thomas' NHS Foundation Trust for the invitation to submit a statement on the Trust's draft Quality Account 2011/12. The committee would also wish to acknowledge the earlier invitation to participate in the Quality Accounts Stakeholder Group.

It has not been possible to formally consider the draft Quality Accounts within the timeline requested and the Committee is not therefore submitting a response. However the Committee would wish to acknowledge the good working relationship that exists between the Scrutiny Committee and the Foundation Trust.

Health and Adults Service's Scrutiny Sub Committee,
London Borough of Lambeth

Elaine Carter

Lead Scrutiny Officer
Scrutiny Team
Finance and Resources
London Borough of Lambeth

May 8 2012

Feedback from Guy's and St Thomas' Trust Governors

Congratulations on a very comprehensive and interesting document. Some suggestions:

1. Patient experience priorities. Add more detail on how to improve care for vulnerable patients – what will you actually do?
2. P22, 3.3 Infection control – you mention norovirus at the top – is it worth mentioning the incidence of norovirus infections and their control?
3. P30, 8 patient experience standards – no. 4 – include training for staff, as this is relevant for receptionists and telephonists who also have contact with patients.
4. I would have expected to see something about complaints. Need to handle them promptly. Any trends?

Jenny Cobley

Governor

May 2 2012

Other Trust Governor Feedback

- Not enough mention of Evelina Children's Hospital.
- General editing and typo correction.
- Request definition on what 'Lambeth and Southwark safeguarding children boards are'.
- Generally excellent
- The respiratory medicine audit results have 'TBC' against many of them.
- The case histories are listed, but missing in the draft.

NHS South East London response

The draft Guy's and St Thomas' Hospitals NHS Foundation Trust (GSTT) Quality Report 2011/12 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.

GSTT are to be commended on a comprehensive document which highlights not only areas of excellence but those areas where work has been required during the year e.g. complaints. The development of a quality strategy during the year is a very positive reflection of the priority that GSTT places on quality issues and is welcomed.

It is good to see how the Quality Account priorities have developed over the past three years. These Quality Accounts clearly set out how the Trust has prioritised its key delivery areas for 2011/12, for both acute and community services, including good stakeholder engagement. It would have been helpful to present graphical current local data information on all the priorities in order to more clearly demonstrate why they were chosen and what success would look like in the next year in a similar way to how performance has been presented e.g. MRSA and VTE screening.

In respect of one of the patient safety priorities, to 'improve staff knowledge', it would have been helpful to include more information for clarity on the actions to be taken and the measures to be used to determine how this will be met.

Given the importance of serious incidents and in particular Never Events, we would have liked to see how these events informed the patient safety priorities. NHS SEL recognises the work being done to fully implement the WHO surgical safety checklist across the organisation.

The national outpatient survey results are to be commended and progress has been made in respect of the national inpatient survey. There is excellent work being undertaken in respect of ongoing GSTT patient survey processes which will be rolled out to the community services in this next year. Some recognition of the areas of concern within the national inpatient

survey which continue to be a challenge, and actions being taken to address these, would have given a more rounded picture, particularly as these issues have also been identified in the internal survey.

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, *C.Difficile* (*C.diff*) infections and screening for blood clots, which are national priorities. The Trust has led the way with *C.diff* assessments by introducing a new, more sensitive *C.diff* test. Accident and Emergency and 18-week targets were — and continue to be — particularly challenging. The implementation of action plans is ongoing.

It is very encouraging to see where audits have led to improved quality of services within the Trust. It would be helpful to understand how the Board have been involved in national and local audit reviews, particularly given the national Quality Account guidance requirement for information on the proportion reviewed by the Board.

It is very positive to see the progress against last years' priorities and we welcome the ongoing excellent relationship we have as local commissioners with GSTT and are committed to working closely to ensure the ongoing delivery of high quality services throughout this next year. 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 and these will continue.

Jane Fryer, Medical Director, NHS SE London



We are committed to saving energy and reducing the amount of waste we generate. We are proud to recycle 35 per cent of the waste we generate, and our waste management teams deliver around 60 tonnes of recycling a month to a waste management plant in Bow.

Our organisational structure

Our governors continue to play a vital part in the work of the Trust. We are also fortunate to benefit from a strong Board of Directors, whose extensive 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 patients and the wider community we serve.

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 has detailed input into the annual business planning process.

The patient, public and staff members of the Council are elected from and by the Foundation Trust membership to serve for three years. With the integration of community services in April 2011, the Council of Governors agreed to change our constitution to create an additional staff governor to represent the community directorates.

Main elections for the new governors in the public, patient and staff constituencies took place in Spring 2012 with the greatest number of places on the Council available since we became a Foundation Trust.

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: last year, the group took a particular interest in the ongoing development of King's Health Partners, including the feasibility review, which has led to the development of a Strategic Outline Case to consider closer collaboration between the partner organisations; the Trust's transformation programme; and the Forward Plan required by Monitor.

Patient experience: the group ensured that the outpatient experience was high on the Board's agenda and was instrumental in improving the important basics, such as reducing numbers of lost phone calls and addressing the problem of waiting times in clinics. They also monitored patient surveys and supported the patient environment action team inspections.

Membership development, involvement and communications: this group led the development of an induction programme for new governors to support candidates standing for election, as well as once elected. They also provided input into the redesign of the Trust's new public website and advised on the member seminar programme for 2012.

Last year, members of the working groups were, for the first time, invited to attend Board committees, including Finance and Investment, Workforce, Community and Quality, and have taken on their new role with enthusiasm.

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.

The Committee has this year recommended the renewal of Jan Oliver's appointment as a Non-Executive Director for a further year, expiring on 31st December 2012 and the appointment of Girda Niles as Non-Executive Director for a four year term from 1st January 2012.

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

Nominations Committee membership and attendance

Name	Actual/possible
Pauline Anderson	2/2
Judith Ellis	1/2
Dawn Hill	2/2
Sir Ron Kerr	2/2
Sir Hugh Taylor	2/2
David Treacher	2/2

Our membership

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

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

Public: residents of Lambeth, Southwark, Lewisham, Wandsworth 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 19,578 members, of whom 3,332 are patient members, 4,160 are public members and 12,086 are staff members. We strive for a membership that represents the diverse communities we serve.

Members receive regular mailings and are invited to events including our Annual Public Meeting, joint Board of Directors and Council of Governors meetings and other events, such as our regular health seminars. The seminars are extremely well attended; recent topics have included men's health, heart disease, and bones and joints.

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, c/o communications department, Block C, South Wing, St Thomas' Hospital, Westminster Bridge Road, London SE1 7EH, or email: members@gstt.nhs.uk

Board of Directors

Our Board of Directors is made up of our Chairman, Sir Hugh Taylor, seven 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 that the Trust provides high quality, effective and patient-focused services;
- ensure high standards of corporate governance and personal conduct;
- promote effective dialogue between the Trust and the local communities we serve.

Membership is balanced, complete and appropriate. The Trust is confident that all the Non-Executive Directors are independent in character and there are no relationships or circumstances which are likely to affect, or could appear to affect, their judgment. We therefore have not appointed a senior independent director. Rory Maw, Partner and Chief Financial Officer of Bridges Community

Council of Governors

Patient governors	Elected from	Actual/possible attendance
Mr Michael Craft	July 1 2009	1/1
Ms Susan Hardy*	June 1 2011	3/3
Ms Dawn Hill	July 1 2009	3/4
Mr Brian Lymbery	July 1 2009	4/4
Mr Jeremy Marsh	July 1 2009	4/4
Ms Niamh O'Sullivan	July 1 2007	4/4
Sir Richard Thompson	July 1 2007	2/4
Ms Jane Wardle	July 1 2009	2/4
Mrs Paula Young	July 1 2010	4/4
*Ms Susan Hardy replaced Mr Michael Craft mid-term and will therefore serve until June 30 2012.		

Staff governors	Constituency	Elected from	Actual/possible attendance
Ms Liz Dunn**	Nursing and midwifery	July 1 2009	1/1
Mrs Margaret Evison**	Other health professionals	July 1 2009	2/2
Mr Richard Gurney	Community services directorate	September 1 2011	1/3
Mrs Mia Hilborn	Other	July 1 2010	3/4
Mr Shamim Khan	Medical and dental practitioners	July 1 2009	0/4
Dr David Treacher	Medical and dental practitioners	July 1 2009	3/4
Mr Jeff Whitear*	Non clinical	April 1 2011	4/4
*Mr Jeff Whitear replaced a previous governor mid-term and will therefore serve until June 30 2012.			
** Ms Liz Dunn and Mrs Margaret Evison stepped down mid-term.			

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

Stakeholder governors	Organisation	Actual/possible attendance
Mr Stuart Bell*	South London and the Maudsley	0/1
Dora Dixon-Fyle	Southwark Council	2/4
Professor Judith Ellis	London South Bank University	3/4
Mr Robert Foster	King's College Hospital	4/4
Ms Sue Gallagher	Lambeth PCT	4/4
Professor Denise Lievesley	King's College London	1/4
Ms Madeliene Long**	South London and the Maudsley	1/3
Cllr Jane Pickard	Lambeth Council	3/4
*Mr Stuart Bell replaced Ms Madeliene Long mid-term.		
**Ms Madeliene Long stepped down mid-term.		

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

Ventures, has been Vice Chairman since May 2009.

In September 2011, around 150 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.

Board meeting attendance		
Name	Position	Actual/possible
Dr Ian Abbs	Medical Director	10/10
David Dean	Non-Executive Director	10/10
Mike Franklin	Non-Executive Director	7/10
Sir Ron Kerr	Chief Executive	10/10
Ann Macintyre	Director of Workforce and Organisational Development	9/10
Mr Rory Maw (Vice Chair)	Non-Executive Director	10/10
Steve McGuire	Director of Capital Estates and Facilities	9/10
Professor Frank Nestle	Non-Executive Director	10/10
Girda Niles	Non-Executive Director	2/2
Jan Oliver	Non-Executive Director	8/10
Hugh Risebrow	Commercial Director	9/10
Martin Shaw	Finance Director	10/10
Eileen Sills	Chief Nurse/ Chief Operating Officer	10/10
Diane Summers	Non-Executive Director	9/10
Sir Hugh Taylor	Chairman	10/10

Committee	Membership Apr – Dec 2011	Membership Jan – Mar 2012
Assurance and Risk (renamed Quality from Jan 2012)	Mike Franklin (Chair) Jan Oliver, David Dean Dr Ian Abbs, Eileen Sills Steve McGuire Sir Ron Kerr	Sir Hugh Taylor (Chair) David Dean, Girda Niles Jan Oliver, Diane Summers Dr Ian Abbs, Eileen Sills Steve McGuire, Sir Ron Kerr
Audit	David Dean (Chair) Rory Maw Diane Summers	David Dean (Chair) Rory Maw, Sir Hugh Taylor Diane Summers
Community Services	Diane Summers (Chair) David Dean, Jan Oliver Sir Hugh Taylor, Eileen Sills Martin Shaw, Ann Macintyre Dr Ian Abbs	Diane Summers (Chair) Girda Niles, Eileen Sills Martin Shaw Ann Macintyre Dr Ian Abbs
Finance and Investment	Rory Maw (Chair) David Dean, Diane Summers Frank Nestle, Martin Shaw Sir Ron Kerr, Steve McGuire Hugh Risebrow	Rory Maw (Chair) David Dean, Frank Nestle Martin Shaw, Sir Ron Kerr Steve McGuire Hugh Risebrow
Workforce	Jan Oliver (Chair) Mike Franklin Diane Summers Steve McGuire, Eileen Sills Sir Ron Kerr, Ann Macintyre	Mike Franklin (Chair) Sir Hugh Taylor Jan Oliver, Ann Macintyre Steve McGuire, Eileen Sills Sir Ron Kerr
Remuneration	Sir Hugh Taylor (Chair) all Non-Executive Directors	

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 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 Forward 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.

Audit Committee membership and attendance

Name	Actual/possible
David Dean (Chair)	4/4
Rory Maw	2/4
Diane Summers	3/4
Sir Hugh Taylor	2/2

Remuneration Committee

The Remuneration Committee decides the pay, 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 that it understands their views and those of our members.

Governors were able to attend Board Meetings to present a formal report of the activities of the Council and its working groups, while Board members were able to do the same at Council of Governors' meetings. During 2012-13, these meetings will be combined to ensure that governors have the opportunity to question the Board about key issues such as finance performance, the quality of our services and the patient experience.

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

Remuneration Committee membership and attendance

Name	Actual/possible
David Dean	2/2
Mike Franklin	1/2
Mr Rory Maw	2/2
Professor Frank Nestle	2/2
Girda Niles	0/0
Jan Oliver	2/2
Diane Summers	2/2
Sir Hugh Taylor	2/2

Trust Management Executive

The membership of the Trust 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:

- Clinical Governance and Risk Management;
- Investment Portfolio Board;
- IT Investment Board;
- Integrated Planning Group;
- Cancer Centre Project Board;
- Information Governance Committee;
- Research and Development Committee.

Board of Directors – Executive Directors



Sir Ron Kerr CBE

Chief Executive

Sir Ron 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 Chairman 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 in 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 Lambeth and Southwark community services.



Ann Macintyre

Director of Workforce and Organisational Development

Ann Macintyre joined the Trust in November 2009, and has over thirty years' 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 Social Partnership Forums working with health ministers and trade unions on workforce policy. Ann is also a member of the Department of Health's revalidation delivery board and acts as an expert adviser to a range of national groups.



Steve McGuire

Director of Capital, Estates, Facilities and IT&T

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 also spent two years with the NHS Modernisation Agency.

Hugh's early career was in strategic consultancy and he holds an engineering degree from Cambridge University. Until he joined the Trust, he chaired the CBI's health panel.

Hugh left the trust at the end of March.



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. She was awarded a CBE in 2003 for services to nursing.

From April 2012



Amanda Pritchard

Chief Operating Officer

Amanda joins the Trust as Chief Operating Officer, a new Executive Director position. She previously held the post of Deputy Chief Executive at Chelsea and Westminster Hospital NHS Foundation Trust.

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 had 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.

Sir Hugh chairs the both the Quality and the Remuneration Board Committees as well as the main board. He is a resident of Southwark.



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 19 years and is a Trustee 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 Workforce Committee.



Rory Maw

Non-Executive Director and Vice Chairman

Rory Maw is Partner and 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 appointed Vice Chairman in May 2009. He 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 a member of the NIHR Biomedical Research Centre executive.

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.



Girda Niles

Non-Executive Director

Girda is a local community consultant specialising in community development, engagement and strategy. She has extensive experience in social enterprise, financial management and training. Through her previous role as a Non-Executive Director of Lambeth Primary Care Trust, she has a thorough understanding of how health and social care systems work.

Girda joined the board in January 2012.



Jan Oliver

Non-Executive Director

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

Jan has lived in Streatham for 20 years and is involved with many local organisations, including Lambeth Black Family Forum and Community Police Consultative Group for Lambeth.

Jan joined the Board in January 2004 and has just been re-appointed for another year.



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 Community Services Committee.



Our imaginative health and well-being initiatives include a 'walk the stairs' club in the 29 floor Guy's Tower and lunchtime walks enabling staff to get together and get fit while also enjoying the vibrant South Bank community.

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 2011/12, 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 96 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' notice 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.



Sir Ron Kerr, Chief Executive, 30 May 2012



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Annual accounts

Foreword to the accounts

These accounts, for the year ended 31 March 2012, have been prepared by the Guy's and St Thomas' NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the NHS Act 2006.

A handwritten signature in blue ink, consisting of a large, stylized 'R' followed by a wavy line.

Sir Ron Kerr, Chief Executive and Accounting Officer, 30 May 2012

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").

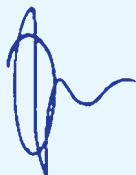
Under the NHS Act 2006, Monitor has directed Guy's and St Thomas' NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state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



Sir Ron Kerr, Chief Executive and Accounting Officer, 30 May 2012

Annual Governance Statement 2011/12

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Guy's and St Thomas' NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Guy's and St Thomas' NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Trust has in place a Risk Management Policy which clearly sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust. Operational responsibility for the implementation of risk management has been delegated to executive and other named directors. Risk management is a core component of the job descriptions of senior managers within the Trust. A range of risk management training is provided to staff and there are policies 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.

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.

The Trust undertakes an information assurance assessment of key indicators each month, reported to the Board as part of the monthly performance report. The assessment assigns a weighted risk scoring to each indicator. Those with higher scores are subject to mitigating actions that are described more fully in the commentary. The assurance assessment assigns scores across eight domains.

This risk assessment helps determine priorities of the programme of audits undertaken by Internal Audit, and the commissioning of any external assurance help. In the past year, the Trust has sought advice from the Intensive Support Team of the Department of Health in reviewing the Trust's pathway reporting processes; and has

commissioned external reviews from Deloitte's and Price Waterhouse Cooper's that have looked more broadly at information assurance processes.

In addition, and in common with all trusts, the Quality Accounts are subject to external audit; clinical coding is subject to external audit by the Audit Commission; and local data quality assessments are made in line with the requirements of the Information Governance Toolkit.

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 Care Quality Commission (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's 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 Quality Committee (previously the Assurance and Risk Committee).

Information governance

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.

Following the integration of community services into the Trust, a thorough review of all information governance processes was undertaken. The secure transfer of data was part of the review and recommendations were made and an action plan developed to mitigate any identified risks. The plan is being implemented.

Risks

The Trust has identified in its Board Assurance Framework a potential risk to its Monitor governance rating from not meeting performance targets, in particular the referral to treatment, accident & emergency and 62 day cancer waiting time targets. The Trust has met the accident and emergency four hour target in 2011/12, however the Trust continues to experience a significant increase in the number of patients attending the A&E department and recognises this as an area of risk for 2012/13. Plans are in place including the opening of a new Urgent Care Centre on the Guy's site. The 62 day cancer waiting time target was not met in 2011/12, capacity has been increased in radiotherapy and the cancer day unit, and plans for 2012/13 include a new endoscopy unit to increase diagnostic capacity. Midway through the year, the Trust identified more people on the admitted referral to treatment pathway than previously reported. A comprehensive action plan was developed to address the

longest waits. This plan is on target, however the Trust does not expect to meet the admitted referral to treatment target by the end of September 2012. Further information about performance against the national targets is given in the Quality Accounts.

In 2010/11, the Trust identified weaknesses in control with our information assurance arrangements and so is implementing a 12-month action plan. However, we are not complacent and have commissioned independent external reviews of our information assurance processes. This remains an ongoing area of risk, which will continue to be monitored externally and through the Trust's committee structure.

The Trust intends to have no avoidable cases of MRSA and remains assured about the effectiveness of its infection control arrangements based on considerable evidence, including an external independent review, critical friend visit and a large research study conducted at the Trust. Despite this, the Trust has identified a future risk to its governance rating following the setting of a target of no more than four cases of MRSA in 2012/13, which poses a challenge for a Trust of this size and complexity.

Equality duties

The Trust is required to demonstrate how it takes due regard of the general duties under the Equality Act (2010) and the revised Public Sector Equality Duties.

The Trust's Management Executive requires all papers submitted to consider the impact on equality and equity. All HR policies are subject to an equality impact assessment. This is monitored at the Trust HR policy sub group.

The Trust is legally compelled to publish its equality objectives for 2012/13. One objective pertains to equality analysis and assessment, where the Trust will revise the documentation, ensuring it is more outcomes focussed (as required under the new Public Sector Equalities Duties). The Trust will be required to publish progress on ensuring transformation projects have an equality analysis/assessment.

Incident reporting

Incident and near miss reporting is encouraged across all staff groups and specialties across the Trust within an open and fair culture. During 2011/12, junior doctors have, in particular, been encouraged to report incidents via the Trust's web-based reporting system, with an emphasis on recording medication-related incidents. Significant work has been carried out in the year to reduce the number of patient falls resulting in fractures. Rapid response and review of falls incidents by members of a dedicated multi-disciplinary falls group and the introduction of local falls champions and a falls care plan, saw the achievement of 100 days of 'falls without fractures' by early February 2012.

Patient involvement in risk

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 2011/12, the Trust has invited the local involvement networks (LINKs) to participate in a user reference group to support the development of capital schemes for a new outpatient centre, to attend and give feedback on the designs for the new cancer treatment centre and to participate in workshops to develop the priorities for the Quality Accounts for both 2011/12 and 2012/13.

The views of patients have been sought in a variety of ways, including the recently implemented system of near time patient electronic surveys, nationally mandated surveys, comment cards and other

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.

When developing plans for significant service changes, the proposer has to show clearly how stakeholders might be affected and the engagement plans that will be completed to ensure they are consulted and that their views are addressed; equality impact assessments are part of this process.

The Trust has an agreed process of advising and engaging with Southwark and Lambeth Adult Health and Social Care Scrutiny Sub Committees when there are proposed service changes that may impact on local people. The Trust endeavours to work closely with patients and the public to ensure that any changes minimise the risk.

As a Foundation Trust, we also have a responsibility to inform the Trust's Council of Governors of any proposed changes, which includes how any potential risk to patients will be minimised.

The Trust is fully compliant with the CQC essential standards of quality and safety. The Trust has been inspected by the CQC on five occasions during 2011/12, the CQC found the Trust compliant with the essential standards of quality and safety that were reviewed. The standards and locations covered in these inspections are described in the Quality Accounts of this report.

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 met. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme's rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

The Trust has undertaken risk assessments and developed an adaptation plan to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

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

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 set by 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.

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. As a result of these procedures the external auditors have concluded that they do not intend to issue a qualified audit certificate in respect of arrangements for securing economy, efficiency and effectiveness in the Trust's use of resources.

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 Accounts. 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 quality work streams and establishing the priorities for the 2011/12 Quality Accounts.

To inform our priorities for the coming year, the Trust reviewed key hospital and community regulation, staff and patient surveys and external reviews such as Age UK's report, *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 distributing 200 questionnaires to staff 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 of our priorities.

Under each of the three mandated domains, we are pleased that we have selected several of the top priorities chosen by our public stakeholders. Throughout the process, the Trust's governors were actively engaged, offering essential guidance and critical advice on the process. In preparation for community integration, we involved community colleagues from the outset, engaging with and incorporating their views and those of their stakeholders. The final priorities reflected our forthcoming integration, with a balanced mix of hospital and community and joint priorities.

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's Patient Safety and Experience Report, produced jointly by the Chief Nurse and Medical Director. External assurance on aspects of our Quality Accounts has been provided by the Trust's external auditors.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report which will be a separate document and summary chapter in 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 of Directors, the Audit Committee and the Quality 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 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.

Controls of the risks associated with pathway measurement have been strengthened through 2011/12, minimising risk arising from variation in the interpretation of definitions. An expert sub-group of the Trust's data quality executive 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 Board Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements.

Internal Audit work to a risk based audit plan, agreed by the Audit Committee, and covering risk management, governance and internal control processes, both financial and non-financial, across the Trust. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS internal audit standards. A report is produced at the conclusion of each audit assignment and, where scope for improvement was found, recommendations were made and appropriate action plans agreed with management. Reports are issued to and followed up with the responsible Executive Directors, and the results of audit work are reported to the Audit Committee. Internal audit reports are also made available to the external auditors, who may rely on them in arriving at their annual opinion. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. The Department also provides an anti-fraud service to the Trust.

Internal Audit work also covered service delivery and performance, financial management and control, human resources, operational and other reviews. Based on the work undertaken, including a review of the Trust's Board Assurance Framework process, the head of internal audit concluded that there was in place a generally sound system of internal control, designed to meet the Trust's objectives, and that controls were generally being applied consistently.

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. The Quality Committee replaced the Assurance and Risk Committee from January 2012 and will focus on assurance of clinical quality and performance with specific reference to the Quality Strategy, launched in November 2011, and the quality indicators set out in the work plan.

The Board Assurance Framework is reviewed by the Assurance and Risk Committee and has been updated throughout the year to reflect the risks associated with failing to achieve the Trust's strategic objectives. From January 2012 the Board Assurance Framework has been reviewed by the Audit Committee.

The Clinical Governance and Risk Management Committee reports to the Trust Management Executive and the Quality Committee. Through its work on establishing a system for reviewing the trust's clinical procedures and guidelines, it contributes to maintaining the system of internal control.

The Trust has robust systems and controls in place to ensure that high quality clinical audits are conducted and their findings acted upon by all directorates and specialties across the Trust. There is a policy in place that describes the responsibilities and accountabilities for staff at all levels in devising, conducting, reporting and acting on the findings of clinical audits. Each directorate has a clinical audit lead and each specialty within a directorate has a clinical audit lead. Specialty and directorate audit leads are responsible for developing, monitoring and reporting an annual clinical audit programme that reflects local and/or Trust issues around service quality or patient safety. All audit projects are registered on an electronic system and monitored to completion and subsequent re-audit. Directorate audit leads sit on the Trust's Clinical Audit Group which is responsible and accountable to the Trust Clinical Governance and Risk Management Committee.

The Trust's Clinical Audit Group is responsible for monitoring directorate clinical audit plans, ensuring that audit results are acted upon, approving and monitoring Trust wide audit projects and ensuring that the Trust participates in all appropriate national audits. Clinical audit is supported by the clinical governance team who provide advice and support to staff at all levels, provide guidance and support to directorates for their annual audit programmes, provide specialist audit training to Trust staff, provide escalation reports where audits are not completed to agreed timescales and administer the electronic audit system and the Trust Clinical Audit Group.

The Trust has agreed a plan with Monitor to address the performance risks outlined above and has a 12-month action plan in place to address the information assurance issues. Progress against these plans is being monitored internally through the trust's committee structures.

Conclusion

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 policies, aims and objectives and that those control issues have been or are being addressed.



Sir Ron Kerr, Chief Executive and Accounting Officer, 30 May 2012

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 & St Thomas' NHS Foundation Trust for the year ended 31 March 2012 which comprise the Consolidated Statement of Comprehensive Income, the Group and Trust Statement of Financial Position, the Consolidated Cash Flow Statement, the Group and Trust Statement of Changes in Taxpayers Equity and the related notes 1 to 36. 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 Council 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 31 March 2012 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

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 and prepared in accordance with the National Health Service Act 2006.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- 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.



Susan Barratt, BA, ACA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Reading, UK

30 May 2012

Consolidated statement of comprehensive income for the year ended March 31 2012

		March 31 2012	March 31 2011
			Restated*
	NOTE	£000	£000
Operating income	4.1	851,479	715,481
Other operating income	5	284,947	279,796
Operating expenses	6.1	(1,104,483)	(953,767)
OPERATING SURPLUS		31,943	41,510
FINANCE COSTS			
Finance income	11	552	838
Finance expenses	12	(247)	(293)
Public Dividend Capital dividend payable	31	(20,756)	(20,905)
Net finance costs		(20,451)	(20,360)
Share of operating loss in joint ventures	9	–	(329)
Corporation Tax	13	(78)	(2)
SURPLUS FOR THE YEAR		11,414	20,819
Other comprehensive income			
Impairments	17	(22,046)	(30,038)
Revaluations		14,504	27,108
Other reserve movements		1,496	1,166
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		5,368	19,055

The notes on pages 88 to 92 form part of these accounts. All revenue and expenditure is derived from continuing operations.

* Prior years have been restated to reflect the changes to the accounting treatment of donations to fund capital expenditure.

Further details are identified in Note 2

Statement of financial position as at March 31 2012

		GROUP			TRUST		
		March 31 2012	Restated*	Restated*	March 31 2012	Restated*	Restated*
	NOTE	£000	March 31 2011 £000	1 April 2010	£000	March 31 2011 £000	1 April 2010
NON CURRENT ASSETS							
Property plant and equipment	15	847,228	861,209	838,854	847,228	861,209	838,854
Intangible assets	16	31,092	27,286	20,000	30,850	27,074	19,959
Investments in associates (joint controlled operations)	18	83	–	–	71	–	–
Trade and other receivables	21	2,047	2,360	2,093	3,328	3,605	4,055
Other financial assets	22	3,500	–	–	3,500	–	–
TOTAL NON-CURRENT ASSETS		883,950	890,855	860,947	884,977	891,888	862,868
CURRENT ASSETS							
Inventories	20	15,138	14,595	14,252	15,138	14,595	14,252
Trade and other receivables	21	57,726	69,135	58,687	55,085	68,620	56,411
Tax receivable					2,618	589	2,328
Cash and cash equivalents	27	143,929	100,139	111,911	143,638	100,001	111,825
TOTAL CURRENT ASSETS		216,793	183,869	184,850	216,479	183,805	184,816
CURRENT LIABILITIES							
Trade and other payables	23	(120,634)	(98,183)	(88,482)	(120,482)	(97,959)	(88,403)
Tax payable	23	(14,047)	(11,492)	(11,192)	(13,967)	(11,490)	(11,190)
Other liabilities	23	(15,826)	(21,293)	(17,444)	(15,826)	(21,293)	(17,444)
Provisions	24	(2,562)	(2,475)	(2,254)	(2,562)	(2,475)	(2,254)
TOTAL CURRENT LIABILITIES		(153,069)	(133,443)	(119,372)	(152,837)	(133,217)	(119,291)
NON-CURRENT LIABILITIES							
Other liabilities	23	–	(2,680)	(6,225)	–	(2,680)	(6,225)
Provisions	24	(8,323)	(8,301)	(8,955)	(8,323)	(8,301)	(8,955)
Borrowings	23	(3,683)	–	–	(3,683)	–	–
TOTAL NON-CURRENT LIABILITIES		(12,006)	(10,981)	(15,180)	(12,006)	(10,981)	(15,180)
TOTAL ASSETS EMPLOYED		935,668	930,300	911,245	936,613	931,495	913,213
TAX PAYERS' EQUITY							
Public Dividend Capital		355,766	355,766	355,766	355,766	355,766	355,766
Revaluation reserve		277,789	285,194	293,053	277,789	285,194	293,053
Other reserves		743	743	743	743	743	743
Income and expenditure reserve		301,370	288,551	261,714	302,315	289,746	263,682
Merger Reserve surplus/(deficit)		–	46	(31)	–	46	(31)
TOTAL TAXPAYERS' EQUITY		935,668	930,300	911,245	936,613	931,495	913,213

Prior years have been restated to reflect the changes to the accounting treatment of donations to fund capital expenditure.



Sir Ron Kerr

Chief Executive and Accounting Officer, 30 May 2012

Statement of changes in Taxpayers' equity

GROUP	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 31 March 2011	355,766	285,194	743	46	288,551	930,300
TCS and merger adjustments	–	–	–	–	1,170	1,170
Taxpayers' equity at 1 April 2011 restated	355,766	285,194	743	46	289,721	931,470
Surplus for the year	–	–	–	–	11,414	11,414
Impairments	–	(22,046)	–	–	–	(22,046)
Revaluations	–	14,504	–	–	–	14,504
Other reserve movements	–	137	–	(46)	235	326
Taxpayers' equity as at 31 March 2012	355,766	277,789	743	–	301,370	935,668

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 1 April 2010	355,766	220,326	216,505	743	(31)	117,936	911,245
Effect of change in accounting policy for donated and government grant funded assets	–	72,727	(216,505)	–	–	143,778	–
Taxpayers' Equity at 1 April 2010 restated	355,766	293,053	–	743	(31)	261,714	911,245
Surplus for the year	–	–	–	–	–	20,819	20,819
Impairments	–	(30,038)	–	–	–	–	(30,038)
Revaluations	–	27,108	–	–	–	–	27,108
Other reserve movements	–	(4,929)	–	–	77	6,018	1,166
Taxpayers' equity as at 31 March 2011	355,766	285,194	–	743	46	288,551	930,300

TRUST	NOTE	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2011		355,766	285,194	743	46	289,746	931,495
TCS and merger adjustments	36	–	–	–	–	1,170	1,170
Taxpayers' equity at 1 April 2011 restated		355,766	285,194	743	46	290,916	932,665
Surplus for the year		–	–	–	–	11,164	11,164
Impairments		–	(22,046)	–	–	–	(22,046)
Revaluations		–	14,504	–	–	–	14,504
Other reserve movements		–	137	–	(46)	235	326
Taxpayers' equity as at 31 March 2012		355,766	277,789	743	–	302,315	936,613

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 1 April 2010	355,766	220,326	216,505	743	(31)	119,094	912,403
Effect of change in accounting policy for donated and government grant funded assets	–	72,727	(216,505)	–	–	143,778	–
Taxpayers' Equity at 1 April 2010 restated	355,766	293,053	–	743	(31)	262,872	912,403
Surplus for the year	–	–	–	–	–	20,859	20,859
Impairments	–	(30,038)	–	–	–	–	30,038
Revaluations	–	27,108	–	–	–	–	27,108
Other reserve movements	–	(4,929)	–	–	77	6,015	1,163
Taxpayers' equity as at 31 March 2011	355,766	285,194	–	743	46	289,746	931,495

Consolidated cash flow statement for the year ended 31 March 2012

	NOTE	March 31 2012 £000	Restated* March 31 2011 £000
Cash flows from operating activities			
Operating surplus from continuing operations		31,943	41,510
Non-cash income and expenses			
Depreciation and amortisation		41,336	39,073
Impairments and reversals		6,172	4,538
Amortisation of government grants		762	(354)
Decrease/(increase) in trade and other receivables		11,391	(12,714)
Increase in inventories		(543)	(343)
(Decrease)/increase in other liabilities		(8,147)	4,169
Increase in trade and other payables		18,274	10,677
Increase/(decrease) in provisions		109	(1,284)
Tax received		448	2,037
Investment in associate and joint ventures		(71)	–
Other movements in operating cash flows		920	(722)
NET CASH GENERATED FROM OPERATING ACTIVITIES		102,594	86,587
Cash flows from investing activities			
Interest received		551	829
Purchase of intangible assets		(9,276)	(10,281)
Purchase of property, plant and equipment		(32,096)	(66,227)
Proceeds from sale of property, plant and equipment		–	608
NET CASH GENERATED USED IN INVESTING ACTIVITIES		(40,821)	(75,071)
Cash flows from financing activities			
Other loans received		3,683	–
Public Dividend Capital dividend paid		(21,861)	(20,478)
Cash flows from /(used in) other financing activities		195	(2,810)
NET CASH GENERATED USED IN FINANCING ACTIVITIES		(17,983)	(23,288)
Net increase/(decrease) in cash and cash equivalents		43,790	(11,772)
Cash and cash equivalents at 1 April		100,139	111,911
Cash and cash equivalents at 31 March	27	143,929	100,139

* Prior years have been restated to reflect the changes to the accounting treatment to fund capital expenditure.

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 2011/2012 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* (FReM) 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.

Going concern

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.2 Basis of consolidation

The group financial statements consolidate the financial statements of the Trust and entities controlled by the Trust (its subsidiaries) and incorporate its share of the results of 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 of subsidiaries are consolidated in full into the appropriate financial statement lines.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where differences are material.

All intragroup balances and transactions, including unrealised profits arising from intragroup transactions, have been eliminated in full. 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.

Joint ventures are separate entities over which the Trust has joint control with one or more parties. The meaning of control is the same as that for subsidiaries. Joint ventures are recognised in the Trust's financial statements using the equity method. The investment is initially recognised at cost.

A separate income statement for the parent organisation has not been presented in accordance with the guidelines in the FT ARM.

1.3 Acquisitions and mergers

On 1 April 2011, Guy's and St Thomas' NHS Foundation Trust merged with the Community Services functions of Lambeth and Southwark Primary Care Trusts. Please see Note 36 for further details.

The 2011/12 HM Treasury FReM requires that all transfers of functions between public sector bodies are accounted for using merger accounting. The Department of Health has considered the feasibility of this restatement for all local bodies, including NHS Foundation Trusts, and has concluded it is impracticable to undertake this restatement for all bodies on the basis of cost and availability of information, and has issued a reporting limitation. To achieve consistency, NHS Foundation Trusts will not include prior year comparators for transfers under

Transforming Community Services, and have instead actioned the amendments to 2011/12 opening balances. The limitation only applies to the prior year comparators that are included in the 2011/12 accounts for the Transfer of Community Services, and cannot be applied in any other context.

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 healthcare services. Income relating to spells that are partially completed at year end are apportioned across the financial years on a pro rata basis. This basis is based on the costs incurred over the length of the treatment and the expected or actual length of stay.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5 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.

1.6 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, GP 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.

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

a) 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.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

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. Actuarial assessments undertaken in intervening years between formal valuations using

updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are calculated taking into account the best of the last three years pensionable pay for each year of service, and are based on 1/80th of the 1995 section and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.7 Expenditure on goods and services

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

1.8 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

All property, plant and equipment is 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.

Land and buildings are valued by an independent registered chartered surveyor on a regular basis and in accordance with Royal Institution of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect fair value. As at March 31 2012 the land and buildings assets were revalued.

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.

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.

Subsequent expenditure

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates assets over the following ranges:

- Buildings, 10 – 49 years
- Plant and machinery, 3 – 15 years
- Transport equipment, 2 – 7 years
- IT hardware, 3 – 15 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.

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.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
 - management are committed to a plan to sell the asset;
 - an active programme has begun to find a buyer and complete the sale;
 - the asset is being actively marketed at a reasonable price;
 - the sale is expected to be completed within 12 months of the date of classification as 'held for sale';
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/ grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. This is a change in accounting policy compared to previous years. Please see Note 2 for further details.

The majority of donated assets have funding received retrospectively, so that restrictions imposed by the donor are met upon the receipt of the donated cash. If donated assets are no longer used for the purpose intended for treating patients and they still had a net book value, the donor would be notified. There were no restrictions placed on the donations received in the year.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.9 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 e.g. the presence of a market for it or its output, or, where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

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

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value which is typically amortised cost. Revaluation gains and losses and impairments are treated in the same manner as property, plant and equipment.

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

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The Trust depreciates intangible assets over the following ranges:

- Information technology, 1 – 10 years
- Software, 1 – 15 years
- Licences and Trademarks, 5 – 10 years.

1.10 Government and other revenue grants

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

1.11 Inventories

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

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are

disclosed in the Contingencies note where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the Contingencies note, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.13 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid over as Public Dividend Capital. The charge is calculated at the 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 for all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.14 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input tax is recoverable, the amounts are stated net of VAT.

1.15 Corporation tax

Current tax assets and liabilities are measured at the amount expected to be recovered from or paid to the taxation authorities, based on tax rates and laws that are enacted or substantively enacted by the Statement of Financial Position date.

1.16 Other reserves

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

1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of

the transaction or on re-translation at the Statement of Financial Position date) are recognised as income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.18 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent that performance occurs, i.e. when receipt or delivery of the goods or services is made.

Regular purchases or sales are recognised and de-recognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: a loan to 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, including transaction costs, and measured subsequently at fair value, with gains and losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are not sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

Financial liabilities are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from independent valuations.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure', are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.19 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.20 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; and it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% (2010/11: 2.9%) in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in the notes to the Statement of Comprehensive Income.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to 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.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 34 to the accounts.

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.23 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors, that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Provisions

A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities.

Provision for impairment of receivables

Management will use their judgement to decide when to write-off revenue or to provide against the probability of not being able to collect debt.

Impairments and estimated asset lives

The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives.

Valuations of land and buildings

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See Note 1.8 for further details.

Key sources of estimation uncertainty

Management has made the following critical judgements in the process of applying the entity's accounting policies and this has had a significant effect on the amounts recognised in the accounts:

- 1) The use of estimated asset lives in calculating depreciation (See Note 1.8 and Note 1.9).
- 2) Provisions for early voluntary retirement pension contributions and injury benefit obligations are estimated using expected life tables and discounted at the pensions rate of 2.9% (See Note 1.20).

1.24 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011/12. The application of the Standards as revised would not have a material impact on the accounts for 2011/12, were they applied in that year:

- IAS 1 Presentation of financial statements (Other Comprehensive Income) – subject to consultation
- IAS 12 Income Taxes (amendment) – subject to consultation
- IAS 19 Post-employment benefits (pensions) – subject to consultation
- IAS 27 Separate Financial Statements – subject to consultation
- IAS 28 Investments in Associates and Joint Ventures – subject to consultation
- IFRS 7 Financial Instruments: Disclosures (annual improvements) – effective 2012-13
- IFRS 9 Financial Instruments – subject to consultation
- IFRS 10 Consolidated Financial Statements – subject to consultation
- IFRS 11 Joint Arrangements – subject to consultation
- IFRS 12 Disclosure of Interests in Other Entities – subject to consultation
- IFRS 13 Fair Value Measurement – subject to consultation
- IPSAS 32 - Service Concession Arrangement – subject to consultation.

2 The impact of changes to the accounting treatment of donations to fund capital expenditure

2010/11	Current Accounting Policies £000	Previous Accounting Policies £000	Change £000
Statement of comprehensive income			
Income from activities	715,481	715,481	–
Other income			
– Donations towards capital expenditure	9,749	–	9,749
– Transfers from the donated asset reserve	–	6,810	(6,810)
All other income	270,047	270,047	–
Total other income	279,796	276,857	2,939
Total income	995,277	992,338	2,939
Expenditure			
– Depreciation on donated assets	6,810	6,810	–
– All other expenditure	946,957	946,957	–
Total expenditure	953,767	953,767	–
Operating surplus	41,510	38,571	2,939
Financing Costs and other adjustments	20,691	20,691	–
Surplus for the year	20,819	17,880	2,939
Other comprehensive adjustments	(1,764)	(2,468)	704
Transfer from donated asset reserve	–	(6,810)	6,810
Donations received	–	9,749	(9,749)
Total comprehensive income for the year	19,055	18,351	704

This is the change in activity from previous year as a result of the impact of changes to the accounting treatment of donations to fund capital expenditure.

The impact on the statement of financial position was a decrease in current other liabilities of £331k and a decrease in non current other liabilities of £373k. See note 23.3 for the restated balances.

The impact on the consolidated cash flow statement was an increase in net cash generated from operating activities of £9,876k offset with a corresponding decrease in net cash generated from investing activities.

3 Segmental reporting

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
INCOME		
Patient care income	851,479	715,481
Non patient care income	284,947	279,796
Total income	1,136,426	995,277
EXPENDITURE		
Clinical divisions	(916,865)	(650,905)
Corporate	(208,147)	(323,553)
Total expenditure	(1,125,012)	(974,458)
SURPLUS	11,414	20,819

During 2012 day-to-day financial control was devolved to:

- Fourteen Clinical Directorates accountable to the Board of Directors via the Chief Nurse and Medical Director;
- Two community directorates accountable to the Board of Directors via the Chief Nurse;
- 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.

4 Operating income

4.1 Income from activities by source

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Strategic Health Authorities	7,342	5,539
Primary Care Trusts	814,167	682,977
NHS Trusts	2,251	2,230
Non NHS:		
– Private patients	21,230	19,033
– Overseas patients (non-reciprocal)	1,851	1,954
– NHS injury scheme	1,038	991
– Other	3,600	2,757
	851,479	715,481

4.2 Income from activities by type

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Elective income	191,992	161,228
Non-elective income	103,305	115,163
Outpatient income	141,266	132,059
Other type of activity income	284,331	268,247
Accident and Emergency income	18,968	17,797
Private and overseas patient income	23,081	20,987
Community services	88,536	–
	851,479	715,481

4.3 Income from activities arising from mandatory and non mandatory services

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Mandatory services	828,398	694,494
Non mandatory services	23,081	20,987
	851,479	715,481

4.4 Private patient income

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Private patient income	23,081	20,987
Total patient related income	851,479	715,481
Proportion as a percentage	2.71%	2.93%

Under the revised definition agreed in 2009/10, Section 44 of the NHS Act 2006 requires that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed the equivalent proportion whilst the body was an NHS Trust in 2002/03. For Guy's and St Thomas' the equivalent figure is 3.04%

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

5 Other operating income

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Research and development	50,619	51,514
Education, training and research	79,255	77,404
Charitable and other contributions to expenditure	12,667	16,107
Non-patient care services to other bodies	20,599	14,242
Other income (see below)	100,883	97,652
Reversal of impairments of property, plant and equipment	–	45
Profits on disposal of fixed assets	4	392
Income in respect of staff recharges	20,920	22,440
	284,947	279,796

Other income includes income from commercial activities, staff accommodation rentals, clinical excellence awards, catering, foreign currency gains of £434k (gains of £661k in 2010/2011) and other direct credits.

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

6 Operating expenses

6.1 Operating expenses comprise:

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Services from other NHS Trusts	2,421	3,156
Services from other NHS bodies	8,119	24,904
Services from NHS Foundation Trusts	2,719	7,141
Purchase of healthcare from non-NHS bodies	6,897	1,780
Executive Directors' costs	1,566	1,442
Non-Executive Directors' costs	185	181
Staff costs	621,098	531,433
Drugs	90,259	83,579
Supplies and services – clinical	138,317	112,565
Supplies and services – general	7,245	7,289
Establishment	25,632	24,752
Research and development	111	95
Transport	10,109	7,759
Premises	67,277	52,196
Increase/(Decrease) in Bad Debts Provision	9,637	(469)
Depreciation and amortisation	41,336	39,073
Impairments of property, plant and equipment	6,172	4,583
Impairments of intangible assets	762	–
Audit fees – statutory audit	130	126
Other auditor regulatory services	21	67
Clinical negligence	7,844	6,935
Other*	56,626	45,180
	1,104,483	953,767

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

6.2 Audit fees

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Audit services for statutory audit	121	117
Audit fee for subsidiary companies	9	9
Other audit regulatory services	21	67
	151	193

In addition to the above, a fee was paid to our Auditor for £207k. This non-audit work was for a consultation on a business case review for the Cancer Treatment Centre.

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 2011/2012 or 2010/2011.

6.4 Operating leases

As Lessee

6.4.1 Payments recognised as an expense:

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Minimum lease payments under operating leases recognised as an expense in the year	17,412	6,649

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 2012 £000	Year ended March 31 2011 £000
Within 1 year	6,637	6,527
Between 1 and 5 years inclusive	16,563	17,154
After 5 years	10,577	13,182
	33,777	36,863

The Trust currently leases a number of properties from which community services are provided. The Trust expects to enter into formal leases for some of these properties during 2012/13. Lease negotiations were still ongoing at 31 March 2012 and so amounts relating to these leases are not included in the lease commitment figures shown above. It is expected that nine of these properties will be transferred to the ownership of the Trust during 2012/13, under the framework of the guidance issued by the Department of Health in August 2011, *PCT Estate: future ownership and management of estate in the ownership of primary care trusts in England*.

As Lessor

6.4.2 Rental revenue:

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Income	3,548	4,130
	3,548	4,130

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Within 1 year	3,262	3,354
Between 1 and 5 years inclusive	10,993	12,752
After 5 years	4,661	9,249
	18,916	25,355

6.5 2011/12 Salary and pension entitlements of senior managers

A) Remuneration

		Year ended March 31 2012	Year ended March 31 2011
Name	Title	Total remuneration £000	Total remuneration £000
Executive Directors			
I. Abbs	Medical Director	197	49
E. Baker	Joint Director of Clinical Leadership and Medical Director (until September 2010)	–	103
D. Hamilton-Fairley	Acting Medical Director (for the period September 2010 to December 2010)	–	57
R. Kerr	Chief Executive	251	254
A. Macintyre	Director of Workforce and Organisational Development	146	146
S. McGuire	Director of Capital, Estates, Facilities and IT&T	157	157
H. Risebrow	Commercial Director	150	150
M. Shaw	Director of Finance	157	157
E. Sills	Chief Nurse/Director of Infection Prevention and Control	173	173
		1,231	1,246
Non-Executive Directors			
D. Dean	Non-Executive Director and Chairman Audit Committee	20	20
M. Franklin	Non-Executive Director	17	17
R. Maw	Non-Executive Director	17	17
P. Moberly	Chairman (until January 2011)	–	51
F. Nestle	Non-Executive Director	17	17
G. Niles	Non-Executive Director (appointed January 2012)	4	–
J. Oliver	Non-Executive Director	17	17
D. Summers	Non-Executive Director	17	17
H. Taylor	Chairman (appointed February 2011)	60	10
		1,400	1,412

Hutton Review of Fair Pay

Highest Paid Director's Total Remuneration	£ 250,755
Medium Total Remuneration	£ 36,802
Remuneration Ratio	6.81

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 2012 £000	Cash equivalent transfer value at March 31 2012 £000	Real increase in cash equivalent transfer value at March 31 2012 £000
I. Abbs	Medical Director	50	310	1,181	340
R. Kerr*	Chief Executive	–	–	–	–
A. Macintyre	Director of Workforce and Organisational Development	1	202	845	85
S. McGuire	Director of Capital, Estates, Facilities and IT&T	9	131	543	84
H. Risebrow	Commercial Director	4	39	139	32
M. Shaw	Director of Finance	0	248	1,216	66
E. Sills	Chief Nurse/Director of Infection Prevention and Control	4	234	889	127

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

* 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.

7 Employee costs and numbers

7.1 Employee costs (including executive directors)

	Permanently employed £000	Other £000	Year ended March 31 2012 Total £000	Year ended March 31 2011 Total £000
Salaries and wages	478,201	424	478,625	419,598
Social security costs	43,539	–	43,539	34,430
Employer contributions to NHSPA	54,359	–	54,359	47,118
Termination benefits	1,516	–	1,516	604
Agency and contract staff	–	44,625	44,625	30,779
Seconded staff	–	–	–	346
	577,615	45,049	622,664	532,875

Termination benefits incurred during 2011/2012 and 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 2012 Total number	Year ended March 31 2011 Total number
Medical and dental	1,505	77	1,582	1,491
Administration and estates	2,764	329	3,093	2,493
Healthcare assistants and other support staff	797	173	970	926
Nursing, midwifery and health visiting staff	3,620	464	4,084	3,493
Nursing, midwifery and health visiting learners	648	133	781	492
Scientific, therapeutic and technical staff	1,956	104	2,060	1,801
Social care staff	1	–	1	1
	11,291	1,280	12,571	10,697

7.3 Management costs

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Management costs	43,954	36,981
Income	1,136,426	992,338
Management costs as a percentage	3.87%	3.73%

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 2011/12 there were 10 early retirements from the Trust agreed on the grounds of ill-health (four in the year ended March 31 2011). The estimated additional pension liabilities of these ill-health retirements is £394k (£166k in 2010/11). These retirements represented 0.38 per 1,000 active scheme members. The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

8 Better Payment Practice Code

8.1 Measure of compliance

	Number	Year ended March 31 2012 £000	Number	Year ended March 31 2011 £000
Total bills paid in the year	318,485	558,889	268,188	521,135
Total bills paid within target	261,745	437,286	216,897	352,555
Percentage of bills paid within target	82%	78%	81%	68%

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 2012 £000	Year ended March 31 2011 £000
GSTS Pathology LLP	–	(329)
	<u>–</u>	<u>(329)</u>

The Group has not recognised its share of losses exceeding the Group's interest.

10 Profit on disposal of non-current assets

Profit on the disposal of non-current assets is made up as follows:

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Profit on disposal of plant and equipment	4	392
	<u>4</u>	<u>392</u>

11 Finance income

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Interest on loans and receivables (including cash and bank balances)	552	838
	<u>552</u>	<u>838</u>

12 Finance costs

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
Loans from the Foundation Trust Financing Facility	(2)	–
Unwinding of discounts on provision and other finance costs	(245)	(293)
	<u>(247)</u>	<u>(293)</u>

13 Taxation

	Year ended March 31 2012 £000	Year ended March 31 2011 £000
UK corporation tax		
Current tax payable on income at 26%	(78)	(2)
	<u>(78)</u>	<u>(2)</u>

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

14 Surplus attributable to the Trust

The surplus for the Trust was £11,164k (2010/11 surplus of £20,859k), 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 – March 31 2012

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

Group and Trust			Assets under construction and payments on account	Plant and machinery	Transport equipment	IT Hardware	Furniture and fittings	Total at April 1 2011
Cost or valuation	Land £000	Buildings excluding dwellings £000	£000	£000	£000	£000	£000	£000
at April 1 2011	181,195	568,682	26,817	162,563	232	35,166	1,164	975,819
Additions purchased	–	3,632	24,878	1,211	–	1,191	–	30,912
Additions donated	–	802	3,650	913	–	–	–	5,365
Impairments	–	(21,722)	–	–	–	–	–	(21,722)
Reclassifications	–	15,998	(23,026)	4,726	(56)	2,358	–	–
Revaluation	14,305	(25,169)	–	–	–	–	–	(10,864)
Disposals	–	–	–	(14,440)	–	–	–	(14,440)
At March 31 2012	195,500	542,223	32,319	154,973	176	38,715	1,164	965,070
Accumulated depreciation at April 1 2011	–	951	–	91,701	144	21,203	611	114,610
Provided during the year	–	20,179	–	11,128	19	5,275	105	36,706
Impairments	–	6,086	–	–	–	–	–	6,086
Reclassifications	–	8	–	–	(9)	1	–	–
Revaluation surpluses	–	(25,122)	–	–	–	–	–	(25,122)
Disposals	–	–	–	(14,438)	–	–	–	(14,438)
At March 31 2012	–	2,102	–	88,391	154	26,479	716	117,842
Net book value								
Purchased assets	107,195	435,708	23,722	59,857	88	13,905	199	640,674
Donated asset	74,000	131,722	3,066	9,990	–	(29)	354	219,103
Government granted assets	–	301	29	1,015	–	87	–	1,432
Total at April 1 2011	181,195	567,731	26,817	70,862	88	13,963	553	861,209
Purchased assets	115,700	417,571	30,934	55,444	22	12,207	162	632,040
Donated assets	79,800	122,550	1,288	9,931	–	7	286	213,862
Government granted assets	–	–	97	1,207	–	22	–	1,326
Total at March 31 2012	195,500	540,121	32,319	66,582	22	12,236	448	847,228

In the year ending 31 March 2012 a valuation exercise was carried out on the Trust's properties by the Valuation Office. The purpose of this exercise was to determine a fair value for Trust land and buildings as at 31st March 2012. The valuation was conducted in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards.

a) Depreciated Replacement Cost (DRC)

The basis used for the valuation of specialised operational property for financial accounting purposes is Depreciated Replacement Cost (DRC). The RICS Standards at Appendix 4.1, restating International Valuation Application 1 (IVA 1) provides the following definition:

"The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."

Those buildings which qualify as specialised operational assets, and therefore fall to be assessed using the Depreciated Replacement Cost approach, have been valued on a modern equivalent asset basis.

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for financial accounting purposes under IAS 16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS1.3 as:

"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

c) Market Value (MV)

Market Value is the basis of valuation adopted for the reporting of non-operational properties, including surplus land, for financial accounting purposes. The RICS Standards at PS3.2 define MV as:

"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction after proper marketing wherein the parties had each acted knowledgeably, prudently and without compulsion."

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

Group and Trust at March 31 2011	Assets under construction and payments on account						Furniture and fittings	Total
	Land	Buildings excluding dwellings	Plant and machinery	Transport equipment	Information technology			
Cost or valuation	£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)	(29,188)	–	–	–	–	–	(30,038)
Reclassifications	–	38,582	(37,673)	2,738	–	(2,612)	(1,035)	–
Revaluations	15,095	(12,073)	–	–	–	–	–	3,022
Disposals	–	–	–	(5,807)	–	(3,632)	–	(9,439)
At March 31 2011	181,195	568,682	26,817	162,563	232	35,166	1,164	975,819
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	–	4,538	–	–	–	–	–	4,538
Reclassifications	–	–	–	1,907	–	(872)	(1,035)	–
Revaluation surpluses	–	(24,086)	–	–	–	–	–	(24,086)
Disposals	–	–	–	(5,591)	–	(3,632)	–	(9,223)
At March 31 2011	–	951	–	91,701	144	21,203	611	114,610
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	131,722	3,066	9,990	–	(29)	354	219,103
Government granted assets	–	301	29	1,015	–	87	–	1,432
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 2012 comprises:

	Land	Buildings	Other	Total property, plant and machinery
	£000	£000	£000	£000
Protected	195,500	531,136	–	726,636
Unprotected	–	8,985	111,607	120,592
Net book value	195,500	540,121	111,607	847,228

16 Intangible assets

16.1 As at March 31 2012

Group	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
Cost April 1 2011	742	30,831	10,371	1,585	43,529
Reclassification	–	11,143	(11,143)	–	–
Other revaluation	–	–	–	246	246
Additions purchased	–	2,208	5,553	–	7,761
Additions donated	–	–	1,245	–	1,245
Additions Government granted	–	–	–	270	270
Impairments	–	–	–	(324)	(324)
Gross cost at March 31 2012	742	44,182	6,026	1,777	52,727
Amortisation April 1 2011	408	15,835	–	–	16,243
Provided during the year	82	4,548	–	–	4,630
Impairments	–	–	–	762	762
Amortisation at March 31 2012	490	20,383	–	762	21,635
Net book value					
Purchased assets April 1 2011	333	14,972	9,646	1,585	26,536
Donated assets April 1 2011	1	24	725	–	750
Total at April 1 2011	334	14,996	10,371	1,585	27,286
Purchased assets at March 31 2012	252	23,765	4,493	–	28,510
Donated assets at March 31 2012	–	34	1,533	1,015	2,582
Total at March 31 2012	252	23,799	6,026	1,015	31,092

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)	–
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 £242k of information technology intangible assets held by the Group.

17 Impairments

Land and buildings were valued independently by the Valuation Office as at March 31 2012 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 £13,636k (£7,467k 2010/11), of which £6,172k (£4,583k 2010/11) 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 £27,869k (£33,770k 2010/11) on buildings. There were positive valuation movements on other Trust buildings of £3k (£12,058k 2010/11) and land of £14,305k (£15,095k 2010/11) respectively.

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 2012 are set out below. The accounting date of the financial statements for the subsidiaries is March 31 2012 and for the joint ventures December 31. For the joint venture undertakings that have different accounting year end dates, interim accounts to March 31 have been consolidated.

	Country of incorporation	Beneficial interest	Principal activity
Subsidiary undertakings			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
GTI Forces Healthcare Ltd ¹	UK	100%	Healthcare services
Pathology Services Ltd ¹	UK	100%	Healthcare services
Associate and joint ventures			
SSAFA GSTT Care LLP ¹	UK	50%	Healthcare services
GSTS Pathology LLP ¹	UK	33%	Healthcare services
SpotOn Diagnostics Ltd ¹	UK	30%	Healthcare services
King's Health Partners Ltd ²	UK	25%	Healthcare services

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

² Limited by guarantee – no cash investment has been made, Guy's and St Thomas' NHS Foundation Trust holds 25% voting rights

19 Aggregated amounts relating to associates and joint ventures

	March 31 2012 £000	March 31 2011 £000
Non current assets	3,863	5,128
Current assets	5,600	9,937
Non current liabilities	(4,757)	(4,054)
Current liabilities	(6,390)	(10,933)
Group share net assets (liabilities)	<u>(1,684)</u>	<u>78</u>
Revenue	35,108	42,530
Expenditure	<u>(36,871)</u>	<u>(42,637)</u>
Group share net (loss)	<u>(1,763)</u>	<u>(107)</u>

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 2012 £000	March 31 2011 £000
Group share of unrecognised losses	2,861	1,098

All figures are based on unaudited figures.

20 Inventories

	GROUP		TRUST	
	March 31 2012 £000	March 31 2011 £000	March 31 2012 £000	March 31 2011 £000
Raw materials and consumables	15,138	14,595	15,138	14,595
	<u>15,138</u>	<u>14,595</u>	<u>15,138</u>	<u>14,595</u>

21 Trade and other receivables

21.1 Current

	GROUP		TRUST	
	March 31 2012	March 31 2011	March 31 2012	March 31 2011
	£000	£000	£000	£000
NHS receivables	15,992	17,088	15,992	17,088
Other receivables	33,555	45,767	30,915	45,841
Provision for impaired receivables	(18,969)	(10,526)	(18,969)	(10,526)
Prepayments	5,359	2,574	5,359	2,574
Accrued income	21,789	13,643	21,788	13,643
Corporation Tax	–	589	–	–
	<u>57,726</u>	<u>69,135</u>	<u>55,085</u>	<u>68,620</u>

21.2 Non current

	GROUP		TRUST	
	March 31 2012	March 31 2011	March 31 2012	March 31 2011
	£000	£000	£000	£000
NHS receivables	–	564	–	564
Other receivables with related parties	–	–	–	1,244
Other receivables	2,047	1,796	3,328	1,797
	<u>2,047</u>	<u>2,360</u>	<u>3,328</u>	<u>3,605</u>

21.3 Provision for impaired receivables

	GROUP		TRUST	
	March 31 2012	March 31 2011	March 31 2012	March 31 2011
	£000	£000	£000	£000
At April 1	10,526	16,907	10,526	16,907
Increase in provision	9,637	(7,095)	9,637	(7,095)
Amounts utilised	(1,194)	(5,912)	(1,194)	(5,912)
Unused amounts reversed	–	6,626	–	6,626
At March 31	<u>18,969</u>	<u>10,526</u>	<u>18,969</u>	<u>10,526</u>

21.4 Ageing of trade and other receivables

	GROUP		TRUST	
	March 31 2012	March 31 2011	March 31 2012	March 31 2011
	£000	£000	£000	£000
Not past due date	26,867	55,822	26,867	55,896
Up to three months	4,806	7,149	4,806	7,149
In three to six months	4,375	5,151	4,375	5,151
Over six months	7,932	2,784	7,932	4,028
	<u>43,980</u>	<u>70,906</u>	<u>43,980</u>	<u>72,224</u>

21.5 Analysis of impaired receivables

	GROUP	
	March 31 2012	March 31 2012
	£000	£000
	Impaired	Non-impaired
Not past due date	8,589	18,278
Up to three months	554	4,252
In three to six months	1,461	2,914
Over six months	8,365	244
	<u>18,969</u>	<u>25,688</u>

22 Other financial assets

	GROUP		TRUST	
	March 31 2012	March 31 2011	March 31 2012	March 31 2011
	£000	£000	£000	£000
Non-current				
Loan and receivables	3,500	–	3,500	–
	<u>3,500</u>	<u>–</u>	<u>3,500</u>	<u>–</u>

Within other receivables with related parties, is an amount of £3,500k which relates to a loan to the joint venture, GSTS Pathology LLP, with a maturity date of January 1 2014 and a variable rate of interest (Libor + 2%).

23 Trade and other payables

23.1 Current

	GROUP			TRUST	
	March 31 2012	March 31 2011		March 31 2012	March 31 2011
	£000	£000		£000	£000
Receipts in advance	869	698		869	698
NHS payables – revenue	15,033	8,837		17,177	8,837
Trade payables – capital	3,945	2,400		3,945	2,400
Other trade payables	39,941	36,861		39,863	36,861
Other payables	10,265	8,963		8,954	8,963
Accruals	50,581	40,424		49,674	40,201
	120,634	98,183		120,482	97,960

NHS payables includes £6,990k outstanding pension contributions at March 31 2012 (£5,911k at March 31 2011).

Trade and other payables includes amounts owed to GSTS Pathology LLP, £471k in other trade payables and £2,421k is included in accruals.

23.2 Current taxes payable

	GROUP			TRUST	
	March 31 2012	March 31 2011		March 31 2012	March 31 2011
	£000	£000		£000	£000
Other taxes payable including Social Security and VAT	14,047	11,492		13,967	11,490
	14,047	11,492		13,967	11,490

23.3 Other liabilities

	GROUP				TRUST		
	March 31 2012	March 31 2011	April 1 2010		March 31 2012	March 31 2011	April 1 2010
	£000	£000	£000		£000	£000	£000
Current							
Deferred income	12,843	21,180	17,079		12,843	21,180	17,079
Deferred grants income	2,983	113	365		2,983	113	365
	15,826	21,293	17,444		15,826	21,293	17,444
Non-current							
Deferred income	–	2,680	6,225		–	2,680	6,225
	–	2,680	6,225		–	2,680	6,225

23.4 Borrowings

	GROUP			TRUST	
	March 31 2012	March 31 2011		March 31 2012	March 31 2011
	£000	£000		£000	£000
Non-Current					
Loans from the Foundation Trust Financing Facility	3,683	–		3,683	–
	3,683	–		3,683	–

24 Provisions for liabilities

24.1 Overall provisions

Group and Trust	Current		Non Current		Total Provisions	
	March 31 2012 £000	March 31 2011 £000	March 31 2012 £000	March 31 2011 £000	March 31 2012 £000	March 31 2011 £000
Pensions relating to other staff	774	780	7,134	7,122	7,908	7,902
Legal claims	194	353	–	–	194	353
Other	1,594	1,342	1,189	1,179	2,783	2,521
	2,562	2,475	8,323	8,301	10,885	10,776

24.2 Changes in provisions

	Pensions relating to former staff £000	Legal claims £000	Other £000	Total £000
As at April 1 2011	7,905	351	2,520	10,776
Arising during the year	814	238	327	1,379
Utilised during the year	(790)	(286)	(33)	(1,109)
Reversed unused	(250)	(109)	(47)	(406)
Unwinding of discount	229	–	16	245
As at March 31 2012	7,908	194	2,783	10,885

24.3 Expected timing of cash flows

Timing of Provisions	Pensions relating to former staff £000	Legal claims £000	Other £000	Total £000
Within one year	775	194	1,593	2,562
Between one and five years	2,889	–	756	3,645
After five years	4,244	–	434	4,678
	7,908	194	2,783	10,885

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 dilapidations.

£96,074k is included in the provision of the NHS Litigation Authority under legal claims at 31 March 2012 in respect of clinical negligence liabilities of the Foundation Trust (£88,904k at 31 March 2011).

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS Professionals in the respective areas.

25 Prudential borrowing limit

The Trust is required to comply and remain within Prudential Borrowing Limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratios tests set out in the Prudential Borrowing Code for NHS Foundation Trusts. The financial risk rating set under Monitor's Compliance Framework determines one of these ratios and therefore can impact on the long term borrowing limit; and
- the amount of any working capital approved by Monitor.

Further information on the Prudential Borrowing Code for NHS Foundation Trusts and Compliance Framework can be found on Monitor's website. www.monitor-nhsft.gov.uk/sites/default/files/Prudential%20Borrowing%20Code%20April%202009_0.pdf

	March 31 2012 £000	March 31 2012 £000	March 31 2011 £000
Long term borrowing limit set by Monitor	205,700	3,683	186,500
Working capital facility agreed by Monitor	60,000	–	60,000
	265,700	3,683	246,500

26 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 has a long-term liability at March 31 2012 with the Foundation Trust Financing Facility.
- B) The Minimum Dividend Cover Ratio is 3.84 compared to a minimum cover required of 1 (4.10 in the year ended March 31 2011 as restated).
- C) The Minimum Interest Cover Ratio is 27.6.
- D) The Minimum Debt Service Cover Ratio is 10.67.
- E) The Minimum Debt Service to Revenue Ratio is 1%.

27 Analysis in changes of net cash

GROUP	At April 1 2010 £000	Cash changes in period £000	At March 31 2011 £000	Cash changes in period £000	At March 31 2012 £000
Cash with the Government Banking Service	111,363	(11,804)	99,559	43,221	142,780
Cash at bank and in hand – commercial bank	548	32	580	569	1,149
	<u>111,911</u>	<u>(11,772)</u>	<u>100,139</u>	<u>43,790</u>	<u>143,929</u>
TRUST					
Cash with the Government Banking Service	111,363	(11,804)	99,559	43,221	142,780
Cash at bank and in hand – commercial bank	462	(20)	442	416	858
	<u>111,825</u>	<u>(11,824)</u>	<u>100,001</u>	<u>43,637</u>	<u>143,638</u>

28 Capital commitments

Commitments under capital expenditure contracts at the balance sheet date were £12,568k (£3,116k at March 31 2011) for the Group and the Trust.

29 Events after the balance sheet date

No events occurred after the Balance Sheet date for the year ended March 31 2012.

30 Contingencies

	March 31 2012 £000	March 31 2011 £000
Contingent liability for other claims against the Group and the Trust	(71)	(76)
Net contingent liability	<u>(71)</u>	<u>(76)</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.

31 Public Dividend Capital (PDC) 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 2012 period of account was £20,756k and, based on the average relevant net assets of £592,993k, the Trust's performance on an annualised basis was 3.49% (3.51% to March 2011).

32 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 18 and 19 respectively.

The Board members of SSAFA GSTT Care LLP include the following

directors from the Trust: Ron Kerr, Martin Shaw, Alastair Scarborough, Hugh Risebrow until 31 March 2012 and Graham Elderfield.

The Board members of GSTS Pathology LLP include the following directors from the Trust: Ron Kerr, Martin Shaw and 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.

Significant transactions with related parties include the following:

Organisation	Income £000	Expenditure £000	2011/2012	
			Receivables £000	Payables £000
Barnsley PCT	1,724	–	–	53
Bexley NHS Care Trust PCT	29,104	5	298	2,395
Bromley PCT	36,173	–	278	–
Camden PCT	3,052	–	113	164
City And Hackney Teaching PCT	1,882	–	–	158
Croydon PCT	103,611	–	1,542	–
Eastern And Coastal Kent PCT	29,276	–	1,397	32
Greenwich Teaching PCT	33,529	1	268	2,275
Hampshire PCT	10,359	53	678	–
Hillingdon PCT	1,273	27	32	–
Islington PCT	2,019	–	–	484
Lambeth PCT	190,095	8,739	3,843	3,521
Leicestershire County and Rutland PCT	2,517	–	–	190
Lewisham PCT	59,951	164	803	31
Medway PCT	11,565	–	274	–
Milton Keynes PCT	23	12	–	5
Redbridge PCT	1,996	–	–	183
South East Essex PCT	12,227	–	198	–
Southwark PCT	143,733	5,349	1,848	2,397
Sutton and Merton PCT	8,708	408	267	–
Wandsworth PCT	19,675	294	567	–
West Kent PCT	37,809	4	–	210
West Sussex PCT	20,540	–	837	1
Westminster PCT	12,649	2	514	275
HM Revenue & Customs – VAT	–	–	2,337	–
HM Revenue & Customs – other taxes and duties	342	43,539	281	11,714
NHS Pensions Agency	–	54,359	–	7,220
NHSLA	–	8,321	–	150

The debtors balance for NHS bodies at the 31st of March 2012 is £15,992k (£17,088k at 31 March 2011).

In addition, the Trust has had a number of material transactions with other Government departments and other central and local Government bodies. £37,473k (£38,371k at 31 March 2011) has been received from the Ministry of Defence for health services supplied. There were also many transactions with King's College London totalling £10,028k (£7,619k at 31 March 2011).

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 £20,820k (£20,732k at 31 March 2011). The balance for Guy's and St Thomas' Charity debtors was £3,553k (£4,041k at 31 March 2011) and for creditors £1,609k (£1,296k for 31 March 2011). Guy's and St Thomas' Charity is regarded as a related party.

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

Ron Kerr, Chief Executive, is a member of the King's Fund General Advisory Council.

Sir Hugh Taylor, Chairman, is a Trustee of Macmillan Cancer Support, Royal College of Physicians, Nuffield Trust and Cicely Saunders International.

The Council of Governors includes representatives from organisations that work closely with the Trust including Lambeth Council, Southwark Council, Lambeth PCT, Southwark PCT, Lewisham PCT, 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.

33 Financial assets and liabilities

33.1 Financial assets

	GROUP		TRUST	
	March 31 2012	March 31 2011	March 31 2012	March 31 2011
	£000	£000	£000	£000
Denominated in £ Sterling	194,926	166,335	195,893	167,516
In other currencies, restated in £ Sterling	4,298	2,137	4,298	2,137
Gross financial assets at March 31	199,224	168,472	200,191	169,653

33.2 Analysis of financial liabilities

	GROUP		TRUST	
	March 31 2012	March 31 2011	March 31 2012	March 31 2011
	£000	£000	£000	£000
Denominated in £ Sterling	134,332	108,261	134,182	108,038
Gross financial liabilities at March 31	134,332	108,261	134,182	108,038

33.3a Financial assets by category

	GROUP	TRUST
	Loans and receivables	Loans and receivables
	£000	£000
At March 31 2012		
Assets as per balance sheet		
NHS debtors	15,992	15,992
Accrued income	21,789	21,788
Other debtors	32,983	34,242
Other financial assets	3,500	3,500
Provision for doubtful debts	(18,969)	(18,969)
Cash at bank and in hand	143,929	143,638
Total at March 31 2012	199,224	200,191
At March 31 2011		
NHS debtors	17,652	17,652
Accrued income	13,643	13,643
Other debtors with related parties	–	1,244
Other debtors	47,564	47,639
Provision for doubtful debts	(10,526)	(10,526)
Cash at bank and in hand	100,139	100,001
Total at March 31 2011	168,472	169,653

33.3b Financial liabilities by category

	GROUP	TRUST
	Loans and receivables	Loans and receivables
	£000	£000
Other financial liabilities		
At March 31 2012		
Assets as per balance sheet		
NHS creditors	15,033	17,178
Other creditors	54,150	52,762
Accruals	50,581	49,674
Provisions under contract	10,885	10,885
Borrowings	3,683	3,683
Total at March 31 2012	134,332	134,182
At March 31 2011		
NHS creditors	8,837	8,837
Other creditors	48,223	48,223
Accruals	40,423	40,200
Provisions under contract	10,778	10,778
Total at March 31 2011	108,261	108,038

33.4 Fair values of financial assets at March 31 2012

	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	2,047	2,047	3,328	3,328
Other	143,929	143,929	143,638	143,638
	145,976	145,976	146,966	146,966

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.

33.5 Maturity of financial liabilities

	GROUP		TRUST	
	March 31 2012 £000	March 31 2011 £000	March 31 2012 £000	March 31 2011 £000
Less than one year	122,327	108,261	122,174	108,038
	122,327	108,261	122,174	108,038

33.6 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 2012					
Sterling	139,631	139,180	–	451	0.3
Other	4,298	33	–	4,265	0.3
Gross financial assets	143,929	139,213	–	4,716	
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	
TRUST					
Currency	Total £000	Floating rate £000	Fixed rate £000	Non- interest bearing £000	Weighted average interest rate %
At March 31 2012					
Sterling	139,340	139,180	–	160	0.3
Other	4,298	33	–	4,265	0.3
Gross financial assets	143,638	139,213	–	4,425	
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	

33.7 Loan disclosure

	Weighted average effective interest rate %	1–5 years £000	5+ years £000	Total £000
At March 31 2012				
Fixed interest rate instruments	3.09	–	3,683	3,683

33.8 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 31 March 2012 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.

34 Third party assets

The Trust held £18,706 cash and cash equivalents at 31 March 2012 (£7,274 at 31 March 2011) which relates to monies held by the Trust on behalf of patients. This has been excluded in the cash at bank and in hand figure reported in the accounts.

35 Losses and special payments

There were 1,173 cases of losses and special payments totalling £858k (1827 cases totalling £6,722k at 31 March 2011) approved during the year to 31 March 2012. This includes cash payments during the year. These are not calculated on an accruals basis.

36 Acquisitions and mergers

On 1 April 2011, Guy's and St Thomas' NHS Foundation Trust merged with the community services functions of Lambeth and Southwark Primary Care Trusts. The fair value of the consideration for Lambeth PCT was £1,229k. This included a net transfer of assets of £60k as listed below, and in addition, the transfer of retained surplus for that service of £1,170k. Net liabilities transferred for Southwark PCT were £291k. The breakdown of the transferred items is detailed below.

As per the Monitor Guidance, the prior year accounts have not been restated.

Lease arrangements for buildings moved across to the Trust and expenditure of £10,320k was incurred on these leases in 2011/12.

	Lambeth PCT £000	Southwark PCT £000
Petty cash	3	2
Inventories	–	302
Prepayments	155	83
Other receivables	89	40
Accruals	(188)	(222)
Deferred income	–	(496)
	<u>60</u>	<u>(291)</u>

contacts

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 7346

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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Tel: 020 7188 5577

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www.guysandstthomas.nhs.uk



We want our staff to enjoy participating in our corporate social responsibility work, and a group of staff created a 'flash mob' by dancing in our restaurant to demonstrate their enthusiasm and passion.

Guy's and St Thomas' NHS Foundation Trust

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