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# Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2012-13

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 and – as part of King's Health Partners – we are one of the UK's first Academic Health Sciences Centres, bringing together world-class clinical services, teaching and research. We work closely with our AHSC partners King's College Hospital and South London and

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

We have one of the National Institute for Health Research's (NIHR) Biomedical Research Centres, established with King's College London in 2007, as well as dedicated Clinical Research Facilities at Guy's, St Thomas' and the Evelina Children's Hospital.

We have around 13,200 employees, making us one of the biggest employers locally. We aim to reflect the diversity of local communities we serve and continue to develop new and existing partnerships with local people, patients, neighbouring NHS organisations, local authorities and charitable bodies and GPs.

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

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](http://www.kingshealthpartners.org)



A team from the operating theatres at the Evelina Children's Hospital has built links with medical staff in Vietnam to share knowledge and expertise.

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Staff and patients enjoyed the view from St Thomas' as London celebrated the Queen's Diamond Jubilee.

# Chairman's statement

2012/13 was an exciting and challenging year for the Trust. New legislation has brought significant changes to the way services are commissioned. The Francis Report into standards of care at Mid Staffordshire NHS Foundation Trust has renewed the focus on how every hospital and NHS worker treats their patients.

The impact of funding pressures on the NHS and the wider economic climate continues to be felt by the Trust and all our staff. Nevertheless, as this report demonstrates, thanks to the professionalism and dedication of our staff, we continue to provide high quality services to our patients in our hospitals and in the community. And we continue to invest in improvements to the fabric of our hospitals and to the services we offer.

This year marked the beginning of the work of re-cladding the Guy's Tower and we saw the first steps towards the construction of the Cancer Centre at Guy's which will provide leading edge care in state-of-the-art facilities. We also opened new facilities on the St Thomas' site: a new outpatient centre at Gassiot House; the redeveloped Newcomen Centre; and a stunning new imaging research facility, The Centre for the Developing Brain.

During the course of the year, the four organisations which form King's Health Partners agreed to develop a full business case that will consider proposals to create a single academic healthcare organisation. We will, of course, listen carefully to the views of our internal and external partners, including local MPs, as we take this forward.

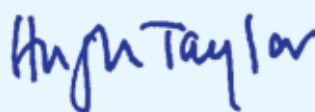
We were delighted to play our part in a summer of celebration in London. The Diamond Jubilee and the London 2012 Games were an historic moment in the history of our city and our special location provided us with the opportunity to be at the heart of these unique events. Our staff worked hard to

ensure that hospital and community services were unaffected by these events. Many staff participated in the memorable opening ceremony for the London 2012 Games and we welcomed a wide range of guests to the Trust to enjoy the celebrations.

The Council of Governors continued to support the development of the Trust's strategy, providing challenge and support. This year, Lead Governor, Niamh O'Sullivan and several governors have completed their terms of office and we are grateful for their hard work, focussed attention and collaboration in improving services for patients.

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 local MPs and other South Bank leaders to ensure that we listen to and serve our local community.

Finally, I would like to thank the Board of Directors for their continued commitment and leadership. This year, Rory Maw and Jan Oliver have both completed their terms as Non-Executive Directors. Their insight and experience has been invaluable and they leave the Trust in a strong position.



**Sir Hugh Taylor**, Chairman





Nabeel Nanuck was the first child to benefit from a pioneering transplant procedure. He received a kidney transplant from his mother despite their blood types being incompatible.

## Directors' report 2012/13

Guy's and St Thomas' has performed well once again – both operationally and financially – during a particularly busy and demanding year. We have sought to balance high quality patient care with achieving our performance targets in a challenging financial environment.

During a busy and demanding year for London, Guy's and St Thomas' continues to deliver excellent patient care, whilst seeking to maintain a strong financial position that will allow us to drive forward quality and service improvements for our patients. Striking a balance between quality and service delivery and a healthy financial position, with surpluses to reinvest, is an enduring challenge and one which we remain keenly focussed on.

We have worked hard towards achieving our CQUIN (Commissioning for Quality and Innovation) targets, QIPP (Quality, Innovation, Productivity and Prevention) requirements and to comply with the requirements of our regulators, the Care Quality Commission and Monitor. We have also been preparing for the changes resulting from the Health and Social Care Act by building strong and productive relationships with our local Clinical Commissioning Groups, with specialist commissioners and with our local Health and Well-Being Boards.

### High quality care

This year, the publication of Robert Francis QC's report following the public inquiry into Mid Staffordshire NHS Foundation Trust, has brought the issue of patient safety and quality of care into sharp focus. As a Trust, we remain firmly committed to providing high quality, safe care for all our patients. The Francis Report has provided us with an opportunity to renew this commitment and to explore what more we can do to improve the patient experience.

Our Chief Nurse and other colleagues have held a series of briefing sessions and listening events for staff, Board members and governors to discuss the findings of the inquiry. Following these events, we are developing a detailed action plan that will drive improvements in patient care and safety, and ensure that all staff support the delivery of the Trust's values of putting patients first, taking pride in what we do, respecting others, striving to be the best and acting with integrity.

In September 2012 we embarked on a campaign to raise awareness of dementia amongst all staff working in our hospitals and in the community. All of our 13,200 staff were asked to attend an innovative training session. As part of this, staff watch 'Barbara's story' – an award-winning film that was created by the Trust about an elderly woman and her experiences during a hospital visit. We are delighted that this training was recognised as an example of good practice in the Department of Health's response to the Francis Report.

The results of the 2012 national inpatient survey, published by the Care Quality Commission, indicate that the quality of care provided by staff at Guy's and St Thomas' hospitals has improved significantly over the 12 months to July 2012. These results are encouraging, but we are not complacent and will continue to work hard to ensure that we provide the best possible care to our patients all of the time.

We recognise the importance of continuing to improve the quality of our services, and the

challenge of balancing this with the constant demand to work more efficiently and cost effectively. In response, we are developing our *'Fit for the Future'* programme. This comprises 19 clinical and non-clinical work streams that combine the need to maintain focus on high quality care and deliver a positive patient experience with the drive for improved productivity and efficiency.

We remain firmly committed to providing high quality, safe care for all our patients

### King's Health Partners

The Trust remains committed to the continuing development of our Academic Health Sciences Centre, King's Health Partners, in partnership with King's College Hospital and South London and Maudsley NHS Foundation Trusts and our shared university partner King's College London. Our vision for King's Health Partners underpins all that we do and represents our ambition to be a truly world-class organisation for the benefit of the local communities we serve, and patients nationally and internationally.

We have achieved a great deal over the past four years, and the Clinical Academic Groups which are at the heart of the AHSC continue to work across the partners to drive service improvements, teaching and research for the benefit of patients.

For example, we are delighted to have successfully consolidated inpatient vascular services and opened a new hybrid theatre at St Thomas' during the past year, ensuring patients are treated using the very latest technology and strengthening our position as a leading centre for vascular research.

The Clinical Academic Groups have been a powerful voice telling us that they want the AHSC to go further, faster. In February 2013, the King's Health Partners Board agreed to develop a full business case for proposals to create a single academic healthcare organisation. This process will consider various organisational models, up to and including the possible merger of the three Foundation Trusts. All the partners are committed to strong local stakeholder engagement throughout this process and will listen to and consider the views of our internal and external partners.

Work to develop a full business case, which will rigorously test whether the benefits of this proposal can be realised and the potential risks can be properly managed, is now underway and we expect this will be completed in autumn 2013.

We are delighted that our bid to the Department of Health to create an Academic Health Sciences Network for South London has been successful. Members include King's Health Partners, St George's NHS Healthcare Trust and other NHS Trusts, local authorities, GPs and academic institutions. As an AHSN we are committed to focusing on key public health issues affecting people in south London,

working together to ensure that the communities we serve benefit from health care innovations that will drive improvements in the quality of care that they receive.

Our research activities have continued to grow, and highlights include the opening of a new Centre for Clinical Infection and Diagnostics Research which was launched in collaboration with King's College London. The centre will focus on improving the prevention, diagnosis and treatment of infectious diseases which affect our local population and those further afield. Last year also saw the start of a new funding cycle for our NIHR Biomedical Research Centre, and we welcomed the Technology Strategy Board's Catapult Centre focussed on cell therapy to Guy's which will complement our own research activities. The Technology Strategy Board is a public body established to drive innovation.

The education agenda has also been moving forward, building on our success as part of the Health, Innovation and Education Cluster (HIEC) for south London. We continue to provide training and education opportunities for a wide range of professional staff, as well as employment opportunities for local people, and we work hard to ensure their experiences are positive and rewarding. We look forward to working with our partners in the newly authorised Local Education and Training Board (LETB) going forward.

The integrated fundraising team for King's Health Partners continues to explore opportunities to increase philanthropic support for services,

teaching and research and has had a successful year in which we saw a particular focus on fundraising for a new Cancer Centre as well as a range of local fundraising initiatives to support our services.

### Our local and wider role

As a Trust, we provide a full range of local hospital services to people living in Lambeth, Southwark and Lewisham, as well as a wide range of specialist services for local people and patients from further afield. We continue to collaborate across King's Health Partners and with organisations across south east London and the capital, as well as nationally and internationally, to support and enhance service delivery, research and education.

Following the Secretary of State's decision to place South London Healthcare NHS Trust in to administration, King's Health Partners responded jointly to the formal consultation, reflecting our shared commitment to support the delivery of a sustainable future for health services in south east London. We continue to engage with this complex agenda and are working to understand the implications for Guy's and St Thomas', King's Health Partners and the wider health economy.

In response to the national Safe and Sustainable Review of Children's Congenital Cardiac Services, in July 2012 the Joint Committee of Primary Care Trusts decided to designate the Evelina Children's Hospital as a specialist centre for children's heart surgery. We welcome the decision and await the outcome of the current judicial process. We will

work with the other London centres to ensure a smooth transition that will deliver the best possible service to children and their families in the future.

We continue to play an active role in the south east London cancer and cardiac networks. We are also an active member of the London Cancer Alliance and are delighted that Professor Arnie Purushotham has recently been appointed Clinical Director of the Alliance.

St Thomas' provides a wide range of very specialist services and sub-specialties, as well as one of the largest intensive care units in the UK. We have many regional and national centres of excellence, including a major cardiac centre and a comprehensive range of women's and children's services, many of which benefit from being co-located on a single site.

Our services at Guy's also serve a wide population across south east England, either from central London or through a growing network of outreach clinics and satellite centres. As well as renal services and complex surgery, cancer services at Guy's are a key strategic priority for the Trust and King's Health Partners. In November, Southwark Council approved our plans for the new £160 million Cancer Centre and work began on site at Guy's in March, with construction expected to start in summer 2013 and the building planned to open in spring 2016.

As the provider of community, as well as hospital, services in Lambeth and Southwark we continue to explore ways to improve patient care by working in a truly integrated way. This year

saw the opening of the Akerman Health Centre in Brixton, bringing GP and community health services together under one roof.

We are also focussed on care for older people and patients with long-term conditions through Southwark and Lambeth Integrated Care (SLIC), formerly the Integrated Care Programme, which has received generous support from Guy's and St Thomas' Charity. We have developed new services such as home ward and enhanced rapid response to enable our staff to better support people in their own homes and avoid the need for hospital treatment, working closely with social care colleagues and other partners.

The Trust has a long tradition of innovation, ranging from medical breakthroughs and translational research to our commercial activities

### Investing in our future

During the past year, the Trust has continued to make substantial investments in its buildings and IT and medical equipment to deliver enhanced services for our patients. To achieve this we are committed to ambitious investment plans to enable us to provide the best possible facilities and access to the latest treatments.

We have made substantial investment in: our vascular service

at St Thomas', including a state-of-the-art hybrid theatre; an expanded endoscopy unit to meet the growing demand for diagnostic tests; a new sexual health centre in the community at Burrell Street near Guy's to replace the outdated Lydia Clinic; and a new satellite renal service at Long Lane, also close to Guy's, which will provide a more relaxed and comfortable setting for many of our dialysis patients.

We have opened a new paediatric neurosciences centre, audiology service and sleep centre at St Thomas', adjacent to the Evelina Children's Hospital, and our cleft lip and palate service will soon be moving to St Thomas'.

Improvements to our infrastructure and support services have also been a key priority over the past year, and we have invested in an expanded sterile services centre at Guy's; made good progress with substantial work to re-clad the Guy's Tower; and are about to begin work on the exterior of the East Wing at St Thomas', which will include a new atrium and additional lifts.

### Developing commercial partnerships

The Trust has a long tradition of innovation, ranging from medical breakthroughs and translational research to our commercial activities. We seek actively to exploit the Trust's intellectual property by capturing and developing innovations in patient care. We are also committed to exploring broader commercial opportunities that will generate



additional income to support the delivery of NHS services.

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

- Setting up Essentia Trading which will deliver non-clinical services such as facilities management and patient transport for other healthcare organisations, building on existing contracts. Essentia Trading will draw on the knowledge and expertise of our experienced facilities, estates and procurement teams and we expect this to become an important source of additional revenue over the next five years.
- The Ministry of Defence has renewed our longstanding contract to provide healthcare to British Forces and their families in northern Europe for a further seven years. This includes the provision of a comprehensive range of hospital services as well as primary and community health services which are provided in partnership with the Soldiers, Sailors, Airmen and Families Association (SSAFA), and we are proud to be providing this important service.
- A successful partnership with J Sainsbury plc now means all our outpatient dispensing is provided by two Sainsbury's pharmacies, one on each of our main hospital sites, which provide a number of benefits including extended opening hours and the facility to dispense GP as well as hospital prescriptions.

## Business review

Guy's and St Thomas' performed well in 2012/13, despite an increasingly challenging financial environment. The Trust has declared a surplus of £9.1 million for the financial year before accounting for an impairment of £25.9 million due to the revaluation of the Trust's buildings, exceptional items of £2.9 million, and the receipt of £4.8 million of capital donations.

The Trust had planned to achieve a surplus of £13 million to deliver the ambitious plans for capital investment which underpin our estates strategy. Although the Trust did not fully achieve the surplus target, we believe this is a good performance at a time when efficiency savings have proved increasingly difficult to achieve without impacting adversely on patient care.

Pressures such as the London 2012 Games and the Jubilee celebrations, severe winter weather conditions and an increase in the number of patients who come to us with very complex conditions have added to operational challenges during the year, although staff responded exceptionally and patient care was maintained to a high standard throughout.

The Trust plans to achieve a further £80 million savings in 2013/14 to deliver a balanced financial position. The Trust expects to identify additional in-year efficiencies to ensure we end the financial year in financial surplus, which will be added to those surpluses achieved in previous years. These surpluses will

then be available to reinvest in service developments and our estate in support of our strategic vision over the coming years.

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

- the changing economic environment;
- the ongoing development of King's Health Partners, including Clinical Academic Groups;
- changes to commissioning arrangements for clinical services;
- changes in the configuration of healthcare in London;
- savings and activity plans;
- Commissioning for Quality and Innovation targets (CQUIN);
- commercial opportunities and income diversification.

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

We have a well established financial service line reporting model that includes detailed monthly scorecard reporting of national and Trust performance targets to both the Board of Directors and the Trust Management Executive. In addition, our Board committees have developed a range of key performance indicators, and local performance indicators are well developed throughout the organisation.

### Performance and inspections

Under the Care Quality Commission's (CQC) system for regulating health and social care organisations, Guy's and St Thomas' is registered to provide services without conditions or restrictions, having complied with 16 essential standards for quality and safety.

Sustaining operational performance against a wide range of national and local targets and measures and Monitor's compliance framework, as well as ensuring the delivery of high quality and clinically safe care to over two million patient contacts a year remains an enormous challenge. It requires sustained effort from frontline staff and managers, and we work hard to support them, for example through our 'Clinical Fridays', weekly 'Safe in our Hands' briefings and visible clinical leadership. This year, we have brought these strands of work together into a single overarching programme, '*Fit for the Future*' and we have been undertaking an extensive staff 'listening' exercise in response to the Francis Report.

We continue to work hard to reduce hospital infections and retain a sharp focus on quality, safety and clinical effectiveness through the objectives we have agreed with local stakeholders for our Quality Accounts.

We were delighted that both Guy's and St Thomas' were rated as 'excellent' in an inspection by the Patient Environment Action Team in 2012 covering key areas such as the quality of food and the patient environment. Following inspection visits in February 2013, we also received positive feedback from the

Care Quality Commission on the quality and safety of care in our hospitals.

We are aware that there is more that we can do to improve the quality and timeliness of care for our patients, and we are continuing to make this a priority throughout the organisation with close involvement from the Board of Directors and Council of Governors.

### Corporate social responsibility

The Trust has a strong track record for acting responsibly in terms of the environment, staff, the local community and wider population. As a healthcare provider, we recognise our duty to promote health and well-being, to minimise our environmental impact and to maximise the resources for patient care.

We have won many awards nationally for our commitment to sustainability and tackling climate change and achieved Carbon Trust Standard certification in 2009. We consider ourselves to be at the forefront of these environmental initiatives in the NHS – from generating our own energy using Combined Heat and Power engines to promoting sustainable transport schemes.

As a significant member of the local economy, we are committed to buying goods and services locally wherever possible and we participate in the Cross River Partnership's supply initiative to engage with small local businesses. We also actively support a number of initiatives to help local people into work.

We encourage and support our

staff to participate in voluntary work and fundraising activities. This year, our 2012 Staff Challenge provided a unique opportunity to celebrate the London 2012 Games and create a local legacy through fundraising, getting active, volunteering and changing the way that we work. Our staff completed an amazing range of challenges, raising over £65,000 for charity and volunteering almost 6,000 hours of their time over the summer months. Their achievements, as well as those of our CARE award winners – staff nominated by patients and their colleagues – were all recognised at our annual Trust awards ceremony in November.

As part of King's Health Partners, we have made a strong commitment to improving the health and well-being of communities overseas as well as locally. We are proud to have developed formal links with health organisations in a number of African countries, including Zambia and Tanzania. In addition, we are proud of the many informal links and volunteering opportunities that are pursued by individual staff.

### Board of Directors

The Board of Directors brings a wide range of experience and expertise to their stewardship of the Trust and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive. In the past year, the Trust thanked Rory Maw and Jan Oliver for their considerable hard work and commitment as Non-Executive Directors. We also welcomed Robert Drummond, who will bring a wealth

of skill and experience to his role as a Non-Executive Director.

In 2012/13, Board membership consisted of the following Executive Directors: Chief Executive, Sir Ron Kerr; Chief Operating Officer, Amanda Pritchard; Director of Finance, Martin Shaw; Medical Director, Ian Abbs; Chief Nurse and Director of Patient Experience and Infection Control, Eileen Sills; Director of Essentia (capital, estates and facilities), Steve McGuire; and Director of Workforce and Organisational Development, Ann Macintyre.

And the following Non-Executive Directors: Chairman, Sir Hugh Taylor, and David Dean; Robert Drummond from March 2013; Mike Franklin; Rory Maw to March 2013; Professor Frank Nestle; Girda Niles; Jan Oliver to December 2012; and Diane Summers.

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

The Board considers the Trust to be compliant with the principles of the NHS Foundation Trust Code of Governance, as well as with the provisions of the Code in all but the following areas where we have alternative arrangements in place: appraisal of the Chairman; the designation of independent directors and a senior independent director; Chief Executive and Executive Director terms of appointment; information about

elected governors standing for re-election; and independent professional advice for Non-Executive Directors. Further details can be found in the full compliance statement which is available on the Trust website.

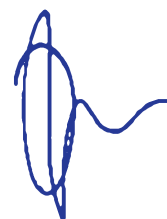
### Looking ahead

Guy's and St Thomas', in common with the health service and public sector as a whole, is operating in a fast changing and extremely demanding external environment, particularly as we establish relationships and new ways of working with partners in the new health landscape.

We recognise the need to significantly increase efficiency whilst maintaining high quality care at a time when budgets will be tight. We will ensure that all our staff, from the Board to the frontline, work together to respond to these challenges. We believe the freedoms that we are afforded as an NHS Foundation Trust will enable us to continue to thrive and set our own strategic direction for the benefit of the patients and communities we serve, as well as our staff.

It remains to thank the people who have helped us to achieve so much in this historic year, most notably our hospital and community staff for their continued hard work, loyalty and commitment. We are also grateful to: our Council of Governors and our wider membership; Guy's and St Thomas' Charity for their ongoing and generous investment; our King's Health Partners collaborators; and our many external stakeholders

and supporters, in particular our local Clinical Commissioning Groups and other NHS organisations in south east London with whom we work closely.



**Sir Ron Kerr**

Chief Executive

On behalf of the Board of Directors



Food services assistant Charlie is now full time at the Trust after participating in Project Search, a programme that offers work placements for young people with autistic spectrum disorders.

# 3

## Operational and financial review

Guy's and St Thomas' is one of the largest and busiest Trusts in the country. During 2012/13, we saw 956,000 outpatients, 83,000 inpatients, 74,000 day case patients and 176,000 accident and emergency attendances. We cared for 790,000 patients in the community, bringing our total patient contacts to over two million a year.

### Our performance

The Trust's performance is externally monitored against a range of national standards and targets. Last year was a particularly demanding year for the NHS as all trusts, including Guy's and St Thomas', have sought to provide the highest standards of care while achieving significant efficiency savings. Throughout the year, our hard-working staff have strived to balance patient safety, quality and efficiency with excellent patient outcomes, whilst maintaining performance against these targets.

Activity levels across the Trust have increased as we have worked hard to reduce waiting times and meet the expectations of our patients. We have treated seven per cent more inpatients and day cases, and our accident and emergency department remains extremely busy. This increased activity presents challenges to the Trust and we have worked hard to ensure that patients are seen in a timely manner.

This year, we have seen significant improvements against national referral to treatment standards, although we know there is still more work to be done. The Trust continues to identify areas for improvement and has put robust plans in place to enable us to meet our targets. We have made excellent progress during the year and are in a stronger position to deliver a good performance in the future.

The Trust is registered to provide services by the Care Quality Commission (CQC). The CQC requires the Trust to meet 16 essential standards of quality and safety, covering

everything from medicines management and safeguarding vulnerable people to infection control and effective records management. In 2012/13, the Trust has been registered to provide services with no conditions or improvement notices.

### Meeting national targets

This year, we have continued to work hard so that most of our patients are seen within 18 weeks. We have consistently achieved this national standard for outpatients, and over half of our admitted patients waited seven weeks or less for treatment, against a comparable national average of eight weeks. However, we know that some patients whose treatment requires hospital admission are waiting more than 18 weeks.

Last year, we put in place a comprehensive action plan to tackle the longest waits, which were concentrated in a small number of specialist areas. We offered additional treatment sessions and worked hard to ensure diagnostic tests were carried out quickly. As a result of this focussed effort, since October 2012, we have consistently achieved all the national 18 week referral to treatment standards and most of our patients are seen more quickly.

We have also virtually eliminated the very longest waits, often for the most specialist and complex treatment which is only available in centres such as Guy's and St Thomas'. In 2012/13, we had over 400 patients waiting more than 52 weeks for treatment, but we have now reduced this to just three patients – a result



of exceptional effort in a small number of our specialist services.

We continue to experience exceptional demand in our accident and emergency department at St Thomas' and we have also seen an increase in patients attending with complex needs. Unfortunately, we have failed to consistently achieve the national target for diagnosing, treating and discharging or admitting 95 per cent of patients within four hours.

Our hard-working staff strive to balance patient safety, quality and efficiency with excellent patient outcomes

During the year, we have reviewed how patients move through our emergency department and through the hospital if they need tests or inpatient care so that we can plan effectively for the future and improve care for our patients. We have introduced measures to improve the ability of our A&E department to respond at times of peak activity, and to ensure that patients are able to leave hospital safely as soon as they are ready so that beds are available for other patients. These measures include increasing capacity and starting winter planning earlier. In 2013 the Board of Directors approved a £19 million investment to redesign our A&E department and services for patients requiring emergency admission to hospital.

We are working with our

commissioners to offer alternatives to A&E for patients not needing emergency treatment. In summer 2012, an Urgent Care Centre opened at Guy's Hospital, managed by local GPs, to treat patients with minor injuries and urgent medical problems. The GPs are supported by emergency nurse practitioners and the centre offers x-rays and a range of other diagnostic tests and treatment.

Thanks to robust planning, strong partnership working and the hard work of all our staff, we were able to continue treating patients as usual during the Jubilee celebrations and the London 2012 Games. Our staff also had the opportunity to celebrate and create an Olympic legacy focussed on health and well-being.

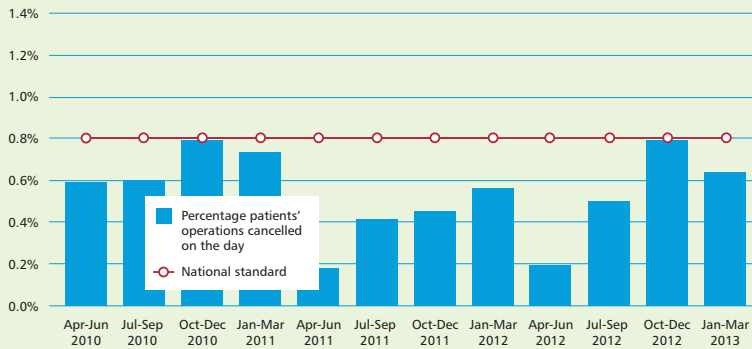
We have continued to see improvements in our performance against the national cancer targets, for example, achieving the national target to see all patients within two weeks of an urgent GP referral.

In common with trusts receiving referrals for specialist diagnosis and treatment from other hospitals, we continue to find it difficult to achieve the 62-day maximum referral to treatment target. We met this target for virtually all patients already being treated at Guy's and St Thomas', but failed to meet this for some patients referred to us later in their pathway from other hospitals. We are working with these hospitals to ensure that delays are minimised for these patients.

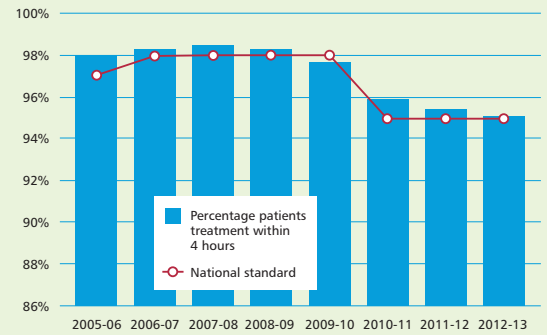
To support our drive to reduce cancer waiting times further, we are investing in new equipment

## Performance against national targets

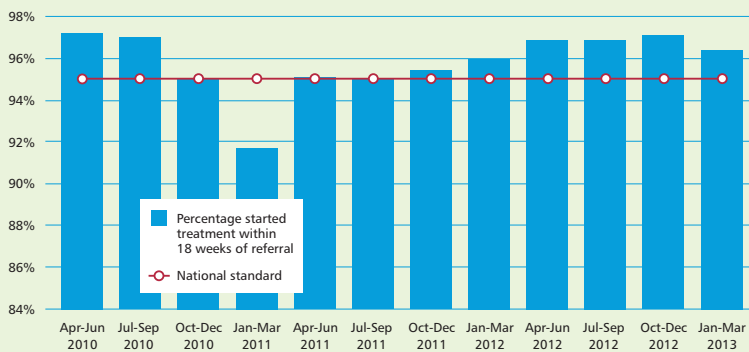
Percentage of patients' operations cancelled on the day



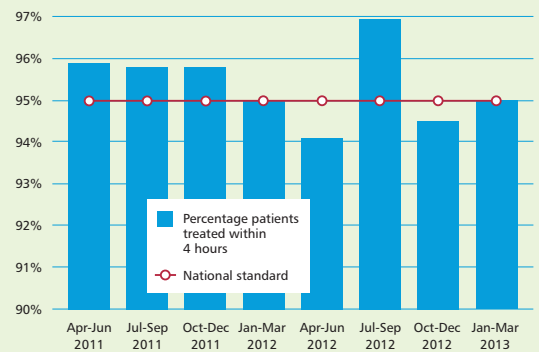
Percentage of patients treated within four hours in A&E (all categories)



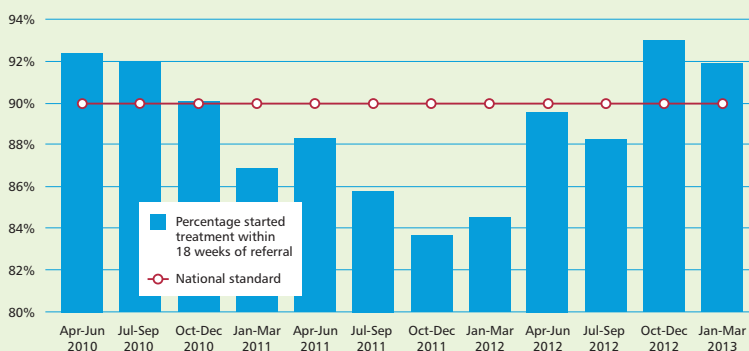
Percentage of patients starting non-admitted treatment within 18 weeks of referral



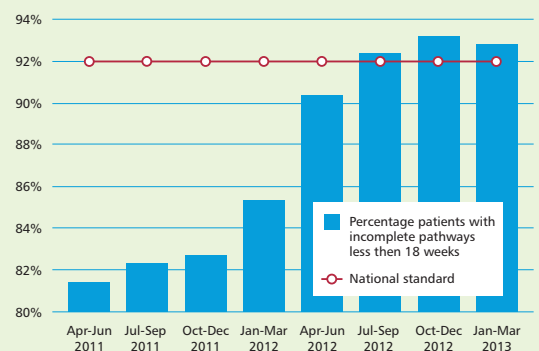
Percentage of patients treated within four hours in A&E by quarter (all categories)



Percentage of patients starting admitted treatment within 18 weeks of referral

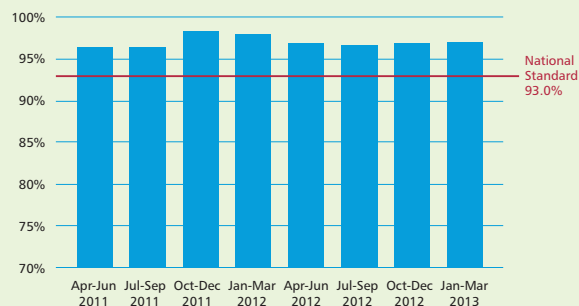


Percentage of patients with incomplete pathways less than 18 weeks

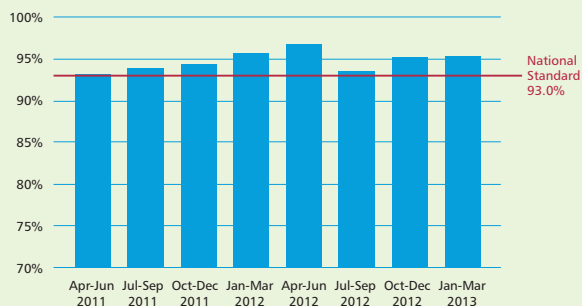


## Performance against cancer access targets

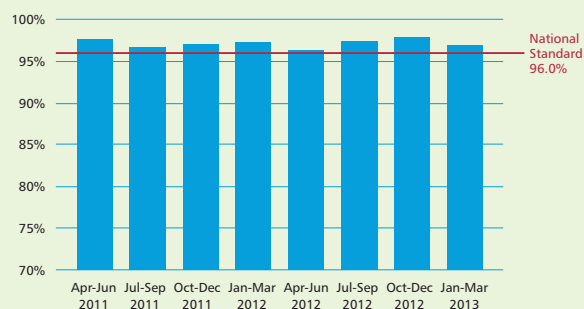
### Urgent GP referrals seen within two weeks



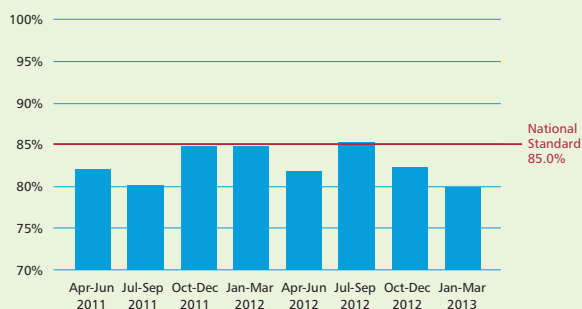
### Breast symptomatic referrals seen within two weeks



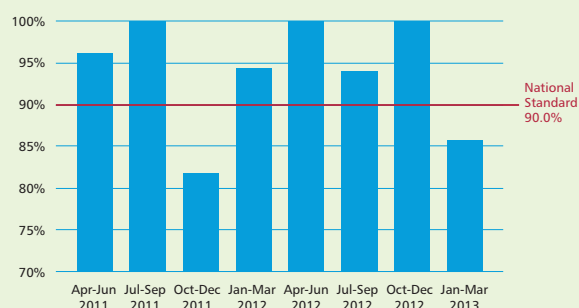
### First treatment within 31 days



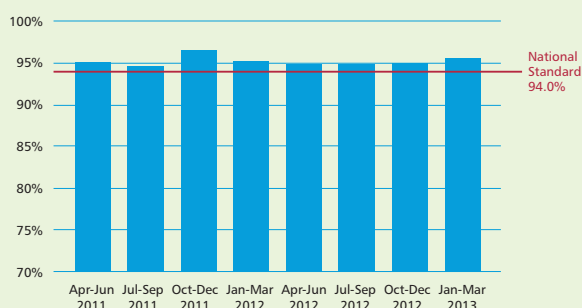
### Treatment within 62 days of an urgent GP referral



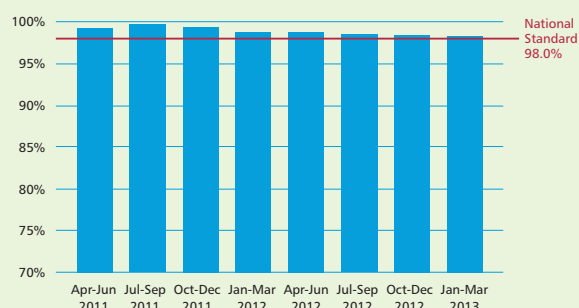
### Treatment within 62 days of referral from screening



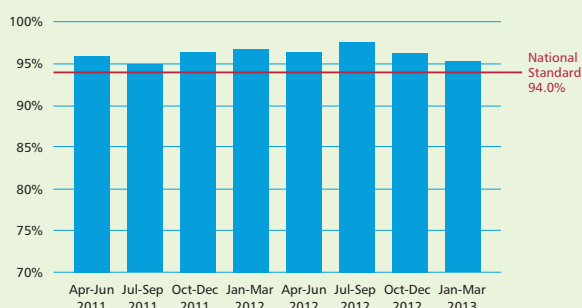
### Subsequent treatment (surgery) within 31 days



### Subsequent treatment (chemotherapy) within 31 days



### Subsequent treatment (radiotherapy) within 31 days



and our ability to provide access to the very latest cancer diagnosis and treatments for our patients so they receive the best possible care as quickly as possible.

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

Reducing the rate of MRSA blood infections is a key national target and is indicative of the degree to which hospitals prevent the risk of infection by ensuring the cleanliness of their facilities and good infection control compliance by staff. In 2012-13, we had only one attributable MRSA blood infection, an outstanding achievement for an organisation of our size and complexity.

This year, we have also reduced the number of *C.difficile* infections in our hospitals. We reported 48 cases, against a target of 58 cases agreed with our commissioners.

In the community, we have been striving to increase the proportion of patients contacted within 24 hours of being referred to the district nursing service. During the year, 85 to 90 per cent of patients have been contacted within 24 hours and we are continuing to implement measures to improve this further to achieve the national target of 95 per cent.

Our health visitors continue to work hard to achieve national standards for visiting more than 95 per cent of babies within 14 days

of birth, and for childhood immunisations. Through focussed effort, we saw 96 per cent of babies within 14 days of birth in March 2013 in both Lambeth and Southwark. Our health visitors also successfully exceeded locally agreed targets to follow up children who are more than four months overdue for their MMR2 or pre-school booster immunisations.

We have significantly improved the accuracy and 'depth' of our clinical coding, which ensures that we are appropriately recording the treatment we provide to patients and details about the complexity of their care and underlying health problems. Not only does this ensure we are correctly paid for their care, but it also allows us to publish accurate information about our clinical outcomes.

### CQUIN targets

Commissioners hold the NHS budget for their area and decide how to spend this on hospital care and other health services. Our commissioners set us goals based on quality and innovation, and 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, 2.5 per cent of our clinical income was conditional upon achieving quality improvement and innovation goals agreed with Lambeth, Southwark and Lewisham Primary Care Trusts and our specialist commissioners. This equates to more than £17 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.

From April 2013, the Trust's CQUIN targets will be agreed with the new Clinical Commissioning Groups and NHS England, and will require us to achieve a number of 'high impact innovations' as well as a range of targets.

For further details of the Trust's performance in 2012/13 and our targets for 2013/14, see chapter 6. The Trust's annual Quality Accounts are also published separately and are available online at NHS Choices ([www.nhs.uk](http://www.nhs.uk)) as well as on the Trust's website.

### NHS Litigation Authority

We were last assessed by the NHS Litigation Authority against their risk management standards for acute trusts and maternity services in June 2010, and 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 an assessment against level three of the maternity standards in June 2013.

## Our performance against key standards

National indicators		National standard	2012/13 Prov	2011/12 Final	2010/11 Final
<b>A&amp;E access</b>	% patients discharged within 4 hours in A&E (all categories) <sup>1</sup>	>95%	95.1% ●	95.6% ●	95.9% ●
<b>Infection control</b>	MRSA bacteraemia reduction <sup>2</sup>	<4	1 ●	8 ●	4 ●
	C.difficile acquisitions in over 2's <sup>2</sup>	<58	48 ●	109 ●	118 ●
	MRSA screening of non-elective admissions <sup>2</sup>	>95%	94.7% ●	92.5% ●	95.7% ●
	MRSA screening for elective admissions <sup>2</sup>	>98%	98.4% ●	98.7% ●	99.0% ●
<b>18 week referral to treatment times</b>	% admissions within 18 weeks <sup>1</sup>	>90%	90.2% ●	85.4% ●	90.4% ●
	% non-admissions within 18 weeks <sup>1</sup>	>95%	96.8% ●	95.4% ●	95.6% ●
	% incomplete pathways within 18 weeks <sup>1</sup>	>92%	92.1% ●	82.7% ●	
<b>Cancer access</b>	Urgent GP referrals seen within 2 weeks <sup>3</sup>	>93%	96.9% ●	97.4% ●	96.6% ●
	Breast symptomatic referrals seen within 2 weeks <sup>3</sup>	>93%	95.3% ●	94.5% ●	96.2% ●
	Cancer treatments started within 1 month of decision to treat <sup>3</sup>	>96%	97.1% ●	97.2% ●	96.2% ●
	Cancer treatments started within 2 months of urgent GP referral <sup>3</sup>	>85%	82.0% ●	83.5% ●	79.2% ●
	Treatments started within 2 months of referral from screening <sup>3</sup>	>90%	95.1% ●	94.1% ●	97.0% ●
	Subsequent surgical treatment within 1 month <sup>3</sup>	>94%	95.2% ●	95.5% ●	93.2% ●
	Subsequent chemotherapy treatment within 1 month <sup>3</sup>	>98%	98.8% ●	99.2% ●	99.6% ●
	Subsequent radiotherapy treatment within 1 month <sup>3</sup>	>94%	96.1% ●	96.2% ●	94.3% ●
Local indicators					
<b>Hospital</b>	Hospital mortality – unadjusted counts of deaths (monthly average)	<90	82 ●	81 ●	91 ●
	Hospital standardised mortality ratio (HSMR)	<85	70 ●	75 ●	80 ●
	% elective operations cancelled on day of operation	<0.8%	0.62% ●	0.50% ●	0.67% ●
	% cancellations not re-admitted within 28 days	<5%	1.9% ●	4.1% ●	0.0% ●
	Patients seen within 48 hours of referral to GUM clinic	>99%	100% ●	100.0% ●	100% ●
	Ethnic coding of inpatients	>90%	91.7% ●	92.2% ●	91.7% ●
	Door to balloon time for primary angioplasty – % under 120 minutes	>80%	82.6% ●		
	Readmission rate (emergency readmissions within 28 days)	<4.5%	5.2% ●	5.3% ●	5.4% ●
	Venous thromboembolisms – % patients screened	>90%	93.3% ●	92.0% ●	92.7% ●
	Patient slips trips and falls resulting in harm (month averages)	<5	2.6 ●	2.1 ●	3.1 ●
	Pressure ulcer acquisitions (monthly averages)	<12.7	6.4 ●	6.5 ●	13.0 ●
	Smoking cessation referrals per month	>150	184 ●	184 ●	150 ●
<b>Maternity</b>	% Caesarean births	<27%	29.3% ●	27.4% ●	27.6% ●
	Health assessments completed within 12 weeks	>80%	94.2% ●	93.4% ●	93.0% ●
	Smoking during pregnancy	<5%	3.7% ●	3.7% ●	3.8% ●
<b>Community</b>	District nurse: referral to patient contact (<24hrs)	>95%	84% ●	86% ●	
	% infants breastfeeding at 6–8 weeks	>75%	76.5% ●	76.0% ●	
	% new birth visits within 14 days	>95%	95.7% ●	91.0% ●	

Data sources:

All indicators are derived from Trust clinical and administrative systems.

National indicators are reported through UNIFY (1), Health Protection Agency (2), and National Cancer Waiting Times Database (3).

● Target fully achieved

● Target partially achieved

● Target not met



## Environmental impact performance indicators 2012/13

Area	Non-financial metric 2012/13	Non-financial metric 2011/12		Financial data (£000k) 2012/13	Financial data (£000k) 2011/12
<b>Finite resources</b>					
Water	446,277 m <sup>3</sup>	437,166 m <sup>3</sup>	Water	£663	£606
Imported electricity	136,020 GJ	152,904 GJ	Energy	£10,272	£9,063
Gas	753,651 GJ	647,878 GJ			
CO <sub>2</sub> emissions from building energy use	58,324 tonnes	55,922 tonnes			
<b>Waste</b>					
High temperature disposal	2,207 tonnes	271 tonnes	Total waste cost	£1,328	£1,365
Alternative treatment (offensive waste)	1,273 tonnes	1,339 tonnes			
Landfill waste	176 tonnes	1,370 tonnes			
Recycling – by % of total	23	18*			

\* Recycling figure for 2011-12 has been amended due to a change in calculation methodology. The original figure reported in last year's report, was 32%.

### Sustainability and climate change

The Trust has renewed its commitment to its award-winning environmental sustainability strategy, in line with the NHS carbon reduction strategy. We remain on target to cut our carbon emissions by 10 per cent by 2015, by 34 per cent by 2020 and by 80 per cent by 2050.

Combined Heat and Power engines were installed on both hospital sites in 2009 and reduce our CO<sub>2</sub> emissions by over 11,000 tonnes a year and save us approximately £1.5 million each year. During the long, cold winter of 2012/13 we did experience increased gas consumption. However, we expect our continued investment in energy saving technology such as LED lighting and highly efficient chillers to have a positive impact on our energy consumption and carbon emissions.

We actively monitor and report on carbon consumption and other key performance indicators to ensure that we are consistently reducing our environmental impact. We are

committed to reducing our construction waste to landfill by 80 per cent, exceeding the government target of 50 per cent, in cooperation with the Waste Reduction Action Programme (WRAP). We are also committed to generating energy from high temperature waste incineration as we work towards our target of sending zero waste to landfill.

We now 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. Everyone is encouraged to take responsibility for saving energy and water, and for reducing waste, and we continue to engage staff in this work through events linked to Climate Week and NHS Sustainability Day of Action. Our network of more than 130 staff who are local environmental representatives also support us in this work.

We are committed to promoting sustainable travel for staff, patients and visitors, and achieved stage two of London NHS

Cycling Strategy in 2011. We regularly hold events for staff, patients and visitors to encourage cycling, and we offer free cycle training to staff in partnership with Southwark Council.

The Trust remains committed to improving the environmental impact of our supply chain for goods and services. We have recently completed the first assessment of the carbon impact of our supply chain with the Carbon Trust and we host the London Procurement Partnership which delivers savings to London trusts and brings positive benefits for local suppliers.

### Corporate social responsibility

As the largest employer in south London, the Trust has a significant impact on the local environment and on local residents and businesses, as well as on the health and well-being of our patients, visitors and staff.

Corporate social responsibility embodies the best of Guy's and St Thomas' and our values. Our vision is to support and enhance the

communities we serve, and to 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 sharing learning;
- Promoting healthy and sustainable lifestyles.

We are proud to be one of the first 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. We are delighted that almost half of the participants found employment with the Trust following their placement. 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 Zambia and Tanzania.

### Our strategic vision

Our ambitious clinical service strategy is focussed on providing

integrated acute and community services for local people, being a nationally recognised specialist services provider, including a centre of excellence for women, children and young people, a major centre for planned surgery, and the pre-eminent research hub for south London.

As part of King's Health Partners we are pioneering better health and well-being locally and globally, by integrating excellence in patient care, education and training and research. Our aim is to ensure our patients are cared for safely and with the utmost compassion. We are committed to delivering high quality sustainable services and progressing a limited number of clinical and academic developments. To achieve this we will continue to develop our Academic Health Sciences Centre, transform major pathways of care and improve our systems to support this.

### Information risks

The Trust is required to assess and report information risks and data losses in a standard format. In 2012/13, the Trust reported one serious loss of data to the Information Commissioner's Office. The incident involved the loss of an unencrypted memory stick, containing patient details.

We take all incidents very seriously and these are investigated in the same way as clinical incidents so that we learn lessons and take action to prevent similar issues occurring. Following this incident, an awareness campaign was launched to remind all staff of the need to ensure that portable

media, including memory sticks, are encrypted. The Trust is also implementing additional controls to prevent unencrypted memory sticks from being connected to our network.

### Quality

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

Our quality strategy focuses on patient safety and the patient experience, and both previous and current quality priorities have been developed with our stakeholders. They are described in chapter 6. Delivery against our priorities and all measures of quality is closely monitored by the Board's Quality Committee and regularly reported to the Board of Directors. The Annual Governance Statement on page 95 describes the structures and information used to provide assurance to the Board of Directors. It also describes the significant risks managed during the year and those identified for 2013/14.

### Sickness absence

The Trust is required by the regulator to report the sickness absence rate of our staff. In 2012/13, the sickness absence rate was 3.5 per cent and the Trust is looking to reduce this through its campaign "Who cares if you are not there?" which aims to support the rehabilitation of staff back into work and raise attendance levels to over 97 per cent.

Guy's and St Thomas' has again performed well financially in 2012/13, despite the continuing difficult economic environment. The Trust declared a surplus of £9.1 million for the financial year, before accounting for an impairment of £25.9 million due to the revaluation of the Trust's assets, non-operating items of £2.9 million, and the receipt of £4.8 million of capital donations, which combined with the underlying surplus leads to an overall deficit of £14.9 million.

### Our financial performance

In 2012/13, the Trust planned for a surplus of £13 million, excluding capital donations, impairments and exceptional items, in order to deliver our ambitious plans for capital investment which underpin our estates strategy. Although, the Trust did not fully achieve the surplus target 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 £52.3 million efficiency improvement, equivalent to 4.6 per cent of 2011/12 turnover, which would have delivered the planned £13 million surplus. At the end of the year, we had achieved £38.9 million (74 per cent) of these savings. In addition, we delivered increased activity and productivity improvements alongside these efficiency savings.

The annual accounts reflect not only the performance of the Trust, but also the consolidated results of its wholly owned subsidiaries: Guy's and St. Thomas' Enterprises Limited; GTI Forces Healthcare Limited; and Pathology Services Limited; and its joint ventures: GSTS Pathology Limited

Table 1	2012/13 Plan £ millions	2012/13 Actual £ millions	Variance £ millions
Total income	1,143.3	1,169.0	25.7
Expenses excluding depreciation	-1,067.3	-1,092.5	-25.2
Impairments and exceptional items	0.0	-28.8	-28.8
Depreciation	-41.6	-42.5	-0.9
<b>Operating surplus</b>	<b>34.4</b>	<b>5.2</b>	<b>-29.2</b>
Public Dividend Capital dividend	-21.6	-20.3	1.3
Finance income	0.5	0.5	0.0
Other	-0.3	-0.3	0.0
<b>Retained surplus/-deficit</b>	<b>13.0</b>	<b>-14.9</b>	<b>-27.9</b>

Liability Partnership; and SSAFA GSTT Care Limited Liability Partnership; and associate companies: Spot on Diagnostics Limited; and King's Health Partners Limited.

The year end surplus reflects the Trust's successful delivery of a significant programme of cost reduction and increased efficiency. The Trust's income position exceeded our planned income for this period by £25.7 million, of which £4.8 million related to donated capital assets, whilst expenditure was £25.2 million above plan, excluding non-operating items and impairments, reflecting the additional costs of delivering these higher levels of activity.

The Trust's depreciation charge was £0.9 million above plan and the dividend on Public Dividend Capital costs was £1.3 million below plan.

Table 1 compares the 2012/13 outturn to the 2012/13 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. The income above plan also includes £4.8 million of income from charitable sources for investment in capital assets.

### Financial performance 2012/13

Guy's and St Thomas' has performed well financially in 2012/13 and the Trust has declared an underlying surplus of £9.1 million for the financial year, before

accounting for an impairment of £25.9 million due to the revaluation of the Trust's buildings, exceptional items of £2.9 million, and the receipt of £4.8 million for capital donations, which combined with the underlying surplus leads to an overall deficit of £14.9 million. The Trust had planned to achieve a surplus of £13 million to deliver our ambitious target for capital investment to deliver our estates strategy.

Table 2 shows the Trust's financial performance for 2011/12 and 2012/13.

Table 2	2012/13 Actual £ millions	2011/12 Actual £ millions
Total income	1,169.0	1,136.4
Expenditure including depreciation	-1,163.8	-1,104.5
<b>Operating surplus</b>	<b>5.2</b>	<b>31.9</b>
Public Dividend Capital dividend	-20.3	-20.8
Interest on loans & receivables/other	0.2	0.3
<b>Retained surplus/-deficit</b>	<b>-14.9</b>	<b>11.4</b>
<b>Add back:</b>		
Impairments	25.9	6.9
Non-operating expenses	2.9	-0.8
Less capital donations	-4.8	-6.6
<b>Underlying surplus</b>	<b>9.1</b>	<b>10.9</b>

The Trust made an underlying surplus of £10.9 million in 2011/12 (before accounting for impairments and non-operating costs of £6.1 million, and charitable funding of £6.6 million for capital schemes) and achieved an underlying surplus of £9.1 million in 2012/13, prior to the accounting adjustments set out above. These surpluses have been allocated to develop services and to implement our ambitious estates strategy.

The surpluses were primarily

due to the following positive factors:

- Additional activity which has resulted in increased income from Primary Care Trusts;
- Additional funding from the Department of Health to recognise the specialist activity undertaken by the Trust and funded at national tariffs;
- The recovery of prior year income;
- 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 delivering national waiting time targets.

The Trust delivered efficiency savings of £38.9 million in 2012/13, 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.

In April 2012 the Trust took over the hosting of the London Procurement Programme from St George's Healthcare NHS Trust, with an annual turnover of £3.7 million.

### Trends in activity, income and expenditure

Charts 1 to 5 on page 25 show activity and income and expenditure growth over a five year period from 2008/09 to 2012/13.

### Activity trends

Charts 1 to 3 show the growth in inpatient and day case activity, measured as completed patient spells – up by 17 per cent, and growth in outpatient attendances – up by 18 per cent.

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 time targets. The majority of the activity growth over the period relates to day case activity.

Total outpatient activity has grown by 17 per cent (new outpatient referrals increased by 33 per cent and follow-up referrals increased by 12 per cent) over the period.

In July 2012, the management of the Guy's Hospital Minor Injuries Unit (MIU) was transferred to local GP practice, the Bermondsey and

## Trends in activity, income and expenditure

Chart 1: Completed patient spells

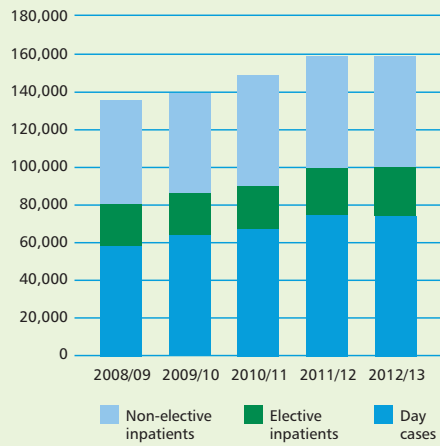


Chart 2: Consultant outpatient attendances

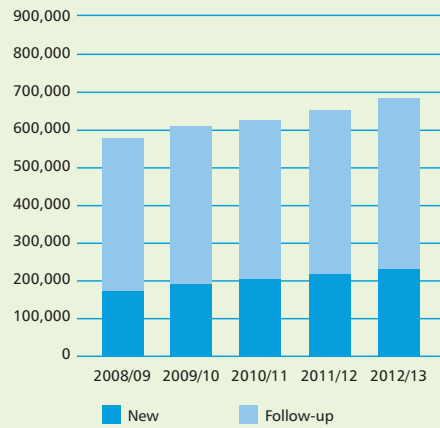


Chart 3: A&E attendances

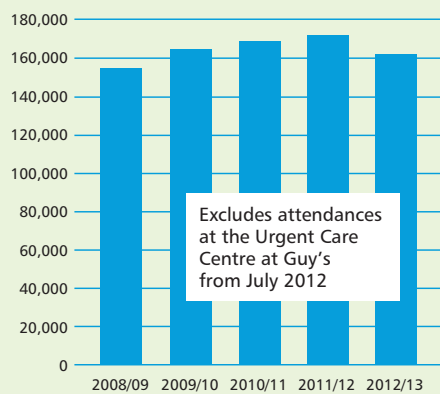


Chart 4: Income £000s

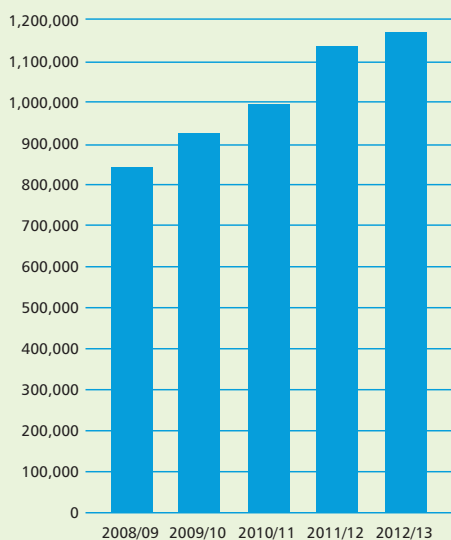
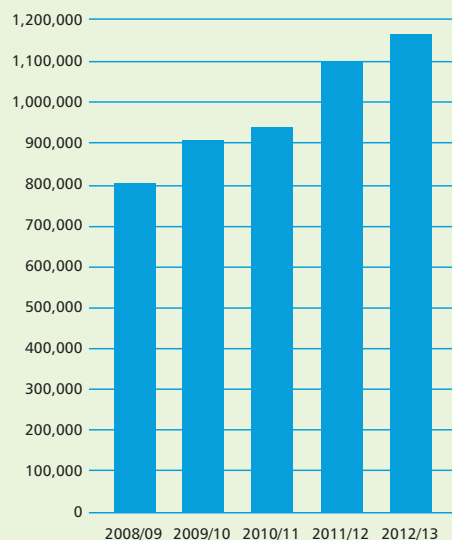


Chart 5: Expenditure £000s





Lansdowne Medical Mission, resulting in a reduction of around five per cent in the total accident and emergency attendances from 2011/12. After adjusting the total activity for the MIU service transfer, the overall accident and emergency attendances in 2012/13 were comparable with 2011/12 attendances. Overall accident and emergency attendances are up ten per cent over the five year period after adjusting for the MIU service transfer.

Chart 4 shows the growth in income over the five year period from April 2008 to March 2013.

### Increasing the efficiency of our services whilst sustaining high quality, safe care is a key goal

Income has grown at approximately 10 per cent a year. However this includes the transfer of the London Procurement Programme from St George's Healthcare NHS Trust, the transfer of Lambeth and Southwark Community Services, and the transfer of the NHS Revalidation Team and South East London and South West London Shared Service Partnership in previous years. After adjusting for these, the underlying growth in income is six 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 grown significantly at an average rate of 11 per cent a year, adjusted to six per cent a year after accounting for the recent service transfers and the 2012/13 impairment charge. The underlying six per cent growth in expenditure each year is primarily the result of inflationary costs, additional staff and non-pay costs associated with delivering additional activity, as well as quality improvements.

However, it should be noted that the change in income and expenditure between financial years 2011/12 and 2012/13 is below the five year average with both income and expenditure growing at slightly above two per cent a year. This reflects the changing economic climate and the increased efficiency savings the Trust is required to deliver. It is expected that reduced income growth and the need for further efficiency and productivity improvements will continue in 2013/14 and future years.

### Cash flow and balance sheet

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

The Trust ended the year with £129.4 million cash in the bank, against a plan of £93.4 million. This was an increase in cash of £36 million compared to plan, and a reduction of £14.5 million when compared with the £143.9 million

position at the end of 2011/12. The increase in cash against plan is mainly due to the Trust under-spending against the capital expenditure plan by £47.6 million on NHS funded assets and the variance in working balances against a plan of £17.2 million, offset by reductions in the drawdown of loans from the Foundation Trust Financing Facility of £24.9 million, as well as a shortfall in the income and expenditure cash surplus of £3.9 million.

The Trust had a planned capital spend of £143.2 million for the year, excluding capital donations.

The actual capital expenditure during the year was £100.4 million, this being £95.6 million on NHS funded assets and £4.8 million from charitable funds. The Trust drew down £26.3 million, against a planned draw down of £51.2 million, from a total of £160 million of loans secured from the Foundation Trust Financing Facility to support its capital programme. We expect to complete all schemes within the agreed timetable.

The Trust's land and buildings were valued independently by the Valuation Office at March 2013, in line with the accounting policies. The valuation included positive and negative adjustments. All valuation movements were the result of changes in market price.

Overall there was a net impairment charge of £15.9 million. £23.3 million was charged to the consolidated statement of comprehensive income as the Trust's buildings had insufficient revaluation reserves to fund the valuation movement.

The valuation included negative valuations of £29.9 million on buildings, as well as positive valuation movements on the Trust's land assets of £14 million.

In addition to the valuation movements, the Trust identified that the values of Bloomfield Clinic and Newcomen Centre were impaired at 31 March 2013. This is because the centres were demolished in April 2013 to allow for the construction of the new Cancer Centre. The total impairment of these two buildings was £1.9 million.

Further impairments of £0.7 million were also charged to the

## 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 2012/13, the Trust spent £4.8 million from charitable grants on capital projects, and also received £5.5 million in charitable contributions towards revenue expenditure.

## Capital expenditure

Capital expenditure during 2012/13 was focussed on protected assets and included backlog maintenance, the provision of medical equipment

Table 3	NHS Funded £ millions	Donated £ millions
Buildings	8.7	0.6
Assets under construction	83.2	4.0
Plant and machinery	2.0	0.2
Information technology (IT)	1.3	0.0
Furniture and fittings	0.0	0.0
Software licenses etc	0.4	0.0
<b>Total</b>	<b>95.6</b>	<b>4.8</b>

consolidated statement of comprehensive income.

As at 1 April 2013, eight properties previously leased to provide community services have transferred to Trust ownership from Lambeth and Southwark Primary Care Trusts. These properties have been excluded from the lease commitments. In addition to this, the Trust will be taking on the leasehold of another two community properties. There are also a number of other properties from which community services are provided by the Trust, but where the leasehold will not transfer.

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

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

The Trust's contract with the Ministry of Defence for the provision of health services to British Forces in northern Europe was renewed in October 2012 until March 2020. This is a seven year contract linked to the rate of withdrawal of UK troops from Germany.

### Prudential Borrowing Limit

A Prudential Borrowing Limit (PBL) is set by Monitor and is reviewed at least annually. The total amount that the Trust borrows must be within this limit. Monitor sets the Prudential Borrowing Limit for each Foundation Trust with reference to financial ratios and the individual Trust's working capital facility. In 2012/13 the Trust arranged a working capital facility of £60 million but did not need to draw on these funds. This facility has not been renewed for 2013/14.

The Trust has agreed loans totalling £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 for four of these projects totaling £150 million. In 2012/13 the Trust drew down £26.3 million of the agreed loans to cover the expenditure incurred. The Trust's performance against the Prudential Borrowing Limit indicators is described in note 24 of the annual accounts.

### External audit services

In 2010 the Council of Governors agreed that Deloitte LLP should be the Trust's external auditor for a three year period including the 2012/13 financial year. The Trust incurred £131,640 in audit services fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries' to 31 March 2013. A further £25,200 was incurred auditing the Trust's Quality Accounts for 2012/13.

### 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 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:

- The changing economic environment;
- The ongoing development of King's Health Partners, including Clinical Academic Groups;
- Changes to commissioning arrangements for clinical services;
- Changes in the configuration of healthcare in London;
- Savings and activity plans;
- Commissioning for Quality and Innovation targets (CQUIN);
- Commercial opportunities and income diversification.

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 all 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, 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 £80 million savings in 2013/14 to deliver a balanced financial position. The Trust expects to identify additional in-year efficiency opportunities to ensure we end the financial year in financial surplus, 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 ambitious strategic vision.

Increasing the efficiency of our services is a key goal for the next three years whilst sustaining high quality, safe services and responding to the recommendations following the Francis Report. In order to deliver the scale of change required to achieve the level of efficiencies needed over the coming years, the Trust has established a strategic, Trustwide programme '*Fit for the Future*'. This comprises 19 clinical and non-clinical workstreams that will maintain high quality care and a positive patient experience whilst driving improved productivity and efficiency. Workstreams include: non-clinical pay reduction, improving procurement, reducing length of stay, improving clinical coding, reducing bureaucracy, surgical productivity, improving outpatients and maximising capital investment benefits.

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.

### The economic environment

The global economic downturn has impacted significantly on future funding likely to be available to the NHS. This will require that increased efficiency savings of over four per

cent a year are achieved by NHS Trusts.

In addition, changes to funding arrangements for education which are 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 monitoring and improving the quality of patient care and 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 university partner King's College London, we form King's Health Partners, an 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 patients and communities we serve.

During 2013/14 we will continue to support a programme of activities that will enable King's Health Partners to achieve its strategic objectives and support its formal bid for reaccréditation. These include clinical, research and education strategies, work to integrate physical and mental health, and the development of the South London Academic Health Science Network (AHSN), in collaboration with a range of

partners across south London.

King's Health Partners will continue to work towards closer integration to achieve its tripartite mission. A strategic outline case to create a single academic healthcare organisation was agreed in 2012. Work is now underway to develop a full business case to further test the case for merging organisations, and the opportunities this presents to improve the effectiveness and quality of our services, while reducing unnecessary duplication.

King's Health Partners continues to present exciting opportunities for service development, income growth and diversification, as well as for greater efficiency and fundraising.

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

### Changes to commissioning arrangements

The Trust is working closely with the new commissioning organisations including Clinical Commissioning Groups, NHS England and local authorities to agree contracts for clinical services for 2013/14.

These changes in commissioning arrangements have led to a number of financial risks as the new arrangements are established and the activity level for each commissioner is identified and contracts agreed. The delay in agreeing contract baselines with new healthcare commissioners may lead to short-term cash flow difficulties for the Trust. The Trust is

mitigating this risk through discussions with local commissioners on cash management.

Commissioning intentions for 2013/14 focus on referral management and productivity improvements which are to be delivered through locally agreed quality, innovation, productivity and prevention initiatives. We will continue to monitor the impact on the Trust of these new arrangements once we have concluded our contract negotiations with commissioners.

Plans to rationalise specialist services may be reflected in the future commissioning intentions.

in outer south east London have been confirmed, the Trust will plan for expected changes in maternity, emergency and other flows.

The central location of the accident and emergency department at St Thomas' means that we expect emergency patient flows to increase as a result of the implementation of commissioning strategies in other parts of London and we will keep this situation under review.

Key challenges will be to plan capacity for unpredictable numbers of patients using our services whilst maintaining the quality and safety of our emergency services within the current tariff. The Trust is currently planning major changes to the emergency care pathway including the reconfiguration of the accident and emergency department, to better support the Trust in managing the risks.

### Savings and activity plans

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

We are also working with local Clinical Commissioning Groups on a number of key productivity improvements and demand management protocols to deliver overall system sustainability in south east London so that the activity delivered by the Trust is both affordable and can be delivered within the funding available.

We have a positive track record of working closely with our local commissioners to deliver system change

We are well placed to assist with the consolidation of specialist services and, if asked, would provide services for an agreed population as part of networked pathways of care.

### Changes to healthcare configuration in London

Changes to the provision of healthcare, as proposed by the South London Healthcare Trust Special Administrator, are expected to impact on the Trust over the next three years. We will work closely with commissioners and the Trust Special Administrator to identify associated risks and opportunities.

Once models of care for services



The risk of not meeting these targets will be that the Trust and local Clinical Commissioning Groups are 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 commissioners to deliver system change within the funding available to all parties. The Trust's *'Fit for the Future'* 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 (CQUIN)

The Trust has agreed a number of acute and community CQUIN targets that reflect national, regional and local clinical priorities with our local Clinical Commissioning Groups and NHS England. These initiatives will account for 2.5 per cent of the Trust's income and will be based on 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 and income diversification

The Trust benefits from having one of the largest and most successful commercial directorates in the NHS. Safeguarding our future by ensuring that we continue to be financially sustainable is critical to the delivery of clinical services. This team

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.

In addition, we are establishing Essentia Trading, which will allow us to maximise income generation from our capital, estates and facilities expertise going forward.

Over the coming years we will continue to develop and/or deliver the following commercial opportunities and joint ventures:

- Primary care and onward secondary care services for British Forces in northern Europe;
- A partnership with HCA to run private patient cancer services at Guy's;
- Growing our private inpatient, medical and maternity services at St Thomas';
- Continuing to develop our joint venture pathology services, GSTS – a limited liability partnership between Guy's and St Thomas', King's College Hospital and Serco PLC;
- Providing outpatient pharmacy services, with J Sainsbury plc on both main hospital sites, with further retail development in 2013 on the Guy's site;
- Promoting an active programme to capture and commercially develop our intellectual property.

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.



We have focussed on improving care for our most vulnerable patients, and have developed a unique training programme based on a film about Barbara's story.

# 4

## Our people – patients, staff and partners

The Trust strives to improve the quality of care and the hospital environment in consultation with our patients, our staff and partners. This enables us to deliver services that meet the needs of the diverse local communities we serve and those who come from further afield for specialist care.

### Patients

Our patients lie at the heart of everything we do. With over two million patient contacts in our hospitals and in the community each year, we care for a wide range of patients, but strive to care for each as an individual. It is only through listening to our patients, their relatives, carers and visitors that we can provide the best possible services.

### Listening to patients

We are committed to listening to patients and value their feedback to help us monitor and improve services.

We use an electronic near-time patient feedback system that enables us to capture and respond to patient's views more rapidly. In the last year, more than 6,500 inpatients and 5,500 outpatients completed a survey via this system.

We continue to see high levels of satisfaction with the services we provide, with 87 per cent of inpatients and 84 per cent of outpatients reporting that they were satisfied with their visit to our hospitals and the quality of care they received, and 90 per cent of both inpatients and outpatients saying that they always had confidence and trust in the staff treating them. Feedback on the cleanliness of the ward environment and facilities remains high, with between 89 and 95 per cent of patients reporting that areas were very or fairly clean.

We also participate in the Care Quality Commission's (CQC) annual inpatient survey and this showed high levels of satisfaction

with those aspects of care that we know are important to patients – 84 per cent of inpatients felt that they were always treated with dignity and respect during their stay and 88 per cent of patients reported that they were always given enough privacy when being examined or treated.

We are building on the success of the near-time patient feedback system in our hospitals by piloting a similar system in a number of our community services sites. This is in addition to the results of the national patient survey and provides more timely feedback from patients at individual community locations, giving staff a richer picture of the patients' experience.

By asking patients what they think we continue to make changes that patients and visitors want. The results and observations are fed back to the relevant clinical teams for action and reported to the Board of Directors and Council of Governors' patient experience working group.

Last year the Trust's environmental improvement programme continued to enhance patient facilities, and this has included work to ensure that patients do not share sleeping accommodation and bathroom facilities with patients of the opposite sex, except where there is an exceptional clinical need. Results from the CQC survey show that more than 90 per cent of patients did not share a ward, bay or bathroom facilities with patients of the opposite sex.

Our staff work hard to ensure that every patient's stay in hospital is as safe and comfortable as possible. This year, we have

introduced a ward pack that is given to all new inpatients when they arrive on a ward. The pack includes key information about ward routines and hospital facilities, as well as practical items such as ear plugs, safety socks and an eye mask. Staff carry out regular ward rounds to ensure we are meeting patients' needs. In addition, our senior nurses speak to each inpatient every one to two hours. This provides the opportunity for patients to raise any questions or concerns they may have, and enables staff to check that all patients are comfortable.

We are committed to listening to patients and value their feedback to help us monitor and improve services

### Learning from complaints

We take complaints very seriously. They form a crucial part of our learning from patient feedback. We receive complaints related to clinical care and to other aspects of patient experience including transport, catering and the attitude of staff. We are working hard to learn from the feedback and to reduce complaints further across all areas.

We know we can do more to improve the quality and timeliness of our complaint responses. This year we have included this as a key

priority area in our Quality Accounts, with a focus on combined learning from complaints, PALs and other patient feedback.

### Patient involvement

The Trust is committed to involving patients and the public in the development and improvement of services. This year, we have continued to implement our patient and public involvement strategy – a three year plan to embed a positive approach to involvement across the Trust.

This has included involving patients in thinking about the future redevelopment of our accident and emergency department at St Thomas'. Patients also helped staff to test the new electronic check in system for our new Outpatient Centre in Gassiot House in readiness for its opening in June 2012.

Patients have been at the heart of the design of our new Cancer Centre at Guy's. A patient reference group continues to work with staff to inform the design and delivery of services, and those involved were invited to a celebration event in November 2012 to acknowledge their contribution so far.

Young patients and their families have also contributed their views to the design and layout of the new South Thames Cleft Service which is relocating from Guy's to St Thomas' in summer 2013. From the feedback received, it is clear that patients and their families feel positive about the move which will see this service co-located with other children's services.

As part of our patient and public involvement strategy, we

work with Participate and the Consultation Institute to provide specialist training for staff, supported by funding from Guy's and St Thomas' Charity.

### Patient information

The Trust is committed to providing patients with clear, informative and clinically accurate information about conditions and treatments to enable them to make informed decisions about their care. All information produced by the Trust is monitored and approved using a rigorous process to ensure that it is evidence-based, meets national standards and has been reviewed by patients. The Trust holds the highest possible accreditation – level 3 – from the Clinical Negligence Scheme for Trusts for the quality of its patient information.

During the year, the Trust produced over 450 new patient publications and reviewed existing publications to ensure their accuracy. We now have over 800 bespoke publications in use across the Trust. We also approve externally produced patient information from a range of organisations. This year, we have been working to improve the way our information is used by staff and provided to patients.

The Knowledge and Information Centre at St Thomas' continues to provide a place for patients and their families to enquire about health services, use computers and search the internet, as well as to visit the PALS walk-in service. Last year nearly 52,000 people visited the centre and staff also responded to almost 9,000 queries by email

and telephone.

During the year, PALS received over 10,000 enquiries and staff work closely with Trust colleagues to resolve concerns at an early stage whenever possible. They can also advise patients on how to make a formal complaint. Themes identified through the PALS team are fed back to senior colleagues and contribute to the patient experience data used to improve our services.

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

### Our staff

Last year, we employed around 13,200 staff, clinical and non-clinical, all of whom contribute to providing high quality patient care in our hospitals and across the local community. Our staff work hard to improve efficiency, to meet national and local quality and access targets, and to bring innovations in care to patients.

### Communicating with staff

The Trust is committed to involving staff in decision-making and keeping them informed of changes and developments across the organisation. The Trust's two-day corporate induction programme is a valuable source of information for new recruits and the

Knowledge and Information Centre at St Thomas' provides email and computer access for staff, as well as regular information and training sessions.

We do our best to ensure staff are aware of the issues affecting the organisation, such as the recent changes to the NHS and the impact of the Francis Report. Our range of well-established communications channels include a monthly team briefing, a regular staff email bulletin and our intranet, **GTi**, which is a central resource for policies, guidance and online tools. We hold regular face to face briefings on both clinical and management issues and produce a popular magazine for staff, patients and our Foundation Trust members.

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

Staff throughout the organisation are encouraged to voice opinions and get involved in developing local services to drive continuous improvement. Staff members of the Council of Governors make a valuable contribution to the governance and development of the organisation.

### Staff survey

We participate in the annual NHS national staff survey which provides a valuable insight into the views of our staff. In 2012, we chose to



survey all staff, not just the 850 staff required by the Care Quality Commission (CQC), and achieved a 42 per cent response rate. The areas of best and weakest performance can be seen in the table on page 39.

The latest results for 2012 show that the Trust has continued to perform well in a number of key areas, including staff satisfaction with the quality of care they are able to deliver. 82 per cent of staff said that they would recommend the Trust as a place to receive treatment – well above the national average for staff in similar trusts which is 60 per cent. Our staff also rated us among the top five acute Trusts nationally for job satisfaction, structured appraisals levels and for feeling able to contribute to improvements at work.

The Trust uses the results of the national survey and other staff feedback to address any areas of concern and improve working life. We work with staff side representatives to address issues raised through the staff surveys at Trustwide and local level. This has enabled us to focus on key areas for improvement, such as improved equality and diversity training and the development of a health and well-being programme for staff.

The Trust continues to recognise and honour staff for their outstanding contributions to the care of patients and the running of our hospitals. Our monthly CARE awards and annual Trust awards provide us with an opportunity to acknowledge and thank staff. In addition, we also celebrate the contributions made by staff through

volunteering. Last year, as part of our 2012 Staff Challenge to celebrate the London 2012 Games, staff raised £65,000 and volunteered almost 6,000 hours for voluntary and charity projects and completed an amazing range of sporting endeavours. They also found ways to work more effectively and time to celebrate London's very special summer.

### Equality and diversity

The Trust serves diverse local communities in Lambeth and Southwark – a diversity that is reflected in the profile of our patients and workforce. Our equality objectives have been developed in consultation with our staff and local health partners, and have been endorsed by the Board of Directors. They set out our priorities to drive improvements in patient care and staff experience and to reduce inequalities for our diverse workforce and patients.

Our objectives reflect an inclusive approach to the strands of equality – age, disability, ethnicity, gender, race, religion and belief and sexual orientation – and are a requirement of the Equalities Act and our public sector equality duties.

They include:

- Working in partnership with our local authorities, for example through Health and Well-Being Boards;
- Improving the provision of accessible information and the way that we communicate with patients;
- Helping vulnerable people to participate in public life by widening access to employment and new skills;

- Better monitoring of how we are doing, both as an employer and in delivering care to patients.

These objectives build on our existing Equality and Human Rights Scheme 2010-2013. The Trust's Associate Director of Equality and Diversity takes overall responsibility for monitoring our operations against these priorities and reporting our performance.

The Trust works hard to meet the needs of patients with learning disabilities by providing accessible information and making reasonable adjustments. We have introduced a 'hospital passport' to improve communication and understanding.

This wallet-sized card is a simple record of known conditions and personal preferences which patients with learning disabilities carry with them to their hospital appointments. It empowers patients and helps hospital staff to make appropriate clinical decisions that take into account every aspect of a patient's needs.

The Trust continues to develop fair recruitment practices to ensure equal access to employment opportunities for all. We use the 'two tick' symbol on recruitment materials, signifying our positive attitude towards recruitment of disabled people, and we continue to support disabled staff, including anyone who becomes disabled during their employment.

The Trust participates in a number of projects and initiatives to widen access to employment opportunities including:

- A partnership with local community social enterprise, the Lilian Bayliss Community Action

Zone, where staff have used their skills to improve a derelict school site, and take young people on work placements

- Hands Up for Health: a project that gives young people practical understanding of health and safety through use of simulation facilities
- Clinical Insight: a project that aims to improve access to clinical placements for a wider range of young people, from all backgrounds
- The Autism Project (TAP): a work placement programme to support young people with autistic spectrum disorders to gain qualifications and skills to find work
- Award winning recruitment campaigns run in partnership with South Bank Employers Group and Jobcentre Plus targeted at getting local people into work.

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

## Training and development

The Trust is committed to the training, career development and promotion of all staff and offers a range of opportunities to support this, including short courses, management development programmes, mandatory training, mentoring schemes and access to university programmes. The purpose designed Education Centre at York Road, close to St Thomas' provides high quality teaching and learning facilities for staff.

In addition to the well-developed

programme of mandatory and other training courses, the Trust has introduced a number of new initiatives during the last year. The most notable of these is 'Barbara's story', a major campaign to raise awareness of dementia amongst our staff. As part of this initiative, every member of staff must attend an innovative training session, the main focus of which is a short film about Barbara and her experiences during a hospital visit.

All staff are expected to have a good understanding of the issues faced by patients with dementia so that they can recognise and support these vulnerable patients. This award-winning initiative was recognised as an example of good practice in the Department of Health's response to the Francis Report and has also won a number of other national awards.

This year, the Trust achieved the Investors in People Gold Standard, the highest level of recognition any organisation can achieve under the Investors in People scheme. This standard recognises our work to develop leaders and managers, involve and empower staff, and continuously improve performance.

The Trust runs an apprenticeship scheme to provide work-based training for staff seeking to gain the knowledge and skills required to undertake their role and tasks more effectively. Around 200 apprenticeships have been established covering a wide range of areas, including roles in nursing, maternity and administration, as well as in pharmacy, housekeeping and engineering services.

The Trust also offers a cadet

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

## Volunteers

Our patients and staff benefit greatly from the support of a team of almost 400 volunteers who contribute an estimated 1,200 hours a week to the Trust. Their work includes welcoming and guiding patients and visitors, supporting the spiritual care team, escorting patients to the MediCinema to watch the latest films, assisting patients at meal times and helping new mothers to breast feed.

The voluntary services team that co-ordinates this work, has created 19 new roles for volunteers this year. These new roles give volunteers greater opportunities to support patients and staff in our hospitals and in community settings, and enables them to work in partnership with local voluntary organisations.

## Safe working environment

We place a strong focus on health, safety and well-being to maintain an environment that is safe and supportive for staff, patients and visitors.

We know that our staff value initiatives which support their health and well-being. In response to this feedback we have introduced a number of initiatives that increase the opportunities for staff to get healthy at work, such as support

with nutrition and weight loss; enhanced smoking cessation services; self-referral physiotherapy services; and access to cognitive behavioural therapy. The Trust was shortlisted for the 2013 Guardian Sustainable Business Awards in the category of Health and Well-being for this comprehensive programme.

In recognition of this work, we have also been awarded 'excellent' status by the Department of Health in the workplace wellbeing charter award – a framework which helps organisations to assess and gain recognition for what they are doing to improve the health and well-being of staff. We have also been accredited against the Health and Well-being award, which evaluates how an organisation supports its staff in terms of their physical and emotional needs.

Our occupational health service remains one of the largest in the country, employing a team of doctors, nurses, counsellors and support staff, who not only serve our staff, but also have contracts to provide services for a number of local businesses. Based at York Road Education Centre, the occupational health service offers services such as pre-employment screening, work-related health checks and a vaccination and immunisation programme. There is also a rehabilitation centre where disabled employees can test adapted office equipment to support their individual needs.

### Partnerships to improve healthcare

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

During 2012, a strategic outline case for an integrated academic health care organisation has been developed and shared with local stakeholders. The King's Health Partners Board has agreed to move to the next stage by developing a full business case that will consider various organisational models, including the possible merger of our three foundation trusts. Local stakeholders, patients and staff will be asked for their views as we develop the full business case during 2013.

The Trust works closely with Lambeth and Southwark local authorities through their Overview and Scrutiny Committees, for example when deciding on the Trust's quality priorities which are set out in the Trust's Quality Accounts, and where potential changes to the provision of services are proposed.

This year, we have also engaged with and supported the development of the new Health and Well-Being Boards for Lambeth and Southwark as they take on their formal responsibilities from April 2013. The Trust welcomed the invitation to become a formal member of these boards, with representation provided by the Trust Chief Executive and the King's Health Partners Director of Clinical Strategy. The Health and Well-Being Boards have already made a valuable contribution by helping define the strategic direction of health services locally and we look forward to working closely with them in the coming year.

We continue to work closely with the South Bank Employers

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

### Consultations

As part of the national Safe and Sustainable Review of Children's Congenital Cardiac Services, the Evelina Children's Hospital has been confirmed as one of the centres to provide specialist heart surgery, and this supports our ambitions to provide a full range of local and specialist child health services and to improve child health.

The London Cancer Alliance (LCA) brings together 17 NHS provider organisations, including Guy's and St Thomas' and King's College Hospital from King's Health Partners, and aims to drive a step change improvement in outcomes and experience for cancer patients in south and north west London. We are delighted that Professor Arnie Purushotham has been appointed Clinical Director of the Alliance and will help drive its success.

### 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 health care innovation and services across the Trust. The Trust is the principal beneficiary of the Charity and, during 2012–13, the Charity

	2012		2011		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
Response Rate	41%	49%	51%	53%	Deterioration
<b>Areas of best performance</b>					
Staff recommending the Trust as a place to work or receive treatment	4.08*	3.57*	4.05*	3.50*	Improvement
Staff reporting a high level of job satisfaction	3.71*	3.58*	3.60*	3.47*	Improvement
Percentage of staff having a well structured appraisal	47%	36%	46%	34%	Improvement
Percentage of staff experiencing physical violence from patients, relatives or the public	8%	15%	6%	8%	Deterioration
Percentage of staff able to contribute towards improvements at work	74%	68%	68%	61%	Improvement
<b>Areas of weakest performance</b>					
Percentage of staff working extra hours	76%	70%	70%	65%	Deterioration
Percentage of staff receiving health and safety training in the last 12 months	67%	74%	84%	81%	Deterioration
Percentage of staff having equality and diversity training in the last 12 months	38%	55%	32%	48%	Improvement
Percentage of staff believing the Trust provides equal opportunities for career progression	81%	88%	85%	90%	Deterioration
Percentage of staff reporting experiencing discrimination at work in the last 12 months	17%	11%	17%	13%	No change

\* Scored out of 5.

committed a total of £32.5 million to current and future developments. This included 67 grants.

Most notably, the Charity confirmed its strategic alignment with the Trust's priorities, including the development of the new Cancer Centre at Guy's, for which the Charity has agreed to provide a £25 million capital contribution, as well as a further £1.7 million grant to support an exciting arts strategy that will create a very special environment for patients attending the new centre once it opens in 2016.

Other grants included £3.4 million to transform the delivery and effectiveness of imaging services; £813,000 to support the integration of primary and community care with

hospital services for children; and £230,000 to improve the way that patients suffering from malnutrition can be supported in the community.

The Charity continues to support the Trust's staff development and well-being initiative through a £1.57 million grant over three years, and delivers a wide range of arts and cultural projects, including an innovative performing arts programme, for the benefit of patients, visitors and staff.

For more information visit [www.gsttcharity.org.uk](http://www.gsttcharity.org.uk)

In 2011, the Charity's fundraising function transferred to King's Health Partners as a fundraising partnership for the Foundation Trusts and King's College London within King's Health

Partners, known as 'together we can'. The Trust is very grateful for the continued support of patients and their families, the local community, businesses and individuals who support us through both donations and fundraising activities.





Over 120 staff and student volunteers from across King's Health Partners helped inspire thousands of children by demonstrating the vast variety of healthcare careers at the Big Bang Fair in March 2013.

# 5

## Teaching and research and development

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

### Teaching

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

Education and research are central to our responsibilities as leading teaching hospitals and a major academic centre, and underpin our vision for our Academic Health Sciences Centre, King's Health Partners. They have also been fundamental to King's Health Partners' role in the Health, Innovation and Education Cluster for South London (HIEC), which was jointly led by King's Health Partners and the South West London Academic Health and Social Care System.

The HIEC has now successfully completed the goals after three years' funding and leaves a legacy of innovative education and training which has been shared across south London and beyond. Networks of practitioners and health and social care professionals have been developed with a common goal to improve patient outcomes.

The new Local Education and Training Board (LETB) for South London was authorised on 1 April 2013 to design, develop and deliver a workforce to improve the health and well-being of people in south London, and support the delivery of world class care and high quality patient outcomes through education and training.

### The Simulation and Interactive Learning (SaLL) Centre

The Simulation and Interactive Learning (SaLL) Centre at St Thomas' provides clinical staff and students with the opportunity to learn using life-sized, high-fidelity manikins to simulate real-life scenarios. Real clinical incidents are played out and the root causes of situations are analysed. The environment allows students to practice dealing with uncertainty, breaking bad news and end of life decision making in a realistic, but safe environment.

The SaLL Centre complements other simulation facilities and in-situ equipment across King's Health Partners, including newly acquired baby and child manikins and a birthing manikin. The centre also hosts a mock GP consulting room and a home environment, as well as more traditional hospital settings including a six-bedded ward, an operating theatre, an intensive care ward and a surgical simulation room.

In the last year, over 4,000 undergraduate and postgraduate doctors, nurses, allied health professionals and other staff have undertaken training at the SaLL Centre. This high volume of activity and the wide variety of courses offered, resulted in the Centre being awarded commendations by London Deanery's Educational Excellence Awards of 2012 for Educational Productivity and Academic Activity.

Last year, King's Health Partners was awarded £468,000 by the Simulation and Technology-enhanced Learning Initiative (STeLI)



to develop facilities for simulated training in ultrasound procedures. This will help to ensure that those expected to perform an invasive or ultrasound procedure receive high-quality simulated training at an early stage.

Together with our colleagues at St George's, the Centre has been awarded funding by the South London Health Innovation and Education Cluster (HIEC) to develop and host a Simulation Network. The network brings together ten simulation centres across south London to share best practice and raise the standard of simulation education across South London.

### The Trust is committed to undertaking research which involves and benefits our local population

We continue to host visits from local school children through the 'Hands up for Health' outreach programme, as part of our commitment to widening access to medical careers in the local community. In March 2013, we participated in the Big Bang Fair for young scientists and engineers, giving young people hands on experience of healthcare.

#### Undergraduate education

Each year, more than 300 consultants and many administrative and other medical staff make a significant contribution to the

education and development of over 1,300 undergraduate medical students from our university partner, King's College London.

The Trust continues to engage newly appointed consultants in the education programme, ensuring they have dedicated time for teaching, hosting students and providing lectures, particularly in the September introductory week, and by assessing competency in July's final clinical exams. These staff also support students throughout the academic year, and make a valuable contribution to interviewing prospective students and supporting examinations.

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

This year we have seen the significant expansion of our clinical skills training programme for undergraduate students, making use of innovative technologies available through the SaLL Centre to teach practical skills in a safe setting.

An undergraduate education committee meets bi-monthly with representatives from each of the Trust's clinical directorates and from King's College London, to ensure that the quality of teaching and the student experience is continuously scrutinised. We welcome feedback from students and we work hard to respond to this and improve where

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

### Postgraduate education

The Postgraduate Medical Education Department continues to deliver excellent training and education programmes from purpose built facilities in the Education Centre at York Road and in healthcare settings across south London.

The department remains successful in securing funding from the London Deanery to expand its innovative portfolio of courses and training to clinical staff. This year, we have secured £56,525 to run a series of educational supervision and skills courses. We have also secured £21,523 for Excellence in Leadership which supports our Developing Future Leaders programme for doctors in training. Through this programme our trainees are leading innovative patient safety and quality improvement initiatives within their specialty areas.

The education and training team is responsible for delivering a wide range of courses for consultants, junior doctors and other healthcare professionals, including Teaching for Teachers, Clinical Supervision and Education Supervisor courses. The department's foundation programme team continues to lead successful induction programmes for all incoming junior doctors, which include a robust online induction programme and a number of smaller, specialist inductions throughout the year.

Last year, the London

Commissioner for Medical and Dental Education selected the Trust as 'lead provider' of postgraduate medical education programmes valued at £11.5 million a year. The training programmes cover a wide range of medical and surgical specialties, with the training delivered in healthcare providers across south London.

### Nursing training

We continue to work closely with our academic partners to recruit and retain the nurses who we have supported during their training. We are proud to be able to offer nursing staff exciting opportunities to work across hospital and community settings, and to participate in research and academic work.

We offer strong mentorship support for undergraduate nurses to enhance their learning in clinical settings and provide robust foundation programmes for newly qualified nurses to ensure that they continue to receive the support they need as they enter their first year of clinical practice.

We value the hard work and commitment of our healthcare support workers and invest in their training and development. This year, we have reviewed their development opportunities, established a clear and progressive career path for this staff group and confirmed a change in title to 'nursing assistant' and 'senior nursing assistant' to reflect their crucial role within the nursing teams on our wards.

This year, our nursing staff, along with all Trust staff have been watching a powerful new film, 'Barbara's story' to improve their

awareness and understanding of the issues faced by patients with dementia.

### Research and development

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

We are one of only five National Institute for Health Research (NIHR) funded Biomedical Research Centres. As such, we are committed to driving forward research and innovation which will benefit our local population and have a positive impact on healthcare nationally and internationally.

According to the NIHR Clinical Research Network, we are one of the Trusts 'leading the way in providing opportunities for patients to take part in clinical research studies'. Their league table to 2011/12 ranks Guy's and St Thomas' third for quantity of research and ninth for number of patients involved in a study.

Our research and development portfolio is constantly increasing. The 16th Floor of Guy's Tower provides a 'one stop shop' for research expertise and is now home to a wide range of research facilities and partnerships, including: the Biomedical Research Centre; the King's Health Partners Clinical Trials Office; the Primary Care Research Network for Greater London (PCRN); the Local Research Network (CLRN) for London (South); and the South London Primary Care Research and Development team.

During the year 311 non-commercial projects involving patients and volunteers were approved, while over 1,100 active non-commercial research studies and 368 clinical trials led by commercial organisations have been taking place across the Trust and King's College London this year.

Last year, over 25,000 patients took part in clinical trials and other patient-focussed studies, making us the most successful Trust in terms of recruitment in the London (South) Comprehensive Local Research Network, which we also host. Of these, almost 18,000 were for NIHR portfolio studies.

Studies taking place across the Trust are diverse, ranging from projects looking at the causes of diseases to the use of robotics in health care, the viability of new treatments and the detailed analysis of patient samples to further understand how various diseases progress. A particular highlight this year was the first in-human trial of a therapy to fight rheumatoid arthritis using the patient's own immune system. This ground-breaking trial is being carried out by researchers from King's College London and clinicians from Guy's and St Thomas', funded by Arthritis Research UK and supported by our NIHR Biomedical Research Centre.

It is vital that we continue to increase our capacity to undertake research, so that we can expand the opportunities for our patients to take part in and benefit from that research. In 2012, a new Centre for Clinical Infection and Diagnostics Research was launched in collaboration with King's College

London, with consultant microbiologist Dr Jonathan Edgeworth appointed as its Founding Director. The centre brings together research-active doctors, nurses, scientists and epidemiologists to focus on improving the prevention, diagnosis and treatment of infectious diseases relevant to our local population and beyond.

During the summer of 2012, the Technology Strategy Board – a public body established to drive innovation – chose the Trust to host a new national cell therapy Catapult Centre. The centre will bridge the gap between academic invention and real life commercial products by addressing technical issues of cell therapies in pre-clinical studies, carrying out clinical trials and developing effective manufacturing processes. With state-of-the-art facilities, we hope that these research facilities will encourage more patients and healthy volunteers to participate in clinical studies.

We continue to award protected time to our consultant staff to enable them to carry out research and have also offered GPs the opportunity to undertake research. This has fostered a new generation of investigative talent and seen the launch of many new studies, with staff publishing over 200 articles in peer-reviewed journals as a direct result of involvement in NIHR funded research.

### Biomedical Research Centre

The NIHR-funded Biomedical Research Centre secured renewed funding of £58.7 million from April 2012 to March 2017. As a result,

the Centre has developed a new strategy for the delivery of its translational research agenda through the establishment of interdisciplinary clusters. These five clusters are: experimental medicine and therapeutics; biomarkers, co-diagnostics and imaging; population sciences; translational and experimental medicine; and operational infrastructure.

The work of the Centre is focussed on: cancer; cardiovascular disease; cutaneous medicine; environment, respiratory health and allergy; imaging and bioengineering; immunity and infection; transplantation; and translational genetics.

During the year, the Centre's capacity was boosted by the opening of new facilities. The MRC-NIHR Phenome Centre, the first of its kind in the world, will use the leading edge facilities developed for the London 2012 Games to drive more targeted treatment for patients by studying the phenome patterns in their blood and urine samples.

The Arthritis Research UK Experimental Arthritis Treatment Centre aims to investigate new and better ways to diagnose and treat patients with inflammatory arthritis.

During the year, the highly successful training schemes run by the Biomedical Research Centre continued to provide opportunities for consultants, junior doctors, allied health professionals, nurses and midwives and PhD students to secure funding for their work. The first BRC-funded PhD was awarded in November 2012 to Deborah Kronenberg-Versteeg for her work in immunology.

The Faculty of Translational Medicine continues to flourish. It brings together clinicians, scientists, nurses, midwives, allied health professionals and managers in the search for new treatments and diagnostic tests for a wide range of diseases and conditions.

### Clinical Research Facilities

The Trust is home to three Clinical Research Facilities at Guy's, St Thomas' and in the Evelina Children's Hospital. Over 90 studies involving more than 4,000 patients and healthy volunteers have taken place during the year in our clinical research facilities, helping us to find more effective ways to tackle major health problems such as obesity and heart disease.

The Trust's Clinical Research Facilities have been awarded £5.6 million to support early-stage research for people with diseases such as cancer, cardio-vascular disease, infection, transplant rejection, respiratory disease and allergies. This funding will enable more patients to be involved in clinical studies and help us to develop new and more effective treatments more quickly.

This year, the Trust and King's College London have also installed a new MRI scanner as part of a dedicated new NIHR Clinical Research Facility within the neonatal intensive care unit. This location means that premature or sick babies have immediate access to imaging facilities, and will allow researchers to study this most vulnerable group of young patients.

### Involving patients

The Trust is committed to undertaking research which involves and benefits our local population. We have worked hard to develop ways for patients, carers and family members, as well as members of the public and representatives from patient and charitable organisations to have their say about the research taking place within our hospitals.

For example, we run a quarterly community event, Café Research that gives local people the chance to hear a researcher talk about their work, ask questions and discuss research topics of interest.

The Consumer Research Panel for Cancer brings together patients and carers with experience of living with cancer who advise researchers on research design, recruitment to studies and what is important to patients who participate in trials.

We are working to demystify the research process for patients and to provide patient information to explain the benefits of taking part in research studies. We also provide research staff with a detailed guide, 'Developing information materials for research studies' to ensure that information given to patients participating in research is clear and unambiguous.



Last year we improved our welcome pack to help patients feel at ease during their stay. As well as an information booklet the pack contains a number of useful items such as a toothbrush and non slip safety socks.



## Chief Executive's statement

This quality report sets out the approach we are taking to improve quality at Guy's and St Thomas' and how we are translating this into improvements in patient care.

We aim to provide high quality, safe care for all our patients and this commitment was recognised by a number of key achievements this year:

- We were named in the top five hospital trusts in England for low mortality rates by the Dr Foster Hospital Guide, an annual independent healthcare survey published in November 2012.
- Our 'Barbara's story' dementia training video for staff was highlighted as an example of good practice in the Department of Health's response to the Francis Report and more than 10,000 of our 13,200 staff have attended a 'Barbara's story' training session.
- We met challenging targets to reduce the number of cases of both MRSA blood infections bacteraemias and *C.difficile* infections.
- The Trust met all the essential standards of quality and safety assessed by the Care Quality Commission during unannounced inspections on both the Guy's and St Thomas' hospital sites in February 2013.
- 82% of our staff, compared to a national average of 60%, would recommend Guy's and St Thomas' to their family and friends as a place to be treated, according to the results of the national staff survey published in February 2013.

Our performance improved markedly this year, especially in terms of reduced waiting times for treatment and in tackling infections, and it was 'business as usual' despite the London 2012 Games. But we are not complacent and there is still plenty of room for improvement, especially in terms of waiting times for cancer patients and for patients coming to our A&E.

The Francis Report into failings at Stafford Hospital was published in February 2013. It made shocking reading and should make all of us who work in the NHS reflect on how we can ensure that we provide the highest quality care. One of the key lessons from the Francis Report is that we must take the time to listen to and learn from the people who know the NHS best – patients and staff.

Following its publication, our Chief Nurse, Eileen Sills, led a series of listening events attended by more than 500 staff – and a further 1,300 staff took part in focus groups at ward and department level – to talk about the report's implications for the care that we provide.

I was proud that the Care Quality Commission (CQC) reported so many heartfelt comments from patients praising our staff and the care that they provide during unannounced visits to both Guy's and St Thomas' hospital sites in February 2013.

At Guy's, one patient said "Every member of staff involved in my care from the senior doctor to the person cleaning the ward are committed and friendly" while another patient said "I've been to a lot of hospitals and this is the best ward I've been on".

At St Thomas' a patient told the CQC inspectors "Staff always talk to me and explain things as they go" and another patient said "The staff are always there to help me".

We are pleased that patients and relatives who spoke to the CQC's inspectors clearly felt safe and well cared for in our hospitals which is heartening because the Francis Report must make people feel anxious about having to spend time in any hospital. The care we provide for our patients should be what we would expect for our loved ones, and I would like to thank all staff for making the CQC visits such a positive experience.



Last year CQC and OFSTED inspectors also reviewed the services we provide for looked after children and other vulnerable children who fall under safeguarding arrangements, with very positive outcomes and feedback.

In these tough financial times we must ensure that the quality of our clinical services is not compromised by the need to work more efficiently and our *'Fit for the Future'* programme sets out how quality, safety and efficiency can be balanced. Our commitment to this principle underpins our quality priorities for the 2013-14 financial year.

I look forward to working with our patients, Foundation Trust governors, staff and others who take an interest in our work and the services we provide as we redouble our efforts to provide high quality care for all our patients.

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

# Successes in 2012-13

- We consistently have one of the lowest mortality rates in the NHS in England, including out of hours and at weekends.
- We have very low levels of cardiac arrests on our wards – sustained year on year.
- We have seen a significant improvement in our inpatient experience as measured through the national inpatient survey.
- We launched 'Barbara's story', an innovative staff education programme aimed at raising awareness of patients living with dementia.
- We are one of the best performing Trusts for infection prevention – and we achieved our MRSA and *C.difficile* targets this year.
- We had no attributable grade four pressure ulcers in the last year, across our hospital and community services.
- Our community sexual health and Three Boroughs teams won a national award for their innovative outreach service to support vulnerable people.

## Where we need to improve

- Despite improvements, we need to continue to reduce waiting times for some treatments.
- Although we have made progress, we want to do more to improve our response to patients or relatives if they are unhappy with our services.

## Our quality priorities for 2013-14

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 11 quality priorities that we will focus on from 1 April 2013 to 31 March 2014.

We have selected areas that combine our hospital and community priorities, and 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, whilst 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 their care and discharge; and being treated without avoidable delays.

We agreed with our stakeholders to 'roll-over' some of last year's priorities as many of our priorities are major areas of work which will take several years to fully implement. In addition, 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 2013-14 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.

### How we chose our priorities

At our 2012 King's Health Partners 'Safety Connections' conference we distributed questionnaires to our staff asking for their ideas about what should be included in this year's Quality Accounts.

Our list of quality priorities was then considered by our governors, Local Involvement Networks (LINKs), our commissioners, local GPs, local authority health Overview and Scrutiny Committees and our colleagues from King's College Hospital at two stakeholder events. We asked them to review, comment and add to the priorities.

The Chief Nurse and Medical Director informed the Board of Directors and the Trust Management Executive of our priorities in March 2013, and these were then agreed.

## Patient safety

### Our quality priorities and why we chose them

#### Keep our patients safe and reduce the risk of harm

A continued focus on reducing the major harms in hospital; with a particular emphasis on pressure ulcers, falls, infection and never events/serious incidents.

We have chosen this priority to support our trust objective to become a UK leader in reducing avoidable harm and provide our patients with an excellent experience. Continually seeking areas where safety can be improved will ensure that we do not rest on past success but identify further improvement opportunities.

#### Keep everyone informed about our performance

Transforming how we publish and present our outcome data to our patients and the public. We want to make a wide range of information about our performance available.

We believe that being open and transparent about our safety record and our outcomes will ensure that our local community and patients are able to hold us to account and will strengthen how we continue to learn and improve.

#### Capture how we are doing

Continue to use the national safety thermometer<sup>1</sup> across our hospital and community services. We want to be able to compare our performance on safety with trusts across the country to achieve our goal of leading in the reduction of avoidable harm.

### What success will look like

- We will reduce pressure ulcers in line with our CQUIN targets, with zero attributable grade 4 pressure ulcers across our hospitals and community services.
- We will reduce moderate and severe harm events associated with falls by at least 10% in our hospitals and inpatient community services.
- We will achieve our 2013-14 *C.difficile* target of no more than 47 cases during the year.
- We will have put in place an improvement programme to reduce the number of urinary tract infections associated with catheters.
- We will achieve 100% compliance with the WHO surgical safety checklist in all areas where our policy requires it to be used.
- We will have zero 'never events'.

- We will create a 'hub' of quality and patient experience information on our website, increasing the frequency, content and quality of data that we publish, including links to information about our services published by other organisations.
- Each hospital ward and community inpatient service will publish its Family and Friends Test results and provide regular updates on other performance and patient safety measures, including the number of days since the last patient safety incident and what has been done to prevent it happening again.

- In line with our acute and community CQUIN; we will embed the national patient safety thermometer in the hospital and roll this out to our community services.

(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.

## Clinical effectiveness

### Our quality priorities and why we chose them

#### Focus on quality standards from Board to ward

Assuring the Board of our quality standards and reducing the administrative burden on our front-line clinical staff.

#### Improve communication between GPs and community nurses

Reliable and consistent communication between GPs and community nurses is essential to ensure our local community receives high quality community healthcare. Improvements were made in 2012-13 but we believe we can do this even better and more consistently.

#### Protect the future health of local children

by improving childhood immunisation rates across Lambeth and Southwark. Poor immunisation rates can lead to an increase in preventable disease with the potential for devastating impact on children and their families. We want to increase our immunisation rates to improve the health of our local children.

### What success will look like

- Weekly 'Board to Ward' quality reviews will be considered by the Trust's executive directors.
- Board to Ward quality improvement: Trust executive directors will 'use & test' systems as if they were a ward sister or junior doctor.
- Report progress via the quarterly Quality and Patient Safety Report.

- We will see further improvement in consistent communication between the community nursing teams and the patient's GP after initial assessment of a patient and following discharge.

- We will continue this improvement programme and will achieve our CQUIN target to increase the proportion of MMR1 and pre-school booster immunisations.

## Our quality priorities for 2013-14

### Patient experience

#### Our quality priorities and why we chose them

##### Improve our complaints and PALs services

Complaints provide us with valuable feedback from our patients and their families. We want to ensure that patients are satisfied with how we respond to their complaints and that we miss no opportunity to learn from what they tell us.

##### Improve the care of older people

A continued focus on patients with dementia and their carers. The majority of our patient contacts are with people over 65. We want to ensure that we are responsive to the needs of our most vulnerable patients and provide staff with the support they need to ensure that our patients are protected, safe and that their dignity is maintained.

##### Extend user involvement in our quality checks

Known as the ward accreditation assessment which we carry out on each hospital ward and in each community inpatient service each year. Providing high quality care for patients is a key priority. We want to have a responsive approach to monitoring the standards of care which reflects the views and experiences of our patients. Involving representatives from our local community, including Foundation Trust governor members and Healthwatch bodies in Lambeth and Southwark, in these assessments will help ensure the assessments and subsequent action plans are informed by feedback on what matters most to our patients.

##### Achieve our hospital and community patient experience CQUIN targets

The Trust is committed to listening to and learning from our patients. We want to ensure that as many of our patients as possible have a positive experience of care across all settings of care. We want to ensure that we have timely feedback from patients to ensure that we can respond promptly to any suggestions for improvement.

##### Improve our outpatient department efficiency

We have a brand new outpatient centre at St Thomas' but can do more to improve efficiency and the patient experience. We want our patients to have a good experience of our outpatient services. Patients tell us that their experience is generally good but we believe we can do even better by continuing to reduce waiting times. When patients do not attend an appointment an opportunity for another patient to be seen is lost. We therefore want to work with patients to make appointments that are convenient for them and they are able to keep.

#### What success will look like

- We will formally review both our complaints and PALs services and will recommend and consult on improvements to processes that will ensure rapid Trust-wide learning from the feedback we receive.
- We will improve the timeliness and quality of our responses to complaints.

- In line with our CQUIN target we will focus on individualised care for patients with dementia, including early assessment, identification and intervention, and we will also focus on 'caring for the carers' of patients with dementia.
- We will see an increase of 10% in referrals to the delirium and dementia team (DAD).
- We will achieve a 30% increase in use of the delirium bundle.
- We will build on the work we have done using Barbara's story to develop a culture of understanding, knowledge and empathy amongst all staff and will take forward the next phase of that project.

- We continually assess the quality of our care, including through the annual Safe in Our Hands ward accreditation assessment carried out by our staff and governors. We invite representatives from our local community to participate in the assessments and feedback sessions.
- Following our recent pilot, we will further develop our 'mystery shopper' programme and report our findings and actions to the Board.

- We will roll out and embed the Family and Friends Test across our hospital wards and the Accident and Emergency department at St Thomas'.
- We will achieve our community patient experience CQUIN and roll-out of the 'Near Patient Experience' system to our community services.

- We will reduce the number of patients who 'do not attend' for their appointment.
- We will reduce how long patients have to wait for their first appointment.
- We will reduce outpatient clinic waiting times.

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## 2.1 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.

## 2.2 A review of our services

During the reporting period 2012-13 Guy's and St Thomas' provided 60 NHS services, this number includes both hospital and community services. The detailed list of services is available in the Trust's Statement of Purpose.

The Trust has reviewed all the data available on the quality of care in all of these services through its performance management framework and its assurance processes.

The income generated by the services reviewed in 2012-13 represents 100 per cent of the total income received for the provision of NHS services in 2012-13.

## 2.3 Participation in clinical audits and National Confidential Enquiries

A clinical audit aims to improve patient care by reviewing services and making changes where necessary. National Confidential Enquiries investigate an area of healthcare and recommend ways to improve it.

We are committed to participating in relevant National Confidential Enquiries to help assess the quality of healthcare nationally and to make improvements in safety and effectiveness.

During 2012-13 we took part in 44 national clinical audits and three national confidential enquiries. By doing so, we participated in 95 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 and National Confidential Enquiries that we were eligible to participate in during 2012-13 are shown in the table on the following pages, together with those that we participated in and for which data collection was completed during 2012-13. 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.



## National clinical audits 2012-13

Audit title	Participation	% cases submitted
<b>Women and children's health</b>		
Child health programme (CHR-UK) (also known as the Child Health Clinical Outcome Review Programme)	Yes	100%
Epilepsy 12 audit (childhood epilepsy)	Yes	100%
Neonatal intensive and special care (NNAP) (subscription funded from April 2012)	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	100%
Paediatric fever (College of Emergency Medicine)	Yes	100%
Paediatric intensive care (PICANet)	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	100%
<b>Acute care</b>		
Adult community acquired pneumonia (British Thoracic Society)	Yes	100%
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
Emergency use of oxygen (British Thoracic Society)	Yes	100%
National Joint Registry (NJR)	Yes	97% Q1, 100% Q2, Q3 & Q4 not yet available
Non-invasive ventilation – adults (British Thoracic Society)	Yes	100%
Renal colic (College of Emergency Medicine)	Yes	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	60%
<b>Long term conditions</b>		
Adult asthma (British Thoracic Society)	Yes	100%
Bronchiectasis (British Thoracic Society)	No relevant cases to report	No relevant cases to report
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%
Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services (previously listed separately in 2010-11 quality accounts)	Yes	100%
Pain database	No	We were not asked to participate
Renal replacement therapy (Renal Registry)	Yes	100%
Renal transplantation (NHSBT UK Transplant Registry)	Yes	100%
<b>Heart</b>		
Acute coronary syndrome or acute myocardial infarction (MINAP) (subscription funded from April 2012)	Yes	100%
Adult cardiac surgery audit (ACS)	Yes	100%
Cardiac arrhythmia (HRM)	Yes	100%
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	100%
Coronary angioplasty (subscription funded from April 2012)	Yes	100%
Heart failure (HF) (subscription funded from April 2012)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	100%
Pulmonary hypertension audit	N/A	We are an outreach centre for the Royal Free Hospital
<b>Mental health</b>		
National audit of psychological therapies (NAPT)	N/A	N/A
Prescribing Observatory for Mental Health (POMH) (Prescribing in mental health services)	N/A	N/A

## National clinical audits 2012-13

### Older people

Carotid interventions audit (CIA) (subscription funded from April 2012)	Yes	100%
Fractured neck of femur	Yes	100%
Hip fracture database (NHFD)	Yes	100%
National audit of dementia (NAD)	Yes	85% STH site
Parkinson's Disease (National Parkinson's Audit)	Yes	100%
Sentinel Stroke	Yes	100%
National Audit Programme (SSNAP) – programme combines the following audits, which were previously listed separately:		
a) Sentinel stroke audit (2010-11, 2012-13)		
b) Stroke improvement national audit project (2011-12, 2012-13)		

### Other

Elective surgery (National PROMs Programme)	Yes	12/13 data not available from national programme at time of report
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### Cancer

Bowel cancer (NBOCAP) (subscription funded from April 2012)	Yes	100%
Head and neck oncology (DAHNO) (subscription funded from April 2012)	Yes	100%
Lung cancer (NLCA) (subscription funded from April 2012)	Yes	100%
Oesophago-gastric cancer (NAOGC) (subscription funded from April 2012)	Yes	100%

### Blood and transplant

Intra-thoracic transplantation (NHSBT UK Transplant Registry)	N/A	N/A
National Comparative Audit of Blood Transfusion – programme includes the following audits, which were previously listed separately:	Yes	100%
a) O neg blood use (2010-11)		
b) Medical use of blood (2011-12)		
c) Bedside transfusion (2011-12)		
d) Platelet use (2010-11)		
Potential donor audit (NHS Blood and Transplant)	Yes	100%

## National Confidential Enquiries 2012-13

Medical and surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (also known as Medical and Surgical Clinical Outcome Review Programme, or Patient Outcome and Death)	Yes	100%
National Review of Asthma Deaths (NRAD)	Yes	100%
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) (also known as suicide and homicide in mental health, or the Mental Health Clinical Outcome Review Programme)	N/A	N/A
Maternal, infant and newborn programme (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical Outcome Review Programme)	We are waiting to hear more about the pilot phase and currently collecting paper records in the Neonatal Intensive Care Unit (NICU) for calendar year 2013.	
* This programme was previously also listed as Perinatal Mortality (in 2010-11, 2011-12 Quality Accounts)		

The reports of 30 national clinical audits were reviewed in 2012-13 and we intend to take the following actions to improve the quality of the healthcare we provide:

- Following the National Diabetes Audit, the Trust continues to implement actions through the Safety and Quality Improvement Group in Diabetes. The Think Glucose campaign is targeting tighter glycaemic control for patients.
- The neonatal team continue to promote a number of standards in the NNAP project. Actions have included a review of individual circumstances where antenatal steroids were not given, the introduction in 2012 of transport incubators for transfers from the Birth Centre, the introduction of review forms for hypothermia and the continued promotion of breast milk feeds.
- The Trust's Organ Donation Committee, chaired by the Medical Director, looks at the data from the potential donor audit quarterly and addresses any concerns. They also discuss individual cases with the senior doctor involved. The committee use the data to develop an annual plan for promoting and facilitating organ donation in the Trust.

The reports of 231 local clinical audits were reviewed last year and the Trust intends to take the following actions to improve the quality of our services:

- A number of actions have been implemented following a pharmacy audit to improve prescribing accuracy. These include an amended list of abbreviations now available on the intranet, a promotional campaign for the revised inpatient drug chart, featuring the completion of the prescriber's printed name and registration number as key messages, and further reinforcement of messages around recording of pharmacist initials and time of review on the inpatient drug chart.
- Improving the traceability of all blood components from donor to recipient. A new procedure was devised by the blood transfusion team to mimic that used when administering controlled drugs. The new procedure has been audited and, over a six month period, compliance rose from 91 per cent to 97 per cent.
- A significant proportion of patients admitted to hospital require the administration of intravenous (IV) fluids as part of their treatment. A local guideline was put together by a multi-disciplinary team in acute medicine, based on national guidance, and has established seven local 'gold standards' surrounding IV fluid usage. Audits were carried out pre and post guideline implementation on 53 and 48 patients respectively. All seven local 'gold standards' showed improved compliance. In one standard, compliance increased to 100 per cent from a previous position of 29 per cent compliance.

Further detail on clinical audit and improvements can be found in the Annual Clinical Audit report 2012-13.

### Trustwide audit projects

In addition to the national clinical audits, Trustwide projects also inform NHSLA compliance and compliance with the CQC Essential Standards of Quality and Safety. The clinical governance team work with senior clinicians to translate these monitoring exercises into quality improvement and patient focussed clinical audits.

This year has seen the introduction of quarterly snapshot audits of the quality of documentation. These review eight patients on every ward and look at whether their records meet the documentation standards of the Trust, along with other aspects of the record such as completion of falls documentation, consent information and discharge planning. By doing these smaller audits more frequently, we aim to achieve more targeted improvements in a shorter timescale.

Other projects include the Trustwide falls audit, which continues to show strong compliance with use of the STRATIFY falls assessment tool. The patient identification audit has led to improvements in ensuring all required information is included on identity bracelets, and audits of the nursing Patient Care Assessment Plan have shown an improvement in levels of completion.

## Community audit projects

Every service in the community was asked to carry out a quality improvement project in 2012-13. Teams could choose whether to re-audit a project from a previous year, or to carry out a new clinical audit. There were a wide range of topics, many of them aligned to the quality priorities for 2012-13, such as new birth visits and pre-school immunisations.

Our community services took part in a local project to assess a quality tool which looked at how aware staff were of local governance arrangements. The inpatient community services also took part in the NHSLA documentation audit in December 2012.

The results of the foot health team's audits led to reduced waits for appointments and no overdue patients. The number of complaints received by this team has reduced by 50 per cent as a result.

## Safety Connections Conference 2012

In October last year the Trust held its second Safety Connections Conference, which was, for the first time, a joint event across King's Health Partners. The event featured a mix of internal and external speakers covering a wide range of patient safety topics. These included safety lessons learned from the other industries, including the London 2012 Games and the construction of the Shard; care and compassion; and educating staff for safety.

Each afternoon the conference featured 30 different *Safety Connections workshops* – 45-90 minute sessions which covered topics such as turning complaints into service improvements, writing for publication and learning from medication safety incidents.

There was also a poster competition, showcasing quality improvement and patient safety initiatives over the past year which have made a difference to patients. There were eight categories, with the winners in each receiving a prize and a certificate. Over 50 entries were received, 22 of which were shortlisted into eight categories. Four categories were won by Trust staff. These were:

Category	Winning poster
Education and training in patient safety	Medicines safety lectures and posters for pharmacy staff
Technology and IT to improve patient safety	Wound care for Epidermolysis Bullosa
Patient involvement in patient safety projects	Patient empowerment for blood transfusion
Partnership working	Pre-printed electronic operation notes for transplant cases to improve access to vital information

Over a hundred conference attendees signalled their interest in joining a 'Safety Connections Network' and this is being taken forward by the steering group, with a series of network events to be held over the next year. It is proposed to hold the next Safety Connections Conference in February 2014.

### 2.4 Our participation in clinical research

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

We are part of King's Health Partners; one of five accredited Academic Health Sciences Centres in the UK. A wide cross section of research was carried out last year, some of which focussed on the service areas we specialise in, including allergy, dental services, women's health, cardiovascular services and renal transplantation.

During 2012-13, 311 non commercial studies began, as well as 71 commercial studies. Last year, over 29,000 patients took part in research which was approved by our research ethics committee (NRES). During 2012-13, over 1,000 clinical research studies were active. We used the nationally recommended systems and protocols to manage these studies and to ensure that the results are passed into practice in a timely and safe manner.

Guy's and St Thomas' and King's Health Partners are at the cutting edge of national and international research. We managed over £7 million of research grants for the National Institute Health Research in 2012-13. More detail about the research we do at the Trust can be found in chapter five of the annual report.

**Number of active non-commercial (portfolio) projects – 472**

**Number of active non-commercial (non-portfolio) projects – 634**

**Number of non-commercial studies registered – 311 (174 portfolio studies)**

**Commercial studies registered – 77 (41 portfolio studies)**

**Number of recruits in non-portfolio non-commercial trials – 18,000+**

**Number of recruits in portfolio non-commercial trials – 11,055**

**Number of recruits in commercial trials – 1,627**

#### *Our research studies by groupings within King's Health Partners*

Studies split by group	Commercial active trial totals	Non-commercial active trial totals
Allergy, respiratory, critical care and anaesthetics, therapies	14	108
Cancer, haematology and palliative care	163	220
Cardiovascular	46	65
Child health	15	97
Dental	32	83
Diabetes, endocrine, nutrition, obesity, vision and related surgeries	34	71
Genetics, rheumatology, infection and dermatology	36	167
Imaging and biomedical engineering	3	51
Liver, renal, urology, transplant and gastro/GI surgery	17	86
Medicine	1	81
Orthopaedics, trauma, emergency, ENT and plastics	4	21
Pharmaceutical sciences	0	10
Women's health	3	45
<b>Total</b>	<b>368</b>	<b>1,106</b>

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## 2.5 Our 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; and a proportion of our income is conditional on achieving these goals. This system is called the Commissioning for Quality and Innovation (CQUIN) payment framework.

In 2011-12, 1.5 per cent of our clinical income depended on achieving these goals. This equated to £10 million of our income for 2011-12, and we secured 94.12 per cent of this.

In 2012-13, 2.5 per cent of our clinical income depended on achieving quality improvement and innovation goals agreed with Lambeth, Southwark and Lewisham Primary Care Trusts and the Specialist Services Commissioners. This equated to over £17 million of our total income for 2012-13, we have achieved virtually all the targets and secured more than 90 per cent of this income.

## 2.6 Statements from the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Guy's and St Thomas' NHS Foundation Trust during 2012-13.

Guy's and St Thomas' NHS Foundation Trust is subject to periodic review by the Care Quality Commission and three sites were inspected in March 2013 – St Thomas' Hospital, Guy's Hospital and our renal satellite unit at Tunbridge Wells. The Trust was found to be fully compliant with the Essential Standards of Quality and Safety that were assessed.

The reports of these inspections are available on the CQC website.

## 2.7 Our 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 and commissioned an independent external review of our processes. Since then, we have sought further external review of our pathway management reporting arrangements from the Department of Health's Intensive Support Team, with very positive findings.

The quality of our clinical coding has been a concern and this is being addressed through an extensive education programme, linked to improved use of electronic record-keeping, and this is being led by the Medical Director.

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

The percentage of records in the published data that included a patient's valid NHS number was 98.1 per cent of inpatients, 98.2 per cent of outpatients, and 82.7 per cent of accident and emergency patients.

The percentage of records which had the patient's valid GP registration code was 97.9 per cent of inpatients, 96.2 per cent of outpatients, and 93.6 per cent of accident and emergency patients.

## 2.8 Information governance toolkit

Good information governance means keeping the information we hold about our patients and staff safe.

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

Our Information Governance Assessment Report overall score for 2012-13 was 74 per cent and was graded green.



## 2.9 Our clinical coding error rate

During 2012-13 we were subject to the Payment by Results clinical coding audit by the Audit Commission. The error rates reported in the draft audit for diagnoses and treatment coding (clinical coding) were 60 per cent higher than in 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 – 27 per cent
- secondary diagnosis incorrect – 39 per cent
- primary procedures incorrect – 33 per cent
- secondary procedures incorrect – 46 per cent.

We code our episodes based on our electronic patient record whereas the audit is based on the paper record. The audit concluded that we underestimated the complexity and value of our care. We have achieved significant improvements in the quality of our coding during 2012-13 and have a well established project to continue that improvement in 2013-14.

## 2.10 Mortality

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

The Trust believes our excellent SHMI score is the result of the following:

- Our ongoing work focussed on patient safety and quality which aims to ensure that all our patients receive the highest quality care.
- We also have a low mortality rate at weekends; which is a marker of consistent, safe care both in and out of normal working hours, and contributes to our below average SHMI score.
- Our mortality rate has shown a significant improvement since 2010, and improvements in clinical coding during the past year have contributed to this.

We have taken the following actions to further improve the quality of our services:

- Ongoing quality improvement programmes focussed on how we treat patients with serious infection or acute kidney injury, and on the management of frail older patients, particularly those with dementia.
- Closely monitoring mortality data by ward, speciality and diagnosis, with detailed reviews if there are any trends that raise a concern.
- Systematic reviews of patients who suffer a cardiac arrest on our wards, to identify any factors that may have been avoidable so these can inform our future patient safety work.

Our low mortality rates were noted in the Dr Foster 'Is your hospital fit for the future' report published in 2012. The report can be found here: <http://drfosterintelligence.co.uk/thought-leadership/hospital-guide>

Summary Hospital-level Mortality Indicator	2010/11				2011/12				2012/13	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Guy's and St Thomas'	92.09	89.5	94.68	86.92	85.44	83.95	90.63	91.68	77.17	72.36
National average										100
Highest Trust Q2 2012/13										63.37
Lowest Trust Q2 2012/13										116.37

Data source: Health and Social Care Information Centre

## 2.11 Patient reported outcome measures

Patient reported outcome measures (PROMs) measure quality from the patient perspective, and seek to calculate the health gain experienced by patients following one of the following four clinical procedures:

- Hip replacement
- Knee replacement
- Hernia repair
- Varicose vein treatment.

Patients who have these procedures are asked to complete a short questionnaire which measures a patient's health status or health related quality of life at a single point in time. Patients are given the same questionnaire both before and after their surgery or treatment. The difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient.

The health status information captured from patients in this way provides an indication of the quality of care delivered. In the table below a higher number shows that patients have experienced a greater improvement in their health.

Hip replacement	Adjusted average health gain		
	2009/10	2010/11	2011/12
<b>Guy's and St Thomas'</b>	<b>0.366</b>	<b>0.377</b>	<b>0.411</b>
2011/12 average			0.416
Lowest 2011/12			0.316
Highest 2011/12			0.469

Hernia repair	Adjusted average health gain		
	2009/10	2010/11	2011/12
<b>Guy's and St Thomas'</b>	<b>0.067</b>	<b>0.052</b>	<b>0.082</b>
2011/12 average			0.087
Lowest 2011/12			0.003
Highest 2011/12			0.143

Knee replacement	Adjusted average health gain		
	2009/10	2010/11	2011/12
<b>Guy's and St Thomas'</b>	<b>0.261</b>	<b>0.281</b>	<b>0.248</b>
2011/12 average			0.302
Lowest 2011/12			0.18
Highest 2011/12			0.371

Varicose vein treatment	Adjusted average health gain		
	2009/10	2010/11	2011/12
<b>Guy's and St Thomas'</b>	<b>0.095</b>	<b>0.074</b>	<b>0.086</b>
2011/12 average			0.094
Lowest 2011/12			0.047
Highest 2011/12			0.167

Data source: Health and Social Care Information Centre

Scores for the Trust show that the perceptions of health gain among patients across all four procedures are slightly below average. We believe this is because:

- The number of patients completing a PROMs questionnaire needs to be increased as the low response rate in some areas has an impact on the reported results.
- We are a specialist referral centre and so we often treat patients with complex treatment needs and whose perception of health gain may be influenced by other health factors.

We are taking the following actions to improve the quality of our services:

- Regularly reviewing scores at service and Trust level to increase our responsiveness to feedback from patients and so patient views can be incorporated into our quality improvement programmes.
- Increasing the involvement and understanding of staff in how we use the information received through PROMs, and working with staff to increase response rates.
- Providing better support from our central quality improvement team if patients need help to complete the questionnaire.

## 2.12 Readmission within 28 days of discharge

At the time of this report, the information available from the Health Information Centre does not include 2011-12 or 2012-13 data. We have therefore included Trust data for these periods.

The unplanned readmission rate for adult patients treated at Guy's and St Thomas' is similar to the NHS average. We believe our performance reflects that we are a large Trust that treats both local patients and patients with specialist or complex medical conditions.

Emergency readmissions to hospital within 28 days patients under 14 years	2009/10	2010/11	2011/12	2012/13
Total spells	13,215	14,201	14,775	14,866
Readmissions within 28 days	562	535	582	589
28 Day readmission rate	4.25%	3.77%	3.94%	3.96%

Emergency readmissions to hospital within 28 days patients 15 years and over	2009/10	2010/11	2011/12	2012/13
Total spells	44,568	48,820	51,668	50,689
Readmissions within 28 days	3,345	4,273	4,487	4,743
28 Day readmission rate	7.51%	8.75%	8.68%	9.36%

We are taking the following actions to reduce the number of patients requiring readmission:

- Our outcomes group continues to monitor readmissions on a monthly basis and identifies any areas where there is a trend or change which may be a cause for concern.
- Our elderly care team reviews all cases at multi-disciplinary team meetings, and is actively seeking to improve clinical practice.
- We are working with GPs and community teams to review patients who have been readmitted so that we can agree specific actions for these patients, and also plan and develop a better health care for the future.

## 2.13 Patient experience

Our composite score for the national inpatient survey's five questions relating to responsiveness to personal care is above the regional and national average when compared with the trend data in the Department of Health's 'A tool for patient responsiveness to inpatients' personal needs'.

A number of initiatives have contributed to this improvement. Over the past few years, our clinical directorates have developed individual patient experience action plans focussed on the five questions. In addition, Trustwide initiatives, such the development of a ward information pack and introduction of 'comfort rounds' on inpatient wards, have helped patients to feel more involved in their care and have provided increased opportunities for them to raise any concerns they may have.

When reviewing the responses to the individual questions that contribute to the overall score, as well as the Trust's local survey results, we recognise that there is room for further improvement. For example, we want to do more to involve patients in their care, to ensure patients know who to speak to if they have any worries or fears, and to explain their medication and any side effects more clearly.

We will continue to develop and implement action plans to respond to these issues. We are also planning further work to understand the issues that impact our patients' experience as they prepare to leave hospital. We will then develop plans to improve these aspects of their care.

Responsiveness to the personal needs of patients	2008/09	2009/10	2010/11	2011/12	2012/13
Guy's and St Thomas'	67.6	66.3	65.5	69.7	71.4
2011/12 national average	67.1	66.7	67.3	67.4	68.1
Highest 2011/12				85	
Lowest 2011/12				56.5	

Data source: Health and Social Care Information Centre

## 2.14 Staff recommendation to family and friends

The Trust has high levels of staff engagement and our results in the new Friends and Family Test show that staff perception of the Trust's services continues to be high. The Trust was in the top 20 per cent when compared to all hospital trusts nationally, and we believe the willingness of staff to recommend the Trust as a place to be treated is a strong and positive indicator of the standard of care provided.

Percentage of staff who would recommend the Trust to family or friends	2009/10	2010/11	2011/12	2012/13
Guy's and St Thomas'	82	85	85	82
2012/13 average (median)				60
Highest 2012/13				86
Lowest 2012/13				35

Data source: Health and Social Care Information Centre

### 2.15 Infection control

Our performance on infection prevention and control represents continued improvement. The significant change in the data since 2010 relates to the introduction of new testing regimes, as required by the Department of Health, with the new test having a significantly higher sensitivity than those previously used across the NHS. The peak of cases in 2011 relates to the reporting of all individuals in whom *C.difficile* was identified through the new test, not all of whom showed signs of infection. However, in accordance with the Department of Health reporting requirements, from January 2012, reporting of cases has been restricted to those with infection as identified by the presence of toxins, and demonstrates our improving performance.

The Trust will continue to implement a range of actions to tackle infection and improve the quality of our services. These include antibiotic stewardship and improved environmental hygiene, supported by continuous staff engagement and education.

C-difficile rates per 100,000 bed-days	2009/10	2010/11	2011/12	2012/13
Bed-days	303,658	304,692	304,843	346,706
C.difficile cases	72	120	107	48
C.difficile rate	23.7	39.4	35.1	13.8
2011/12 national average			21.8	
Highest 2011/12			51.6	
Lowest 2011/12			0	

Data source: Health and Social Care Information Centre

### 2.16 Patient safety incidents

#### Patient safety incidents resulting in severe harm or death

This is the first time that this indicator has been reported in our Quality Accounts, including comparative data, where available, from the Health and Social Care Information Centre.

The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning.

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to report patient safety incidents under the NRLS's voluntary arrangements.

As there is no nationally established and regulated approach to the reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance when reporting, categorising and validating patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals.

In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation and this may result in the classification being changed. This change may not be reported externally and the data held by a trust may therefore differ from that held by the NRLS. This may make it difficult to explain the differences between the data reported by different trusts as the data may not be directly comparable.



The Trust's reporting rate for patient safety incidents is above the NHS average, and we believe this reflects a positive culture for reporting all patient safety incidents, including 'near misses' and any unexpected deaths. All incidents reported as resulting in moderate or severe harm, or death, are fully investigated and final classification may later be altered, depending on the outcome of the investigation. It is rare that a death or severe harm incident is confirmed as avoidable and the outcome of an error.

A high incident reporting rate is considered an indicator of an open and transparent organisation that uses incidents to learn and make improvements in care.

We are taking the following actions to improve our incident reporting rate and so the quality of our services:

- Our on-line incident reporting system, Datix, is being simplified to encourage timely and accurate incident reporting.
- Training in the reporting and investigation of incidents is being extended to more of our clinical teams.
- All managers are formally trained in 'root cause analysis' so that we learn from incidents and can improve our systems and knowledge where necessary.
- The outcomes of our investigations feed into our quality improvement work.

Number of patient safety incidents reported and rate per 100 admissions	Apr 11 - Sept 11	Oct 11 - Mar 12	Apr 12 - Sept 12
Total number of incidents reported	4,189	4,925	5,222
Incident report rate per 100 admissions	6.5	7.6	7.6
Reported incidents causing severe harm or death	19	15	19
Percentage of incidents causing severe harm or death	0.45%	0.30%	0.36%
April to September 2012 acute teaching trusts median reporting rate			6.8
April to September 2012 acute teaching trusts average % of incidents causing severe harm or death			0.50%
April to September 2012 lowest reporting rate			2.8
April to September 2012 highest reporting rate			12.1
April to September 2012 lowest % of incidents causing severe harm or death			0%
April to September 2012 highest % of incidents causing severe harm or death			2.10%

The data in this table comes from the National Reporting and Learning System (NRLS) and only provides information for six months of 2012-13. Data available from our internal incident management database gave figures for the entire year of 0.28% for incidents causing severe harm or death.

### 2.17 Venous thrombo-embolism

Venous thrombo-embolism – VTE, or blood clots – is a major cause of death in the UK. Some blood clots can be prevented by early assessment. Over the last year we have worked hard to improve our VTE assessment figures so that over 95 per cent patients are now assessed for their risk of thrombosis and bleeding on admission to hospital. We have exceeded the national target of 90 per cent. In addition we have exceeded our target for appropriate thromboprophylaxis, and we give all our patients written information about hospital acquired thrombosis before they leave hospital.

Our clinical staff remain at the forefront of venous thrombo-embolism care nationally and internationally, including through clinical research and service development. Over the coming year we are looking to further increase the number of patients assessed for VTE risk through improved education programmes across the Trust.

Rate of admitted patients assessed for VTE	2011/12				2012/13			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Assessed	48,687	51,365	51,098	52,486	51,743	52,253	51,984	51,664
Admitted	53,077	55,699	55,814	56,848	55,453	55,607	55,118	54,334
<b>Guy's and St Thomas'</b>	<b>91.7%</b>	<b>92.2%</b>	<b>91.6%</b>	<b>92.3%</b>	<b>93.3%</b>	<b>94.0%</b>	<b>94.3%</b>	<b>95.09%</b>
2012/13 Q3 average							94.1%	
2012/13 Q3 highest							100%	
2012/13 Q3 lowest							84.6%	
NHS target	90%	90%	90%	90%	92%	92%	92%	92%

Data source: Health and Social Care Information Centre

# Progress against priorities for 2012-13

Of the 10 targets we set ourselves in last year's Quality Accounts, we have fully achieved six (60%), partially achieved three (30%) and did not achieve one (10%). Details of our progress against priorities are in the following tables. Where a priority is also a CQUIN target, our predictions are based on our submission to the Primary Care Trust in December 2012 (quarter 3). The final position will not be confirmed until June 2013.

All the data used to assess our success in achieving our objectives has been derived from the Trust performance management systems and all indicators used adhere to national definitions where applicable.

## How did we do against last year's priorities?

Patient safety		
Our quality priorities and why we chose them	What success will look like	How did we do?
<b>Improving staff knowledge of patient safety</b> 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"> <li>– In line with our CQUIN targets, we will introduce the national NHS safety thermometer tool<sup>1</sup> in our high risk wards and departments by the end of March 2013.</li> <li>– We will recruit 130 students to assist ward staff in collecting and analysing data for weekly safety reports.</li> </ul>	We achieved this. <sup>2</sup> We rolled the national safety Thermometer out to over 40 clinical areas, and provided teaching to over 140 student nurses on data collection and patient safety methods. (based on Q3 CQUIN data)
<b>Reducing severe harm events</b> 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"> <li>– We will further reduce fall-related fractures in hospital by 10 per cent.</li> <li>– We will have zero attributable grade 4 pressure ulcers across our hospital and community sites.</li> <li>– 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.</li> <li>– We will achieve our hospital MRSA and <i>C.difficile</i> targets.</li> </ul>	We partially achieved this. <sup>3</sup> Although the number of patients who suffer a falls related fracture continue to remain very low, we did not achieve the target that we set ourselves and we are working hard to improve this. We have achieved the hospital pressure ulcer target that we set ourselves. We have achieved our infection control targets for MRSA and <i>C.difficile</i> . These priorities will be 'rolled over' into this year's Quality Accounts.
<b>Increase new birth visits</b> 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"> <li>– We will increase the percentage of newborn babies who receive a visit within 14 days to at least 95 per cent by the end of March 2013.</li> </ul>	We achieved this. <sup>4</sup>

(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) Data based on our NHS safety thermometer submissions to the Department of Health database in accordance with the national definitions.

(3) Falls and pressure ulcer data as per national definitions and *C.difficile* and MRSA as per our submissions to Health Protection Agency in accordance with national definitions.

(4) Data source from our community service performance information as per national definitions.

## Progress against 2012-13 priorities

Clinical effectiveness		
Our quality priorities and why we chose them	What success will look like	How did we do?
<b>Improve the efficiency of outpatient services</b> 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"> <li>– We will reduce how long our patients have to wait for their first appointment.</li> <li>– We will reduce clinic waiting times.</li> <li>– We will reduce the number of patients who 'did not attend' or cancel their appointment.</li> </ul>	We did not achieve this. <sup>1</sup> Although we have made many improvements during the year, including opening a new state-of-the-art outpatient department and making some progress against these targets, overall we did not deliver sustained improvement.  These priorities will be 'rolled over' into this year's Quality Accounts.
<b>Supporting our ward sisters/charge nurses</b> 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"> <li>– We will support staff and strengthen the voice, role and accountability of the ward sister across our hospitals and in the community.</li> <li>– We will establish a ward leaders expert group to drive quality improvements.</li> <li>– We will further strengthen the links between ward leaders and senior ward doctors (specialist registrars).</li> </ul>	We achieved this. <sup>2</sup> We launched and evaluated an innovative sisters' development programme.  We have a dynamic expert sisters group, which reports directly to the Chief Nurse, advising on key quality issues at ward level.  We established a new multi-professional patient experience group, this group includes sisters, doctors and managers from across the Trust, and has recently been supported by the Trust's Dignity Champions.
<b>Improving childhood immunisation rates</b> 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"> <li>– In line with our CQUIN targets we will increase the proportion of MMR2 and pre-school booster immunisations.</li> </ul>	We have achieved this. <sup>3</sup> (based on Q3 CQUIN data)
<b>Improve communication between GPs and community nurses.</b> Since community services were integrated into the Trust, we have improved communications between GPs and community nurses, but further improvements can be made.	<ul style="list-style-type: none"> <li>– Our community teams will confirm receipt of GP referrals.</li> <li>– Community teams will also communicate with a patient's GP after an initial assessment and when a patient is discharged from their care.</li> </ul>	We partially achieved this. <sup>4</sup>  These priorities will be 'rolled over' into next year's Quality Accounts.

(1) Data sourced from Trust systems in accordance with national definitions.

(2) This is not governed by national definitions and has been measured locally using relevant subjective indicators.

(3) Data source from our community service performance information as per national definitions.

(4) Data source from our community service performance information using local indicators designed to measure this objective.

## Patient experience

### Our quality priorities and why we chose them

### What success will look like

### How did we do?

#### 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.

- 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 rounds'<sup>1</sup> for all inpatients by the end of March 2013.

We achieved this.<sup>2</sup>

New ward welcome packs are offered to all adult inpatients on admission.

As part of the new welcome pack we have introduced a 'please ask us' card, whereby patients or family can phone to speak directly to a senior nurse 24/7.

We have rolled out 'comfort rounds' across all inpatient wards.

#### Improving the care of vulnerable patients

This will focus on patients with dementia and delirium.

- 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.

We achieved this.<sup>3</sup>

(based upon Q3 CQUIN data).

We have launched Barbara's story training programme for staff, aimed at improving the experience of patients with dementia and other vulnerable patients and their carers.

To date 10,000 staff have attended the programme.

#### 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.

- 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.

We partially achieved this.<sup>4</sup>  
(based upon Q3 CQUIN data)

Although we did not fully meet the targets set by commissioners in relation to the five CQUIN patient experience questions; we have made significant improvements in the CQC national inpatient survey.

In line with the community CQUIN, the community directorate has successfully met their target to pilot the near patient experience system in selected services.

(1) 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.

(2) This is not governed by national definitions and has been measured locally using relevant subjective indicators.

(3) Indicators measured on dementia in accordance with national or London definitions.

(4) Data from national and local surveys.



### National targets

In carrying out their formal audit of these Quality Accounts, the auditors conducted a detailed review of two areas of the Trust's performance against national indicators as required by Monitor. These were our performance against:

- 62 day cancer waits;
- *C.difficile*.

We have included details about our performance against both these indicators here.

### Cancer targets

Clinical evidence demonstrates that the sooner patients with cancer symptoms are assessed, diagnosed and treated, the better their clinical outcomes and survival rates.

Last year we continued to achieve most of the national cancer targets, despite increasing numbers of patients requiring fast track investigations and treatment.

In 2012-13, the Trust achieved the 62 day cancer referral to treatment target 82 per cent of that time, against a target of 85 per cent. Performance in 2011-12 was 83.5 per cent.

In common with trusts receiving referrals from other hospitals, we struggled to achieve the maximum 62 day referral to treatment target. We met this target for patients already registered at Guy's and St Thomas', but we did not meet this for patients referred to us later in their pathway from other hospitals. We are working with the hospitals that refer patients to us to ensure that delays are minimised for these patients.

To support our drive to reduce cancer waiting times further, we are investing in new equipment and our ability to provide access to the very latest cancer diagnosis and treatments for our patients so they receive the best possible care as quickly as possible.

### Healthcare acquired infection

The Trust has continued to successfully reduce *C.difficile* infection in our patients and the number of cases reduced to 48 against a target of 58. Full details of our performance against the *C.difficile* indicator is given on page 64.

In 2012-13, we had only one attributable MRSA blood infection, an outstanding achievement for an organisation of our size and complexity.

Chapter three of this report – see pages 15 to 19 – provides a detailed overview of how we performed against all national targets as well as a range of local indicators. There is a chart summarising our performance on page 20.

### Safeguarding children

The Trust has been involved in two inspections carried out jointly by Ofsted and the Care Quality Commission looking at the services that are delivered across partner agencies in Lambeth and Southwark to keep children and young people safe in 2012. Both the inspections generated positive results.

The contribution of health agencies in keeping children and young people safe was deemed good. The inspectors identified many areas of excellent leadership, performance and partnership working across all services in regard to safeguarding of children. The Trust was noted to have demonstrated good governance arrangements and systems in place to keep children and young people safe. Most importantly, the inspectors noted positive outcomes for children and young people, and found that children and young people in the boroughs generally felt safe. While the inspection highlighted many achievements, the report also provided some recommendations to further improve our safeguarding and services for looked after children. These include reviewing school nurse capacity to deliver the full healthy child programme; addressing health care needs for young people in preparation for leaving care; and increasing immunisation rates for children who are looked after.

Progress has also been made in policy development. A revised safeguarding children policy and procedures have been

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produced, with some new additions including sections on chaperoning, restraint, the prevent agenda and gang association. In addition, a safeguarding children supervision policy has been agreed. There is an ongoing commitment to ensure that the workforce has the right skills and knowledge in relation to the safeguarding of children through the delivery of safeguarding training. Safeguarding children training is provided through in-house and multi-agency provision.

Partnership working continues with both Lambeth and Southwark's Safeguarding Children Boards. A new initiative between Lambeth Council, the Metropolitan Police and health organisations has been created to strengthen efforts to protect children in Lambeth from harm. It is called the Multi Agency Safeguarding Hub (MASH) and involves bringing professionals from a number of agencies together in one place to share information on any referrals or contacts where concerns have been raised about a child's welfare. By centralising professionals from different agencies in one place, referrals can be investigated and decisions made more quickly, resulting in better outcomes for vulnerable children. A similar approach will be undertaken within Southwark during 2013.

## Safeguarding adults

The safeguarding adults team has been considerably enhanced with a trainer, an administrator, and a safeguarding lead for hospital and for community services, together with a dementia and delirium clinical nurse specialist for the community.

Referrals to the team are continuing to increase, with a considerable rise in the referrals from the community. There have been huge efforts to support the community staff with safeguarding adults at risk training and this is now at nearly 80 per cent compliance. Our hospital services are 82 per cent compliant. The team were very involved in the making of the Barbara's story film which has been used to provide dementia awareness training.

A clinical nurse specialist for learning disabilities was successfully recruited and now works very closely with safeguarding colleagues. This post has raised the profile of learning disabilities within the organisation and has received a huge number of referrals within a short period of time.

## Caring for patients with dementia

We have over two million patient contacts each year and two-thirds of these patients are over the age of 65. A quarter of patients in UK hospitals have a dementia, and this number is growing. At present one in 14 patients over the age of 65 have this diagnosis.

Nationally the focus on dementia has increased considerably and, across the NHS, we are expected to have services that are responsive to the needs of our most vulnerable patients. To achieve this we must ensure that our staff have the right level of skills and the right level of understanding to ensure our patients are protected and safe. We are completely committed to ensuring that all of our patients, especially those who are most vulnerable, are treated with the utmost respect, are always protected and receive outstanding care.

In September, we embarked on a campaign to raise awareness of dementia amongst all staff working in our hospitals and in the community. All of our 13,200 staff are required to attend an innovative training session. As part of this they watch Barbara's story – a powerful film that was created by the Trust about the experiences of a woman with dementia during a hospital visit. The training is presented in a way that reinforces the Trust's values of putting patients first, taking pride in what we do, respecting others, striving to be the best and acting with integrity. When we have shown this to the whole workforce we would like Barbara's story to evolve into a further set of scenarios as we follow her progress.

Through this initiative we have focussed on the care of older people and those with dementia. However these principles apply to all of our patients. We want our staff to do one small thing differently everyday for our older patients which will help to make their experience even better.

Barbara's story is already having an impact, with clinical services thinking about how they can make their services more friendly, and many of our staff have signed up as volunteers to support patients at meal times or as activity coordinators.

# Statements

## Statement of Directors' responsibilities in respect of the Quality Report

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

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 2012/13;
- 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 2012 to June 2013
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
  - Feedback from the commissioners dated 20/05/2013
  - Feedback from governors dated 24/04/2013
  - Feedback from Local Healthwatch organisations dated 13/05/2013
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2013;
  - The 2012 national patient survey April 2013
  - The 2012 national staff survey 28/02/2013
  - The Head of Internal Audit's annual opinion over the trust's control environment dated March 2013
  - CQC quality and risk profiles dated 04/04/2013.
- 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](http://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](http://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.

By order of the Board



**Sir Ron Kerr**, Chief Executive  
29 May 2013

## Independent Auditor's 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 2013 (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 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Guy's and St Thomas' NHS Foundation Trust for our work or this report 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 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 day cancer waits
- *C.difficile*

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 Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has

come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in *Detailed Guidance for External Assurance on Quality Reports*; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* 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 consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

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

### Assurance work performed

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

### Statements

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

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

### Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques 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 scope of our assurance work has not included governance over quality of 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 2013:

- 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*;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed Guidance for External Assurance on Quality Reports*; and
- 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

29 May 2013

## Lambeth CCG statement on Guy's and St Thomas' NHS Foundation Trust 2012 Quality Accounts – received 20 May 2013

On behalf of NHS Lambeth, Southwark and Lewisham Clinical Commissioning Groups

The draft Guy's and St Thomas' NHS Foundation Trust (GSTT) Quality Report 2012/13 was reviewed by a range of local commissioning stakeholders, including representatives from NHS Lambeth, NHS Southwark and NHS Lewisham Clinical Commissioning Groups (CCGs). The coordination of feedback has been undertaken by NHS Lambeth CCG, 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 extra work has been undertaken during the year e.g. health visitor new birth visits and immunisation targets and patient views concerning the delivery of inpatient personal care.

It is good to see how the Quality Account priorities have developed over the past three years and in the past year, the active participation of members of the public in the major building and service projects is welcomed. These Quality Accounts clearly set out how the Foundation Trust has prioritised its key delivery areas for 2012/13 across both acute and community services, and the involvement of stakeholders in determining these. It would have been helpful to include more information about why some of the priorities were chosen for this year.

In respect of the Patient Safety priorities we would be keen to see the publication of patient safety incident issues, lessons learned and actions taken to prevent these happening again within the success criteria for the priority, 'keeping you informed of how we are doing'. Additionally, within the priority, 'keeping our patients safe and reducing the risk of harm', it would be helpful to include a specific measure building on work already commenced within the Foundation Trust to fully implement the WHO surgical safety checklist across the organisation and reduce Never Events.

The CCGs recognise the work being undertaken across the Trust to involve patients and the public but would welcome the addition of a specific patient

feedback measure under the Clinical Effectiveness priority, 'improve our out-patient department efficiency'. Additionally, under the 'Patient Experience' priority, 'improve our complaints and PALs services', the inclusion of specific metrics to establish the satisfaction of users of the service and to improve timely response rates would be welcomed.

Good progress in the National Inpatient Survey results are to be commended and the excellent work being undertaken implementing the internal Foundation Trust survey is helping to identify actions for improvement.

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 and *C.difficile* infections, which are national priorities. Achievement in full Accident and Emergency and 18-week standards were, and continue to be, particularly challenging. The implementation of action plans is ongoing. The rate of unplanned readmissions within 28 days of discharge is similar to the NHS average and the CCG welcomes the South London Integrated Care Programme work being undertaken with secondary, primary and social care colleagues to develop a better health system to reduce readmissions.

It is very encouraging to see where clinical audits have led to improved quality of services within the Foundation Trust. Reference to the GSTT Annual Clinical Governance Report where further audit detail can be found would be welcomed. 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.

GSTT participate in a significant amount of excellent clinical research which is not included within the Quality Accounts. A link to more detailed information could be included.

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. We remain committed to working closely to ensure the ongoing delivery of high quality services throughout this next year. NHS Lambeth CCG has processes for regularly reviewing quality issues with GSTT through our regular Clinical Quality Review, as well as a number of other



quality review mechanisms. These will continue over 2013/14 and we will work in partnership to ensure the learning from the Francis Review informs how we can best assure the quality of the Foundation Trusts services

**Dr Adrian McLachlan,**

Chair, NHS Lambeth Clinical Commissioning Group

**Andrew Eyres,**

Chief Officer, NHS Lambeth Clinical Commissioning Group

### Joint response from Healthwatch Southwark and Healthwatch Lambeth to Guy's & St Thomas' Foundation Trust Quality Accounts – received 13 May 2013

Guy's and St Thomas' Foundation Trust (GSTT) is one of three Acute Providers to provide health services to the residents of Lambeth and Southwark borough. We share similar issues and therefore welcome the opportunity to jointly respond to your Quality Accounts.

Where appropriate or possible, Healthwatch Southwark and Healthwatch Lambeth will work together to ensure our limited resources are best placed towards monitoring the quality of local services and having an effective and influential patient and public voice.

#### General comments

- We appreciate that GSTT has listened to our comments on previous accounts relating to our concerns and become more 'user and reader friendly' through your simplified 'success scenario'. It would be helpful for responses to our previous comments if not addressed in the published edition. *How widely accessed are the Quality Accounts by members of the public?*
- We believe it would be beneficial to have **regular feedback on these priorities** throughout the year, similar to our quarterly meetings with South London and Maudsley Foundation Trust.
- We welcome the achievements and successes achieved including the low mortality rate achieved. For us to analyse the data effectively, completeness, problems and improvements also need to be mentioned. Huge developments including the possibility of **King's Health Partners merger** and the building of the **Integrated Cancer Centre** which is being developed at Guy's should be mentioned including how it could affect current and future priorities.
- We appreciate the progress against the 'big areas' relating to Cancer, A & E and referral to treatment time. However, we do have some concerns relating to experiences of disjointed cancer care pathway.

#### Progress against 2012-2013 priorities

- We would like to commend your innovation in introducing the Welcome pack for inpatients and the "Please ask us" initiative.

- We have heard good things about “Barbara’s story” and it is excellent it is seen by so many – contributing to dementia awareness.
- There is a general lack of specific ‘whys’ relating to the achievements, especially relating to where the priority was not achieved.

### 2013-2014 priorities

- Keeping you informed on how we are doing – ‘hub project’ sounds interesting and could be helpful if it is joined up with Healthwatch websites and communication strategies.
- It might be helpful to put ‘specific targets’ on the – reduction of patients on ‘Do Not Attend’ and reducing the wait for their first appointment. Do these numbers include those people that are asked not to attend Outpatient Clinics such as Ear, Nose and Throat because they have a cold.
- We support the **review with the Complaints and PAL service**. This is timely given the transfer of NHS PCT PALs service to new Healthwatch organisations and the recent gaps this has highlighted for Healthwatch. We are keen for Healthwatch organisations to work more closely with the Trust so that our signposting service complements or is part of a seamless communication/support channel for patients and public. We would wish to see this enlarged through adding a target to promote more general feedback from Healthwatch and other sources.
- Improve the care of older people. This section mentions treating patients with “**dignity and respect**”. What examples of work have been done to ensure the hospital is following The Dignity Code, which sets out the minimum standard of treatment required for older people in hospitals or in the community.
- Developing **greater training, development and co-working** between GSTT Governors and Healthwatch.
- The Account has **little clear references to Carers and Families**. The role carers and families play are integral to the maintenance or wellbeing and support of patients and should be widely recognised and supported.
- **More visual presentation** such as graphs and tables could help the public understand the Trust’s real achievements i.e. Data comparison on group mortality on page 17.
- **Re-admission** could be broken down via age groups as it assumes Older People are being re-admitted
- **Lack of data is an issue** and the timing of these reports for consultation may need to be reconsidered for future years.
- We would welcome some record of how choices for **research** are made and how far decisions are made locally and how far nationally, or even internationally?
- We welcome future discussion on the *Trust Wide Falls Audit*. It would be helpful for older people to understand what it means and reassure them on the care given in this.
- Breaking down the CQUIN and what the Trust did to achieve the amount might help members of the public understand what the NHS PCT/CCG commissioned them to do.

### Nicola Kingston and Aisling Duffy

Healthwatch Lambeth Co-Chairs

On behalf of Healthwatch Southwark Interim Board

### Further comments

- We recommend inclusion of at least one specific equalities target.
- We commend your work in response to the *Francis Report*, and in ensuring that staff at the front line is involved in discussions. Healthwatch Lambeth in their response to Francis recommended that the Health and Wellbeing Board bring together all NHS bodies in Lambeth to make a joint response. This was agreed and we would welcome GSTT involvement.

#### **Feedback from Health and Adult Services Scrutiny Committee, London Borough of Lambeth – received 16 May 2013**

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 2012/13. The committee would also wish to acknowledge the earlier invitation to the Quality Account Stakeholder event to develop the QA and draft priorities which was attended by a member of the committee.

It has not been possible to formally consider the draft QA 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.

**Elaine Carter,**

Lead Scrutiny Officer, London Borough of Lambeth

#### **Feedback from Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee – received 20 May 2013**

Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee met on 25 March 2013 to consider an earlier draft. This session also considered additional information on Serious Incidents and a summary of GSST complaints. Following this session the committee asked for follow up information on Pressure Sores. A previous meeting, on 6 March 2013, received Southwark's annual Vulnerable Adults Safeguarding report.

Following the 25 March meeting the committee asked for more assurance that community acquired Pressure Sores are followed up by GSST, particularly when patients have acquired these at home or in a social care setting and that referral mechanisms are adequate and an agency will take appropriate action. The committee also asked for more analysis of why Pressure Sores are increasing generally.

When the committee considered the Southwark Vulnerable Adults Safeguarding report it was noted that there were no safeguarding alerts for GSST. The committee requested more assurance on the Safeguarding process, and that there are adequate systems in place for reporting alleged abuse, investigation, Safeguarding training and effective whistle-blowing procedures.

**Cllr Mark Williams,**

Chair, Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee

## Feedback from Guy's and St Thomas' Trust Governors – received 24 April 2013

Staff are to be congratulated on some outstanding achievements during a challenging year.

Noteworthy recognition should go to the successful launch of 'Barbara's story' which has had a powerful and emotional impact upon all of us – helping to underpin the values in everything we strive to achieve on a daily basis in the most positive way possible.



Bowley Close Rehabilitation Centre, part of our community services, was proud to support some of the elite athletes taking part in the London 2012 Paralympic Games.

# 7

## Our organisational structure

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

### Council of Governors

The Council of Governors (our equivalent of the Board of Governors described in Foundation Trust legislation) continues to play a vital part in the work of the Trust, advising on how best to meet the needs of our patients and wider communities.

It has a number of statutory duties, including appointing the Chairman and Non-Executive Directors, deciding on their remuneration and ratifying the appointment of the Chief Executive. The Council of Governors also receives the Trust's Annual Report and Accounts and the Auditor's Report, and helps to set the Trust's quality account priorities.

The patient, public and staff members of the Council are elected from and by the Foundation Trust membership to serve for three years. Elections for new governors in the public, patient and staff constituencies take place in spring 2013, with seven places available. In addition, some of the organisations we work most closely with are able to nominate a stakeholder governor. See page 83 for a full list of governors.

### Constitution

Our constitution is on the website of our regulator, Monitor: [www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

### Working groups

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

**Service strategy** – contributing to the Trust's strategy, including service developments. This year the group took a particular interest in the response by the Trust Special Administrator to the issues at South London Healthcare NHS Trust, and in the development of the Trust's IT strategy.

**Patient experience** – reviewing the results of patient surveys and feedback. The group took particular interest in improving patients' experience when discharged from hospital and our outpatient services. They were also involved in improvements to the care of patients with dementia and proposals for the development of an intermediate care and amputee rehabilitation centre.

**Membership development, involvement and communications** – improving communication and increasing member involvement. This year the group has developed an induction programme for new governors and improved information for governors and members on our website.



### Nominations Committee

The Nominations Committee makes recommendations to the Council of Governors on the appointment and remuneration of the Chairman and Non-Executive Directors, and considers the independent appraisal of the Chairman.

This year it has recommended the renewal of Diane Summer's appointment as a Non-Executive Director for a further four years, until 16 June 2016, and also the appointment of Robert Drummond as a new Non-Executive Director for a four year term from 9 March 2013.

The committee has also recommended a freeze on non-executive directors' remuneration until 2012/13.

Nominations Committee membership and attendance	
Name	Actual/possible
Prof Judith Ellis	0/5
Sue Gallagher	3/3
Dawn Hill	5/5
Tom Hoffman	4/5
Dr David Treacher	5/5

### Our membership

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

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

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

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

We have 22,687 members, of whom 3,320 are patient members, 6,812 are public members and 12,555 are staff members. We continue to aim for a membership that represents the diverse communities we serve.

Members receive regular mailings and are invited to events including our Annual Public Meeting, Council of Governors' meetings and other events such as our regular health seminars. The seminars are extremely popular, and recent topics include health and well-being, cancer and allergy.

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

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

Tel: 020 7188 7188 ext 53186

Email: [members@gstt.nhs.uk](mailto:members@gstt.nhs.uk)

### Board of Directors

Our Board of Directors is made up of our Chairman, Sir Hugh Taylor, six other Non-Executive Directors and seven Executive Board Directors, including Chief Executive, Sir Ron Kerr. Its role is to:

- Set our overall strategic direction within the context of NHS priorities;
- Monitor our performance against objectives;
- Provide effective financial stewardship;
- Ensure the Trust provides high quality, effective and patient-focussed services;
- Ensure high standards of corporate governance and personal conduct;
- Promote effective dialogue between the Trust and the local communities we serve.

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

## Council of Governors

Patient governors	Elected from	Actual/possible attendance
Anita Campolini	July 2012	3/3
Susan Hardy	July 2012	3/4
Dawn Hill	July 2012	4/4
Brian Lymbery	July 2009	1/1
Jeremy Marsh	July 2009	1/1
Niamh O'Sullivan	July 2010	4/4
Dr Sir Richard Thompson	July 2010	2/4
Jane Wardle	July 2009	0/1
Paula Young	July 2010	4/4

Staff governors	Constituency	Elected from	Actual/possible attendance
Noreen Ging	Clinical	July 2012	1/3
Richard Gurney	Community services directorate	September 2011	3/3
Rev Mia Hilborn	Non-clinical	July 2010	4/4
Shamim Khan	Clinical	July 2009	1/1
Jason Simons	Clinical	July 2012	3/3
Dr David Treacher	Medical and dental practitioners	July 2012	4/4
Jeff Whitear	Non-clinical	July 2012	4/4

Public governors	Elected from	Actual/possible attendance
Pauline Anderson	July 2009	1/1
Jean Bates	July 2009	0/1
Prof Kevin Burnand	July 2012	3/3
Jenny Coble	July 2010	3/4
Yvonne Craig	July 2012	3/3
Dr Felix Greaves	July 2012	2/3
Tom Hoffman	July 2012	3/3
Patricia Prendergast	July 2010	3/4
Barry Silverman	July 2012	3/3
Victoria Silvester	July 2009	1/1
Cllr Peter Truesdale	July 2010	2/4
Simon Wallace	July 2009	1/1

Stakeholder governors	Organisation	Actual/possible attendance
Prof Sir George Alberti	King's College Hospital	1/4
Stuart Bell	South London and the Maudsley	1/2
Dora Dixon-Fyle	Southwark Council	0/1
Prof Judith Ellis	London South Bank University	0/4
Sue Gallagher	Lambeth Primary Care Trust	4/4
Gus Heafield	South London and the Maudsley	1/1
Prof Denise Lievesley	King's College London	2/4
Cllr Catherine McDonald	Southwark Council	3/3
Cllr Jane Pickard	Lambeth Council	2/4

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 0008

## Our organisational structure

Rory Maw, Partner and Chief Financial Officer of Bridges Community Ventures, was Vice Chairman between May 2009 and March 2013. David Dean became Vice Chairman from 27 March 2013. Jan Oliver left the Board in December 2012, Rory Maw left in March 2013 and Robert Drummond joined the Board in March 2013.

In September 2012, 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	9/10
Robert Drummond	Non-Executive Director	1/1
Mike Franklin	Non-Executive Director	5/10
Sir Ron Kerr	Chief Executive	10/10
Ann Macintyre	Director of Workforce and Organisational Development	10/10
Rory Maw (Vice Chair)	Non-Executive Director	7/9
Steve McGuire	Director of capital, estates and facilities	8/10
Prof Frank Nestle	Non-Executive Director	9/10
Girda Niles	Non-Executive Director	10/10
Jan Oliver	Non-Executive Director	6/7
Amanda Pritchard	Chief Operating Officer	10/10
Martin Shaw	Finance Director	9/10
Eileen Sills	Chief Nurse/Director of Patient Experience and Infection Control	8/10
Diane Summers	Non-Executive Director	10/10
Sir Hugh Taylor	Chairman	10/10

Committee	Membership
<b>Audit</b>	David Dean (Chair), Rory Maw, Diane Summers, Sir Hugh Taylor
<b>Community Services</b>	Diane Summers (Chair), Dr Ian Abbs, Ann Macintyre, Girda Niles, Martin Shaw, Eileen Sills
<b>Finance &amp; Investment</b>	Rory Maw (Chair), David Dean, Sir Ron Kerr, Steve McGuire, Frank Nestle, Martin Shaw
<b>Quality</b>	Sir Hugh Taylor (Chair), Dr Ian Abbs, David Dean, Sir Ron Kerr, Steve McGuire, Girda Niles, Jan Oliver (to Dec 2012), Eileen Sills, Diane Summers
<b>Remuneration</b>	Sir Hugh Taylor (Chair), all Non-Executive Directors
<b>Workforce</b>	Mike Franklin (Chair), Sir Ron Kerr, Ann Macintyre, Steve McGuire, Jan Oliver (to Dec 2012), Eileen Sills, Sir Hugh Taylor

## 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 2012, the Committee reviewed the draft Annual Accounts and approved their submission to the auditors. During the year, the Committee also reviewed the Trust's Annual Plan and its Quality Accounts, and received reports on a number of topics including matters relating to King's Health Partners.

### Audit Committee membership and attendance

Name	Actual/possible
David Dean (Chair)	5/5
Rory Maw	4/5
Diane Summers	5/5
Sir Hugh Taylor	4/5

## Remuneration Committee

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

### Remuneration Committee membership and attendance

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

## Working with the Council of Governors

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

Last year, for the first time, governors attended a number of Board committees, including Finance and Investment, Workforce, Community and Quality, and they fed back to their respective working groups. They also attended Board meetings and we introduced a new arrangement where governors now have the opportunity to reflect on discussions at the Board during the subsequent Council of Governors meeting.

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

In addition to regular items about the work of its working groups, the Council of Governors has discussed workforce planning, the Trust's annual report and quality accounts, Essentia and complaints. There have also been a

number of discussions about progress with the development of King's Health Partners

## Trust Management Executive

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

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

The Management Executive has the following sub-committees:

- Cancer Centre Project Board;
- Capital Investment;
- IT Programme Board;
- Integrated Planning Group;
- Information Governance Committee;
- Research and Development;
- Risk and Quality.

### Board of Directors – Executive Directors



**Sir Ron Kerr CBE**  
Chief Executive

Sir Ron Kerr has been Chief Executive of Guy's and St Thomas' since 2007.

His first Chief Executive Officer appointment was in 1985 and his other roles have included, Regional General Manager for North Thames Regional Health Authority, Chief Executive of the National Care Standards Commission, Chief Executive of United Bristol Healthcare NHS Trust, Deputy Director of Financial Management for the NHS Executive and Chief Executive of the South East London Commissioning Agency.

He is current Chair of the Association of UK University Hospitals and a Member of the Council of University of Bristol. He holds an MBA from London Business School. He received a Knighthood in the 2011 New Year's honours for services to healthcare.



**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 30 years' NHS experience working at national, regional and local level.

Ann is the 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 Forum, working with Health Ministers and Trade Unions on workforce policy and working with the National Clinical Commissioning Board to support the delivery of seven day services. Ann is also a member of the Department of Health's Revalidation Delivery Board for England and acts as an expert adviser to a range of national groups.



**Steve McGuire**  
Director of Essentia  
(capital, estates and  
facilities)

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.



**Amanda Pritchard**  
Chief Operating Officer

Amanda joined the Trust in April 2012. Previously, she held the post of Deputy Chief Executive at Chelsea and Westminster Hospital NHS Foundation Trust. Prior to that she held a number of senior operational management positions and served as Director of Strategy and Service Development.

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



**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 Patient Experience and  
Infection 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 was awarded a CBE in 2003 for services to nursing.

Eileen holds two visiting professorships, at King's College London and London South Bank Universities. She is a member of the NHS Employers policy board and the Chair of the grant's committee for the Burdett Trust for Nursing. Eileen has a national reputation for strong, visible, clinical leadership, and her drive to take senior nurses back to the bedside has earned her a national reputation for her Clinical Fridays initiative.

## Board of Directors – Non-Executive Directors



**Sir Hugh Taylor**  
Chairman

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

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

Sir Hugh chairs both the Finance and Investment and Remuneration Committees as well as the 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 20 years and is a Trustee of the Dulwich Festival.

David joined the Board in June 2007 and chairs the Audit Committee. He became Vice Chairman in March 2013.



**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 Racial and Violent Crime Task Force 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 chaired the Finance and Investment Committee until his term ended in March 2013.



**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 National Institute for Health Research (NIHR) Senior Investigator and 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 Social Business Coach specialising in strategy for social businesses and those who want to make a social difference. She has extensive experience in strategy in the community and voluntary sectors, social enterprise, financial management and training.

Through her previous role as a Non-Executive Director of Lambeth Primary Care Trust, she has a thorough understanding of how health and social care systems work.

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



**Jan Oliver**  
Non-Executive Director

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

Jan 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 her term ended in December 2012.



**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 Quality Services Committee.



**Robert Drummond**  
Non-Executive Director

Robert has spent his career serving the community in a number of roles. He was a council member and then Chairman of the British Venture Capital Association. In 2010 he was appointed Non-Executive Board member of Surrey Community Health. As a provider of venture capital Robert has also backed a number of medical businesses that achieved a Stock Exchange listing in London.





Guy's and St Thomas' is home to the Evelina Children's Hospital which treats children from across the UK. Our children's services see over 55,000 patients each year.

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 2012/13, in line with recommendations on national agreements. Details of remuneration, including the salaries and pension entitlements of the Board of Directors, are published in note 6 of the annual accounts.

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

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

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

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by either party with six months notice, or 12 months in the case of the Chief Executive. The Trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

In line with the Treasury recommendations made in August 2012, no senior officials with significant financial responsibilities are employed via an off payroll engagement; it is Trust policy that no staff in substantive positions may be employed on this basis. The Trust does employ a number of temporary contractors. In response to the Treasury recommendations, the Trust has incorporated into its standard contractual terms and conditions the requirement to allow the Trust to seek reassurance around tax obligations.

A review of existing contractors initially focussed efforts on reducing all temporary contractors, concentrating on high value contractors. In February 2013, a census of the remaining high value long term off payroll arrangements identified 72 such arrangements where their contracts pre-dated the change to the standard contract.

The table below sets out the current status of these arrangements.

Off-payroll engagements at a cost of over £58,200 per annum that were in place as of 1 February 2013	
Number of off payroll engagements at 1 February 2013	<b>72</b>
Number that have subsequently been terminated or come to an end	<b>8</b>
Number that have since been re-negotiated/re-engaged to allow the Trust the Trust to seek reassurance as to their tax obligations	<b>43</b>
Current off-payroll contracts yet to be brought within the standard contractual terms and conditions	<b>21</b>

Action is ongoing to ensure that all such arrangements are brought within the standard contractual terms and conditions as soon as possible.



**Sir Ron Kerr**, Chief Executive  
29 May 2013







A number of celebrities and VIPs passed through our doors last year, including new Secretary of State for Health Jeremy Hunt, our Olympic gold medallist, canoeist Etienne Stott, and superstar Tinie Tempah.



# 9

## Annual accounts

### Foreword to the accounts

These accounts, for the year ended March 31 2013, 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, appearing to read 'Sir Ron Kerr', with a stylized flourish extending to the right.

**Sir Ron Kerr**, Chief Executive and Accounting Officer  
29 May 2013



## Statement of the Chief Executive's responsibilities as the Accounting Officer of Guy's and St Thomas' NHS Foundation Trust.

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer's 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 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  
29 May 2013

# Annual Governance Statement 2012/13

## 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 March 31 2013 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 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, and performance management, continuing professional development, clinical audit and application of evidence based practice.

## The risk and control framework

The Risk Management Policy and supporting procedures set out the key responsibilities for managing risk within the organisation, including ways in which the risk is identified, evaluated and controlled. A risk management matrix is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and incidents. The Trust's appetite for risk is articulated through the boundaries within the risk evaluation matrix that have been defined by the Board of Directors in the Risk Management Policy. Risks rated as red are not acceptable and are monitored by the Board of Directors to ensure mitigating actions are identified and delivered to reduce to an acceptable level of risk. The process for the management and monitoring of risk assessments is 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 Quality Committee monitors the delivery of the quality priorities for the Trust, the priorities include a number of indicators agreed with stakeholders from our local community together with national indicators of quality including access to services and patient feedback.

During 2012/13, the Trust has continued to build on its systems for monitoring compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, set out in the 16 essential standards of quality and safety. Each standard has an executive lead

and an outcome lead, with responsibility for a particular area of service. The focus during the year has been on ensuring the standards are being met across all areas of the Trust, and a range of tools is in place to monitor this, including the ward accreditation scheme and a new system of ward walkabouts, led by members of the senior nursing team, Trust governors and the clinical governance team. A self-assessment undertaken by directorates for the annual governance statement provides reasonable assurance that these processes are in place. In addition, the Trust monitors the contents of the quality and risk profile published by the CQC on a monthly basis, and brings any areas of concern to the Trust Risk and Quality Committee and the Quality Committee for actions to be agreed.

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. 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 reviews.

The Trust sought advice from the Intensive Support Team (IST) of the Department of Health in reviewing the Trust's pathway reporting processes', and commissioned external reviews from Deloitte and Price Waterhouse Coopers that have looked more broadly at information assurance processes.

The limited assurance opinion from external audit of the Quality Report; an internal audit programme reviewing key Monitor performance metrics and external review by the IST of pathway management have been positive. Required improvements in existing clinical coding processes identified by the Trust and highlighted in the Payment by Results assurance audit are being addressed through an extensive change programme, led by the Medical Director.

A new group has been established to review clinical outcome indicators derived from external benchmarking on a monthly basis, enabling data to be checked and assured before receiving quality alerts. The Trust obtains operational sign-off of key returns, for example referral to treatment data, produced by informatics staff, prior to submission. A self-assessment undertaken by directorates provides reasonable assurance that appropriate processes are in place.

## 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 bespoke training offered to teams and departments. 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 or specialty responsible for monitoring and managing information security risks. A quarterly report from each department or specialty is generated and included in the quarterly information governance report which is submitted to the Audit Committee. All data security incidents are reported via the Trust's incident database – DATIX. Incidents are reviewed at the bi-monthly Information Governance Committee chaired by the Senior Information Risk Owner. Where an ongoing risk is identified it is recorded on the information governance and Caldicott risk and issues log and the Trust wide risk register for monitoring of the effectiveness of the risk mitigation plan.

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 has been implemented. Work continues with both community health services and the hospitals to improve the processes around health records management.

In 2012/13 the Trust reported one serious loss of data to the Information Commissioner's Office. The incident involved the loss of an unencrypted memory stick containing patient details. Following this incident an awareness campaign was launched to remind all staff of the need to ensure that any portable media is encrypted. The Trust is implementing further controls to prevent unencrypted memory sticks being connected to the Trust network.

## Risks

A number of drivers for change which present risks as well as opportunities have been identified. These are the changing economic environment; the ongoing development of King's Health Partners; changes to commissioning arrangements for clinical services; changes in the configuration of healthcare in London; savings and activity plans; Commissioning for Quality and Innovation targets (CQUIN) targets; and commercial opportunities and income diversification.

Risks are monitored to ensure that mitigating actions are effective through the well established financial and performance reporting model. This includes detailed monthly scorecard reporting against national and Trust performance targets. Mitigating actions are recorded in the Board Assurance Framework and monitored by the Board of Directors through the Audit Committee.

## 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 Human Resources (HR) policies are subject to an equality impact assessment. This is monitored at the Trust HR policy sub group.

The Trust's equality objectives for 2012/13 were developed to support the Trust's strategic objectives and to be integral to Trust activity. Any transformation project must carry out an equality analysis. The Trust has improved the tool used for this analysis to extend analysis of the impact on equality beyond protected characteristics to consideration of the impact on health and socio-economic inequalities.

## 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 2012/13 the Trust has continued to promote reporting by junior doctors and in particular, encouraged reports of medication related incidents via the Trust's web based reporting system. As part of their preceptorship programme, training was also given to newly qualified nurses and midwives on the importance of incident reporting in order to learn and provide safer patient care. Significant work has been carried out in-year to promote safer surgery and consistent use of the WHO surgical checklist, and has seen the introduction of wide application of checklists for non-surgical procedures to reduce the risk of wrong site interventions.

## Patient involvement in risk

The Trust's public involvement and consultation process ensures compliance with relevant legislation, and is described in 'Putting Patients First: A Policy for Involvement and Consultation'. All departments, clinical and non-clinical, are responsible for planning and undertaking patient and public involvement initiatives.

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

The Trust has an agreed process of advising and engaging with Southwark and Lambeth Overview and Scrutiny 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 inform the Trust's Council of Governors of proposed changes, including how potential risk to patients will be minimised.

## Compliance statements

The Trust is fully compliant with the CQC essential standards of quality and safety. The Trust has been inspected by the CQC on three occasions during 2012/13. The CQC found that the Trust was meeting all the essential standards of quality and safety that were inspected. The standards and locations covered in these inspections are described in the Quality Reports of the Annual 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 complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

The Trust has undertaken risk assessments and developed an Adaptation Plan to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKC P09), to ensure that this organisation's obligations under the Climate Change Act are met.

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

As part of their annual audit, our external auditor is required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They do this by examining documentary evidence and through discussions with senior managers.

The 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 (Trust 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.

## Annual Quality Report

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

The Chief Nurse and the Medical Director are the nominated Trust executives for the Quality Report; two clinical leads have been put in place to support the Chief Nurse, a Deputy Chief Nurse and the Deputy Medical Director for Quality Improvement. An executive group was established and charged with reviewing current Trust quality work streams and establishing the priorities for the 2012/13 Quality Report. To inform the priorities for the coming year, the Trust reviewed key hospital and community services information, staff and patient surveys and reports from external agencies.

The quality priorities were developed in consultation with a wide range of stakeholders. As well as a staff consultation at the 'Safety Connections' Conference, two stakeholder events were held December 2012 and January 2013. These were led jointly by representatives from the Chief Nurse and Medical Directors' Offices. The events were well attended by Trust governors, Lead GP Commissioners, Lambeth and Southwark LINKs, Local Overview and Scrutiny Committees, and other trusts from King's Health Partners. At these events stakeholders were asked to review and comment on the priorities for 2013-14. Where appropriate our priorities have been aligned with 2013-14 Commissioning for Quality and Innovation (CQUIN) targets. The quality priorities were agreed by the Board and will be monitored by the Quality Committee through the Quality and Patient Safety Report.

For the Annual Quality Report, the Trust employs the same information assurance processes as are 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 more accurate 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 Quality and Patient Safety Report, produced jointly by the Chief Nurse and Medical Director. A limited assurance opinion on a number of indicators in the Quality Report 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 by monitoring 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 undertaken 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.

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 provide advice and assistance to senior management on control issues and other matters of concern. The internal audit team also provides an anti-fraud service to the Trust.

Internal Audit work also covers service delivery and performance, financial management and control, human resources, operational and other reviews. Based on the work undertaken, including a review of the Trust's Board Assurance Framework process, the Head of Internal Audit Opinion concluded that significant assurance could be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are 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 Quality and Audit Committees.

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

The Trust Risk and Quality Committee (TRaQ) reports to the Trust Management Executive and the Quality Committee. Its work on establishing a system for reviewing the Trust's clinical procedures and guidelines contributes to maintaining the system of internal control.

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. 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 Risk and Quality 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, including guidance and support to directorates on their annual audit programmes, specialist audit training to Trust staff, and escalation reports where audits are not completed to agreed timescales. They also administer the electronic audit system and support the Trust Clinical Audit Group. A self-assessment undertaken by directorates provides reasonable assurance that clinical audits are undertaken and improvement actions implemented to identify and mitigate potential risks to quality. The Quality Report includes detailed information about the Trust's participation in national and local clinical audits.

## Conclusion

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 no significant internal control issues have been identified.



**Sir Ron Kerr**, Chief Executive and Accounting Officer  
29 May 2013

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

We have audited the financial statements of Guy's and St Thomas' NHS Foundation Trust for the year ended March 31 2013 which comprise the Consolidated Statement of Comprehensive Income, the Group & 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 35. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ('the Boards') of Guy's and St Thomas' NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

## Respective responsibilities of the accounting officer and auditor

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

## Scope of the audit of the financial statements

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

## Opinion on financial statements

In our opinion the financial statements:

- Give a true and fair view of the state of the Trust's affairs as at March 31 2013 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.

## 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

For and on behalf of Deloitte LLP  
Chartered Accountants and Statutory Auditor  
Reading, UK

29 May 2013



## Consolidated statement of comprehensive income for the year ended March 31 2013

	NOTE	March 31 2013 £000	March 31 2012 £000
Operating income	3	891,856	851,479
Other operating income	4	277,107	284,947
Operating expenses	5	(1,163,749)	(1,104,483)
<b>OPERATING SURPLUS</b>		<b>5,214</b>	<b>31,943</b>
<b>FINANCE COSTS</b>			
Finance income	10	508	552
Finance expenses	11	(319)	(247)
Public Dividend Capital dividend payable	30	(20,330)	(20,756)
<b>Net finance costs</b>		<b>(20,141)</b>	<b>(20,451)</b>
Corporation Tax	12	26	(78)
<b>(DEFICIT)/SURPLUS FOR THE YEAR</b>		<b>(14,901)</b>	<b>11,414</b>
<b>Other comprehensive income</b>			
Impairments	16	(11,240)	(22,046)
Revaluations	17	18,656	14,504
Other reserve movements		30	1,496
<b>TOTAL COMPREHENSIVE (EXPENDITURE)/INCOME FOR THE YEAR</b>		<b>(7,455)</b>	<b>5,368</b>

The notes on pages 104 to 129 form part of these accounts.  
All revenue and expenditure is derived from continuing operations.

### Note to Statement of Comprehensive Income

Total comprehensive income as above		(7,455)	5,368
Less reserve movements in other comprehensive income	a	(7,446)	6,046
<b>Total comprehensive income before reserve movements</b>		<b>(14,901)</b>	<b>11,414</b>
Add back impairments and reversals of impairments included in (deficit)/surplus above	b	25,908	6,848
Other non-operating items	c	2,905	(764)
Less capital donations		(4,771)	(6,609)
<b>NET SURPLUS EXCLUDING ITEMS ABOVE</b>		<b>9,141</b>	<b>10,889</b>

This is the primary view which is used by the Board of Directors to monitor the Trust's financial performance.

- a. This is the total of the three items shown in Other Comprehensive Income.
- b. This is the total impairments and impairment reversals charged to expenditure or credited to income (Note 16).
- c. This includes a lease termination payment, profit and losses on disposals of assets and an EU emissions income release.

## Statement of financial position as at March 31 2013

		GROUP		TRUST	
	NOTE	March 31 2013 £000	March 31 2012 £000	March 31 2013 £000	March 31 2012 £000
<b>NON CURRENT ASSETS</b>					
Property plant and equipment	14	884,350	847,228	884,353	847,228
Intangible assets	15	33,156	31,092	33,154	30,850
Investments in associates (joint controlled operations)	18	71	83	71	71
Trade and other receivables	20.2	1,804	2,047	3,121	3,328
Other financial assets	21	–	3,500	–	3,500
<b>TOTAL NON-CURRENT ASSETS</b>		<b>919,381</b>	883,950	<b>920,699</b>	884,977
<b>CURRENT ASSETS</b>					
Inventories	19	15,276	15,138	15,276	15,138
Trade and other receivables	20.1	68,357	57,726	68,171	57,703
Other financial assets	21	3,500	–	3,500	–
Cash and cash equivalents	26	129,389	143,929	129,119	143,638
<b>TOTAL CURRENT ASSETS</b>		<b>216,522</b>	216,793	<b>216,066</b>	216,479
<b>CURRENT LIABILITIES</b>					
Trade and other payables	22.1	(133,784)	(120,634)	(133,721)	(120,482)
Tax payable	22.2	(13,972)	(14,047)	(13,971)	(13,967)
Other liabilities	22.3	(15,962)	(15,826)	(15,962)	(15,826)
Provisions	23	(3,503)	(2,562)	(3,503)	(2,562)
Borrowings	22.4	(625)	–	(625)	–
<b>TOTAL CURRENT LIABILITIES</b>		<b>(167,846)</b>	(153,069)	<b>(167,782)</b>	(152,837)
<b>NON-CURRENT LIABILITIES</b>					
Trade and other payables	22.1	(147)	–		
Other liabilities	22.3	(772)	–	(919)	
Provisions	23.1	(8,720)	(8,323)	(8,718)	(8,323)
Borrowings	22.4	(29,405)	(3,683)	(29,405)	(3,683)
<b>TOTAL NON-CURRENT LIABILITIES</b>		<b>(39,044)</b>	(12,006)	<b>(39,042)</b>	(12,006)
<b>TOTAL ASSETS EMPLOYED</b>		<b>929,013</b>	935,668	<b>929,941</b>	936,613
<b>TAX PAYERS' EQUITY</b>					
Public Dividend Capital		356,566	355,766	356,566	355,766
Revaluation reserve		285,124	277,789	285,124	277,789
Other reserves		743	743	743	743
Income and expenditure reserve		286,580	301,370	287,508	302,315
<b>TOTAL TAXPAYERS' EQUITY</b>		<b>929,013</b>	935,688	<b>929,941</b>	936,613



**Sir Ron Kerr**, Chief Executive and Accounting Officer  
29 May 2013

## Statement of changes in Taxpayers' equity

GROUP 2012/13	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' equity at April 1 2012</b>	355,766	277,789	743	–	301,370	<b>935,668</b>
Deficit for the year	–	–	–	–	(14,901)	<b>(14,901)</b>
Impairments	–	(11,240)	–	–	–	<b>(11,240)</b>
Revaluations	–	18,656	–	–	–	<b>18,656</b>
Transfer between reserves	–	(81)	–	–	81	–
Public Dividend Capital received	800	–	–	–	–	<b>800</b>
Other reserve movements	–	–	–	–	30	<b>30</b>
<b>Taxpayers' equity as at March 31 2013</b>	<b>356,566</b>	<b>285,124</b>	<b>743</b>	<b>–</b>	<b>286,580</b>	<b>929,013</b>

GROUP 2011/12	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' equity at April 1 2011</b>	355,766	285,194	743	46	288,551	<b>930,300</b>
Prior period adjustment	–	–	–	–	1,170	<b>1,170</b>
<b>Taxpayers' Equity at April 1 2011 restated</b>	355,766	285,194	743	46	289,721	<b>931,470</b>
Surplus for the year	–	–	–	–	11,414	<b>11,414</b>
Impairments	–	(22,046)	–	–	–	<b>(22,046)</b>
Revaluations	–	14,504	–	–	–	<b>14,504</b>
Other reserve movements	–	137	–	(46)	235	<b>326</b>
<b>Taxpayers' equity as at March 31 2012</b>	<b>355,766</b>	<b>277,789</b>	<b>743</b>	<b>–</b>	<b>301,370</b>	<b>935,668</b>

TRUST 2012/13	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' equity at April 1 2012</b>	355,766	277,789	743	–	302,315	<b>936,613</b>
Deficit for the year	–	–	–	–	(14,919)	<b>(14,919)</b>
Impairments	–	(11,240)	–	–	–	<b>(11,240)</b>
Revaluations	–	18,656	–	–	–	<b>18,656</b>
Transfer between reserves	–	(81)	–	–	81	–
Public Dividend Capital received	800	–	–	–	–	<b>800</b>
Other reserve movements	–	–	–	–	31	<b>31</b>
<b>Taxpayers' equity as at March 31 2013</b>	<b>356,566</b>	<b>285,124</b>	<b>743</b>	<b>–</b>	<b>287,508</b>	<b>929,941</b>

TRUST 2011/12	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' equity at April 1 2011</b>	355,766	285,194	743	46	289,746	<b>931,495</b>
Prior period adjustment	–	–	–	–	1,170	<b>1,170</b>
<b>Taxpayers' Equity at April 1 2011 restated</b>	355,766	285,194	743	46	290,916	<b>932,665</b>
Surplus for the year	–	–	–	–	11,164	<b>11,164</b>
Impairments	–	(22,046)	–	–	–	<b>(22,046)</b>
Revaluations	–	14,504	–	–	–	<b>14,504</b>
Other reserve movements	–	137	–	(46)	235	<b>326</b>
<b>Taxpayers' equity as at March 31 2012</b>	<b>355,766</b>	<b>277,789</b>	<b>743</b>	<b>–</b>	<b>302,315</b>	<b>936,613</b>

## Consolidated cash flow statement for the year ended March 31 2013

	NOTE	March 31 2013 £000	March 31 2012 £000
<b>Cash flows from operating activities</b>			
Operating surplus from continuing operations		5,214	31,943
<b>Non-cash income and expenses</b>			
Depreciation and amortisation		42,535	41,336
Impairments and reversals		25,949	6,848
Reversal of impairments		(41)	–
Loss/(Gain) on disposal		721	(2)
Interest accrued and not paid		–	–
Dividends accrued and not paid		(205)	–
(Increase)/Decrease in trade and other receivables		(10,674)	11,391
(Increase) in inventories		(138)	(543)
(Decrease)/Increase in other liabilities		908	(8,147)
Increase in trade and other payables		1,973	18,274
Increase in provisions		1,337	109
Tax received		5	448
Movements in operating cash flow in respect of Transforming community services transaction		–	1,170
Other movements in operating cash flows		(196)	(233)
<b>NET CASH GENERATED FROM OPERATING ACTIVITIES</b>		<b>67,388</b>	<b>102,594</b>
<b>Cash flows from investing activities</b>			
Interest received		508	551
Purchase of intangible assets		(9,697)	(9,276)
Purchase of property, plant and equipment		(79,633)	(32,096)
<b>NET CASH GENERATED USED IN INVESTING ACTIVITIES</b>		<b>(88,822)</b>	<b>(40,821)</b>
<b>Cash flows from financing activities</b>			
Other loans received		26,347	3,683
Public dividend received		800	–
Public dividend capital paid		(20,125)	(21,861)
Interest paid on loans from Foundation Trust Financing Facility		(128)	–
Cash flows from other financing activities		–	195
<b>NET CASH GENERATED USED IN FINANCING ACTIVITIES</b>		<b>6,894</b>	<b>(17,983)</b>
<b>Net (decrease)/increase in cash and cash equivalents</b>		<b>(14,540)</b>	<b>43,790</b>
Cash and cash equivalents at April 1		143,929	100,139
<b>Cash and cash equivalents at March 31</b>	26	<b>129,389</b>	<b>143,929</b>

# 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 2012/13 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual* (FRM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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

#### Going concern

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

The 2011/12 HM Treasury FRM required that all transfers of functions between public sector bodies be accounted for using merger accounting. The Trust accounted for the integration of the community service functions of Lambeth and Southwark Primary Trusts in 2011/12 as a merger.

### 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. Revenue

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

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

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

### 1.5 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 Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://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 FRM 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 published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ended March 31 2004. Consequently, a formal actuarial valuation would have been due for the year ended March 31 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 due in 2015.

The Scheme regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform the contribution rates to be used from April 1 2015.

#### 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. The valuation of the scheme liability as at March 31 2013, is based on the valuation data as at March 31 2012, updated to March 31 2013 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 for 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 April 1 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 ended 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Price 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 AVCs 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
- They form 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 2013 the land and building 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 April 1 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 – 46 years
- Plant and machinery, 2 – 15 years
- Transport equipment, 2 – 7 years
- IT hardware, 5 – 10 years
- Furniture and fittings, 10 years.

Buildings and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the NHS Foundation Trust's professional valuer. The Trust adopts a policy revaluing its estates on an annual basis. This has the impact that the useful life for buildings may vary subtly year on year.

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

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

### Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating 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 ie:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

### Donated, government grant and other grant funded assets

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

The majority of donated assets have funding received retrospectively, so that restrictions imposed by the donor are met upon the receipt of the donated cash. If donated assets were no longer used for the purpose intended for example 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 value of at least £5,000.

They are recognised only where it is probable that the future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

### Internally generated Intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Trust intends to complete the asset and sell or use it;
- The Trust has the ability to sell or use the asset;
- The intangible asset will generate probable future economic or service delivery benefits eg the presence of a market for it or its output, or where it is for internal use;
- Adequate financial, technical and other resources are available to the Trust to complete the development and sale or use the asset; and
- The Trust can measure reliably the expenses attributable to the asset during development.

### Software

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

### Measurement

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

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

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

### Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates intangible assets over the following ranges:

- information technology, 5 – 15 years;
- software licences and trademarks, 5 – 10 years.

## 1.10 Heritage artefacts and archives

The Trust reviews heritage artefacts in accordance with FRS 30 – Heritage Assets. Where there is an open market, such assets will be valued at market value, assets with no marketable value will be held at replacement cost.

Where it is impossible to establish a value by either of these methods, the Trust will consider other valuation methodologies such as insurable value, otherwise the asset will be held at nil value but disclosed as a note to the accounts.

Further information on the acquisition, disposal, management and preservation of the Trust's heritage asset as required by FRS 30 can be found in Note 35.

### 1.11 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.

### 1.12 EU Emissions Trading Scheme

The EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within 12 months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income are valued at fair value at the end of the reporting period.

### 1.13 Inventories

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

### 1.14 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.

### 1.15 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.

### 1.16 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.

### 1.17 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.

### 1.18 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.

### 1.19 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 March 31;
- 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.

### 1.20 Financial assets and financial liabilities

#### Recognition

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

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

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

#### De-recognition

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

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

#### Classification and measurement

Financial assets are categorised as 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.

## 1.21 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.

## 1.22 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, except for early retirement provisions which uses the HM Treasury's pension discount rate of 2.35% (2011/12: 2.9%) in real terms.

### Clinical negligence costs

The NHS Litigation Authority (NHS LA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS LA which in return settles all clinical negligence claims. Although the NHS LA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS LA 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 NHS LA and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excess' payable in respect of particular claims, are charged to operating expenses as and when the liability arises.

### Commercial insurance

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

## 1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 33 to the accounts. The Trust is also holding £1m on behalf of our tenants.

## 1.24 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.

## 1.25 Critical accounting judgements and key sources of estimation uncertainty

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

### Critical judgements in applying accounting policies

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

#### Provisions

A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities. The following discount rates as published by HM Treasury have been used in calculating the injury benefit provision: short-term -1.8%, medium-term -1.0% and long-term 2.2%. Early voluntary retirement pension provision has been calculated by applying a 2.35% discount rate as advised by HM Treasury.

#### Provision for impairment of receivables

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

### Impairments and estimated asset lives

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

#### Valuations of land and buildings

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See Note 1.8 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 2.35% (2.9% 2011/12) (See Note 1.22).

## 1.26 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 2012-13.

The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

Change published	Published by IASB	Financial year for which the change first applies
<b>IFRS 9</b> Financial Instruments Financial Assets: Financial Liabilities:	November 2009 October 2010	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project.
<b>IFRS 10</b> Consolidated Financial Statements	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
<b>IFRS 11</b> Joint Arrangements	May 2011	Effective date 2013/14 but not yet adopted by the EU.
<b>IFRS 12</b> Disclosure of Interests in Other Entities	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
<b>IFRS 13</b> Fair Value Measurement	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
<b>IAS 12</b> Income Taxes Amendment	December 2010	Effective date of 2012/13 but not yet adopted by the EU.
<b>IAS 1</b> Presentation of Financial Statements, on Other Comprehensive Income (OCI)	June 2011	Effective date of 2013/14 but not yet adopted by the EU.
<b>IAS 27</b> Separate Financial Statements	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
<b>IAS 28</b> Associates and Joint Ventures	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
<b>IAS 19</b> (Revised 2011) Employee Benefits	June 2011	Effective date of 2013/14.
<b>IAS 32</b> Financial Instruments: Presentation – amendment offsetting financial assets and liabilities	December 2011	Effective date of 2014/15 but not yet adopted by the EU.
<b>IFRS 7</b> Financial Instruments: Disclosures – amendment offsetting financial assets and liabilities	December 2011	Effective date of 2013/14 but not yet adopted by the EU.

## 2 Segmental reporting

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
<b>INCOME</b>		
Patient care income	891,856	851,479
Non patient care income	277,107	284,947
<b>Total income</b>	<b>1,168,963</b>	<b>1,136,426</b>
<b>EXPENDITURE</b>		
Clinical/community directorates	(974,016)	(916,865)
Corporate	(209,848)	(208,147)
<b>Total expenditure</b>	<b>(1,183,864)</b>	<b>(1,125,012)</b>
<b>(DEFICIT)/SURPLUS</b>	<b>(14,901)</b>	<b>11,414</b>
<b>Adjusting for:</b>		
Impairments	25,908	6,848
Other non-operating items	2,905	(764)
Capital donations	(4,771)	(6,609)
<b>Underlying surplus</b>	<b>9,141</b>	<b>10,889</b>

Day-to-day financial control is devolved to:

- Sixteen Clinical Directorates and the Community Directorates who are accountable to the Board of Directors via the Chief Operating Officer;
- Corporate and other support services are 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. The summary is in line with the detail disclosed above. The report is made available to the public at the meeting and via the public website [www.guysandstthomas.nhs.uk](http://www.guysandstthomas.nhs.uk) – see the Board of Directors page.

The ultimate decision maker for the Trust is the Board of Directors.

## 3 Operating income

### 3.1 Income from activities by source

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
Strategic Health Authorities	10,318	7,342
Primary Care Trusts	858,111	814,167
Other NHS and WGA Bodies	2,440	2,251
Non NHS:		
– Overseas patients (non-reciprocal)	1,961	1,851
– NHS injury scheme	951	1,038
– Other	18,075	24,830
	<b>891,856</b>	<b>851,479</b>

### 3.2 Income from activities by type

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
Elective income	195,777	191,992
Non-elective income	124,838	103,305
Outpatient income	155,796	141,266
Other NHS clinical income	283,725	284,331
Accident and Emergency income	19,118	18,968
Private and overseas patient income	19,195	23,081
Community services	93,407	88,536
	<b>891,856</b>	<b>851,479</b>

### 3.3 Income from activities arising from mandatory and non mandatory services

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
Mandatory services	872,661	828,398
Non mandatory services	19,195	23,081
	<b>891,856</b>	<b>851,479</b>

## 4 Other operating income

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
Research and development	46,701	50,619
Education, training and research	79,027	79,255
Charitable and other contributions to expenditure	10,259	12,667
Non-patient care services to other bodies	24,765	20,599
Other income (see below)	90,104	97,335
Rental revenue from operating leases – minimum lease payments	7,448	3,548
Reversal of impairments of property, plant and equipment	41	–
Profits on disposal of fixed assets	13	4
Income in respect of staff recharges	18,749	20,920
	<b>277,107</b>	<b>284,947</b>

Other income includes income from commercial activities, staff accommodation rentals, clinical excellence awards, catering, foreign currency gains of £376k (gains of £434k in 2011/2012) and other direct credits.

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



## 5 Operating expenses

### 5.1 Operating expenses comprise:

	Year ended March 31 2013	Year ended March 31 2012 Restated £000
Note	£000	£000
Services from other NHS Trusts	5,720	7,223
Services from other NHS bodies	4,403	8,221
Services from NHS Foundation Trusts	11,460	12,750
Purchase of healthcare from non-NHS bodies	8,010	7,123
Executive Directors' costs	1,525	1,566
Non-Executive Directors' costs	193	185
Staff costs	650,127	619,582
Drug costs (non inventory drugs only)	93,612	89,588
Drug inventories consumed	491	125
Inventories written down (net, including inventory drugs)	951	514
Rentals under operating leases – minimum lease payments	19,179	19,494
Supplies and services – clinical	142,802	136,734
Supplies and services – general Establishment	8,860	7,245
Research and development	9,020	10,521
Transport	23	111
Premises	10,775	8,807
Increase in Bad Debts Provision	53,136	50,507
Depreciation and amortisation	986	9,637
Impairments of property, plant and equipment	42,535	41,336
Impairments of intangible assets	25,624	6,086
Impairment of financial assets	313	762
Audit fees – statutory audit	12	–
Other auditor regulatory services	5.2 132	130
Clinical negligence	5.2 25	21
Consultancy costs	8,712	7,844
Redundancy	10,345	16,750
Early retirements	941	1,516
Other*	543	344
	<b>53,294</b>	<b>39,761</b>
	<b>1,163,749</b>	<b>1,104,483</b>

\*Other operating expenses includes expenditure on commercial activities, training and legal fees. The prior year has been restated to include comparatives of disclosure of additional categories of expenditure in 2012/13. In addition, there has been a recategorisation of expenditure between establishment and eervices from NHS bodies.

### 5.2 Audit fees

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
Audit services for statutory audit	122	121
Audit fee for subsidiary companies	9	9
Audit fee regulatory reporting	25	21
	<b>156</b>	<b>151</b>

There were no payments made to our Auditor for non-audit work in 2012/13 (2011/12 £207k).

### 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2012/2013 or 2011/2012.

### 5.4 Operating leases

#### As Lessee

#### 5.4.1 Payments recognised as an expense:

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
Minimum lease payments under operating leases recognised as an expense in the year	19,179	19,494

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 2013 £000	Year ended March 31 2012 £000
Within 1 year	12,653	6,637
Between 1 and 5 years inclusive	24,251	16,563
After 5 years	17,290	10,577
	<b>54,194</b>	<b>33,777</b>

As at 1 April 2013, properties previously leased to provide community services have transferred to Trust ownership from Lambeth and Southwark Primary Care Trusts. These properties have been excluded from the lease commitments. There are also a number of other properties from which community services are provided by the Trust. Lease negotiations are still ongoing as at March 31 2013. For the purposes of compiling this note, we have been provided with assurance that these leases will continue for at least one year from March 31 2013.

#### As Lessor

#### 5.4.2 Rental revenue:

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
Rental revenue from operating losses – minimum lease receipts	7,448	3,548
	<b>7,448</b>	<b>3,548</b>

#### Future minimum lease receipts due:

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
Within 1 year	4,454	3,262
Between 1 and 5 years inclusive	15,497	10,993
After 5 years	3,576	4,661
	<b>23,527</b>	<b>18,916</b>



## 6 2012/13 Salary and pension entitlements of senior managers

### A) Remuneration

		Year ended March 31 2013	Year ended March 31 2012
Name	Title	Total remuneration £000	Total remuneration £000
Executive Directors			
I. Abbs	Medical Director	197	197
R. Kerr	Chief Executive	251	251
A. Macintyre	Director of Workforce and Organisational Development	145	146
S. McGuire	Director of Essentia (Capital, Estates and Facilities)	157	157
H. Risebrow	Commercial Director (left March 2012)	–	150
A. Pritchard	Chief Operating Officer (appointed April 2012)	150	–
M. Shaw	Director of Finance	157	157
E. Sills	Chief Nurse/Director of Infection Prevention and Control	173	173
		1,230	1,231
Non-Executive Directors			
D. Dean	Non-Executive Director and Chair of Audit Committee	20	20
R. Drummond	Non-Executive Director (appointed March 2013)	1	–
M. Franklin	Non-Executive Director	17	17
R. Maw	Non-Executive Director (left March 2013)	16	17
F. Nestle	Non-Executive Director	17	17
G. Niles	Non-Executive Director (appointed January 2012)	17	4
J. Oliver	Non-Executive Director (left December 2012)	13	17
D. Summers	Non-Executive Director	17	17
H. Taylor	Chairman	60	60
		1,408	1,400

	Year ended March 31 2013	Year ended March 31 2012
Highest Paid Director's Total Remuneration	£250,755	£250,755
Median Total Remuneration	£32,288	£35,830
Remuneration Ratio	7.77	7.00

### B) Pension benefits

Name	Title	Real increase/ (decrease) in pension and related lump sum at age 60 £000	Total accrued pension and related lump sum at age 60 at March 31 2013 £000	Cash equivalent transfer value at March 31 2013 £000	Real increase in cash equivalent transfer value at March 31 2013 £000
<b>I. Abbs</b>	Medical Director	(4)	322	1,626	26
<b>R. Kerr*</b>	Chief Executive	–	–	–	–
<b>A. Macintyre</b>	Director of Workforce and Organisational Development	(3)	209	990	12
<b>S. McGuire</b>	Director of Essentia (Capital, Estates and Facilities)	7	145	714	55
<b>A. Pritchard</b>	Chief Operating Officer	13	104	317	47
<b>M. Shaw</b>	Director of Finance	(5)	256	1,361	12
<b>E. Sills</b>	Chief Nurse/Director of Infection Prevention and Control	(3)	242	1,085	16

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 a cash equivalent transfer value (CETV) for individuals over 60.

A 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 2013 Total £000	Year ended March 31 2012 Total £000
Salaries and wages	512,486	974	513,460	482,128
Social security costs	44,447	–	44,447	43,539
Employer contributions to NHSPA	54,374	–	54,374	54,359
Termination benefits	941	–	941	1,516
Agency and contract staff	–	52,911	52,911	49,350
Seconded staff	–	–	–	–
	<b>612,248</b>	<b>53,885</b>	<b>666,133</b>	<b>630,892</b>
included in above:				
Costs capitalised as part of assets	(4,828)	(8,712)	(13,540)	(8,228)
Total staff costs	<b>607,420</b>	<b>45,173</b>	<b>652,593</b>	<b>622,664</b>
<b>Analysed into Operating Expenditure (note 5)</b>				
Employee expenses – staff	604,954	45,173	650,127	619,581
Employee expenses – executive directors	1,525	–	1,525	1,567
Redundancy	941	–	941	1,516
	<b>607,420</b>	<b>45,173</b>	<b>652,593</b>	<b>622,664</b>

### 7.2 Average number of people employed

	Permanently employed number	Other number	Year ended March 31 2013 Total number	Year ended March 31 2012 Total number
Medical and dental	1,590	94	1,684	1,582
Administration and estates	2,928	338	3,266	3,093
Healthcare assistants and other support staff	793	226	1,019	970
Nursing, midwifery and health visiting staff	3,776	547	4,323	4,084
Nursing, midwifery and health visiting learners	670	151	821	781
Scientific, therapeutic and technical staff	1,948	161	2,109	2,060
Social care staff	1	–	1	1
	<b>11,706</b>	<b>1,517</b>	<b>13,223</b>	<b>12,571</b>

### 7.3 Retirements due to ill-health

During 2012/13 there were 15 early retirements from the Trust agreed on the grounds of ill-health (10 in the year ended March 31 2012). The estimated additional pension liabilities of these ill-health retirements is £705k (£394k in 2011/12). 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.

### 7.4 Analysis of termination benefits

	Year ended March 31 2013	Year ended March 31 2012
Number of cases	52	91
Cost of cases (£000)	1,666	2,157

## 7.5 Staff sickness absence

	Year ended March 31 2013 £000	Year ended March 31 2012 £000
<b>Included within:</b>		
Days lost (long-term)	121,665	104,516
Days lost (short-term)	38,869	36,914
<b>Total days lost</b>	<b>160,534</b>	<b>141,430</b>

\* Long-term sickness is over 20 consecutive days.

<b>Total staff years</b>	<b>11,472</b>	11,171
Average working days lost	<b>14.0</b>	12.7
Total staff employed in period (headcount)	<b>12,555</b>	12,085
Total staff employed in period with no absence (headcount)	<b>4,917</b>	4,749
<b>Percentage staff with no sick leave</b>	<b>39.2%</b>	39.3%

## 7.6 Other compensation schemes – exit packages 2012/13

GROUP 2012/13						
Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000	Number of other departures agreed Number	Cost of other departures agreed £000	Total number of exit packages Number	Total cost of exit packages £000
< £10,000	23	122	2	177	25	299
£10,001 – £25,000	9	159	3	190	12	349
£25,001 – £50,000	7	263	–	–	7	263
£50,001 – £100,000	4	292	–	–	4	292
£100,001 – £150,000	4	463	–	–	4	463
<b>Total</b>	<b>47</b>	<b>1,299</b>	<b>5</b>	<b>367</b>	<b>52</b>	<b>1,666</b>

## 7.7 Other compensation schemes – exit packages 2011/12

GROUP 2011/12						
Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000	Number of other departures agreed Number	Cost of other departures agreed £000	Total number of exit packages Number	Total cost of exit packages £000
< £10,000	12	160	8	49	20	209
£10,001 – £25,000	24	357	11	193	35	550
£25,001 – £50,000	22	738	9	317	31	1,055
£50,001 – £100,000	4	288	1	54	5	342
<b>Total</b>	<b>62</b>	<b>1,543</b>	<b>29</b>	<b>613</b>	<b>91</b>	<b>2,156</b>

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

# 8 Better Payment Practice Code

## 8.1 Measure of compliance

	Year ended March 31 2013 Number      £000		Year ended March 31 2012 Number      £000	
Total bills paid in the year	337,175	619,124	318,485	558,889
Total bills paid within target	283,028	481,302	261,745	437,286
Percentage of bills paid within target	84%	78%	82%	78%

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 (Loss)/Profit on disposal of non-current assets

<b>Profit on the disposal of non-current assets is made up as follows:</b>	<b>Year ended March 31 2013 £000</b>	<b>Year ended March 31 2012 £000</b>
Profit on disposal of property, plant and equipment	13	4
Loss on disposal of intangible fixed assets	(700)	–
Loss on disposal of property, plant and equipment	(34)	–
	<u>(721)</u>	<u>4</u>

## 10 Finance income

	<b>Year ended March 31 2013 £000</b>	<b>Year ended March 31 2012 £000</b>
Interest on loans and receivables (including cash and bank balances)	508	552
	<u>508</u>	<u>552</u>

## 11 Finance expenses

	<b>Year ended March 31 2013 £000</b>	<b>Year ended March 31 2012 £000</b>
Loans from the Foundation Trust Financing Facility	(133)	(2)
Unwinding of discounts on provision and other finance costs	(186)	(245)
	<u>(319)</u>	<u>(247)</u>

## 12 Taxation

	<b>Year ended March 31 2013 £000</b>	<b>Year ended March 31 2012 £000</b>
<b>UK corporation tax</b>		
Current tax payable on income at 20% (26% 11/12)	(26)	78
	<u>(26)</u>	<u>78</u>

Corporation tax is applicable to the profits of GTI Forces Healthcare Limited, a subsidiary of the Trust.

## 13 Deficit/surplus attributable to the Trust

The deficit for the Trust was £14,917k (2011/12 surplus of £11,164k), 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.

## 14 Property, plant and equipment – March 31 2013

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

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	IT Hardware £000	Furniture and fittings £000	Total £000
<b>Cost or valuation at April 1 2012</b>	195,500	542,223	32,319	154,973	176	38,715	1,164	965,070
Additions purchased	–	8,665	74,838	1,982	–	953	–	86,438
Additions donated	–	575	3,294	177	–	–	–	4,046
Additions – government granted	–	52	382	40	–	–	–	474
Impairments	–	(52,095)	–	–	–	–	–	(52,095)
Reclassifications	–	37,081	(46,021)	6,667	–	2,368	–	95
Revaluation	14,000	1,396	–	–	–	–	–	15,396
Disposals	–	–	–	(12,765)	–	(3,329)	–	(16,094)
Other	–	–	1,151	–	–	(3,271)	–	(2,120)
<b>Cost or valuation At 31 March 2013</b>	<b>209,500</b>	<b>537,897</b>	<b>65,963</b>	<b>151,074</b>	<b>176</b>	<b>35,436</b>	<b>1,164</b>	<b>1,001,210</b>
<b>Accumulated depreciation at April 1 2012</b>	–	2,102	–	88,391	154	26,479	716	117,842
Provided during the year	–	19,502	–	11,396	18	4,979	101	35,996
Elimination of accumulated depreciation on revaluation	–	(18,532)	–	–	–	–	–	(18,532)
Reclassification	–	307	–	(326)	–	3	–	(16)
Disposals	–	–	–	(12,731)	–	(3,329)	–	(16,060)
Other	–	–	–	–	–	(2,370)	–	(2,370)
<b>At March 31 2013</b>	<b>–</b>	<b>3,379</b>	<b>–</b>	<b>86,730</b>	<b>172</b>	<b>25,762</b>	<b>817</b>	<b>116,860</b>
Other relates to adjustments in relation to alignments to ledger.								
<b>Net book value 2012/13</b>								
Purchased assets	124,000	417,087	64,454	54,773	4	9,640	129	670,087
Donated asset	85,500	116,990	1,468	8,443	–	20	218	212,639
Government granted assets	–	441	41	1,128	–	14	–	1,624
<b>Total at March 31 2013</b>	<b>209,500</b>	<b>534,518</b>	<b>65,963</b>	<b>64,344</b>	<b>4</b>	<b>9,674</b>	<b>347</b>	<b>884,350</b>

In the year ended March 31 2013 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 March 31 2013. 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 the financial accounting purposes under IAS16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS 1.3 as:

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

#### c) Market Value (MV)

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

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

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

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	IT Hardware £000	Furniture and fittings £000	Total £000
<b>Cost or valuation</b>								
<b>At April 1 2011</b>	181,195	568,682	26,817	162,563	232	35,166	1,164	975,819
Additions purchased	–	3,632	24,759	1,211	–	1,191	–	30,793
Additions donated	–	802	3,701	913	–	–	–	5,416
Additions – government granted	–	–	68	–	–	–	–	68
Impairments	–	(21,722)	–	–	–	–	–	(21,772)
Reclassifications	–	15,998	(23,026)	4,726	(56)	2,358	–	–
Revaluations	14,305	(25,169)	–	–	–	–	–	(10,864)
Disposals	–	–	–	(14,440)	–	–	–	(14,440)
<b>Cost or valuation</b>								
<b>At 31 March 2012</b>	<b>195,500</b>	<b>542,223</b>	<b>32,319</b>	<b>154,973</b>	<b>176</b>	<b>38,715</b>	<b>1,164</b>	<b>965,070</b>
<b>Accumulated depreciation</b>								
<b>At April 1 2011</b>	–	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)
<b>At March 31 2012</b>	<b>–</b>	<b>2,102</b>	<b>–</b>	<b>88,391</b>	<b>154</b>	<b>26,479</b>	<b>716</b>	<b>117,842</b>
<b>Net book value 2011/12</b>								
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
<b>Total at March 31 2012</b>	<b>195,500</b>	<b>540,121</b>	<b>32,319</b>	<b>66,582</b>	<b>22</b>	<b>12,236</b>	<b>448</b>	<b>847,228</b>

## 14.3 The net book value of property, plant and equipment at March 31 2013 comprises:

	Land £000	Buildings £000	Assets under construction £000	Other £000	Total property, plant and machinery £000
Protected	209,500	518,365	–	–	727,865
Unprotected	–	16,153	65,963	74,369	156,485
<b>Net book value</b>	<b>209,500</b>	<b>534,518</b>	<b>65,963</b>	<b>74,369</b>	<b>884,350</b>



## 15 Intangible assets

### 15.1 As at March 31 2013

Group	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
<b>Cost April 1 2012</b>	742	44,182	6,026	1,777	52,727
Reclassification	792	5,739	(6,626)	–	(95)
Revaluations	–	–	–	–	(827)
Additions purchased	430	–	8,268	–	8,698
Additions donated	–	–	114	–	114
Additions internally generated	–	392	–	–	392
Additions government granted	–	–	264	229	493
Impairments	–	–	(248)	–	(248)
Disposals	(163)	(4,494)	(432)	–	(5,089)
Other	–	1,307	(287)	(827)	1,020
<b>Gross cost at March 31 2013</b>	<b>1,801</b>	<b>47,126</b>	<b>7,079</b>	<b>1,179</b>	<b>57,185</b>
Amortisation April 1 2012	490	20,383	–	762	21,365
Provided during the year	149	6,390	–	–	6,539
Impairments to the Income & Expenditure	–	–	–	–	65
Reclassifications	–	16	–	–	16
Revaluations	–	–	–	–	(827)
Disposals	(163)	(4,226)	–	–	(4,389)
Other	–	990	–	(762)	990
<b>Amortisation at March 31 2013</b>	<b>476</b>	<b>23,553</b>	<b>–</b>	<b>–</b>	<b>24,029</b>
<b>Net book value March 31 2013</b>					
Purchased assets at March 31 2013	1,325	22,352	6,687	–	30,364
Donated assets at March 31 2013	–	1,221	392	1,179	2,792
<b>Total at March 31 2013</b>	<b>1,325</b>	<b>23,573</b>	<b>7,079</b>	<b>1,179</b>	<b>33,156</b>

### 15.2 As at March 31 2012

Group	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
<b>Cost April 1 2011</b>	742	30,831	10,371	1,585	43,529
Reclassification	–	11,143	(11,143)	–	–
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)
<b>Gross cost at March 31 2012</b>	<b>742</b>	<b>44,182</b>	<b>6,026</b>	<b>1,777</b>	<b>52,727</b>
Amortisation April 1 2011	408	15,835	–	–	16,243
Provided during the year	82	4,548	–	–	4,630
Reclassification	–	–	–	–	–
Impairments	–	–	–	762	762
<b>Amortisation at March 31 2012</b>	<b>490</b>	<b>20,383</b>	<b>0</b>	<b>762</b>	<b>21,635</b>
<b>Net book value</b>					
Purchased assets at March 31 2012	252	23,765	4,493	–	28,510
Donated assets March 31 2012	–	34	1,533	1,015	2,582
<b>Total at March 31 2012</b>	<b>252</b>	<b>23,799</b>	<b>6,026</b>	<b>1,015</b>	<b>31,092</b>

A separate schedule for the Trust's intangible assets has not been produced as the subsidiaries' information technology intangible assets are fully depreciated.

## 16 Impairments

Land and buildings were valued independently by the Valuation Office as at March 31 2013 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. Revaluation gains were taken to the revaluation reserve. Revaluation losses were taken to the revaluation reserve to the extent there was a revaluation surplus for that property. Any losses over and above the revaluation surplus were charged to the Statement of Comprehensive Income (SOI). The movement arising from the professional valuation can be summarised as follows:

	<b>Revaluation Reserve</b>	<b>SOI</b>
	<b>£000</b>	<b>£000</b>
Increase in value of land to revaluation reserve	<b>14,000</b>	–
Increase in value of buildings to revaluation reserve	<b>4,656</b>	–
Impairments – reduction in value of buildings to revaluation reserve	<b>(11,240)</b>	–
Reduction in value of buildings to Statement of Comprehensive Income	–	(23,314)
<b>Total</b>	<b>7,416</b>	<b>(23,314)</b>

In addition to the valuation movements, the Trust identified that the values of Bloomfield Clinic and Newcomen Centre were impaired at March 31 2013. This is because the centres were demolished in April 2013 in order to allow for the construction of the Cancer Treatment Centre. The total impairment for these two buildings was £1,894k.

The total impairments charged to the SOI are set out below:

	<b>£000</b>
Impairment of Newcomen and Bloomfield clinic	<b>1,894</b>
Impairments arising from professional valuation	<b>23,314</b>
Other impairments	<b>416</b>
<b>Impairment of property, plant and equipment</b>	<b>25,624</b>
Impairment of intangible assets	<b>313</b>
Impairment of financial assets	<b>12</b>
<b>Total impairment charged to Statement of Comprehensive Income</b>	<b>25,949</b>

## 17 Revaluation reserve movements

### 17.1 Property, plant and equipment

	<b>Year ended March 31 2013</b>	<b>Year ended March 31 2012</b>
	<b>£000</b>	<b>£000</b>
Revaluation reserve at April 1	<b>277,789</b>	285,166
Impairments	<b>(11,240)</b>	(21,722)
Revaluations	<b>18,656</b>	14,258
Transfers to other reserves	<b>(81)</b>	–
Other reserve movements	–	137
<b>Revaluation reserve at March 31</b>	<b>285,124</b>	<b>277,789</b>

### 17.2 Intangible assets

	<b>Year ended March 31 2013</b>	<b>Year ended March 31 2012</b>
	<b>£000</b>	<b>£000</b>
Revaluation reserve at April 1	–	78
Impairments	–	(324)
Revaluations	–	246
<b>Revaluation reserve at March 31</b>	<b>–</b>	<b>–</b>

## 18 Subsidiaries and interests 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 2013 are set out below. The accounting date of the financial statements for the subsidiaries is March 31 2013 and for the joint ventures 31 December. 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
<b>Subsidiary undertakings</b>			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
GTI Forces Healthcare Ltd <sup>1</sup>	UK	100%	Healthcare services
Pathology Services Ltd <sup>1</sup>	UK	100%	Healthcare services
<b>Associate and joint ventures</b>			
SSAFA GSTT Care LLP <sup>1</sup>	UK	50%	Healthcare services
GSTS Pathology LLP <sup>1</sup>	UK	33%	Healthcare services
SpotOn Diagnostics Ltd	UK	30%	Healthcare services
King's Health Partners Ltd <sup>2</sup>	UK	25%	Healthcare services

<sup>1</sup> Not directly owned by Guy's and St Thomas' NHS Foundation Trust

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

### 18.1 Investments

	<b>Investments in associates (and jointly controlled operations) March 31 2013 £000</b>	Investments in associates (and jointly controlled operations) March 31 2012 £000
Carrying value at April 1	<b>83</b>	–
Impairments	<b>(12)</b>	83
<b>Carrying value at March 31</b>	<b>71</b>	83

### 18.2 Aggregated amounts relating to associates and joint ventures

	<b>March 31 2013 £000</b>	March 31 2012 £000
Non-current assets	<b>4,491</b>	3,863
Current assets	<b>9,725</b>	5,600
Non-current liabilities	<b>(829)</b>	(4,757)
Current liabilities	<b>(14,676)</b>	(6,390)
Group share net assets (liabilities)	<b>(1,289)</b>	(1,684)
Revenue	<b>36,485</b>	35,108
Expenditure	<b>(36,094)</b>	(36,871)
Group share net (loss)	<b>391</b>	(1,763)

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

	<b>March 31 2013 £000</b>	March 31 2012 £000
Group share of unrecognised losses	<b>2,471</b>	2,861

All figures are based on unaudited figures.

## 19 Inventories

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
Raw materials and consumables	15,277	15,138	15,277	15,138
	<u>15,277</u>	<u>15,138</u>	<u>15,277</u>	<u>15,138</u>

## 20 Trade and other receivables

### 20.1 Current

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
NHS receivables	13,234	15,992	13,296	15,992
Other receivables	41,695	30,029	38,910	27,389
Provision for impaired receivables	(19,350)	(18,969)	(19,350)	(18,969)
Prepayments	3,576	5,359	3,576	5,359
Accrued income	25,962	21,789	25,962	21,788
PDC dividend receivable	703	908	703	908
VAT receivable	2,537	2,618	2,537	2,618
	<u>68,357</u>	<u>57,726</u>	<u>65,634</u>	<u>55,085</u>

### 20.2 Non current

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
Other receivables	1,804	2,047	1,804	3,328
	<u>1,804</u>	<u>2,047</u>	<u>1,804</u>	<u>3,328</u>

### 20.3 Provision for impaired receivables

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
At April 1	18,969	10,526	18,969	10,526
Increase in provision	986	9,637	986	9,637
Amounts utilised	(605)	(1,194)	(605)	(1,194)
At 31 March	<u>19,350</u>	<u>18,969</u>	<u>19,350</u>	<u>18,969</u>

### 20.4 Ageing of trade and other receivables

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
Not past due date	31,707	26,867	31,707	26,867
Up to three months	2,792	4,806	2,792	4,806
In three to six months	1,237	4,375	1,237	4,375
Over six months	15,805	8,609	15,805	8,609
	<u>51,541</u>	<u>44,657</u>	<u>51,541</u>	<u>44,657</u>

### 20.5 Analysis of impaired receivables

	GROUP	
	March 31 2013	March 31 2013
	£000	£000
	Impaired	Non-impaired
Not past due date	7,289	24,418
Up to three months	561	2,231
In three to six months	349	888
Over six months	11,151	4,654
	<u>19,350</u>	<u>32,191</u>

## 21 Other financial assets

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
<b>Current</b>				
Loan and receivables	3,500	–	3,500	–
	<u>3,500</u>	<u>–</u>	<u>3,500</u>	<u>–</u>
<b>Non-current</b>	£000	£000	£000	£000
Loan and receivables	–	3,500	–	3,500
	<u>–</u>	<u>3,500</u>	<u>–</u>	<u>3,500</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 1 January 2014 and a variable rate of interest (Libor + 2%).

## 22 Trade and other payables

### 22.1 Current

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
Receipts in advance	985	869	985	869
NHS payables – revenue	5,933	15,033	5,933	17,177
Trade payables – capital	21,593	3,945	21,593	3,945
Amounts due to related parties – revenue	7,687	6,990	7,687	6,990
Other trade payables	47,184	39,941	47,120	39,863
Other payables	1,570	3,275	1,572	3,275
Accruals	48,832	50,581	48,832	49,674
	<u>133,784</u>	<u>120,634</u>	<u>133,722</u>	<u>121,793</u>

### Non-current

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
Other payables	147	–	–	–
	<u>147</u>	<u>–</u>	<u>–</u>	<u>–</u>

Trade and other payables includes amounts owed to GSTS Pathology LLP: £8,095k (2011/12 £471k) in other trade payables and £446k (2011/12 £2,421k) is included in accruals.

### 22.2 Current taxes payable

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
Other taxes payable including Social Security and VAT	13,972	14,047	13,972	13,967
	<u>13,972</u>	<u>14,047</u>	<u>13,972</u>	<u>13,967</u>

### 22.3 Other liabilities

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
<b>Current</b>				
Deferred income	13,314	12,843	13,314	12,843
Deferred grants income	2,648	2,983	2,648	2,983
	<u>15,962</u>	<u>15,826</u>	<u>15,962</u>	<u>15,826</u>
<b>Non-current</b>				
Deferred income	772	–	772	–
	<u>772</u>	<u>–</u>	<u>772</u>	<u>–</u>

## 22.4 Borrowings

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
<b>Current</b>				
Loans from Foundation Trust Financing Facility	625	–	625	–
	<u>625</u>	<u>–</u>	<u>625</u>	<u>–</u>
<b>Non-current</b>				
Loans from Foundation Trust Financing Facility	29,405	3,683	29,405	3,683
	<u>29,405</u>	<u>3,683</u>	<u>29,405</u>	<u>3,683</u>

Loans drawn down from the Foundation Trust Financing Facility are as follows:

- £5.2m drawn down against a facility of £80m – repayable over 25 years;
- £19.9m drawn down against a facility of £75m – repayable over 25 years; and
- a loan of £5m – repayable over 5 years.

## 23 Provisions for liabilities

### 23.1 Overall provisions

Group and Trust	Current		Non Current		Total Provisions	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000	£000	£000
Pensions relating to other staff	826	774	7,375	7,134	8,201	7,908
Legal claims	975	194	–	–	974	194
Other	1,702	1,594	1,345	1,189	3,047	2,783
	<u>3,503</u>	<u>2,562</u>	<u>8,720</u>	<u>8,323</u>	<u>12,222</u>	<u>10,885</u>

### 23.2 Changes in provisions

	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
As at April 1 2012	7,908	194	2,783	10,885
Arising during the year	1,048	844	497	2,389
Utilised during the year	(804)	–	(142)	(946)
Reversed unused	(137)	(64)	(91)	(292)
Unwinding of discount	186	–	–	186
<b>As at March 31 2013</b>	<u>8,201</u>	<u>974</u>	<u>3,047</u>	<u>12,222</u>

### 23.3 Expected timing of cash flows

Timing of Provisions	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
Within one year	826	975	1,702	3,503
Between one and five years	3,088	–	831	3,919
After five years	4,287	(1)	514	4,800
	<u>8,201</u>	<u>974</u>	<u>3,047</u>	<u>12,222</u>

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

£113,519k is included in the provision of the NHS Litigation Authority under legal claims at March 31 2013 in respect of clinical negligence liabilities of the Foundation Trust (£96,074k at March 31 2012).

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



## 24 Prudential borrowing limit

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.

[http://www.monitor-nhsft.gov.uk/sites/default/files/Prudential%20Borrowing%20Code%20April%202009\\_0.pdf](http://www.monitor-nhsft.gov.uk/sites/default/files/Prudential%20Borrowing%20Code%20April%202009_0.pdf)

	Available at March 31 2013 £000	Facility used March 31 2013 £000	Available at March 31 2012 £000	Facility used March 31 2012 £000
Long term borrowing limit set by Monitor	295,400	30,030	205,700	3,683
Working capital facility agreed by Monitor	60,000	–	60,000	–
	<u>355,400</u>	<u>30,030</u>	<u>265,700</u>	<u>3,683</u>

## 25 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.

Financial performance ratios	March 2013	March 2012	Thresholds
Dividend cover	3.61	3.84	> 1x
Interest cover	25.46	27.60	> 2x
Debt service cover	9.84	10.67	> 1.5x
Debt service to revenue	1%	1%	< 10%

## 26 Analysis in changes of net cash

GROUP	At April 1 2011 £000	Cash changes in period £000	At March 31 2012 £000	Cash changes in period £000	At March 31 2013 £000
Cash with the Government Banking Service	99,559	43,221	142,780	(13,945)	128,835
Cash at bank and in hand – commercial bank	580	569	1,149	(595)	554
	<u>100,139</u>	<u>43,790</u>	<u>143,929</u>	<u>(14,540)</u>	<u>129,389</u>

TRUST	At April 1 2011 £000	Cash changes in year £000	At March 31 2012 £000	Cash changes in year £000	At March 31 2013 £000
Cash with the Government Banking Service	99,559	43,221	142,780	(13,945)	128,835
Cash at bank and in hand – commercial bank	442	416	858	(574)	284
	<u>100,001</u>	<u>43,637</u>	<u>143,638</u>	<u>(14,519)</u>	<u>129,119</u>

## 27 Capital commitments

Commitments under capital expenditure contracts at the SOFP date for the Group and the Trust were £151,349k, (£12,568k at March 31 2012), largely relating to the construction of the Cancer Treatment Centre.

## 28 Events after the balance sheet date

As at April 1 2013, the ownership of properties used to provide community services transferred from Lambeth and Southwark Primary Care Trusts to Guy's and St Thomas' NHS Foundation Trust. Details are still being finalised. It is expected that 10 properties, 8 freehold and 2 leasehold buildings, will transfer onto the Trust's Statement of Financial Position. These land and building values total £38,347k.

## 29 Contingencies

	March 31 2013 £000	March 31 2012 £000
Contingent liability for other claims against the Group and the Trust	(125)	(71)
<b>Net contingent liability</b>	<b>(125)</b>	<b>(71)</b>

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.

## 30 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 2013 period of account was £20,330k and, based on the average relevant net assets of £580,853k, the Trust's performance on an annualised basis was 3.50% (3.49% to March 2012).

## 31 Related party transactions

Guy's and St Thomas' NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Trust has taken advantage of the exemption provided by IAS 24 'Related Party Disclosures', where the parent's own financial statements are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation. The debtor and creditor trading balances with the Group's joint ventures are presented in notes 21 and 22 respectively.

The Board members of SSAFA GSTT Care LLP include the following employees from the Trust: Ron Kerr, Martin Shaw, Alastair Scarborough, Victoria Cheston and Beverley Hunt.

The Board members of GSTS Pathology LLP include the following employees from the Trust: Ron Kerr, Martin Shaw, Jonathan Edgeworth, Mark Gladman and Beverley Hunt.

The Department of Health is regarded as a related party. During the year Guy's and St Thomas' NHS Foundation Trust has had a significant number of material transactions with entities for which the department is regarded as the parent. The main local commissioners were Lambeth and Southwark Primary Care Trusts, Croydon Primary Care Trust and Lewisham Primary care Trust from which the Trust received £523,836k at March 31 2013 for health care contracts (£498,561K at March 31 2012). Additionally the Trust has transacted with a large number of other PCTs and NHS Trusts including West Kent, Bromley, Greenwich and Bexley, as well as the NHS Litigation Authority and NHS Logistics.

The debtors balance for NHS bodies as at March 31 2013 stood at £16,781k (£15,992k at March 31 2012).

In addition, the Trust has had a number of material transactions with other Government departments and other central and local Government bodies. £32,597k at March 31 2013 (£37,473k at 31 March 2012) has been received from the Ministry of Defence for health services supplied. There were also many income transactions with King's College London totalling £18,696k at March 31 2013 (£10,028k at March 31 2012).

The Trust has also received revenue and capital payments from a number of charitable funds, principally £33,304k from Guy's and St Thomas' Charity in the year to March 31 2013 (£20,820k at 31 March 2012). The balance for Guy's and St Thomas' Charity debtors was £704k for March 31, 2013 (£3,553k at 31 March, 2012) and for creditors £1,709k for March 31 2013 (£1,609k for March 31 2012). 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 rents accommodation from the Trust at a commercial market rate.

Sir Hugh Taylor (Non-Executive Director) is a Trustee of Macmillan Cancer Support, Royal College of Physicians, the Nuffield Trust and Cicely Saunders International which interact with Guy's and St Thomas' Charity.

The Council of Governors includes representatives from organisations that work closely with the Trust including Lambeth Council, Southwark Council, Lambeth and Southwark Primary Care Trust, Lewisham Primary Care Trust, London Strategic Health Authority, 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 has undertaken any material transactions with Guy's and St Thomas' NHS Foundation Trust.

Significant transactions with related parties include the following:

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
Barnsley PCT	2,182	–	–	71
Barnet PCT	4,475	–	348	–
Brent Teaching PCT	3,039	–	85	–
Bexley NHS Care Trust PCT	29,817	–	1,108	–
Bristol PCT	6,065	–	–	31
Bromley PCT	38,081	51	1,694	–
Camden PCT	2,667	–	–	677

## 31 Related party transactions continued

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
City and Hackney Teaching PCT	2,626	–	1	83
Croydon PCT	118,330	1	1,146	–
Eastern and Coastal Kent PCT	28,999	–	568	–
Ealing PCT	2,977	–	281	1
Enfield PCT	2,563	–	170	0
Greenwich Teaching PCT	33,641	–	574	11
Hampshire PCT	10,784	15	986	–
Hertfordshire PCT	5,112	–	95	–
Haringey Teaching PCT	2,231	–	41	9
Islington PCT	2,369	–	98	–
Kensington and Chelsea PCT	2,391	–	73	–
Kingston PCT	2,979	–	190	–
Lambeth PCT	198,013	8,426	2,259	1,051
Leicestershire County and Rutland PCT	2,708	1	102	–
Lewisham PCT	59,141	71	491	–
Medway PCT	12,961	–	601	7
Newham PCT	3,387	–	176	–
Redbridge PCT	2,492	–	226	–
Richmond and Twickenham PCT	3,050	–	15	–
South East Essex PCT	13,634	15	646	–
Southwark PCT	148,352	4,885	2,172	1,300
Surrey PCT	12,679	8	1,048	–
Sutton And Merton PCT	8,685	300	442	–
Tower Hamlets PCT	3,206	–	188	–
Waltham Forest PCT	2,409	–	55	–
Wandsworth PCT	19,817	179	436	–
West Kent PCT	39,917	19	1,833	1
West Sussex PCT	25,872	–	1,035	–
Westminster PCT	14,865	–	1,553	–
HM Revenue & Customs – VAT	–	–	–	–
HM Revenue & Customs – Other taxes and duties	–	44,447	–	13,970
NHS Pensions Agency	–	54,374	–	–
NHSLA	–	9,193	–	–

## 32 Financial assets and liabilities

### 32.1 Financial assets

	GROUP		TRUST	
	March 31 2013 £000	March 31 2012 £000	March 31 2013 £000	March 31 2012 £000
Denominated in £ Sterling	191,477	194,926	184,983	195,893
In other currencies, restated in £ Sterling	7,997	4,298	7,997	4,298
<b>Gross financial assets at March 31</b>	<b>199,474</b>	<b>199,224</b>	<b>192,980</b>	<b>200,191</b>

### 32.2 Analysis of financial liabilities

	GROUP		TRUST	
	March 31 2013 £000	March 31 2012 £000	March 31 2013 £000	March 31 2012 £000
Denominated in £ Sterling	175,198	134,332	174,987	134,182
<b>Gross financial liabilities at March 31</b>	<b>175,198</b>	<b>134,332</b>	<b>174,987</b>	<b>134,182</b>

### 32.3a Financial assets by category

	GROUP Loans and receivables £000	TRUST Loans and receivables £000
<b>At March 31 2013</b>		
<b>Assets as per balance sheet</b>		
NHS debtors	13,234	13,296
Accrued income	25,962	25,962
Other debtors with related parties	777	–
Other debtors	45,962	43,954
Provision for doubtful debts	(19,350)	(19,350)
Other financial assets	3,500	–
Cash at bank and in hand	129,389	129,119
<b>Total at March 31 2013</b>	<b>199,474</b>	<b>192,981</b>
<b>At March 31 2012</b>		
NHS debtors	13,938	14,310
Accrued income	21,789	21,788
Other debtors with related parties	2,054	–
Other debtors	32,984	39,424
Provision for doubtful debts	(18,969)	(18,969)
Other financial assets	3,500	–
Cash at bank and in hand	143,929	143,638
<b>Total at March 31 2012</b>	<b>199,225</b>	<b>200,191</b>

### 32.3b Financial liabilities by category

	GROUP £000	TRUST £000
<b>Other financial liabilities</b>		
<b>At March 31 2013</b>		
NHS creditors	5,933	5,933
Other creditors	78,182	77,971
Accruals	48,832	48,832
Provisions under contract	12,221	12,221
Borrowings	30,030	30,030
<b>Total at March 31 2013</b>	<b>175,198</b>	<b>174,987</b>
<b>At March 31 2012</b>		
NHS creditors	17,049	17,178
Other creditors	52,911	52,762
Accruals	49,805	49,674
Provisions under contract	10,884	10,884
Borrowings	3,683	3,683
<b>Total at March 31 2012</b>	<b>134,332</b>	<b>134,181</b>

## 32.4 Fair values of financial assets at March 31 2013

	GROUP		TRUST	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Debtors over one year – Agreements with commissioners to cover creditors and provisions	1,804	1,804	1,804	1,804
Other	129,389	129,389	129,119	129,119
	<b>131,193</b>	<b>131,193</b>	<b>130,923</b>	<b>130,923</b>

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

## 32.5 Maturity of financial liabilities

	GROUP		TRUST	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
Less than one year	<b>132,800</b>	122,327	<b>136,240</b>	122,174
	<b>132,800</b>	122,327	<b>136,240</b>	122,174

## 32.6 Financial assets interest risk

GROUP				
Currency	Total	Floating	Non-	Weighted
	£000	rate	interest	average
		£000	bearing	interest
			£000	rate %
<b>At March 31 2013</b>				
Sterling	121,391	120,871	520	0.3
Other	7,997	8	7,989	0.1
<b>Gross financial assets</b>	<b>129,388</b>	<b>120,879</b>	<b>8,509</b>	
<b>At March 31 2012</b>				
Sterling	139,630	139,179	451	0.3
Other	4,298	33	4,265	0.3
<b>Gross financial assets</b>	<b>143,928</b>	<b>139,212</b>	<b>4,716</b>	
<b>TRUST</b>				
Currency	Total	Floating	Non-	Weighted
	£000	rate	interest	average
		£000	bearing	interest
			£000	rate %
<b>At March 31 2013</b>				
Sterling	121,122	120,871	251	0.3
Other	7,997	8	7,989	0.1
<b>Gross financial assets</b>	<b>129,119</b>	<b>120,879</b>	<b>8,240</b>	
<b>At March 31 2012</b>				
Sterling	139,339	13,179	160	0.3
Other	4,298	33	4,265	0.3
<b>Gross financial assets</b>	<b>143,637</b>	<b>13,212</b>	<b>4,425</b>	

## 32.7 Loan disclosure

	Weighted average effective interest rate %	1–5 years £000	5+ years £000	Total £000
<b>At March 31 2013</b>				
Fixed interest rate instruments	2.82%	625	29,405	30,030

## 32.8 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 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

### Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at March 31 2013 are in receivables from customers, as disclosed in the Trade and other receivables note.

### Liquidity risk

The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

## 33 Third party assets

The Trust held £128k cash and cash equivalents at March 31 2013 (£19k at March 31 2012) 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.

## 34 Losses and special payments

There were 1,331 cases of losses and special payments totalling £1,644k (1,173 cases totalling £858k at March 31 2012) approved during the year to March 31 2013. This includes cash payments during the year.

## 35 Heritage assets note

### Historic artefacts

There are remains of a Roman boat on the site of Guy's Hospital, in the land where the new Cancer Centre is being built. As well as being of significance in its own right, the artefact assists in interpreting and presenting our hospital to the public and provides a valuable research resource for heritage professionals. Subject to conditions not deteriorating, the current plan is that the Roman boat will remain preserved in situ and thus will remain on the Trust's land. The ground conditions around the boat will be subject to regular monitoring. Should conditions deteriorate to a certain level then a decision will be taken to remove the boat. The Trust has received scheduled monument consent from the Department for Culture, Media and Sport. The artefact has been disclosed as a non-operational heritage asset.

The Trust does not consider that reliable cost or valuation information can be obtained for the Roman boat, and even if valuations can be obtained, the cost would be onerous compared with the additional benefits derived by the Trust and the users of the accounts. This is because of the nature of the asset held and the lack of comparable market values. The Trust therefore does not recognise this asset on its Statement of Financial Position.

Donated artefacts received during the year had a value of nil (2012: nil). There were no disposals of artefacts during either year.



# 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](mailto: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](mailto:pals@gstt.nhs.uk)

## **Membership**

If you are interested in becoming a member of our NHS Foundation Trust, contact:

Tel: 020 7188 7188 extension 53186

Email: [members@gstt.nhs.uk](mailto: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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