

Guy's and St Thomas'
NHS Foundation Trust



Annual Report
and Accounts 2013-14

Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2013-14

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.

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

We have a long tradition of clinical and scientific achievement and – as part of King's Health Partners – we are one of the UK's six 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 Evelina London.

We have around 13,500 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 as the dedication and skill of our employees ensure that our services are high quality, safe and patient focussed.

King's Health Partners is one of only six 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



Our values have been developed in close collaboration with staff who strive to provide our patients with exceptional care every day. Last year we made a short film with our staff explaining what the values mean to them. To watch the film visit our website www.guysandstthomas.nhs.uk/about-us/our-values-and-pledges

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David (right) and Jonathan Dimbleby pictured at the foundation stone laying ceremony for the new Cancer Centre at Guy's. They are supporting a new fundraising appeal to complete the Centre where their charity, Dimbleby Cancer Care, will provide support and information for patients.

Chairman's statement

2013/14 was another exciting and challenging year for the Trust. We remain focused on improving standards of care for all the patients we serve in our hospitals and in the community, including our most vulnerable patients, in light of the Francis Report. This year, we have restated this commitment through a renewed emphasis on our values and a series of pledges that the Trust makes to our staff and patients to ensure that we listen and engage with them as we seek to provide safe, compassionate care.

We continue to invest in improving our hospitals and services. This year marked the beginning of a £20 million plan to redesign the Accident and Emergency department and transform the emergency care 'pathway' for patients at St Thomas'. This exciting project should be completed in March 2016. Construction work also continues on the £160 million Cancer Centre at Guy's which will provide leading edge care in state-of-the-art facilities. We have completed a £40 million scheme to refurbish the exterior of Guy's; and a similar scheme to refurbish the exterior of the East Wing at St Thomas' will be completed in 2014. We have made improvements to operating theatre facilities. New facilities for our dermatology, lupus and rheumatology services have been opened at Guy's.

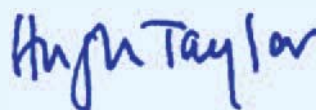
We are able to make investments like these because of the continued efforts of all our staff to maintain a balanced focus on quality, safety and efficiency. Focused programmes such as *Fit for the Future* have delivered excellent results and ensure that we enter 2014/15 on the front foot.

During the course of the year, King's Health Partners, our Academic Health Sciences Centre was accredited by the Department of Health for a further five years. The four organisations which form King's Health Partners have been considering a number of options about how the partners might work more closely together

in future and achieve more for patients. We have also been working with GPs, service users, carers and other health and social care and voluntary sector partners to shape our vision for Southwark and Lambeth Integrated Care (SLIC), a major initiative designed to join up services across all parts of the NHS locally and with social care. The programme, supported by a significant grant from Guy's and St Thomas' Charity, aims to provide better co-ordinated care and to enable people to take a more active role in their own health.

The Council of Governors continued to support the development of the Trust's strategy, providing valuable challenge and support. This year, we welcomed Lead Governor, John Porter and several other new governors following elections in June 2013.

The Trust remains indebted to the partners with whom we work and on whom we rely for support, notably Guy's and St Thomas' Charity. 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.



Sir Hugh Taylor, Chairman



Patient Celia Lewis pictured with ward sister Joyce Kakala. Last year Joyce was instrumental in developing new bedside name boards which allow staff and patients to record information that helps us to provide personalised care.

Directors' report 2013/14

Guy's and St Thomas' performed well – both operationally and financially – during another busy and demanding year. We continue to work hard to balance high quality patient care with achieving our performance targets in a challenging financial environment.

2013/14 was another busy and demanding year for the Trust as we continued 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 focused on.

Our staff have worked hard to achieve our CQUIN (Commissioning for Quality and Innovation) targets, QIPP (Quality, Innovation, Productivity and Prevention) demands and to comply with the requirements of our regulators, the Care Quality Commission and Monitor. We continue to build strong and productive relationships with our local Clinical Commissioning Groups, with specialist commissioners, our local Health and Well-Being Boards and Healthwatch groups.

High quality care

This year, the Trust has maintained its focus on providing high quality, safe and compassionate care for all our patients. Following the publication of the Francis Report, we have renewed this commitment and explored what more we can do to improve the patient experience.

Our Chief Nurse and other colleagues led a series of briefing sessions and listening events for staff, Board members and governors to discuss the findings of the Francis Report and what they mean for us. More than 2,000 staff took part in these events and, as a result of their

views and ideas, the Trust renewed its 'Showing we care' strategy which reaffirms our values and translates these into pledges that we make to patients and staff. Our pledges define the quality of care that patients will receive, and the mutual support and respect that our staff are expected to show each other.

This year, we have sharpened our focus on ensuring that we get the basics right for all our patients. The 'Fundamentals of Care' is a new programme that has been introduced across the Trust. All our senior staff, including the Chief Nurse and her senior team, have been assessed to ensure that they deliver exceptional basic care.

We continue to raise awareness of dementia amongst all our staff. Our award winning training programme – Barbara's Story – is now part of the Trust's corporate induction. Following the success of the initial film, a further five short films and training programmes have been developed with the generous support of the Burdett Trust to allow staff to learn from Barbara's experiences in different hospital and community settings as her health deteriorates.

The results of the 2013 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 over the 12 months to July 2013. 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 all of 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. Our *Fit for the Future* programme 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. During the year, over 600 staff have attended briefings on the programme, over 100 ideas for improvement have been submitted and 70 innovative ideas have been brought to our 'Dragon's Den'.

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.

This year, King's Health Partners was accredited for a further five years by the Department of Health following a highly competitive selection process. This renewed accreditation enables us to continue to deliver our ambition to be a world-leading health organisation through the integration of research, education and patient care.

Working as part of King's Health Partners enables us to deliver real benefits for patients and our local communities through closer working and better alignment of research and clinical services, and by integrating the diagnosis and care of patients' physical and mental health. With our partners, we have

made significant progress towards this ambition over the last year.

Our research activities continue to grow, with a 20 per cent increase in 2013 in the number of patients recruited to clinical trials across King's Health Partners. Our education agenda has also been moving forward, as part of the new Local Education and Training Board (LETB). 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. In 2013, our university partner, King's College London was ranked in the top 20 universities in the world, with life sciences and medicine ranked 19th globally.

There have been important developments in patient care across our partnership. In February 2014, the King's Health Partners Pathway Homeless Team was launched with the charity Pathway to coordinate care and services for homeless people admitted to our hospitals. A single multi-disciplinary team working across King's Health Partners ensures that these vulnerable patients are cared for in an integrated and effective way. In diabetes care, the i3-diabetes programme is a unique collaboration between King's Health Partners and global health care company Novo Nordisk that will lead to more effective and efficient ways of caring for people with diabetes.

The education agenda has progressed well this year, with the development of the Education

Academy to oversee all education and training activities across the partner organisations. In June 2013, King's Health Partners also launched an online learning hub for staff, students and trainees, providing access to learning materials on a wide range of healthcare topics.

The Trust is working as part of the wider south London health community to share innovations across the health system and capitalise on teaching and research strengths as part of our local Academic Health Science Network.

During 2013, the King's Health Partners Board developed an outline business case that considered various organisational models for an integrated academic health care organisation, including the possible merger of our three foundation trusts. Organisational change on such a scale and complexity requires a measured pace, informed by clear evidence of the benefits for patients and communities. In November 2013, it was decided that it was not the right time to progress merger considerations due to uncertainties in the external regulatory environment.

Most recently, King's Health Partners has agreed a revised governance structure to meet the needs of our Academic Health Sciences Centre over the next five years. The new structure will bring together a wider group of senior staff to support the development of Clinical Academic Groups. Leading non-executives will also be appointed to provide independent advice as part of the King's Health Partners Board.

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 decision to dissolve South London Healthcare Trust, we have worked closely with commissioners and other providers to support the provision of health care to the population of south London. The Trust has committed to providing a Kidney Treatment Centre and cancer services at Queen Mary's Hospital, Sidcup. This will enable the provision of world class care closer to home for patients with cancer and kidney disease.

We continue to play an active role in the south east London cancer and cardiac networks. We are an active member of the London Cancer Alliance (LCA), which brings together 16 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.

At St Thomas' we provide a wide range of very specialist services and sub-specialties. The site is home to Evelina London Children's Hospital, as well as one of the largest

intensive care units in the UK. We have many regional and national centres of excellence, including a major cardio-vascular centre and a comprehensive range of women's and children's services, many of which benefit from being co-located on a single site. This year, St John's Institute for Dermatology celebrated 150 years since it was first established in 1863, and remains a world leader for its clinical and research excellence.

Our services at Guy's also serve a wide population from across south London and further afield through a growing network of outreach clinics and satellite centres. As well as renal, urology and orthopaedic services, including complex surgery, cancer services at Guy's are a key strategic priority for the Trust and King's Health Partners.

We continue to make good progress with the development of the new £160 million Cancer Centre. Construction work began on site at Guy's in summer 2013 and the building is due to open in 2016. The Guy's Tower has become a major hub for research and includes a wide range of specialist facilities, which are strengthening our position as a leader in genomics, imaging and regenerative medicine.

As the provider of hospital and community services in Lambeth and Southwark we continue to explore ways to improve patient care by working in a more integrated way. The Trust is a key partner in Southwark and Lambeth Integrated Care (SLIC) which is initially focusing on improving care for older people and people with long term conditions.

This year, we opened a new amputee rehabilitation unit in Lambeth to support patients ready to leave hospital and prepare for life at home and we have expanded services such as our @home service and enhanced rapid response service to better support people in their own homes. From April 2014, children's community services have been fully integrated with Evelina London Children's Hospital to ensure that our young patients receive seamless care.

Investing in our future

During the past year, the Trust has continued to make substantial investments in its buildings, 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.

In January 2014, we committed £20 million to the redevelopment of the emergency floor and two admissions wards at St Thomas'. The new emergency floor at St Thomas' will include a larger urgent care centre, a refurbished A&E department and improved facilities for patients requiring emergency admission to hospital. We expect this work to be completed by 2016.

This year we have also made substantial investment in improved facilities for dermatology, lupus and rheumatology services at Guy's; expanded our endoscopy services at St Thomas' to meet growing demand for diagnostic tests; and created a comprehensive

cardio-vascular surgical centre at St Thomas'.

Improvements to our infrastructure have also been a key priority over the past year. We have completed work to re-clad the Guy's Tower and begun work to refurbish the exterior of East Wing at St Thomas'.

Looking forward, the Board has also approved significant investment to expand the services provided by Evelina London Children's Hospital, as well as continued investment in IT projects to deliver transformative technology such as e-noting, e-prescribing and new ways of working in our community services.

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

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 our NHS services.

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

- our longstanding contract with the Ministry of Defence to provide healthcare to British Forces and their families in northern Europe continues for a further six 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).
- a partnership with Remeo Healthcare, a division of BOC, is developing a satellite respiratory unit at East Surrey Hospital in Redhill which is progressing well, and will provide care closer to home for patients in Surrey. It is expected to open in late 2014.
- Essentia Trading is capitalising on our estates and facilities management expertise to generate income by providing services to other NHS organisations. It is building a small team to drive the business forward and has appointed an independent Chairman to its Board with other non-executive director appointments to follow.

Following a review of our governance arrangements, Guy's and St Thomas' Enterprises Ltd is now formally responsible to the Trust for the performance of its commercial ventures, including Essentia Trading. It is chaired by Robert Drummond and has recently appointed an external non-executive director, Philip Whitecross.

Business review

Guy's and St Thomas' has again performed well financially in 2013/14, despite the increasingly challenging financial environment. The Trust declared a surplus of £15.4 million for the financial year, before accounting for the gain from the transfer of community assets to the Trust of £41.6 million, revaluation of the Trust's fixed assets of £65.4 million, impairments of £18.4 million largely due to the revaluation of the Trust's assets, non-operating items of £0.3 million, and the receipt of £9.7 million of capital donations, which combined with the underlying surplus leads to an overall surplus of £113.4 million.

The Trust had planned to break-even prior to accounting for capital donations, impairments and the transfer of community assets, with an aspiration to achieve a £10 million surplus. The Trust has delivered an actual surplus of £15.4 million, this equates to circa 1.25 per cent of the Trust's turnover. The Trust believes 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 is planning to achieve a further £68 million savings in 2014/15 to deliver a small surplus of £3 million required to meet the principal payments of loans falling due in the financial year. The Trust expects to identify additional in-year efficiency opportunities to ensure we end the financial year with a financial surplus in excess of this, 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.

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;
- 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.

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 that 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.

The Trust was also named 'Trust of the year for London' by the Dr Foster Hospital Guide for our low mortality rates and safe care at weekends.

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. Our *Fit for the Future* programme brings together our work to ensure efficiency and high quality care are delivered in a co-ordinated way across the Trust. Staff have actively engaged with this agenda and contributed ideas and suggestions through a range of activities, including listening events and our 'Dragon's Den' challenge. These activities have contributed to the successful delivery of a £79 million cost improvement programme – achieved through a combination of efficiency savings and additional activity which has helped to generate income.

We continue to work hard to reduce hospital infections and to maintain an unrelenting focus on quality, safety and clinical

effectiveness throughout the organisation, including through the quality priorities we have agreed with local stakeholders for our Quality Accounts.

We were delighted to be rated above the national average in all four categories of the new Patient Led Assessments of the Care Environment (PLACE), covering key areas such as the quality of food and the cleanliness of the patient environment. These new inspections are carried out by teams made up of patients, the public and staff who score our facilities and services against 150 different standards.

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, our staff, the local community and the 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 available for patient care.

In April 2013, the Board approved a new sustainability strategy for the Trust that built on our successes to date and set ambitious targets for the next two years.

As part of our commitment to tackle climate change, we have

entered into an Energy Performance Contract (EPC) in partnership with British Gas to reduce energy consumption and carbon emissions by at least 10 per cent across our buildings, saving approximately £1.3 million a year. Through this partnership, British Gas will also invest in improvements to promote energy efficiency locally, including providing support for vulnerable patients to help them insulate their homes.

This year, we have focused on reducing water use through improvements to our infrastructure. So far, the Trust has saved over five million litres of water and we will continue with this programme of work as we aim to reduce our water use by 20 per cent each year.

As a major local employer, we actively support a number of initiatives to help local people into work. The Trust currently offers 28 roles for apprentices in non-clinical departments. Trust staff visit schools and colleges to promote careers within the NHS and to provide mentoring to young people.

In November 2014, the Trust took part in the Capital Experience event, to talk to young people about the range of career opportunities available within non-clinical services at the Trust.

We are also committed to supporting local businesses, and buy goods and services locally wherever possible.

We encourage and support our staff to lead healthy, active lives and provide facilities for patients, staff and visitors who cycle to work. The Trust provides cycle maintenance and safety checks for staff as well as

bike marking to improve security and road awareness training. Last year, 100 additional cycle spaces were created for visitors and staff at our hospitals and a secure cycle shed for staff was opened at St Thomas'.

As part of King's Health Partners, we have made a strong commitment to improving the health and well-being of communities overseas. We are proud to have developed links with health organisations in a number of African countries, including Zambia and Tanzania. The Agoon project enables medical students and junior doctors from the Trust to discuss mental health issues with students in Somaliland and Sierra Leone. While Project Zimbabwe supports collaboration in learning and research between students in the UK and Zimbabwe.

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. This year, the Trust welcomed Dr Sheila Shribman, formerly National Clinical Director for Children, Young People and Maternity, to the Board as an additional Non-Executive Director.

In 2013/14, 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; Mike Franklin; Professor Frank Nestle; Girda Niles; Sheila Shribman, from June 2013; 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: governors seeking the opinions of members on forward plans; appraisal of the Chair; and the evaluation and communication of the Council of Governors' performance. Further

details can be found in the full compliance statement on the Trust website.

The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess our performance, business model and strategy.

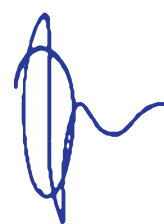
Looking ahead

Guy's and St Thomas' operates in a dynamic and demanding external environment, as the health and social care sectors respond to significant financial challenges, changes in the commissioning and regulatory landscape and the growing needs of our local populations. Our ability to respond is strengthened by the relationships that we build with partners across health, social care, research and education.

We continue our overarching focus on increasing efficiency whilst maintaining safe, high quality care, and 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 during the past year, most notably our 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 colleagues in King's Health Partners; and our many external stakeholders and supporters, in particular our local authorities, MPs, 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



Last year we were one of very few trusts in London to consistently meet the A&E target – that requires 95 per cent of patients to be diagnosed, treated and discharged from A&E within four hours – throughout the winter months.

Guy's and St Thomas' is one of the largest and busiest trusts in the country. During 2013/14, we saw 1,033,000 outpatients, 83,000 inpatients, 82,500 day case patients and 184,000 accident and emergency attendances. We also provided 866,000 patient contacts in the community, bringing our total to over two million a year.

About the Trust

Guy's and St Thomas' NHS Foundation Trust provides integrated hospital and community services, as well as a range of non-clinical support services to other healthcare providers through Essentia, our capital, estates and facilities directorate, which has recently established a commercial entity, Essentia Trading. We provide local health services, including community services, to people in Lambeth and Southwark, and specialist services to patients from across south London, south east England and further afield.

We care for patients at St Thomas' Hospital, Guy's Hospital and Evelina London Children's Hospital, and in over fifty community locations in Lambeth and Southwark including health centres and clinics, schools and nursing homes, as well as in people's homes. The central London locations of our hospitals, close to major transport hubs at Waterloo and London Bridge, make our sites ideal for local patients in south London and for those travelling to our hospitals from surrounding areas.

We are developing new models of care to respond to the changing needs of our patients and to innovations in healthcare. Through initiatives such as Southwark and Lambeth Integrated Care (SLIC), we recognise and support the aim of our local commissioners to deliver timely, high quality, patient focussed services in the most appropriate setting. As well as offering more care outside hospital, we are extending our services into evenings and weekends to make them more convenient for patients.

We offer nationally designated specialist services, including a unique range of sub-specialties many of which are dependent on co-location with other clinical services or our teaching and research activities.

As a major centre for emergency care, we are building capacity at St Thomas' by developing a new £20 million emergency floor due to open in March 2016. Guy's Hospital provides an important focus for elective and ambulatory care, and is also where we are building a £160 million Cancer Centre due to open to patients in 2016.

The scale of the Trust's operations is unique, with over two million patient contacts each year. We are currently one of the largest providers of specialist services to NHS England, providing specialist services valued at approximately £366 million a year, or 39 per cent of the Trust's clinical income. We are also commissioned to provide services by 98 clinical commissioning groups across the country.

We manage a wide range of service networks, outreach clinics and dedicated centres located across the south east. We continue to build on this strength with new services currently under development at Queen Mary's Sidcup and at East Surrey Hospital. As part of the healthcare community, we also provide specialist clinical and management support to other trusts and service providers.

We are part of King's Health Partners, one of six Academic Health Sciences Centres in the UK. As such, we are pioneers in health research and provide high quality teaching

and education. We are committed to integrating clinical care, teaching and research for the benefit of our patients, and our clinical research facilities at Guy's Tower place us in a strong position to drive research and innovation in emerging fields such as genomics, new imaging technology and regenerative medicine. Other collaborations in which we actively participate include the South London Academic Health Sciences Network, known as the Health Innovation Network South London, and the London Cancer Alliance, which brings together cancer services across south and north west London.

As an NHS Foundation Trust, we are accountable to Parliament, rather than the Department of Health, and regulated by Monitor. We are still part of the NHS and must meet national standards and targets, but we have more financial freedom to retain our surpluses and decide how we invest this money. Our governors and members ensure that we are accountable and listen to the needs and views of our patients.

Our strategic direction

Our Board of Directors sets the overall strategic direction of the Trust, within the context of NHS priorities, and monitors our performance against objectives. It also provides financial stewardship, clinical governance and corporate governance to ensure that we continue to provide high quality care that offers value for money.

Our ambitious clinical service strategy is focused on providing

integrated hospital and community services for local children and adults with ambitious plans to deliver high quality, cost effective care for our most vulnerable patients. We are also a leading 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.

Our strategic vision is underpinned by our four objectives, which are to:

- provide safe productive care;
- use resources effectively;
- release the talent of staff;
- build strong partnerships.

These objectives support our Trust values and our *Fit for the Future* programme which is essential in helping us to deliver a balanced performance that brings together quality, safety and efficiency, and puts the needs of our patients first.

Prudent financial management enables the Trust to generate surpluses year on year to support our ambitious capital programme, including innovative service developments and investment in new technologies. We continue to manage our estate in the most effective way and take advantage of commercial opportunities to diversify our income and develop new services for the benefit of our NHS patients.

In addition to our objectives, there are continuing priorities which we also need to deliver. These include national and local performance targets, a strong

financial performance in an increasingly difficult economic environment, and of course a range of quality and safety standards as we respond to the Francis, Berwick and Keogh reports.

This approach ensures that the Trust is uniquely well placed to play a leading role in the potential consolidation of specialist centres across the country, while continuing to provide health services to our local communities, including health promotion and prevention services.

Our performance

The Trust's performance is externally monitored against a range of national standards and targets. The Board of Directors also monitor performance against our Trust objectives and a range of other measures.

Our operational performance in 2013/14 was a tribute to the hard work of our staff and reflects some significant achievements.

We were one of very few trusts in London to consistently meet the A&E target – that requires 95 per cent of patients to be diagnosed, treated and discharged from A&E within four hours – throughout the winter months. New processes for managing the way that patients move through the A&E department are proving very successful and this is a positive achievement as we embark on major investment in improved facilities.

In January 2014 the Board of Directors approved a £20 million project to transform our A&E department and services for patients requiring emergency

admission to hospital by creating a redesigned 'emergency floor' at St Thomas'. Following consultation with staff and patients, work has now begun and we expect this to be completed in 2016.

While we met the majority of the national cancer access targets throughout the year, we continue to struggle to meet the target that all patients should be treated within 62 days of referral from their GP.

Since January 2014 we have met this target for all patients who are referred directly to Guy's and St Thomas' by their GP. However, we also see many patients who are referred to us for specialist diagnosis and treatment, having initially been seen at their local hospital. In common with other specialist cancer centres, we struggle to start treatment with 62 days for some of these patients, particularly where they are referred to us late in their pathway – often after 42 days.

We recognise the importance of providing prompt treatment for all patients and we are working closely with our commissioners and other hospitals in south east London to minimise delays at every stage in the patient journey. As a result we hope to see improvements during 2014.

We continue to have very low levels of hospital acquired infection and are committed to reducing this even further through a drive for cleanliness and zero tolerance of poor hand hygiene and clinical practice.

Last year we had three cases where MRSA blood infection was attributed to the Trust, against a target of none, and 44 cases of

C.difficile infection against a target of no more than 47 cases during the year. While we are not complacent, and recognise the constant need for vigilance, this is a good performance in an organisation of our size and complexity.

Going forward, in an environment where we are faced with a national and international increase in infections that are difficult to treat with standard antibiotics, we will renew our efforts to ensure appropriate anti-microbial prescribing for all patients.

Despite increased demand for our services last year – up 10 per cent on 2012/13 – we have continued to achieve the national referral to treatment targets that at least 90 per cent of admitted and 95 per cent of non-admitted patients should be treated with 18 weeks. As a result of the increase in referrals, our waiting lists have not decreased as planned and we are monitoring the situation very closely.

In the course of the year we have successfully reduced waiting times for diagnostic tests and imaging, with almost 99 per cent of patients being treated within six weeks of referral.

We continue to work hard to improve the accuracy and 'depth' of our clinical coding to ensure that we are appropriately recording the treatment we provide to patients, including details about the complexity of their care and any underlying health problems. This ensures we are paid correctly for the care provided and we are able to publish accurate information about clinical outcomes.

Our health visitors continue to

work hard to achieve national standards, including that they visit more than 95 per cent of babies within 14 days of birth. Through focused effort, we have achieved this target in both Lambeth and Southwark. They also deliver a programme of immunisation and exceeded their target of delivering the first dose of the MMR vaccine to those who had not been immunised within four months of their scheduled date.

Our school nurses also exceeded the target to give the MMR pre-school booster to those who had not been immunised within four months of their scheduled date, while our community reproductive and sexual health teams screen patients for alcohol problems, providing advice or referral for treatment where appropriate.

District nursing staff in Lambeth and Southwark, in common with colleagues across the country, continue to experience high vacancy levels and difficulty recruiting new staff, which impact on staff morale and leadership. We are putting in place a range of measures to strengthen this vital community service, although we recognise the challenge this presents given the national shortage of district nurses and the complexity of the workload in our local boroughs.

Our enhanced rapid response service has continued to increase its caseload over the past year and the @home service has been extended so that it is now offered across all localities in Lambeth and Southwark.

The Trust is registered to provide services by the Care Quality

Key performance indicators

		Performance		Quarterly Trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	MRSA bacteraemia attributable to Trust	0	3 ●	1	1	0	1
	C Diff (Clostridium difficile) acquisitions	<47	44 ●	4	15	13	12
Cancer access – initial appointments	Urgent GP referrals seen within 2 weeks	>93%	94.8% ●	95.6%	94.5%	95.0%	94.4%
	Non-urgent GP referrals to breast surgery within 2 weeks	>93%	94.4% ●	93.4%	96.8%	93.6%	93.7%
Cancer access – initial treatments	First treatments within 62 days of urgent GP referral	>85%	76.2% ●	76.0%	76.4%	74.0%	78.3%
	First treatments within 31 days of decision to treat	>96%	96.8% ●	97.6%	97.8%	94.9%	96.7%
Cancer access – subsequent treatments	Surgical treatments within 31 days	>94%	95.5% ●	98.0%	96.6%	89.7%	98.0%
	Chemotherapy treatments within 31 days	>98%	98.7% ●	98.7%	99.0%	99.1%	98.3%
	Radiotherapy treatments within 31 days	>94%	96.7% ●	96.9%	95.2%	98.0%	97.0%
Referral to treatment times	% admitted treatments within 18 weeks	>90%	91.9% ●	92.7%	92.3%	91.4%	91.1%
	% non-admitted treatments within 18 weeks	>95%	96.1% ●	96.6%	96.3%	95.7%	95.8%
	% incomplete pathways less than 18 weeks	>92%	93.5% ●	93.7%	93.6%	93.3%	93.6%
A&E access	% A&E patients treated or admitted within 4 hours	>95%	96.0% ●	95.6%	95.3%	96.5%	96.4%

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 2013/14, the Trust has been registered to provide services with no conditions or improvement notices.

Trust objectives

As well as successfully delivering a range of national targets, the Trust set its own objectives which were wide ranging and ambitious.

Our safety and patient experience work is described in chapter 6, and includes our staff 'listening exercise' in response to the Francis Inquiry; the development of Barbara's Story, with a series of additional films that further challenged our approach to caring for patients with dementia; as well as our response to the introduction of the Friends and

Family Test, which included a renewed focus on the small things that matter to our patients.

Other Trust objectives focused on our commitment to develop cancer and children's services, both within Guy's and St Thomas' and to benefit patients across the wider network. As well as the new Cancer Centre at Guy's, we are developing a satellite radiotherapy unit at Queen Mary's Hospital in Sidcup, and developing plans to enhance access to chemotherapy across south east London.

An outline business case was developed and approved which will enable us to expand the services provided by Evelina London Children's Hospital, both in response to increased demand for children's services, and to ensure that we are well placed and ready to respond to the possible consolidation of specialist services in future years.

Our commitment to the integration of community and

hospital services took a step forward on 1 April 2014 when we introduced a single management team for children's services.

We also progressed the Evelina London Child Health Project, a pioneering programme that is exploring new opportunities to better coordinate care and improve health outcomes for children and young people locally.

An equally ambitious initiative, Southwark and Lambeth Care (SLIC), made good progress last year as it seeks to breakdown organisational boundaries to improve care for older people and those with long term conditions. Both initiatives are fortunate to benefit from support from Guy's and St Thomas' Charity.

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. From April 2013, the Trust's CQUIN targets were agreed with our local clinical commissioning groups and NHS England. These targets required us to achieve a number of 'high impact innovations' as well as a range of targets.

Last year, the Trust achieved 98 per cent of its CQUIN targets agreed with commissioners, generating over £20 million of income.

For further details of the Trust's

performance in 2013/14 and our quality targets for 2014/15, see chapter 6. The Trust's annual Quality Accounts are also published separately and are available online at NHS Choices (www.nhs.uk) as well as on the Trust's website.

NHS Litigation Authority

The Trust was last assessed by the NHS Litigation Authority against their risk management standards for maternity services in June 2013, and we achieved level three – the highest level possible.

The assessments, which measure our effectiveness in managing risk, look at standards covering a wide range of activities from patient information to mandatory training for staff.

The Trust also holds the level three standard for acute services, although the NHS Litigation Authority will no longer be carrying out these assessments for acute services as it will be basing trust contributions to the scheme on an organisation's claims history.

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 our quality priorities have been developed with our stakeholders. Delivery against our priorities, and all measures of quality are closely monitored by the Board's

Quality Committee and regularly reported to the Board of Directors.

The Annual Governance Statement on page 94 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 2014/15.

Information risks

The Trust is required to assess and report information risks and data losses in a standard format. In 2013/14, the Trust reported no incidents to the Information Commissioner's Office.

Equality and human rights

The Trust serves the diverse local communities of Lambeth and Southwark, as well as caring for patients from further afield. This diversity is reflected in the profile of our patients and workforce, and brings many benefits. However, it is important to recognise that inequalities still exist, which may affect the quality of patient care or the experience of our patients or staff.

Our equalities objectives, developed in consultation with staff and with local health partners and endorsed by the Board of Directors, set out our priorities to drive improvements in patient care, staff experience and reduce inequalities for our diverse workforce and patient population. In developing these objectives, we have considered all strands of equality – age, disability, gender, ethnicity, race, religion and belief and sexual orientation – in accordance with the

Equalities Act and our public sector equality duties.

These objectives build on our existing Equality and Human Rights Scheme 2010-2013 and 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;
- ensuring that our facilities and services are accessible to all who need to use them.

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

We also recognise the importance of respecting and protecting the human rights of our patients, staff and local community members. The Trust is committed to safeguarding all our patients, including the most vulnerable.

We participate in our local, multi-agency Safeguarding Boards and ensure that valid consent is secured for treatment, including through robust Deprivation of Liberty Safeguards where required. All clinical staff receive training to ensure that they explain treatment options to patients before obtaining consent.

The Trust provides a comprehensive patient information and 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 now provide many of our core information leaflets in an Easy Read format. A multi-faith spiritual care team is available to support patients, and reflects the diverse faiths and beliefs of our local population.

Each clinical directorate has a dementia and delirium champion who works with colleagues to implement best practice in their area. In April 2013, the Trust won the Excellence in Care Category at the CHKS Top Hospital Awards in recognition of the high quality care provide to patients with dementia.

Under the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005 and the Equality Act 2006, employers are required to set out arrangements for how they meet specific employment duties. The

Permanently employed Trust staff – gender breakdown

All Trust staff 2013/14*	Number of staff	Full time equivalent	Percentage of full time equivalent
Female	9,748	8,850.72	73.05
Male	3,414	3,265.53	26.95
Total	13,162	12,116.24	
Directors and senior managers**			
Female	6	6	40
Male	9	9	60
Total	15	15	

*These figures are based on staff employed at March 31 2014 and exclude temporary staff.

**Directors and senior managers include all executive and non-executive directors.

Safeguarding training is given to all staff as part of the Trust's corporate induction programme. This now includes 'Barbara's story', our award-winning training film which aims to raise awareness of dementia and the issues faced by vulnerable patients and their families. The Trust has also signed up to the Dementia Action Alliance and is working with partners to provide better services for people with dementia, including through the creation of dementia friendly communities.

Trust collects a range of employment data to monitor diversity and inequalities, and we publish the results in annual workforce monitoring reports on the Trust's website.

The Trust undertakes equality impact assessments to provide assurance that our policies, functions and services are not discriminatory. Where any remedial action is identified by the assessment, we develop and implement an action plan to address this.

We work hard to involve patients in decisions about the development of our services. We have regularly involved patients and the local community in our plans to improve A&E and emergency services at St Thomas'. In November, we held a workshop with a group of lesbian, gay, bisexual and transgender patients to understand more about their experiences of using Trust services and how services could be improved.

The Trust strives to provide an environment equally welcoming to people of all backgrounds, cultures, nationalities and religions. 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 is a Stonewall diversity champion and a member of the Employers' Forum on Disability. In December, four of our staff were among 50 nationally named in the Health Service Journal's BME Pioneers list, celebrating outstanding contributions to the NHS by healthcare professionals from black and minority ethnic backgrounds.

Sickness absence

The Trust is required by Monitor to report the sickness absence rate amongst our staff. In 2013/14, the sickness absence rate was 3.4 per cent. We are continuing to address this issue through our campaign 'Who cares if you are not there?' which supports staff back into work after a period of sickness absence

and aims to raise attendance levels to over 97 per cent.

Sustainability and environmental performance

The Trust remains committed to acting sustainably and minimising our environmental impact. In April 2013, the Board approved a new sustainability strategy for the Trust that builds on our successes to date and set ambitious targets for the next two years. 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.

As part of our commitment to tackle climate change, this year we have reduced our carbon emissions by 8 per cent compared 2012/13. This has been achieved through a range of measures including by reducing our gas use through the replacement of the combustion management system and controls on the main boilers at St Thomas'.

The Trust has significant ambitions to reduce the impact of energy use even further, and has entered an Energy Performance Contract (EPC) partnership with British Gas to reduce energy consumption and carbon emissions further.

Through this partnership, we aim to reduce energy consumption and carbon emissions by an additional 10 per cent, saving approximately £1.3 million a year. Through this partnership, British Gas will also invest in improvements to provide energy efficiency locally, including providing support for vulnerable patients to help insulate their home.

Water consumption has increased in 2013/14 due, in part, to additional precautions against hospital acquired infections. The Trust is taking action to address this increase through investing in a comprehensive water saving programme to reduce water use wherever possible, improve infrastructure and save 20 per cent of our water use each year. Through this programme, which began in winter 2013, the Trust has saved over six million litres of water.

Combined Heat and Power engines, installed on both hospital sites in 2009, continue to reduce our carbon emissions by over 11,000 tonnes, saving us approximately £1.5 million a year. 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 waste to deliver cost savings and environmental benefit. In 2013/14, we increased the rate of recycling by 17 per cent, recycling an additional 174 tonnes of waste and we reduced our costs for dealing with waste by 15 per cent.

To reduce the environmental impact of transporting waste, all general waste from our hospitals is taken by barge along the Thames to an energy-from-waste facility in Kent. The energy from this facility powers homes in the London Borough of Bexley.

This year, the Trust awarded a new waste contract, which will further build on our strong environmental credentials, reduce waste costs even further, and

Environmental impact performance indicators 2013/14

Area	Non-financial metric 2013/14	Non-financial metric 2012/13		Financial data (£000k) 2013/14	Financial data (£000k) 2012/13
Finite resources					
Water	510,404 m ³	446,277 m ³	Water	£847	£664
Imported electricity	135,189 GJ	136,020 GJ	Energy	£10,259	£10,273
Gas	691,083 GJ	753,651 GJ			
CO ₂ emissions from building energy use	52,069 tonnes	58,324 tonnes			
Waste					
High temperature disposal	1,964 tonnes	2,207 tonnes	Total waste cost	£1,132	£1,328
Alternative treatment (offensive waste)	1,196 tonnes	1,273 tonnes			
Landfill waste	178 tonnes	176 tonnes			
Recycling – by % of total	28	23			

ensure that all staff in the waste management team are paid at least the London Living Wage.

The Trust remains committed to improving the environmental impact of our supply chain for goods and services and we work with the Carbon Trust to assess and monitor the carbon impact of our supply chain. We buy goods and services locally wherever possible. We host the London Procurement Partnership which delivers savings to London trusts and brings positive benefits for local suppliers.

In March 2014, the Trust won the Sustainable Procurement Award at the NHS Sustainability Day Awards, in recognition of our work to use our significant buying power for good – benefiting the environment, reducing costs, sourcing from ethically responsible suppliers, and directing investment to benefit the local community.

All our staff are 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 the NHS Sustainability Day of Action. A network of more than 130 staff, who act as local environmental representatives, support us in this work.

The Trust supports staff to lead healthy, active lives and provides facilities for patients, staff and visitors who cycle to work. The Trust provides cycle maintenance and safety checks for staff, as well as bike marking and road awareness training. Last year, 100 additional cycle spaces were created for visitors and staff at our hospitals and a secure cycle shed for staff was opened at St Thomas’.

Through Essentia Trading, we also offer sustainability and environmental management services to other health and social care organisations, including NHS trusts and clinical commissioning groups, to enable them to benefit from our expertise.

Guy's and St Thomas' has again performed well financially in 2013/14, despite the continuing difficult economic environment. The Trust declared a surplus of £15.4 million for the financial year, before accounting for the gain from the transfer of community assets to the Trust of £41.6 million, revaluation of the Trust's fixed assets of £65.4 million, impairments of £18.4 million due to the revaluation of the Trust's assets, non-operating items of £0.3 million, and the receipt of £9.7 million of capital donations, which combined with the underlying surplus leads to an overall surplus of £113.4 million.

Our financial performance

In 2013/14, the Trust set a financial plan to break-even prior to accounting for capital donations, impairments and the transfer of community assets, with an aspiration to achieve a £10 million surplus. The Trust has delivered an actual surplus of £15.4 million, this equates to circa 1.25 per cent of the Trust's turnover. The Trust believes this is a good performance at a time when efficiency savings have proved increasingly difficult to achieve without impacting adversely on patient care.

In setting the plan the Trust had identified the requirement for a £78 million efficiency improvement, equivalent to 6.7 per cent of 2012/13 turnover. At the end of the year, we had achieved £79.2 million 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; Pathology Services Limited; and

Table 1	2013/14 Plan £ millions	2013/14 Actual £ millions	Variance £ millions
Total income excluding capital donations and revaluation	1,184.5	1,223.3	38.8
Expenses excluding depreciation and impairments	-1,116.0	-1,140.1	-24.1
Depreciation	-44.5	-44.2	0.3
Operating surplus	24.0	39.0	15.0
PDC	-23.0	-21.8	1.2
Finance income	0.5	0.4	-0.1
Finance expenses	-1.5	-2.2	-0.7
Underlying surplus/-deficit for the year	0.0	15.4	15.4
Capital donations	7.4	9.7	2.3
Impairments and non-operating items	-26.6	-18.7	7.9
Gain from transfer from demising bodies	39.3	41.6	2.3
Revaluation		65.4	65.4
Total comprehensive I&E for the year	20.1	113.4	93.3

Essentia Trading Limited and its joint ventures: GSTS Pathology Limited 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 £41.1 million, of which £2.3 million related to donated capital assets. Expenditure was £24.1 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 £0.3 million below plan and the dividend on Public Dividend Capital costs was £1.2 million below plan. The Trust's financial charges, including interest on loans from the Independent Trust Financing Facility, were £0.8M above plan due to the earlier draw down of capital.

Table 1 compares the 2013/14 outturn to the 2013/14 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 clinical commissioning groups and NHS England 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 £2.3 million of income from charitable sources for investment in capital assets.

donations, which combined with the underlying surplus leads to an overall surplus of £113.4 million.

The Trust set a financial plan to break-even prior to accounting for capital donations, impairments and the transfer of community assets, with an aspiration to achieve a £10 million surplus. The Trust has delivered an underlying surplus of £15.4 million, this equates to circa 1.25 per cent of the Trust's turnover.

Table 2 shows the Trust's financial performance for 2012/13 and 2013/14.

Table 2	2013/14 Actual £ millions	2012/13 Actual £ millions
Total income	1,241.2	1,169.0
Expenditure including depreciation	-1,198.4	-1,163.8
Operating surplus	42.8	5.2
PDC	-21.8	-20.3
Interest on loans & receivables/other	-1.8	0.2
Retained surplus/-deficit	19.2	-14.9
Adjusting for:		
Impairments included above	13.8	25.9
Non-operating expenses	0.3	2.9
Revaluation included above	-8.2	0.0
Capital donations	-9.7	-4.8
Underlying surplus	15.4	9.1

Financial performance 2013/14

Guy's and St Thomas' has performed well financially in 2013/14 and the Trust has declared an underlying surplus of £15.4 million for the financial year, before accounting for the gain from the transfer of community assets to the Trust of £41.6 million, revaluation of the Trust's fixed assets of £65.4 million, impairments of £18.4 million due to the revaluation of the Trust's assets, non-operating items of £0.3 million, and the receipt of £9.7 million of capital

The Trust made an underlying surplus of £9.1 million in 2012/13 (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 £15.4 million in 2013/14, 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 clinical commissioning groups (CCGs);
- additional funding from the NHS England to recognise the specialist activity undertaken by the Trust and funded at national tariffs;
- the successful delivery of a significant cost improvement programme;
- continued benefits of supply stock cabinets.

These 'gains' have been partially offset by:

- the increase in costs associated with providing increased activity for commissioners, including meeting national waiting time targets.

The Trust delivered efficiency savings of £79.2 million in 2013/14, and will continue to drive down costs in future years as part of its plan to meet anticipated financial risks and to deliver surpluses that can be reinvested in service developments and our estate in support of the Trust's strategic vision.

Trends in activity, income and expenditure

Charts 1 to 5 on page 25 show activity and income and expenditure growth over a five year period from 2010/11 to 2013/14.

Activity trends

Charts 1 to 3 show the growth in inpatient and day case activity over the five year period, measured as completed patient spells – up by 19 per cent, and growth in outpatient attendances – up by 21 per cent.

Trends in activity, income and expenditure

Chart 1: Completed patient spells

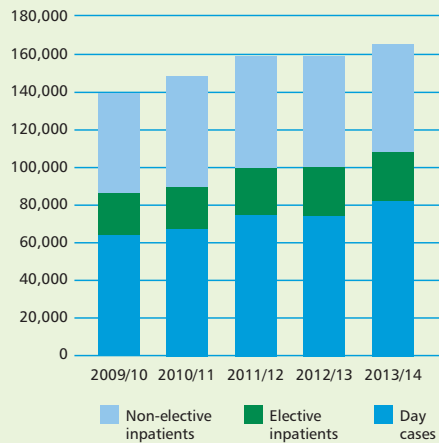


Chart 2: Consultant outpatient attendances

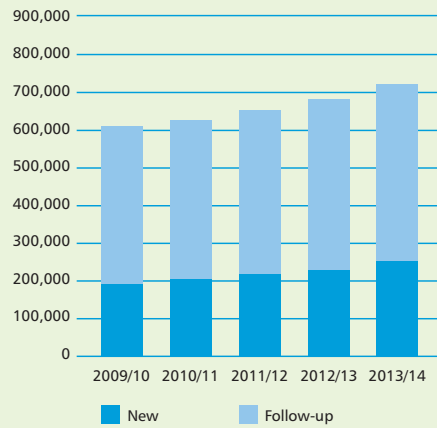
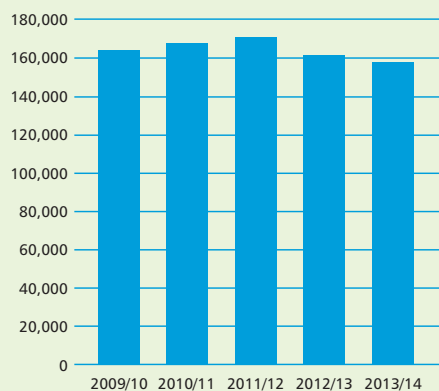


Chart 3: A&E attendances



Due to management changes, reported A&E attendances have included:

- until July 2012 - minor injuries unit attendances at Guy's
- from July 2012 to April 2014 - no activity at Guy's
- from April 2014 - will include urgent care centre attendances at Guy's

See page 26 for details.

Chart 4: Income £000s

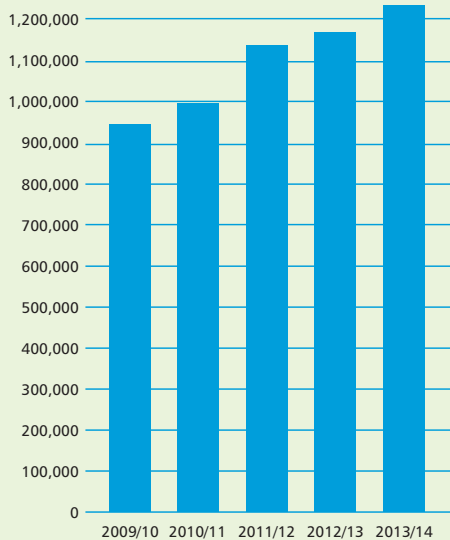
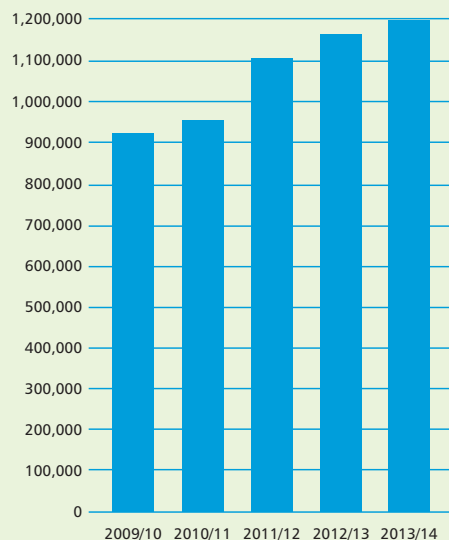


Chart 5: Expenditure £000s



The growth in inpatient and day case activity relates to increased demand for specialist (tertiary) services and the increased activity purchased by NHS England and clinical commissioning groups to achieve national waiting time targets. The majority of the activity growth over the period relates to day case activity.

Our operational performance in 2013/14 was a tribute to the hard work of our staff

Total outpatient activity has grown by 21 per cent (new outpatient referrals increased by 35 per cent and follow-up referrals increased by 15 per cent) over the period, reflecting the drive to reduce follow up attendances.

In July 2012, the management of the Guy's Hospital Minor Injuries Unit (MIU) was transferred to local GP practice, the Bermondsey and Lansdowne Medical Mission. The full year impact of this transfer has resulted in a further reduction in attendances of around 2.5 per cent in the total accident and emergency attendances from 2012/13. This service will transfer back to the Trust in April 2014. After adjusting the total activity for the MIU service transfer, the overall accident and emergency attendances in 2013/14 were comparable with 2012/13 attendances. Overall accident and

emergency attendances are up eight 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 2009 to March 2014. Income has grown at approximately eight per cent a year. However this includes the transfer of the London Procurement Programme from St George's Healthcare NHS Trust; Lambeth and Southwark Community Services; the NHS Revalidation Team and the South East London and South West London Shared Service Partnership in previous years. After adjusting for these, the underlying growth in income is circa five per cent a year over the five year period. The increase in income, above inflation, is mainly as a result of the commissioners of clinical services 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 eight per cent a year, adjusted to four per cent a year after accounting for the recent service transfers and the 2012/13 impairment charge. The underlying four 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 improvement in financial performance in 2013/14 is significantly better than that seen

in previous years, with income growing at six per cent, compared to three per cent in 2012/13 and expenditure growing at three per cent compared to five per cent in 2012/13. This improvement reflects the Trust's focus on improving productivity whilst reducing waste and inefficiency, including through our successful *Fit for the Future* programme.

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 £135.9 million cash in the bank, against a plan of £78.6 million. This was an increase in cash of £57.3 million compared to plan, and an increase of £6.5 million when compared with the £129.4 million position at the end of 2012/13. The increase in cash against plan is mainly due to the Trust under-spending against the capital expenditure plan by £42 million on NHS funded assets, the improved income and expenditure position of £15.4 million above plan and the increased draw down of loans of £13.6 million, offset by the variance in working balances against a plan of £13.7million

The Trust had a planned capital expenditure of £134.7 million for the year, excluding capital donations.

The actual capital expenditure was £102.5 million, consisting of £92.8 million from NHS funded assets and £9.7 million from charitable funds. The Trust drew down £70 million, against a

planned draw down of £56.4 million, from a total of £169 million of loans secured from the Independent Trust Financing Facility to support its capital programme.

The Trust's land and buildings were valued independently by the Valuation Office at March 2014, in line with the accounting policies. The valuation included positive and negative valuation movements.

Overall there was a net increase in the valuation of £49.6 million. £11.2 million was charged to the Consolidated Statement of Comprehensive Income as the Trust's buildings had insufficient revaluation reserves to fund the valuation movement. A net benefit of £52.5 million was recognised in the Statement of Financial Position. Positive valuations were charged to the Revaluation Reserve of £25.4 million on land and £31.7 million on buildings. For positive revaluations, a further £8.3 million of previous year impairments were

the revaluation reserve.

In addition to the valuation movements, an impairment of £2.4 million was charged to the Statement of Comprehensive Income for intangible assets, primarily for an asset no longer in use. There were further tangible asset impairments of £0.2 million charged to the Statement of Comprehensive Income.

As at 1 April 2013, the ownership of nine properties, and some plant and equipment associated with those properties, transferred to the Trust from Lambeth and Southwark Primary Care Trusts. The total value of the assets transferred was £41.6 million.

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 2013/14, the Trust spent

The scale of the Trust's operations is unique, with over two million patient contacts each year

reversed and recognised in other operating income in the statement of Statement of Comprehensive Income, where in previous years there had been insufficient revaluation reserve balances to offset impairments. An impairment of £4.6 million was also charged to

£9.7 million from charitable grants on capital projects, and also received £7.5 million in charitable contributions towards revenue expenditure.

Capital expenditure

Capital expenditure during 2013/14 was focussed on protected assets and included backlog maintenance, the provision of medical equipment and investment in IT projects. The Trust's major development of the Cancer Treatment Centre at Guy's is now well under way and is due to open in 2016. Table 3 shows a breakdown of the different sources of the capital and how this has been spent.

Table 3	NHS or grant funded £ millions	Donated £ millions
Buildings	8.6	1
Assets under construction	82.3	8.7
Plant and machinery	0.1	
IT	1.8	
Total	92.8	9.7

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 and their families in northern Europe was renewed from April 2013 until March 2020. This is a seven year contract linked to the rate of withdrawal of UK troops from Germany.

Income from the provision of healthcare in England continues to make up the vast majority of the income the Trust receives, and is considerably greater than the aggregate income received for other purposes – for more detail, see Notes 3 and 4 to the accounts.

Prudential Borrowing Limit

The Prudential Borrowing Code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1st April 2013 by the Health and Social Care Act 2012.

Capital loans

The Trust has agreed loans totalling £169 million with the Independent 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 2013/14 the Trust drew down £70 million of the agreed loans to cover the expenditure incurred, and a total of £100 million of the £169 million has now been utilised. In 2013/14 the Trust repaid £0.625 million principle of the loans drawn down and plans to repay a further £3 million in 2014/15.

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 2013/14 financial year. The Trust incurred £130,700 (excluding VAT) in audit services fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries' to 31 March 2014. This included £17,500 (excluding VAT) for assurance work in relation to the Trust's quality report.

Going concern

The Directors have reasonable expectations that the Trust has adequate resources to continue in

operational existence for the foreseeable future. For this reason the Trust continues to adopt the going concern basis in preparing the accounts.

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 continuity of service risk rating of the Trust, introduced in 2013/14.

Monitor uses two criteria to assess the Trust's continuity of service financial risk rating, these being capital service cover and liquidity. At the end of the financial year the Trust achieved a risk rating of four, in a range of one to four where four 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;
- 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 £68 million savings in 2014/15 to deliver a small surplus of £3 million required to meet the principal payments of loans falling due in the financial year. The Trust expects to identify additional in-year efficiency opportunities to ensure we end the financial year with a financial surplus in excess of this, 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 coming financial years whilst sustaining high quality, safe services and responding to the recommendations following the Francis, Berwick and Keogh reports. To deliver the scale of change required to achieve the level of efficiency needed over the coming years, the Trust has established a strategic, trust wide programme *Fit for the Future*. This consists of 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, surgical productivity, improving outpatient services and maximising the benefits of capital investment.

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 that 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.

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 2014/15.

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.

Commissioning intentions for 2014/15 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.

Changes to healthcare configuration in London

National and regional policy and commissioning strategies mean we expect to see changes in the way that services are commissioned and provided in the medium term. These changes may include the potential centralisation of specialist services into fewer centres and a review of emergency care. The Trust has considered the risk and opportunities associated with these potential changes as follows:

Specialist services: NHS England has signalled that there could be large-scale changes to specialised commissioning in medium-term, potentially centralising specialised service providers from over 148 providers currently to 15-30 'centres of excellence'. Any planned consolidation of specialised services resulting in them not being provided by the Trust, is a serious risk to our income. However, we are well placed to be a new 'centre of excellence' and continue to achieve the numerous clinical co-dependency and efficiency benefits that result from our current extensive portfolio of specialised services.

Emergency care: NHS England has also signalled that they intend to run a national emergency care centre review process, designating either 'emergency centres' or 'major emergency centres'. We plan to continue to have a major emergency centre (our current A&E) at St Thomas' Hospital and are investing significantly in this service as part of our emergency floor project. Not being designated risks both our income flows resulting from

emergency attendances and, more importantly, the economies of scale created by having emergency, acute medical, specialised and elective work all on the St Thomas' site.

Elective centre: We have worked hard to become an efficient elective service provider, with a particular focus on the Guy's Hospital site. Changes to the configuration of elective services as a result of changes to the market or the configuration of services in south east London, risks our elective service income streams. We believe that we are well placed to increase our market share of elective activity given the Trust's location close to London Bridge and Waterloo, as well as due to the scale and quality of services currently provided.

Savings and activity plans

The Trust has set itself challenging financial targets over the coming 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 affordable and can be delivered within the funding available.

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 this 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 around 2.5 per cent of the Trust's clinical income, which will be dependent 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 have established 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;
- grow our private inpatient medical, children's and maternity services at St Thomas';

- continue to develop our joint venture pathology services, GSTS Pathology, recently renamed Viapath – a limited liability partnership between Guy's and St Thomas', King's College Hospital and Serco PLC;

- provide outpatient pharmacy services, with J Sainsbury plc on both main hospital sites, with further retail development in 2014 on the Guy's site;

- expand our international portfolio, in line with our clinical and academic strategies;

- promote an active programme to capture and commercially develop our intellectual property.

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



Sir Ron Kerr

Chief Executive
and Accounting Officer
29 May 2014



Trust Chairman Sir Hugh Taylor, and Chair of staff side Dino Williams, sign the new 'Inspire your Future' learning agreement between the Trust and local trade unions to give staff better access to education and training.
Photographer: Jess Hurd.

4

Our people – patients, staff and partners

The Trust aims to improve the quality of care and the experience of patients using our services by working closely with patients, families and carers, staff and other partners. This enables us to 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 by hearing the views of our patients, their relatives, carers and visitors that we can provide the best possible services.

Listening to patients

We remain 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 14,500 inpatients and more than 14,400 outpatients completed a survey using this system.

We continue to see high levels of satisfaction with the services we provide, with 89 per cent of both inpatients and outpatients reporting that they were satisfied with their visit to our hospitals and the quality of care they received, while 93 per cent of inpatients and outpatients said that they always had confidence and trust in the staff treating them. Satisfaction with the cleanliness of the ward environment and bathroom facilities remains high, with between 92 and 99 per cent of patients reporting that areas were very clean or fairly clean.

Young patients and their families also complete our local survey to share their views on the services provided by Evelina London

Children's Hospital. Within children's services, 88 per cent of inpatients and 84 per cent of outpatients tell us that they were satisfied with their visit to Evelina London, while 92 per cent of inpatients said that they received the right amount of information about their condition and treatment.

Following a successful pilot of near-time patient feedback in a selection of our community clinics, this year we have extended the system to cover district nursing and health visiting services. 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.

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.

Like other hospital trusts in England, we have introduced the Friends and Family Test to ask patients whether they would recommend our wards and A&E department to a friend or family member if they needed similar care or treatment. The Trust has achieved scores above the national average, with 79 per cent of inpatients and 55 per cent of patients attending A&E saying that they would recommend our services. In the second half

of the year the test was extended to women using our maternity services in the community and in our hospitals.

This year, the Trust has piloted a new national service, Care Connect that enables patients to tell us about their experiences at our hospitals, including any problems, by phone, text, online or via social media. Issues raised are passed to our Patient Advice and Liaison Service (PALS) who help to resolve them as quickly as possible.

Our staff work hard to ensure that every patient's experience of care is as safe and comfortable as possible

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 experience of care is as safe and comfortable as possible. This year, we have focused on reducing noise on our hospital wards at nights, working with contractors to minimise noise from essential building work and introducing simple measures such as soft close bins to ensure that the ward is as peaceful as possible. We are also taking steps to improve the information that we give patients when they leave hospital. Following the success of the ward pack that is given to all new inpatients when they arrive on a ward, we are developing a 'discharge pack' to support patients when they leave hospital.

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 the patient experience such as patient transport, catering and the attitude of staff. We are working hard to learn from this 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, the Trust has introduced new patient-led assessments of the care environment (PLACE), an NHS England inspection programme that has replaced patient experience action team (PEAT) inspections.

The Trust recruited and supported 40 patients and members of the public to participate in these assessments with our staff and governors. The views of patient assessors also informed the development of an action plan that the Trust has implemented over the past 12 months.

This year, the Trust secured funding from the Department of Health and the King's Fund to improve the ward environment for patients with dementia. Patients, carers and staff contributed ideas to help us improve our existing older people's wards. We also displayed the proposed designs on the Trust website and at St Thomas', gathering feedback from over 100 patients, members of the public and community groups. The ward improvement programme starts in 2014.

Patients remain at the heart of the development of our new Cancer Centre at Guy's. This year, an arts steering group of patients and staff selected three artists to develop artworks, funded by Guy's and St Thomas' Charity, that will form part of the design and fabric of the new building when it opens in 2016.

Patients, including older people, patients with long term conditions and mental health service users have contributed their views to the £20 million redevelopment of the emergency floor, including A&E at St Thomas'. In July 2013, patients and their families were invited to a workshop to share their experiences, discuss the proposed layout and explore improvements to emergency care at the Trust.

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 600 new or updated patient publications. We now have over 1,000 bespoke publications in use across the Trust. We also approve externally produced patient information from a range of organisations. This year, new

publications included family care packs for relatives and carers of patients who are at the end of their life, and Easy Read translations of key information on Trust services that are especially relevant to patients with learning disabilities.

In September, the Trust was awarded the British Medical Association (BMA) award for innovation in patient information for our hospital welcome pack. The pack provides patients with information about what to expect during their stay, as well as an airline-style safety card, anti-slip safety socks and other essential items such as toiletries.

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 46,500 people visited the centre and staff also responded to almost 6,500 queries by email and telephone.

During the year, PALS received over 11,000 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 13,500 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.

By asking our patients what they think, we continue to make changes and improvements that they want

Accounting policies for pensions and other retirement benefits are set out in Note 1 to the accounts, and details of senior employee's remuneration can be found in Note 6 to the accounts.

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.

We work hard to ensure all staff are aware of the issues affecting the organisation, such as changes to the NHS and the impact of the Francis Report. This year, our 'listening exercise', conducted in response to the Francis Report, saw around 600 staff attend Trustwide drop-in briefing sessions and almost 1,300 staff attended 100 local focus groups. This provided a valuable opportunity to listen to staff and ask what we can all learn from Francis so that we provide a patient experience that remains true to the core NHS values of care and compassion. Our 'listening exercise' won best internal communications at the national Association for Healthcare Communications and Marketing (AHCM) Awards.

Our range of well-established communications channels include a monthly team briefing, a regular staff email bulletin and our intranet, GTi, which provides a central resource where staff can find policies, guidance and online tools. We hold regular face to face briefings on both clinical and management issues and produce a popular magazine, *The GiST*, 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 Trust 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 2013, surveys were sent to a random sample of 828 staff, and 50 per cent completed the survey. The areas of best and weakest performance are shown in the table on page 38.

The results for 2013 show that the Trust has continued to perform well in a number of key areas. 86 per cent of staff said that they were satisfied with the quality of care they are able to deliver, compared to a national average of 79 per cent. On a scale of one to five, staff rated the Trust at 4.15 as a place they would recommend to work or receive treatment – well above the national average for staff in similar trusts which is a score of 3.68.

The Trust uses the results of the national staff survey, the Friends and Family Test and other staff feedback to address any areas of concern and to improve working life. We work with staff representatives to addresses issues raised by staff and 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.

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 Trust awards provide us with an opportunity to acknowledge and thank staff. This year we have also introduced a 'going the extra mile' badge, which is awarded to staff who go above and beyond in demonstrating care, compassion, commitment, competence, courage and communication – the 6Cs essential to the delivery of compassionate care.

Equality and diversity

We serve diverse local communities in Lambeth and Southwark – and this diversity is also reflected in the profile of our workforce. The Trust remains committed to providing services that are inclusive across all strands of equality – age, disability, gender, ethnicity, race, religion and belief and sexual orientation – in accordance with the Equalities Act and our public sector equality duties.

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 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;

- ensuring that our facilities and services are accessible to all who need to use them.

These objectives build on our 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 regularly reporting back on our performance.

The Trust is committed to paying all permanently employed staff the London Living Wage, and is working with its contractors to negotiate the same minimum wage guarantee for staff employed by them. All staff receive pay awards in line with national recommendations.

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 has an active Lesbian, Gay, Bisexual and Transgender (LGBT) network, which works closely with Stonewall and helps us to provide support for staff and services which meet the needs of our diverse communities.

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

- a national pilot scheme for e-mentoring, enabling Trust staff to mentor young people from local schools and colleges through an online forum;

Staff survey

	2013		2012		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
Response rate	50%	50%	41%	49%	Improvement
Areas of best performance					
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	86%	79%	83%	78%	Improvement
Staff recommending the Trust as a place to work or receive treatment	4.15*	3.68*	4.08*	3.57*	Improvement
Percentage of staff reporting good communication between senior management and staff	43%	29%	37%	27%	Improvement
Percentage of staff experiencing physical violence from staff in last 12 months	1%	2%	2%	3%	Improvement
Areas of weakest performance					
Percentage of staff having equality and diversity training in the last 12 months	41%	60%	38%	55%	Improvement
Percentage of staff experiencing discrimination at work in last 12 months	16%	11%	17%	11%	Improvement
Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	30%	28%	26%	29%	Deterioration
Percentage of staff believing the Trust provides equal opportunities for career progression	84%	88%	81%	88%	Improvement

* Scored out of 5.

- an expanding range of apprenticeships with departments across the Trust;
- the Autism Project (TAP): a work placement programme to support young people with autistic spectrum disorders to gain qualifications and the skills needed to find work;
- partnerships with Centrepont and ThamesReach to offer work placements and careers advice to formerly homeless people, supporting them to re-enter employment;
- hands Up for Health: a project that gives young people practical understanding of health careers through courses held in our simulation facilities;

- clinical Insight: a project that aims to improve access to clinical placements for a wider range of young people, from all backgrounds.

In December, four of our staff were among 50 nationally named in the Health Service Journal's BME Pioneers list which celebrates outstanding contributions to the NHS by healthcare professionals from black and minority ethnic backgrounds.

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 Education Centre at York Road, close to St Thomas', provides high quality teaching and learning facilities for staff.

In addition, the Trust has introduced a number of new initiatives during the last year. 'Inspire your Future' is a new learning agreement between the Trust and local trade unions to give staff better access to education and training.

Our award winning training programme to raise awareness of dementia among all staff – Barbara's Story – is now part of the

Trust's corporate induction. Following the success of the initial film, a further five short films and training programmes have been developed with the generous support of the Burdett Trust to allow staff to learn from Barbara's experiences in different hospital and community settings as her health deteriorates.

Following our 'listening exercise' in response to the Francis Report, during which staff reflected on the report's findings and what they mean for us, the Trust has further developed its 'Showing we care' strategy. This reaffirms our commitment to the Trust's values and develops them into pledges that we make to our patients and staff. These pledges define the quality of care that patients will receive, and the support and respect that staff are expected to show each other.

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

Volunteers

Our patients and staff benefit greatly from the support of a team of volunteers. This year, their number has grown to over 520 volunteers who contributed an estimated 28,000 hours 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 overseen the completion of 21 projects and has recruited volunteers to 26 ongoing projects. These projects give volunteers opportunities to support patients and staff in our hospitals and in community settings, and enable 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 '5 ways to a healthier you', a programme of initiatives that increase the opportunities for staff to get healthy at work, such as support with nutrition and weight loss; self-referral physiotherapy services; and access to cognitive behavioural therapy.

From January 2014, staff were no longer permitted to smoke anywhere on Trust premises, in line with recommendations from the National Institute for Health and Care Excellence (NICE). Staff are offered support to stop smoking through the Trust's enhanced smoking cessation services, and can also learn more about how to support patients who want to give up smoking through a new

e-learning training programme.

In recognition of our approach to staff health and well-being, we hold 'excellent' status in the Department of Health's 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, including annual flu vaccinations for staff. 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, with a clear vision to bring clinical services, research and education more closely together for the benefit of patients.

During 2013, the King's Health Partners Board developed an outline business case to consider

various organisational models for an integrated academic health care organisation, including the possible merger of our three foundation trusts. Organisational change on such a scale and complexity requires a measured pace, informed by clear evidence of the benefits for patients and communities. In November 2013, this Board decided that it was not the right time to progress merger considerations due to uncertainties in the external regulatory environment.

King's Health Partners remains committed to an ambitious programme of work and has

closely with a wide range of partners including local authorities, clinical commissioning groups, GPs, voluntary organisations, other hospital and mental health trusts and Guy's and St Thomas' Charity. Our shared aim is to improve care for older people and people with long term conditions, avoiding unnecessary hospital admissions wherever possible.

The Trust is represented on the Health and Well-Being Boards for Lambeth and Southwark by the Trust Chief Executive and the King's Health Partners' Director of Clinical Strategy. The Health and Well-Being Boards continue to make a valuable contribution by helping define the strategic direction of health and social care services locally. The Trust also works closely with Lambeth and Southwark local authorities through their Health Overview and Scrutiny Committees, for example when deciding on the Trust's quality priorities or when potential changes to the provision of services are proposed.

Representatives from the Trust regularly meet with Healthwatch Lambeth and Healthwatch Southwark, our local patient voice organisations. This year, we have benefited from the support and insight of Healthwatch representatives as we develop the Trust's patient and public engagement strategy. They have participated in the workshops and also discussed the emerging strategy at their public meetings.

We work closely with the South Bank Employers Group and last year we provided over 400 work placements for local school

Guy's and St Thomas' Charity and the Trust continue to work closely on a number of long-term transformational programmes

developed a new governance structure to enable the organisation to deliver continued improvements in education, research and clinical services.

The Trust is a founding member of Southwark Lambeth Integrated Care (SLIC), a system-wide programme that aims to change how care services are delivered to ensure that physical and mental health and social care services are integrated and coordinated to meet each patient's needs. Through the programme, we work

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.

Following the Secretary of State decision to dissolve South London Healthcare Trust, we have worked closely with commissioners and other providers to support the provision of health care to the population of south London. The Trust have committed to providing a Kidney Treatment Centre and cancer services at Queen Mary's Hospital, Sidcup. This will enable to provision of world class care for patients with cancer and kidney disease closer to home.

The London Cancer Alliance (LCA) brings together 16 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 continue to work with our partners in the LCA to develop an integrated system of care.

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 healthcare innovation and services across the Trust and King's Health Partners. The Trust is the principal beneficiary of the Charity and during 2013-14, the Charity made 56 new awards to the Trust, with a total value of £7 million.

The Charity and the Trust continue to work closely on a number of longer-term transformational programmes, to which the Charity has made significant contributions in recent years. These include 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. The Charity also supports two important integration programmes – Southwark and Lambeth Integrated Care (SLIC), and the Evelina Child Health Programme.

This year, the Charity has continued to support the Trust's staff development and health and well-being initiative through a grant of £1.5 million over a further three years. In addition, the Charity has made 39 individual staff awards to support professional development and training. The Charity has also made a major contribution of £4.3 million to the Biomedical Research Centre, a collaboration between the Trust and King's College London which is dedicated to 'translating' scientific discoveries into improvements in treatment which will benefit patients at the earliest opportunity. Other grants have included £581,000 to support the Trust to develop a pioneering arts-based learning programme for health professionals with a focus on developing team-work, leadership and decision-making skills in high stress situations.

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, known as *Together we can*. The Trust is very appreciative of the continued support of patients and their families, the local community, businesses and individuals who support us through donations and a wide range of fundraising activities.



Dr Emma Craythorne, consultant dermatologist and dermatological surgeon pictured examining skin samples. Last year we celebrated the 150th anniversary of the world-renowned St John's Institute of Dermatology.

5

Teaching and research and development

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

Teaching

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

Education and research are central to our responsibilities as leading teaching hospitals and a major academic centre, and underpin our vision for our Academic Health Sciences Centre, King's Health Partners. They are also fundamental to King's Health Partners' relationship with the new Local Education and Training Board (LETB), Health Education South London (HESL), which is responsible for the design, development and delivery of a workforce to improve the health and well-being of people in south London. This year, the Trust has been awarded strategic funding by HESL to develop education programmes in paediatrics, end of life care, sonography, widening participation and workforce redesign. We also work closely with HESL to develop placements in the community and to enable health professionals to work together.

This year, the Trust has begun to implement a new, three-year education, training and development strategy. Developed in consultation with our staff and local education partners, this approach will enable us to meet the changing health needs of our local population, to attract and nurture outstanding healthcare professionals and to prepare our staff to respond to the changing

external environment. In February, Trust Chairman, Sir Hugh Taylor, and the Chair of staff side signed a new learning agreement that commits the Trust and our staff to work in partnership to support staff learning and development.

The Trust continues to develop our training and development programmes to ensure that they reflect 'real life' experience and patient feedback, and are in line with new standards introduced by the Care Quality Commission. We also make best use of new technologies to offer e-learning packages, online reporting and multi-media tools, as well as face-to-face learning.

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 across King's Health Partners, including the Olympus Simulation Laboratory at Guy's that provides additional simulators and part-task trainers. The centre at St Thomas' 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.

Last year, over 4,500 undergraduate and postgraduate doctors, nurses, allied health professionals and other staff have undertaken training in the SaLL Centre. This high volume of activity and the wide variety of courses offered is supported by funding from a number of sources, including Health Education South London.

We offer a wide and growing variety of courses for different groups of healthcare professionals, including those working in primary, community and residential care. We have continued to expand the range of innovative programmes we offer to support staff development in areas including patient safety, patients with delirium and dementia, and ethics and the law in an emergency setting.

We work as part of a Simulation Network that brings together ten simulation centres across south London to share best practice and raise the standard of simulation education across the region. We remain committed to widening access to medical careers and host visits from local school children through the 'Hands up for Health' outreach programme.

Undergraduate education

Each year, more than 320 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 a well-rounded education experience for our students. This includes 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 continued to expand opportunities for teaching and learning through increased funding for new education programmes. Undergraduate students benefit from our clinical skills training programme, 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 to improve where necessary. Education leads within each of our clinical directorates also work closely with College colleagues to develop the undergraduate curriculum and to ensure that we maintain high standards of teaching.

Postgraduate education

The Postgraduate Medical Education Department continues to deliver excellent training and education programmes from the Education Centre at York Road, the Sherman Education Centre at Guy's and in healthcare settings across south London.

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 in August, which include a robust online induction programme and a number of smaller, specialist inductions throughout the year. The team also provides an advisory service for all junior doctors and offers bespoke programmes for trainees who need additional support.

The postgraduate medical education department supports the continuing professional development of consultants, doctors in training and other healthcare professionals. We offer a wide range of courses that develop leadership, teaching and supervision skills in our staff.

The department remains successful in securing funding from Health Education South London to expand its innovative portfolio of courses and training for clinical staff. This year, we have secured £79,000 to support our education and training programmes, including the development of training leads and directors for postgraduate programmes. We have also secured a £4,800 bursary from Health Education England for paired learning which directly supports our leadership programme for junior and higher specialty doctors. Through this programme, our trainee doctors are leading innovative patient safety and quality improvement initiatives within their specialty areas.

The Trust is 'lead provider' for 19 higher specialty training programmes, funded by the London Commissioner for Medical and Dental Education, making us the largest lead provider of postgraduate programmes in south London. 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, London Southbank University and King's College London to recruit and retain the nurses who we have supported during their training. Last year, we recruited 181 newly qualified nurses. 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 undergraduate clinical placements to over 500 nursing students and midwives each year. 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. Our Chief Nurse meets all students throughout their placements to support their learning and listen to their experiences.

We support the continuing professional development of our nursing staff and offer a range of postgraduate education opportunities, supporting those who wish to undertake masters degrees, PhDs and district nursing and health visiting qualifications. Newly qualified nurses and health visitors also benefit from preceptorship programmes to support them during 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 started to roll out the nursing assistant diploma and over 180 staff attended two nursing assistant conferences. Nursing assistants also made a valuable contribution to the Trust's input into the Cavendish Review, which was recognised at a reception held in the House of Commons. The Trust has worked with this staff group to develop a nursing

assistant code of conduct, which launched in November.

This year, we have renewed our commitment to the six C's of nursing – care, compassion, competence, communication, courage and commitment. We continue to encourage our nursing staff, along with other colleagues, to watch 'Barbara's story', our award-winning films which are designed to improve awareness and understanding of the issues faced by patients with dementia.

Research and development

Our hospitals have a long tradition of making significant medical break-throughs 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 six 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.

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 home to a wide range of research facilities and partnerships, including: the Biomedical Research Centre; the King's Health Partners Clinical Trials Office; the Clinical Research Network for South London; the Research Design Service London and the South London Primary Care

Research and Development team.

The Cell Therapy Catapult Centre, funded by the Technology Strategy Board – a public body established to drive innovation – is co-located with the Trust's Biomedical Research Centre and Experimental Medicine Hub on the 12th floor of Guy's Tower. The centre seeks to bridge the gap between academic discovery and real life application through pre-clinical studies and clinical trials, and by 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.

During the year 330 non-commercial projects involving patients and volunteers were approved, while over 1,100 active non-commercial research studies and 280 clinical trials led by commercial organisations have been taking place across the Trust and King's College London. The Trust has one of the largest and best performing research portfolios in the country when measured against the Department of Health's benchmark to recruit patients to new trials within 70 days.

Last year, over 25,000 patients took part in clinical trials and other patient-focused studies, making us one of the most successful Trust in terms of recruitment. Of these, over 15,000 were for NIHR portfolio studies, an increase of 32 per cent on the previous year.

The NIHR Clinical Research Network league table of research portfolio activity for 2013 shows

that the Trust runs the second largest number of recruiting studies in the country, and is ranked sixth for the number of patients recruited.

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 and the viability of new treatments. Particular highlights this year include the 'first-in-human' trial of a new drug for rheumatoid arthritis; the REVIVED study into heart failure; and an NIHR-funded study into preventing hand dermatitis in nurses.

It is vital that we continue to increase our capacity to undertake research, so that we can expand the opportunities for our patients to benefit from research. In November, the Comprehensive Cancer Imaging Centre (CCIC) at King's College London and University College London was among four centres to receive £35 million funding to develop leading-edge imaging technologies for basic and clinical cancer research. This funding, from Cancer Research UK and the Engineering and Physical Sciences Research Council (EPSRC), will bring together clinicians, scientists and engineers to develop new imaging techniques that will help clinicians to learn more about how tumours grow.

In 2013, King's Health Partners appointed Professor Rezi Razavi as its new Director of Research to drive forward research activities across the partner organisations. This year, Professor Razavi was awarded £10 million by the Wellcome Trust and the EPSRC

Innovative Engineering for Health scheme to develop advanced imaging technology that will help to better diagnose birth defects in unborn babies.

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.

Much of the research across the trust is facilitated by the 140 research nurses who work within clinical areas on a range of studies. Over half of these research nursing posts are NIHR funded. The Trust continues to support the development of the research nurse workforce and to identify ways to integrate research into career development for nursing staff.

Collaboration for Applied Health Research and Care (CLAHRC)

This year, as part of King's Health Partners, the Trust was awarded £9 million funding – with St George's Healthcare NHS Trust and St George's, University of London – to lead the new NIHR Collaboration for Applied Health Research and Care (CLAHRC) South London. The CLAHRC will also receive £9 million of matched funding from the local partners over five years.

The collaboration will enable researchers to work together to

investigate new ways to prevent and treat chronic diseases such as stroke and to tackle public health issues such as alcohol-related harm.

Biomedical Research Centre

In 2011, the NIHR-funded Biomedical Research Centre secured renewed funding of £58.7 million to cover the period from April 2012 to March 2017. The Centre's translational research activity is organised around four clusters that bring together world class science, translational research expertise, infrastructure and commercial and patient participation. The clusters are: experimental medicine and therapeutics; biomarkers, co-diagnostics and imaging; population sciences; and translational and experimental medicine.

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

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. The BRC also continues to run highly successful training schemes and provide opportunities for a wide range of health professionals and PhD students to secure funding for their work.

During the year, the BRC was instrumental in launching a commercial spin out company,

Cydar, which offers an image fusion system that automatically overlays pre-operative 3D CT scans onto live x-ray images to improve precision in endovascular surgery.

Clinical Research Facilities

The Trust is home to three Clinical Research Facilities – at Guy's, St Thomas' and Evelina London Children's Hospital. Over 190 studies involving more than 9,000 patients and healthy volunteers have taken place during this year, for example to help find more effective ways to tackle major health problems such as obesity and heart disease. Other areas of focus include: cancer, cardiovascular disease, infection, transplant rejection, respiratory disease and allergy.

This year, the Trust and King's College London opened the Evelina Newborn Imaging Centre, a major new investment within the neonatal intensive care unit which includes a state of the art MRI scanner that will allow premature or very sick babies 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.

This year, we have run 18 events

to encourage engagement in research, including events aimed at primary and secondary school children in collaboration with the SaLL Centre. As part of our adult education programme, we have also run research roadshows in the local community and worked with the Royal Society of Chemistry and the Institute of Pharmaceutical Society on joint events.

Our Research and Development Patient and Public Involvement Advisory Group celebrated its first anniversary this year and is working hard to inform patients about opportunities to participate in research. The group is also developing an evaluation tool to capture feedback from patients.

In addition, the Consumer Research Panel for Cancer brings together patients and carers with experience of living with cancer to advise researchers on research design, recruitment to studies and what is important to patients who participate in trials. A course for patients and members of the community also gives them a better understanding of research, and we work hard to ensure that information given to patients participating in research is clear and accessible.



Nursing staff pictured during a bedside handover. During the past 12 months our nursing staff have continued to respond to the recommendations of the Francis Report, focussing on the 6Cs – care, compassion, competence, communication, courage and commitment.

Statement on quality from the Chief Executive 2013-14

This quality report sets out the approach we are taking to improve quality and safety at Guy's and St Thomas'. 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 the only trust in England to be rated as "better than expected for all four key mortality indicators" in the Dr Foster Hospital Guide, an annual independent healthcare survey published in December 2013 – Dr Foster also named us as 'Trust of the year for London'
- Guy's and St Thomas' was one of only five trusts shortlisted for a CHKS Top Hospitals Quality of Care Award in April 2014 in recognition of our achievements in healthcare quality and improvement over the last 12 months
- Our 'Barbara's Story' dementia training video for staff was adopted by a number of other healthcare providers both nationally and internationally – all staff at Guy's and St Thomas' were recognised as Dementia Friends by the Alzheimer's Society for attending 'Barbara's Story' training sessions
- The Trust met all essential standards of quality and safety assessed by the Care Quality Commission during a number of unannounced inspections on both the Guy's and St Thomas' hospital sites
- The Trust's overall performance in the national NHS adult inpatient survey was one of the best among London's main teaching hospitals and also compared well with other teaching hospitals nationally.

Our performance this year was excellent, especially in A&E where we were one of very few trusts in London to consistently meet the target that 95 per cent of patients are diagnosed, treated or discharged within four hours.

However, we are not complacent and we know there is still plenty of room for improvement, especially in terms of reducing waiting times for cancer patients – we are working with hospitals that refer cancer patients to us for specialist treatment to ensure this happens in a timely manner.

The past year was characterised by a series of high profile, national reports – Francis, Berwick and Keogh – that should make all of us who work in the NHS reflect on how we can ensure that we provide the highest quality care.

Following publication of the Francis Report, Chief Nurse Eileen Sills led a 'listening exercise' with staff so we listened to and learned from the experiences of staff before responding to Francis' recommendations.

More than 2,000 staff took part in Trustwide open forums and focus groups at ward and department level – their views helped shape the Trust's response to the Francis Report.

We also took the opportunity to recommit ourselves to the Trust's values by developing the 'Showing we care' strategy which defines the behaviours that we expect from all staff when treating patients and working with colleagues.

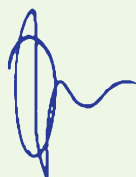
A film featuring staff and patients talking about what our values mean to them personally was shown for the first time at our Annual Public Meeting in September 2013.

This year we launched our *Fit for the Future* programme to improve quality, safety and efficiency, in recognition of the fact that we must all find new ways of working more efficiently without compromising patient care.

Hundreds of staff have taken part in Trustwide sessions to discuss how we meet this challenge and dozens of staff applied for funding from our Dragons' Den which gave staff the opportunity to bid for £5,000 to implement a good idea that will improve quality, safety and efficiency.

Fit for the Future is a three to five year programme and this year we will focus on embedding it within the organisation at all levels and among all staff groups.

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

Our quality priorities for 2014-15

We aim to provide patients with an excellent experience of care and to be the UK leader in reducing avoidable harm. This ambition is reflected in our strategic objectives. The publication of the Francis, Berwick and Keogh reports prompted us to bring a renewed focus to bear on ensuring that patients are at the heart of all that we do. It also reminded us that strong quality governance and assurance systems serve to increase the confidence of our patients, Foundation Trust governors, staff and everyone else who takes an active interest in our work.

Our quality strategy for 2014-15 is to ensure that we improve our contribution to the provision of healthcare for our patients both in the community and in hospital settings as well as mitigate any quality risks that may arise from our challenging financial cost improvement plans. We view quality, safety and efficiency as mutually beneficial. Our commitment to this principle underpins our quality priorities for 2014-15, together with the *Fit for the Future* programme.

We have developed a set of priorities and ensured that these are embedded across the Trust through individual directorate business plans for 2014-15. Each priority comes under one of 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.

How we chose our priorities

We have met throughout the year with our stakeholders to tell them about our progress in delivering our priorities for 2013-14. In February 2014 we held a workshop attended by a range of stakeholders including our local Healthwatch, representatives of our commissioners and members of our Council of Governors to consider the developing quality priorities for 2014-15. We agreed that we will carry forward last year's priorities where these focussed on basic patient safety practices that will consolidate and maintain focus on the reduction of avoidable harm. A number of new quality priorities were proposed, these have been finalised and approved by the Board of Directors at the Quality Committee and are set out in the following tables.

Staff have also been engaged in the identification of quality priorities through business planning, and all directorates have developed plans setting out how they will contribute to achieving the Trust quality objectives. Our progress against our quality priorities will be reported every three months to the Quality Committee.

Patient safety

Our quality priorities and why we chose them

Achieve compliance with the London Quality Standards for emergency care

We want to further improve the quality and safety of emergency services for both adults and children by reducing the variation between services available at weekdays and weekends.

To do this we will agree a staffing model to meet the standards; increase out of hours consultant decision making and supervision; develop a staged plan to increase support for consultant led care throughout the week; implement the national early warning score; monitor post partum women using the national modified obstetric warning score; and implement real time, risk rated, ward bed occupancy.

Investment to improve patient safety by the standardisation of how clinical decisions are described and recorded

Standardising the recording of observations and decisions reduces errors of interpretation and the possibility of mistakes being made when information is transferred. To achieve this we are working towards fully electronic records. The e-noting project will lead to the replacement of paper notes and it will improve patient safety and information governance.

Prompts will ensure staff know exactly what is needed for a specific patient; alerts will be consistent and visible and observations will be easier to monitor.

Establish new ways of working to ensure safe and seamless handovers

When the care of a patient is handed over from one clinician to another there is a recognised patient safety risk. It is recognised that the handover process is not consistent across the Trust and it has been identified as a specific area for improvement.

A standardised model will be developed for end of shift handover which can be rolled out across the Trust; it will include standardising handover information, an electronic handover system and a code of conduct for handover meetings.

Consolidate the gains we have made with patient safety priorities from previous years

Our focus on reducing major harms over the past five years has led to reductions in avoidable harm and has driven improvements in patient safety and experience.

We will consolidate the progress we made last year in preventing health care acquired infections; avoidable pressure ulcers; acute kidney injury and never events and we will further embed the safety thermometer.

We will continue to work with surgical teams and directorates to keep use of the surgical safety checklist and venous thrombosis risk assessment at 95%.

A new falls pathway will be used to assess all patients for risk of falls and to ensure that the most vulnerable patients receive an in depth, multi-factorial assessment to help prevent falls.

Catheter associated urinary tract infection (CAUTI) is the most frequent harm identified through our Safety Thermometer data and is a Trust quality improvement programme.

What success will look like

- We will demonstrate that we are compliant with the 118 London Quality Standards* by end of March 2015.
- We will achieve the emergency care CQUIN.

*www.londonhpa.nhs.uk/wp-content/uploads/2013/06/London-Quality-Standards-Acute-Emergency-and-Maternity-Services-February-2013-FINALv2.pdf

- We will successfully deploy e-noting in the HIV outpatient service.
- We will successfully deploy e-noting in St Thomas' endoscopy unit.
- A "Proceed to deployment" decision will be reached with clinical leads for gastro-intestinal surgery and the medical wards and clinics.

- In January 2014 all doctors in the Trust were asked to answer a handover satisfaction questionnaire via Survey Monkey and 37% of 80 respondents answered 'yes' to the question 'have you personally witnessed a patient safety incident due to the handover system in place at this time?'
- By the end of the 2014-15 we will repeat the survey and have a response that shows doctors have seen no patient safety incidents due to handover.
- Another indicator of a safe and effective handover is identifying patients doctors were called to see during their shift that they were not informed of at handover, 'surprise patients'. This is a new indicator for the Trust (adopted from Lothian NHS) and will be implemented by August 2014.
- By the end of the 2014-15 the number of 'surprise patients' will be zero.

- The total number of *C.difficile* infections will not exceed 37 for the year.
- We will have no grade 4 pressure ulcers in our hospital and community services.
- We will have no never events
- Our WHO surgical safety checklist audit will show compliance at 95% or more.
- Our new falls risk assessment and pathway will have been successfully implemented.
- Our audit will show 80% compliance with the falls risk assessment tool.
- By December 2014, we will be among the 25% of trusts with the lowest rates for catheter associated urinary tract infection.

Clinical effectiveness

Our quality priorities and why we chose them

Continue our focus on patients who have dementia and their carers

We will continue to focus on providing individualised care for patients with dementia and their carers. We want to build on the success of the 'Barbara's Story' project and develop further a culture of understanding, knowledge and empathy across all staff groups.

This year we will focus on improving the preparation and management of vulnerable patients admitted for surgical procedures.

We will ensure that a culture of compassionate care is embedded in our daily practice through the '6Cs' of care, compassion, competence, communication, courage and commitment.

What success will look like

- The perioperative older person's service (POPS) will be assessing and supporting a greater number of older people. An increase of at least 10% will be seen from September 2014 against numbers seen in 2013-14.
- We will improve our performance in the national inpatient survey on the questions relating to the 6Cs.

Increase access to information on quality that is benchmarked against our peers

We know that we can learn from our colleagues across the NHS and that solutions to common challenges may already have been developed by others. We want to promote an attitude of 'borrowing from the best'.

- Every three months we will identify a new way of addressing an improvement challenge that we have seen successfully used in another NHS organisation, and these will be reported to the Quality Committee.
- Progress reports on improvement actions will also be reported to the Quality Committee.

Integration of our hospital and community services for children

We are responsible for managing both the hospital and community services used by the local families of Lambeth and Southwark and have the opportunity to integrate hospital and community services.

We already have examples of joint working between hospital and community children's services supporting families with complex and multiple needs. We want to look at how we can integrate and improve care pathways across hospital and community services to further improve the experience of children and their families.

- We will have reviewed our key neuro-developmental pathways for local children that span hospital and community services and taken action to integrate them wherever possible and appropriate.
- We will have established a tool and a robust baseline in our measurement of children and families' experience of our services, sharing good practice between hospital and community.

Our quality priorities for 2014-15

Patient experience

Our quality priorities and why we chose them

Improving community based adult services

We want to strengthen the local community services we offer to adults in Lambeth and Southwark and to focus on implementing best practice models of integrated care. This will enable us to improve the experience of patients needing both hospital and community services.

Evidence shows that going to hospital imposes its own stress on patients' health and well being, we will give priority in this year to the development of our district nursing service and the Guy's and St Thomas' @home service.

Improve our complaints and PALS services

We learn a great deal about the experience of our patients from complaints. We want to ensure our patients are satisfied with how we respond to their complaints, and that we take every opportunity to learn from what they tell us. Last year we reviewed the complaints and PALS services and considered the benefits of integrating them. We did not proceed after considering the recommendations of a national review. This year we will look again at how the two services can work together to provide the most responsive and effective service possible for our patients.

Continue to monitor patient satisfaction

We are 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 our services and to use timely feedback to enable us to respond promptly to any suggestions for improvement.

We will continue efforts to increase the participation of our patients in the Friends and Family Test and other satisfaction surveys, and we will work to improve our scores when patients are asked to rate their experience of care.

Implement the new principles of care for dying patients

We take our responsibilities towards patients in the last days of life very seriously, including the need to support their families. We have developed a new tool to assist our staff when they are delivering care at this time. Our aim is to guide clinicians to develop an individual end of life care plan with the emphasis on frequent and regular review of both the patient and family's wishes.

What success will look like

- There will be an agreed plan for development of adult local services and a supporting implementation plan that is meeting delivery targets.
- A suite of performance metrics is being agreed and will be used to measure improvement throughout 2014-15.

- We will reduce the median time taken to investigate and reply to a complaint by 10% compared with performance in 2013-14.
- A PALS and complaints service structure will be agreed by the end of 2014-15 and implemented in 2015-16.

- We will have maintained our position as one of the top two performing London Trusts in the national inpatient survey and improve our performance against the measures that look at patient experience when leaving hospital.
- We will extend the Friends and Family Test to outpatients, day case patients and community services.
- At least 40% of all inpatients and 20% of all A&E patients will be asked to provide feedback on the quality of their care.

- At least 25% of all adult inpatient deaths will have had an end of life care EPR notification order, triggering CNS review of plan of care and staff feedback.

Statements of assurance from the Board of Directors

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

A review of our services

During the 2013-14 reporting period Guy's and St Thomas' provided sixty NHS services, this number includes both hospital and community services. A detailed list is available in the Trust's Statement of Purpose, available on the Trust's website.

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

The income generated by the services reviewed in 2013-14 represents 100 per cent of the total income received for the provision of NHS services in 2013-14.

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 2013-14, we took part in 35 national clinical audits and four national confidential enquiries. By doing so we participated in 92 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 2013-14 are shown in the table on the following pages, together with those that we participated in and for which data collection was completed during 2013-14. The information provided also includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in national clinical audits 2013-14

Audit title	Participation	% of cases submitted
Women and children's health		
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	95 (to September 2013)
Moderate or severe asthma in children – care provided in emergency departments	Yes	100
Paediatric asthma audit	Yes	100
Neonatal intensive and special care (NNAP)	Yes	100
Paediatric intensive care (PICANet)	Yes	100
The Child Health Clinical Outcome Review Programme (CHR-UK)	Yes	100
Childhood Epilepsy (Epilepsy 12 audit)	Yes	100
Acute care		
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100
Emergency use of oxygen (British Thoracic Society)	Yes	100
National Audit of Seizure in Hospitals (NASH)	Yes	100
National Emergency Laparotomy Audit (NELA)	Yes	100
National Joint Registry (NJR)	Yes	90
Paracetamol overdose – care provided in emergency departments (College of Emergency Medicine)	Yes	100
Severe sepsis & septic shock (College of Emergency Medicine)	Yes	100
Severe trauma (Trauma Audit & Research Network, TARN) *Insufficient resource to complete all data collection	Yes	5*
Long term conditions		
Chronic Obstructive Pulmonary Disease (COPD)	Yes	not available at time of report – data collection closes 31 May
Paediatric bronchiectasis *Due to maternity leave insufficient capacity in the paediatric respiratory team to participate in 2013-14. We will be able to participate in 2014-15.	No*	0
Renal replacement therapy (Renal Register)	Yes	100
Rheumatoid and early inflammatory arthritis *Audit in process of setup for 14-15	No*	0
National Diabetes Inpatient Audit (NADIA)	Yes	100
Diabetes (Paediatric) (NPDA)	Yes	100
Inflammatory bowel disease (IBD) *Insufficient resource to complete all data collection	No*	0

Audit title	Participation	% of cases submitted
Heart		
Acute coronary syndrome or acute myocardial infarction (MINAP)	Yes	100
National Adult cardiac surgery audit (ACS)	Yes	100
National Cardiac Arrest Audit (NCAA)	Yes	100
Cardiac arrhythmia management (CRM)	Yes	100
Congenital heart disease (paediatric cardiac surgery) (CHD)	Yes	100
Coronary angioplasty	Yes	100
Heart failure (HF)	Yes	100
National Vascular Registry	Yes	100
Pulmonary Hypertension Audit <i>We are an outreach centre for the Royal Free Hospital who submit the data for this audit.</i>	N/A	N/A
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP),	Yes	100
Sentinel Stroke National Audit Programme (SSNAP)	Yes	>90
Other		
Elective surgery (National PROMS Programme)	Yes	This information is not available from the national programme at time of report.
Cancer		
Bowel cancer (NBOCAP)	Yes	100
Head and neck oncology (DAHNO)	Yes	100
Lung cancer (NLCA)	Yes	100
Oesophago-gastric cancer (NAOGC)	Yes	100
Blood and transfusion		
National Comparative Audit of Blood Transfusion Programme	Yes	100

National Confidential Enquiries 2013-14

Audit title	Participation	% of cases submitted
Lower limb amputation	Yes	Not finalised
Tracheostomy care	Yes	>90
Subarachnoid haemorrhage	Yes	100
Alcohol related liver disease	Yes	66 (2/3 cases)

The reports of 28 national clinical audits were reviewed in 2013-14 and we intend to take the following actions to improve the quality of the healthcare we provide:

Adult critical care (Case Mix Programme – ICNARC CMP) – We have introduced automated detection of ‘unplanned’ readmissions and plan to introduce direct notification to responsible consultant/senior nurse to allow timely review and feedback.

Emergency use of oxygen (British Thoracic Society) – Whilst we are better than the national average for patients on oxygen without prescription (GSTT – 29.8%, national – 44.9%) we will include oxygen in our electronic prescribing system to improve on this figure. We were worse than average (GSTT – 21.4%, national – 7.1%) for not signing oxygen chart on ward rounds. Our nursing Matrons are leading on introducing better nursing monitoring and oxygen care.

Oesophago-gastric cancer (NAOGC) – We are speeding up the patient pathway by introducing one stop assessment to further improve on our excellent audit results. We are also participating in research into staging and predicting outcomes from multi-modality therapy which will lead to better selection of patients for therapy.

Coronary angioplasty – We are improving our systems for identification, data collection and analysis. This will ensure that nationally published data is accurate in risk stratification and supports the move towards individual consultant outcome data.

Acute coronary syndrome or acute myocardial infarction (MINAP) – Median call to balloon time is an important national indicator; the national target is under 150 minutes. The most recent audit shows that we have reduced our median call to balloon time from 111.5 minutes in 2011/12 to 80 minutes in 2012/13. We continue to highlight for investigation any case where the target is not reached and continue to work with other trusts who transfer patients to us to reduce this time further.

Congenital heart disease (paediatric cardiac surgery) – We have recruited a dedicated data analyst to increase and improve the quality of our submissions. We have improved our co-morbidity coding from 15-20% of all submissions to 30-40% and have increased the depth of our clinical coding over the last 12 months. We will continue to work to

improve our coding further and undertake investigations as to the cause of duplicates appearing on the national audit system.

Renal replacement therapy (Renal Registry) – We will analyse in detail the recently published audit report and, where we are outliers, use this as a basis for improvement work. We will continue with our comprehensive programme of internal audits, using the national results as comparators.

National Diabetes Inpatient Audit (NADIA) – We have successfully piloted the Think Glucose package on 3 wards and seen improvements in overall diabetes control and fewer medication errors. We will roll this out across the rest of the Trust.

Falls and Fragility Fractures Audit Programme (FFFAP) – Despite good audit results we will work to reduce length of stay to improve the percentage of patients who are given a post-operative mental test score.

Sentinel Stroke National Audit Programme (SSNAP) – We will improve mood and cognitive screening rates for appropriate patients. We will work to increase the amount of therapy that patients receive and we will increase access to psychology for those patients that require it.

Child health Clinical Outcome Review programme (CHR-UK) – We are developing a discharge checklist as well as an asthma information pack for junior doctors.

Childhood Epilepsy (Epilepsy 12 Audit) – We have appointed a clinical nurse specialist who will be working to ensure that we meet all of the audit standards.

Neonatal intensive and special care (NNAP) – Following the 2012 audit report we have improved the number of patients reviewed by senior medical staff within 24 hours and have introduced a structured temperature review form and guidance on thermo-regulation. We will work to ensure a standardised approach to line insertion and dressing changes and will introduce internal audit to identify any common failings.

Local clinical audit

The reports of 417 local clinical audits were reviewed last year and here examples from across the Trust demonstrate some of the actions taken to improve the quality of our services:

- Our community paediatricians are working to improve the assessments and reports that they provide as part of child protection investigations. A recent audit has shown considerable improvement and identified areas for further work.
- Community physiotherapists are creating low back pain information notice boards and leaflets for patients and are updating patient booklets with the latest NICE information. They are also working to implement research results that demonstrate identifying low risk patients via a screening tool and then offering them an 'advice only' approach led to good outcomes at reduced cost.
- Radiologists have been auditing and improving their knowledge of treating radiology emergencies. They have run simulation teaching, and audit results show improved test scores. They will work to develop and introduce this training as part of the departmental mandatory training schedule.
- Following an audit our genetics team are making changes to ensure that all patients at risk of Wilms Tumour are appropriately screened. They are also making changes to appointment letters and to clinics to reduce the number of patients who fail to attend their appointment.
- Following an audit of MEOWS (maternity early observations warning system) Trust midwives are introducing updated teaching sessions for themselves and healthcare assistants, working to ensure that MEOWS charts are discussed at handover and introducing spot checks to monitor improvement.
- Our dentists are implementing actions to reduce the number of local anaesthetic syringes that fail during administration. Although the number is small, this has been identified as a patient safety issue. They are making changes to sterilisation procedures and working with staff on improving syringe handling techniques.
- Following a review of patient experience of cleft lip and palate surgery, our children's services team is reviewing and amending guidance for anaesthetists and making changes to the system for providing drugs when patients are ready to leave hospital.
- Our specialist therapy assessment team audited their response times to referrals for emergency support and have made substantial changes to the way the service is delivered, including moving to seven day working. Response times to priority 1-3 patients have improved substantially, and the team continues to work to improve them further.
- An audit of bronchiectasis by the acute medicine team showed that better integration with the specialist clinic at King's College Hospital would improve the patient pathway. They are working with King's to agree a common pathway, and have developed an electronic order set for these patients to improve their care.
- Our pain team looked at the safety and effectiveness of percutaneous interventional endoscopic epidural adhesiolysis. The audit showed that this is a safe procedure but had poor outcomes for some categories of patients and was not effective for some conditions. The pain team will update the patient pathway, inclusion and exclusion criteria, and modify the procedure to produce better outcomes for more patients.

Our participation in clinical research

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

We are part of King's Health Partners; one of six Academic Health Science Centres in the UK. A wide range of research was carried out last year, some of which included the areas we specialise in such as allergy, dental, women's health, cardiovascular disease and renal transplantation. 330 non commercial studies began in 2013-2014, and 100 commercial studies were also initiated.

Last year, over 25,000 patients took part in research which was approved by our research ethics committee (NRES). During 2013-14, over 1,300 clinical research studies were active during the year. We used the nationally recommended systems and protocols to manage these studies and to ensure that the results 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 £42.8 million in research awards in 2013-2014 (National Institute Health Research).

For more information about our research activity, see chapter five of this report.

Our CQUIN performance

A proportion of our clinical income is conditional on achieving quality improvement and innovation (CQUIN) goals agreed with Lambeth and Southwark clinical commissioning groups and NHS England.

In 2012-13 we secured 90 per cent of the CQUIN targets, generating £17 million income. In 2013-14 we achieved 98 per cent of the CQUIN targets agreed with our commissioners generating over £20 million of our total income.

Further details of the agreed goals for 2013-14 and for the following year are available at www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf.

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 the Trust during 2013-14.

We are subject to periodic review by the Care Quality Commission and there were inspections at Guy's Hospital in August 2013 and at St Thomas' Hospital in November 2013. The Trust was found to be fully compliant with the essential standards of quality and safety that were assessed.

The reports of the inspections at both hospitals are available on the CQC website.

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 informs the wider health community about disease trends, as well as ensures that we receive the correct income for the care and treatment provided.

The Trust has identified opportunities to improve clinical coding processes, which were also highlighted in the Payment by Results assurance audit. These are being addressed through an extensive change programme which forms part of the *Fit for the Future* programme. A steering group, chaired by a Deputy Medical Director, meets fortnightly to review progress across a range of process and quality indicators.

The percentage of records in the published Secondary Uses Service data (up to the end of February) that included a patient's valid NHS number was 97.7 per cent of inpatients, 98.1 per cent of outpatients and 82.9 per cent of accident and emergency patients.

The percentage of records which had the patient's valid GP registration code was 100 per cent of inpatients, 100 per cent of outpatients and 99.8 per cent of accident and emergency patients.

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

Information governance toolkit

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

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

The Information Governance Assessment Report overall score for 2013-14 was 72 per cent, and was graded satisfactory.

Clinical coding error rate

We were subject to the Payment by Results clinical coding audit by the Audit Commission during the reporting period. The error rates reported in the draft audit for diagnoses and treatment coding (clinical coding) were 50 per cent lower 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 – 13 per cent
- secondary diagnosis incorrect – 29 per cent
- primary procedures incorrect – 15 per cent
- secondary procedures incorrect – 32 per cent.

The services reviewed within the sample were obstetric deliveries and mouth, head, neck and ear procedures.

The Trust continues to work hard to improve the accuracy and 'depth' of clinical coding, see page 17 and opposite for details.

National quality indicators

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

For each indicator our performance is reported together with the national average and the performance of the best and worst performing trusts.

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.

We believe our performance reflects the following, that:

- the Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived;
- data is collated internally and then submitted on a monthly basis to Health and Social Care Information Centre (HSCIC) via the Secondary Uses Service (SUS). The SHMI is then calculated by HSCIC;
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

Summary Hospital-level Mortality Indicator	2011/12 SHMI	% admissions with palliative care coding	2012/13 SHMI	% admissions with palliative care coding	2013/14 Q1 SHMI	% admissions with palliative care coding
Guy's and St Thomas'	87.98	0.97%	78.68	0.91%	76.85%	0.94%
Best performing trust					57.17	0.00%
Worst performing trust					120.94	1.08%

Source: Healthcare Evaluation Data (HED)

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

Patient reported outcome measures

Patient reported outcome measures (PROMs) measure quality from the patient perspective, and seek to calculate the health gain experienced by patients following one of four clinical procedures. We are reporting on patients who have had a hip replacement or a knee replacement. We have not carried out a statistically significant number of varicose vein treatments or hernia repairs (defined as fewer than 30 cases) so they are not reported here.

We believe our performance reflects the following, that:

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

Hip replacement – primary	Adjusted average health gain		
	2010/11 Final	2011/12 Final	2012/13 Provisional
Guy's and St Thomas'	0.377	0.403	0.429
Average	0.405	0.416	0.438
Lowest	0.264	0.306	0.319
Highest	0.503	0.499	0.543

Knee replacement – primary	Adjusted average health gain		
	2010/11 Final	2011/12 Final	2012/13 Provisional
Guy's and St Thomas'	0.281	0.251	0.305
Average	0.299	0.302	0.319
Lowest	0.176	0.181	0.195
Highest	0.407	0.385	0.409

Source: www.HSCIC.gov.uk

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

Scores for the Trust show that the perceptions of health gain among patients having hip or knee replacement are slightly below average, we consider that a factor contributing to this may be that as a specialist referral centre we often treat patients with complex treatment needs whose perception of health gain may be influenced by other health factors.

Actions are being taken to improve the patient health gain scores and to improve the quality of our services. Clinicians regularly review scores at service and Trust level to ensure that what we learn from patient feedback is incorporated into our quality improvement programmes.

Readmission within 28 days of discharge

Information available from the Health Information Centre does not include 2012-13 data, for this reason we have used Healthcare Evaluation Data which also gives the national average performance and benchmarking data.

We believe our performance reflects the following, that:

- the Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived;
- data is collated internally and then submitted on a monthly basis to Health and Social Care Information Centre (HSCIC) via Secondary Uses Service (SUS). This data is then used by Healthcare Evaluation Data to calculate readmission rates;
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

Emergency readmissions within 30 days 2012/13		Under 18	Over 18	Total
Guy's and St Thomas'	Discharges	15,859	53,178	69,037
	30 day readmissions	318	6,037	6,335
	30 day readmission rate	2.0%	11.4%	9.2%
	National average	2.6%	12.5%	10.2%
	Best performing trust	0.77%	8.29%	6.73%
	Worst performing trust	11.35%	18.57%	13.19%

Defined as any ordinary admission (i.e. not a daycase or regular attendee) where the patient is readmitted to any provider within 30 days as an emergency admission. PbR guidance is used to define the readmitting spell.

Source: Healthcare Evaluation Data (HED)

We continue to take the following actions to reduce the number of patients requiring readmission and to improve the quality of our services. We have a clinical outcomes group which monitors readmissions on a monthly basis and identifies any areas where there is a trend or change which may be a cause for concern. Our elderly care team reviews all cases at multi-disciplinary team meetings and is actively seeking to improve clinical practice. We are also working with GPs and community teams to review patients who have been readmitted so that we can agree specific actions for these patients.

Patient experience

We perform well in the national inpatient survey and our results, shown below, are above the national average.

We believe our performance reflects the following, that:

- the Trust outsources the collection of data for the patient experience survey;
- data is collected by Picker and then submitted on an annual basis to the Care Quality Commission;
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

Patient experience – responsiveness to personal needs of patients	2010/11	2011/12	2012/13
Guy's and St Thomas'	65.5	69.7	71.4
National Average	67.3	67.4	68.1
Highest scoring trust	82.6	85	84.4
Lowest scoring trust	56.7	56.5	57.4

Source: www.england.nhs.uk

We have taken the following actions to improve the quality of our services: clinical directorates continue to develop individual patient experience action plans; and we also have trust-wide initiatives such as our welcome pack and regular 'comfort rounds' on our inpatient wards, to help patients to feel involved in their care. We have also provided increased opportunities for patients 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

Staff recommendation to family and friends

We believe our performance reflects the following, that:

- the Trust outsources the collection of data for the staff survey;
- data is collected by Quality Health and submitted on an annual basis to the National NHS Staff Survey Co-ordination Centre;
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

Family and Friends Test	2011	2012	2013
Guy's and St Thomas'	85	82	86.6
Average (median) for acute and acute specialist trusts	62	60	66.2
Highest scoring acute trust	89	86	93.9
Lowest scoring acute trust	33	35	39.6

Source: www.nhsstaffsurveys.com

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

Patient recommendation to family and friends

We believe our performance reflects the following, that:

- the Trust has a process in place for collating data on the Friends and Family Test;
- data is collated internally and then submitted on a monthly basis to Department of Health;
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

Patients Friends and Family Test 2013/14		Inpatient	A&E
Response Rate	Guy's and St Thomas'	31.40%	9.60%
	National average	29.20%	13%
	Best performing trust	100%	44.10%
	Worst performing trust	12.20%	0.80%
Net-promoter score	Guy's and St Thomas'	78.6	64.9
	National average	72.3	54.9
	Best performing trust	95.9	80.4
	Worst performing trust	44.1	1.1

Source: NHS England

Infection control

We believe our performance reflects the following, that:

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

C-Diff rates per 100,000 bed-days	2010/11	2011/12	2012/13	2013/14
Guy's and St Thomas'				
Trust apportioned	120	107	48	40
Total bed-days	295,804	299,154	314,389	349,277
Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	40.6	35.8	15.3	11.5
National average			17.3	
Best performing trust			0	
Worst performing trust			30.8	

Source: Public Health England

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

Patient safety incidents

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

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission. To avoid duplication of reporting, all incidents resulting in severe harm or death are reported to the NRLS, who then report them to the Care Quality Commission.

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

We believe our performance reflects the following, that:

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

Incident Reporting	Sep 2012	Mar 2013	Sep 2013
Guy's and St Thomas'			
Total reported incidents	5,222	5,048	5,835
Incident reporting rate per 1,000 admissions	7.60%	7.32%	8.66%
Incidents causing severe harm or death	19	15	8
% incidents causing severe harm or death	0.36%	0.30%	0.14%
Acute teaching trusts			
Lowest incident reporting rate	2.80%	3.21%	4.87%
Highest incident reporting rate	12.10%	13.70%	12.84%
Acute teaching trusts median rate	6.80%	7.48%	7.98%
Lowest % incidents causing severe harm or death	0	0.05%	0.03%
Highest % incidents causing severe harm or death	2.10%	1.44%	0.88%
Acute teaching trusts average % of incidents causing severe harm or death	0.50%	0.43%	0.34%

Source: National Reporting and Learning System (NRLS)

The number of patient safety incidents reported continues to increase and we believe this reflects a positive culture for reporting all patient safety incidents, including near misses. The number and percentage of incidents resulting in severe harm or death is significantly lower than in the previous year. This is in part due to action taken to ensure that any changes made to incident classifications following a root cause investigation are reported to the NRLS and that data is reviewed and validated against Trust data to ensure it is consistent.

We continue to use the outcomes of root cause investigations of patient safety incidents to develop quality improvement projects.

Venous thrombo-embolism

Venous thrombo-embolism or blood clots, are a major cause of death in the UK. Some blood clots can be prevented by early assessment of the risk for a particular patient. Over 95 per cent of our patients are assessed for their risk of thrombosis and bleeding on admission to hospital.

We believe our performance reflects the following, that:

- the Trust has a process in place for collating data on venous thrombo-embolism assessments;
- data is collated internally and then submitted on a monthly basis to Department of Health;
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

VTE assessment rate	2011/12	2012/13	2013/14
Guy's and St Thomas'			
Assessed	203,636	207,644	218,516
Admitted	221,438	220,512	226,837
Assessment rate	91.96%	94.16%	96.33
National average			95.67%
Best performing trust			100%
Worst performing trust			79.86%

Source: www.england.nhs.uk

Our clinical staff remain at the forefront of venous thrombo-embolism care nationally and internationally, including through clinical research and service development and so continue to improve the quality of our services.

Progress against priorities for 2013-14

The progress we have made in delivering our quality priorities for last year, is set out in the following tables. All the data used to assess our success in achieving our objectives has been derived from the Trust performance management systems and, where applicable, the indicators are consistent with national definitions.

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?
<p>Keep our patients safe and reduce the risk of harm</p> <p>A continued focus on reducing the major harms in hospital; with a particular emphasis on pressure ulcers, falls, infection and never events/serious incidents.</p> <p>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.</p>	<ul style="list-style-type: none"> – We will reduce pressure ulcers, 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 <i>C.difficile</i> 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'. 	<p>We partially achieved this.</p> <p>One grade 4 pressure ulcer was acquired while the patient was under our care.</p> <p>A 10% reduction in falls with harm was achieved, however these events continue to happen and we want to maintain focus on reducing this harm and this will remain a priority for 2014-15.</p> <p>We achieved our infection control target for <i>c.difficile</i></p> <p>An improvement programme is in place and we will continue to focus on catheter associated urinary tract infections in 2014-15.</p> <p>An observational audit carried out in November 2013 identified 95% compliance with full completion of the WHO surgical safety checklist. This is a significant improvement but to maintain the drive for 100% compliance this will remain a priority for 2014-15.</p> <p>One never event occurred in May 2013 and we continue to aim for no never events in 2014-15.</p>
<p>Keep everyone informed about our performance</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> – 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. 	<p>We achieved this.</p> <p>We have developed a suite of information for publication on our website. The content is being tested with patients prior to publication in summer 2014.</p> <p>We also publish a range of information at ward level.</p>
<p>Capture how we are doing</p> <p>Continue to use the national safety thermometer 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.</p>	<ul style="list-style-type: none"> – 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. 	<p>We achieved this.</p> <p>We now use the safety thermometer in our community services.</p>

Clinical effectiveness

Our quality priorities and why we chose them

What success will look like

How did we do?

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.

- 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 achieved this.

Non-executive directors and executive directors have been visiting hospital and community services to listen to patient and staff experiences. They report back to the directorate management team and the Board of Directors.

Quality reporting to the Board of Directors occurs through the quarterly patient safety and experience report.

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.

- 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 partially achieved this.

We wanted to see 75% of planned monthly meetings take place between GPs and district nurses. We achieved 64% due to cancellation of meetings by both GPs and district nursing teams. We are using the 'quality alert' system to understand this further. Concerns are investigated and we are identifying opportunities to make our communication more effective, including through attendance at GP locality meetings.

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.

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

We achieved this.

We achieved the CQUIN target and increased pre-school immunisation rates.

Patient experience

Our quality priorities and why we chose them

What success will look like

How did we do?

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.

- 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.

We partially achieved this.

A review and consultation was undertaken. However, following a national report published in late 2013, we decided not to proceed with the current proposal to integrate the PALS and complaints services.

Patient experience

Our quality priorities and why we chose them

What success will look like

How did we do?

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.

We will achieve our CQUIN target regarding dementia, specifically:

- To achieve compliance against the Fair, Assess, Investigate and Refer (FAIR) initiative, which focuses on the identification, assessment and referral of dementia patients. The CQUIN will be met if 90% compliance is achieved for each FAIR phase over a consecutive 3 month period.
- To ensure clinical leadership is in place for dementia, and to agree a training programme relating to dementia and report performance.
- To undertake a monthly audit of carers with dementia, including whether carers feel adequately supported.
- 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 achieved this.

We met the dementia CQUIN as follows:

FAIR compliance of 90% was exceeded for the 3 consecutive months of April to June 2013.

A clinical lead was assigned for dementia, and training programmes were planned and delivered in year.

Monthly audits of carers of patients with dementia were undertaken.

We have seen an increase of more than 10% in referrals to the specialist dementia and delirium team as well as an increase of over 30% in use of the delirium 'bundle' to deliver appropriate care.

An evaluation was carried out and five further episodes of Barbara's Story were produced to further develop staff understanding, knowledge and empathy. The training materials have attracted wide acclaim and interest.

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.

- 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 achieved this.

All inpatient wards completed the annual accreditation programme with continued support from our governors. Local residents and patients took part in the PLACE assessments.

Our mystery shopping programme has been rolled out to 14 locations, and a new initiative has been developed to monitor the quality of our telephony services. Quarterly updates are included in the Patient Safety and Experience report to the Board.

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.

- 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 achieved this.

The Friends and Family Test has been rolled out to all inpatients, A&E patients and also maternity services, in line with the 2013-14 CQUIN requirements. Work continues to embed the test in A&E and maternity.

The near-time feedback system has been rolled out to our community inpatient units and home care services for both adults and children.

Improve our outpatient department efficiency

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.

- 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.

We partially achieved this.

While the planned reduction has not been achieved there has been a reduction in 'did not attend' numbers.

Comparing waits with 2012/13, there has been a reduction in long waits for a first appointment.

Our performance against Monitor Risk Assessment Framework indicators

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

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

Key performance indicators

		Performance		Quarterly Trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	MRSA bacteraemia attributable to Trust	0	3 ●	1	1	0	1
	C Diff (Clostridium difficile) acquisitions	<47	44 ●	4	15	13	12
Cancer access – initial appointments	Urgent GP referrals seen within 2 weeks	>93%	94.8% ●	95.6%	94.5%	95.0%	94.4%
	Non-urgent GP referrals to breast surgery within 2 weeks	>93%	94.4% ●	93.4%	96.8%	93.6%	93.7%
Cancer access – initial treatments	First treatments within 62 days of urgent GP referral	>85%	76.2% ●	76.0%	76.4%	74.0%	78.3%
	First treatments within 31 days of decision to treat	>96%	96.8% ●	97.6%	97.8%	94.9%	96.7%
Cancer access – subsequent treatments	Surgical treatments within 31 days	>94%	95.5% ●	98.0%	96.6%	89.7%	98.0%
	Chemotherapy treatments within 31 days	>98%	98.7% ●	98.7%	99.0%	99.1%	98.3%
	Radiotherapy treatments within 31 days	>94%	96.7% ●	96.9%	95.2%	98.0%	97.0%
Referral to treatment times	% admitted treatments within 18 weeks	>90%	91.9% ●	92.7%	92.3%	91.4%	91.1%
	% non-admitted treatments within 18 weeks	>95%	96.1% ●	96.6%	96.3%	95.7%	95.8%
	% incomplete pathways less than 18 weeks	>92%	93.5% ●	93.7%	93.6%	93.3%	93.6%
A&E access	% A&E patients treated or admitted within 4 hours	>95%	96.0% ●	95.6%	95.3%	96.5%	96.4%
Community care data completeness	Referral to treatment information	50%	62.0% ●	60%	60.2%	64.5%	67.6%
	Referral information	50%	92.0% ●	92%	91.8%	90.6%	91.4%
	Activity information	50%	92.0% ●	93%	93.2%	91.7%	90.7%

In addition to these indicators, we were certified in compliance with the requirements to ensure that people with a learning disability can access health care in the Annual Plan submitted to Monitor for 2013/14, and so also met this performance indicator.

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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.

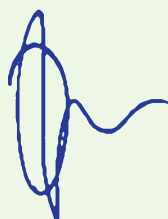
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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 2013/14;
- 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 2013 to March 2014
 - Papers relating to Quality reported to the Board over the period April 2013 to March 2014
 - Feedback from the commissioners dated 21/05/2014
 - Feedback from Local Healthwatch organisations dated 21/05/2014
 - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2014;
 - The 2013 national patient survey April 2014
 - The 2013 national staff survey March 2014
 - The Head of Internal Audit's annual opinion over the trust's control environment dated March 2014
 - CQC Intelligent Monitoring Reports October 2013, March 2014.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)

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

By order of the Board



Sir Ron Kerr, Chief Executive
29 May 2014

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 2014 (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 2014, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Guy's and St Thomas' NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Cancer 62 day waits for first treatment (from urgent GP referral); and
- Number of reported *Clostridium 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 the Detailed guidance for external assurance on quality reports, issued by Monitor; 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:

- board minutes for the period April 2013 to 23 May 2014;
- papers relating to quality reported to the board over the period April 2013 to 23 May 2014;
- feedback from local Clinical Commissioning Groups dated 21 May 2014;
- feedback from local Healthwatch organisations dated 21 May 2014;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated May 2014;
- the latest national inpatient survey dated April 2014;
- the national staff survey dated March 2014;

Statements

- Care Quality Commission intelligent monitoring report dated March 2014; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated March 2014.

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:

- 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 affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- 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, issued by Monitor; 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*.

The logo for Deloitte LLP, featuring the word "Deloitte" in a stylized blue script font, followed by "LLP" in a bold, blue, sans-serif font.

Deloitte LLP

Chartered Accountants

Reading

29 May 2014

Lambeth CCG statement on Guy's and St Thomas' NHS Foundation Trust 2013 Quality Accounts – on behalf of NHS Lambeth, Southwark and Lewisham Clinical Commissioning Groups

The draft Guy's and St Thomas's Hospitals NHS Foundation Trust (GSTT) Quality Report 2013/14 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.

It is good to see how the Quality Account priorities have developed and progress monitored in the past year, with the participation of a range of stakeholders, including Healthwatch, the CCGs and the Trust Council of Governors. This year's Quality Accounts clearly set out how the Foundation Trust has progressed against the priorities for 2013/14 across both acute and community services. It is very clear which have been fully or partially achieved and the commitment to continue to make progress in prioritised areas going forward.

GSTT has made good progress against last year's targets and quality priorities and is to be congratulated, particularly in meeting the difficult infections target, which is a national priority.

Achievement in meeting Accident and Emergency and 18-week standards were, and continue to be, particularly challenging. The implementation of action plans is ongoing.

This year's Quality Accounts contain more information on the process of choosing and approving the priorities for the coming year. In respect of the quality priorities for 2014/15 it is good to see that for most of the success criteria, improvement percentage targets have been set however confirmation of the current baseline performance would have been helpful.

We note that in the 'Patient experience' quality priority related to improvement in Complaints and PALS service section, a 10% reduction in the median time

taken to investigate and reply to a complainant has been set as a target. We welcome this as a priority, however we would have liked to have seen a more challenging target for this area of quality performance and for complainant feedback measures to have been included.

We note the priority for developing adult local services and look forward to working closely with the Trust for the delivery of the action plans and achievement of targets.

It is very encouraging to see the high level of participation in national clinical audits and the inclusion of the actions that have been identified to improve patient care and look forward to updates in year of the impact these actions have on the quality of service in the Trust.

We would also welcome more detail in next year's Quality Accounts of the impact of actions following the local clinical audits carried out.

At a recent Clinical Quality Review Group it was asked that consideration is given to future reports of either reducing the number of acronyms and abbreviations used, or the inclusion of a glossary to ensure that all information is quickly and easily understood by all readers of the report.

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

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.

It has been a year since Healthwatch has been in existence and we appreciate the strides and work the Trust has achieved and are continually doing. In particular Healthwatch Southwark and Healthwatch Lambeth have been working with the Patient Engagement Team at Guys, to develop the incoming Trust Wide Patient Engagement strategy. This is a great, positive and receptive approach orientated around users. We look forward to seeing its publication in due course.

General comments

We appreciate the vast areas of work Guys & St. Thomas FT are producing to a high standard and to condense the work into these pages is great. A few general comments first, the priorities are positive actionable ones; it is quite easy to read with all acronyms/terms explained. i.e. CQUINs, PROMS, and will give the lay reader a good insight into trust performance. It might also be helpful if a little information was made available current about cancer service changes or future service changes or developments and collaborative projects.

Progress against 2013-2014 priorities

We welcome your continued focus on dementia patients and carers and suggest if relationships with local alzheimers or other support groups offering ongoing information and support sessions could further enhance this area. Other hospitals have adopted a similar approach, and it has been positive.

We note missing information around your priority to

improve GP and community nurses. This is important for follow-up and pre-post acute care. We have had experiences concerning disjointed communication and hope to focus on this and other areas with Healthwatch Southwark and Lambeth's joint focus on discharge.

We support the board to ward initiative and believe speaking to patients is just as important as treatment.

2014-2015

We applaud your aim to comply with the London Quality Standards for emergency care. This has present media and the national discussions regarding urgent and emergency care.

We support your 'borrowing from the best' approach in benchmarking and sharing good practice approach from your peers. In particular we would like to enquire and/or suggest if and how best practice from specialist services and practices are being taken up by teaching hospitals and services? For example, Marsden.

We welcome the priority to improve outpatient experience and would suggest placing standards to be measured against. Whilst we have heard positive experiences about staff professionalism, we have also received not so good ones around waiting times for scheduled appointments.

Healthwatch Lambeth Healthwatch Southwark



Apprentice David Lammas pictured with Candace Miller, Director of the National Skills Academy for Health who spent a day on the NHS frontline with David during National Apprenticeship week.

Our organisational structure

Our governors continue to 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 continued success.

Council of Governors

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

It has a number of statutory duties, including: holding the non-executive directors individually and collectively to account for the performance of the Board of Directors; representing the interests of foundation trust members and of the public; appointing the Chair and other non-executive directors; approving the appointment of the Chief Executive; receiving the annual report and accounts, and auditor's report; appointing the auditor; approving increases in non-NHS income of more than five per cent of total income; approving acquisitions, mergers, separations and dissolutions; approving changes to the Trust's constitution; and expressing a view on the Board's plans for the NHS foundation trust, in advance of the plan's submission to Monitor.

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 took place in spring 2013 with seven places available. In addition, some of the organisations we work most closely with nominate a governor. See page 81 for a full list of governors.

Constitution

This year the Council of Governors provided valuable input to a review of the Trust's

constitution. Members of our Foundation Trust were consulted on the proposed changes to the constitution prior to and at the Annual Public Meeting in September 2013.

The latest version of our constitution is available on our website:

www.guysandstthomas.nhs.uk/resources/membership/trust-constitution.pdf

There is also a range of information for members and anyone interested in becoming a member.

Working groups

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

Service strategy – this group reviewed and helped to refine the Trust's plans for e-noting, outpatient transformation and the *Fit for the Future* programme. The group also supported the development of the education and training strategy. Members continued to provide input and challenge to our business planning processes, with a particular focus on assessing the implications of the proposed changes to healthcare in south east London.

Quality and engagement (formerly patient experience) – during the year this group changed its focus to consider patient safety matters as well as issues relating to patient and public engagement. The group was renamed to reflect these changes.

Membership development, involvement and communications – this group continued its

work to ensure that our membership better reflects the communities we serve.

Governors now attend Board committees, including Finance and Investment, Workforce, Adult Local Services (formerly Community Services), Quality and Evelina London Development committees. They feedback to their respective working groups and to the Council of Governors on the issues discussed.

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, the Committee recommended the appointment of Dr Sheila Shribman as Non-Executive Director for a four year term from 13 June 2013. It also endorsed King's College London's nomination of Professor Frank Nestle as Non-Executive Director for the second and final four year term until 4 May 2017.

Nominations Committee membership and attendance	
Name	Actual/possible
Prof Judith Ellis	2/3
Dawn Hill	3/3
Tom Hoffman	3/3
Sir Hugh Taylor	3/3
Dr David Treacher	3/3

Our membership

Our membership is an essential and valuable asset. Members help guide our work and decision making as well as our adherence to Trust and NHS values. 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 23,230 members, of whom 4,340 are patient members, 5,717 are public members and 13,173 are staff members. We strive for a membership that represents the diverse communities we serve.

Members receive regular mailings and are invited to events including our Annual Public Meeting, joint Board of Directors and Council of Governors meetings and other events, such as our regular health seminars. The seminars are extremely well attended; recent topics have included stroke, living with diabetes, Southwark and Lambeth Integrated Care (SLIC), and rheumatoid arthritis.

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

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Board of Directors

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

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

Membership is balanced, complete and appropriate. The Trust is confident that all the Non-Executive Directors are independent in character and there are no relationships or circumstances which are likely to

Council of Governors

Patient governors	Elected from	Actual/possible attendance
Devon Allison	July 2013	2/3
John Burns	July 2013	2/3
Anita Campolini	July 2012	3/4
Sue Hardy	July 2012	4/4
Dawn Hill	July 2012	3/4
Niamh O'Sullivan	July 2010	1/1
David Spratt	July 2012	0/4
Gail Thompson	July 2012	2/4
Dr Sir Richard Thompson	July 2010	1/1
Paula Young	July 2013	4/4

Staff governors	Constituency	Elected from	Actual/possible attendance
Noreen Ging	Clinical	July 2012	4/4
Richard Gurney	Community services	Sept 2011	3/4
Mia Hilborn	Non-clinical	July 2010	0/1
Jason Simons	Clinical	July 2012	3/4
Dr David Treacher	Medical and dental practitioners	July 2012	3/4
Jeff Whitear	Non-clinical	July 2012	4/4
Bryn Williams	Non-clinical	July 2013	3/3

Public governors	Elected from	Actual/possible attendance
Prof Kevin Burnand	July 2012	3/4
Jenny Coble	July 2010	1/1
Yvonne Craig Inskip	July 2012	4/4
Felix Greaves	July 2012	1/1
Kate Griffiths-Lambeth (Replaced Felix Greaves who stepped down before the end of his term)		3/3
Ken Hayes	July 2013	3/3
Tom Hoffman	July 2012	4/4
John Porter	July 2013	3/3
Patricia Prendergast	July 2010	1/1
Barry Silverman	July 2012	4/4
Jenny Stiles	July 2013	3/3
Peter Truesdale	July 2010	1/1

Stakeholder governors	Organisation	Actual/possible attendance
Prof Sir George Alberti	King's College Hospital	3/4
Jo Champness	NHS England	3/3
Prof Judith Ellis	London South Bank University	0/4
Sue Gallagher	Lambeth Clinical Commissioning Group	3/4
Gus Heafield	South London and Maudsley	2/3
Prof Denise Lievesley	King's College London	4/4
Catherine McDonald	Southwark Council	1/4
Robert Park	Southwark Clinical Commissioning Group	3/3
Dr Matthew Patrick	South London and Maudsley	0/1
Jane Pickard	Lambeth Council	1/4

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

affect, or could appear to affect, their judgment. We therefore have not appointed a senior independent director.

David Dean has been Vice Chairman since March 2013. Sheila Shribman joined the Board in June 2013.

In September 2013, over 200 people attended our Annual Public Meeting, where members, local people, patients, staff and other stakeholders heard about how we performed during the year. There was also an opportunity to meet and ask questions of the Board of Directors and the Council of Governors and to hear presentations about the new Cancer Centre being built at Guy's.

Details of external directorships or other positions of authority held by the Directors of the Trust can be found in Note 30 (Related Parties) to the annual accounts.

Board meeting attendance		
Name	Position	Actual/possible
Sir Hugh Taylor	Chairman	9/9
David Dean (Vice Chair)	Non-Executive Director	9/9
Robert Drummond	Non-Executive Director	6/9
Mike Franklin	Non-Executive Director	9/9
Professor Frank Nestle	Non-Executive Director	8/9
Girda Niles	Non-Executive Director	8/9
Dr Sheila Shribman (from June 13 2013)	Non-Executive Director	6/7
Diane Summers	Non-Executive Director	8/9
Sir Ron Kerr	Chief Executive	9/9
Dr Ian Abbs	Medical Director	9/9
Ann Macintyre	Director of Workforce and Organisational Development	9/9
Steve McGuire	Director of Essentia	9/9
Amanda Pritchard	Chief Operating Officer	8/9
Martin Shaw	Finance Director	9/9
Eileen Sills	Chief Nurse/Director of Patient Experience and Infection Control	8/9

Committee	Membership
Adult Local Services Development Board (Formerly Community Services)	Girda Niles (Chair), Dr Ian Abbs, Ann Macintyre, Amanda Pritchard, Martin Shaw, Sheila Shribman, Eileen Sills, Diane Summers
Audit	David Dean (Chair), Robert Drummond, Diane Summers
Evelina London Development (from Jan 2014)	Sheila Shribman (Chair), Dr Ian Abbs, Sir Ron Kerr, Girda Niles, Amanda Pritchard, Diane Summers, Sir Hugh Taylor,
Finance & Investment	Sir Hugh Taylor (Chair), David Dean, Robert Drummond, Frank Nestle, Girda Niles, Sir Ron Kerr, Steve McGuire, Amanda Pritchard, Martin Shaw
Quality	Diane Summers (Chair), Dr Ian Abbs, David Dean, Sir Ron Kerr, Steve McGuire, Girda Niles, Dr Sheila Shribman, Eileen Sills, Sir Hugh Taylor
Remuneration	Sir Hugh Taylor (Chair), all Non-Executive Directors
Workforce	Mike Franklin (Chair), Dr Ian Abbs, Sir Ron Kerr, Steve McGuire, Ann Macintyre, Girda Niles, Amanda Pritchard, 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 2013, the Committee reviewed the draft Annual Report and Accounts, including the Quality Accounts and approved their submission to the auditors. During the year, the Committee also reviewed the Trust's operational plans and strategies, including those submitted to Monitor, and received reports on a number of topics including matters relating to King's Health Partners.

External audit attended the Committee regularly, providing an opportunity for the Committee to assess their effectiveness.

Audit Committee membership and attendance

Name	Actual/possible
David Dean (Chair)	5/5
Robert Drummond	3/5
Diane Summers	4/5

Remuneration Committee

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

Remuneration Committee membership and attendance

Name	Actual/possible
David Dean	1/1
Robert Drummond	0/1
Girda Niles	1/1
Mike Franklin	1/1
Prof Frank Nestle	1/1
Dr Sheila Shribman	0/1
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 that it understands their views and those of our members.

Governors are invited to attend our four public Board meetings which take place in the month when financial and performance reports are sent to Monitor. These Board meetings are immediately followed by a meeting of the Council of Governors, attended by members of the Board. This provides governors with the opportunity to reflect on the business discussed by the Board and to ask questions of the Board.

Members of the Council of Governors attend the meetings of all Board committees apart from the Audit and Remuneration committees.

Members of the Board attend meetings of the Council of Governors' working groups.

Trust Management Executive

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

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

The Management Executive has the following sub-committees:

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

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 CEO 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 currently 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 work 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 currently chairing national negotiations for the reform of the consultant contract across England and Ireland. She is a member of Sir Bruce Keogh's Seven Day Services Forum. She is also a member of the national Social Partnership Forum, working with Health Ministers and Trade Unions on workforce policy. Ann is also a member of NHS England's Revalidation Implementation Board for England.



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 had been the Director of Property and Support Services.

Steve is a Chartered Engineer, and before he joined the NHS he worked for the British Coal Corporation, where he held a number of posts.

In 2013, information technology services and South West London Community Services were integrated into the directorate of capital, estates and facilities to form Essentia, which provides the Trust with the majority of its non-clinical services.



Amanda Pritchard
Chief Operating Officer

Amanda joined the Trust in April 2012. She previously 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 the Shelford and Project Diamond Finance Directors' Groups.



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 Friday's initiative. In August 2013 Eileen was appointed as the Clinical Director for London's Strategic Network for Dementia.

Board of Directors – Non-Executive Directors



Sir Hugh Taylor
Chairman

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

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

Sir Hugh chairs both the Finance and Investment and the Remuneration Committees as well as the Board. He is a resident of Southwark.



David Dean
Non-Executive Director
and Vice Chairman

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 21 years and is a Trustee of the Dulwich Festival.

David joined the Board in June 2007 and chairs the Audit Committee. Since October 2013 he has also been the Interim Chairman of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.



Robert Drummond
Non-Executive Director

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

Robert is the advisory chairman of a European government supported provider of finance to small businesses in

the North East of England; chairman of an AIM listed Italian company in the renewable energy sector, and a non-executive director of an MoD subsidiary that helps commercialise technology developed through government research. Robert joined the Board in March 2013.



Mike Franklin
Non-Executive Director

Mike Franklin recently retired from his role as Commissioner and board member of the National Independent Police Complaints Commission (IPCC). He was previously a member of the TUC race relations committee and Vice-Chair of the Metropolitan Police Service Racial and Violent Crime Task Force Independent Advisory Group (IAG), 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.



Professor Frank Nestle
Non-Executive Director

Professor Frank Nestle holds the Mary Dunhill Chair of Cutaneous Medicine and Immunotherapy at St John's Institute of Dermatology, King's College London. He is a Member of the Academy of Medical Sciences, 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 Adult Local Services (formerly Community Services) Development Committee.



Dr Sheila Shribman
Non-Executive Director

Dr Sheila Shribman CBE was the Department of Health's National Clinical Director for Children, Young People and Maternity for seven years until March 2013. She was a consultant paediatrician for more than 25 years and was Medical Director of Northampton General Hospital for 11 years. She led the successful integration of children's services in hospital, community and mental health settings, working closely with the local authority.

Sheila joined the Board in June 2013, and chairs the Evelina London Development Committee.



Diane Summers
Non-Executive Director

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

Since 2006, Diane has been a freelance writer, editor and consultant. She is an independent adviser to the BBC Trust and is a member of the complaints and appeals panel of Resolution, the solicitors' family law organisation.

Diane joined the Board in June 2008 and chairs the Quality Committee.



Ray Askew with his daughter Abi Claggett, a patient at Evelina London Children's Hospital. Our commitment to the integration of community and hospital services took a step forward on 1 April 2014 when we introduced a single management team for children's services.

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 award a 1 per cent cost of living allowance for executives for the period 2013/14, 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.

Off payroll engagements

The Trust has a policy that all substantive staff are paid through the payroll. No Board members or senior officials with significant financial responsibility were engaged on an off-payroll basis between 1 April 2013 and 31 March 2014.

The Trust employs a number of contractors to support fixed term projects in the areas of information technology and asset management who are engaged on an off-payroll basis. The numbers involved are shown in the tables below for all off-payroll engagements as of 31 March 2014, for more than £220 per day, that have lasted for longer than six months.

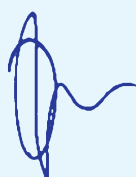
Table 1: All off-payroll engagements at 31 March 2014

Length of engagement	Number
Less than one year (but more than 6 months)	20
Between one and two years	24
Between two and three years	13
Between three and four years	6
For four or more years	8
Total	71

All the existing engagements, outlined above, have at some point been subject to an assessment as to whether assurance needs to be sought that the individual is paying the right amount of tax and, where necessary, that assurance has been sought. Table 2 below sets out the action that has been taken to obtain assurance from new off-payroll engagements.

Table 2: New off-payroll engagements and tax assurance

Assurance status	Number
New engagements at 31 March 2014	20
New engagements where the Trust has the right to request assurance in relation to income tax and national insurance obligations	20
Contractors for whom assurance has been requested	20
Contractors for whom assurance has been received	14
Contractors for whom assurance has not been received	6
Terminations as a result of assurance not received	0



Sir Ron Kerr, Chief Executive
29 May 2014



An artist's impression of the new £160 million Cancer Centre at Guy's which will open in 2016.

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Annual accounts

Foreword to the accounts

These accounts, for the year ended March 31 2014, have been prepared by the Guy's and St Thomas' NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the NHS Act 2006.

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

Sir Ron Kerr, Chief Executive and Accounting Officer
29 May 2014

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 Monitor.

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Financial Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- prepare the financial statements on a going concern basis and;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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 2014

Annual Governance Statement 2013/14

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Guy's and St Thomas' NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Guy's and St Thomas' NHS Foundation Trust for the year ended 31 March 2014 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 taken to reduce risk to an acceptable level. 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 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 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.

The Trust has not identified any risks to compliance with the NHS foundation trust condition 4 (FT governance). In order to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b), the Trust has assessed the extent with which it complies with the Code of Governance and this was reviewed by the Audit Committee. The Board is undertaking one of its periodic reviews of board capability and capacity and commissioned a review into the performance of the Board covering the areas in the second domain of Monitor's Quality Governance framework.

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.

A range of tools are in place to monitor compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, set out in the 16 Essential Standards of Quality and Safety. These include the ward accreditation scheme and a system of ward walkabouts, led by members of the senior nursing team, governors and the quality improvement team. A self-assessment undertaken by directorates for the annual governance statement provides reasonable assurance that these processes are still in place. In addition, the Trust monitors the contents of the Care Quality Commission's Intelligent Monitoring Report which replaced the Quality and Risk Profile. Areas of concern are brought to the Trust Risk and Quality Committee for actions to be agreed, and to the Quality Committee for review.

The Trust has undertaken an information assurance assessment of key indicators reported each month. 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 internal audit programme reviewing key Monitor performance metrics, and external review by the Department of Health's Intensive Support Team (IST) of pathway management have been positive. Required improvements in existing clinical coding processes identified by the Trust and highlighted in the payment by result assurance audit are being addressed through an extensive change programme, forming part of the Trust's Fit for the Future programme. A steering group, chaired by the Deputy Medical Director, meets fortnightly to review progress across a range of process and quality indicators.

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. This group also reviews external assessments of the Trust published by the CQC through its newly-created 'Intelligent Monitoring' system, and has been responsible for producing a replica 'Keogh' report. The Trust obtains operational sign-off for key returns prior to sign off, for example the referral to treatment data, produced by the informatics teams. A self-assessment undertaken by directorates provides reasonable assurance that appropriate processes are in place.

Information governance

The Trust carried out a self assessment against the Information Governance Toolkit for 2013-14. The Trust achieved a "satisfactory" rating which meant that the Trust achieved at least level two compliance in all 45 requirements.

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 certain staff groups to have

annual information training. This is done via a series of modules on Connecting for Health's Information Governance Training Toolkit, via bespoke training offered to teams and departments or via a six minute video. Additionally, there is a wealth of policies, guidance, and best practice information on the Trust's intranet.

An Information Asset Owner (IAO) has been assigned for each department or specialty. They are responsible for monitoring and managing information security risks and updating the register of information assets. 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 and hospital services to improve the processes around health records management.

In 2013/14 there were no incidents that fell within the category needing to be reported to the Information Commissioner's Office.

Risks

The table below includes a summary of the Trust's principal risks (in-year and future) together with controls and mitigation. In-year risks to delivery of the Trust's objectives are recorded in detail in the Board Assurance Framework and corporate risk register which are monitored quarterly by the Board through the Audit Committee. The Board has identified future risks during a series of strategic risk planning activities.

Risk description	Control and mitigation activities
The high level of uncertainty relating to the impact of service configuration in the South East and other parts of London makes it difficult to plan services, and may result in the trust being unable to cope with increased numbers of patients especially in A&E and maternity and failing to meet targets in these or other areas.	<p>The Trust has:</p> <ul style="list-style-type: none"> engaged in external discussions with commissioners, the Trust Special Administrator and working groups as appropriate provided support for directorates to enable them to plan implemented a 4 hour standard recovery and improvement plan for A&E begun the Emergency Floor rebuild monitored predicted birth numbers on a weekly basis and capped out of area maternity referrals when appropriate held regular meetings as a Clinical Academic Group with King's College Hospital, and also as a sector at the South East London maternity network, to discuss the possible impact of service reconfigurations effective bed management procedures.
A serious and widening gap over the next 2-5 years between income and expenditure due to the changing economic environment with potential impact on the ability to deliver services.	<p>The Trust has:</p> <ul style="list-style-type: none"> implemented well planned and managed cost improvement through the <i>Fit for the Future</i> programme performance review meetings Board level engagement and commitment a realistic and achievable financial plan for 2014/15 agreed with Monitor an experienced and dedicated contract negotiating team. <p>The Trust plans to:</p> <ul style="list-style-type: none"> continue with stringent savings plans as part of the <i>Fit for the Future</i> programme continue to negotiate with NHS England and Clinical Commissioning Groups (CCGs) for funding in line with the Trust's activity continue to keep the capital programme under tight scrutiny.
Changes in how clinical services are commissioned may result in the Trust losing local and specialist NHS work with potential impact on the Trust's financial plan.	<p>The Trust has:</p> <ul style="list-style-type: none"> dedicated specialist staff establishing effective working relationships with commissioning bodies an integrated planning process to work on tenders. <p>The Trust plans to:</p> <ul style="list-style-type: none"> continue to develop specialised services to ensure they meet new clinical standards such as NICE recommendations and new commissioning quality standards.

continued overleaf

Risk description	Control and mitigation activities
The scale of change, speed and staff engagement required to deliver 10% savings target may result in the Trust being unable to reduce cost, improve productivity and make efficiencies thereby not achieving its financial plan for 2014-15 and being unable to reinvest in clinical services.	<p>The Trust has:</p> <ul style="list-style-type: none"> implemented well planned and managed cost improvement through the <i>Fit for the Future</i> programme an established financial and performance reporting model detailed monthly scorecard reporting against national and Trust performance targets a realistic and achievable financial plan for 2014/15 agreed with Monitor. <p>The Trust plans to:</p> <ul style="list-style-type: none"> continue with stringent savings plans as part of the <i>Fit for the Future</i> programme.
There is a risk that that Trust will not meet the 90% target for admitted patients treated within 18 weeks due to the growth in the waiting list for elective services and increased demand beyond planned levels.	<p>The Trust plans to:</p> <ul style="list-style-type: none"> avoid a backlog of patients waiting over 18 weeks whilst continuing to achieve all targets monitor demand closely and flex capacity where required.
There is a risk that the Trust will not meet the threshold for C.difficile infections of not exceeding 37 cases in 2014/15 as this represents a further 21% reduction when the numbers are already at a minimal level for a Trust of this size considering the patient population	<p>The Trust plans to:</p> <ul style="list-style-type: none"> continue to deliver the C.difficile action plan which includes tightening up on existing measures particularly concerning antibiotic prescribing.

Despite our quality strategy and work to improve our critical infrastructure, the Trust has not been meeting the 85% threshold for first treatment within 62 days of an urgent GP cancer referral, or 90% for first treatment following an NHS screening referral in 2014/15. We are confident that we can meet these targets for patients referred directly to us from GPs, and from services organised by the Trust. Our performance overall, however, includes patients referred from other trusts and these are often sent late in the patient pathway. Our priority in 2014/15 is to work with partners to ensure that these inter-hospital pathways are managed optimally so that we can meet the standard for all patients.

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.

All Human Resources (HR) policies are subject to an equality impact assessment. This is monitored at the Trust Joint Policy Forum. The Trust's equality objectives are in line with the requirements of the Public Sector Equality Duties to set four year objectives. The objectives have been developed to support the Trust's strategic objectives and are integral to Trust activity. A key objective is to ensure that each 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 include consideration of the impact on health and socio-economic inequality.

The Trust has also undertaken a project to improve further Equality Impact Assessments (EIA) through the creation of a toolkit that maps health inequalities against protected characteristics. The toolkit will be published internally in 2014/15 and will further improve the EIA process.

Incident reporting

Incident and near miss reporting is encouraged by all staff groups and specialties across the Trust within an open and fair culture. During 2013/14 the Trust has continued to promote incident reporting by junior doctors and in particular, encouraged reports of medication related incidents via the Trust's web-based reporting system. Training is also provided to newly appointed consultant staff. As part of their preceptorship programme, training was given to newly qualified nurses and midwives on the importance of incident reporting as being a central component of safe patient care. A recent trust wide audit of compliance with the World Health Organisation (WHO) surgical checklist

audit has demonstrated significant compliance with its use. Following the introduction of the Duty of Candour, the Trust has provided a briefing paper for all clinical staff, raised awareness through various risk forums and will be providing training on having difficult conversations with patients and/or their families, carers or friends.

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, both 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 clearly how stakeholders might be affected and the engagement plans that will be completed to ensure they are consulted and how their views will be addressed - equality impact assessments are part of this process.

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

A Trust and Local Healthwatch Liaison Group has been established to enable regular liaison and communication between the Trust and Lambeth and Southwark Healthwatch. This group will identify opportunities for the involvement of local Healthwatch members in Trust activities and for the Trust to support relevant activities of the local Healthwatch groups.

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 2013/14. The CQC found that the Trust was meeting all the Essential Standards of Quality and Safety that were inspected.

As an employer with staff entitled to membership of the NHS Pension

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

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

The Trust has undertaken risk assessments and developed an Adaptation Plan to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP 09), to ensure that this organisation's obligations under the Climate Change Act are met.

Sustainability and carbon reduction have been included, for governance purposes into the Emergency Preparedness, Resilience and Response arrangements for the Trust. The Trust Sustainability Manager is now a core member of the Trust Resilience Working Group. As a result of the winter flooding, the Trust is re-assessing the potential impact of flooding on Trust facilities and a comprehensive review of risks was recently undertaken with officers from the Environment Agency, local Borough representatives and representatives from the London Fire Brigade.

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

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

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

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.

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 Medical Director is the nominated Trust Executive for the Quality Report. The quality priorities were developed in consultation with a wide range of stakeholders. A stakeholder meeting was held to give feedback on progress with the priorities for 2013-14, and to provide an opportunity for stakeholders to contribute to discussion about the choice of quality priorities for 2014-15. The events were well attended by governors, Lead GP Commissioners, Lambeth and Southwark LINKs, Local Overview and Scrutiny Committees, and other local trusts. The quality priorities were agreed by the Board of Directors 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 truer assessment of performance; allows better decision-making. It also 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 directorate management teams. A quarterly update summary is submitted to the Board of Directors via the Trust's Quality and Patient Safety Report, produced jointly by the Chief Nurse and Medical Director.

Trust policies and procedures are the authorised statement of what the Trust does to manage particular risks, meet specific regulatory and legal requirements, set particular standards and support particular areas of decision-making. Clinical Guidance documents ensure that quality care is provided and is managed via the Clinical Guidance Group. The processes and activities described in the authorised policies and procedures are reviewed periodically, and results reported through governance structures to assure the Trust that they are carried out effectively, and lead to the desired outcomes.

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 as well as other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee and the Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. Through its committees, the Board regularly reviews a '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. The 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 including 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 follow-ups undertaken to assess performance improvement.

An assessment of the controls applicable to the key indicators is included as part of the 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 Public Sector 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 make use of them when planning their own work. In addition to the planned programme of work, internal audit provide advice and assistance to senior management on control issues and other matters of concern. The internal audit team also provides an anti-fraud service to the Trust.

Internal Audit work also covered service delivery and performance, financial management and control, human resources, operational and other reviews. Based on the work undertaken, including a review of the Trust's Board Assurance Framework process, the Head of Internal Audit Opinion concluded 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.

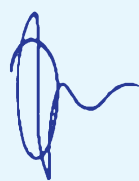
The Board Assurance Framework is reviewed by the Audit Committee and has been updated throughout the year to reflect the risks associated with failing to achieve the Trust's strategic objectives.

The Trust Risk and Quality Committee reports to the Trust Management Executive and the Quality Committee, and 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 Quality Improvement Team who provide advice and support to staff at all levels, provide guidance and support to directorates for their annual audit programmes and provide specialist audit training to Trust staff. The team also provides escalation reports where audits are not completed to agreed timescales and administer the electronic audit system. 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 Annual 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
29 May 2014

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 31 March 2014 which comprise of 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 Council of Governors and Board of Directors ("the Boards") of Guy's and St Thomas' NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements 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 31 March 2014 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 part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- The information given in the Strategic Report and 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 2014

Consolidated statement of comprehensive income for the year ended March 31 2014

		March 31 2014 NOTE £000	March 31 2013 £000
Operating income	3	947,318	891,856
Other operating income	4	293,938	277,107
Operating expenses	5	(1,198,417)	(1,163,749)
OPERATING SURPLUS		42,839	5,214
FINANCE COSTS			
Finance income	10	394	508
Finance expenses	11	(2,200)	(319)
Public Dividend Capital dividend payable	29	(21,800)	(20,330)
Net finance costs		(23,606)	(20,141)
Corporation Tax	12	10	26
SURPLUS/(DEFICIT) FOR THE YEAR		19,243	(14,901)
Other comprehensive income			
Gains from transfer by absorption from demising bodies	35	41,589	–
Impairments	16	(4,570)	(11,240)
Revaluations	17	57,107	18,656
Other reserve movements		–	30
TOTAL COMPREHENSIVE (EXPENDITURE)/INCOME FOR THE YEAR		113,369	(7,455)

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

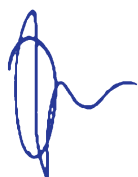
Note to Statement of Comprehensive Income

Total comprehensive income/(expenditure) as above		113,369	(7,455)
Less reserve movements in other comprehensive income	a	(94,126)	(7,446)
Total comprehensive income/(expenditure) before reserve movements		19,243	(14,901)
Add back in year impairments and reversals of impairments included in (deficit)/surplus above (see note 16)	b	5,569	25,908
Other non-operating items	c	335	2,905
Less capital donations		(9,703)	(4,771)
NET SURPLUS EXCLUDING ITEMS ABOVE	d	15,444	9,141

- This is the total of the three items shown in Other Comprehensive Income.
- This is the total impairments and impairment reversals charged to expenditure or credited to income (Note 16).
- This includes profit and losses on disposals of assets and EU emissions income release. 12/13 figure also included a lease termination payment.
- Represents the primary view used by the Board of Directors to monitor the Trust's financial performance.

Statement of Financial Position as at March 31 2014

		GROUP		TRUST	
	NOTE	March 31 2014 £000	March 31 2013 £000	March 31 2014 £000	March 31 2013 £000
NON CURRENT ASSETS					
Property plant and equipment	14	1,028,006	884,350	1,028,006	884,350
Intangible assets	15	35,637	33,156	35,637	33,156
Investments in associates (joint controlled operations)	18	71	71	322	71
Trade and other receivables	20.2	2,006	1,804	2,006	1,804
Other financial assets	21	3,500	–	4,902	1,318
TOTAL NON-CURRENT ASSETS		1,069,220	919,381	1,070,873	920,699
CURRENT ASSETS					
Inventories	19	17,917	15,276	17,917	15,276
Trade and other receivables	20.1	100,453	68,357	100,574	68,171
Other financial assets	21	–	3,500	–	3,500
Cash and cash equivalents	25	135,878	129,389	135,262	129,119
TOTAL CURRENT ASSETS		254,248	216,522	253,753	216,066
CURRENT LIABILITIES					
Trade and other payables	22.1	(126,997)	(133,784)	(126,942)	(133,721)
Tax payable	22.2	(14,278)	(13,972)	(14,277)	(13,971)
Other liabilities	22.3	(21,180)	(15,962)	(21,181)	(15,962)
Provisions	23.1	(3,437)	(3,503)	(3,437)	(3,503)
Borrowings	22.4	(2,953)	(625)	(2,953)	(625)
TOTAL CURRENT LIABILITIES		(168,845)	(167,846)	(168,790)	(167,782)
NON-CURRENT LIABILITIES					
Trade and other payables	22.1	–	(147)		
Other liabilities	22.3	(329)	(772)	(329)	(919)
Provisions	23.1	(9,273)	(8,720)	(9,273)	(8,718)
Borrowings	22.4	(96,448)	(29,405)	(96,448)	(29,405)
TOTAL NON-CURRENT LIABILITIES		(106,050)	(39,044)	(106,050)	(39,042)
TOTAL ASSETS EMPLOYED		1,048,573	929,013	1,049,786	929,941
TAX PAYERS' EQUITY					
Public Dividend Capital		362,757	356,566	362,757	356,566
Revaluation reserve		348,977	285,124	348,977	285,124
Other reserves		743	743	743	743
Income and expenditure reserve		336,096	286,580	337,309	287,508
TOTAL TAXPAYERS' EQUITY		1,048,573	929,013	1,049,786	929,941



Sir Ron Kerr, Chief Executive and Accounting Officer
29 May 2014

Statement of changes in Taxpayers' equity

GROUP 2013/14

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' Equity at April 1 2013	356,566	285,124	743	286,580	929,013
Surplus for the year	–	–	–	19,243	19,243
Transfers by modified absorption: Gains on 1 April transfers from demising bodies	–	–	–	41,589	41,589
Transfers by modified absorption: transfers between reserves	–	11,347	–	(11,347)	–
Transfers between reserves	–	(31)	–	31	–
Impairments	–	(4,570)	–	–	(4,570)
Revaluations – property, plant and equipment	–	57,107	–	–	57,107
Public Dividend Capital Received	6,191	–	–	–	6,191
Taxpayers' equity as at March 31 2014	362,757	348,977	743	336,096	1,048,573

GROUP 2012/13

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

TRUST 2013/14

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2013	356,566	285,124	743	287,508	929,941
Surplus for the year	–	–	–	19,528	19,528
Transfers by modified absorption: Gains on 1 April transfers from demising bodies	–	–	–	41,589	41,589
Impairments	–	(4,570)	–	–	(4,570)
Transfers by modified absorption: transfers between reserves	–	11,347	–	(11,347)	–
Revaluations – property, plant and equipment	–	57,107	–	–	57,107
Transfer between reserves	–	(31)	–	31	–
Public Dividend Capital received	6,191	–	–	–	6,191
Taxpayers' equity as at March 31 2014	362,757	348,977	743	337,309	1,049,786

TRUST 2012/13

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

Consolidated cash flow statement for the year ended March 31 2014

	NOTE	March 31 2014 £000	March 31 2013 £000
Cash flows from operating activities			
Operating surplus from continuing operations		42,839	5,214
Non-cash income and expenses			
Depreciation and amortisation	5.1	44,237	42,535
Impairments	16	13,831	25,949
Reversal of impairments	16	(8,262)	(41)
Loss on disposal	9	726	721
Dividends accrued and not paid		–	(205)
(Increase) in trade and other receivables		(32,787)	(10,674)
(Increase) in inventories		(2,640)	(138)
Increase in other liabilities		4,775	908
Increase in trade and other payables		679	1,973
Increase in provisions		343	1,337
Tax received	12	10	5
Other movements in operating cash flows		2	(196)
NET CASH GENERATED FROM OPERATING ACTIVITIES		63,753	67,388
Cash flows from investing activities			
Interest received	10	394	508
Purchase of intangible assets		(11,494)	(9,697)
Purchase of property, plant and equipment		(98,359)	(79,633)
NET CASH GENERATED USED IN INVESTING ACTIVITIES		(109,459)	(88,822)
Cash flows from financing activities			
Loans received from the Independent Trust Financing Facility		69,995	26,347
Loans repaid to the Independent Trust Financing Facility		(625)	–
Public dividend capital received		6,191	800
Public dividend capital paid		(21,311)	(20,125)
Interest paid on loans from Independent Trust Financing Facility	11	(2,055)	(128)
NET CASH GENERATED FROM FINANCING ACTIVITIES		52,195	6,894
Net (decrease)/increase in cash and cash equivalents		6,489	(14,540)
Cash and cash equivalents at April 1		129,389	143,929
Cash and cash equivalents at March 31	25	135,878	129,389

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 2013/14 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Going concern

The directors have a reasonable expectation that the NHS Foundation Trust 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 on consolidation. Subsidiaries are consolidated from the date on which control is obtained by the Group and cease to be consolidated from the date on which control is no longer held by the Group.

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statements using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (eg revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, eg share dividends, are received by the Trust from the associate.

Joint ventures are 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 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Revenue relating to spells that are partially completed at year-end are apportioned across the financial years on a pro rata basis. This basis is based on the costs incurred over the length of the treatment and the expected or actual length of stay.

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

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

1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.5 Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the 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. 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.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on the valuation data as 31 March 2013, updated to 31 March 2014 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.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the 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 ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were 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 was carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided 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 normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

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

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

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

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

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1 April 2013, employees' pay contributions will be on a tiered scale from 5% to 13.3% of their pensionable pay.

In addition the Trust also operates a NEST scheme for staff not eligible for the NHS Pension Scheme.

1.6 Expenditure on goods and services

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and,
- individually it costs at least £5,000; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250;
- the assets are functionally interdependent, they had broadly simultaneous purchase dates, are
- anticipated to have simultaneous disposal dates and are under single managerial control; or
- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Valuation

All property, plant and equipment is measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings are valued by an independent registered chartered surveyor on a regular basis and in accordance with Royal Institution of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect fair value. As at 31 March 2014 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 1 April 2009 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives. New fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

Subsequent expenditure

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

Depreciation

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

The Trust depreciates assets over the following ranges:

- Buildings, 4 – 54 years

- Plant and machinery, 2 – 15 years
- Transport equipment, 2 – 7 years
- IT hardware, 3 – 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 treating patients and they still had a net book value, the donor would be notified. There were no restrictions placed on the donations received in the year.

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

1.8 Intangible fixed assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets are capitalised when: they are capable of being used in the Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

1.9 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 GSTT's heritage asset as required by FRS 30 can be found in Note 34.

1.10 Government and other revenue grants

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

1.11 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within 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.

1.12 Inventories

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

1.13 Public Dividend Capital

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

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid over as Public Dividend Capital. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value for all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1 April 2013, and (iv) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.14 Value Added Tax

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

cost of fixed assets. Where output tax is charged or input tax is recoverable, the amounts are stated net of VAT.

1.15 Corporation tax

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

1.16 Other reserves

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

1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

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

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised as income or expenditure in the period in which they arise.

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

1.18 Financial assets and financial liabilities

Recognition

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

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

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as 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 (now Viapath), current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

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

Available-for-sale financial assets

Non-derivative financial assets classified as available-for-sale are either specifically designated in this category or not classified in any of the other categories. Available-for-sale financial assets are initially recognised at fair value, including transaction costs, and measured subsequently at fair value, with gains and losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are not sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Financial liabilities

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

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

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

Determination of fair value

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

Impairment of financial assets

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

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

1.19 Leases

Finance leases

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

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

Operating leases

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

Leases of land and buildings

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

1.20 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; 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 1.80% (2012/13: 2.35%) in real terms.

Clinical negligence costs

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

Non-clinical risk pooling

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

Commercial insurance

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

Contingencies

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

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

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

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 32 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.22 Losses and special payments

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

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

1.23 Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

Provisions

A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities. The following discount rates as published by HM Treasury have been used in calculating the injury benefit provision: Short-term -1.9%, Medium-term -0.65% and Long-term 2.2%. Early voluntary retirement pension provision has been calculated by applying a 1.8% discount rate as advised by HM Treasury.

Provision for impairment of receivables

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

Impairments and estimated asset lives

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

Valuations of land and buildings

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See Note 1.7 for further details.

Key sources of estimation uncertainty

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

- 1) The use of estimated asset lives in calculating depreciation (See Note 1.7 and Note 1.8).
- 2) Provisions for early voluntary retirement pension contributions and injury benefit obligations are estimated using expected life tables and discounted at the pensions rate of 1.8% (2.35% 2012/13) (See Note 1.20).

1.24 Transfer of functions from other NHS bodies

For functions that have been transferred to the Trust from Southwark and Lambeth Primary Care Trust (PCTs), the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred from Southwark and Lambeth PCTs is recognised within the income and expenditure reserve in accordance with HM Treasury's modified absorption accounting guidance for 2013/14.

For property, plant and equipment assets and intangible assets, the Trust has recognised the net book value of the transferred assets as the new cost of the assets. It has not shown the Cost and Accumulated Depreciation of the assets separately.

Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

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 2013-14.

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

Change published	Published by IASB	Financial year for which the change first applies
IFRS 9 Financial Instruments	October 2010	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project.
IFRS 10 Consolidated Financial Statements	May 2011	Effective from 2014/15*.
IFRS 11 Joint Arrangements	May 2011	Effective from 2014/15*.
IFRS 12 Disclosure of Interests in Other Entities	May 2011	Effective from 2014/15*.
IFRS 13 Fair Value Measurement	May 2011	Effective date of 2013/14 but not yet adopted by HM Treasury
IAS 27 Separate Financial Statements	May 2011	Effective from 2014/15*.
IAS 28 Associates and Joint Ventures	May 2011	Effective from 2014/15*.
IAS 32 Financial Instruments: Presentation – amendment offsetting financial assets and liabilities	December 2011	Effective from 2014/15.

* This reflects the EU-adopted effective date rather than the effective date in the standard.

2 Segmental reporting

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
INCOME		
Patient care income	947,318	891,856
Non patient care income	293,938	277,107
Total income	1,241,256	1,168,963
EXPENDITURE		
Clinical/Community Directorates	(1,013,357)	(974,016)
Corporate and finance costs	(208,656)	(209,848)
Total Expenditure	(1,222,013)	(1,183,864)
SURPLUS/(DEFICIT)	19,243	(14,901)
Adjusting for:		
Impairments and reversal of impairments	5,569	25,908
Other non-operating items	335	2,905
Capital donations	(9,703)	(4,771)
Underlying surplus	15,444	9,141

Day-to-day financial control is devolved to:

- Fifteen Clinical Directorates and two 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 – 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 2014 £000	Year ended March 31 2013 £000
Strategic Health Authorities	–	10,318
Primary Care Trusts	–	858,111
Clinical Commissioning Groups (CCGs)	506,145	–
NHS England	409,188	–
Other NHS and Government Bodies	3,948	2,440
Non NHS:		
– Overseas patients (chargeable to patients)	2,846	1,961
– NHS injury scheme	1,006	951
– Other	24,185	18,075
	947,318	891,856

3.2 Income from activities by type

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Elective income	169,257	195,777
Non-elective income	110,549	124,838
Outpatient income	160,153	155,796
Other NHS clinical income	376,323	288,725
Accident and Emergency income	17,719	19,118
Private and overseas patient income	18,806	19,195
Community services	94,511	93,407
	947,318	891,856

3.3 Income from activities arising from mandatory and non-mandatory services

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Commissioner requested services	928,512	872,661
Non Commissioner requested services	18,806	19,195
	947,318	891,856

4 Other operating income

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Research and development	47,774	46,701
Education, training and research	76,977	79,027
Charitable and other contributions to expenditure	17,047	10,259
Non-patient care services to other bodies	28,899	24,765
Other income (see below)	89,647	90,104
Rental revenue from operating leases – minimum lease payments	7,210	7,448
Reversal of impairments of property, plant and equipment	8,262	41
Profit on disposal of fixed assets	–	13
Income in respect of staff recharges	18,122	18,749
	293,938	277,107

Other income includes income from commercial activities, staff accommodation rentals, clinical excellence awards, catering, 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 2014	Year ended March 31 2013
Note	£000	Restated £000
Services from other NHS Trusts	4,152	5,720
Services from other NHS bodies	232	4,403
Services from NHS Foundation Trusts	11,135	11,460
Services from CCGs and NHS England	268	0
Purchase of healthcare from non-NHS bodies	11,553	8,010
Executive Directors' costs	1,517	1,525
Non-Executive Directors' costs	195	193
Staff costs	668,854	650,127
Drug costs	102,669	95,054
Rentals under operating leases – minimum lease payments	16,137	19,179
Supplies and services – clinical	152,565	142,802
Supplies and services – general	9,253	8,860
Establishment	10,443	9,020
Research and development	96	23
Transport	12,764	10,775
Premises	62,756	53,136
Increase in Bad Debts Provision	8,889	986
Depreciation and amortisation	44,237	42,535
Impairments of property, plant and equipment	11,414	25,624
Impairments of intangible assets	2,417	313
Impairment of financial assets	–	12
Audit fees – statutory audit	5.2 134	132
Other auditor regulatory services	5.2 21	25
Clinical negligence	9,656	8,712
Consultancy costs	11,326	10,345
Redundancy	840	941
Early retirements	1,074	543
Other*	43,820	53,294
	1,198,417	1,163,749

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

5.2 Audit fees

	Year ended March 31 2014	Year ended March 31 2013
	£000	£000
Audit services for statutory audit	122	123
Audit fee for subsidiary companies	12	9
Audit fee regulatory reporting	21	25
	155	157

Payments made to our Auditor for non-audit work in 2013/14 were £17k (2012/13 £0k).

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 2013/2014 or 2012/2013.

5.4 Operating leases

Expenditure as lessee

5.4.1 Payments recognised as an expense:

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Minimum lease payments under operating leases recognised as an expense in the year	16,137	19,179

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 2014 £000	Year ended March 31 2013 £000
Within 1 year	13,777	12,653
Between 1 and 5 years inclusive	28,374	24,251
After 5 years	12,703	17,290
	54,854	54,194

Income as Lessor

5.4.2 Rental revenue:

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Rental revenue from operating leases – minimum lease receipts	7,210	7,448
	7,210	7,448

Future minimum lease receipts due:

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Within 1 year	4,237	4,454
Between 1 and 5 years inclusive	15,485	15,497
After 5 years	41	3,576
	19,763	23,527

6 2013/14 Salary and pension entitlements of senior managers

A) Remuneration

Name	Title	2013/14 Salaries and Fees £000	2013/14 Pension-related Benefits £000	2013/14 Total £000
Executive Directors				
I. Abbs	Medical Director and Director of Patient Safety	199	11	210
R. Kerr	Chief Executive	253	–	253
A. Macintyre	Director of Workforce and Organisational Development	147	11	158
S. McGuire	Director of Essentia (Capital Estates and Facilities)	159	26	185
A. Pritchard	Chief Operating Officer	157	63	220
M. Shaw	Director of Finance	159	7	166
E. Sills	Chief Nurse and Director of Patient Experience	174	10	184

Non-Executive Directors

D. Dean	Non-Executive Director, Vice Chairman and Chairman of Audit Committee	20	–	20
R. Drummond	Non-Executive Director	19	–	19
M. Franklin	Non-Executive Director	17	–	17
F. Nestle	Non-Executive Director	19	–	19
G. Niles	Non-Executive Director	17	–	17
S. Shribman	Non Executive Directed (appointed June 2013)	14	–	14
D. Summers	Non-Executive Director	17	–	17
H. Taylor	Chairman	60	–	60

This year, this Note includes additional disclosures covering pensions related benefits. These are calculated using the 'HMRC method' and data from NHS Pensions, taking into account the effect of inflation and the value of employee contributions.

The NHS Pension Scheme is a 'final salary' scheme. So, where a director's salary increases this will be reflected in a larger movement in the overall value of their pension entitlement. Similarly, where there is a limited increase in the value of the pension payable relative to inflation and the employee's contributions, then the calculation can show a 'negative' pension figure for the year, which is then shown as a 'nil' figure in the table.

These factors mean that year on year there can be significant volatility in the level of pension remuneration for an individual.

Name	Title	2012/13 Salaries and Fees £000	2012/13 Pension-related Benefits £000	2012/13 Total £000
Executive Directors				
I. Abbs	Medical Director and Director of Patient Safety	197	–	197
R. Kerr	Chief Executive	251	–	251
A. Macintyre	Director of Workforce and Organisational Development	145	–	145
S. McGuire	Director of Essentia	157	24	181
A. Pritchard	Chief Operating Officer	150	59	209
M. Shaw	Director of Finance	157	–	157
E. Sills	Chief Nurse and Director of Patient Experience	173	–	173

Non-Executive Directors

D. Dean	Non-Executive Director and Chairman Audit Committee	20	–	20
R. Drummond	Non-Executive Director (appointed March 13)	1	–	1
M. Franklin	Non-Executive Director	17	–	17
R. Maw	Non-Executive Director (left March 13)	16	–	16
F. Nestle	Non-Executive Director	17	–	17
G. Niles	Non-Executive Director (appointed January 12)	17	–	17
J. Oliver	Non Executive Directed (left December 12)	13	–	13
D. Summers	Non-Executive Director	17	–	17
H. Taylor	Chairman	60	–	60

For 13/14 and 12/13, there were no taxable benefits or annual or long-term performance related bonuses.

	Year ended March 31 2014	Year ended March 31 2013 restated
Highest Paid Director's Total Remuneration	£253,267	£250,755
Median Total Remuneration	£38,366	£33,272
Remuneration Ratio	6.60	7.54

Median remuneration is based on total staff including agency and Bank staff as per best practice guidance. Prior year figures have been restated to include Bank staff.

B) Pension benefits

Name	Title	Total accrued pension at age 60 at 31 March 2014 £000	Real increase in year in accrued pension and related lump sum at age 60 £000	Total accrued pension and related lump sum at age 60 at 31 March 2014 £000	Cash equivalent transfer value at 31 March 2013 £000	Real increase in cash equivalent transfer value during year £000	Cash equivalent transfer value at 31 March 2014 £000
I. Abbs	Medical Director	85	9	338	1,626	96	1,758
R. Kerr*	Chief Executive	–	–	–	–	–	–
A. Macintyre	Director of Workforce and Organisational Development	55	5	219	990	57	1,069
S. McGuire	Director of Essentia	39	8	156	714	60	790
A. Pritchard	Chief Operating Officer	30	15	121	317	55	380
M. Shaw	Director of Finance	67	5	266	1,361	68	1,459
E. Sills	Chief Nurse/Director of Infection Prevention and Control	63	6	254	1,085	58	1,167

see above for notes

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

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

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 2014 Total £000	Year ended March 31 2013 Total £000
Salaries and wages	495,166	–	495,166	480,699
Social security costs	45,601	–	45,601	44,447
Employer contributions to NHSPA	59,714	–	59,714	54,374
Termination benefits	840	–	840	941
Agency and contract staff	–	83,978	83,978	85,672
	601,321	83,978	685,299	666,133
included in above:				
Costs capitalised as part of assets	(4,534)	(9,554)	(14,088)	(13,540)
Total staff costs	596,787	74,424	671,211	652,593
Analysed into Operating Expenditure (note 5.1)				
Employee expenses – staff	594,430	74,424	668,854	650,127
Employee expenses – executive directors	1,517	–	1,517	1,525
Redundancy	840	–	840	941
	596,787	74,424	671,211	652,593

7.2 Average number of people employed

	Permanently employed number	Other number	Year ended March 31 2014 Total number	Year ended March 31 2013 Total number
Medical and dental	1,664	55	1,719	1,684
Administration and estates	2,985	291	3,276	3,266
Ancillary staff	750	256	1,006	1,019
Nursing, midwifery and health visiting staff	3,925	515	4,440	4,323
Nursing, midwifery and health visiting learners	763	126	889	821
Scientific, therapeutic and technical staff	2,036	131	2,167	2,109
Social care staff	1	–	1	1
	12,124	1,374	13,498	13,223

7.3 Retirements due to ill-health

During 2013/14 there were 12 early retirements from the Trust agreed on the grounds of ill-health (15 in the year ended March 31 2013). The estimated additional pension liabilities of these ill-health retirements is £462k (£705k in 2012/13). 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 2014	Year ended March 31 2013
Number of cases	62	52
Cost of cases (£000)	1,517	1,666

7.5 Staff sickness absence

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Included within:		
Days lost (long-term)*	101,908	121,665
Days lost (short-term)	34,446	38,869
Total days lost	136,354	160,534

* Long-term sickness is over 20 consecutive days.

Total staff years	12,117	11,472
Average working days lost	11.3	14.0
Total staff employed in period (headcount)	13,166	12,555
Total staff employed in period with no absence (headcount)	5,541	4,917
Percentage staff with no sick leave	42.1%	39.2%

The above data is derived from the Electronic Staff Records system, the National Workforce System used across the NHS.

7.6 Other compensation schemes – exit packages 2013/14

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	£000	Number	£000	Number	£000
<£10,000	6	42	8	46	14	88
£10,001 – £25,000	19	336	9	163	28	499
£25,001 – £50,000	6	226	9	285	15	511
£50,001 – £100,000	2	114	1	58	3	172
£100,001 – £150,000	1	125	1	122	2	247
Total	34	843	28	674	62	1,517

7.7 Other compensation schemes – exit packages 2012/13

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	£000	Number	£000	Number	£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
Total	47	1,299	5	367	52	1,666

7.8 Exit packages: other (non-compulsory) departure payments in 2013/14

	Payments agreed	Total value of agreements
	Number	£000
Voluntary redundancies including early retirement contractual costs	–	0
Mutually agreed resignations (MARS) contractual costs	21	413
Early retirements in the efficiency of the service contractual costs	–	–
Contractual payments in lieu of notice	–	–
Exit payments following Employment Tribunals or court orders	6	216
Non-contractual payments requiring HMT approval*	1	45
Total	28	674

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 2014		Year ended March 31 2013	
	Number	£000	Number	£000
Total bills paid in the year	329,298	679,359	337,175	619,124
Total bills paid within target	263,917	494,588	283,028	481,302
Percentage of bills paid within target	80%	73%	84%	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 on disposal of non-current assets

Loss on disposal of non-current assets is made up as follows:	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Profit on disposal of property, plant and equipment	–	13
Loss on disposal of intangible fixed assets	(154)	(700)
Loss on disposal of plant and equipment	(505)	(34)
Loss on disposal of land and buildings	(67)	–
	<u>(726)</u>	<u>(721)</u>

10 Finance income

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Interest on bank accounts	290	240
Interest on loans and receivables	104	102
Other	–	166
	<u>394</u>	<u>508</u>

11 Finance expenses

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
Interest on loans from the Independent Trust Financing Facility	(2,055)	(128)
Unwinding of discounts on provisions and other finance costs	(145)	(186)
Other	–	(5)
	<u>(2,200)</u>	<u>(319)</u>

12 Taxation

	Year ended March 31 2014 £000	Year ended March 31 2013 £000
UK corporation tax		
Current tax payable on income at 20% (20% 12/13)	10	26
	<u>10</u>	<u>26</u>

The 13/14 and 12/13 refunds flow from the sharing of group losses in 12/13 which related to the tax change in 11/2.

The Trust's portion of the non-trade financial losses (interest expense) from GSTS Pathology from 11/12 tax year (the 3 months to 31/3/12) became available for group loss relief in 12/13.

13 Surplus/deficit attributable to the Trust

The surplus for the Trust was £19,528k (2012/13 deficit of £14,919k), 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 2014

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
Cost or valuation at April 1 2013	209,500	537,897	65,963	151,074	176	35,436	1,164	1,001,210
Transfers by absorption – modified	19,566	19,721	–	249	–	1,438	615	41,589
Additions purchased	–	8,553	72,014	108	–	1,071	3	81,749
Additions – grants/donations in cash	–	961	8,389	(49)	–	–	–	9,301
Impairments charged to operating expenses	–	(11,208)	(179)	(18)	–	(1)	(8)	(11,414)
Impairments charged to the revaluation reserve	–	(4,570)	–	–	–	–	–	(4,570)
Reclassifications	–	63,100	(75,065)	9,293	–	2,161	216	(295)
Revaluation	25,424	21,731	–	–	–	–	–	47,155
Disposal	–	(71)	–	(9,586)	–	(17,740)	(23)	(27,420)
Cost or valuation At 31 March 2014	254,490	636,114	71,122	151,071	176	22,365	1,967	1,137,305
Accumulated depreciation at April 1 2013	–	3,379	–	86,730	172	25,762	817	116,860
Provided during the year	–	20,102	–	12,932	4	4,285	177	37,500
Reversal of impairments credited to operating income	–	(8,262)	–	–	–	–	–	(8,262)
Reclassification	–	50	–	(57)	–	–	7	–
Revaluation	–	(9,952)	–	–	–	–	–	(9,952)
Disposals	–	(4)	–	(9,537)	–	(17,306)	–	(26,847)
At March 31 2014	–	5,313	–	90,068	176	12,741	1,001	109,299
Net book value 2013/14								
Purchased assets	159,490	506,075	65,528	53,087	–	9,455	816	794,451
Donated assets	95,000	123,640	5,594	7,007	–	161	150	231,552
Government granted assets	–	1,086	–	909	–	8	–	2,003
Total at March 31 2014	254,490	630,801	71,122	61,003	–	9,624	966	1,028,006

In the year ended 31 March 2014 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 31 March 2014. The valuation was conducted in accordance with the terms of the Royal Institution of Chartered Surveyors' (RICS) Valuation Standards.

a) Depreciated Replacement Cost (DRC)

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

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

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

b) Existing Use Value (EUUV)

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 EUUV, 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."

Property, plant and equipment – March 31 2013

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

Group and Trust			Assets under construction and payments on account	Plant and machinery	Transport equipment	IT Hardware	Furniture and fittings	Total
	Land £000	Buildings excluding dwellings £000	£000	£000	£000	£000	£000	£000
Cost or valuation								
At April 1 2012	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
Revaluations	14,000	1,396	–	–	–	–	–	15,396
Disposal	–	–	–	(12,765)	–	(3,329)	–	(16,094)
Other	–	–	1,151	–	–	(3,271)	–	(2,120)
Cost or valuation								
At 31 March 2013	209,500	537,897	65,963	151,074	176	35,436	1,164	1,001,210
Accumulated depreciation								
At April 1 2012	–	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)
Reclassifications	–	307	–	(326)	–	3	–	(16)
Disposals	–	–	–	(12,731)	–	(3,329)	–	(16,060)
Other	–	–	–	–	–	(2,370)	–	(2,370)
At March 31 2013	–	3,379	–	86,730	172	25,762	817	116,860
Net book value 2012/13								
Purchased assets	124,000	417,087	64,454	54,773	4	9,640	129	670,087
Donated assets	85,500	116,990	1,468	8,443	–	20	218	212,639
Government granted assets	–	441	41	1,128	–	14	–	1,624
Total at March 31 2013	209,500	534,518	65,963	64,344	4	9,674	347	884,350

15 Intangible assets

15.1 As at March 31 2014

Group	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
Cost April 1 2013	1,801	47,126	7,079	1,179	57,185
Additions purchased / internally generated	70	512	10,265	–	10,847
Additions – grants / donations of cash	–	–	542	105	647
Impairments charged to operating expenses	–	(3,117)	–	(391)	(3,508)
Reclassification	736	1,614	(2,055)	–	295
Disposals	(31)	(6,981)	(152)	–	(7,164)
Gross cost at March 31 2014	2,576	39,154	15,679	893	58,302
Amortisation April 1 2013	476	23,553	–	–	24,029
Provided during the year	439	6,298	–	–	6,737
Impairments charged to operating expenses	–	(1,091)	–	–	(1,091)
Disposals	(31)	(6,979)	–	–	(7,010)
Amortisation at March 31 2014	884	21,781	–	–	22,665
Net book value March 31 2014					
Purchased assets at March 31 2014	1,460	17,317	15,064	–	33,841
Donated assets at March 31 2014	232	56	615	893	1,796
Total at March 31 2014	1,692	17,373	15,679	893	35,637

15.2 As at March 31 2013

Group	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
Cost April 1 2012	742	44,182	6,026	1,777	52,727
Additions purchased	430	–	8,268	–	8,698
Additions donated	–	–	114	–	114
Additions – internally generated	–	392	–	–	392
Additions government granted	–	–	264	229	493
Reclassification	792	5,739	(6,626)	–	(95)
Impairment	–	–	(248)	–	(248)
Disposals	(163)	(4,494)	(432)	–	(5,089)
Other	–	1,307	(287)	(827)	193
Gross cost at March 31 2013	1,801	47,126	7,079	1,179	57,185
Amortisation April 1 2012	490	20,383	–	762	21,635
Provided during the year	149	6,390	–	–	6,539
Impairments (through I&E)	–	–	248	–	248
Reversal of impairments (through I&E)	–	–	–	–	–
Reclassification	–	16	–	–	16
Revaluation	–	–	(248)	–	(248)
Disposals	(163)	(4,226)	–	–	(4,839)
Other	–	990	–	(762)	228
Amortisation at March 31 2013	476	23,553	0	0	24,029
Net book value March 31 2013					
Purchased assets at March 31 2013	1,325	22,352	6,687	–	30,364
Donated assets March 31 2013	–	1,221	392	1,179	2,792
Total at March 31 2013	1,325	23,573	7,079	1,179	33,156

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

	March 31 2014 £000	March 31 2013 £000
Impairments charged to Statement of Comprehensive Income (SOI)	13,831	25,949
Reversals of prior year impairments charged to SOI	(8,262)	(41)
Impairments charged to Revaluation Reserve	4,570	11,240
Total	10,139	37,148

The majority of the 2013/14 impairment charge relates to the property valuation.

Land and buildings were valued independently by the Valuation Office as at 31 March 2014 in line with the accounting policies. The valuation included positive and negative valuation movements. Revaluation losses were taken to the revaluation reserve to the extent there was a revaluation surplus. Any losses over and above the revaluation surplus were charged to the Statement of Comprehensive Income.

Where the revaluation resulted in an increase in an asset's value, this increase was credited to the revaluation reserve unless it reversed a revaluation loss previously recognised in operating expenses, in which case it was credited initially to operating income and thereafter to the revaluation reserve.

The movement arising from the professional valuation can be summarised as follows:

	March 31 2014 Revaluation Reserve £000	March 31 2013 SOI £000	Revaluation Reserve £000	SOI £000
Increase in value of land to revaluation reserve	25,425	–	14,000	–
Increase in value of buildings to revaluation reserve	31,682	–	4,656	–
Impairments – Reduction in value of buildings to revaluation reserve	(4,570)	–	(11,240)	–
Reduction in value of buildings to Statement of Comprehensive Income	–	(11,199)	–	(23,314)
Reversal of previous year impairments	–	8,262	–	41
Total	52,537	(2,937)	7,416	(23,273)

The total impairments to the Statement of Comprehensive Income are set out below:

	March 31 2014 £000	March 31 2013 £000
Impairment of Newcomen and Bloomfield clinic	–	1,894
Impairments arising from professional valuation	11,199	23,314
Other impairments	215	416
Impairment of property, plant and equipment	11,414	25,624
Impairment of intangible assets	2,417	313
Impairment of financial assets	–	12
Total impairment charged to Statement of Comprehensive Income	13,831	25,949
Reversed impairments	(8,262)	(41)
Net impact on Statement of Comprehensive Income	5,569	25,908

17 Revaluation Reserve movements

Property, plant and equipment

	2013/14 £000	2012/13 £000
Revaluation reserve at April 1	285,124	277,789
Transfers by absorption – modified	11,347	–
Impairments	(4,570)	(11,240)
Revaluations	57,107	18,656
Transfers to other reserves	(31)	(81)
Revaluation reserve at March 31	348,977	285,124

18 Subsidiaries and interests in associates and joint ventures

The Guy's and St Thomas' principal subsidiary undertakings, associates and joint ventures as included in the consolidation at 31 March 2014 are set out below. The accounting date of the financial statements for the subsidiaries is 31 March 2014 and for the joint ventures 31 December 2014. For the joint venture undertakings that have different accounting year-end dates, interim accounts to 31 March have been consolidated..

	Country of incorporation	Beneficial interest	Principal activity
Subsidiary undertakings			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
GTI Forces Healthcare Ltd ¹	UK	100%	Healthcare services
Pathology Services Ltd ¹	UK	100%	Healthcare services
Essentia Trading Ltd ¹	UK	100%	Healthcare services
Associate and joint ventures			
SSAFA GSTT Care LLP	UK	50%	Healthcare services
GSTS Pathology LLP ³	UK	33%	Healthcare services
Spot on Diagnostics Ltd	UK	30%	Healthcare services
King's Health Partners Ltd ²	UK	25%	Healthcare services

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

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

³ On May 1 2014 GSTS Pathology LLP became Viapath. Guy's and St Thomas' NHS Foundation Trust's interest, structure and ownership of Viapath remain the same.

18.1 Investments

	Investments in associates (and jointly controlled operations) 2013/14 £000	Investments in associates (and jointly controlled operations) 2012/13 £000
Carrying value at April 1	71	83
Impairments	–	(12)
Carrying value at March 31	71	71

18.2 Aggregated amounts relating to joint ventures

	March 31 2014 £000	March 31 2013 £000
Current assets	11,753	9,725
Non-current assets	4,579	4,491
Non-current liabilities	(4,809)	(829)
Current liabilities	(11,684)	(14,676)
Group share net assets (liabilities)	(161)	(1,289)
Revenue	57,703	36,485
Expenditure	(56,579)	(36,094)
Group share net (loss)	1,124	391

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

	March 31 2014 £000	March 31 2013 £000
Group share of unrecognised losses	1,346	2,471

All figures are based on unaudited figures.

19 Inventories

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
Raw materials and consumables	17,917	15,276	17,917	15,276
	<u>17,917</u>	<u>15,276</u>	<u>17,917</u>	<u>15,276</u>

20 Trade and other receivables

20.1 Current

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
NHS receivables	43,640	13,234	43,640	13,296
Other receivables	46,263	41,695	46,425	41,447
Provision for impaired receivables	(27,897)	(19,350)	(27,897)	(19,350)
Prepayments	5,915	3,576	5,915	3,576
Accrued income	28,988	25,962	28,988	25,962
PDC dividend receivable	214	703	214	703
VAT receivable	3,330	2,537	3,289	2,537
	<u>100,453</u>	<u>68,357</u>	<u>100,574</u>	<u>68,171</u>

20.2 Non current

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
Other receivables	2,006	1,804	2,006	1,804
	<u>2,006</u>	<u>1,804</u>	<u>2,006</u>	<u>1,804</u>

20.3 Provision for impaired receivables

	GROUP		TRUST	
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
At April 1	19,350	18,969	19,350	18,969
Increase in provision	8,889	986	8,889	986
Amounts utilised	(342)	(605)	(342)	(605)
At 31 March	<u>27,897</u>	<u>19,350</u>	<u>27,897</u>	<u>19,350</u>

20.4 Ageing of trade and other receivables

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
Not past due date	52,783	31,707	49,382	31,707
Up to three months	8,603	2,792	8,603	2,792
In three to six months	4,646	1,237	4,646	1,237
Over six months	23,871	15,805	23,871	15,805
	<u>89,903</u>	<u>51,541</u>	<u>86,502</u>	<u>51,541</u>

20.5 Analysis of trade and other receivables

	GROUP		
	March 31 2014	March 31 2014	31 March 2014
	£000	£000	£000
	Impaired	Non-impaired	Total
0 – 30 days	6,693	45,820	52,783
30 – 60 days	1,954	6,649	8,603
60 – 90 days	883	3,763	4,646
90 – 180 days	2,288	2,704	4,992
Over 180 days	15,809	3,070	18,879
	<u>27,897</u>	<u>62,006</u>	<u>89,903</u>

21 Other financial assets

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
Current				
Loan and receivables	–	3,500	–	3,500
	<u>–</u>	<u>3,500</u>	<u>–</u>	<u>3,500</u>
Non-current	£000	£000	£000	£000
Loan and receivables	3,500	–	4,902	1,318
	<u>3,500</u>	<u>–</u>	<u>4,902</u>	<u>1,318</u>

Within Loan and Receivables is an amount of £3,500k which relates to a loan to the joint venture – GSTS Pathology LLP, with a maturity date of 31 December 2016 and a variable rate of interest (Libor + 2%). This loan has been reclassified from current to non-current in 13/14 following an extension to the loan by mutual agreement. Within Trust other receivables is an amount of £1,402k which relates to a loan and accumulated interest to the subsidiary – Pathology Services Ltd. This loan has a maturity date of 31 March 2018 and a variable rate of interest (Libor + 2%).

22 Trade and other payables

22.1 Current

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
Receipts in advance	809	985	809	985
NHS payables – revenue	12,067	5,933	12,067	5,933
Trade payables – capital	14,284	21,593	14,284	21,593
Amounts due to related parties – revenue	8,990	7,687	8,990	7,687
Other trade payables	31,628	47,183	31,615	47,119
Other payables	1,806	1,571	1,806	1,572
Accruals	57,413	48,832	57,371	48,832
	<u>126,997</u>	<u>133,784</u>	<u>126,942</u>	<u>133,721</u>

Non-current

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
Other payables	–	147	–	147
	<u>–</u>	<u>147</u>	<u>–</u>	<u>147</u>

22.2 Current taxes payable

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
Other taxes payable including Social Security and VAT	14,277	13,972	14,277	13,972
	<u>14,277</u>	<u>13,972</u>	<u>14,277</u>	<u>13,972</u>

22.3 Other liabilities

	GROUP		TRUST	
	March 31 2014	March 31 2013	March 31 2014	March 31 2013
	£000	£000	£000	£000
Current				
Deferred income	20,353	13,314	20,353	13,314
Deferred grants income	828	2,648	828	2,648
	<u>21,181</u>	<u>15,962</u>	<u>21,181</u>	<u>15,962</u>
Non-current				
Deferred income	329	772	329	772
	<u>329</u>	<u>772</u>	<u>329</u>	<u>772</u>

22.4 Borrowings

	GROUP		TRUST	
	March 31 2014 £000	March 31 2013 £000	March 31 2014 £000	March 31 2013 £000
Current				
Loans from Independent Trust Financing Facility	2,953	625	2,953	625
	<u>2,953</u>	<u>625</u>	<u>2,953</u>	<u>625</u>
	GROUP		TRUST	
	March 31 2014 £000	March 31 2013 £000	March 31 2014 £000	March 31 2013 £000
Non-current				
Loans from Independent Trust Financing Facility	96,448	29,405	96,448	29,405
	<u>96,448</u>	<u>29,405</u>	<u>96,448</u>	<u>29,405</u>

Loans drawn down from the Foundation Trust Financing Facility are as follows:

- £40.5m drawn down against a facility of £80m – repayable over 25 years;
- £54.6m drawn down against a facility of £75m – repayable over 25 years;
- £5m drawn down against a facility of £5m – repayable over 5 years of which £625k was repaid this year;
- In addition, the Trust has also negotiated a loan for £9m which has not yet been drawn down;
- No security has been pledged against these loans.

23 Provisions for liabilities

23.1 Overall provisions

Group and Trust	Current		Non-current		Total Provisions	
	March 31 2014 £000	March 31 2013 £000	March 31 2014 £000	March 31 2013 £000	March 31 2014 £000	March 31 2013 £000
Pensions relating to other staff	836	826	7,949	7,375	8,785	8,201
Legal claims	416	975	–	–	416	974
Redundancy	59	–	–	–	59	–
Other	2,126	1,702	1,324	1,345	3,450	3,047
	<u>3,437</u>	<u>3,503</u>	<u>9,273</u>	<u>8,720</u>	<u>12,710</u>	<u>12,222</u>

23.2 Changes in provisions

	Pensions relating to other staff £000	Legal claims £000	Other £000	Total £000
As at April 1 2013	8,201	974	3,047	12,222
Arising during the year	1,354	482	531	2,367
Utilised during the year	(846)	(649)	(31)	(1,526)
Reversed unused	(72)	(391)	(35)	(498)
Unwinding of discount	148	–	(3)	145
As at March 31 2014	<u>8,785</u>	<u>416</u>	<u>3,509</u>	<u>12,710</u>

23.3 Expected timing of cash flows

Timing of Provisions	Pensions relating to other staff £000	Legal claims £000	Other £000	Total £000
Within one year	836	416	2,185	3,437
Between one and five years	3,198	–	142	3,340
After five years	4,751	–	1,182	5,933
	<u>8,785</u>	<u>416</u>	<u>3,509</u>	<u>12,710</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 consist of provisions for EU emissions, injury benefits and dilapidations.

£121,581k is included in the provision of the NHS Litigation Authority under legal claims at March 31 2014 in respect of clinical negligence liabilities of the Foundation Trust (£113,519k at March 31 2013).

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 Prudential Borrowing Code requirements in section 41 of the NHS Act 2006 have been repealed with effect from April 1 2013 by the Health and Social Care Act 2012.

25 Analysis in changes of net cash

GROUP	At April 1 2012 £000	Cash changes in period £000	At March 31 2013 £000	Cash changes in period £000	At March 31 2014 £000
Cash with the Government Banking Service	142,780	(13,945)	128,835	6,272	135,107
Cash at bank and in hand – commercial bank	1,149	(595)	554	217	771
	<u>143,929</u>	<u>(14,540)</u>	<u>129,389</u>	<u>6,489</u>	<u>135,878</u>

TRUST	At April 1 2012 £000	Cash changes in year £000	At March 31 2013 £000	Cash changes in year £000	At March 31 2014 £000
Cash with the Government Banking Service	142,780	(13,945)	128,835	6,272	135,107
Cash at bank and in hand – commercial bank	858	(574)	284	(129)	155
	<u>143,638</u>	<u>(14,519)</u>	<u>129,119</u>	<u>6,143</u>	<u>135,262</u>

26 Capital commitments

Commitments under capital expenditure contracts at the Statement of Financial Position date for the Group and the Trust were £107,285k, (£151,349k at 31 March 2013), largely relating to the construction of the Cancer Centre at Guy's.

27 Events after the reporting date

On May 1 2014 GSTS Pathology LLP became Viapath. Guy's and St Thomas' NHS Foundation Trust's interest, structure and ownership of Viapath remains the same.

28 Contingencies

	March 31 2014 £000	March 31 2013 £000
Contingent liability for other claims against the Group and the Trust	(145)	(125)
Net contingent liability	(145)	(125)

All contingent liabilities recorded are in respect of Public and Employee liability cases as advised by the NHS Litigation Authority. This represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

29 Public Dividend Capital (PDC) dividend

The Trust is required to demonstrate that the PDC dividend payable is in line with the actual rate of 3.5% of average relevant net assets. The dividend payable relating to the period to 31 March 2014 was £21,800k, based on the average relevant net assets of £746,564k. The current net book value of the community assets transferred to the Trust which has been excluded from the PDC calculation was £44,847k in line with guidance received.

30 Related party transactions

Guy's and St Thomas' NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

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 20 and 22 respectively.

The Board members of SSAFA GSTT Care LLP include the following employees from the Trust: Martin Shaw, Alastair Scarborough and Victoria Cheston.

The Board members of GSTS Pathology LLP include the following employees from the Trust: Beverley Hunt, Martin Shaw, Jonathan Edgeworth and Mark Gladman.

The Trust's biggest source of income in 2013-14 was £430m from NHS England.

During the year the Trust also had a significant number of material transactions with entities for which NHS England is regarded as the parent. The main local commissioners are Bexley CCG, Bromley CCG, Greenwich CCG, Lambeth CCG, Lewisham CCG, Southwark CCG, Wandsworth CCG from whom the Trust received £378.6m during 2013/14 for healthcare contracts. Additionally the Trust has received income from a large number of other CCGs, including Croydon CCG, Dartford, Gravesham and Swanley CCG, Slough CCG and West Kent CCG. The Trust also received £80.3m from Health Education England.

The Trust received £22.5m from King's College London in 2013/14 (£18.7m in 2012/13).

The debtors balance for NHS bodies as at 31st March 2014 stood at £43.6m (£13.2m at 31st March 2013).

The Trust has also received revenue and capital payments from a number of charitable funds, principally £9.8m from Guy's and St Thomas' Charity during 2013/14 (£7.2m in 2012/13). The balance for Guy's and St Thomas' Charity debtors was £2,973k for 31 March 2014 (£704k at 31 March 2013) and for creditors

£1,716k for 31 March, 2014 (£1,709k for 31 March 2013). 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 (Chairman) 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. He has been appointed as interim Chair at The Christie NHS Foundation Trust in Manchester during the year.

David Dean is interim Chair at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

Eileen Sills is a Trustee of the Burdett Trust and chairs the Grant Committee. The Burdett Trust supported the development of a Trust initiative through a grant.

Eileen also holds the following positions: Trustee of the Royal College of Nursing Foundation; visiting Professor at King's College London and London Southbank Universities; and Clinical Director for London Strategic Clinical Network on Dementia (1 day a week).

Marie McDonald, Joint Clinical Director Women's Services, is an elected member of the Royal College of Midwives Board and an appointed member of the Nursing and Midwifery Council's statutory Midwifery Committee.

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

Aside from these transactions none of the other Board members, the members of the Council of Governors, members of the key management staff or parties related to them have undertaken any material transactions with Guy's and St Thomas' NHS Foundation Trust.

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
Ashford CCG	1,628		35	
Barnet CCG	2,583		127	
Bexley CCG	17,377		1,782	99
Brent CCG	1,649			69
Brighton and Hove CCG	1,430		1	23
Bromley CCG	19,779		1,462	
Camden CCG	1,706		54	
Canterbury and Coastal CCG	2,706			18
Central London (Westminster) CCG	12,568		534	
City and Hackney CCG	2,235		221	
Coastal West Sussex CCG	2,014		505	
Croydon CCG	6,926		668	0
Dartford, Gravesham and Swanley CCG	9,005		777	
Ealing CCG	1,342		5	1
East and North Hertfordshire CCG	1,276			254
East Surrey CCG	1,342		210	
Eastbourne, Hailsham and Seaford CCG	1,473			132
Enfield CCG	1,155		105	
Greenwich CCG	20,888		1,604	
NHS England	429,810	1,778	29,171	3,239
NHS Hammersmith and Fulham CCG	1,236		215	
NHS Haringey CCG	1,753		469	1
NHS Harrow CCG	1,028		36	
NHS Hastings and Rother CCG	1,389		159	
NHS Havering CCG	1,268			75
NHS Herts Valleys CCG	1,629		22	
NHS High Weald Lewes Havens CCG	1,569		182	
NHS Horsham and Mid Sussex CCG	1,152			469
NHS Hounslow CCG	1,085		45	0
NHS Islington CCG	1,659			40
NHS Kingston CCG	1,474		44	
Lambeth CCG	150,324	58	2,261	219
Lewisham CCG	37,714		743	0
Medway CCG	3,815			470
Merton CCG	1,801			25
Newham CCG	2,582		582	
North West Surrey CCG	2,046		409	
Redbridge CCG	1,700		300	
Richmond CCG	1,598		82	
Slough CCG	281		0	123
South Kent Coast CCG	2,515		0	89
Southwark CCG	118,146	12	1,511	348
Surrey Downs CCG	2,192		132	
Sutton CCG	1,305		288	4

continued overleaf

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
Swale CCG	1,635			51
Thanet CCG	1,740		320	13
Tower Hamlets CCG	2,573		502	
Waltham Forest CCG	2,006		784	
Wandsworth CCG	14,394	5	609	
West Kent CCG	9,811		851	
West London (K&C & Qpp) CCG	2,012		333	
Great Ormond Street Hospital for Children NHS Foundation Trust	1,909	220	738	25
King's College Hospital NHS Foundation Trust	1,193	5,797	2,403	3,412
South London and Maudsley NHS Foundation Trust	3,062	2,560	869	733
The Royal Marsden Hospital NHS Foundation Trust	1,040	3,316	105	53
Hounslow and Richmond Community HealthCare NHS Trust	1,365		379	
Lewisham and Greenwich NHS Trust	2,025	1,066	1,649	1,041
St George's Healthcare NHS Trust	987	2,403	238	306
HM Revenue & Customs – VAT			3,330	
HM Revenue & Customs – Other taxes and duties		45,601		14,278
NHS Pensions Agency		59,732		9,240
NHSLA		10,464		61
NHS Blood & Transplant	270	5,551	5	35

31 Financial assets and liabilities

31.1 Financial assets

	GROUP		TRUST	
	March 31 2014 £000	March 31 2013 £000	March 31 2014 £000	March 31 2013 £000
Denominated in £ Sterling	224,310	188,940	225,260	189,802
In other currencies, restated in £ Sterling	8,282	7,997	8,282	7,997
Gross financial assets at March 31	232,592	196,937	233,542	197,799

31.2 Analysis of financial liabilities

	GROUP		TRUST	
	March 31 2014 £000	March 31 2013 £000	March 31 2014 £000	March 31 2013 £000
Denominated in £ Sterling	236,474	173,384	236,419	173,320
Gross financial liabilities at March 31	236,474	173,384	236,419	173,320

31.3a Financial assets by category

	GROUP Loans and receivables £000	TRUST Loans and receivables £000
As at March 31 2014		
Assets as per balance sheet		
NHS debtors	43,640	43,640
Accrued income	28,988	28,988
Other debtors with related parties	8,702	8,702
Other debtors	39,781	41,348
Provision for doubtful debts	(27,897)	(27,897)
Other financial assets	3,500	3,500
Cash at bank and in hand	135,878	135,262
Total at March 31 2014	232,592	233,542
At March 31 2013	Restated	Restated
NHS debtors	13,234	13,296
Accrued income	25,962	25,962
Other debtors with related parties	777	–
Other debtors	43,425	43,954
Provision for doubtful debts	(19,350)	(19,350)
Other financial assets	3,500	4,818
Cash at bank and in hand	129,389	129,119
Total at March 31 2013	196,937	197,799

31.3b Financial liabilities by category

	GROUP £000	TRUST £000
Other financial liabilities		
At March 31 2014		
NHS creditors	12,067	12,067
Other creditors	56,708	56,695
Accruals	57,413	57,371
Provisions under contract	10,885	10,885
Borrowings	99,401	99,401
Total at March 31 2014	236,474	236,419
At March 31 2013	Restated	Restated
NHS creditors	5,933	5,933
Other creditors	78,035	77,971
Accruals	48,832	48,832
Provisions under contract	10,554	10,554
Borrowings	30,030	30,030
Total at March 31 2013	173,384	173,320

31.4 Fair values of financial assets at March 31 2014

	GROUP		TRUST	
	Book value £000	Fair value £000	Book value £000	Fair value £000
Non current trade and other receivables excluding non financial assets	2,006	2,006	2,006	2,006
Other	3,500	3,500	4,902	4,902
	<u>5,506</u>	<u>5,506</u>	<u>6,908</u>	<u>6,908</u>

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.

31.5 Maturity of financial liabilities

	GROUP March 31 2014 £000	March 31 2013 £000	TRUST March 31 2014 £000	March 31 2013 £000
Less than one year	130,753	135,260	130,698	135,195
Greater than one year	105,721	38,124	105,721	38,125
	<u>236,474</u>	<u>173,384</u>	<u>236,419</u>	<u>173,320</u>

31.6 Financial assets interest risk

GROUP				
Currency	Total £000	Floating rate £000	Non- interest bearing £000	Weighted average interest rate %
At March 31 2014				
Sterling	127,596	126,767	829	0.3
Other	8,282	–	8,282	0.1
Gross financial assets	<u>135,878</u>	<u>126,767</u>	<u>9,111</u>	
At March 31 2013				
Sterling	121,391	120,871	520	0.3
Other	7,998	8	7,990	0.1
Gross financial assets	<u>129,389</u>	<u>120,879</u>	<u>8,510</u>	
TRUST				
Currency	Total £000	Floating rate £000	Non- interest bearing £000	Weighted average interest rate %
At March 31 2014				
Sterling	126,980	126,767	213	0.3
Other	8,282	0	8,282	0.1
Gross financial assets	<u>135,262</u>	<u>126,767</u>	<u>8,495</u>	
At March 31 2013				
Sterling	121,122	120,871	251	0.3
Other	7,997	8	7,989	0.1
Gross financial assets	<u>129,119</u>	<u>120,879</u>	<u>8,239</u>	

31.7 Loan disclosure

	Current £000	Non current £000	Total £000	Weighted average interest rate
At March 31 2014				
Fixed interest rate instruments	2,953	96,448	99,401	3.0%
At March 31 2013				
Fixed interest rate instruments	625	29,405	30,030	2.82%

31.8 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 CCGs and the way those CCGs are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has an operation overseas with British Forces in Germany 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 Monitor. The borrowings are for 1–25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has limited exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

32 Third party assets

The Trust held £167k cash and cash equivalents at 31 March 2014 (£128k at 31 March 2013) which relates to monies held by the Trust on behalf of patients. £1.151m is held as client monies on behalf of tenants as a result of assurances. £16k is held on deposit for Viapath (formerly GSTS Pathology). These balances have been excluded in the cash at bank and in hand figure reported in the accounts.

33 Losses and special payments

Losses	2013/14		2012/13	
	Cases	£000	Cases	£000
Cash losses	230	163	276	951
Stores losses	20	49	122	43
Bad debts and claims abandoned	607	627	906	643
Total losses	857	839	1,304	1,637

Special payments	2013/14		2012/13	
	Cases	£000	Cases	£000
Ex gratia payments	65	169	27	7
Total losses	65	169	27	7

In 2013/14 there were no individual losses or special payments that were over £250,000. The amounts quoted above are reported on an accruals basis but exclude provision for future losses.

34 Heritage assets note

Historic artefacts

The remains of a Roman boat have been discovered 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. 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 (2013: nil). There were no disposals of artefacts during either year.

35 Transfer of functions

As at 1 April 2013, the ownership of some Property, Plant and Equipment assets transferred from Lambeth and Southwark Primary Care Trusts to Guy's and St Thomas' NHS Foundation Trust.

In total £41,589k worth of assets were transferred to Guy's and St Thomas' NHS Foundation Trust. The transfer was accounted for using Modified Absorption Accounting, following advice from HM Treasury.

9 buildings and their land were transferred to Guy's and St Thomas' NHS Foundation Trust totalling £38,405k. The remaining assets that transferred related to leasehold improvements (£881k categorised within buildings) and several low value items of plant and equipment, furniture and fittings and some items of IT equipment.

In summary the transfer of assets had the following effect on the Trust's financial statements as at 1 April 2013:

Non current Assets Transferred	£000
Transferred from Southwark Primary Care Trust	
Land	4,416
Buildings	5,413
Plant and equipment	99
Furniture and fittings	169
IT hardware	1,438
Subtotal	11,535
Transferred from Lambeth Primary Care Trust	
Land	15,150
Buildings	14,308
Plant and equipment	150
Furniture and fittings	446
IT hardware	–
Subtotal	30,054
Total non current assets transferred resulting in an increase in non current assets	41,589
Corresponding increase in Trust's I&E reserve on April 1 2013	41,589

Following the transfer on April 1 2013 the following adjustments were made in relation to transferred assets:

Balance transferred from I&E reserve into revaluation reserve (per HM Treasury guidance)	11,347
Transferred assets written off to income and expenditure (assets could not be verified)	505
Transferred assets impaired in income and expenditure (under Trust capitalisation threshold)	35
Total expenditure in 13/14 resulting from adjustments to transferred assets	540

contacts

Chief Executive

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

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Tel: 020 7188 0001

Email: chief.executive@gstt.nhs.uk

Patient Advice and Liaison Service (PALS)

If you require information, support or advice about our services, contact:

PALS

Tel: 020 7188 8801 (St Thomas')

or 020 7188 8803 (Guy's)

Email: pals@gstt.nhs.uk

Membership

If you are interested in becoming a member of our NHS Foundation Trust, contact:

Tel: 020 7188 7188 extension 53186

Email: members@gstt.nhs.uk

Recruitment

If you are interested in applying for a job at Guy's and St Thomas', contact:

The Recruitment Centre

Tel: 020 7188 0044

<http://jobs.gstt.nhs.uk>

Further information

If you have a media enquiry or require further information, contact:

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