

Guy's and St Thomas'
NHS Foundation Trust



Annual Report
and Accounts
2014-15



Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2014-15

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

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

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

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

We have a long tradition of clinical and scientific achievement and – as part of King's Health Partners – we are one of England's six Academic Health Sciences Centres, 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 13,650 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 England 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



We are committed to involving patients, carers and staff in the development of our services.

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The new £160 million Cancer Centre at Guy's reached an important milestone in its construction with an official 'topping out' ceremony in March. The Centre is due to open in 2016.

Chairman's statement

The Trust had much to celebrate in 2014/15. We received consistently positive feedback from our patients and staff about the quality of services we provide in our hospitals and in the community; and many of our staff have received national recognition for both outstanding examples of care and compassion in action and new, innovative approaches to delivery of our services - which are the hallmark of an organisation committed to a restless search for improvement in all that it does.

It was not an easy year. As elsewhere in the NHS, our emergency care pathway came under huge pressure, particularly in the final part of the year. We have also seen significantly increased demand for diagnostic services and elective treatment and this, combined with other pressures on health systems across south east London, has made it difficult to achieve national standards for the 18 week patient pathway and some cancer waiting times.

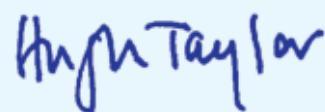
Our staff have responded magnificently to these challenges. Our community-based initiatives to reduce hospital admissions through our A&E and to support earlier discharge from hospital are beginning to show really positive results. We are making better, more efficient use of our operating theatres and imaging equipment. New technology on our wards is helping staff to manage their patients even more safely and effectively. But we will have to build further on these and other successes if we are to meet the year on year challenge of delivering improved services more productively and efficiently, while continuing to invest in new facilities such as the new Cancer Centre on the Guy's site and the new Emergency Floor at St Thomas' – which are both progressing well and are due to be completed in 2016.

The Council of Governors continued to support the development of the Trust's strategy and to provide challenge to the Board in line

with its statutory duties. An innovation this year was the introduction of two 'accountability sessions' in which the Board responded to a series of questions and challenges from the Council of Governors on a range of issues selected by the governors themselves.

We continue to work closely with our local health and social care partners to find ways to provide better co-ordinated care for our local patients and to enable people to take a more active role in supporting their own health and well-being.

We remain indebted to Guy's and St Thomas' Charity for the contribution which it makes to the infrastructure and environment of the Trust, as well as supporting innovation in our services and making a key contribution to staff welfare. We also work closely with a range of other local partners, including our local MPs, the local commissioners, the local authorities, the Metropolitan Police, and other employers in the area to ensure that we play an active part in the life of our local community.



Sir Hugh Taylor, Chairman



In January 2015 we launched our first ever website for Evelina London. Patients, parents and staff all helped to develop the new site www.evelinalondon.nhs.uk.

Directors' report 2014/15

This has been another demanding year, with the dual need to meet national standards and maintain financial stability proving a test for all acute trusts. Guy's and St Thomas' has met this challenge head on and performed well across the year – both operationally and financially. We are now focused on the 2015/16 financial year, which we recognise will be one of the toughest that the NHS has faced.

We continue to make every effort to balance high quality, safe patient care with achieving our performance targets in a difficult financial environment.

Our staff work hard to deliver excellent patient care, achieve our CQUIN (Commissioning for Quality and Innovation) targets, QIPP (Quality, Innovation, Productivity and Prevention) demands and comply with the requirements of our regulator, Monitor.

During the year, we have sought to maintain a strong financial position that will allow us to drive forward quality and service improvements for our patients. Along with other members of the Shelford Group of leading NHS trusts, we are engaged in detailed discussions with Monitor and NHS England to ensure future tariffs are set at an appropriate level to enable sustainable and safe care, particularly for specialist services.

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.

Delivering high quality care

This has been a demanding year operationally, particularly in terms of our ability to meet a number of key national standards on a consistent basis. Achieving the A&E four hour target, the 18-week patient pathway, and some cancer waiting times targets has proved difficult.

Despite a complex rebuilding project, our A&E continues to perform relatively well when

compared with other hospitals, but since January 2015 we have struggled to meet the target that 95% of patients should be seen, diagnosed, discharged or admitted within four hours.

The A&E department has experienced some exceptionally busy days when it has been difficult to maintain patient flows through the department. While we met the 95% target from April to December, and over the whole year at 95.3%, we failed to meet the target in the final quarter – achieving 93.8%.

We continued to see a significant increase in demand for planned inpatient treatment last year – up 8% on 2013/14. We have focused efforts on containing the growth in the number of patients waiting longer than 18 weeks from referral, holding extra outpatient clinics, and running Saturday and evening operating lists. The Trust agreed in advance with our commissioners and Monitor to target this additional capacity specifically to treat patients who had been waiting the longest. Our backlog is decreasing as a consequence, but this has meant we have not always been able to achieve the national targets that at least 90% of admitted and 95% of non-admitted patients should be treated within 18 weeks.

We continue consistently to achieve the waiting time standards for more than 93% of patients referred with suspected cancer to be seen within two weeks. We have also continued to provide radiotherapy and chemotherapy treatments within 31 days of the decision to treat.

However, we have not always been able to meet the increasing demand for specialist surgical treatments for urological, colorectal or skin cancers, and so we have not always provided these treatments within 31 days of the decision to treat or within 62 days of the referral. We have increased capacity and hope to be able to achieve these waiting times in 2015/16.

In common with other specialist cancer centres, we struggle to start treatment within 62 days for some patients, particularly where they are referred to us from other trusts very late in their pathway – often after 42 days. We recognise the importance of providing prompt treatment for all patients. As well as improving our own processes, we are working closely with our commissioners and other hospitals in south-east London to minimise delays at every stage in the patient journey, which we hope will result in improvements during 2015/16.

While working hard to improve efficiency and meet national targets, the Trust has maintained its focus on providing high quality, safe and compassionate care for all our patients. Our staff remain key to our ability to deliver excellent patient care and we work hard to ensure they are actively engaged in improving care for our patients.

The results of the 2014 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 remained consistently high over the 12 months to July 2014. The Trust's overall performance remains among the

best when compared with other trusts and teaching hospitals in London and the ten Shelford Group trusts. 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.

King's Health Partners

The Trust continues to play a central role in King's Health Partners, our Academic Health Sciences Centre. Our partnership with King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London has made significant progress since being accredited for a further five years by the Department of Health in 2014. We remain committed to working across our partnership to ensure that our patients and local communities benefit from our collective strengths.

In July 2014, King's Health Partners published 'Improving health and wellbeing, locally and globally', a five-year plan to achieve excellence through the integration of world-leading research, education and patient care.

A key priority is to join up mental and physical healthcare so that we treat the whole person, mind and body. We are uniquely placed to achieve this with South London and Maudsley and the Institute of Psychiatry, Psychology and Neuroscience at the heart of our partnership. For example, the award-winning 3 Dimensions of care for Diabetes (3DFD) is focusing on the psychological impact on

patients living with diabetes in south-east London, while the hugely successful King's Health Partners Pathway Homeless Team has been helping co-ordinate care and services for homeless people admitted to our hospitals.

Since the end of 2014, clinical staff across King's Health Partners (KHP) have had access to electronic patient records that are held by the partner trusts through a new KHP online portal. Developed in-house, this new system is enabling clinicians to improve care for our patients and reduce duplication.

King's Health Partners is co-ordinating the contribution of the partner trusts to the Southwark and Lambeth Integrated Care (SLIC) programme. Our shared ambition is to integrate care across local primary, secondary and social care services to make it easier for people to access the care and support they need. This work is closely aligned with our own Adult Local Services programme and the work of our community staff to develop out-of-hospital services for both adults and children locally.

Across King's Health Partners we have a shared commitment to improve the health of our local communities by tackling inequalities and supporting people to make healthy lifestyle choices. We have developed local strategies to tackle smoking and alcohol misuse. As part of this, all hospital sites across the partnership will be smoke-free from June 2015.

We are a founding member of the South London NHS Genomics Centre, which was announced as a successful bidder in the Government's

ground-breaking 100,000 Genomes Project. The alliance follows a successful pilot project at Guy's and St Thomas' and builds on a growing area of clinical and research strength in our hospitals. The three-year project has the potential to transform the future of healthcare through new and more precise diagnostic tests and the personalisation of drugs and other treatments. Patients with particular cancers and other rare diseases will benefit from this.

During 2014/15, we were awarded, with Leeds University, the contract to provide the National Institute for Health Research (NIHR) Clinical Research Network Co-ordinating Centre for the five years from April 2015, further strengthening our research base.

Our research activities continue to grow. For the third year running we were among the top three trusts for NHS research in the National Institute for Health Research's annual league tables, published during 2014, ranking third for quantity of research with 422 studies. Our performance in recruiting patients into non-commercial Clinical Research Network (CRN) portfolio studies was up 80% on the previous year, making us the highest recruiting trust in England.

King's College London, our academic partner, is now ranked 16th in the world and achieved outstanding results in the 2014 Research Excellence Framework (organised by the Higher Education Funding Council of England). The results have a direct impact on the funding received by the university and demonstrate the tremendous

progress made in recent years as well as the opportunities for health research to improve care and treatment for our patients. Clinical Medicine at King's is now ranked 3rd in the country for research quality.

Further afield, the King's Sierra Leone Partnership has played a critical role at the heart of the Ebola response in West Africa. The team has delivered a full clinical response at Connaught Hospital in Freetown, and has also played a central role advising and supporting local and international partners. We have been inspired by the commitment and dedication of current and former staff who have volunteered to work in such a challenging environment.

Our local and wider role

As a Trust, we provide a full range of local hospital and community health 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.

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

of women's and children's services, many of which benefit from being co-located on a single site.

Our services at Guy's also serve a wide population from across south London and further afield through a growing network of outreach clinics and satellite centres. As well as 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 at Guy's and the building is on track to open in 2016. 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.

In April 2015, we agreed a collaborative plan that will enable the move of major vascular surgery from King's College Hospital to St Thomas', with King's joining the South East Thames Vascular Network and Guy's and St Thomas' forming the hub of this network. This will ensure patients receive the best possible care and will provide enhanced opportunities for research.

With our partners in King's Health Partners, local GPs, and the clinical commissioning groups and local authorities, citizens and the voluntary sector in Lambeth and Southwark, we continue to explore the best models to provide integrated care and promote resilience among local people – initially focusing on older people and

adults with long-term conditions. In keeping with the thinking expressed in the NHS Five Year Forward View, we want to break down traditional boundaries so that patients receive comprehensive, co-ordinated care that no longer depends on passing patients from one team to another.

Plans to strengthen our local services for adults, whether in hospital or in the community, are also being developed and implemented by our acute medicine, therapies, adult community, cardio-vascular and medical specialties directorates.

A similar vision to integrate hospital and community care for children and young people is also being actively pursued. Since April 2014, all our children's health services have been managed by a single team as part of Evelina London.

We manage a wide range of service networks, outreach clinics and dedicated centres located across the south east. We continued to build on this strength this year, opening the Lane Fox REMEO® Respiratory Centre at East Surrey Hospital in October – the UK's first purpose-built weaning and home ventilation unit. This will operate as a satellite to the renowned Lane Fox Respiratory Unit at St Thomas', and will enable more patients eventually to return home. By moving patients out of intensive care wards and into a multi-disciplinary specialist centre, the Lane Fox REMEO® Respiratory Centre will also free up hospital intensive care beds for other acutely ill people.

Guy's and St Thomas' has a

reputation for developing and sharing best practice and we are conscious of our responsibility to use that expertise for the benefit of both our own patients and the wider NHS. We are therefore undertaking an 18-month collaboration with Medway NHS Foundation Trust as part of the 'buddying' system that allows successful NHS trusts to support other NHS organisations.

This collaboration is designed to assist local managers to implement and embed improvements to strengthen clinical leadership and effectiveness, leading to improved quality of care and better outcomes for patients. Our collaboration will initially focus on clinical governance, clinical leadership, operational management and informatics.

During the year, the Trust began construction of a new cancer centre at Queen Mary's Hospital, Sidcup, and we are also committed to providing a Kidney Treatment Centre there. Together, they will deliver world class care closer to home for patients with cancer and kidney disease.

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.

Good progress is being made with the £20 million programme to redevelop the Emergency Floor and two admissions wards at St

Thomas'. As well as a larger Urgent Care Centre and a refurbished Emergency Department, we are redesigning care pathways across the hospital for patients needing emergency admission.

The structure of the 14-storey Cancer Centre at Guy's is now complete and the clinical fit-out is well underway. This £160 million investment in a state-of-the-art building will transform the experience of cancer treatment for our patients. Patients have been closely involved in planning the building and the way that services will be delivered.

This year we have also invested in improved facilities for dermatology, lupus and rheumatology patients at Guy's, re-clad Guy's Tower, and almost completed the refurbishment of the exterior of East Wing at St Thomas'.

In December, we opened a new children's dental centre at St Thomas' Hospital, marking an important step to bring children's hospital services together on the St Thomas' site focused around Evelina London Children's Hospital. Children with long-term and complex conditions can now see all their clinicians on the same hospital site.

We continue to invest in major IT projects that will transform care for our patients, such as e-Noting, e-Prescribing, and improved digital access and mobile working for our staff. Through these investments we are seeking to deliver our ambitious vision for a 'digital hospital', fully integrated community services, and to drive efficiency across the Trust.

Developing commercial partnerships

We recognise the need to remain financially strong in an increasingly difficult economic context and our commercial activities are a key part of our strategy to diversify our income and secure our long-term financial stability. 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.

Over the coming year we will continue to develop and deliver a range of commercial opportunities, including primary and secondary care services for British Forces based in northern Europe, private patient cancer services at Guy's, and satellite respiratory services at Redhill in Surrey, closer to patients. In addition, the Trust provides services to other NHS organisations through Essentia Trading, capitalising on our estates and facilities management expertise.

Our commercial activities are overseen by the Trust's wholly owned subsidiary, Guy's and St Thomas' Enterprises, which supervises the Trust's commercial subsidiaries and investments such as Essentia Trading and Viapath – our pathology joint venture.

Business review

Guy's and St Thomas' has performed well financially in 2014/15. The Trust has declared an underlying surplus of £18.1 million for the financial year against a plan of £3 million. This

underlying surplus has been allocated to develop services and to implement our ambitious estates strategy.

The Trust generated £71.3 million in total comprehensive income for the year; this figure includes non-recurrent items such as £42.5 million resulting from the net revaluation of the Trust's fixed assets and £12.1 million of capital donations. The full statement of comprehensive income can be found in the annual accounts.

This strong financial performance was primarily due to the following positive factors:

- additional activity which has resulted in increased income from clinical commissioning groups (CCGs);
- additional funding from the Department of Health to recognise the specialist activity undertaken by the Trust not adequately funded by 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 £64.1 million in 2014/15.

Looking forward, we have identified a number of potential external factors that could have an impact on our financial performance. These are:

- the changing economic environment;

- NHS England and CCG commissioning intentions, changes to national tariffs and Commissioning for Quality and Innovation targets (CQUIN);

- changes in the configuration of healthcare in London;
- savings and activity plans;
- commercial opportunities and income diversification.

Further discussion of these factors can be found in the strategic report on pages 28 to 31.

Managing these risks ensures that we are in a strong position to take advantage of potential opportunities. Nevertheless, the Trust continues to set itself challenging financial targets.

We have established a comprehensive Integrated Quality and Performance Report covering all aspects of in year performance, including finance, for both the Board of Directors and the Trust Management Executive.

Performance and inspections

The Trust is registered with the Care Quality Commission (CQC) to carry out a number of regulated activities which they monitor against the 'fundamental standards of care' derived from the Francis Report into care at Mid Staffordshire NHS Foundation Trust.

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.

We are committed to driving improvement and a culture of excellence throughout the organisation, as demonstrated by some key achievements over the past year. Guy's and St Thomas' was one of only five trusts shortlisted for a CHKS Top Hospitals Quality of Care Award in April 2015. 90% of cancer patients at Guy's and St Thomas' rated their care as excellent or very good in the National Cancer Patient Experience Survey published in September 2014, while 81% of Emergency Department (A&E) patients at St Thomas' rated their overall experience as good in the National A&E Survey published in December 2014.

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 are aware that there is always 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

Guy's and St Thomas' is committed to the local communities we serve, and strive to support them through employment opportunities, environmental improvements and local procurement initiatives.

We have a responsibility to do everything we can to offer job opportunities to local people. We are one of the biggest employers in Lambeth and Southwark – our 13,650 staff work in not only our hospitals but also in our community services throughout our two local boroughs.

Many departments offer work experience placements in their areas, and this contribution is making a real difference to the life chances and career prospects of young people locally.

Similarly, Essentia's apprenticeship programme is having significant success in moving apprentices into permanent employment – with 12 out of 13 young people in the second year of the programme securing full-time jobs with the Trust. This year the scheme has expanded to include 25 apprentices working in areas as diverse as transport, business administration, project management, IT, and painting and decorating.

This 'grow your own' approach to recruiting the staff of the future not only breeds loyalty, but also forms part of our commitment to our local communities.

We are leading the NHS with many of our employment and environmentally friendly initiatives – contributing to our communities, saving money and operating more sustainably.

This year, Guy's and St Thomas' was successful in the third annual NHS Sustainability Day Awards, winning the Sustainable Procurement Award and being highly commended for our work to engage staff and patients in environmental sustainability. Our innovative water saving programme, which has reduced the Trust's water consumption by nearly 20% and resulted in savings of £120,000, is just one of a number of important environmental projects that have progressed over the past year.

Board of Directors

The Board of Directors brings a wide range of experience and expertise to their stewardship of the Trust and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive.

In 2014/15, membership comprised the following Executive Directors: Chief Executive, Sir Ron Kerr; Chief Operating Officer, Amanda Pritchard (who went on maternity leave in October 2014, since when Dr Simon Steddon has acted as Chief Operating Officer); Director of Finance, Martin Shaw; Medical Director, Dr Ian Abbs; Chief Nurse and Director of Patient Experience and Infection Control, Dame 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; David Dean (who resigned from the Board in June 2014); Steve Weiner (who joined the Board in July 2014);

Robert Drummond; Mike Franklin; Professor Frank Nestle; Girda Niles; Dr Sheila Shribman; and Diane Summers, who has been Vice Chair since June 2014.

Compliance statements

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 annual governance statement in this Annual Report, and the full compliance statement on the Trust website.

The directors can confirm that the Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

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

Looking ahead

Guy's and St Thomas' currently operates in a demanding external environment dominated by known and potential financial challenges. Possible changes to policy following the General Election in May 2015 are adding to the uncertainty. What is clear is the Trust's unswerving commitment to its patients and to ensuring that their growing needs are met safely, efficiently and to the highest standard.

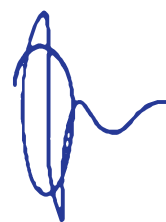
The agenda we have set ourselves is ambitious and demanding. We have significant cost improvements to deliver and our *Fit for the Future* programme is central to achieving them. To ensure that we balance these commitments effectively, we have established a Programme Board and Delivery Group that will oversee the work programme and provide regular updates to our Trust Board.

We continue our overarching focus on increasing efficiency while 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. Our ability to respond is strengthened by the relationships that we build with partners across health, social care, research and education.

It is a positive reflection on the Trust and our staff that we can assist other organisations, including through our collaboration with Medway NHS Foundation Trust. At the same time, it is important that we also remain focused on our core

business to meet our ambitious targets and provide the high standards of care to our own patients – particularly as we know that the 2015/16 financial year will be one of the toughest that the NHS has faced.

It remains for me to thank the people who have helped us to achieve so much during the past year, and who will be so important to us meeting the challenges ahead. Most notably, thanks go to 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 continuing and generous investment, our colleagues in King's Health Partners, and our many external stakeholders and supporters, in particular our local authorities, MPs, local and national commissioners 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



Martha Lane Fox officially opened the Lane Fox REMEO® Respiratory Centre at East Surrey Hospital in Redhill. The new unit is the UK's first purpose-built centre to 'wean' respiratory patients from mechanical ventilation and enable us to treat patients closer to home.

Guy's and St Thomas' provides a full range of hospital and community services for people in Lambeth and Southwark, as well as specialist care for patients from further afield. It is one of the largest and busiest trusts in the country. During 2014/15, we saw 1,072,000 outpatients, 85,000 inpatients, 88,000 day case patients and 192,000 accident and emergency attendances. We also provided 859,000 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 our commercial entity, Essentia Trading. We deliver local health services, including community services, to people in Lambeth and Southwark, and specialist services such as cancer, renal and cardiothoracic care to patients from across south London, south east England and further afield.

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 £383 million a year, or 38% of the Trust's clinical income. We are also commissioned to provide services by 96 clinical commissioning groups across the country.

Our services are provided from multiple locations that are easily accessible from across London and southern England. We care for patients at St Thomas' Hospital, Guy's Hospital and Evelina London Children's Hospital, and in more than 50 community locations in Lambeth and Southwark including health centres and clinics, schools and nursing homes, as well as in people's homes.

As a major centre for emergency care, we are building capacity at St Thomas' by

undertaking a £20 million project to transform our A&E department and services for patients requiring emergency admission. Guy's Hospital provides an important focus for planned and ambulatory care, and is also where we are building a new £160 million Cancer Centre due to open to patients in 2016. Both locations offer nationally designated specialist services.

In keeping with the thinking expressed in the NHS Five Year Forward View, we are breaking down traditional boundaries so that patients receive comprehensive, co-ordinated care that no longer depends on passing patients from one team to the other. Initiatives such as Southwark and Lambeth Integrated Care (SLIC) are helping deliver timely, high quality, patient-focused 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 also manage a wide range of service networks, outreach clinics and dedicated centres located across the south east. We continued to build on this strength this year, opening the Lane Fox REMEO® Respiratory Centre at East Surrey Hospital in October 2014, and starting construction of our new Cancer Centre at Queen Mary's Hospital, Sidcup. 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. Our clinical research facilities in 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 continuing to be a leading provider of:

- local services for children and adults, with ambitious plans to deliver integrated, cost-effective care;
- emergency services, including designation as a Major Emergency Centre at St Thomas' Hospital;
- elective and ambulatory care, with the Guy's site providing an important focus;
- specialised services, including a unique range of sub-specialties, many of which are dependent on co-location with other clinical services or research and teaching activities.

The healthcare environment remains very challenging. Although several external challenges provide us with an opportunity to transform and improve the design and delivery of our services, the constrained financial environment is our main strategic risk. We will continually focus on:

- transforming the way that our staff work and how we deliver key services to respond to changing patient needs, ensuring that we are able to respond to the demands placed on our services and the organisation;
- maximising efficiency and reducing cost so that we are a high value organisation;
- strengthening the way that we work with other organisations and partners, establishing new

partnerships and strategic alliances where this is mutually beneficial and improves the quality and efficiency of our services for patients;

- diversifying our income base to generate additional income to invest in NHS clinical services.

Our performance

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

Our operational performance in 2014/15 was a tribute to the hard work of our staff and reflects some significant achievements given the increasingly challenging environment in which we operate.

We continued to be one of the best performing trusts in London on the A&E target that requires 95% of patients to be diagnosed, treated and discharged from A&E within four hours. While we met the 95% target from April to December, we failed to meet the target in the final quarter – achieving 93.8%. However, we met the target over the whole year, at 95.3%.

We are undertaking 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'. We have also expanded our community services, helping avoid unnecessary hospital admissions and enabling more patients to leave hospital more quickly and be cared for in their own home.

We continue consistently to

achieve the waiting time standards for over 93% of referrals with suspected cancer to be seen within two weeks. We have also continued to provide radiotherapy and chemotherapy treatments within 31 days of the decision to treat.

However, we have not always been able to meet the increasing demand for specialist surgical treatments for urological, colorectal or skin cancers and so we have not always provided these treatments with 31 days of the decision to treat or within 62 days of the referral. We have increased capacity and we hope to be able to achieve these waiting time targets in 2015/16.

We 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 within 62 days for some of these patients, particularly when they are referred to us late in their pathway – often after 42 days.

We recognise the importance of providing prompt treatment for all patients. As well as improving our own processes, 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 2015/16.

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

Last year we had four cases where MRSA blood infection was attributed to the Trust, and 51 cases of *C.difficile* infection against a target of no more than 37 cases during the year, but only five of these involved a lapse in care. Although the overall figure exceeded the target set, it is believed that this reflects the background level of this infection in the local community. The view was reinforced by an expert external review, which concluded that the Trust was applying best practice to reduce the risk of infection, for example by improving antibiotic stewardship.

We continued to see a significant increase in demand for planned inpatient activity last year – up 8% on 2013/14. We struggled to keep pace, and waiting lists for our services grew. We have focused significant effort on reducing the growth in the number of patients waiting longer than 18 weeks from referral, holding extra outpatient clinics and running Saturday and evening operating lists. This additional capacity was targeted specifically at treating patients who had been waiting the longest and we are seeing our backlog decrease as a consequence. As a result, we have not always achieved the national referral to treatment targets that at least 90% of admitted and 95% of non-admitted patients should be treated within 18 weeks, particularly in the early part of the year. This was agreed in advance with our commissioners and Monitor.

The increased demand for our services has also meant that it has

been challenging to maintain progress towards the target that 99% of patients wait less than six weeks for diagnostic tests, although we are determined to achieve this next year.

Strengthening our adult community services in Lambeth and Southwark is an important priority. The Adult Local Services programme has overseen strategic developments during the year. Key achievements have included closer working between clinical teams and providing fully integrated reproductive and sexual health and heart failure services. We have also strengthened our @home and Enhanced Rapid Response services which support people to stay at home rather than come into hospital. As a result we have seen emergency admissions remain relatively stable compared with other parts of the country.

District nursing teams in Lambeth and Southwark, in common with services elsewhere, continue to experience high vacancy levels and difficulty recruiting new staff. We have put in place a range of measures to strengthen this vital community service, although we recognise the continuing challenge given the national shortage of district nurses and the complexity of the workload in our local boroughs.

The Trust is registered to provide services by the Care Quality Commission (CQC). The CQC requires the Trust to meet 16 essential standards of quality and safety, covering everything from medicines management and safeguarding vulnerable people to

Key performance indicators

		Performance		Quarterly Trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	C Diff (Clostridium difficile) acquisitions	<37	51 ●	17	15	6	13
Referral to treatment times	% admitted patients treated within 18 weeks	>90%	87.9% ●	91.1%	84.9%	87.1%	88.5%
	% non-admitted patients treated within 18 weeks RTT	>95%	94.5% ●	95.8%	94.1%	93.8%	94.2%
	% incomplete pathways less than 18 weeks RTT	>92%	92.7% ●	92.7%	92.3%	93.0%	92.8%
A&E access	95% A&E patients wait less than four hours	>95%	95.3% ●	96.5%	96.0%	95.1%	93.8%
Cancer access – initial appointments	Urgent cancer referrals seen within 2 week wait	93%	95.4% ●	96.3%	95.2%	95.4%	94.5%
	Symptomatic breast patients seen within 2 week wait	93%	96.0% ●	95.3%	95.3%	95.8%	97.5%
Cancer access – initial treatments	% cancer patients treated within 62 days of urgent GP referral	>85%	75.0% ●	79.2%	75.0%	74.0%	71.7%
	% patients treated within 62 days from screening referral	90.0%	77.9% ●	84.0%	70.0%	66.7%	90.9%
	% treatment started within 31 days from decision to treat	96.0%	96.1% ●	97.5%	96.8%	95.2%	94.9%
Cancer access – subsequent treatments	Surgical treatments within 31 days	94.0%	93.4% ●	94.2%	96.6%	92.7%	90.0%
	Chemotherapy treatments within 31 days	98.0%	99.4% ●	99.6%	99.6%	99.6%	98.8%
	Radiotherapy treatments within 31 days	94.0%	96.4% ●	96.5%	97.3%	96.1%	95.5%
Community services – data completeness	Referral to treatment information	>50%	61.0% ●	59.0%	61.0%	60.8%	63.6%
	Referral information	>50%	88.0% ●	89.0%	87.9%	87.7%	86.9%
	Activity information	>50%	79.0% ●	81.0%	78.9%	79.0%	78.9%

infection control and effective records management. In 2014/15, 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, we underpinned the Trust's strategic vision through a focus on our four objectives to:

- Provide safe productive care
- Use resources efficiently
- Release the talent of staff
- Build strong partnerships.

These support our values and are aligned with our *Fit for the Future* programme which has been essential in helping us to deliver a balanced performance by putting the needs of our patients first and bringing together quality, safety and efficiency.

We set ourselves priorities that were wide ranging and ambitious.

The top priority was to deliver high quality care at all times. The publication of the Francis, Keogh and Berwick reports during 2013 re-emphasised why it is important that we continue to put quality, safety and patients at the heart of everything we do. Delivering the fundamentals of care and measuring achievement against clear quality, safety and efficiency standards were essential priorities for all staff. They continue to be so, as does the importance of actively listening to patients and staff.

Other Trust priorities are focused on our commitment to develop cancer, cardiovascular and children's services, both within Guy's and St Thomas' and to benefit patients across the wider network. During the year, we completed initial business cases for developing cardiovascular and

children's services. Expansion of Evelina London will enable us to respond to increased demand for children's services, and ensure that we are well placed and ready to respond to the consolidation of specialist services in future years. The new Cancer Centre at Guy's is well on the way to being completed in 2016 and construction of our new Cancer Centre at Queen Mary's Hospital, Sidcup, has now started. This will enhance access to chemotherapy for people across south east London.

We made excellent progress against our ambition to provide patients with integrated healthcare services. Ambitious initiatives – our Adult Local Services Programme and Southwark and Lambeth Integrated Care (SLIC) – made good progress during the year. Creating local clinical leadership, breaking down organisational boundaries, and improving care for older people and those with long-term conditions were key focus areas.

We are also delivering the Evelina London Child Health Partnership, a pioneering programme that is exploring new opportunities to better co-ordinate care and improve health outcomes for children and young people locally. Crucially, we have approved investment which will provide the IT functionality to support those staff delivering integrated care across a range of environments.

Our ambition to provide services seven days per week has made major progress, despite the financial context. Most services have extended clinic times, working

into the evenings, and most theatres now run on a Saturday. We have also begun important work to address staff well-being and ensure we have the right numbers of staff to provide high quality care on every day of the week.

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. A proportion of our clinical income last year was conditional on achieving quality improvement and innovation (CQUIN) goals agreed with Lambeth and Southwark Clinical Commissioning Groups and NHS England.

In 2013/14 we secured 98% of the CQUIN targets generating over £20 million of income. In 2014/15 we achieved 97.8% of the CQUIN targets agreed with our commissioners generating £19.6 million of our income.

For further details of the Trust's performance in 2014/15 and our quality targets for 2015/16, 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 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 holds the Level 3 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 individual trusts' 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 2015/16.

Information risks

The Trust is required to assess and report information risks and data losses in a standard format. In 2014/15, 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

Permanently employed Trust staff – gender breakdown

All Trust staff	Number of staff	Full time equivalent	Percentage of full time equivalent
Female	10,121	9,196.94	73.16
Male	3,530	3,374.71	26.84
Total	13,651	12,571.65	

Senior Managers			
Executive Directors			
Female	3	2.94	37%
Male	5	5	63%
Total	8	7.94	
Non-Executive Directors			
Female	3	3	38%
Male	5	5	62%
Total	8	8	

Southwark, as well as caring for patients from further afield – a diversity reflected in the profile of our patients and workforce, and bringing many benefits. In return, our vision is to support and enhance the communities we serve.

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 include:

- working in partnership with our local authorities, for example through Health and Wellbeing 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 members. The Trust is committed to safeguarding all our patients, including the most vulnerable.

We participate in our local, multi-agency Safeguarding Boards and provide assurance of

safeguarding vulnerable people through a partnership approach. Care and treatment is provided to all patients with their consent and for patients who cannot consent to treatment care is provided in their best interests in accordance with the Mental Capacity Act 2005.

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 also 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.

Safeguarding training is given to all staff as part of the Trust's training programmes. 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.

Each clinical directorate has a dementia and delirium champion who works with colleagues to implement best practice in their area. The Trust is also a member of the Dementia Action Alliance and is working with partners to provide better services for people with dementia, including through the creation of dementia friendly communities.

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 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. When any remedial action is identified by the assessment, we develop and implement an action plan to address this.

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.

Sickness absence

The Trust is required by Monitor to report the sickness absence rate amongst our staff. In 2014/15, the sickness absence rate was 3.3%, a reduction on the previous year. We continue to review how best to manage sickness absence in the Trust and a recent review of the Trust's sickness absence policy has been undertaken. We also work with our

trade union partners to ensure the Trust's policy is positive in its aspirations to raise attendance levels to over 97%, minimise sickness absence, and return people to work from sick leave as soon as possible.

Sustainability and environmental performance

We remain committed to acting sustainably and minimising our environmental impact. Guided by our award-winning sustainability strategy, Guy's and St Thomas' has made significant progress along its firmly established journey to deliver the most sustainable healthcare in the UK.

Our water saving programme has reduced usage by almost 20% through elimination of leaks and the installation of water saving technology and controls. These changes stem from our ongoing partnership with Aquafund, which also donates 1% of its revenue to WaterAid, a charity transforming lives in the world's poorest countries by improving access to clean, safe water.

Energy and carbon emissions have reduced by 9% this year due to a number of projects, including the upgrade of boilers at St Thomas'. This programme has been significantly strengthened by the Trust's recent approval of a further £10 million investment in the Trust's infrastructure to reduce energy costs and carbon emissions through an energy saving partnership with British Gas. This programme will improve patient care through better temperature controls, as well as delivering a guaranteed saving of £1.3 million

Environmental impact performance indicators 2014/15

Area	2014/15	2013/14	% change		2014/15	2013/14	% change
Finite resources							
Water	510,977 m ³	510,404 m ³	+0.1%	Water £	£838,239	£847,947	-1%
Imported electricity	137,409 GJ	135,189 GJ		Energy £	£10,173,293	£10,258,625	
Gas	523,914 GJ	691,083 GJ	-24.2%				
CO ₂ emissions from building energy use	47,435 tonnes	52,059 tonnes	-8.9%				
Waste							
High temperature disposal	410 tonnes	1,964 tonnes	-79%	Total waste cost £	£961,059	£1,132,295	-30%
Alternative Treatment (offensive waste)	1,435 tonnes	1,296 tonnes					
Landfill waste	15 tonnes	178 tonnes					
Recycling – by % of total	30%	28%					

each year following completion of the project. It will also save 11% carbon emissions per annum, helping us to deliver our commitment to help tackle climate change.

The waste management programme has gone through a transformative change this year, with savings of 30% in waste costs. All used cooking oil is reprocessed into biodiesel locally, and waste is transported by barge on the Thames to be used to generate electricity. Food waste recycling has increased tenfold, and we have significantly reduced waste to landfill.

The Trust remains committed to improving the environmental impact of our supply chain for goods and services, and we buy locally wherever possible.

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 NHS Sustainability Day.

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.

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 2014/15, despite the continuing difficult economic environment. The Trust declared an underlying surplus of £18.1 million for the financial year, before accounting for the upward revaluation of the Trust's fixed assets of £47.1 million, impairments of £4.6 million due to the revaluation of the Trust's assets, non-operating items of £1.3 million, and the receipt of £12.1 million of capital donations, which combined with the underlying surplus generated £71.3 million in comprehensive income for the year.

Our financial performance

In 2014/15, the Trust set a financial plan to deliver an underlying surplus of £3 million prior to accounting for capital donations. The Trust has delivered an actual underlying surplus of £18.1 million, this equates to circa 1.14% of the Trust's turnover. 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 £68 million efficiency improvement, equivalent to 5.5% of 2013/14 turnover. At the end of the year, we had achieved over £64 million of these efficiencies and 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 Essentia Trading Limited and its joint ventures: SSAFA GSTT Care

Table 1	2014/15 Plan £ millions	2014/15 Actual £ millions	Variance £ millions
Total income excluding capital donations and revaluation	1,239.5	1,275.5	36.0
Expenses excluding depreciation and impairments	-1,164.0	-1,185.2	-21.2
Depreciation	-44.9	-45.2	-0.3
Operating surplus excluding capital donations, revaluation and impairments	30.6	45.1	14.5
PDC	-24.0	-23.5	0.5
Finance income	0.5	0.5	0.0
Finance expenses	-4.1	-4.0	0.1
Underlying surplus	3.0	18.1	15.1
Capital donations	9.7	12.1	2.4
Impairments and non-operating items	0.0	-6.0	-6.0
Revaluation		47.1	47.1
Total comprehensive income for the year	12.7	71.3	58.6

Limited Liability Partnership; and Viapath Group LLP (which includes Viapath Services LLP and Viapath Analytics LLP).

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 £38.4 million, of which £2.4 million related to donated capital assets. Expenditure was £21.2 million above plan, excluding non-operating items and impairments, reflecting the

additional costs of delivering these higher levels of activity.

The Trust's depreciation charge was £0.3 million above plan and the dividend on Public Dividend Capital costs was £0.5 million below plan. The Trust's financial charges, including interest on loans from the Independent Trust Financing Facility, were £0.1 million below plan.

Table 1 compares the 2014/15 outturn to the 2014/15 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 £2.4 million of income from charitable sources for investment in capital assets.

The Trust had planned for £12.7 million income support for the costs

Trust has declared an underlying surplus of £18.1 million for the financial year, before accounting for the upward revaluation of the Trust's fixed assets of £47.1 million, impairments of £4.6 million due to the revaluation of the Trust's assets, non-operating items of £1.3 million, and the receipt of £12.1 million of capital donations, which combined with the underlying surplus generated £71.3 million in total comprehensive income for the year.

The Trust set a financial plan to

achieved an underlying surplus of £18.1 million in 2014/15, 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 Department of Health to recognise the specialist activity undertaken by the Trust not adequately 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 £64.1 million in 2014/15, 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 2014/15.

Table 2	2014/15 Actual £ millions	2013/14 Actual £ millions
Total income	1,289.9	1,241.2
Expenditure including depreciation	-1,238.6	-1,198.4
Operating surplus	51.3	42.8
PDC	-23.5	-21.8
Interest on loans & receivables/other	-3.5	-1.8
Retained surplus/-deficit	24.3	19.2
Adjusting for:		
Impairments included above	6.9	13.8
Non-operating expenses	1.3	0.3
Reversal of prior year impairment	-2.3	-8.2
Capital donations	-12.1	-9.7
Underlying surplus	18.1	15.4

of specialist activity provided by the Trust in excess of the income from the national tariffs, consistent with income received in previous years. During 2014/15 there was considerable uncertainty regarding whether the Trust would receive this income. Confirmation of funding totalling £17.9 million was received from the Department of Health at the end of the financial year, some £5.2 million above the plan.

Financial performance 2014/15

Guy's and St Thomas' has performed well financially in 2014/15 and the

deliver an underlying surplus of £3 million prior to accounting for capital donations and impairments. The Trust has delivered an underlying surplus of £18.1 million, this equates to circa 1.14% of the Trust's turnover.

Table 2 shows the Trust's financial performance for 2013/14 and 2014/15.

The Trust made an underlying surplus of £15.4 million in 2013/14 (before accounting for revaluations, asset transfers impairments and non-operating costs, and charitable funding for capital schemes) and

Trends in activity, income and expenditure

Chart 1: Completed patient spells

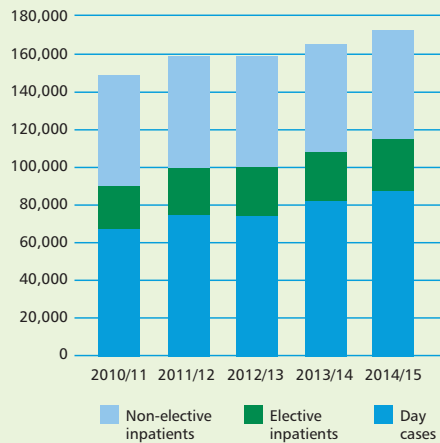


Chart 2: Consultant outpatient attendances

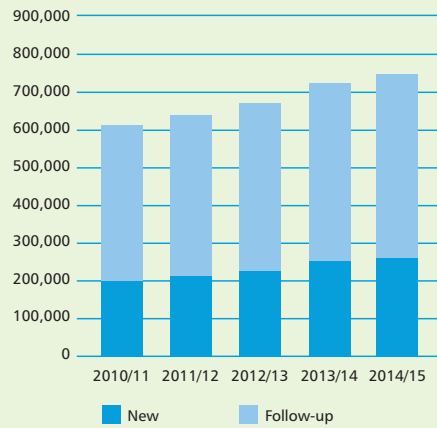
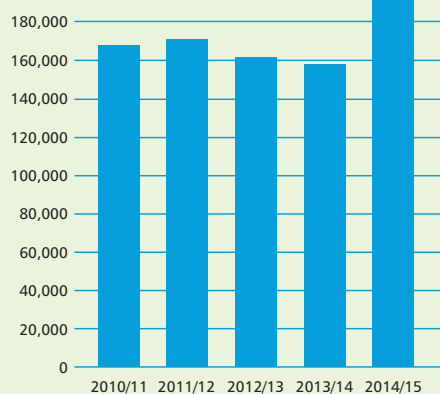


Chart 3: A&E attendances



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 – includes urgent care centre attendances at Guy's

See page 26 for details.

Chart 4: Income £000s

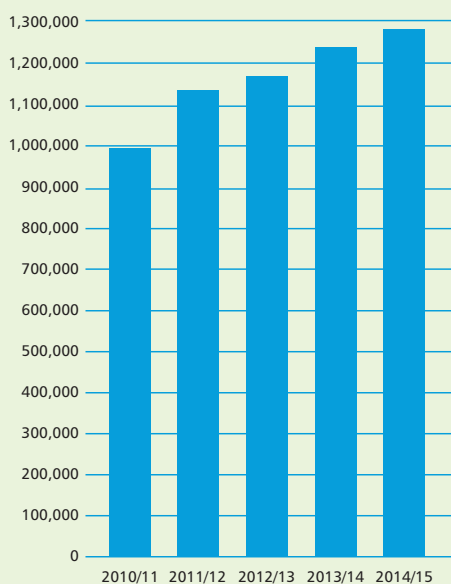
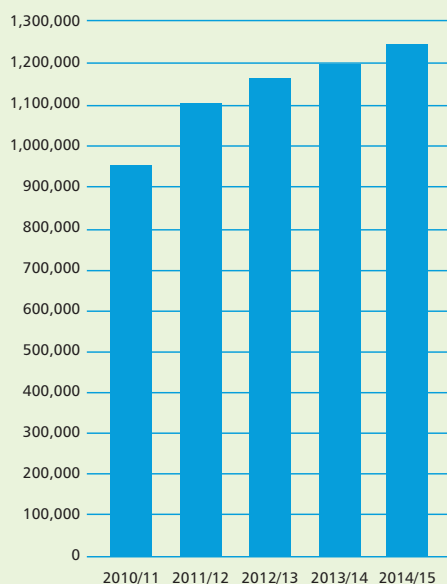


Chart 5: Expenditure £000s



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 17%, and growth in outpatient attendances, up by 22%.

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 and elective activity. Non-elective activity has reduced by circa 1% over the period.

Total outpatient activity has grown by 22% (new outpatient referrals increased by 30% and follow-up referrals increased by 18%) 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 a local GP practice, the Bermondsey and Lansdowne Medical Mission. The service was transferred back to the Trust in April 2014. In 2014/15 total A&E attendances were up by slightly over 4% after adjusting for the MIU. Overall accident and emergency attendances are up 14% over the five-year period. This increase includes an increase in attendances at Guy's MIU of 121% whilst attendances at St Thomas' A&E have increased by less than 6% over the five-year period.

Chart 4 shows the growth in income over the five-year period from April 2010 to March 2015.

Income has grown at over 7% a year. However, this includes the transfer of a number of non-clinical administrative functions from other organisations. After adjusting for these, the underlying growth in income is circa 4% 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 more than 7% a year, adjusted to 4% a year after accounting for the recent service transfers. The underlying 4% 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.

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 £133.4 million cash in the bank, against a plan of £121.3 million. This was an increase in cash of £12.1 million compared to plan, and a decrease of £2.5 million when compared with the £135.9 million position at the end of 2013/14. The increase in cash against plan is mainly due to the Trust under-spending against the capital expenditure plan by £4.3 million on NHS funded assets, the improved

income and expenditure position of £15.1 million above plan and the increased draw down of loans of £5.1 million, offset by the variance in working balances against a plan of £12.4 million.

The Trust had a planned capital expenditure of £137.5 million for the year, including planned capital donations of £9.7 million.

The actual capital expenditure was £135.6 million, consisting of £123.5 million from NHS funded assets and £12.1 million from charitable funds. The Trust drew down £60 million, against a planned draw down of £54.9 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 in March 2015, in line with the accounting policies. The valuation included positive and negative valuation movements.

Overall there was a net increase in the valuation of £42.8 million. This included a positive valuation of land and buildings of £51 million. Positive valuations were charged to the Revaluation Reserve of £33 million on land and £15.6 million on buildings. A further £2.3 million of previous year impairments were reversed and recognised in other operating income in the Consolidated Statement of Comprehensive Income, where in previous years there had been insufficient revaluation reserve balances to offset impairments. The valuation also included a negative valuation of £8.2 million on buildings. £4 million was

charged to the Consolidated Statement of Comprehensive Income where the Trust's buildings had insufficient revaluation reserves to fund the valuation movement. An impairment of £1.9 million was also charged to the revaluation reserve.

In addition to the valuation movements, a total impairment charge of £0.6 million was made to the Statement of Comprehensive Income, consisting of £0.3 million for tangible assets and £0.3 million in intangibles for projects that should have been charged in previous years.

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 2014/15, the Trust spent £12.1 million from charitable grants on capital projects, and also received £10 million in charitable contributions towards revenue expenditure.

Capital expenditure

Capital expenditure during 2014/15 was focused 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 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.

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.

Table 3	NHS funded £ millions	Donated £ millions
Buildings	17.3	0.0
Assets under construction	86.3	12.1
Plant and machinery	9.1	0.0
Information technology (IT)	9.1	0.0
Furniture and fittings	0.5	0.0
Software licences etc.	1.2	0.0
Total	123.5	12.1

Capital loans

The Trust has agreed loans totalling £169 million with the Independent Trust Financing Facility for five major capital schemes. These loans were contingent upon the Board of Directors agreeing business cases for each scheme which have all now been signed off by the Board of Directors. In 2014/15 the Trust drew down £60 million of the agreed loans to cover the expenditure incurred, and a total of £160 million of the £169 million has now been utilised. Since December 2013 the Trust has made

principal repayments totalling £3.6 million, of which £3 million was repaid in 2014/15. The Trust has plans to repay a further £6.5 million in 2015/16.

External audit services

The Trust Auditors are Deloitte LLP. The current contract for external audit is in its fifth and final year (2014/15). The contract for the next audit term is currently subject to tender.

The Trust incurred £155,940 in audit services fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2015. This included £21,000 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 an Integrated Quality and Performance Report (IQPR) to review and monitor performance at both a Trustwide and directorate level. Incorporated within the IQPR, 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, 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;
- NHS England and CCG commissioning intentions;
- changes to national tariffs and Commissioning for Quality and Innovation targets (CQUIN);
- changes in the configuration of healthcare in London;
- savings and activity plans;
- 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.

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 constrained economic environment nationally and in the NHS has been a significant issue for the Trust. There is also huge uncertainty about a number of key financial issues and assumptions such as tariff changes and Agenda for Change pay rates. There continue to be significant risks that the Trust is not fully recompensed for the activity we undertake.

We have planned for different financial scenarios, flagging risks to our commissioners and the regulator, Monitor. We are focusing on improving quality, safety and efficiency, supported by the *Fit for the Future* programme. This includes a relentless focus on maximising utilisation of our facilities and equipment, reducing costs, and diversifying our income streams whilst maintaining our focus on quality and safety.

Commissioner intentions and affordability

The Trust has worked with new commissioning organisations including clinical commissioning groups, NHS England and local authorities as they established

themselves in 2014/15. Given the financial context and possible policy changes following the 2015 General Election, there is significant uncertainty about agreeing contracts for clinical services for 2015/16. This includes risks to the activity level each commissioner wants to commission and the price we are paid for this.

Commissioning intentions for 2015/16 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.

In November 2014 Monitor consulted on its proposed national tariffs and efficiency requirements for 2015/16. These national tariffs were rejected by providers and Monitor was required to withdraw these proposals and consider whether the matter is referred to the Competition and Markets Authority to adjudicate on the tariff proposals or to issue a new tariff proposal for consultation and implementation during the financial year.

In the absence of an agreed tariff, and in order to progress contract discussions with providers, NHS England proposed two tariff options for providers, to choose. These were the Enhanced Tariff Option (ETO) where tariffs would be based on the Monitor proposals with certain adjustments, and the Default Tariff Rollover (DTR), which

rolled over the existing 2014/15 tariffs. The Default Tariff Rollover option also removed CQUIN funding from providers and provides further risk if a new tariff and efficiency requirement is introduced in-year.

The impact of these tariff options, greater commissioner efficiency requirements and increased uncertainty on commissioner funding has led to significant risks that the activity the Trust is required to deliver to meet access and waiting times targets, as well as significant growth in specialist activity, will be unaffordable to commissioners.

In 2014/15 the Department of Health and NHS England provided financial support of £17.9 million to cover the additional costs to the Trust, above those covered by the national tariff, for the specialist services we provide. In February 2015, the Department of Health and NHS England notified the Trust, and a number of other providers of specialist services, that these funds will not be made available in 2015/16. The Trust is engaging with Monitor, the Department of Health and NHS England in putting the case for additional resources for 2016/17.

The impact of the Default Tariff Rollover, increased commissioner QIPP targets and loss of specialist services funding have increased the level of savings required by the Trust by circa £26 million above the forecast saving requirement set out in our five-year plan. The extent to which the Trust struggles to meet this additional saving requirement will impact on our in-year financial performance and our proposed

capital investment, although this has been partly mitigated by the £15.1 million surplus above plan delivered in 2014/15.

Changes to healthcare provision and the healthcare provider environment

We still expect there to be changes in the medium term to the way that some services are commissioned and provided, although the nature of these changes has been influenced by the publication of the NHS Five Year Forward View. We expect:

Integrated care: This is a key priority for NHS England. Several sites around the country are part of prototypes piloting new models such as integrated primary care and hospital services and multi-specialty community providers. Our work on Adult Local Services, the Evelina London Child Health Partnership and as part of SLIC will bring local system change across all health, social care and other providers in Lambeth, Southwark and beyond.

Buddying: National NHS organisations are committed to creating models for sustainable smaller hospitals and providing support for poorer performing NHS trusts. The Trust is part of a buddying relationship with Medway NHS Foundation Trust and we will explore these models further where there is mutual benefit.

Specialist services: NHS England has signalled that they still plan to consolidate specialised services where there is a quality/volume correlation. However, they are no longer planning to consolidate

services from 148 providers to 15-30 centres of excellence. The first round of service reviews are expected in the summer of 2015. We are well placed to be a 'hub' for consolidated services in many specialties but there are financial and numerous clinical co-dependency and efficiency risks that would result if we are not.

Emergency care: NHS England has signalled that it still intends to run a national emergency care centre review process and implement urgent and emergency care networks. Our A&E rebuild is progressing to plan, meaning we will have the capacity to continue to have a Major Emergency Centre (our current A&E) at St Thomas' Hospital. We are investing significantly in this service as part of our Emergency Floor project. We expect guidance on the designation process in the summer of 2015.

Elective centre: We have worked hard to become an efficient elective service provider, with a particular focus on the Guy's Hospital site. There are still risks that any changes to the configuration of elective services as a result of commissioner affordability, changes to the market or the configuration of services in south east London, will impact our elective service income streams. We believe that we provide a unique offering as we are able to provide elective care for complex patients given the co-located critical care services at Guy's.

Maternity services: NHS England will complete a review of maternity services by autumn 2015. This will make recommendations on how

best to develop and sustain maternity services for the future. We are unique in London in being able to provide a full range of adult and children's local and specialised services including an A&E and maternity unit at St Thomas' Hospital. Our maternity care is part of a network of services in which we provide highly specialised, as well as local maternity services for women, including providing antenatal and postnatal care in the community. This places us in a strong position to continue to provide clinically, operationally and financially sustainable maternity services.

Savings and activity plans

The Trust's five-year plan set out the 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, while continuing to provide high quality, effective clinical services to meet the challenge set out in those plans.

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 and the integration of community services give us a firm basis from which to deliver significant service redesign and cost reduction.

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 significant efficiency savings in 2015/16 which, without the additional financial risks described above, will deliver £6.5 million surplus. The Trust expects to identify additional in-year efficiency opportunities to minimise the impact of these additional pressures, and will review in-year if contract negotiations do not reduce the risk.

Increasing the efficiency of our services is a key goal for the coming financial years while 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, we established our strategic, Trustwide programme, *Fit for the Future*.

This consists of clinical and non-clinical workstreams that will maintain high quality care and a positive patient experience while 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.

Commercial opportunities and income diversification

The Trust benefits from having one of the largest and most successful commercial directorates in the NHS. We must safeguard our future by ensuring that we continue to be financially sustainable, and our commercial activities are a key part of our strategy to diversify our income and ensure our long-term financial stability. The commercial team supports and develops a range of initiatives which are inextricably linked to our three core pillars of excellence in clinical services, education and research. All financial surpluses created in this way are used to implement our clinical strategies.

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

- the delivery of a contract for primary and secondary care services for British Forces based in Germany;
- the development of our partnership with HCA to deliver private patient cancer services at Guy's;
- our partnership with BOC Remeo® for the delivery of satellite respiratory services;
- our partnership in south east London with Diaverum for renal services;
- our partnership with Sainsbury's to provide outpatient pharmacy services on both main hospital sites;
- our partnership with Hamad Medical Corporation in Qatar to support the development of local Extra Corporeal Membrane Oxygenation (ECMO);
- provision of services to other NHS organisations by Essentia Trading, capitalising on its estates and facilities management expertise.

Essentia offers consultancy in the fields of strategy development and healthcare planning, estate development advice and support, sustainability and energy performance contracts, and information technology services.

As part of its commercial offer, the Trust has a 100% owned subsidiary organisation – GSTT Enterprises. GSTT Enterprises manages our company portfolio

including Essentia Trading and Viapath – our pathology company owned jointly with King's College Hospital NHS Foundation Trust and Serco. In addition, we have created two spin out companies as a result of the technical innovations of our clinical staff – Cydar and Spot On.

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
27th May 2015



We continue to achieve high scores in the national PLACE assessments, with a score of 99.38% for cleanliness this year.

4

Our people – patients, staff and partners

The Trust is committed to improving the quality of care and the experience of patients, and we work closely with patients, families and carers to ensure we meet the needs of the diverse communities we serve. Our dedicated staff are at the heart of this commitment, aided by the strong support of our partners.

Patients

Our patients lie at the heart of everything we do. Only by listening to what they say about their care, can we provide excellent services that meet their needs. 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 treat each as an individual.

Listening to patients

Guy's and St Thomas' is committed to listening to patients and values 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 patients' views more rapidly. In the last year, more than 16,500 inpatients and more than 14,700 outpatients completed a survey using this system.

Most participants reported a high level of satisfaction with the services we provide, with 90% of both inpatients and outpatients reporting that they were satisfied with their hospital visit and the quality of care they received. 92% of inpatients and 94% of 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 96% and 98% of patients reporting that areas were very clean or fairly clean.

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

When asked, 93% of young inpatients and their families and 83% of young outpatients told us that they were satisfied with their visit to our hospitals, while 95% of young inpatients and 81% of young outpatients said that they felt listened to.

Experience of young patients using our community services is similarly positive with 91% of patients reporting they are satisfied. 97% of young patients felt staff were always friendly and communicated with them clearly.

This year we extended our near-time feedback system to include all the services we provide to our patients in the community. 83% of patients using our community services reported they were satisfied with the care they receive. This provides more timely feedback from patients receiving care at home or at individual community locations, giving staff a richer picture of their patients' experience.

We also participate in the Care Quality Commission's national patient survey programme. This year, in addition to the annual inpatient survey, we undertook a survey of patients attending our Emergency Department (A&E). 81% of patients attending A&E reported that they had a positive experience and 74% felt that they were always treated with dignity and respect. Our inpatient survey results show high levels of satisfaction with those aspects of care that we know are important to patients – 84% of inpatients felt that they were always treated with dignity and respect during their stay and 93% reported that they were always given enough privacy when being examined or treated.

Like other hospital trusts in England, we continue to ask our patients the Friends and Family Test question to find out whether they would recommend our inpatient wards and A&E department to a friend or family member if they needed similar care or treatment. The Trust scored above the national average, with 97% of inpatients and 55% of patients attending A&E saying that they would recommend our services. In the second half of the year the Test was extended to

has included further 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 inpatient survey show that during the last year, more than 95% 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, in response to feedback from patients, we have maintained our focus on reducing noise on our hospital wards at night. Our 'care at night' campaign establishes a night time routine where noise in the ward environment is minimised.

We care for a wide range of patients, but strive to treat each as an individual

patients using day case, day surgery, outpatient and community services.

Following a successful pilot, we extended our mystery shopping programme to more than 43 locations across our hospitals. Trained volunteers used scenarios to test patients' first contact with the Trust, for example requesting directions to locations, asking how they can provide feedback, and observing clinic waiting areas. Feedback has allowed us to make improvements such as the introduction of new maps to help patients find their way to clinics and noticeboards and announcements to update patients on clinic waiting times.

The Trust's environmental improvement programme continues to enhance patient facilities. This

Learning from complaints

We take complaints very seriously, and they form an important part of our learning from patient feedback. When we receive complaints related to clinical care or other aspects of the patient experience, we work hard to address issues and reduce complaints across all areas.

The Patient Advice and Liaison Service (PALS) is a key channel to capture patient feedback. During the year, PALS received over 13,000 enquiries and staff work hard 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 service are fed back to local teams and contribute to the data used to improve our services.

Patient and public involvement in the development of our services

We want to ensure the patient voice is heard in everything we do, and are committed to involving patients, carers and the public in many different activities across the organisation. During the year, we developed a three-year Patient and Public Engagement Strategy with help from Trust staff, patient and public governors, and Lambeth and Southwark Healthwatch. Activities ranged from involving patients in staff recruitment to informing our research agenda and monitoring the quality of our services.

The Trust is pleased with the growing number of patient assessors in the annual Patient-led Assessment of the Care Environment (PLACE). Last year, around 50 patient and public members of the Trust joined our assessment teams. Compared to other trusts, we scored above average in all categories, with some of the best results in London.

Our Patient Insight Forum is a group of members who take part in our mystery shopping, telephone call quality assessor programmes and PLACE assessments. They meet four times a year to review the information we gather through these activities and make suggestions on how we can improve services.

Patients are also at the heart of improvements we are making to our emergency and cancer care services. As the redevelopment of our Emergency Department (A&E) progresses, we continue to seek the views of patients using these services.

Similarly, the Patient Reference Group for the new Cancer Centre at Guy's takes an active role in the transformation of services in readiness for the new building, influencing selection and design of services such as the electronic patient check-in system. Patient representatives have also helped define the food that will be on sale in the Cancer Centre, ensuring we meet the complex dietary needs of our cancer patients.

In addition, carers, patients, staff and other stakeholders (including residents and local businesses) have been regularly updated about the progress of works for the new Cancer Centre through quarterly evening drop-in events, quarterly Cancer Centre newsletters, information on the Trust's website, and articles in a variety of publications.

We recognise the importance of carers, and are doing more to support them across all directorates. During the year, we considered how we could do even better in this area, and are in the process of developing a plan to address this.

The Trust's outpatient programme has also continued to gather regular feedback from patients, using the information to improve patient experience across a range of areas, from improved patient information to faster telephone booking.

Consultations

The Trust has not undertaken any formal consultation during the last year and there are no activities in progress. At the time of this

report there are also no formal consultation activities planned for 2015/16.

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. Our patient information helps patients make informed decisions, so is central to the Trust meeting the CQC's essential standard around consent to care and treatment.

During the year, we produced more than 350 new or updated patient publications. We now have more than 1,100 bespoke publications in use across the Trust. We also approve externally produced patient information from a range of organisations. This year, new publications included a diabetes handbook, a heart monitoring diary as part of the Evelina London home monitoring programme, and a picture book for children visiting Evelina London for heart surgery. Our award-winning patient safety card was also turned into a short film by colleagues at Haelo and Salford Royal NHS Foundation Trust, and launched by the Secretary of State for Health at a national safety conference.

In September, the Trust was awarded the British Medical Association (BMA) award for

innovation in patient information for the second consecutive year, for our hip/knee surgery recovery pack. The pack, which is produced in partnership with Janssen Healthcare Innovation and DePuy Synthes, significantly reduces the time that patients spend in hospital following a hip or knee replacement. Our Easy Read leaflets were also highly commended.

Our Quality Story is a new section of the Trust website to help keep patients and the public informed about how we are doing. The site brings together in one place a wide range of information about our performance such as

and facilities exist to translate information, including into formats such as audio or Easy Read.

Our staff

Last year, we employed around 13,650 clinical and non-clinical staff, 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.

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

Communication and staff involvement

The Trust is committed to involving staff in decision-making and keeping them informed of changes and developments across the organisation. This commitment starts from the day that new recruits join the Trust – a two-day corporate induction programme ensures that all staff understand our values and are provided with key information about how we work.

We strive to ensure all staff are aware of the issues affecting the organisation and have opportunities to provide feedback.

In response to the Francis Report in 2013, our original 'listening exercise' won best internal communications at the national Association for Healthcare

Our staff work hard to improve efficiency, meet quality and access targets and bring innovations in care to patients

waiting times, infection rates, and our Friends and Family Test results.

We have also improved the patient experience of some of our youngest patients through the new Evelina London website. Developed by staff, patients and their families, the new website provides all the information needed for a visit to our children's hospital.

We provide 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

Communications and Marketing (AHCM) Awards. This year more than 1,600 staff took part in our Francis One Year On 'listening exercise', which provided a valuable opportunity to listen to staff and learn more about their experience of working at Guy's and St Thomas'. This is crucial to maintain and improve the quality of care provided to patients.

Under questions on Speaking up Safely, the listening exercise identified that one of the most significant issues for staff in 2013 was getting feedback on issues raised. This has improved significantly in the last year. There were also many positive messages about the overall culture, the benefits of good leadership and management, effective team working and supportive colleagues. However, reviewing all the data showed this was not a consistent experience for all staff and we are developing specific initiatives to address this.

This year saw the introduction of the national Staff Friends and Family Test – a regular online questionnaire which asks staff whether they would recommend their Trust as a place to be treated and as a place to work. More than 1,500 staff completed the test on each of the three occasions it was carried out in 2014/15 – more than 2,500 on the first occasion – and their rating of the Trust was well above the national average.

The results of the national NHS Staff Survey, carried out in Autumn 2014 and published in February 2015, showed that 85% of staff would recommend Guy's and St

Thomas' as a place to be treated – compared with the national average of 64%. 78% of staff would recommend the Trust as a place to work – compared with the national average of 56%. Guy's and St Thomas' was also ranked in the top 20% of NHS trusts nationally for staff engagement, for the fifth year running.

Our internal communications channels include a monthly face-to-face Team Briefing led by the Executive team, 'It's your call' podcasts – interviews with Directors on topical issues – and a regular staff email bulletin.

We also organise face-to-face events to engage staff in initiatives such as the *Fit for the Future* programme, which includes a range of ways staff, particularly at the frontline, can suggest and make improvements to our quality, safety and efficiency. Staff contributions are recognised at monthly Team Briefing sessions where *Fit for the Future* badges are awarded. Staff can also bid for funding to drive local improvement ideas through our bi-annual Dragons' Den competition.

We work closely with staff representatives to ensure employees' voices are heard. The Joint Staff Committee meets bi-monthly, acting as a valuable consultative forum, and six staff are elected to the Council of Governors to ensure the voice of our workforce is represented. In addition our Chair of Staff Side representatives have a place on the Trust's Management Executive.

In November, we recognised the contribution of our staff through a

Trust Awards event and received more than 500 nominations reflecting the outstanding performances of colleagues and teams. Almost 1,000 staff were able to attend the awards event itself.

Staff survey

The Trust uses the results of the national NHS Staff Survey, the Friends and Family Test and other staff feedback to address any areas of concern and to improve working life.

The annual survey has been in place for over 10 years, and in 2014 covered a random sample of 850 of our staff. Results demonstrate that the Trust has continued to perform well in a number of key areas. On the overall indicator of staff engagement, we are once again in the top 20% of acute trusts nationally, with a score of 3.95 on a scale of one to five. This shows a slight increase from our 2013 score.

On a scale of one to five, staff rated the Trust at 4.17 as a place they would recommend to work or receive treatment – well above the national average of 3.67 for similar trusts. The percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department was the highest score of any acute trust in England, at 74%.

Although the Trust has performed well overall, a number of areas require attention in the year ahead:

- concerns about discrimination and career progression, including access to training, with a focus on opportunities for BME staff

Staff survey

	2014 Trust	2013 Trust	2014 National average
Response rate	35%	50%	50%
Areas of best performance			
Percentage of staff agreeing that feedback from patients/ service users is used to make informed decisions in their directorate/department	74%	New measure	56%
Staff recommendation of the Trust as a place to work or receive treatment	4.17	4.15	3.67
Fairness and effectiveness of incident reporting procedures	3.70	3.64	3.54
Work pressure felt by staff	2.90	2.84	3.07
Areas of weakest performance			
Percentage of staff experiencing discrimination at work in the past 12 months	19%	16%	11%
Percentage of staff having equality and diversity training in the last 12 months	41%	41%	63%
Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	32%	30%	26%
Percentage of staff receiving health and safety training in last 12 months	67%	72%	77%

- improvements to support the psychological wellbeing of our staff
- examination of Trust policies to ensure they are not inadvertently contributing to staff feeling pressure to come to work when unwell
- access to health and safety training
- efforts to increase the staff survey response rate
- maintaining high levels of staff engagement.

Equality and diversity

Guy's and St Thomas' is a two ticks employer, guaranteeing an interview for any disabled person who meets the minimum criteria for a role. The Trust, in partnership with the Department for Work and Pensions, launched an Access to

Work programme during 2014-15 and we have ensured that this has been embedded in recruitment processes and all relevant HR policies. It aims to help prospective and current employees who may become disabled with a range of reasonable adjustments that enable them to return to and remain in work.

The Trust Board also reviews access to training by equality protected characteristics to assure itself that disabled employees are not disadvantaged from accessing training and professional and career development opportunities.

In addition, we have worked in partnership with the following groups to support specific areas of recruitment and employment for people with particular disabilities:

- The Autism Project – in partnership with award-winning charity Caretrade, the hospital has provided year-long placements to young learners with autism. As a direct result, a number of students have secured paid employment.
- Working with Orchard Hill, a large non-residential specialist college, we have provided year-long traineeships for young people with learning disabilities who are near to being work ready. Through the support of mentors and buddies, this partnership enables us to tackle the under-representation of people with learning disabilities in the workforce.
- In partnership with the British Dyslexia Association, the Trust has trained staff in coping strategies to

manage dyslexia in the workplace. There is now a Dyslexia Support Group that provides peer-to-peer support.

During the year, the Trust was named as the joint most improved healthcare employer in London by the lesbian, gay and bisexual charity Stonewall, while *Health Service Journal* magazine recognised Jayne King, our Head of Security, as one of the top 25 LGBT leaders in the NHS.

Volunteers

Last year the Voluntary Services team increased the number of Trust volunteers and projects they support – 680 volunteers contributed a staggering 32,363 hours to the Trust. 30 new projects were completed, five of which are in partnership with external organisations. A further 30 projects are underway.

Safe working environment

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

Our occupational health service remains one of the largest NHS occupational health services in the country, employing a multi-disciplinary team of doctors, nurses, counsellors and safety specialists. It not only serves 13,650 Trust staff, but also holds contracts to provide services for a further 73,000 people employed by a number of local businesses.

Services provided range from pre-commencement screening of new staff to assessments of fitness

to work with recommendations for workplace adjustments following serious illness or injury. There are also work-related health checks, screening and immunisation programmes, advice on reducing risks in the workplace, participation in Trust wide policy development, provision of occupational health activity reports and liaison with HR teams and line managers responding to issues that arise within the directorates.

Once again we had an extremely successful staff seasonal flu vaccination programme with our highest ever uptake of 6,870 staff vaccinated. This would not be possible without the support and engagement of senior personnel within the Trust, most notably our Chief Nurse, Dame Eileen Sills, who was trained to be a Peer Vaccinator and administered more than 400 vaccines to our staff.

The Occupational Health Service now leads on the Trust's Health and Wellbeing programme, '5 Ways to a Healthier You', a range of initiatives that increase the opportunities for staff to improve their health and wellbeing at work, such as support with nutrition and weight loss, self-referral physiotherapy services, and access to cognitive behavioural therapy. The programme has received much recognition including 'excellent' status in the Department of Health's workplace wellbeing charter award.

We have also been accredited against the Health and Wellbeing award, which evaluates how an organisation supports its staff in terms of their physical and

emotional needs. Key priorities for this year will be robust evaluation of wellbeing initiatives, accessibility to the programme for all our staff and increasing access to mental health awareness training for staff and managers.

Partnerships to improve healthcare

King's Health Partners, our Academic Health Science Centre partnership with King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London, has made significant progress since being accredited for a further five years by the Department of Health in 2013. See page 8 for details.

The Trust is also committed to working with other local providers and commissioners to provide specialised healthcare closer to home, when it is clinically safe to do so. Examples of this include our new Lane Fox REMEO® Respiratory Centre at East Surrey Hospital in Redhill, the first purpose-built centre to 'wean' respiratory patients from mechanical ventilation, and plans for a Kidney Treatment Centre and Cancer Centre on the Queen Mary's Hospital site in Sidcup.

The Trust is one of 15 NHS providers that form the London Cancer Alliance (LCA), established in 2011 to strengthen the provision of the integrated cancer care system in south and north west London. The Trust continues to work closely with LCA partners to improve treatment outcomes for patients and the experience of care for patients, their families and carers.

Over the next 18 months, senior nurses, doctors and managers are working with colleagues at Medway NHS Foundation Trust to help deliver the Trust's 18-month recovery plan. This is part of the NHS 'buddying' system that allows successful trusts to support other NHS organisations.

The Trust continues to contribute to the work of Health and Wellbeing Boards in Lambeth and Southwark, which help to guide the strategic direction of local health and social care services for adults and children.

The Trust also continues to work closely with Lambeth and Southwark's Health Overview and Scrutiny Committees. Although

their views on patient and public engagement activities. During the year, Healthwatch Southwark invited the Trust to respond to the findings of their research about the experiences of deaf service users accessing local health and care services. The Trust was pleased to respond, outlining the different ways we support deaf and hearing impaired patients through the work of individual teams and the Language Support Service.

As a founding member of Southwark and Lambeth Integrated Care (SLIC) we have continued to provide support and leadership to the partnership, and actively engaged with local citizens. The aims of this ambitious programme are to improve local health outcomes, initially focusing on older people, as well as the use of new technology and contracting arrangements. Both our Enhanced Rapid Response and @home service are good examples of multi-professional partnership working to avoid unnecessary hospital admissions.

Guy's and St Thomas' Charity

The Trust is fortunate to benefit from the support of Guy's and St Thomas' Charity. The Charity provides grants, loans and investment finance to support healthcare innovation and services across the Trust, King's Health Partners and widely across Lambeth and Southwark. The Trust is the principal beneficiary of the Charity and last year we received more than £14.4 million in grants and other funding.

During the year, the Charity also

Last year, volunteers contributed a staggering 32,363 hours to support staff, patients, carers and visitors

there have been no variations to services which have required formal consultation during the last year, the Trust is committed to keeping each committee well informed and we work closely with our local commissioners to provide a consistent and strategic approach to our communications.

Healthwatch is a local health and social care watchdog and a voice for service users in each borough. We continue to work with Healthwatch Lambeth and Healthwatch Southwark, sharing information about potential changes to services and seeking

awarded a grant of £9.9m to support TOHETI (Transforming Outcomes and Health Economics Through Imaging), a major project to improve patient care by making better use of imaging technology. The Charity also committed £1 million towards a new paediatric long-term ventilation and sleep unit and £200,000 to run complementary therapy services for cancer patients.

Funding was also granted to buy and install a specialist medical 3D printer in house, which can build a physical representation of a heart or other organ purely from data provided by imaging equipment. As a result, surgeons can now plan difficult procedures that otherwise might be too complex to contemplate.

The Charity continues to support long-term transformational programmes such as Southwark and Lambeth Integrated Care (SLIC) and has provided £26.7 million for the new Cancer Centre at Guy's, including £1.7 million to support an exciting arts programme to enhance the patient experience. Other investments from the Charity include funding for regular live music performances by Breathe Arts Health Research in the wards and other hospital areas. This is part of a programme to improve the wellbeing of patients and staff through the arts.

The Charity's support has also been instrumental in securing a new and larger Ronald McDonald House closer to Evelina London Children's Hospital at St Thomas'. When it opens in 2016, the new house will provide free accommodation for

families of children being treated at Evelina London, trebling capacity compared to current accommodation near Guy's Hospital.

In addition, the Charity contributed more than £300,000 to support the professional development and training of Trust staff. It also launched a new Bright Ideas Fund, in association with the Trust's Commercial Directorate, to encourage innovative ideas generated from within the Trust that have commercial potential.

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*.



Our community nursing staff regularly take part in face-to-face practical training sessions to develop their clinical skills. End of life specialist Parveen Akhtar trains community staff nurse Olawale Raji.

5

Teaching and research and development

Guy's and St Thomas' is committed to educating the high quality healthcare professionals vital to the delivery of first class healthcare, and groundbreaking advances in medical treatment for the benefit of our patients.

Teaching

As a major academic centre and leading teaching hospitals, Guy's and St Thomas' plays an important role in the clinical education and training of many of the health professionals of the future, including doctors, dentists, nurses, and other health, laboratory and technical staff.

Education, training and development are key responsibilities of the Trust, and we are committed to enabling all staff, students and trainees to build their careers and develop their skills and knowledge.

A three-year education, training and development strategy was developed last year to meet the changing health needs of our local population, nurture outstanding healthcare professionals and prepare our clinical staff for the evolving external environment. Patient involvement played a key role.

We have modernised the workforce planning process and introduced the new role of Physician Associate – health professionals with postgraduate qualifications – to support the medical team.

Across all roles, 2,454 newly recruited staff went through induction during the year, including 1,072 through nursing and midwifery induction. We have also introduced an induction for nursing assistants, incorporating the new national Care Certificate. Gateway programmes for nursing assistants and administrative staff allow recruits to join the Trust and then undertake a diploma or apprenticeship programme, access secondment opportunities and benefit from education and training courses.

We have more than 100 mentors and 80 coaches reinforcing staff development, and have identified a network of more than 1,000 educators and facilitators across the Trust, and support their development as teachers, trainers and supervisors. In May 2014, the Trust hosted its first annual coaching and mentoring conference, which was well attended and received positive feedback. In addition, more than 500 young people have now been supported by the Trust's highly successful online mentoring service, with over 190 mentors trained to act as e-mentors.

We are also investing in new technologies to further enhance our training, offering e-learning packages, online reporting and multi-media tools, as well as face-to-face learning.

We have launched a Passport to Management programme for new managers, and provide a wide range of development opportunities to support leadership development at all levels.

The Trust holds the *Investors in People* Gold Standard, the highest level an organisation can achieve under this national scheme, recognising our work to develop leaders and managers, involve and empower staff, and continuously improve performance.

Our innovative approach to mandatory training has been commended as best practice, with compliance the second highest in London.

Medical education

Guy's and St Thomas' develops current and future doctors so they can deliver innovative, world class patient care. It delivers high quality

undergraduate teaching, postgraduate training and ongoing professional development to students and doctors across the Trust.

Undergraduate medical education

Each year, more than 320 consultants and many administrative and other staff make a significant contribution to the education of more than 1,300 undergraduate medical students from our academic partner King's College London.

Guy's and St Thomas' is committed to the continuous improvement of the quality of teaching we provide. Senior leadership and teaching staff monitor student feedback and other metrics to inform improvement across our programmes.

Key changes in 2014/15 have included the expansion of learning opportunities with the formation of a new department of undergraduate clinical skills. This multi-disciplinary faculty comprising doctors, nurses, pharmacists and technicians is providing scenario based, structured clinical teaching.

Guy's and St Thomas' has also worked with its pathology joint venture partner, Viapath, to ensure all students in the Guy's and St Thomas' cluster have regular phlebotomy training with 1:1 supervision from an experienced training practitioner.

The Trust is working closely with King's College London to develop its new curriculum. This will equip students with the right skills to become tomorrow's doctors, enabling them to manage patients

with complex medical and psychiatric problems, providing patient-centred care to our diverse patient population.

Postgraduate medical education

The Trust is dedicated to the provision of excellence in postgraduate medical education and professional development. In 2014/15 the medical education team delivered high quality training programmes to more than 2,000 medical staff across the Trust, London and south east England.

As a Lead Provider for training programmes across south east London, the Trust provides a high quality learning environment that focuses on the needs of trainees and puts patient safety and experience, and the effectiveness of care at the heart of our programmes. Trainees are provided with a comprehensive induction and shadowing programme to help them prepare for their first shift, and a training programme that encompasses a wide range of learning opportunities at the Trust and across our south London networks.

In addition to the development of clinical skills, the Trust is committed to the strategic development of clinicians as future leaders of the health system. Through our leadership groups, junior doctors and Darzi Fellows have been central to several service redesign and patient safety initiatives. A new programme has been launched to bridge the transition for juniors into the consultant role.

'The School of Improvement' was also launched in 2015. The

programme offers a wide range of courses on leadership, teaching and supervision skills. This blended approach to learning is centred on both peer and self assessed learning, delivered through classroom training, web based lectures and downloadable resources.

SaLL Centre

The Trust's Simulation and Interactive Learning (SaLL) Centre provides an inter-professional programme of more than 230 innovative simulation and training courses, patient safety events and outreach programmes across south London. The programmes are integral to the Trust's quality improvement agenda and include multi-disciplinary courses on infection control, recognising the deteriorating patient, dementia management and admissions avoidance within the community. A major postgraduate programme – *Improving Patient Safety through Simulation* – was enabled by £1.63 million of funding from Health Education South London. The SaLL Centre also plays an important role in quality assuring our patient safety systems, including testing the Trust's preparedness for Ebola this year.

Nursing education

The Trust continues to offer extensive undergraduate and postgraduate opportunities. Our undergraduates are from King's College London and London South Bank University, and we continue to build on close links to support an increased number of nursing students within the Trust, helping to meet future workforce plans. We also help those who don't

meet the standard university requirements gain the needed experience for entry into nurse training, so supporting wider access.

This year, we have successfully developed our graduate nurse scheme, which now has 40 nurses on the programme, allowing staff to rotate between a number of clinical areas including community nursing.

We have been able to offer jobs to all our host students who wanted to take up employment with the Trust. Retaining our newly qualified staff is a priority, reflecting our huge investment in them. Our preceptorship programme provides them with a buddy system and a 'go to' person in their practice area. There is a continual cycle of learning to support newly qualified staff, and our retention rates have improved significantly in recent years.

We are continually exploring ways to support those staff who demonstrate exceptional commitment by mentoring, teaching, supervising and giving feedback to students as part of their wider role.

Since the Francis Inquiry we have taken active steps to enable students to speak out if they see or hear something they are concerned about. Nursing students are given many routes to do this and are supported accordingly.

Guy's and St Thomas' has been chosen as a pilot site for the new nursing and midwifery revalidation scheme and our work will inform the national roll-out from January 2016.

Work experience, apprenticeships and the Essentia Academy

We have a long-standing tradition of providing educational and

employability opportunities to the most disadvantaged Londoners through work experience, trainee-ships, and apprenticeships. Between January and September 2014, we provided work experience opportunities to over 450 young Londoners through a number of innovative programmes, including:

Clinical Insight Programme – the Trust has enabled hundreds of budding healthcare professionals to shadow clinical staff and experience 'a day in the life of'. Hundreds of staff, including doctors, nurses, midwives, physiotherapists and pharmacists, have given up their time to inspire the future NHS workforce.

Next Steps – working with the hospital's Kidney Clinic, we provide careers advice, work experience and learning opportunities to renal patients who have had their education disrupted.

Get into the NHS – in 2011 we launched, in partnership with the Prince's Trust, the first 'Get into the NHS' programme. This offers young Londoners short traineeships providing the necessary skills and confidence to re-enter work. Of the 60 people who have completed the programme, over 50% found paid employment in the hospital; another 25% found employment elsewhere or returned to full time education.

Workwise Programme – last year, we committed to provide work experience and careers advice opportunities to Centrepoin's Workwise programme. This helps young people back into education, training or employment by offering

qualifications, skills, work placements and support.

In parallel with these programmes, the Essentia Apprenticeship Scheme continues to expand. It offers routes into a wide range of professions, and 95% of apprentices have successfully transferred into permanent roles within Essentia, our capital, estates and facilities directorate. The scheme won a bronze award at the International Learning Award for Apprentice Programme of the Year 2015.

In addition, the Essentia Academy offers a broad variety of courses to all Essentia staff. It provides key skills and knowledge to managers, and more than 50 have now graduated at either the foundation or advanced level as part of the nationally recognised Institute of Leadership & Management programme.

Essentia continues to support local communities through its ambassador programme. During the year, 80 ambassadors promoted non-clinical health service careers to local schools, colleges and universities, encouraging many young people to choose a career with Essentia.

Research and development

The NHS is uniquely placed to drive health research and improve clinical outcomes through access to large numbers of patients, diverse populations and committed clinical and academic staff. Research is a vital part of the Trust's work, and our hospitals have a long tradition of making significant medical breakthroughs and developing new

treatments. With our university partner, King's College London, we are a major centre for NHS funded research.

The National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) at Guy's and St Thomas' and King's College London is one of only 11 funded centres in England. As such, we are committed to driving forward research and innovation which will benefit our local population and healthcare nationally and internationally.

Our research and development portfolio has increased with 324 new non-commercial projects involving patients and healthy volunteers initiated during the year. A total of 1,504 active non-commercial research studies and 358 clinical trials led by commercial organisations were active during the year.

For the third year running, Guy's and St Thomas' was one of the top three trusts for NIHR portfolio research (as ranked by the NHS trust research activity league table 2013/14, published by the NIHR). Out of 251 NHS trusts and 15 primary care networks, we ranked third for number of research studies with 422, an increase of 12.5% compared with last year.

The Trust's performance in recruiting research participants has been outstanding. Over 31,000 patients took part in clinical trials and other patient-focused studies, including almost 26,000 for NIHR portfolio studies, an 80% increase on 2013/14. We are now the highest recruiting trust in England.

Over the last year, Guy's and St Thomas' managed more than £11 million in research grants from the

NIHR and we continue to invest protected consultant time to carry out research activity and encourage a new generation of investigative talent.

Research highlights this year included the development of a brand new procedure using MRI imagery to build a high quality 3D view of the heart in real-time, helping surgeons find and treat areas of the heart causing irregular heartbeats; completion of the first UK clinical trial to treat children with rare skin disorders by using stem cells taken from the bone marrow of unrelated donors; and ground breaking peanut allergy tolerance research showing the majority of infants at high risk can be protected from the allergy if they eat peanut frequently, early in life – the first study to show that carefully managed consumption is an effective food allergy prevention strategy.

The Trust played a leading role in the successful south London bid to become one of the new NHS Genomic Medicine Centres – meaning patients with a family history of particular types of cancer and rare diseases can now be part of pioneering programmes to discover 21st century medicines.

Other highlights were an NIHR award to support the NIHR technology co-operative in cardiovascular disease, expanding its role to include children's services; and a one-week workshop in Translational Bioinformatics attracting specialists and clinicians from across the UK and overseas. Our research nurses were also shortlisted for the inaugural Clinical Research Nurse category of the annual *Nursing Times* Awards for

work on developing a supported, structured research nurse workforce.

We also ran, in collaboration with South London and Maudsley NHS Foundation Trust, the first King's Health Partners Research Summer School, providing research experience to local sixth-form students interested in studying science and medicine.

NIHR Clinical Research Network Coordinating Centre

At the end of 2014, the Trust, as part of a successful consortium with Leeds University, won the tender to provide the National Institute for Health Research (NIHR) Clinical Research Network Coordinating Centre for the next five years. The new alliance will work with a number of partner organisations including University of Liverpool, Imperial College London, King's College London and Newcastle University. This will support local research networks and provide national, strategic co-ordination, helping researchers access NHS services and enabling more patients to participate in well-designed research. In return, this will significantly strengthen our research base and will ultimately lead to better care for our patients.

This completes a significant restructure of the NIHR clinical research networks over the past year, with over 100 Local Clinical Research Networks reduced to 15. Guy's and St Thomas' was awarded the NIHR Clinical Research Network for south London, bringing together a number of the previous networks – the Comprehensive Local Research Network, the Primary Care Research

Network for Greater London, the Cancer Research Networks in south west and south east London, the Stroke Research Network for the South East and the Mental Health Research Network for London. This new structure was embedded during the year, facilitating streamlined, more effective clinical studies and increased participation of patients.

Our NIHR Biomedical Research Centre

In April 2014, our External Scientific Advisory Board undertook a mid-term review of our NIHR Biomedical Research Centre (BRC), which received its second five-year funding award in 2012. The Advisory Board provided a positive assessment of progress to date and our strategic plans for the remainder of the current funding period.

The Advisory Board highlighted the clarity of vision and leadership from the Director and senior team and how this was reflected in the activity of the BRC, and the role of the BRC in national programmes such as the NIHR-Health Informatics Collaboration, Genomics England and the NIHR BioResource.

The Board also noted the integration of excellent infrastructure with high quality science programmes, enabling the development of robust translational research pipelines and early phase delivery. Particular highlights were cell therapy, cardiovascular and paediatric programmes and our training and capacity building programmes.

During the year, the BRC was able to further invest in state-of-the-art infrastructure, partly as a

result of a grant from Guy's and St Thomas' Charity.

A further highlight was the launch of two 'first in man' cell therapy studies, with the BRC's renal and liver transplant patients, which seek to prevent transplant rejection by the patient. The studies explore the safety of the treatment, which uses the patient's own regulatory T cells.

Patient and public involvement in research

We have been focusing on three main strands of work - patient and public involvement in research, public engagement in science, and enhancing recruitment to studies, ensuring all patients are offered the opportunity to participate in and become involved in research.

Our Patient and Public Involvement Advisory Group has now increased its membership to 10 lay members and seven BRC staff. This group has led a pilot project in dermatology to test a statement in outpatient letters encouraging patients to ask their doctor or nurse about research.

In collaboration with a range of local partners including local community and voluntary support services, schools, academies, GP services and libraries, 700 people have participated in 18 events and roadshows, encouraging engagement in research. We continue to develop education activities for young people from diverse backgrounds to encourage them to consider a career in science and technology.

We have increased the number of existing patient/public groups that

advise researchers on specific studies for research themes from seven to 10, with new groups established in cardiovascular, children's health and respiratory services. Advice has been provided to 74 individual research groups during the year.

In collaboration with the NIHR Research Design Service London, we have developed a training package for researchers, and 120 researchers and 76 lay people have participated.

In collaboration with Great Ormond Street Children's Hospital and University College London Hospital we have also trained more than 65 paediatric research staff to help them involve children, young people and parents in the development of research.

Our NIHR Clinical Research Facility

The NIHR Clinical Research Facility at Guy's and St Thomas' comprises two adult facilities and a children's facility in Evelina London Children's Hospital as well as a range of imaging facilities on the St Thomas' site. Together they provide dedicated clinical space, equipment and expertise across a broad range of specialties. Over the past year the Clinical Research Facility has supported more than 230 clinical research studies involving over 12,500 patient visits.

The Guy's Clinical Research Facility is co-located with the Good Manufacturing Practice Unit for advanced therapies to support research requiring the manufacture and administration of advanced therapies.



Lambeth and Southwark residents continue to benefit from our @home service. The team provides expert medical support so patients can leave hospital sooner or avoid a hospital stay altogether.

Statement on quality from the Chief Executive 2014/15

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

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

- Frontline clinical staff won a series of national awards – for example, nurses who developed a 'passport' for asthma patients and a nurse-led telephone assessment clinic for patients with suspected bowel cancer were winners at the prestigious *Nursing Times* Awards in October 2014.
- Guy's and St Thomas' was one of only five trusts shortlisted for a CHKS Top Hospitals Quality of Care Award in April 2015 – for the second year in a row.
- 81% of Emergency Department (A&E) patients at St Thomas' rated their overall experience as good in the National A&E Survey published in December 2014 – since the last survey in 2012, the Trust has made significant improvements in areas such as keeping patients informed about waiting times, cleanliness, and advice for patients about medication and self-care.
- The South London-based Genomics Network Alliance, led by Guy's and St Thomas', was announced as a successful bidder to become a pioneering Genomic Medicine Centre – part of the groundbreaking 100,000 Genomes Project to transform patient care by unlocking the power of DNA.
- 90% of cancer patients at Guy's and St Thomas' rated their care as excellent or very good in the National Cancer Patient Experience Survey published in September 2014 – the Trust was in the top 20% of trusts nationally in areas including patients knowing the name of the specialist cancer nurse in charge of their care and having enough ward nurses on duty.

An important part of our role as a major teaching and integrated healthcare trust is to share the expertise of our staff with the wider NHS in order to improve the experience of patients wherever they are treated.

Our award-winning 'airline style' patient safety card is now available for all NHS trusts to download from our website following the launch of a short film version in October 2014 by the Health Secretary, Jeremy Hunt.

Designed as part of our inpatient Welcome Pack, the safety card supports our patients to play an active role in their care. It is based on the concept of safety advice given on aeroplanes before take-off, and patients are provided with an information card with simple advice about preventing falls, blood clots, pressure ulcers and other avoidable complications.

Similarly, our 'Barbara's Story' dementia training film for staff has been adopted by a number of other healthcare providers both at home and abroad – and more than 40,000 people have watched it via our YouTube channel.

Chief Nurse Eileen Sills showed excerpts from the film to the Cabinet as part of their training to become Dementia Friends – and the film has won a number of awards.

Equally, we recognise that there is still plenty of room for improvement in the quality and safety of care that we provide for patients.

Disappointingly, our auditors, Deloitte LLP, found some errors in the recording of dates in the 18 week referral to treatment incomplete pathway indicator, and we have already taken action across the Trust to address this, as outlined later in this Quality report. While much progress has already been made, we are determined to ensure the highest standards of collection, analysis and storage of data, so we will continue to work hard to drive out any remaining training or process issues in the area over the coming year.

Further improvements will be made in other aspects of our work, driven by internal initiatives and by the adoption of best practice from elsewhere.

This year we have introduced the National Early Warning Score (NEWS) system to improve the way that we identify patients at risk of deterioration and we have also started monthly Schwartz Centre rounds.

These are meetings which provide a structured monthly forum for staff from all disciplines to discuss the human aspects of delivering care in a confidential and safe environment. Research into the effectiveness of Schwartz Centre rounds shows the positive impact they have on individuals, teams, patient outcomes and organisational culture.

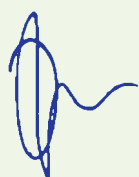
We work hard to create a culture of openness and to develop a positive atmosphere where staff feel safe to report incidents and to speak up and raise concerns. As part of this we have introduced training and support to help staff to meet their new responsibilities as part of the Duty of Candour.

Chief Nurse Eileen Sills, who is also Director of Patient Experience at Guy's and St Thomas', was made a Dame in the Queen's New Year Honours. This was well-deserved recognition of her strong, visible clinical leadership to foster a culture of constant improvement in quality and safety.

She has introduced Clinical Fridays – increasing the amount of time that senior nurses spend on the frontline – and the weekly Safe in Our Hands forum where nurses and other staff share successes and challenges to improve patient care.

Eileen herself said her personal recognition in the Honours would not have happened without the contribution of all staff at Guy's and St Thomas'.

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



Sir Ron Kerr

Chief Executive

27th May 2015

Our quality priorities for 2015/16

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. Throughout this year we have continued our focus on ensuring that patients are at the heart of all that we do. This focus is supported by strong quality governance and assurance systems, which serve to increase the confidence of our patients, Foundation Trust governors, staff and other stakeholders who take an active interest in our work.

Our quality strategy for 2015/16 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 to mitigate any quality risks that result from this or from our challenging financial plan. We view quality, safety and efficiency as mutually beneficial and intrinsically linked. Our commitment to this principle underpins our quality priorities for 2015/16, 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 2015/16. 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

Throughout 2014/15, we met with our stakeholders to tell them about our progress in delivering our priorities for the year. We have agreed that we will carry forward last year's priorities where these focus on basic patient safety practices that maintain focus on the reduction of avoidable harm. Staff have 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's objectives.

Our progress against our quality priorities will be reported every three months to the Quality and Performance Committee, a committee of the Board of Directors.

Patient safety

Our quality priorities and why we chose them

Achieve the 2015/6 CQUIN for the identification and treatment of acute kidney injury (AKI)

We want to improve follow up and recovery for individuals who have sustained Acute Kidney Injury (AKI), reducing the risks of readmission, re-establishing medication for other long term conditions and improving follow up of episodes of AKI which is associated with increased cardiovascular risk. AKI is a sudden reduction in kidney function and usually occurs without symptoms. AKI affects 5-15% of all hospital admissions. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge.

Patients with AKI are also subject to longer, more complex hospital stays, long term conditions and reduced quality of life.

What success will look like

We will track the percentage of patients with AKI treated in the Trust whose discharge summary includes each of four key items:

- stage of AKI (a key aspect of AKI diagnosis);
- evidence of medicines review having been undertaken (a key aspect of AKI treatment);
- type of blood tests required on discharge; for monitoring (a key aspect of post discharge care);
- frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care).

Achieve the 2015/6 CQUIN for the identification and treatment of sepsis

Sepsis is a common and potentially life-threatening condition that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which may reduce blood supply to vital organs such as the brain, heart and kidneys. Sepsis is recognised as a significant cause of poor outcomes and death and is almost unique among acute conditions in that it affects all age groups.

It remains our priority to meet the new national CQUIN on sepsis. We will screen all patients for whom sepsis screening is appropriate and rapidly initiate intravenous antibiotics for patients with suspected severe sepsis, red flag sepsis or septic shock.

We will identify the number of patients who present to us with severe sepsis, red flag sepsis or septic shock (retrospectively via case note review) and establish a baseline for those that receive intravenous antibiotics within 1 hour of presenting.

Improve patient safety through the standardisation of how clinical decisions are described and recorded

This quality priority is being carried forward from 2014/15 and involves a further phase in the standardisation of the recording of observations, decisions and prescriptions. We are continuing to work towards fully electronic records to reduce errors in interpretation and information transfer, and to reduce the thousands of forms used across the Trust.

We will roll out Medchart (EPMA) to women's services, Evelina London and the emergency department during 2015/16.

E-Noting will be deployed to all inpatient areas by the end of 2015/16.

Consolidate progress in core patient safety practices

Excellence in basic practices remains a high priority for the Trust. Our focus on reducing major harms over the past five years has led to significant reductions in avoidable harm and has driven improvements in patient safety and experience.

It will remain a priority for us to prevent health care acquired infections, avoidable pressure ulcers, catheter associated urinary tract infection (CAUTI), venous thromboembolism (VTE), falls, and never events.

We will meet the new targets for health care acquired infections agreed with NHS England.

We will have no grade 4 pressure ulcers in our hospital and community services.

We will continue to be below the lower control limit for CAUTIs across England.

We will continue and improve our record of excellence in managing the risk of VTE.

We will show compliance at 95% or more with the WHO surgical safety checklist.

Our audits will show that we maintain or exceed our 2014/15 compliance of 91% with the falls risk assessment tool.

We will have no never events.

Clinical effectiveness

Our quality priorities and why we chose them

Improve care for Chronic Obstructive Pulmonary Disease

Our local Lambeth and Southwark boroughs have high mortality rates associated with chronic obstructive pulmonary disease (COPD), and this affects a significant proportion of our acute medical admissions and readmissions.

To improve care of patients with COPD we will work with hospital and community teams to support an integrated respiratory pathway for patients with long term respiratory disease, ensuring appropriate follow up of patients identified with COPD in A&E

What success will look like

We will improve the diagnosis of patients attending A&E with breathlessness.

We will work with the Lambeth and Southwark COPD group to track our progress and improve outcomes reported in the annual national COPD audits.

We will improve inpatient care for these patients and will:

- Ensure that patients admitted with COPD exacerbation receive a respiratory specialist opinion within 24 hours, 7 days a week;
- Assess and manage acute and chronic breathlessness in line with Lambeth and Southwark breathlessness pathways and London respiratory strategic clinical network guidance;
- Complete the roll out of smoking cessation advice across the respiratory care service.

Reduce the number of obstetric anal sphincter injuries

We are involved in the Royal College of Obstetricians and Gynaecologists/Royal College of Midwives Initiative to reduce obstetric anal sphincter injuries or OASIs (commonly known as 3rd and 4th degree tears) to improve outcomes for women. Across the NHS there has been a three-fold rise in OASIs over the past ten years and the impact on patients and additional cost to the NHS are high. Recent research suggests that OASIs may be prevented through changes to clinical practice, re-introducing an almost exclusively 'hands-on' technique commonly used in the mid 20th century, combined with enhanced training for staff.

By the end of 2015/16 we will have:

- introduced a new clinical training programme for staff;
- achieved a 50% reduction in the rate of OASI at midwife-led births compared with the Q4 2014/15 rate of 2.4%;
- achieved a 25% reduction of OASI at obstetric-led births compared with the Q4 2014/15 rate of 1.7%.

Improving care for the deteriorating child

We are committed to ensuring that children whose condition deteriorates, or who have the potential to deteriorate, are proactively managed throughout their inpatient stay in the Evelina London Children's Hospital, with all relevant members of the care team aware of any potential for deterioration.

We will achieve this by ensuring early recognition of the deteriorating child, appropriate escalation, and timely and effective mitigation of clinical safety risks.

A case note review from March 2014 to March 2015 revealed failure of recognition or escalation of care for 19 of 102 (19%) unplanned admissions to the Paediatric Intensive Care Unit.

This requires a culture where staff always feel able to raise their concerns, and to have these listened to and acted upon.

Effective mitigation will be underpinned by high-quality paediatric acute illness training for all paediatric staff, and use of evidence-based guidelines.

We will achieve 100% compliance with the Paediatric Early Warning Score (PEWS).

We will demonstrate increased use of the Situation-Background-Assessment-Recommendation (SBAR) tool (compared with the 50% of paediatric intensive care cases found on a recent review to have an SBAR form in the notes).

Through the actions above, we will reduce unplanned admissions to the Paediatric Intensive Care Unit from 19% to 10% in 2015/16.

We will achieve a 50% reduction in medication incidents resulting in harm.

We will be using the Safety Thermometer in all paediatric inpatient areas.

Our quality priorities for 2015/16

Patient experience

Our quality priorities and why we chose them

Continuing our focus on patients with dementia and their carers

The care of people with dementia and delirium remains a Trust priority. All patients with dementia have a personalised care plan agreed with them, and/or their carer, and this is reviewed regularly throughout their stay.

Our aim is to provide the best possible support and care for people with dementia, their families, and carers. Also that our staff have the confidence to champion best practice and create a culture of excellence.

What success will look like

The Trust has agreed five priorities to develop dementia care across the organisation:

- skilled staff who are informed and have time to care
- partnership working with carers
- assessment and early identification
- care plans which are personalised
- environments that are dementia friendly.

Tier 2 Dementia training will continue to be offered to all staff, priority given where less than 25% of nursing staff have received Tier 2 training and raising the % of nursing staff trained at Tier 2 from 50-80%.

#Hello my name is

Our patients tell us that the standard of care they receive across our services is very high, and often praise staff for their kindness. But in nearly 30% of the contacts made with PALS, patients make a reference to not knowing who people are.

In February 2014, NHS England invited all Trusts to sign up to a campaign launched by Dr Kate Granger, a terminally ill cancer patient, who made the stark observation during her stay in hospital, that many staff did not introduce themselves. As a result, she launched the #hello my name is... campaign.

We believe a friendly introduction is about making a human connection, beginning a therapeutic relationship and building trust. The campaign is about more than badges, it is an invitation to staff to introduce themselves to every patient they meet and to encourage others to do the same.

We will roll out #hello my name to all staff across the Trust in 2015/16.

We will see an improvement on the score for 2014/15 on the question in the inpatient survey 'Did you find someone on the hospital staff to talk about your worries and fears'.

Improving medicines management at the time of discharge

We want to reduce medication related problems at or shortly after patients leave hospital. This includes verbal and written communication at discharge with patients, carers and community health professionals. Our goal is to reduce the harm associated with use of medicines at discharge.

A review of incidents shows that a medicine is not provided at discharge or the wrong medicine is provided. After discharge, dose or strength being wrong or unclear was also a commonly reported theme.

We will improve the information we provide for patients on medication at discharge to enable them to better understand and manage their medicines.

We will run an improvement programme throughout 2015/16 to address communication issues and reduce errors associated with medicines when patients leave hospital.

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

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 2014/15 represents 100% of the total income received for the provision of NHS services in 2014/15.

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 2014/15, 39 national clinical audits and four confidential enquiries covered relevant health services that we provide.

In 2014/15, we took part in 36 of these national clinical audits and the four national confidential enquiries. By doing so we participated in 92.3% of national clinical audits and 100% 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 2014/15 are shown in the table on the following pages, together with those that we participated in and for which data collection was completed during 2014/15. 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 2014/15

Audit title	Participation	% of cases submitted
Women and children's health		
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric intensive care (PICANet)	Yes	100%
Childhood Epilepsy (Epilepsy 12 audit)	Yes	100%
Fitting Child (care in emergency departments)	Yes	100%
Acute care		
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
National emergency laparotomy audit (NELA)	Yes	Figure unavailable, as audit ongoing.
National Joint Registry (NJR)	Yes	98%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	60%
Adult community acquired pneumonia	Yes	Figure unavailable, as audit ongoing.
Non-invasive ventilation – adults	N/A	Ran as local audit only but non-participation by Trust.
Pleural procedures	No	0%
Long term conditions		
Chronic Obstructive Pulmonary Disease (COPD)	Yes	100%
Inflammatory bowel disease (IBD)	Yes	Ran as organisational audit only
Renal replacement therapy (Renal Register)	Yes	100%
Rheumatoid and early inflammatory arthritis	Yes	Figure unavailable, as audit ongoing.
Diabetes (Paediatric) (NPDA)	Yes	100%
Diabetes (Adult, includes National Diabetes Inpatient Audit (NADIA), diabetes care in pregnancy and diabetes footcare)	Yes	100%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Dementia (care in general hospitals)	N/A	Pilot
Older people (care in emergency departments)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%

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	
Other		
Ulnar Neuropathy at Elbow (UNE) testing	Yes	Figures unavailable.
Intermediate Care	Yes	100%
Elective surgery (National PROMS Programme)	Yes	This information is not available for the national programme at the time of reporting.
Cancer		
Bowel cancer (NBOCAP)	Yes	100%
Head and neck oncology (DAHNO)	Yes	100%
Lung cancer (NLCA)	Yes	100%
Oesophago-gastric cancer (NOGCA)	Yes	100%
Prostate Cancer	No	A data collection tool and a data manager is in place to enable participation in 2015/16.
Blood and Transplant		
National Comparative Audit of Blood Transfusion Programme	Yes	100%
Mental Health		
Mental Health (care in emergency department)	Yes	100%

National Confidential Enquiries 2014/15

Audit title	Participation	% of cases submitted
Sepsis	Yes	Study still open figures not finalised
Gastrointestinal Haemorrhage	Yes	100%
Lower Limb Amputation	Yes	100%
Tracheostomy Care	Yes	100%

The reports of 32 national clinical audits were reviewed during 2014/15 and we intend to take the following actions to improve the quality of the healthcare we provide:

Inflammatory Bowel Disease: Patients with ulcerative colitis

To appoint an inflammatory bowel disease nurse to ensure review of inpatients on initial admission.

Bowel Cancer (NBOCAP)

The service will enhance its systems to increase data collection coverage of clinical dataset and submission.

Acute coronary syndrome or acute myocardial infarction (MINAP)

The national door to balloon time target is <90 minutes and call to balloon time target is <150 minutes. This is measured from the moment a patient calls for an ambulance to the minute the reperfusion occurs. The service has implemented systems to highlight and investigate those cases where this target is not reached. Additionally we continue to work with other trusts who transfer patients to us to reduce this further.

National Paediatrics Diabetes Audit

We are improving internal systems to increase our participation rate/coverage. We will work to analyse and reduce ethnic variability of HbA1C (Glycated Haemoglobin). We have reduced regional variability through active participation in the SE Thames Network and are leading the Pump audit.

Sepsis

We have reviewed Trust and local policies and procedures to ensure sepsis screening and high flow oxygen management by clinical teams. Increased awareness of sepsis detection and management is being achieved through greater focus in junior doctors' induction, education at nurses' study day and in the middle grade teaching programme.

British Thoracic Society Paediatric Asthma Audit

We have improved discharge planning and follow up arrangements including introduction of regular teaching sessions for junior doctors and nurses, asthma pack to be given at induction and discharge checklist.

Sentinel Stroke National Audit Programme (SSNAP)

We will work to improve access to therapy services and psychological support for patients, ensure that stroke is high on the agenda for the organisation, and further foster strategic links with the Trust Board.

FFAP – Falls & Fragility Fractures Audit Programme

Although reoperation rates are low, they are too high compared to peers. The service is working on implementing a number of strategies to reduce reoperations rates within 30 days, time to surgery and pressure ulcers.

National Intensive and Special Care (NNAP)

We will continue to improve work to increase the parental consultation rates and implement systems to improve data quality. We will also analyse and investigate outcome data to improve performance.

National Heart Failure

We will maintain performance in the top quartile and continue our excellent work in the area – for example 100% of patients receiving echo; and cardiologists and specialist input at 93% and 98% respectively (which are both above national average).

National Oesophagogastric Cancer Audit (NOGAC)

The service will work to improve service capacity including staffing (consultant and clinical nurse specialist and access to theatre).

Congenital heart disease

We have implemented standard operating procedure and work to improve information systems to ensure we meet new dataset requirements.

Local clinical audit

Reports of 196 local clinical audits were reviewed over the last year. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of our services:

- Renal Transplantation team developed and implemented a transplant-specific checklist based on the WHO Safe Surgery Checklist to cover the particular requirements of modern organ transplantation. Compliance with the checklist has improved.
- The Orthopaedic team has streamlined the patient documentation process, including utilising the corporate patient information system and giving a dedicated staff member (junior doctor) responsibility for updating records and ensuring that records are accessible by all treating teams.
- Adult Asthma Allergy staff are actively assessing their knowledge of inhaler device compliance and teaching of technique in patients with asthma.
- Children's Services introduced a new handover process to improve the quality and safety of postnatal ward handover using patient information systems. Audit post-implementation demonstrated significant numbers of staff having awareness and confidence in the new handover process.
- The paediatrics orthopaedic team has improved the management of children coming up to planned orthopaedic and spinal surgery, by adding children to the waiting list only when they are fit for surgery, reducing waiting times.
- The Thoracic surgical team have changed how they assess the blood tests needed before surgery to minimise trauma to our patients as well as delivering savings for the Trust. Other improvements are supporting the introduction of the enhanced patient recovery programme.
- The Sexual Health Service implemented an integrated sexual health young person's safeguarding pathway to improve the assessment and reporting of young person's safeguarding issues. A new software system was implemented to improve waiting times, significantly improving patient satisfaction. Patient feedback has also been positive about receiving texts/emails informing them of the wait.
- The Cardiac Device Service is amending its processes including the development of the care pathway and changes to patient information systems to improve the management of patients with atrial fibrillation. This will enable prompt identification and early referral.
- The Oral Medicine team implemented national guidance to support the safe management of a range of specific conditions, such as NICE guidelines to avoid side effects such as the development of diabetes, when prescribing long term systemic corticosteroids; The British Society of Dermatology recommendations for clinicians to support prescribing of azathioprine (an immunosuppressant used in for example severe lichen planus); and a biopsy checklist based on the WHO guidelines to improve safety and clinical records during the biopsy clinic.
- The Cardiac Device Service is reviewing and amending its processes including the development of the care pathway based on CHA2DS2 calculation and changes to patient information systems to improve the management of patients with atrial fibrillation. This will enable prompt atrial fibrillation identification and early referral.
- Following a successful pilot on one inpatient ward, Diabetes and Endocrinology are working to improve inpatient diabetes care across the Trust using glucometrics. Improvements will also allow wards to compare themselves against others, review their results in detail and take appropriate actions.
- Through a rolling process of audit, The Critical Care Team identified and reduced consistent spikes in the Catheter Related Blood Stream Infection (CRBSI) rate. Subsequent monitoring over the next two months revealed no reported CRBSIs incidents.

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 five 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. 324 non commercial studies began in 2014/2015 and 358 commercial studies were also initiated.

Last year, over 31,000 patients took part in research which was approved by our research ethics committee (NRES). During 2014/15, over 1,504 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 £11 million in research awards in 2014/15 (National Institute Health Research).

For more information about our research activity, see chapter 5 of the Annual Report 2014/15.

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 2013/14 we secured 98% of the CQUIN targets generating £20 million of income. In 2014/15, £19.9 million of income was dependent on achieving CQUIN targets. During the year, we achieved 97.8% of the CQUIN targets agreed with our commissioners, generating £19.6 million of our income.

Statements from the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Guy's and St Thomas' NHS Foundation Trust during 2014/15.

Guy's and St Thomas' NHS Foundation Trust is subject to periodic review by the Care Quality Commission. There have been no inspections of the hospitals or community services or any special reviews in the 2014/15 period. The CQC intelligent monitoring reports published in July and December 2014/15 have placed the Trust in band 6. This is the lowest risk banding and reflects a good performance against the wide range of indicators monitored by the CQC.

The Intelligent Monitoring Reports are published on the CQC website (www.cqc.org.uk).

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

Our data quality

The assurance work carried out by Deloitte LLP in respect of the Quality Report 2014/15 identified some errors in the recording of dates in the 18 week referral to treatment incomplete pathway indicator (these errors were only found amongst a small sample of patients, and Deloitte's have stated that the results should not be directly extrapolated to the patient population as a whole). We will ensure we learn from this, and are determined to ensure the highest standards of collection, analysis and storage of data. As a result, we have already taken action across the Trust to address this.

The Elective Assurance Department have developed a suite of six role specific training packages for all administrative staff. This training provides advice and guidance on the internal and external rules in place to deliver robust pathway management. The training also covers the correct administrative processes to be followed when recording data on trust systems. The training programme is underpinned by the Access Policy. The Elective Assurance Department also provide services with access to expert interpretation of the referral to treatment rules and how these should be applied. Further work is taking place to ensure that specialty specific local guidelines are agreed and that these are approved by clinicians in the speciality.

How the Elective Assurance Department supports the Trust has been reviewed as part of 'Fit for the Future' programme. As a result of this a rolling trust wide administrative review programme has been put in place. Each review will audit the accuracy of data captured at key milestones along a patient's pathway. These reviews start in late May 2015.

To ensure that all administrative staff receive the necessary training to enable them to carry out their role, and have a clear understanding of the referral to treatment rules and how to apply them, with effect from June 2015 new starters will receive the relevant IT and elective assurance training as part of trust induction. It is also planned to make annual refresher training on elective assurance mandatory for staff already in post.

We will continue to work hard to deliver this improvement programme to minimise errors made when dates are recorded, and to drive out any remaining training or process issues in the data quality area over the coming year.

The production of accurate and reliable data about patient care is essential to deliver safe, high quality care for example, how we code a particular procedure or illness is important as it anonymously informs the wider health community about disease trends and supports planning, as well as allowing us to receive the correct income.

The Trust has identified significant opportunities to improve existing clinical coding processes, 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 98.1% of inpatients, 98.4% of outpatients and 85.3% of accident and emergency patients.

The percentage of records which had the patient's valid GP registration code was 100% of inpatients, 100% of outpatients and 99.8% 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 2014/15 was 73% and was graded satisfactory.

Clinical coding error rate

The Trust was not selected for a Payment by Results Pricing and Costing clinical coding audit by the Audit Commission during 2014/15.

National core set of quality indicators

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

For each indicator 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 this data is as described for the following reasons:

- 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.

	Oct 12 – Sept 13	Jan 13 – Dec 13	Apr 13 – Mar 14	July 13 – June 14	Oct 13 – Sept 14
SHMI	81.35	82.2	81.7	84.1	82.7
Banding	3	3	3	3	3
% Deaths with palliative care coding	35.5%	33.9%	34.5%	38.4%	40.8%

Source: HSCIC

SHMI Banding = 3 indicates that the Trust's mortality rate is 'lower than expected'

To improve the quality of our services, we continue to deliver quality improvement programmes focussed on how we treat patients with serious infection or acute kidney injury, and on the management of frail older patients, particularly those with dementia. 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 this data is as described for the following reasons:

- 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 below.

	Adjusted average health gain	2010/11 Final	2011/12 Final	2012/13 Final	2013/14 Provisional
Guy's and St Thomas'	Hip replacement – primary	0.38	0.40	0.42	0.47
Average		0.41	0.42	0.44	0.44
Lowest (2012/13)		0.26	0.31	0.32	0.34
Highest (2012/13)		0.50	0.50	0.54	0.55

Source: www.HSCIC.gov.uk

	Adjusted average health gain	2010/11 Final	2011/12 Final	2012/13 Final	2013/14 Provisional
Guy's and St Thomas'	Knee replacement - primary	0.28	0.25	0.31	0.32
Average		0.30	0.30	0.32	0.32
Lowest (2012/13)		0.18	0.18	0.21	0.22
Highest (2012/13)		0.41	0.39	0.42	0.42

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.

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

The following actions are being taken to improve the patient health gain scores and 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

The most recent information available from the Health Information Centre is for 2011/12. Using data from our own information system we are able to access full year information for 2013/14 and 2014/15. However, national average performance and benchmarking data is not available for these periods.

We believe this data is as described for the following reasons:

- 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);
- data comparing to peers, and highest and lowest performers, is not available for the reporting period.

Emergency readmissions within 28 days		2013/14			2014/15		
		Under 16	16 and over	Total	Under 16	16 and over	Total
Guy's and St Thomas'	Discharges	15,673	72,522	88,195	16,074	72,906	88,980
	28 day readmissions	688	5,870	6,558	657	6,161	6,818
	28 day readmission rate	4.4%	8.1%	7.4%	4.1%	8.5%	7.7%

Source: Trust information system

We continue to take the following actions to reduce the number of patients requiring readmission. 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 consider our score for the five questions in the national inpatient survey relating to responsiveness to personal care to be above the national average as shown below because of a number of initiatives that continue to drive improvement.

Patient experience – responsiveness to personal needs of patients	2010/11	2011/12	2012/13	2013/14
Guy's and St Thomas'	65.5	69.7	71.4	73.1
National Average	67.3	67.4	68.1	68.7
Highest scoring trust	82.6	85	84.4	84.2
Lowest scoring trust	56.7	56.5	57.4	54.4

Source: www.england.nhs.uk

Staff recommendation to family and friends

The information in the table gives the percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends.

We believe this data is as described for the following reasons:

- 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 below.

Family and Friends Test (Staff)	2012/13	2013/14	2014/15
Guy's and St Thomas'	82%	87%	85%
Average (median) for acute and acute specialist trusts	60%	66%	68%
Highest scoring acute trust	86%	94%	93%
Lowest scoring acute trust	35%	40%	36%

Source: www.nhsstaffsurveys.com

The Trust has high levels of staff engagement and our results in the new Friends and Family Test show that staff perception of the Trust's services continues to be high. 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 this data is as described for the following reasons:

- 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;
- This is the first year that the information has been collected in this way and data is not available for previous years.

Family and Friends Test (Patients)	2014/15	
	Accident and Emergency	Inpatient
Response rate	14.7%	37.6%
% would recommend	83.7%	96.9%
% would not recommend	8.6%	0.9%

Source: Trust information system

Infection control

We believe this data is as described for the following reasons:

- 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 below.

<i>C-Difficile</i> rates per 100,000 bed-days	2012/13	2013/14	2014/15
Guy's and St Thomas'			
Trust attributed	48	43	51
Total bed-days	314,389	319,441	368,630
Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust attributed cases)	15.3	13.5	13.8
National Average	17.3	14.6	–
Best performing trust	0	0	–
Worst performing trust	30.8	37.13	–

Source: Public Health England & GSTT data

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

Patient safety incidents

The National Reporting and Learning Service (NRLS) was established in 2003, the system enables patient safety incident reports to be submitted to a national database 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, different trusts may choose to apply different approaches and guidance when reporting, categorising and validating patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may acceptably differ between professionals. For this reason data reported by different trusts may not be directly comparable.

We believe this data is as described for the following reasons:

- 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 on the next page.

Incident Reporting (6 months to date)	Mar 2013	Sep 2013	Mar 2014	Sep 2014
Guy's and St Thomas'				
Total reported incidents	5,048	5,835	6,107	7,146
Incident reporting rate per 1,000 admissions	7.32%	8.66%	9.07%	45.28 (per 1,000 bed-days)*
Incidents causing severe harm or death	15	8	5	17
% incidents causing severe harm or death	0.30%	0.14%	0.08%	0.24%
Acute teaching trusts				
Lowest incident reporting rate	3.2%	4.9%	4.6%	23.61 (per 1,000 bed-days)*
Highest incident reporting rate	13.7%	12.8%	14.9%	60.63 (per 1,000 bed-days)*
Acute teaching trusts median rate	7.5%	8.0%	8.7%	37.08 (per 1,000 bed-days)*
Lowest % incidents causing severe harm or death	0.1%	0.0%	0.0%	0.0%
Highest % incidents causing severe harm or death	1.4%	0.9%	1.0%	0.8%
Acute teaching trusts average % of incidents causing severe harm or death	0.4%	0.3%	0.4%	0.4%

* Note: Information from the April-Sep 14 period the NPSA is provided incidents per 1,000 bed days. Previous periods show incidents per 100 admissions.
Source: National Patient Safety Agency

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 also shows an increase. This is in part due to a change in how serious incidents are being categorised, for example all falls that lead to a fractured hip are now classified as severe incidents. We continue to work closely with commissioners and the NRLS to ensure that any changes made to incident classifications following a root cause investigation are reported to the NRLS and that data provided to NRLS is reviewed and validated against trust data to ensure it is consistent.

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

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% of our patients are assessed for their risk of thrombosis and bleeding on admission to hospital.

We believe this data is as described for the following reasons:

- 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 below.

VTE assessment rate	2012/13	2013/14	2014/15
Guy's and St Thomas'			
Assessed	207,644	218,516	226,514
Admitted	220,512	226,837	233,076
Assessment rate	94.2%	96.3%	97.2
National average	94%	96%	96% up to Jan
Best performing trust	100%	100%	100% up to Jan
Worst performing trust	87%	80%	88% up to Jan

Source: HED and GSTT data for full year

Our clinical staff remain at the forefront of venous thrombo-embolism care nationally and internationally, including through clinical research and service development and have recently been awarded VTE exemplar centre network status.

Progress against priorities for 2014-15

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>Achieve compliance with the London Quality Standards for emergency care</p> <p>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.</p>	<ul style="list-style-type: none"> 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. 	<p>We partially achieved this.</p> <ul style="list-style-type: none"> A focus on the Emergency Care Pathway means it is now largely compliant Evelina London has made significant changes to increase the presence of general paediatric clinicians and is now compliant with all but two standards Women's services is largely compliant, other than obstetric consultant cover. A funded consultant rota will be in place in Q1 2015. Recruitment of emergency surgeons is underway. Critical care standards are the most challenging and to support change all adult critical care areas have been brought together in one directorate. Good progress has been made across many standards, but some are dependent on increased staffing and changes to the estate to enable all critical care to be provided in one location. <p>We achieved this.</p>
<p>Establish new ways of working to ensure safe and seamless handovers</p> <p>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.</p>	<ul style="list-style-type: none"> The response to the question 'have you personally witnessed a patient safety incident due to the handover system in place at this time?' in the handover satisfaction questionnaire will indicate that doctors have seen no incidents due to handover. This will compare with 37% of 80 respondents who answered 'yes' to the question in January 2014. A 'surprise patient' is a patient doctors are called to see during a shift and that they did not hear about at handover. This indicator will be in use by August 2014. By March 2015 the number of 'surprise patients' will be zero. 	<p>We partially achieved this.</p> <p>We have built and refined an e-handover system in Electronic Patient Records (EPR), trained doctors and site nurse practitioners; raised awareness and circulated guidance on the new system and recruited local handover champions.</p> <p>The doctors' survey repeated in November 2014 indicated that 28% of doctors had witnessed an incident due to an issue in the handover system.</p> <p>A project group meets monthly to overcome remaining challenges.</p> <p>The definition of 'surprise patients' has now been developed to exclude patients where deterioration could not have been predicted. In the doctors' survey 48% of respondents reported seeing 'surprise patients' monthly or more often.</p>

Patient safety

Our quality priorities and why we chose them

What success will look like

How did we do?

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

Standardising the recording of observations and decisions reduces 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 replacement of paper notes and 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.

- 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

We achieved this.

We achieved this.

We achieved this.

Deployment proceeded, initially in the cancer wards and clinics and renal wards as the roll out plans were shifted from St Thomas' to the Guy's site.

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 healthcare 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.

- The total number of *C. Difficile* infections attributable to the Trust 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

We did not achieve this.

There were 51 *C-Difficile* cases with an improving trend across the year.

We achieved this.

We came close to having no grade 4 pressure ulcers, but one was identified in the community late in the year.

We did not achieve this.

We reported six never events in the past year. All have been fully investigated and action taken to prevent recurrence.

We nearly achieved this.

In 100% cases the checklist was used for at least part of the process and the vital final stage was carried out in 98% of cases. Compliance with all three sections of the checklist was completed 81% of the time.

We achieved this.

A new pathway mitigating individual risk factors for falls was launched in August 2014.

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

- Our falls 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

We achieved this.

The December 2014 audit showed 91% compliance.

We achieved this.

National Safety Thermometer data does not show quartile performance, however, it does show the Trust is well below the lower control limit and among the best performing Trusts in the country.

Clinical effectiveness

Our quality priorities and why we chose them

What success will look like

How did we do?

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 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 embed a culture of compassionate care through the '6Cs' of care, compassion, competence, communication, courage and commitment.

- The perioperative older person's service (POPS) will be assessing and supporting a greater number of older people. An increase of 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.

We achieved this.

Expansion of the POPS team has recently been agreed, staff likely to be in place by late summer 2015.

Results for the 2014 National Inpatient survey show that the quality of care provided by staff at Guy's and St Thomas' remains high, and our overall performance is amongst the best when compared with other trusts in London and the ten Shelford Group trusts.

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 report to the Quality Committee

We achieved this.

Between the flags has been introduced in the Evelina London Children's Hospital, helping identify the deteriorating child.

Reality rounds were introduced in July 2014 to improve communication between front line staff and senior management.

Schwartz Centre rounds started in November 2014 providing a structured, monthly forum for all staff to explore the human aspects of delivering care.

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 services to further improve the experience of children and their families.

- We will review our key neuro-developmental pathways for local children that span hospital and community services and take action to integrate them wherever possible and appropriate
- We will establish a tool and a robust baseline to measure children and families' experience of our services, sharing good practice between hospital and community.

We achieved this.

We achieved this.

Patient experience

Our quality priorities and why we chose them

What success will look like

How did we do?

Improving community based adult services

We want to strengthen the adult local community services we offer and 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.

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

We achieved this.

The adult local services strategic development programme was agreed in May 2014. A number of work streams monitor delivery and an engagement plan has been implemented.

We achieved this.

A scorecard linking hospital utilisation with effective use of community services is produced monthly covering pathways, workforce, quality, IT and estates.

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, 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 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.

- We will reduce the median time taken to investigate and reply to a complaint by 10%, compared with performance in 2013/14 – target of 35 days.
- PALS and complaints service structure will be agreed by the end of 2014/15 and implemented in 2015/16.

We partially achieved this.

The target to reduce the median to 35 days was met in November 2014 but has not been maintained, reflecting continuing efforts to resolve long running, complex cases. An ongoing improvement plan is being delivered.

We achieved this.

While having close links, the PALS and the complaints services will continue to work independently. Team structures have been reviewed and implemented.

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.

- 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 non-admitted emergency department patients will have provided feedback on the quality of their care.

We achieved this.

The Trust surveys continue to show a high level of patient satisfaction.

We achieved this.

The Friends and Family Test question has been incorporated into all patient experience surveys in our hospitals and community services. Day case and outpatients data capture has been boosted by an SMS system.

We achieved this.

This was achieved for inpatients.

Patient experience

Our quality priorities and why we chose them

What success will look like

How did we do?

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 process 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.

- 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.

We achieved this.

An average of 34% of adult inpatient deaths have been supported by Priorities of Care for the Dying Person process, which now replaces "the principles of care for dying patients". The process supports the development of individualised plans of care particularly emphasises the five priorities for care recognise, communicate, involve, support, plan and do.

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	C Diff (Clostridium difficile) acquisitions	<37	51 ●	17	15	6	13
Referral to treatment times	% admitted patients treated within 18 weeks	>90%	87.9% ●	91.1%	84.9%	87.1%	88.5%
	% non-admitted patients treated within 18 weeks RTT	>95%	94.5% ●	95.8%	94.1%	93.8%	94.2%
	% incomplete pathways less than 18 weeks RTT	>92%	92.7% ●	92.7%	92.3%	93.0%	92.8%
A&E access	95% A&E patients wait less than four hours	>95%	95.3% ●	96.5%	96.0%	95.1%	93.8%
Cancer access – initial appointments	Urgent cancer referrals seen within 2 week wait	93%	95.4% ●	96.3%	95.2%	95.4%	94.5%
	Symptomatic breast patients seen within 2 week wait	93%	96.0% ●	95.3%	95.3%	95.8%	97.5%
Cancer access – initial treatments	% cancer patients treated within 62 days of urgent GP referral	>85%	75.0% ●	79.2%	75.0%	74.0%	71.7%
	% patients treated within 62 days from screening referral	90.0%	77.9% ●	84.0%	70.0%	66.7%	90.9%
	% treatment started within 31 days from decision to treat	96.0%	96.1% ●	97.5%	96.8%	95.2%	94.9%
Cancer access – subsequent treatments	Surgical treatments within 31 days	94.0%	93.4% ●	94.2%	96.6%	92.7%	90.0%
	Chemotherapy treatments within 31 days	98.0%	99.4% ●	99.6%	99.6%	99.6%	98.8%
	Radiotherapy treatments within 31 days	94.0%	96.4% ●	96.5%	97.3%	96.1%	95.5%
Community services – data completeness	Referral to treatment information	>50%	61.0% ●	59.0%	61.0%	60.8%	63.6%
	Referral information	>50%	88.0% ●	89.0%	87.9%	87.7%	86.9%
	Activity information	>50%	79.0% ●	81.0%	78.9%	79.0%	78.9%

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.

Statements

Statement of Directors' responsibilities in respect of the Quality Report

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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2014 to March 2015
 - papers relating to Quality reported to the board over the period April 2014 to March 2015
 - feedback from commissioners dated 20/05/2015
 - 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 May 2015
 - the 2014 national patient survey 21/05/2015
 - the 2014 national staff survey 24/02/2015
 - the Head of Internal Audit's annual opinion over the trust's control environment dated April 2015
 - CQC Intelligent Monitoring Report dated 03/12/2014
- 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.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.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 Hugh Taylor, Chairman
27th May 2015

Sir Ron Kerr, Chief Executive
27th May 2015

2014/15 limited assurance report on the content of the quality reports and mandated performance indicators

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 2015 (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 2015, 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 2015 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
- maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway.

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 2014 to May 2015;
- papers relating to quality reported to the board over the period April 2014 to May 2015;
- feedback from local Clinical Commissioning Groups dated 20 May 2015;
- feedback from local Healthwatch organisations dated 22 May 2015;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated May 2015;

- the latest national inpatient survey dated 21 May 2015;
- the 2014 national staff survey dated 24/2/2015;
- Care Quality Commission intelligent monitoring report dated December 2014; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2015.

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 testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

The "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator requires that the Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in national guidance.

Our testing identified that:

- for 22.5% of the sample tested the start date was not accurately recorded, affecting the calculation of the published indicator; and
- for 7.5% of the sample tested, there were errors in the recording of the clock-stop date for the pathway, affecting the calculation of the published indicator.

Our procedures included testing a risk based sample of items from throughout the year to 31 March 2015, and therefore the error rates identified from that sample should not be directly extrapolated to the population as a whole.

The "Our data quality" section on page 60 of the Trust's Quality Report details the actions that the Trust is taking post year end to resolve the issues identified in its processes.

As a result of the issues identified, we have concluded that there are errors in the calculation of the “maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway” indicator for the year ended 31 March 2015. We are unable to quantify the effect of these errors on the reported indicator.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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*.



Deloitte LLP

Chartered Accountants

Reading

28th May 2015

Lambeth CCG statement on Guy's and St Thomas' NHS Foundation Trust 2014 Quality Accounts – on behalf of NHS Lambeth, Southwark, Bromley and Lewisham Clinical Commissioning Groups

The draft Guy's and St Thomas' Hospitals NHS Foundation Trust (GSTFT) Quality Report 2014/15 was reviewed by a range of local commissioning stakeholders, including representatives from NHS Lambeth, NHS Southwark, NHS Bromley and NHS Lewisham Clinical Commissioning Groups (CCGs). We thank the Trust for the opportunity to comment on the document and for seeking the views of the CCGs in its development. The coordination of feedback has been undertaken by NHS Lambeth CCG as co-ordinating CCG.

GSTFT 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 2014/15 across both acute and community services. It very clear which have been fully or partially

achieved and the commitment to continue to make progress in prioritised areas going forward.

GSTFT has made good progress against last years' targets and quality priorities and is to be congratulated, particularly in meeting the targets relating to the management of falls and the implementation of a new tool to assist staff to develop individualised plans of care for those who are receiving end of life care.

Achievement in meeting the target for c-difficile infections attributable to the Trust was not met however the Trust sought an external review of their infection control systems which raised no major concerns. The target relating to never events was also not met with three surgical errors, two wrong site surgery cases and one medication incident involving methotrexate being reported. All have been fully investigated and actions taken to prevent recurrence however, further work is required on an ongoing basis relating to full implementation of the theatre safety checklist which the CCG will continue to monitor. The Trust priority relating to the Complaints and PALS Services was met in respect of workforce issues but not response times.

Statements

The management of serious incidents and complaints was raised with the Trust as a concern by NHS Lambeth CCG in October 2014. The CCG Clinical Quality Review Group meets monthly with GSTFT with the role of assessing provider quality. The CCG worked with the Trust to agree improvement plans for both services and following an update by the Trust at the April 2015 CCG Integrated Governance Committee, were assured on the management of both services. In particular the CCG is pleased to see an increased emphasis on learning and sharing lessons from both serious incidents and complaints across the organisation.

Consistently meeting Accident and Emergency, 18-week RTT and 62 day cancer waiting time targets continue to be challenging and the Foundation Trust continues to develop, implement and renew action plans in response to these challenges. The implementation of action plans is ongoing.

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 within the presentation of the results would have been helpful.

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 also welcome the inclusion of actions to address the findings of local clinical audits.

In addition to the agreed priority areas listed in the Quality Account we will continue to work together to assure the quality of services across the quality domains of patient safety, clinical effectiveness and patient experience.

We look forward to working with the Trust and to see the Trust making progress against all its quality priorities during 2015/16.

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 and St Thomas' Foundation Trust Quality Accounts

This is a joint response to the GSTT Quality Account 2014/15 from local Healthwatch Lambeth and Southwark, because we share services which operate across both boroughs. We appreciate the opportunity to comment on the quality of services provided by Guy's and St Thomas' Trust.

General comments

We appreciate the number of important achievements highlighted by Sir Ron Kerr in his introduction, including the brief account of the Trust's work to 'create a culture of openness and to develop a positive atmosphere where staff feel safe to report incidents and speak up and raise concerns'. We also congratulate the trust on the ongoing success of 'Barbara's Story', which compellingly shows the power of kindness within the health care system.

Overall, we found the account informative, well written and thought provoking. We have listed below

our thoughts on some of the specific accounts including where we would like to see more detail in the public domain.

Priorities 2014/15

We found the information included in the 'Progress against priorities for 2014/15' clear and easy to read. It is good to see the achievements to improve patient safety by standardisation of how clinical decisions are described and recorded and that the e-noting project will lead to the replacement of paper notes. It would however be useful to know the timeline for this.

We are also pleased to read that the trust had no grade 4 pressure ulcers in either the hospital or the community services, that the new falls pathway has been achieved and that the trust is in the lowest 25% for catheter associated urinary tract infections. We note the problems with achieving success for C Difficile infections and suggested that it would be good for the Trust to

aim for 0 infections in future years.

The information provided on quality benchmarked against your peers is interesting. However, it would be more useful if there was also information on how you chose the three new ways of addressing an improvement challenge and what you learned as a result.

The integration of hospital and community services for children is a positive development and it would be useful to know more about the learning generated from your baseline work to measure children and families' experiences of the trust's services.

Improving community based adult services, including services using district nurses and other hospital avoidance services such as the @home service are of wide interest to patient and their carers. It would be useful to have more information on the scorecard linking hospital utilisation with effective use of community services.

We welcome the positive tone towards learning from PALS, Complaints and patient satisfaction activities. During 2013/14 both Healthwatches worked with the Trust's patient engagement team to develop a new patient engagement strategy, a key part of which was a new commitment to learn from both patients and their families or carers. It would be useful to have more detail on how this strategy has been implemented. It would also be useful to have more information on how recent, less complicated complaints have been managed and whether these have met the target to reduce time taken to investigate and reply to a complaint by 10%.

We welcome the focus on frequent and regular review of both the patient's and family's wishes in care for dying patients. The notes under 'How we did' suggest that the trust is working thoughtfully. It would be useful to have more information on the care experiences of family members.

Priorities 2015/16

We found the rationale and 'what success will look like' for the new quality priorities identified by staff and other stakeholders clear. We welcome the focus on chronic obstructive pulmonary disease, especially the work to ensure that patients with complex breathlessness in the community are supported through primary care, psychological services, out of hours and domiciliary visits where appropriate. This is an important issue for

residents of both boroughs and we look forward to reading about progress next year.

We are also pleased that the care of people with dementia and delirium continues as a Trust priority and that Tier 2 dementia training will continue to be offered to all staff. We note that within 2014/15 priorities the Trust has reported that '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'. The explanation for how this was achieved references a recent agreement to expand the team from September 2015, but does not give actual numbers. There is also no target/indicator related to new priority of partnership working with carers. Healthwatch Lambeth's 2014 review of dementia services in the Clapham Park area identified family members and carers input as essential to quality of care and we would like to see more detail against this priority.

Both Healthwatch welcome the #Hello my name is initiative. We particularly welcome this as a simple but effective way for enhancing and improving the number of patients who rate the care provided by the Trust's staff as kind.

We are aware that a number of initiatives for improving patient and family experience of hospital discharge, or returning home from hospital, are currently working across Lambeth and Southwark. We welcome the Trust's commitment to improving the information you provide for patients on medication and the commitment to ensure that patients better understand and manage their own medication. Our engagement work suggests that it would be useful for patients to also have information on generic drugs. We look forward to reading about progress on this priority next year.

In summary, we are pleased to read of the many improvements to patient experience and outcomes with Guy's and St Thomas' services. We would like to see continued improvements in patient-centred care across all of the Trust's services particularly around dignity and respect, improved hospital discharge systems and electronic and shared records and communication designed to empower patients to regain and maintain their health.

Healthwatch Lambeth and Southwark



Our Chief Nurse Eileen Sills was invited to train members of the Cabinet to be dementia friendly. Eileen's training included a screening of *Barabara's Story*, our award-winning dementia training film.

7

Our organisational structure

Our governors play a vital and active 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 plays a vital part in the work of the Trust, including statutory duties such as appointments and holding the Non-Executive Directors to account for the performance of the Board.

The Council of Governors holds four public meetings a year, which follow public meetings of the Board of Directors. Governors are able to comment on and question the Board on key issues. 'Accountability sessions' twice a year provide governors a further opportunity to question the Board on a range of topics.

During the year, the Council of Governors discussed the Trust's long-term strategy and shorter term business plans, as well as receiving reports from its working groups. It also focused on the Trust's strategy for children, both in hospital and the community, as well as our adult local services strategy.

The patient, public and staff members of the Council of Governors are elected from and by the Foundation Trust membership to serve for three years. The election of a new governor in the community staff constituency took place in summer 2014, with Thelma Bangura being elected. Two of the organisations with whom we work most closely also nominated a new governor during the year, with Jasmine Ali of Southwark Council (replacing Barrie Hargrove) and London South Bank University's Professor Warren Turner also being appointed. Further elections for new governors in the public, patient and staff constituencies took place in May 2015 with 14 places in total available. See page 81 for a full list of governors.

Constitution

This year the Council of Governors supported the proposal to change the Trust's constitution by adopting a revised election scheme to permit electronic voting. Members of the Foundation Trust will be invited to confirm the change at the Annual Public Meeting in September 2015.

The latest version of our constitution is on our website: www.guysandstthomas.nhs.uk/resources/membership/trust-constitution.pdf

Working groups

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

Service strategy: This year, the group reviewed and helped refine plans for imaging, our emergency care pathway and meeting the needs of an ageing population. The group also supported development of our five-year strategic plan and our clinical strategy. It continued to provide valuable input and challenge to business planning, with a specific focus on providing 6/7 day services, the capital programme, and financial plan.

Quality and engagement: In response to the Francis Report, this group's focus now incorporates the broader quality and patient safety agenda. The group explored the patient experience of discharge from hospital, took a keen interest in the Trust's complaints process, and continued to encourage further improvements to outpatient services, reduced waiting times in clinics and a better patient

experience when contacting clinics by telephone.

Membership development, involvement and communications: This year, this group helped develop the Trust's patient and public engagement strategy and our membership survey to ensure the membership of the Trust better reflects the communities we serve.

Governors continued to attend Board Committees, including Finance and Investment, Workforce, Adult Local Services, Quality and Evelina London Development committees, providing feedback to their respective working groups and to the wider Council of Governors.

Nominations Committee

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

The Committee this year recommended the appointment of Steve Weiner as Non-Executive Director for a four-year term from 22 July 2014. It also endorsed Sir Hugh Taylor as Chairman for a second four-year term until 31 January 2019.

Nominations Committee membership and attendance 2014/15

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

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

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

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

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

We have **23,507** members, of whom **4,276** are patient members, **5,678** are public members and **13,651** are staff members.

Members receive regular mailings and are invited to our Annual Public Meeting, public meetings of the Board of Directors and Council of Governors and events such as our regular health seminars. Recent seminar topics have included the new Cancer Centre at Guy's, sleep disorders, cardiology, the new Emergency Floor at St Thomas', the Trust's smoke-free campaign, and Dealing with Patients with Hearing Impairment (joint seminar led by London Ambulance Service).

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

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

Tel: 020 7188 7346

E-mail: members@gstt.nhs.uk

Board of Directors

Our Board of Directors is made up of our Chairman, Sir Hugh Taylor, seven other Non-Executive Directors and seven Executive 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. We are confident that all Non-Executive Directors are independent in character and no relationships or circumstances are likely to affect, or could appear to affect, their judgment. We therefore have not appointed a senior independent director.

Council of Governors – Nominated lead governor: John Porter

Trust Board Directors attended every Council of Governors meeting.

Patient governors	Elected from	Actual/possible attendance
Devon Allison	July 2013	4/4
John Burns	July 2013	4/4
Anita Campolini	July 2012	4/4
Sue Hardy	July 2012	4/4
Dawn Hill	July 2012	2/4
David Spratt	July 2012	1/4
Gail Thompson	July 2012	1/4
Paula Young	July 2013	4/4

Staff governors	Constituency	Elected from	Actual/possible attendance
Thelma Bangura	Community services	Sept 2014	1/2
Noreen Ging	Clinical	July 2012	4/4
Richard Gurney	Community services	Sept 2011	2/2
Jason Simons	Clinical	July 2012	2/3
Dr David Treacher	Chair of the Samaritan Fund	July 2012	3/4
Jeff Whitear	Non-clinical	July 2012	4/4
Bryn Williams	Non-clinical	July 2013	3/4

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

Stakeholder governors	Organisation	Appointed from	Actual/possible attendance
Prof Sir George Alberti	King's College Hospital	Nov 2011	1/4
Jasmine Ali (replacing Barrie Hargrove)	Southwark Council	Oct 2014	1/2
Jo Champness	NHS England	July 2013	3/4
Prof Judith Ellis (council member of the Nursing and Midwifery Council)	London South Bank University	Feb 2010	0/2
Sue Gallagher (Trustee of Guy's and St Thomas' Charity)	Lambeth CCG	July 2013 (reappointed)	3/4
Barrie Hargrove (replacing Catherine McDonald)	Southwark Council	July 2014	0/1
Prof Denise Lievesley	King's College London	July 2009	4/4
Catherine McDonald	Southwark Council	July 2012	1/1
Robert Park	Southwark CCG	July 2013	3/4
Matthew Patrick	South London and Maudsley NHS Trust	Nov 2013	0/4
Jane Pickard	Lambeth Council	July 2013 (reappointed)	1/4

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

Head of Corporate Affairs
4th Floor, Gassiot House
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH
Tel: 020 7188 0008

David Dean resigned from the Board in June 2014. Diane Summers has been Vice Chair since June 2014. Steve Weiner joined the Board in July 2014. Amanda Pritchard went on maternity leave in October 2014, and Dr Simon Steddon was appointed Acting Chief Operating Officer.

The Council of Governors appoints the Non-Executive Directors in accordance with the Trust's constitution which allows them to serve two four-year terms, extendable in certain circumstances by a further two years. Renewal is subject to satisfactory performance and the Council of Governors' approval.

The Board undertook an independent examination of its performance in early 2014 and is in the process of implementing its recommendations.

In September 2014, more than 300 people attended our Annual Public Meeting, where members, local people, patients, staff and other stakeholders heard how we performed during the year. Attendees also had an opportunity to meet and ask questions of the Board of Directors and the Council of Governors and to hear presentations about nursing care in hospital and in the community and the new Emergency Floor at St Thomas'.

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	Title	Actual/possible
Sir Hugh Taylor	Chairman	8/8
David Dean (Vice Chair)	Non-Executive Director (up to June 2014)	2/2
Robert Drummond	Non-Executive Director	8/8
Mike Franklin	Non-Executive Director	7/8
Professor Frank Nestle	Non-Executive Director	8/8
Girda Niles	Non-Executive Director	6/8
Dr Sheila Shribman	Non-Executive Director	8/8
Diane Summers (Vice Chair)	Non-Executive Director	8/8
Steve Weiner (wef July 2014)	Non-Executive Director	4/5
Sir Ron Kerr	Chief Executive	8/8
Dr Ian Abbs	Medical Director	8/8
Ann Macintyre	Director of Workforce	8/8
Steve McGuire	Director of Essentia	8/8
Amanda Pritchard	Chief Operating Officer (Mat leave wef Oct 2014)	4/4
Martin Shaw	Finance Director	8/8
Dame Eileen Sills	Chief Nurse and Director of Patient Experience	6/8
Dr Simon Steddon	Acting Chief Operating Officer, (Acting during Amanda Pritchard's maternity leave)	4/4

Committee	Membership April 2014 – March 2015
Adult Local Services	Girda Niles (Chair), Dr Ian Abbs, Ann Macintyre, Amanda Pritchard/ Dr Simon Steddon, Martin Shaw, Dr Sheila Shribman, Dame Eileen Sills, Diane Summers
Audit	David Dean (Chair, to June 2014), Steve Weiner (from July 2014), Robert Drummond, Diane Summers
Evelina London Development	Dr Sheila Shribman (Chair), Dr Ian Abbs, Sir Ron Kerr, Girda Niles, Amanda Pritchard/Dr Simon Steddon, Diane Summers, Sir Hugh Taylor
Finance & Investment	Sir Hugh Taylor (Chair), David Dean (to June 2014), Robert Drummond, Frank Nestle, Girda Niles, Sir Ron Kerr, Steve McGuire, Amanda Pritchard/Dr Simon Steddon, Martin Shaw, Steve Weiner (from July 2014)
Quality	Diane Summers (Chair), David Dean (to June 2014), Dr Ian Abbs, Sir Ron Kerr, Steve McGuire, Girda Niles, Amanda Pritchard/ Dr Simon Steddon, Dr Sheila Shribman, Dame 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/Dr Simon Steddon, Dame 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 gains assurance through independent external and internal audit, and ensures standards are set. It also 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 2014 the Committee reviewed the draft Annual and Quality Accounts and approved their submission to the auditors before being lodged in the library of the House of Commons. During the year, the Committee also reviewed the Trust's operational plans and strategies, including those submitted to Monitor, and received reports on a number of topics including e-Noting and raising matters of concern.

External auditors 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 up to June 2014)	5/5
Robert Drummond	5/5
Diane Summers	4/5
Steve Weiner (Chair from July 2014)	3/3

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 (up to June 2014)	0/0
Robert Drummond	1/1
Girda Niles	1/1
Mike Franklin	0/1
Prof Frank Nestle	0/1
Dr Sheila Shribman	1/1
Diane Summers	1/1
Sir Hugh Taylor	1/1
Steve Weiner (from July 2014)	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 four public Board meetings per annum in the month when financial and performance reports are to be sent to Monitor. The Board meeting is followed immediately by a meeting of the Council of Governors. This second meeting, attended by members of the Board, opens with a session reflecting on the business transacted by the Board.

Members of the Council of Governors attend 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 following committees report to the Management Executive:

- Cancer Centre Programme Board;
- Information Governance Committee;
- Investment Portfolio Board;
- IT Programme Board;
- Joint Pathology Committee;
- Research and Development Committee;
- Trust 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 holds an MBA from London Business School, and is a Member of the Council of University of Bristol. 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.

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 2008, and has more than 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 also sits on 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 (maternity leave from October 2014)

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 there.

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.



Dame 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 committee for the Burdett Trust for Nursing. Eileen has a national reputation for strong, visible, clinical leadership, and her drive to take senior nurses back to the bedside has earned her a national reputation for her Clinical Fridays initiative. In August 2013 Eileen was appointed as the Clinical Director for London's Strategic Network for Dementia.



Dr Simon Steddon Acting Chief Operating Officer (from October 2014)

Simon is a graduate of King's College London and joined the Trust as a Consultant Nephrologist in 2005, becoming Clinical Lead for the Renal and Transplant Unit in 2007. He has a PhD from Queen Mary University of London and an MBA from Westminster Business School. He is also the author of several key national guidelines and a popular textbook on kidney medicine. He was appointed Clinical Director for Renal and Urological Services in 2008 and joint-Clinical Director of Abdominal Medicine and Surgery in 2010. Simon acted as the Trust's Chief Operating Officer from October 2014 until Amanda Pritchard's return from maternity leave in May 2015.

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 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.



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 backed medical businesses that achieved Stock Exchange listings in London. He is Chairman of a substantial European Government-backed fund that supports small businesses in the North East of England.

He is also a Non-Executive Director of an MoD subsidiary that helps commercialise technology developed through government research. Robert joined the Board in March 2013.



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 chairs the Evelina London Development 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 Committee.



Mike Franklin
Non-Executive Director

Mike Franklin is a Committee Member of the Solicitors Regulation Authority (SRA) and a former Commissioner and board member of the National Independent Police Complaints Commission (NIPCC). 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 and has a long association with Lambeth, having Chaired the Community-Police Consultative Group for Lambeth (CPCG) in the 1990s.

Mike joined the Board in November 2007 and chairs the Workforce Committee.



Diane Summers
Non-Executive Director
(Vice Chair from June 2014)

Diane is a former managing editor of the *Financial Times*, where she worked for 20 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 was an independent adviser to the BBC Trust and was a member of the complaints and appeals panel of Resolution, the solicitors' family law organisation.

Diane joined the Board in June 2008 and since June 2014 has been the Vice Chair, as well as chairing the Quality Committee.



Steve Weiner
Non-Executive Director
(from July 2014)

Steve Weiner lives locally in Southwark. He has spent most of his career in finance with international consumer goods group, Unilever. He is now Group Controller and part of Unilever's finance leadership team. He has extensive experience in making operational and commercial decisions involving large budgets and complex financial constraints and in leading and developing multi-cultural teams.

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



David Dean
Non-Executive Director
and Vice Chairman –
resigned June 2014

David Dean enjoyed a long and successful career in investment banking, with extensive experience in corporate finance and capital markets. David joined the Board in June 2007 and chaired the Audit Committee. He resigned from the Board in June 2014.



Nurse Tonye Oruitemeka with patient Patricia Edwards in the Older Person's Unit which features a specially designed ward environment with soft flooring and colour-coded bays.

Chairman's Annual Statement

As the Chairman of the Remuneration Committee (the Committee), I am pleased to present our Remuneration report for 2014/15.

I can confirm that the Committee approved no changes to the remuneration of Executive Directors for the 2014/15 financial year. A review of executive and senior management salaries was undertaken during the period 2014/15 for the first time in six years. This was undertaken by independent management consultants, Hay Group, and resulted in a change to some executive salaries effective from 1 April 2015.

There is a requirement to establish Trust principles for the ongoing review of senior managers' remuneration, and I am pleased to confirm that key aspects of this work are included in the Committee's programme for the 2015/16 financial year.



Sir Hugh Taylor
Remuneration Committee Chairman
27th May 2015

2014/15 Remuneration policy report

Senior managers' remuneration policy

Remuneration for the Trust's most senior managers (Executive Directors who are members of the Board of Directors) is determined by the Board of Directors' Remuneration Committee, which consists of the Chairman and the Non Executive Directors.

2014/15 Remuneration policy report

The total remuneration for each of the Trust's Executive Directors comprises the following elements:

Salary	+	Pension	=	Total remuneration
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Future policy table

The Trust's Remuneration policy in respect of each of the above elements is outlined in the table overleaf.

Remuneration report

	Salary	Pension and Benefits
Purpose and link to strategy	<p>To provide a core reward for the role.</p> <p>Salary is set at a level appropriate to secure and retain the high calibre individuals needed to deliver the Trust's strategic priorities, without paying more than is necessary.</p>	<p>NHS Pension Scheme arrangements provide a competitive level of retirement income.</p> <p>Life assurance/death in service benefits may be provided as part of the individual's pension arrangements.</p>
Operation	<p>When determining salary levels, an individual's role, experience and performance and independently sourced data for relevant comparator groups are considered.</p> <p>Executive Director salaries are inclusive of High Cost Area supplement.</p> <p>Salary increases typically take effect from 1 April each year.</p>	<p>Executive Directors are eligible to receive pension and benefits in line with the policy for other employees.</p> <p>Pension arrangements are in accordance with the NHS Pension Scheme. There is no cash alternative.</p> <p>New Executive Directors are entitled to join the NHS Pension Scheme, which from April 2015 is a Career Average Revalued Earnings scheme.</p> <p>Where an individual is a member of a legacy NHS defined benefit pension scheme section (1995 or 2008) and is subsequently appointed to the Board, he or she may remain a member of that section of the scheme.</p>
Opportunity	<p>There is no formal maximum limit, however, salary increases will ordinarily be in line with increases for the wider NHS workforce (not including incremental progression increases) as recommended by the NHS Pay Review Body.</p> <p>Increases may be higher to reflect a change in the scope of an individual's role, responsibilities or experience.</p> <p>Where a new Executive Director has been appointed to the Board on a salary lower than the typical Trust level for such a role, it may be reviewed as the Executive Director becomes established in the role.</p> <p>Salary adjustments may also reflect wider external market conditions.</p> <p>Salary levels for 2014/15 are set out in Note 6A of the Notes to the Accounts of this Annual Report.</p>	<p>Existing Executive Directors are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Details of the 2014/15 pension benefits of individual Executive Directors are available in Note 6B of the Notes to the Accounts of this Annual Report.</p> <p>There have been a number of well publicised changes to the NHS Pension Scheme. A new external recruit will be eligible to join the new 2015 NHS Pension. The main features of the new NHS Scheme include:</p> <ul style="list-style-type: none"> • A Career Average Revalued Earnings (CARE) scheme, with benefits based on a proportion of pensionable earnings each year during the individual's career • A build up rate of 1/54th of each year's pensionable earnings with no limit on the number of years that can be taken into account. This is a higher build up rate than both the 1995 and 2008 sections of the NHS Scheme • Revaluation of active members' benefits in line with inflation, currently the Consumer Price Index (CPI), plus 1.5 percent per annum • A normal pension age at which benefits can be claimed without reduction for early payment linked to the State Pension Age. <p>In accordance with NHS Pension Scheme rules, the employer contribution rate is 14% during 2014/15, increasing to 14.3% from April 2015.</p>
Performance measures	The overall performance of the individual is a consideration when reviewing salaries.	None

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

Differences between remuneration for Executive Directors and other employees

The key difference between the remuneration of Executive Directors and other employees is that the fixed salary of Executive Directors is considered to be inclusive of High Cost Area supplement, whereas for other employees, this is a separate pay element.

When setting remuneration levels for the Executive Directors, the Committee considers the prevailing market conditions, the competitive environment (in particular, through comparison with the remuneration of executives at other leading NHS multi-specialty academic healthcare

organisations of similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader Trust workforce.

In particular, the Committee considers base salary increases for the Trust's Agenda for Change workforce, which is considered to be the most relevant comparison as this population reflects most closely the economic environment encountered by the Executive Directors. The Trust does not therefore consult more widely with employees on such senior managers' remuneration matters.

Non-executive director remuneration policy

Element	Purpose and link to strategy	Overview
Fees	To provide an inclusive flat rate fee that is competitive with those paid by other NHS organisations of equivalent size and complexity	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.
Appointment		The Council of Governors appoints the Non-Executive Directors in accordance with the Trust's constitution which allows them to serve two four-year terms, extendable in certain circumstances by a further two years. Renewal is subject to satisfactory performance and the Council of Governors' approval.

Council of Governors

The role played by our Council of Governors in our organisation structure is described in Chapter 7 (Page 83). The Governors are entitled to expenses, in 2014/15 expenditure on expenses was below £100.

Off payroll engagements

The Trust has a policy that all substantive staff are paid through the payroll. No Board member or senior officials with significant financial responsibility were engaged on an off-payroll basis between 1 April 2014 and 31 March 2015.

The Trust has needed to engage a number of contractors to support fixed term assignments in the areas of information technology, asset management and some other areas 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 2015, where daily rates exceed £220 per day and the engagement has lasted longer than six months.

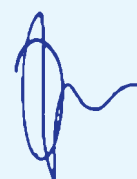
Table 1: All off-payroll engagements at 31 March 2015

Length of engagement	Number
Less than one year (but more than 6 months)	14
Between one and two years	25
Between two and three years	7
Between three and four years	7
Four years or more	10
Total	63

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

Assurance status	Number
New engagements at 31 March 2015	20
New engagements where the Trust has the right to request assurance in relation to income tax and national insurance obligations	20
Contractors from whom assurance has been requested	20
Contractors from whom assurance has been received	17
Contractors from whom assurance has not been received	3
Terminations as a result of assurance not received	0



Sir Ron Kerr, Chief Executive
27th May 2015



This year we completed a major programme of repairs and environmental improvements to Guy's Tower including replacing the windows and providing an energy efficient façade that will save up to 18% of the Tower's energy consumption.

9

Annual accounts

Foreword to the accounts

These accounts, for the year ended 31 March 2015, have been prepared by the Guy's and St Thomas' NHS Foundation Trust under a direction issued by Monitor and 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
27th May 2015

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
27th May 2015

Annual Governance Statement 2014/15

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 2015 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. A Serious Incident Assurance Panel, chaired by a non-executive Board member, has been established to monitor the quality of investigation of serious incidents and progress in embedding subsequent learning.

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

The Trust has not identified any risks to compliance with the NHS foundation trust condition 4 (FT governance). In order to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b), the Trust has assessed the extent with which it complies with the Code of Governance and this was reviewed by the Audit Committee. In 2014/15 the Board undertook 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. It is currently implementing the recommendations from the review.

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, which for 2014/15 were set out in the 16 Essential Standards of Quality and Safety. These tools 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. Audit activity and the use of Reality Rounds, which check understanding of key safety practices, also contribute. 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.

Peer to peer reviews were established in 2014/15. Clinical Directorates are paired up and multidisciplinary teams reviewed each others services in December & January using tools based on CQC methodology. A report was provided for each Directorate following their review and Directorate action plans are monitored at the Trust Risk and Quality Committee (TRaQ). The CQC is due to undertake a scheduled inspection of the Trust in September 2015.

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 and this risk assessment helps determine priorities of the programme of audits undertaken by internal audit.

Required improvements in existing clinical coding processes, identified by the Trust and highlighted in previous Payment by Results external assurance audits, 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.

Information governance

The Trust carried out a self assessment against the Information Governance Toolkit for 2014/15. 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.

Staff mandated to undergo annual information governance refresher training have a choice, dependent on their role, of online training

modules provided by the Health and Social Care Information Centre (HSCIC), or bespoke classroom training and a video provided by the Trust. Additionally, information governance policies, guidance, and best practice are available on the Trust's intranet. An "AskIG" mailbox and phone number is provided to encourage staff to seek specific advice directly from the information governance department.

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 and investigated 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.

In 2014/15 there were no incidents classified as Level 2 in the Information Governance Incident Reporting Tool, and no incidents were reported to the Information Commissioner's Office.

Risks

The major risks to delivery of the Trust's objectives are identified and assessed in detail in the Board Assurance Framework (BAF) and corporate risk register. The Board has reviewed and reassessed the risks which are monitored throughout the year by the Board through the Audit Committee, which reviews both the BAF and corporate risk register.

Strategic risks 2015/16

The principal strategic risks identified for 2015/16 are the changing economic environment; NHS England and CCG commissioning intentions; changes to national tariffs and commissioning for Quality and Innovation targets (CQUIN); changes in the configuration of healthcare in London; the Trust's saving and activity plans; and throughout delivering and continually improving the highest standards of safe, effective and caring services. The major risks identified for 2015/16 are described in more detail in chapter 3 of the Annual Report.

To manage a number of these risks our key goal for the coming year is to increase efficiency whilst sustaining high quality, safe services, and continuing to responding to the recommendations of the Francis, Berwick and Keogh reports. To deliver this a strategic, Trust wide programme 'Fit for the Future' has been established. 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 reducing length of stay, improving clinical coding, improving surgical productivity and improving outpatient services and aim to reduce costs, maximising utilisation of our facilities and equipment, transform services and diversify our income streams whilst maintaining our primary focus on the quality and safety of services.

Risks associated with the changing configuration of healthcare are being managed through a number of programmes, the Adult Local Services programme, the Children and Young People's Health programme and the Southwark and Lambeth Integrated Care (SLIC) programme. These are set out in detail in the Strategic Plan Summary 2014-19 (<http://www.guysandstthomas.nhs.uk>).

Risks identified in 2014/15

Below are the major in-year risks identified during 2014/15 and how we responded to them

Reporting process for plain film diagnostics: The Trust identified a backlog in the reporting of plain film x-rays with a potential adverse impact on patients. This was reported to the commissioners as a serious incident. Much of the backlog related to the regulatory requirement that there should be formal reports to back up the contemporaneous interpretation of X-rays. An action plan is being

implemented to ensure substantive clearance of the backlogs by the end of July 2015. The plan uses a mixture of substantive appointments, in-sourcing, out-sourcing of reporting. The Trust is ensuring better monitoring and management in future by developing a suite of detailed performance reports.

Management of health records: During 2014/15, the Trust created a new Information Governance and Management Directorate to improve the management of health records. A health records improvement programme has been launched to improve the management of all health records including paper and electronic formats. Among the work-streams are recruitment, training and communications and drafting of standard operating procedures. Regular audits are taking place to assess compliance with standards.

Booking practices: During 2014/15, the Trust undertook urgent reviews of booking practices relating to the maintenance of 'partial waiting lists' (at times maintained for diagnostic tests and out patients follow-up) and the urgent cancer referral process (known as cancer 2 week waits). The purposes of the reviews were to ensure that patients needing particularly timely referrals were receiving an appropriate standard of service. The Trust has undertaken exhaustive investigation and has not found that any patients have been harmed as a result of problems identified in the booking processes concerned, but some system issues were identified in the course of the reviews. An action plan is in place to reinforce and assure good practice, and to ensure that patients needing particularly timely referrals were receiving an appropriate standard of service.

Accident & Emergency standard: The Trust responded to deterioration in our Accident and Emergency 4 hour wait performance in quarter four of 2014/15 by working with our partners to identify joint schemes to improve our response in our most challenged areas. The Trust has also implemented and reinforced internal professional standards throughout the hospital to ensure effective response to the Emergency Department. The Chief Executive is leading inquiry groups for adult and paediatric services to help us understand themes and trends and deliver quick, material changes to the emergency care experience for our patients.

Cancer waits: The Trust is committed to achieving internal compliance with the 85% 62-day standard. The quarter four position was at 83%. The key internal issue driving this is a lack of capacity for urological robotic surgery. A new robot has been ordered and is expected to come on-line in May 2015. Theatre time and staff have been allocated in preparation, noting that there will be a time lag from the robot being installed and the backlog cleared. In achieving the Monitor target, the key external issue for 62 days remains the timeliness of inter-hospital transfers. The Trust has submitted a model which allows NHS England to predict performance based on differing performance assumptions applied to referring Trusts.

Referral to treatment standard: During 2014/15 the Trust has consistently achieved the 92% standard for incomplete pathways, but has missed the admitted target from quarter 2 onwards. Since July, this has been in the national context of a suspension of penalties as the NHS has sought to incentivise the accelerated treatment of longer-waiters. Backlogs are concentrated in five key specialties where there is limited alternative provision within the wider health economy. The Trust's elective activity plan for 2015/16 has 10% growth over 2014/15 with higher activity levels in the five key to address the increases in demand arising from higher referral rates.

Never events: Six never events occurred in 2014/15. These events occurred across 5 clinical directorates. Five events were surgery related; each one of these was comprehensively investigated and a root cause analysis was carried out. Action plans were developed to address the factors which contributed to the event including organisational or systemic issues and the root causes. The WHO surgical checklist is being extended and adapted for areas outside of operating theatres, including dental departments; ICU interventional radiology and ward areas. This includes strengthening processes including ensuring the correct site of surgery; review and simplification of surgical count guidelines. The sixth never event involved an error in prescription and administration frequency of a cytotoxic drug for a non-cancer patient. This has resulted in a revision of Trustwide guidelines, and inclusion in induction training for core medical

trainees as well as local actions.

Locally learning is cascaded by inclusion of root cause analysis outcomes and action plans in directorate clinical governance meetings, team meetings, ward meetings, nurse training sessions and theatre staff meetings. Trustwide never event posters are being displayed and safety signals, a fortnightly email bulletin from the medical director, highlighting key safety issues has been established. Never event training for foundation doctors and specialist registrars is being explored with the Programme Director for London, to heighten awareness as early as possible.

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.

Disclosures in relation to staff engagement, and the opportunities available to disabled employees are contained within the Strategic report and Our people (sections 3 and 4 of the Annual Report).

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 2014/15 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 is given to newly qualified nurses and midwives on the importance of incident reporting as being a central component of safe patient care. To further encourage incident reporting, the Trust has implemented a system to automatically notify reporters of incidents about actions taken in response to an incident, if the reporter chooses to receive this feedback. 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

Guy's and St Thomas' NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust is fully compliant with the CQC Essential Standards of Quality and Safety.

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 complied with.

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 a core member of the Trust Resilience Working Group.

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 2014/15, and to provide an opportunity for stakeholders to contribute to discussion about the choice of quality priorities for 2015/16. Local and national commissioners, local Healthwatch, members of the Health Scrutiny committees for Lambeth and Southwark and governors of the Trust were invited. 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 used for other aspects of performance. These aim to identify and correct errors in data recording or data processing, and to give greater certainty that what is reported is an accurate reflection of what has actually happened. This provides a truer assessment of performance; allows better decision-making; and aids the understanding of changes in the pattern of service provision. The Trust's elective assurance team act as guardians of the reliability of waiting time data. Internal Audit carried out two reviews of referral to treatment (RTT) pathway performance data quality during 2014/15, including, for the first time, a review of Community Services RTT data quality. Where improvements could be made to the processes for ensuring accuracy and transparency in relation to data quality, recommendations were made and agreed with management. The findings from these reviews were reported to the Audit Committee.

In terms of monitoring performance, the Trust's monthly integrated quality and performance report (IQPR) includes all elements of waiting time performance and the CQUIN programme. These indicators are also reviewed at Directorate level through the Trust's performance review meeting (PRM) process each month. Indicators are also reviewed on a quarterly basis by the Trust's Quality Committee, a sub-committee of the Board of Directors. In addition, the IQPR is shared with commissioners and external regulators. The assurance work carried out by Deloitte LLP in respect of the Quality Report 2014/15 led to a qualified opinion as some errors were identified in the recording of dates in the 18 week referral to treatment incomplete pathway indicator. The Trust has an action plan in place to address the concerns identified which is described fully in the Quality Report, it includes extending training provided for staff and increasing the frequency of sample audits. Except for this qualification a limited assurance opinion on the indicators in the Quality Report has been provided by the external auditors.

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. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. Through its committees, the Board regularly reviews the Integrated Quality and Performance report (IQPR) which comprehensively covers 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 Integrated Quality and Performance Report is backed up by a cascade of more granular reports reviewed by Board Committees,

monthly performance review meetings between the Chief Operating Officer and the 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 Integrated Quality and Performance Report. 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, the programme includes audits on adherence to guidelines on consent and duty of candour, and use of safety checklists. All audit projects are registered on an electronic system and monitored to completion and subsequent re-audit. 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.

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

Sir Ron Kerr, Chief Executive
27th May 2015

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

Opinion on financial statements of Guy's and St Thomas' NHS Foundation Trust.

In our opinion the financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2015 and of the Group's and Trust's 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.

The financial statements comprise the Consolidated Statement of Comprehensive Income, the Consolidated and Trust Statements of Financial Position, the Group and Trust Statements Changes in Taxpayer's Equity, the consolidated Cash Flow Statement and the related notes 1 to 34. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

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 except that we have qualified our conclusion on the Quality Report in respect of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator.

Going concern

We have reviewed the Accounting Officer's statement contained on page 28 that the Group is a going concern. We confirm that:

- we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Group's ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group's ability to continue as a going concern.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

Enhanced Audit Report

Risk

NHS revenue and provisions

There are significant judgments in the recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to:

- the complexity of the Payment by Results regime, in particular in determining the level of overperformance and Commissioning for Quality and Innovation revenue to recognise;
- the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4; and
- the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and agreement of future year contracts.

The Trust earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position.

Details of revenue recognition policies in relation to the operating income of £997.8m are included in note 1.3. The policy for provisions against NHS receivables (provision of £22.7m) is given in Note 1.23.

How the scope of our audit responded to the risk

- We evaluated the design and implementation of controls over recognition of Payment by Results income.
- We performed detailed substantive testing of the recoverability of overperformance income and adequacy of provision for underperformance through the year.
- We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.
- We tested NHS debtor and revenue balances included in the Intra NHS agreement of balances exercise and investigated significant areas of difference.

Valuation of land and buildings and accounting for capital projects

The Trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation. The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value.

Details of the key policies can be found at note 1.7 in the financial statements.

Note 14.1 shows a year end net book value of fixed assets of £1,153.9m including £112.8m of purchased additions to fixed assets in the year. There are judgments surrounding whether capitalisation criteria, such as timing of commencement of capitalisation and inclusion only of directly attributable costs, have been met in relation to these, and also whether any assets replaced have been appropriately disposed of from the registers.

- We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer.
- We used internal valuation specialists to review and challenge the appropriateness of the valuation approach and the key assumptions used in the valuation of the Trust's properties, including benchmarking against valuations for other NHS Foundation Trusts as at 31 March 2015.
- We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
- We have assessed whether fixed asset additions have been appropriately capitalised by testing whether the capitalisation commenced in the correct period and reviewing the nature of the capitalised costs to verify whether these meet the criteria, and whether any superseded fixed assets have been suitably accounted for including appropriate removal from the fixed asset register. We have reviewed the fixed asset related expense accounts to check for any items which should have been capitalised.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page 95.

Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in

evaluating the results of our work.

We determined materiality for the Group to be £9.9m, which is below 1% of revenue and below 2% of equity.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.2m, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including internal controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust which accounts for >99% of consolidated net assets and revenues. All testing was performed by the main group team, led by the engagement partner. At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.

Opinion on other matters 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

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Audit Code for NHS Foundation Trusts, we are required 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 is inconsistent with information of which we are aware from our audit;
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

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.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we have considered whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

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 for 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. We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team and independent partner reviews.

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

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 Group's and 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.



Susan Barratt ACA, Senior Statutory Auditor
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Reading, United Kingdom

28th May 2015

Consolidated statement of comprehensive income for the year ended March 31 2015

		March 31 2015	March 31 2014
	NOTE	£000	£000
Patient care income	3	997,778	947,318
Non patient care income	4	292,078	293,938
		<u>1,289,856</u>	<u>1,241,256</u>
Operating expenses	5	(1,238,579)	(1,198,417)
OPERATING SURPLUS		51,277	42,839
FINANCE COSTS			
Finance income	10	463	394
Finance expenses	11	(3,973)	(2,200)
Public Dividend Capital dividend payable	28	(23,519)	(21,800)
Net finance costs		(27,029)	(23,606)
Corporation Tax	12	–	10
SURPLUS/(DEFICIT) FOR THE YEAR		24,248	19,243
Other comprehensive income			
Gains from transfer by absorption from demising bodies	34	–	41,589
Impairments	16	(1,917)	(4,570)
Revaluations	17	48,992	57,107
Other reserve movements		(5)	–
		<u>71,318</u>	<u>113,369</u>
TOTAL COMPREHENSIVE (EXPENDITURE)/INCOME FOR THE YEAR		71,318	113,369

The notes on pages 106 to 131 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Note to Statement of Comprehensive Income

Total comprehensive income as above		71,318	113,369
Less reserve movements in other comprehensive income	a	(47,070)	(94,126)
Total comprehensive income before reserve movements		24,248	19,243
Add back in year impairments and reversals of impairments included in surplus above (see note 16)	b	4,631	5,569
Other non-operating items	c	1,280	335
Less capital donations		(12,075)	(9,703)
NET SURPLUS EXCLUDING ITEMS ABOVE	d	18,084	15,444

- 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.
- 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 2015

		GROUP		TRUST	
	NOTE	March 31 2015 £000	March 31 2014 £000	March 31 2015 £000	March 31 2014 £000
NON CURRENT ASSETS					
Property plant and equipment	14	1,153,866	1,028,006	1,153,866	1,028,006
Intangible assets	15	41,313	35,637	41,313	35,637
Investments in associates (joint controlled operations)	18	71	71	500	322
Trade and other receivables	20.2	1,787	2,006	1,787	2,006
Other financial assets	21	3,500	3,500	5,688	4,902
TOTAL NON-CURRENT ASSETS		1,200,537	1,069,220	1,203,154	1,070,873
CURRENT ASSETS					
Inventories	19	19,893	17,917	19,893	17,917
Trade and other receivables	20.1	118,791	100,453	118,650	100,574
Cash and cash equivalents	24	133,427	135,878	132,850	135,262
TOTAL CURRENT ASSETS		272,111	254,248	271,393	253,753
CURRENT LIABILITIES					
Trade and other payables	22.1	(142,785)	(126,997)	(142,805)	(126,942)
Tax payable	22.2	(14,078)	(14,278)	(14,030)	(14,277)
Other liabilities	22.3	(21,810)	(21,180)	(21,810)	(21,181)
Provisions	23.1	(3,414)	(3,437)	(3,414)	(3,437)
Borrowings	22.4	(6,519)	(2,953)	(6,519)	(2,953)
TOTAL CURRENT LIABILITIES		(188,606)	(168,845)	(188,578)	(168,790)
NON-CURRENT LIABILITIES					
Other liabilities	22.3	(329)	(329)	(329)	(329)
Provisions	23.1	(9,405)	(9,273)	(9,405)	(9,273)
Borrowings	22.4	(149,904)	(96,448)	(149,904)	(96,448)
TOTAL NON-CURRENT LIABILITIES		(159,638)	(106,050)	(159,638)	(106,050)
TOTAL ASSETS EMPLOYED		1,124,404	1,048,573	1,126,331	1,049,786
TAX PAYERS' EQUITY					
Public Dividend Capital		367,270	362,757	367,270	362,757
Revaluation reserve		396,007	348,977	396,007	348,977
Other reserves		743	743	743	743
Income and expenditure reserve		360,384	336,096	362,311	337,309
TOTAL TAXPAYERS' EQUITY		1,124,404	1,048,573	1,126,331	1,049,786



Sir Ron Kerr, Chief Executive and Accounting Officer
27th May 2015

Statement of changes in Taxpayers' equity

GROUP 2014/15

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' Equity at April 1 2014	362,757	348,977	743	336,096	1,048,573
Surplus for the year	–	–	–	24,248	24,248
Transfers between reserves	–	(45)	–	45	–
Impairments	–	(1,917)	–	–	(1,917)
Revaluations	–	48,992	–	–	48,992
Public Dividend Capital Received	4,513	–	–	–	4,513
Other Reserve Movements	–	–	–	(5)	(5)
Taxpayers' equity as at March 31 2015	367,270	396,007	743	360,384	1,124,404

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:	–	–	–	41,589	41,589
Gains on 1 April transfers from demising bodies.	–	–	–	–	–
Transfers by modified absorptions: transfers between reserves.	–	11,347	–	(11,347)	–
Transfers between reserves	–	(31)	–	31	–
Impairments	–	(4,570)	–	–	(4,570)
Revaluations	–	57,107	–	–	57,107
Public Dividend Capital received	6,191	–	–	–	6,191
Other reserve movements	–	–	–	–	–
Taxpayers' equity as at March 31 2014	362,757	348,977	743	336,096	1,048,573

TRUST 2014/15

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2014	362,757	348,977	743	337,309	1,049,786
Surplus for the year	–	–	–	24,962	24,962
Impairments	–	(1,917)	–	–	(1,917)
Revaluations	–	48,992	–	–	48,992
Transfer between reserves	–	(45)	–	45	–
Other Reserve Movements	–	–	–	(5)	(5)
Public Dividend Capital received	4,513	–	–	–	4,513
Taxpayers' equity as at March 31 2015	367,270	396,007	743	362,311	1,126,331

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:	–	–	–	41,589	41,589
Gains on 1 April transfers from demising bodies	–	–	–	–	–
Impairments	–	(4,570)	–	–	(4,570)
Transfers by modified absorption: transfers between reserves	–	11,347	–	(11,347)	–
Revaluations	–	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

Consolidated cash flow statement for the year ended March 31 2015

	NOTE	March 31 2015 £000	March 31 2014 £000
Cash flows from operating activities			
Operating surplus from continuing operations		51,277	42,839
Non-cash income and expenses			
Depreciation and amortisation	5.1	45,202	44,237
Impairments	16	6,913	13,831
Reversal of impairments	16	(2,283)	(8,262)
Loss on disposal	9	1,280	726
(Increase) in trade and other receivables		(17,821)	(32,787)
(Increase) in inventories		(1,976)	(2,641)
Increase in other liabilities		630	4,775
Increase in trade and other payables		10,042	679
(Decrease)/Increase in provisions		(52)	343
Tax received	12	–	10
Other movements in operating cash flows		89	2
NET CASH GENERATED FROM OPERATING ACTIVITIES		93,301	63,752
Cash flows from investing activities			
Interest received	10	463	394
Purchase of intangible assets		(9,634)	(11,494)
Purchase of property, plant and equipment		(120,486)	(98,359)
NET CASH USED IN INVESTING ACTIVITIES		(129,657)	(109,459)
Cash flows from financing activities			
Loans received from the Independent Trust Financing Facility		59,975	69,995
Loans repaid to the Independent Trust Financing Facility		(2,953)	(625)
Public Dividend capital received		4,513	6,191
Public Dividend capital paid		(23,817)	(21,311)
Interest paid on loans from ITFF	11	(3,812)	(2,055)
NET CASH GENERATED FROM FINANCING ACTIVITIES		33,906	52,195
Net (decrease)/increase in cash and cash equivalents		(2,450)	6,489
Cash and cash equivalents at April 1		135,878	129,389
Cash and cash equivalents at March 31	24	133,427	135,878

The cashflow above represents the consolidation position of the Group. A Trust-only cash flow has not been presented, as there are no material differences between this and the Group cash flow.

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 2014/15 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FRM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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 joint ventures and associates using the equity method of accounting. The financial statements of the subsidiaries are prepared for the same reporting year as the Trust. Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

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

All intragroup balances and transactions, including unrealised profits arising from intragroup transactions, have been eliminated in full on consolidation. Subsidiaries are consolidated from the date on which control is obtained by the Group and cease to be consolidated from the date on which control is no longer held by the Group.

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

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangements. Joint ventures are accounted for using the equity method.

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

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 FRM 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. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on the valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FRM 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 2012.

The Scheme Regulations 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.

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.

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;
- individually it costs at least £5,000; or

- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250 and;
- the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Valuation

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

Land and buildings are valued by an independent registered chartered surveyor on a regular basis and in accordance with Royal Institution of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect fair value. As at 31 March 2015 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.

- Buildings, 4 – 56 years
- Plant and machinery, 2 – 15 years
- Transport equipment, 2 – 7 years
- IT hardware, 2 - 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 arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

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

De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
 - management are committed to a plan to sell the asset;
 - an active programme has begun to find a buyer and complete the sale;
 - the asset is being actively marketed at a reasonable price;
 - the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; 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 e.g.
- the presence of a market for it or its output, or, where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and 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, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

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

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

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

Amortisation

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

The Trust depreciates intangible assets over the following ranges:

- Information technology, 3 – 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 33.

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 is 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 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, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.14 Value Added Tax

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

1.15 Corporation tax

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

1.16 Other reserves

The other reserves balance of £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, i.e. when receipt or delivery of the goods or services is made.

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

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as 'fair value through income and expenditure', loans and receivables or 'available-for-sale financial assets'.

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

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

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: a loan to Viapath, current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate

that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

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

Available-for-sale financial assets

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

Financial liabilities

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

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

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

Determination of fair value

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

Impairment of financial assets

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

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

1.19 Leases

Finance leases

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

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

Operating leases

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

Leases of land and buildings

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

1.20 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate, except for early retirement provisions which uses the HM Treasury's pension discount rate of 1.30% (2013/14: 1.8%) 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. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.22 Losses and special payments

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

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

1.23 Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

Transitional Funding

The Trust, in line with other specialist providers, has historically received additional funding from NHS England and the Department of Health for the additional complexity of its case mix which was not fully compensated for under standard tariff arrangements. The amount receivable for 2014/15 has been under negotiation, with a final settlement of £17.9 million agreed. This represents the final tranche of this funding, with no further amounts expected to be available for 2015/16 or subsequent years. Although details are not yet available, the Trust anticipates that the announced introduction from 2016/17 of tariffs which recognise more fully the costs of delivering specialised services will at least partially compensate for this loss of funding.

The Trust has considered whether any of the funding received for

2014/15 should be deferred but has concluded that it is appropriate to recognise it in full in the year, as agreed with NHS England and the Department of Health.

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 -1.5%, Medium-term -1.05% and Long-term 2.2%. Early voluntary retirement pension provision has been calculated by applying a 1.3% 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 1.3% (1.85% 2013/14) (See Note 1.20).

1.24 Transfer of functions from other NHS bodies

For functions that were transferred to the Trust from Southwark and Lambeth PCT, modified absorption accounting principles were applied at the date of transfer.

1.25 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 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, 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 13 Fair Value Measurement	May 2011	Adoption delayed by HM Treasury. To be adopted from 2015/16.
IAS 36 (amendment) – Recoverable amount disclosures	May 2013	To be adopted from 2015/16 (aligned to IFRS 13 adoption).
Annual Improvements 2012	December 2013	Effective from 2015/16 but not yet EU adopted.
Annual Improvements 2013	December 2013	Effective from 2015/16 but not yet EU adopted.
IAS 19 (amendment) – Employer contributions to defined benefit pension scheme	November 2013	Effective from 2015/16 but not yet EU adopted.
IFRIC 21 Levies	May 2013	EU adopted in June 2014 but not yet adopted by HM Treasury.

2 Segmental reporting

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
INCOME		
Patient care income	997,778	947,318
Non-patient care income	292,078	293,938
Total income	1,289,856	1,241,256
EXPENDITURE		
Clinical/Community Directorates	(1,069,993)	(1,013,357)
Corporate and finance costs	(195,615)	(208,656)
Total Expenditure	(1,265,608)	(1,222,013)
SURPLUS	24,248	19,243
Adjusting for:		
Impairments and reversal of impairments	4,631	5,569
Other non-operating items	1,280	335
Capital donations	(12,075)	(9,703)
Underlying surplus	18,084	15,444

Day-to-day financial control is devolved to:

- Seventeen Clinical Directorates are accountable to the Board of Directors via the Chief Operating Officer;
- Corporate and other support services accountable to the Board of Directors via the appropriate Executive Directors

The chief mechanism for financial management and control is a detailed budget report and forecast prepared at account code level each month. An aggregated summary budget is presented by the Director of Finance to the Board of Directors at each meeting. 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.

3 Patient care income

3.1 Income from activities by source

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Clinical Commissioning Groups (CCGs)	513,555	506,145
NHS England	438,675	409,188
Other NHS and Government Bodies	4,491	3,948
Non NHS:		
– Overseas patients (chargeable to patients)	3,314	2,846
– NHS injury scheme	921	1,006
– Other	36,822	24,185
	997,778	947,318

3.2 Income from activities by type

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Elective income	176,912	169,257
Non-elective income	113,227	110,549
Outpatient income	134,628	160,153
Other NHS clinical income	438,094	376,323
Accident and Emergency income	21,435	17,719
Private and overseas patient income	20,435	18,806
Community services	93,047	94,511
	997,778	947,318

3.3 Income from activities arising from Commissioner Requested Services

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Commissioner requested services	977,343	928,512
Non Commissioner requested services	20,435	18,806
	997,778	947,318

3.4 Overseas Visitor income

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Income recognised this year	3,314	2,846
Cash payments received in – year (relating to invoices raised in current and previous years)	1,064	898
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	2,234	1,907
Amounts written-off-in-year (relating to invoices raised in current and previous years)	5,063	5

In 2014/15, 1,002 customer accounts with a carrying value of £5m were written off relating to overseas visitors and covering the period from 2007 to 2013 after all reasonable prospect of recovery had been exhausted. The write off followed clarification around the rules for continued recovery after write off. GSTT retains the full records of these debts, continues to notify the UK Border Agency of outstanding amounts where appropriate and will seek to recover payment if the opportunity arises.

4 Non patient care income

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Research and development	48,396	47,774
Education, training and research	81,386	76,977
Charitable and other contributions to expenditure	22,065	17,047
Non-patient care services to other bodies	22,052	28,899
Other income (see below)	94,182	89,647
Rental revenue from operating leases – minimum lease payments	7,531	7,210
Reversal of impairments of property, plant and equipment	2,283	8,262
Income in respect of staff recharges	14,183	18,122
	292,078	293,938

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 2015 £000	Year ended March 31 2014 £000
Services from other NHS Trusts	3,565	4,152
Services from other NHS bodies	4,490	232
Services from NHS Foundation Trusts	13,961	11,135
Services from CCGs and NHS England	1,001	268
Purchase of healthcare from non-NHS bodies	7,585	11,553
Executive Directors' costs	1,582	1,517
Non-Executive Directors' costs	203	195
Staff costs	706,314	668,854
Drug costs	113,286	102,669
Rentals under operating leases – minimum lease payments	13,181	16,137
Supplies and services – clinical	159,558	152,565
Supplies and services – general	10,293	9,253
Establishment	10,745	10,443
Research and development	130	96
Transport	13,988	12,764
Premises	62,677	62,756
Increase in Bad Debts Provision	241	8,889
Change in provision rate	270	–
Depreciation and amortisation	45,202	44,237
Impairments of property, plant and equipment	6,574	11,414
Impairments of intangible assets	339	2,417
Audit fees – statutory audit	135	134
Other auditor regulatory services	21	21
Clinical negligence	9,326	9,656
Consultancy costs	10,321	11,326
Redundancy	693	840
Early retirements	404	1,074
Special Payments recognised in pay costs	15	–
Other*	42,479	43,820
	1,238,579	1,198,417

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

5.2 Audit fees

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Audit services for statutory audit	125	122
Audit fee for subsidiary companies	10	12
Audit fee regulatory reporting	21	21
	156	155

Payments made to our Auditor for non-audit work in 2014/15 were £28k (2013/14 £17k) for VAT review services.

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 2014/2015 or 2013/2014.

5.4 Operating leases

Expenditure as lessee

5.4.1 Payments recognised as an expense:

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Minimum lease payments under operating leases recognised as an expense in the year	13,181	16,137

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 2015 £000	Year ended March 31 2014 £000
Within 1 year	15,862	13,777
Between 1 and 5 years inclusive	31,627	28,374
After 5 years	15,158	12,703
	62,647	54,854

Income as Lessor

5.4.2 Rental revenue:

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Rental revenue from operating leases – minimum lease receipts	7,531	7,210
	7,531	7,210

Future minimum lease receipts due:

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Within 1 year	1,451	4,237
Between 1 and 5 years inclusive	2,999	15,485
After 5 years	21	41
	4,471	19,763

6 2014/15 Salary and pension entitlements of senior managers

A) Remuneration

Name	Title	2014/15 Salaries and Fees £000	2014/15 Pension-related Benefits £000	2014/15 Total £000
Executive Directors				
I. Abbs	Medical Director and Director of Patient Safety	199	–	199
R. Kerr	Chief Executive	253	–	253
A. Macintyre	Director of Workforce and Organisational Development	147	–	147
S. McGuire	Director of Essentia	159	–	159
A. Pritchard	Chief Operating Officer (maternity leave from Oct 14)	91	21	112
M. Shaw	Director of Finance	159	–	159
E. Sills	Chief Nurse and Director of Patient Experience	174	–	174
S. Steddon	Acting Chief Operating Officer (from Oct 14)	93	–	93

Non-Executive Directors

D. Dean	Non-Executive Director, Vice Chairman and Chairman of Audit Committee (left July 2014)	5	–	5
R. Drummond	Non-Executive Director	18	–	18
M. Franklin	Non-Executive Director	17	–	17
F. Nestle	Non-Executive Director	17	–	17
G. Niles	Non-Executive Director	17	–	17
S. Shribman	Non Executive Director	17	–	17
D. Summers	Non-Executive Director	17	–	17
H. Taylor	Chairman	60	–	60
S. Weiner	Non-Executive Director & Chairman Audit Committee (appointed July 2014)	14	–	14

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	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 Committees	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 Director (appointed June 2013)	14	–	14
D. Summers	Non-Executive Director	17	–	17
H. Taylor	Chairman	60	–	60

Median Remuneration

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

	March 31 2015	March 31 2014 Restated	Figures have been
Highest Paid Director's Total Remuneration	£253,267	£253,267	restated to exclude Agency
Median Total Remuneration	£34,651	£35,006	and Bank Staff
Remuneration Ratio	7.31	7.23	

B) Pension benefits

Name	Title	Total accrued pension at age 60 at 31 March 2015 £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 2015 £000	Cash equivalent transfer value at 31 March 2014 £000	Real increase in cash equivalent transfer value during year £000	Cash equivalent transfer value at 31 March 2015 £000
I. Abbs	Medical Director (opted out 1/08/14)	86	–	343	1,758	–	1,781
R. Kerr*	Chief Executive	–	–	–	–	–	–
A. Macintyre	Director of Workforce and Organisational Development	57	3	228	1,069	45	1,143
A. Pritchard	Chief Operating Officer (maternity Oct 14)	33	7	132	380	33	423
M. Shaw	Director of Finance	69	1	274	1,459	48	1,547
E. Sills	Chief Nurse/Director of Patient Experience	66	2	262	1,167	43	1,241
S. Steddon	Acting Chief Operating Officer (from Oct 14)	31	1	125	455	10	491

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.

For 14/15 and 13/14, there were no taxable benefits or annual or long-term performance related bonuses. Expenses paid to Executive Directors amounted to £4,000 in total. Expenses paid to Non-Executive Directors amounted to £80 in total.

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

S. McGuire opted out of the NHS pension Scheme at the beginning of the year.

* 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 2015 Total £000	Restated Year ended March 31 2014 Total £000
Salaries and wages	506,574	56,940	563,514	536,884
Social security costs	47,235	–	47,235	45,601
Employer contributions to NHSPA	62,119	–	62,119	59,714
Termination benefits	693	–	693	840
Agency and contract staff	–	57,708	57,708	49,733
Total gross staff costs	616,621	114,648	731,269	692,772
included in above:				
Costs capitalised as part of assets	(7,184)	(9,458)	(16,642)	(14,088)
less income netted off in staff costs	(6,023)	–	(6,023)	(7,473)
Total staff costs	603,414	105,190	708,604	671,211
Analysed into Operating Expenditure (note 5.1)				
Employee expenses – staff	601,124	105,190	706,314	668,854
Employee expenses – executive directors	1,582	–	1,582	1,517
Redundancy	693	–	693	840
Special Payments	15	–	15	–
	603,414	105,190	708,604	671,211

Staff costs for prior year have been restated to reclassify Bank costs from Agency & Contract staff to Salaries & Wages as per Monitor FT ARM guidance.

7.2 Average number of people employed

	Permanently employed number	Other number	Year ended March 31 2015 Total number	Year ended March 31 2014 Total number
Medical and dental	1,588	164	1,752	1,719
Administration and estates	3,054	497	3,551	3,276
Ancillary staff	773	279	1,052	1,006
Nursing, midwifery and health visiting staff	4,134	645	4,779	4,440
Nursing, midwifery and health visiting learners	842	232	1,074	889
Scientific, therapeutic and technical staff	2,024	231	2,255	2,167
Social care staff	2	–	2	1
	12,417	2,048	14,465	13,498

The numbers above are the average number of Whole Time Equivalents employed at the Trust.

7.3 Retirements due to ill-health

During 2014/15 there were 7 early retirements from the Trust agreed on the grounds of ill-health (12 in the year ended March 31 2014). The estimated additional pension liabilities of these ill-health retirements is £634k (£462k in 2013/14). 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 2015	Year ended March 31 2014
Number of cases	29	62
Cost of cases (£000)	1,066	1,517

7.5 Staff sickness absence

	Year ended March 31 2015 £000	Year ended March 31 2014 £000
Total days lost	91,710	136,354
Total staff years	12,177	12,117
Average working days lost	8	11

The sickness absence figures are reported on a calendar basis, rather than the financial year. These statistics are produced using data from the ESR Data Warehouse and have been provided by the DH. The latest publication, which covers up to December 2014, can be found on the website of the Health and Social Care Information Centre.

7.6 Other compensation schemes – exit packages 2014/15

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000	Number of other departures agreed Number	Cost of other departures agreed £000	Total number of exit packages Number	Total cost of exit packages £000
< £10,000	2	12	2	14	4	26
£10,001 – £25,000	8	140	2	36	10	176
£25,001 – £50,000	4	146	7	222	11	368
£50,001 – £100,000	2	173	–	–	2	173
£100,001 – £150,000	1	126	–	–	1	126
£150,001 – £200,000	1	197	–	–	1	197
Total	18	794	11	272	29	1,066

7.7 Other compensation schemes – exit packages 2013/14

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000	Number of other departures agreed Number	Cost of other departures agreed £000	Total number of exit packages Number	Total cost of exit packages £000
< £10,000	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

7.8 Exit packages: other (non-compulsory) departure payments

	2014/15		2013/14	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Mutually agreed resignations (MARS) contractual costs*	8	172	21	413
Contractual payments in lieu of notice	2	84	–	–
Exit payments following Employment Tribunals or court orders	1	2	6	216
Non-contractual payments requiring HMT approval*	1	14	1	45
Total	12	272	28	674

* 14/15 MARS payments were agreed and accrued for last year.

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 2015		Year ended March 31 2014	
	Number	£000	Number	£000
Total bills paid in the year	351,309	704,678	329,298	679,359
Total bills paid within target	246,460	480,773	263,917	494,588
Percentage of bills paid within target	70%	68%	80%	73%

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 2015	Year ended March 31 2014
	£000	£000
Loss on disposal of intangible fixed assets	(489)	(154)
Loss on disposal of plant and equipment	(791)	(505)
Loss on disposal of land and buildings	–	(67)
	<u>(1,280)</u>	<u>(726)</u>

10 Finance income

	Year ended March 31 2015	Year ended March 31 2014
	£000	£000
Interest on bank accounts	368	290
Interest on loans and receivables	95	104
	<u>463</u>	<u>394</u>

11 Finance expenses

	Year ended March 31 2015	Year ended March 31 2014
	£000	£000
Interest on loans from the Independent Trust Financing Facility	(3,812)	(2,055)
Unwinding of discounts on provisions and other finance costs	(161)	(145)
	<u>(3,973)</u>	<u>(2,200)</u>

12 Taxation

	Year ended March 31 2015	Year ended March 31 2014
	£000	£000
UK corporation tax		
Current tax payable on income at 20%	–	(10)
	<u>–</u>	<u>(10)</u>

The 13/14 refund flows from available group loss relief in 12/13 applied to tax already paid on the 11/12 corporation tax return.

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

13 Surplus attributable to the Trust

The surplus for the Trust was £24,962k (2013/14 surplus of £19,528k), 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 2015

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 2014	254,490	636,114	71,122	151,071	176	22,365	1,967	1,137,305
Additions purchased	–	1,685	109,456	118	–	1,513	–	112,772
Additions – grants/donations in cash	–	(69)	11,591	(74)	–	1	13	11,462
Impairments charged to operating expenses	–	(6,269)	(305)	–	–	–	–	(6,574)
Impairments charged to the revaluation reserve	–	(1,917)	–	–	–	–	–	(1,917)
Reclassifications	–	15,645	(27,545)	8,998	–	2,555	522	175
Revaluation	33,065	(2,377)	–	–	–	–	–	30,688
Disposal	–	–	(10)	(1,824)	–	(270)	–	(2,104)
Cost or valuation At 31 March 2015	287,555	642,812	164,309	158,289	176	26,164	2,502	1,281,807
Accumulated depreciation at April 1 2014	–	5,313	–	90,068	176	12,741	1,001	109,299
Provided during the year	–	22,336	–	14,415	–	3,155	233	40,139
Reversal of impairments credited to operating income	–	(2,283)	–	–	–	–	–	(2,283)
Revaluation	–	(17,995)	–	–	–	–	–	(17,995)
Disposals	–	–	–	(949)	–	(270)	–	(1,219)
At March 31 2015	–	7,371	–	103,534	176	15,626	1,234	127,941
Other relates to adjustments in relation to alignments to ledger.								
Net book value 2014/15								
Purchased assets	182,955	510,354	150,115	47,534	–	10,412	724	902,094
Donated assets	104,600	124,010	14,194	6,521	–	124	544	249,993
Government granted assets	–	1,077	–	700	–	2	–	1,779
Total at March 31 2015	287,555	635,441	164,309	54,755	–	10,538	1,268	1,153,866

In the year ended 31 March 2015 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 2015. The valuation was conducted in accordance with the terms of the Royal Institution of Chartered Surveyors' (RICS) Valuation Standards.

a) Depreciated Replacement Cost (DRC)

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

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

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

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for the financial accounting purposes under IAS16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS 1.3 as:

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

c) Market Value (MV)

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

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

Property, plant and equipment – March 31 2014

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 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 of 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)
Other	–	–	–	–	–	–	–	–
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)
Reclassifications	–	50	–	(57)	–	–	7	–
Revaluation	–	(9,952)	–	–	–	–	–	(9,952)
Disposals	–	(4)	–	(9,537)	–	(17,306)	–	(26,847)
Other	–	–	–	–	–	–	–	–
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

15 Intangible assets

15.1 As at March 31 2015

Group	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
Cost April 1 2014	2,576	39,154	15,679	893	58,302
Additions purchased / internally generated	128	278	10,337	–	10,743
Additions – grants / donations of cash	–	–	690	–	690
Impairments charged to operating expenses	–	–	(339)	–	(339)
Revaluations	–	–	–	309	309
Reclassification	1,074	4,735	(5,984)	–	(175)
Disposals	–	(489)	–	–	(489)
Gross cost at March 31 2015	3,778	43,678	20,383	1,202	69,041
Amortisation April 1 2014	884	21,781	–	–	22,665
Provided during the year	537	4,526	–	–	5,063
Disposals	–	–	–	–	–
Amortisation at March 31 2015	1,421	26,307	–	–	27,728
Net book value March 31 2015					
Purchased assets at March 31 2015	2,178	17,336	19,168	–	38,682
Donated assets at March 31 2015	179	35	1,215	1,202	2,631
Total at March 31 2015	2,357	17,371	20,383	1,202	41,313

15.2 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 government granted	–	–	542	105	647
Reclassification	736	1,614	(2,055)	–	295
Impairment	–	(3,117)	–	(391)	(3,508)
Disposals	(31)	(6,981)	(152)	–	(7,164)
Other	–	–	–	–	–
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 (through I&E)	–	(1,091)	–	–	(1,091)
Disposals	(31)	(6,979)	–	–	(7,010)
Other	–	–	–	–	–
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 March 31 2014	232	56	615	893	1,796
Total at March 31 2014	1,692	17,373	15,679	893	35,637

16 Impairments

	March 31 2015	March 31 2014
	£000	£000
Impairments charged to Statement of Comprehensive Income (SOCl)	6,913	13,831
Reversals of prior year impairments charged to SOCl	(2,283)	(8,262)
Impairments charged to Revaluation Reserve	1,917	4,570
Total	6,547	10,139

The majority of the 2014/15 impairment charge relates to the property valuation.

Land and buildings were valued independently by the Valuation Office as at 31 March 2015 in line with the accounting policies. The valuation included positive and negative valuation movements. Revaluation losses were taken to the revaluation reserve to the extent there was a revaluation surplus. Any losses over and above the revaluation surplus were charged to the Statement of Comprehensive Income (SOCl).

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 2015		March 31 2014	
	Revaluation Reserve	SOCl	Revaluation Reserve	SOCl
	£000	£000	£000	£000
Increase in value of land to revaluation reserve	33,065	–	25,425	–
Increase in value of buildings to revaluation reserve	15,617	–	31,682	–
Impairments – Reduction in value of buildings to revaluation reserve	(1,917)	–	(4,570)	–
Reduction in value of buildings to Statement of Comprehensive Income	–	(6,269)	–	(11,199)
Reversal of previous year impairments	–	2,283	–	8,262
Total	46,765	(3,986)	52,537	(2,937)

The total impairments charged to the Statement of Comprehensive Income are set out below:

	March 31 2015	March 31 2014
	£000	£000
Impairments arising from professional valuation	6,269	11,199
Other impairments	305	215
Impairment of property, plant and equipment	6,574	11,414
Impairment of intangible assets	339	2,417
Total impairment charged to Statement of Comprehensive Income	6,913	13,831
Reversed impairments	(2,283)	(8,262)
Net impact on Statement of Comprehensive Income	4,630	5,569

17 Revaluation Reserve movements

Property, plant and equipment

	2014/15	2013/14
	£000	£000
Revaluation reserve at April 1	348,977	285,124
Transfers by absorption – modified	–	11,347
Impairments	(1,917)	(4,570)
Revaluations	48,992	57,107
Transfers to other reserves	(45)	(31)
Revaluation reserve at March 31	396,007	348,977

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 2015 are set out below. The accounting date of the financial statements for the subsidiaries is 31 March 2015 and for the joint ventures 31 December 2015. 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
Viapath Group LLP ¹	UK	33%	Healthcare services
Viapath Services LLP ¹	UK	33%	Healthcare services
Viapath Analytics LLP ¹	UK	33%	Healthcare services
Spot on Diagnostics Ltd ¹	UK	30%	Healthcare services
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

18.1 Investments

	Investments in associates (and jointly controlled operations) 2014/15 £000	Investments in associates (and jointly controlled operations) 2013/14 £000
Carrying Value at April 1	71	71
Carrying value at March 31	71	71

18.2 Aggregated amounts relating to joint ventures

	March 31 2015 £000	March 31 2014 £000
Current assets	11,322	11,753
Non-current assets	5,039	4,579
Non-current liabilities	(4,789)	(4,809)
Current liabilities	(10,847)	(11,684)
Group share – net assets/(liabilities)	725	(161)
Revenue	57,517	57,703
Expenditure	(56,338)	(56,579)
Group share net profit	1,179	1,124

As per accounting policy note 1.2, the Group accounts for the joint ventures above are 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 2015 £000	March 31 2014 £000
Group share of unrecognised losses	156	1,346

All figures are based on unaudited figures.

19 Inventories

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
Raw materials and consumables	19,893	17,917	19,893	17,917
	<u>19,893</u>	<u>17,917</u>	<u>19,893</u>	<u>17,917</u>

20 Trade and other receivables

20.1 Current

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
NHS receivables	45,581	43,640	45,581	43,640
Other receivables	42,003	46,263	41,983	46,425
Provision for impaired receivables	(22,729)	(27,897)	(22,729)	(27,897)
Prepayments	12,775	5,915	12,775	5,915
Accrued income	37,455	28,988	37,307	28,988
PDC dividend receivable	512	214	512	214
VAT and other tax receivable	3,194	3,330	3,221	3,289
	<u>118,791</u>	<u>100,453</u>	<u>118,650</u>	<u>100,574</u>

20.2 Non current

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
Other receivables	1,787	2,006	1,787	2,006
	<u>1,787</u>	<u>2,006</u>	<u>1,787</u>	<u>2,006</u>

20.3 Provision for impaired receivables

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
At April 1	27,897	19,350	27,897	19,350
Increase in provision	241	8,889	241	8,889
Amounts utilised	(5,409)	(342)	(5,409)	(342)
At 31 March	<u>22,729</u>	<u>27,897</u>	<u>22,729</u>	<u>27,897</u>

20.4 Ageing of trade and other receivables

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	Restated £000	£000	Restated £000
Not past due date	38,009	54,789	37,989	51,388
Up to three months	11,476	8,603	11,476	8,603
In three to six months	16,928	4,646	16,928	4,646
Over six months	22,958	23,871	22,958	23,871
	<u>89,371</u>	<u>91,909</u>	<u>89,351</u>	<u>88,508</u>

20.5 Analysis of trade and other receivables

	GROUP		
	March 31 2015	March 31 2015	31 March 2015
	£000	£000	£000
	Impaired	Non-impaired	Total
0 – 30 days	4,588	33,421	38,009
30 – 60 days	1,332	10,144	11,476
60 – 90 days	2,102	14,826	16,928
90 – 180 days	3,143	6,563	9,706
Over 180 days	11,564	1,688	13,252
	<u>22,729</u>	<u>66,642</u>	<u>89,371</u>

21 Other financial assets

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
Non-current				
Loan and receivables	3,500	3,500	5,688	4,902
	<u>3,500</u>	<u>3,500</u>	<u>5,688</u>	<u>4,902</u>

Within Loan and Receivables is an amount of £3,500k which relates to a loan to the joint venture – Viapath Group LLP, with a maturity date of 31 December 2016 and a variable rate of interest (Libor + 2%). Within Trust other receivables is an amount of £1,438k which relates to a loan and accumulated interest to the subsidiary – Pathology Services Ltd, and a loan of £750k to the subsidiary – Essentia Trading Limited. The loan with PSL has a maturity date of 31 March 2018 and a variable rate of interest (Libor + 2%). The loan with ETL has a maturity date of 31 March 2019 and a variable rate of interest (higher of Libor + 2% or Trust cost of capital (3.5%) + 2%).

22 Trade and other payables

22.1 Current

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
Receipts in advance	1,052	809	1,052	809
NHS payables – revenue	8,492	12,067	8,492	12,067
Trade payables – capital	19,831	14,284	19,831	14,284
Amounts due to related parties – revenue	9,169	8,990	9,169	8,990
Other trade payables	35,712	31,628	35,609	31,615
Other payables	1,869	1,806	1,869	1,806
Accruals	66,600	57,413	66,783	57,371
	<u>142,785</u>	<u>126,997</u>	<u>142,805</u>	<u>126,942</u>

22.2 Current taxes payable

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
Other taxes payable including Social Security and VAT	14,078	14,277	14,030	14,277
	<u>14,078</u>	<u>14,277</u>	<u>14,030</u>	<u>14,277</u>

22.3 Other liabilities

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
Current				
Deferred income	21,510	20,353	21,510	20,353
Deferred grants income	300	828	300	828
	<u>21,810</u>	<u>21,181</u>	<u>21,810</u>	<u>21,181</u>
Non-current				
Deferred income	329	329	329	329
	<u>329</u>	<u>329</u>	<u>329</u>	<u>329</u>

22.4 Borrowings

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
Current	£000	£000	£000	£000
Loans from Independent Trust Financing Facility	6,519	2,953	6,519	2,953
	<u>6,519</u>	<u>2,953</u>	<u>6,519</u>	<u>2,953</u>
	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
Non-current	£000	£000	£000	£000
Loans from Independent Trust Financing Facility	149,904	96,448	149,904	96,448
	<u>149,904</u>	<u>96,448</u>	<u>149,904</u>	<u>96,448</u>

Loans drawn down from the Independent Trust Financing Facility which have been fully drawn down. Details as follows:

- £80m – repayable over 25 years (interest rate 2.85%);
- £75m – repayable over 25 years of which £1.7m was repaid this year (interest rate 3.27%);
- £5m repayable over 5 years of which £1.3m was repaid this year and £0.6m was repaid last year (interest rate 1.05%).
- In addition, the Trust has 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

	Current		Non-current		Total Provisions	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000	£000	£000
Pensions relating to other staff	836	836	7,937	7,949	8,773	8,785
Legal claims	352	416	–	–	352	416
Redundancy	–	59	–	–	–	59
Other	2,226	2,126	1,468	1,324	3,694	3,450
	<u>3,414</u>	<u>3,437</u>	<u>9,405</u>	<u>9,273</u>	<u>12,819</u>	<u>12,710</u>

23.2 Changes in provisions

	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
As at April 1 2014	8,785	416	3,509	12,710
Arising during the year	558	134	425	1,117
Utilised during the year	(842)	(53)	(92)	(987)
Reversed unused	(155)	(145)	(152)	(452)
Unwinding of discount	158	–	3	161
Change in Discount Rate	269	–	1	270
As at March 31 2015	<u>8,773</u>	<u>352</u>	<u>3,694</u>	<u>12,819</u>

23.3 Expected timing of cash flows

Timing of Provisions	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
Within one year	836	352	2,226	3,414
Between one and five years	3,236	–	170	3,406
After five years	4,701	–	1,298	5,999
	<u>8,773</u>	<u>352</u>	<u>3,694</u>	<u>12,819</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.

£132m is included in the provision of the NHS Litigation Authority under legal claims at March 31 2015 in respect of clinical negligence liabilities of the Foundation Trust (£122m at March 31 2014).

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 Analysis in changes of net cash

GROUP	At April 1 2013 £000	Cash changes in period £000	At March 31 2014 £000	Cash changes in period £000	At March 31 2015 £000
Cash with the Government Banking Service	128,835	6,272	135,107	(2,413)	132,694
Cash at bank and in hand – commercial bank	554	217	771	(38)	733
	<u>129,389</u>	<u>6,489</u>	<u>135,878</u>	<u>(2,451)</u>	<u>133,427</u>

TRUST	At April 1 2013 £000	Cash changes in year £000	At March 31 2014 £000	Cash changes in year £000	At March 31 2015 £000
Cash with the Government Banking Service	128,835	6,272	135,107	(2,413)	132,694
Cash at bank and in hand – commercial bank	284	(129)	155	1	156
	<u>129,119</u>	<u>6,143</u>	<u>135,262</u>	<u>(2,412)</u>	<u>132,850</u>

25 Capital commitments

Commitments under capital expenditure contracts at the Statement of Financial Position date for the Group and the Trust were £71,203k, (£107,285k at 31 March 2014), largely relating to the construction of the cancer treatment centre.

26 Events after the reporting date

There were no events warranting disclosure after the reporting date.

27 Contingencies

	March 31 2015 £000	March 31 2014 £000
Contingent liability for other claims against the Group and the Trust	(137)	(145)
Net-contingent liability	(137)	(145)

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.

28 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 2015 was £23,519k, based on the average relevant net assets of £822,876k.

29 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 the Operating Board for Viapath Group LLP include the following employees from the Trust: Beverley Hunt, Martin Shaw, Jonathan Edgeworth and Mark Gladman. The Board members of the Viapath Members Board for Viapath Group LLP include the following members from the Trust: Martin Shaw, Vicki Cheston and Ron Kerr.

The Trust's biggest source of income in 2014/15 was £455m 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 £378.5m during 2014/15 for healthcare contracts (£378.6m during 2013/14). 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 £81.1m from Health Education England.

The Trust recorded an income balance of £12.6m from King's College London in 2014/15.

The Trust has also received revenue and capital payments from a number of charitable funds, principally £14.1m is recorded in income from Guy's and St Thomas' Charity during 2014/15 (£9.8m in 2013/14). The balance for Guy's and St Thomas' Charity included within Other Receivables was £1.7m for 2014/2015 and £0 included within Other Payables. 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, as does Janet Powell, Director of Nursing for Evelina London Children's Hospital.

Sir Hugh Taylor (Non-Executive Director) is a Trustee of Macmillan Cancer Support, Royal College of Physicians, the Nuffield Trust, Cicely Saunders International and the National Skills Academy for Health which interact with the Trust from time to time. He was also Chairman of The Christie NHS Foundation Trust from March to September 2014.

David Dean was a Director of both The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and its associated charity.

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 Dementia for NHSE (London).

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.

The debtors balance for NHS bodies as at March 31, 2015 stood at £76.8m (£65.1m at March 31, 2014).

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Ashford CCG	2,098		426	
NHS Barking And Dagenham CCG	1,352		341	
NHS Barnet CCG	2,590		81	
NHS Bexley CCG	19,251		1,698	
NHS Brent CCG	1,435			
NHS Brighton And Hove CCG	1,190			
NHS Bromley CCG	20,067		850	
NHS Camden CCG	1,703		259	
NHS Canterbury And Coastal CCG	3,021		284	
NHS Central London (Westminster) CCG	11,656		431	
NHS City And Hackney CCG	2,191		260	
NHS Coastal West Sussex CCG	2,383		541	3
NHS Croydon CCG	7,236		445	
NHS Dartford, Gravesham And Swanley CCG	9,753		814	
NHS Ealing CCG	1,521		180	
NHS East And North Hertfordshire CCG	1,189			
NHS East Surrey CCG	1,530		120	
NHS Eastbourne, Hailsham And Seaford CCG	1,248			
NHS Enfield CCG	1,188		188	
NHS Greenwich CCG	23,190		2,340	
NHS Haringey CCG	1,371		106	
NHS Hastings And Rother CCG	1,558		179	
NHS Havering CCG	1,397		205	
NHS Herts Valleys CCG	1,818		158	
NHS High Weald Lewes Havens CCG	1,823		372	
NHS Horsham And Mid Sussex CCG	1,454		339	
NHS Islington CCG	1,911		508	
NHS Kingston CCG	1,355		130	
NHS Lambeth CCG	144,462	456	1,847	282
NHS Lewisham CCG	38,085		775	73
NHS Medway CCG	5,771		905	
NHS Merton CCG	1,919		165	
NHS Newham CCG	2,597		500	
NHS North West Surrey CCG	1,631			
NHS Redbridge CCG	2,245		597	
NHS Richmond CCG	1,692		133	
NHS South Kent Coast CCG	3,524		751	
NHS Southwark CCG	120,797	432	939	270
NHS Surrey Downs CCG	2,076		148	
NHS Sutton CCG	1,375		92	
NHS Swale CCG	1,814		109	
NHS Thanet CCG	1,609		61	
NHS Thurrock CCG	1,059		118	
NHS Tower Hamlets CCG	2,755		768	
NHS Waltham Forest CCG	1,765			
NHS Wandsworth CCG	12,607			
NHS West Essex CCG	1,022		302	
NHS West Kent CCG	11,467		656	
NHS West London (K&C & Qpp) CCG	2,016		111	
Great Ormond Street Hospital for Children NHS Foundation Trust	1,864	78	538	29
Kings College Hospital NHS Foundation Trust	2,367	7,060	4,675	3,866

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
South London And Maudsley NHS Foundation Trust	1,691	3,509	1,036	319
St George's Healthcare NHS Foundation Trust	1,061	2,450	348	218
The Royal Marsden Hospital NHS Foundation Trust	440	4,130	422	144
NHS Litigation Authority	5	9,946	6	9
NHS Property Services	704	1,858	940	751
Community Health Partnerships	605	3,217		3,714
Hounslow and Richmond Community HealthCare NHS Trust	1,522	18	59	17
Lewisham and Greenwich NHS Trust	1,867	1,041	1,081	854
Total NHS England	455,182	1,408	24,079	4,060
Health Education England	81,099		3,207	2,505
Department of Health	56,558	41	13,956	37
HM Revenue & Customs – VAT			3,194	
HM Revenue & Customs – Other taxes and duties		47,266		14,078
HM Revenue & Customs – Other non tax		1,169		
NHS Pensions Agency		62,128		9,348
NHS Blood & Transplant	214	4,650	2	42
Southwark London Borough Council	2,686	3,305	900	668
Lambeth London Borough Council	9,764	3,045	782	200
Welsh Health Bodies – Public Health Wales NHS Trust	1,073	6	21	
Northern Ireland Office	3,111		751	

30 Financial assets and liabilities

30.1 Financial assets

	GROUP		TRUST	
	March 31 2015 £000	March 31 2014 £000	March 31 2015 £000	March 31 2014 £000
Denominated in £ Sterling	231,794	224,310	233,237	225,260
In other currencies, restated in £ Sterling	9,742	8,282	9,742	8,282
Gross financial assets at March 31	241,536	232,592	242,979	233,542

30.2 Analysis of financial liabilities

	GROUP		TRUST	
	March 31 2015 £000	March 31 2014 £000	March 31 2015 £000	March 31 2014 £000
Denominated in £ Sterling	309,148	236,474	309,169	236,419
Gross financial liabilities at March 31	309,148	236,474	309,169	236,419

30.3a Financial assets by category

	GROUP Loans and receivables £000	TRUST Loans and receivables £000
As at March 31 2015		
Assets as per balance sheet		
NHS debtors	45,581	45,581
Accrued income	37,454	37,308
Other debtors with related parties	4,845	4,845
Other debtors	39,458	39,436
Provision for doubtful debts	(22,729)	(22,729)
Other financial assets	3,500	5,688
Cash at bank and in hand	133,427	132,850
Total at March 31 2015	241,536	242,979
At March 31 2014		
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

30.3b Financial liabilities by category

	GROUP £000	TRUST £000
Other financial liabilities		
At March 31 2015		
NHS creditors	8,493	8,493
Other creditors	66,579	66,477
Accruals	66,660	66,783
Provisions under contract	10,994	10,994
Borrowings	156,423	156,423
Total at March 31 2015	309,148	309,169
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

30.4 Fair values of financial assets at March 31 2015

	GROUP		TRUST	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Non current trade and other receivables excluding non financial assets	1,787	1,787	1,787	1,787
Other	3,500	3,500	5,688	5,688
	<u>5,287</u>	<u>5,287</u>	<u>7,475</u>	<u>7,475</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.

30.5 Maturity of financial liabilities

	GROUP		TRUST	
	March 31 2015	March 31 2014	March 31 2015	March 31 2014
	£000	£000	£000	£000
Less than one year	149,840	130,753	149,861	130,698
Greater than one year	159,308	105,721	159,308	105,721
	<u>309,148</u>	<u>236,474</u>	<u>309,169</u>	<u>236,419</u>

30.6 Financial assets interest risk

GROUP				
Currency	Total	Floating rate	Non-interest bearing	Weighted average interest rate %
	£000	£000	£000	
At March 31 2015				
Sterling	123,684	122,984	700	0.3
Other	9,742	–	9,742	0.1
Gross financial assets	<u>133,426</u>	<u>122,984</u>	<u>10,442</u>	
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>	
TRUST				
Currency	Total	Floating rate	Non-interest bearing	Weighted average interest rate %
	£000	£000	£000	
At March 31 2015				
Sterling	123,107	122,984	123	0.3
Other	9,742	–	9,742	0.1
Gross financial assets	<u>132,849</u>	<u>122,984</u>	<u>9,865</u>	
At March 31 2014				
Sterling	126,980	126,767	213	0.3
Other	8,282	–	8,282	0.1
Gross financial assets	<u>135,262</u>	<u>126,767</u>	<u>8,495</u>	

30.7 Loan disclosure

	Current	Non current	Total	Weighted average interest rate
	£000	£000	£000	
At March 31 2015				
Fixed interest rate instruments	6,519	149,904	156,423	3.0%
At March 31 2014				
Fixed interest rate instruments	2,953	96,448	99,401	3.0%

30.8 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 the Clinical Commissioning Groups (CCG), 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 2015 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds generated from free cash flow and donations. The details of our borrowing to fund Capital Expenditure is detailed in the Borrowings Note.

31 Third party assets

The Trust held £156k cash and cash equivalents at 31 March 2015 (£167k at 31 March 2014) which relates to monies held by the Trust on behalf of patients. This has been excluded in the cash at bank and in hand figure reported in the accounts. £148k is held as client monies on behalf of tenants (£1,151k at 31 March 2014).

32 Losses and special payments

Losses	2014/15		2013/14 (restated)	
	Cases	£000	Cases	£000
Cash losses	23	108	12	100
Stores losses	213	290	247	212
*Bad debts and claims abandoned	1,362	5,428	381	333
Total losses	1,598	5,826	640	645

Special payments	2014/15		2013/14	
	Cases	£000	Cases	£000
Ex gratia payments	40	32	65	169
Total losses	40	32	65	169

In 2014/15 there were no individual losses or special payments that were over £300,000. The amounts quoted above are reported on an accruals basis but exclude provision for future losses.

*In 2014/15, 1,002 customer accounts with a carrying value of £5m were written off relating to overseas visitors and covering the period from 2007 to 2013 after all reasonable prospect of recovery had been exhausted. The write off followed clarification around the rules for continued recovery after write off. GSTT retains the full records of these debts, continues to notify the UK Border Agency of outstanding amounts where appropriate and will seek to recover payment if the opportunity arises.

33 Heritage assets note

Historic artefacts

The remains of a Roman boat lies in the Guy's Hospital site, on the land where the new Cancer Treatment Centre is being built. The artefact has been disclosed as a non-operational heritage asset. As well as being of significance in its own right, the artefact assists in interpreting and presenting our hospital to the public and provides a valuable research resource for heritage professionals. Subject to conditions not deteriorating, the Roman Boat will remain preserved in situ and thus will remain on the Trust's land. The ground conditions around the boat are subject to regular monitoring. Should conditions deteriorate to a certain level then a decision will be taken to remove the boat. The Trust holds scheduled monument consent from the Department for Culture, Media and Sport.

The Trust does not consider that reliable cost or valuation information can be obtained for the Roman boat, and even if valuations can be obtained, the cost would be onerous compared with the additional benefits derived by the Trust and the users of the accounts. This is because of the nature of the asset held and the lack of comparable market values. The Trust therefore does not recognise this asset on its Statement of Financial Position.

Donated artefacts received during the year had a value of nil (2014: nil). There were no disposals of artefacts during either year.

34 Transfer of functions

There were no transfers of functions in 14/15. Prior year transfers of £41.6m related to the transfer of Property, Plant and Equipment assets from Lambeth and Southwark PCTs.

contacts

Chief Executive

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

Ron Kerr, Chief Executive

Tel: 020 7188 0001

Email: chief.executive@gstt.nhs.uk

Patient Advice and Liaison Service (PALS)

If you require information, support or advice about our services, contact:

PALS

Tel: 020 7188 8801 (St Thomas')

or 020 7188 8803 (Guy's)

Email: pals@gstt.nhs.uk

Membership

If you are interested in becoming a member of our NHS Foundation Trust, contact:

Tel: 020 7188 7346

Email: members@gstt.nhs.uk

Recruitment

If you are interested in applying for a job at Guy's and St Thomas', contact:

The Recruitment Centre

Tel: 020 7188 0044

<http://jobs.gstt.nhs.uk>

Further information

If you have a media enquiry or require further information, contact:

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