

Annual Report  
and Accounts 2015-16





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# Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2015-16

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.

We have around 15,000 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 focused.

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





Consultant ophthalmologist Samantha Mann screens diabetes patient Danny Ball. Danny appeared in our film to promote the importance of eye-screening and the risk of sight loss to patients with diabetes.

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Radio 1xtra DJ Clair Hermet with musician Tinie Tempah. After undergoing a preventative double mastectomy at Guy's in January, Clair took part in the Guy's Urban Challenge in October helping to fundraise for the new Cancer Centre which is due to open at Guy's Hospital in autumn 2016.



# Chairman's statement

2015-16 has been another challenging year for the Trust, but one in which our staff have shown a relentless commitment to high quality care.

We continue to receive positive feedback from patients about the quality of the services we provide in our hospitals and in the community. In September 2015, the Care Quality Commission (CQC) inspected our services and their 'Outstanding' rating for caring services was a further endorsement of the hard work and compassion of staff across the organisation. The CQC also identified a number of areas requiring improvement and we are currently working hard to address these.

Our staff are highly engaged in improving the quality, safety and efficiency of the care that we provide through the Trust's *Fit for the Future* programme. Many staff have received national recognition for developing innovative new approaches to delivery of services and for their care and compassion – which are the hallmark of an organisation committed to continuous improvement in all that it does.

In common with other NHS organisations, our Emergency Department came under significant pressure during the year, seeing more patients than ever before. However, investment in major transformation of the Emergency Floor, expansion of our Older Persons Unit and community services such as @home are beginning to show positive results for patients and staff. We have also seen substantially increased demand for planned treatment and diagnostic testing, which 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. By increasing capacity in diagnostic services, clinics and operating theatres, we are able to treat more patients more quickly. Community-based initiatives are also helping to reduce hospital admissions through A&E, and increasing opportunities for patients to be cared for in their own home. In addition, we are making better, more efficient use of new

technology both on our wards and in the community to enable staff to manage patients even more safely and efficiently.

This year, the opening of two new cancer centres – at Guy's and at Queen Mary's Sidcup – will provide greater capacity and exceptional facilities for patients and staff.

The Council of Governors continues to support and advise the organisation on how best to meet the needs of patients and provides constructive challenge to the Board in line with its statutory duties.

The Trust benefits greatly from its participation in King's Health Partners and through close partnership working with local health and social care organisations. By working together, we can bring our collective strength and expertise to bear 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.

Guy's and St Thomas' Charity continues to make a generous contribution to the development of the Trust's infrastructure and environment, as well as supporting innovation in our services and improvements in staff welfare. We are grateful for their continuing support and delighted to welcome both a new Chairman, Wol Kolade, and a new Chief Executive, Kieron Boyle. The Trust also benefits from working closely with MPs, our commissioners, local authorities, the Metropolitan Police, and other employers in the area to ensure that we play an active part in the life of our community in Lambeth, Southwark and further afield.

Finally, it remains to thank Board colleagues for their continued support, particularly Mike Franklin, whose second term as a Non-Executive Director ended in October, and Diane Summers and Frank Nestle who will step down shortly.



**Sir Hugh Taylor**, Chairman



Amanda Pritchard was appointed Chief Executive of Guy's and St Thomas' on 18 January 2016.

## Annual Performance Statement from the Chief Executive

The Trust performed well both operationally and financially during 2015-16.

It was an exceptionally busy year as we saw planned (elective) activity increase by as much as 10% in many services, with similar increases in attendances in our Emergency Department.

Our staff have worked very hard to respond to these pressures, and remain focused on the delivery of high quality patient care, whilst also striving to achieve both performance and financial targets.

We recognise that the impact of rising demand was particularly significant in the last three months of the year, and made it difficult to meet a number of access targets.

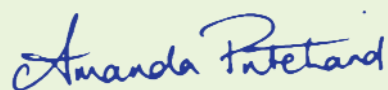
We are currently implementing a range of plans to help us to recover performance on a sustainable basis. These include working closely with partner Trusts that refer cancer patients to us, often too late in their pathway for us to be able to begin treatment within 62 days.

Despite these challenges, our staff have continued to progress many quality and service improvements, including our ambitious capital programme. We are pleased to have completed a number of major developments during 2015-16 and these are described on pages 27 and 28 in the Directors' Report.

We set a deficit budget for the first time in 2015-16, for the reasons explained on page 11. Despite this, we believe our financial outcome at the year end represents a positive achievement in the current financial environment. Our underlying deficit of £11 million, following adjustment for capital donations and impairments, was £8 million better than our planned deficit of £19 million.

Through cost savings and efficiencies, as well as extra income arising from additional activity, we delivered savings of £93 million in 2015-16. This proved extremely challenging, and it is a tribute to the efforts of staff across the organisation that we were able to do so.

As we reflect on performance, it is also important to remember that patients are at the heart of everything we do. Through our monthly CARE awards we often hear from patients about the exceptional compassion of our staff: *"every staff member demonstrated a quality of care that went far beyond expectations"; "nothing was too much trouble, they were always willing to talk and also listen to you if you have concerns."*



**Amanda Pritchard**

Chief Executive

25 May 2016

# Overview

Guy's and St Thomas' NHS Foundation Trust provides 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. The Trust was formed in 1993 from the merger of Guy's and St Thomas' Hospitals. The new Evelina London Children's Hospital was opened in 2005 and in 2011, Lambeth and Southwark community services joined the Trust.

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

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 dental, 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 have a long tradition of clinical and scientific achievement. In 2007, we were awarded one of the National Institute for Health Research's (NIHR) Biomedical Research Centres, with King's College London.

In 2009, King's Health Partners was accredited as one of the UK's first Academic Health Sciences Centres, bringing together world-class clinical services, teaching and research. We work closely with our AHSC partners King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London, our shared university partner.

We have around 15,000 employees, making us one of the biggest employers locally. We aim to reflect the diversity of local communities we serve and continue to develop new and existing partnerships with local people, patients, neighbouring NHS organisations, local authorities and charitable bodies and GPs.

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

## Financial risks

In 2016-17, the Trust faces a number of financial risks which are listed below and then described in further detail on pages 15 and 16:

- achieving the required efficiency savings for 2016-17;
- failure to secure an adequate contract with NHS England;

- the ability of our commissioners to afford forecast increases in activity levels;
- local authority funding reductions;
- the Trust's physical capacity to deliver activity to the required standards and activity levels;
- the costs of implementing the move towards seven-day services;
- delivering the Trust's commitments under the Sustainability and Transformation Fund.

## Operational risks

A number of operational risks, which are described more fully in the Annual Governance Statement, have also been identified:

- the ability to recruit and retain sufficient staff to meet demand and maximise usage of our facilities;
- potential delays in the completion of capital schemes adversely affecting our ability to sustain waiting time standards;
- disruption to normal activity from junior doctor strikes or other events;
- increased demand on Trust services impacting on our ability to deliver waiting times targets;
- service disruption in neighbouring health sectors increasing referrals.

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.



## Performance analysis – clinical

Our overall performance during 2015-16 reflected a very challenging external environment. Given this wider context, we are extremely proud of the hard work of our staff as well as their determination to improve the care and experience of the patients who use our services.

The Trust's performance is monitored against key national standards. In addition, our Board of Directors regularly reviews progress against a range of internal and external metrics through our Integrated Quality and Performance Report (IQPR).

Our emergency services recorded their busiest ever year, with over 175,000 attendances at our Emergency Department at St Thomas'. In addition, we are part way through a major transformation project to improve the whole of the Emergency Floor, which has involved significant temporary changes to the layout of our A&E and its associated wards.

Despite these challenges, we were one of the better performing Trusts in London against the target that 95% of patients are diagnosed, treated and discharged within four hours. However, it proved difficult to achieve this target consistently through the entire year, although we did meet it between April and June. We were also pleased to maintain one of the best ambulance handover records, so that those patients arriving in A&E with the most urgent medical need received their treatment without delay.

To help reduce demand on our inpatient hospital services, we have continued to expand both our community and ambulatory

services, including our Older Persons Unit. Our aim is to improve timely access to the most appropriate care, reducing demand on our emergency beds and increasing opportunities for patients to be cared for in their own home.

During the past year, we have also experienced a significant increase in demand for planned (elective) care – up 10% compared with 2014-15, and in addition to an 8% increase in demand last year. This demand has caused our waiting lists to grow and more patients are having to wait longer than 18 weeks for their treatment following referral.

We managed to meet the required referral to treatment target (92% of patients waiting less than 18 weeks) for most of the year, but were not able to maintain this through December and January. As a result, our clinical teams have focused on treating those patients who have waited the longest; have improved our administrative processes; and have increased capacity through additional evening and weekend clinics and operating lists.

High demand for our services has also made it difficult to meet the target that 99% of patients should wait less than six weeks for a diagnostic test. However, we have made significant improvements during the year, and we are

confident that additional capacity across our diagnostic services will enable us to achieve this target consistently during 2016-17.

We consistently met the two week waiting time for reviewing patients with suspected cancer between April and November, but found this difficult to maintain from December to March. This was because more patients chose to wait longer for a particular diagnostic procedure, rather than attend at the times we offered them. However, additional appointments within our endoscopy service mean that patients now have a greater choice of appointment times for these tests.

In recent years we have not always been able to meet the demand for specialist cancer treatments in some surgical specialties, therefore failing to provide these treatments within 31 days of a decision to treat, or within 62 days of the initial referral. However, we have increased surgical capacity in key services, such as urological robotic surgery, and this will allow us to treat additional patients and meet these standards more consistently in 2016-17.

We see many patients who are referred to us for specialist treatment, having initially been seen at their local hospital. In common with other specialist cancer centres, we often find it difficult to start

## Performance report

### Key performance indicators

		Performance		Quarterly Trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	C.diff acquisitions (including: cases deemed not to be due to lapse in care and cases under review)	51	51 ●	13	19	6	13
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	92.3% ●	93.1%	92.3%	91.9%	91.8%
A&E access	95% A&E patients wait less than 4 hours	95%	92.8% ●	95.1%	93.3%	92.7%	90.2%
Cancer access initial appointments	Urgent cancer referrals seen within 2 week wait	93%	92.8% ●	93.3%	94.8%	93.6%	89.7%
	Symptomatic breast patients seen within 2 week wait	93%	95.0% ●	96.6%	95.0%	95.5%	92.5%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	69.4% ●	69.6%	67.8%	70.3%	69.9%
	% patients treated within 62 days from screening referral	90%	88.8% ●	87.0%	93.8%	92.6%	84.4%
	From diagnosis to first treatment within 31 days	96%	94.3% ●	94.4%	94.2%	94.7%	94.1%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	91.6% ●	92.2%	92.5%	90.5%	91.3%
	Chemotherapy treatments within 31 days	98%	98.7% ●	99.1%	99.1%	98.5%	98.1%
	Radiotherapy treatments within 31 days	94%	96.0% ●	96.7%	96.1%	95.8%	95.5%
Community care information completeness	Referral to treatment information completeness	50%	63.2% ●	64.7%	64.9%	60.4%	64.4%
	Referral information completeness	50%	85.5% ●	85.2%	85.6%	92.6%	76.0%
	Activity information completeness	50%	83.9% ●	78.7%	79.6%	93.0%	85.8%

treatment for these patients within 62 days, particularly when patients are referred to us late in their clinical pathway, and in some cases after 42 days. We recognise the importance of providing timely treatment for all patients, regardless of where their care starts, and are currently working hard with our partner hospitals who refer patients to us to prevent unnecessary delays.

We already meet the targets to begin radiotherapy and chemotherapy treatment within 31 days, but hope that the new cancer centres opening at Guy's Hospital and at Queen Mary Hospital, Sidcup during 2016 will further enhance our ability to provide prompt, high quality care to our patients.

We continue to have very low levels of hospital acquired infections and are committed to reducing these further, for example through zero tolerance of poor hand hygiene and other measures such as a strong focus on anti-microbial stewardship.

Last year we had one case of MRSA blood infection that was attributed to the Trust, with a further case still under investigation. There were 51 reportable cases of C.difficile

infection, against a target of no more than 51 cases during the year. All cases are investigated, and only four of these cases were thought to be due to a 'lapse in care', such as inappropriate antibiotic prescribing.

During the year we saw an increase in never events and serious incidents. We take these very seriously and have launched a campaign, 'Always Safe', to raise awareness; encourage reporting as part of a 'no blame culture'; and ensure lessons are shared and learnt.

Our Adult Local Services have continued to engage with local people, GPs, the voluntary sector and other partner organisations within health and social care, to collaboratively strengthen the community services in Lambeth and Southwark. This has helped to improve patient experience, strengthened preventative care and supported people to stay at home rather than attend hospital.

Key achievements this year include the further development of both our @home and Enhanced Rapid Response services, including a unified point of access for both; direct access to the @home service

for the London Ambulance Service; and new overnight @home services which include domiciliary support for people at the end of their lives.

Another notable achievement was a successful bid with local partners to provide a 20 bed neuro-rehabilitation service, as well as a neuro-navigation service that will streamline access to care for patients across south east London.

In common with other areas, the district nursing workforce in Lambeth and Southwark is experiencing high levels of vacancies, but we are pleased that a successful recruitment campaign has helped us to strengthen this vital service. We are also actively exploring new models of care to meet the challenges of a complex and growing workload locally.

Following the discontinuation of the national community IT system service by NHS England, we were required to procure an alternative system. The new system, Advanced Care Notes, went live in November 2015. Its implementation has proved challenging and we have been grateful to our staff for their patience and continued support.

## Performance analysis – financial

2015-16 was a challenging year financially for Guy's and St Thomas' – as it was for most trusts – reflecting the difficult economic environment across the public sector. The Trust declared an £11 million underlying deficit for the financial year – £8 million better than the £19 million underlying deficit planned at the start of the year. The underlying deficit is calculated before accounting for capital donations (£27 million) and impairments arising from the revaluation of land and buildings (£51 million). When these are taken into account, the operating deficit for the year was £34 million.

### Our financial performance

At the start of the financial year, the Trust set a plan to achieve a £19 million underlying deficit. The underlying deficit is calculated before accounting for capital donations and impairments in the value of our land and buildings. It is one of the key measures used consistently from year to year by directors and Monitor, our regulator, to assess our financial performance. The Trust actually achieved a smaller deficit than planned – £11 million – which equates to 0.84% of our annual income (£1,313 million, excluding capital donations).

Although this is the first time the Trust has had to plan for an underlying deficit since we became a Foundation Trust, achieving a smaller deficit than planned is still a very positive performance in the current financial environment within the NHS. It was made possible by a huge effort from many staff across the Trust achieving challenging efficiency improvement targets and coping well with a range of in-year financial pressures.

Towards the end of 2014-15, the Board of Directors had reluctantly concluded that it would not be possible for the Trust to achieve an underlying break even position in 2015-16 as the size of the savings required became unrealistic. There were four significant external changes whose full effects only became apparent late in the planning process:

- the withdrawal of Project Diamond funding (£18 million) – monies used to pay for the costs of very highly specialised treatments not accounted for in the Tariff;
- a significant reduction in CQUIN quality payments (£15 million) as a result of the Trust remaining on the 2014-15 Tariff in 2015-16;
- the substantial increase in the Trust's contributions to the Clinical Negligence Scheme for Trusts (£5 million) due to a change in the way that contributions are calculated;
- significant adverse changes in the Tariff (the basis on which the Trust gets paid for providing patient care) – considerable uncertainty remained as we approached the new financial year.

These changes left a gap too large to be bridged by additional savings plans which could be delivered in time for their impacts to address the underlying deficit during 2015-16.

In setting its financial plan, the Trust identified the requirement for a £93 million efficiency improvement programme, equivalent to 7.4% of income, excluding capital donations (at 2014-15 levels). This was the largest efficiency programme in our history.

During the first quarter of 2015-16, it became apparent that delivering our savings programme was going to be even more challenging than anticipated. In response, the Trust adopted a turnaround strategy with an internal financial recovery programme which included:

- a comprehensive communications strategy including frequent face to face briefings, events and updates to ensure staff were fully engaged with the Trust's financial recovery plans;
- actively encouraging staff suggestions and local efficiency savings in the directorates;

- Executive-led town hall style meetings attended by hundreds of staff;
- twice weekly meetings of the financial recovery group, with dedicated staff assigned from operations and finance to support this work;
- clear lines of accountability from Board to ward for specific savings programmes, with named individuals responsible for each objective at all levels from Executive down;
- rigorous monitoring and reporting systems.

At the end of the year, we had achieved over £79 million of these efficiencies and savings, at a time when efficiency savings have proved increasingly difficult to deliver without adversely impacting on patient care. In addition,

alongside these efficiency savings, we delivered increased activity, associated income and productivity improvements, bringing the total to £93 million.

The annual accounts reflect not only the performance of the Trust, but also the consolidated results of its wholly owned subsidiaries and its joint ventures. A full list can be found in note 18 to the accounts on page 122.

Table 1 compares the 2015-16 outturn to the 2015-16 plan.

The achievement of a lower underlying deficit than planned reflects the Trust's successful delivery of a significant programme of cost reduction, increased efficiency and higher income resulting from higher activity. The Trust's income position exceeded our planned income by £64 million (5.2%). Expenditure was £56

million above plan (4.4%), excluding non-operating items and impairments, reflecting the additional cost of delivering higher levels of activity.

The £51 million impairment charge was not included in the plan at the start of the year. The impairment arises from the revaluation of our land and buildings in year. This is a non-cash technical accounting change and has no implications – now or in the future – for the fitness of our land and buildings to support the present level of patient care.

Table 2 compares our performance in 2015-16 with our performance in the previous year.

In 2015-16, income (excluding capital donations) increased by £34 million (2.6%). The main factors were:

- income for providing patient care increased by £65 million (6.5%), of which £38 million was planned growth;
- other operating income fell by £21 million, a combination of the loss of Project Diamond funding (£18 million in 2014-15) and the planned reduction in funding for the British Forces Germany contract (£8 million), offset by currency gains and increases in funding for hosted services.

In 2015-16, expenditure (excluding impairments) increased by £63 million (4.8%). The main factors in this increase were:

- pay costs increased by £23 million (3.3%), reflecting increased staffing levels (see note 7 on page 115);

**Table 1: Financial performance against plan**

	2015/16 Plan £ millions	2015/16 Actual £ millions	Variance £ millions
Total income excluding capital donations	1,249	1,313	64
Expenses excluding impairments	1,268	1,324	-56
Underlying operating deficit for the year excluding capital donations and impairments	-19	-11	8
Capital donations	27	27	0
Impairments	0	51	-51
Operating surplus/deficit for the year	8	-34	-43

**Table 2: Financial performance comparison**

	2015/16 Actual £ millions	2014/15 Actual £ millions	Change
Total income excluding capital donations	1,313	1,279	34
Expenses excluding impairments	1,324	1,261	63
Underlying operating surplus/deficit for the year excluding capital donations and impairments	-11	18	-29
Capital donations	27	11	16
Impairments	51	5	-46
Operating surplus/deficit for the year	-34	24	-59



## Trends in activity, income and expenditure

Chart 1: Completed patient spells

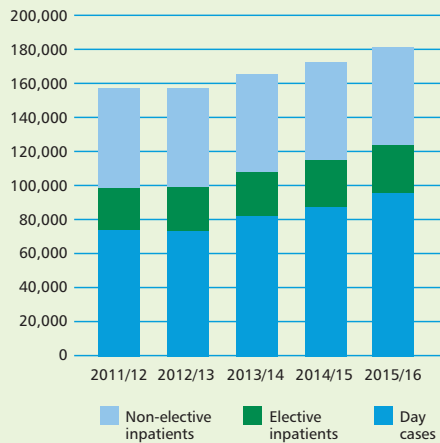


Chart 2: Consultant outpatient attendances

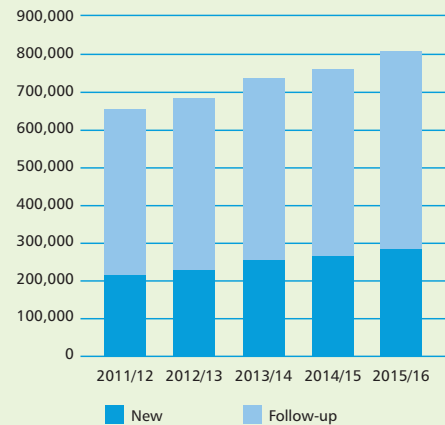
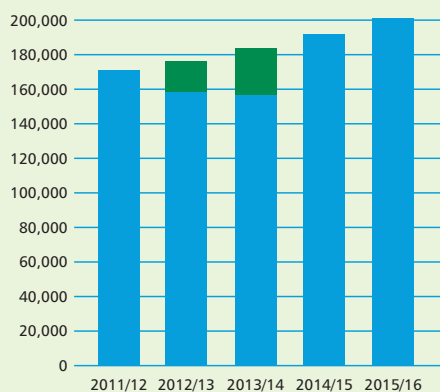


Chart 3: A&E attendances



During 2015/16, we saw 1,148,000 outpatients, 86,000 inpatients, 96,000 day case patients and 201,000 accident and emergency attendances. We also provided over 800,000 patient contacts in the community, bringing our total to over 2.3 million patient contacts a year.

Chart 4: Income £000s

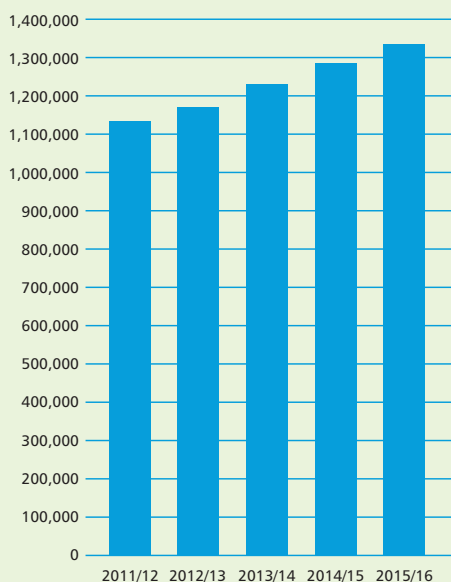
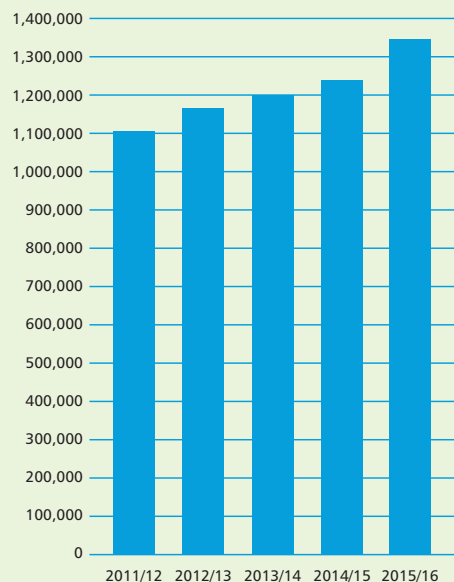


Chart 5: Expenditure £000s



- drug costs increased by £9 million (8.2%) reflecting price rises and increased usage (especially of high costs drugs in cancer services);
- premises costs increased by £16 million reflecting IT costs and one off costs for repairs to leased property and capital schemes;
- the purchase of healthcare from non-NHS bodies increased by £7 million (90%), reflecting the increased use of external MRI and PET services and the new Lane Fox Unit at Redhill;
- the Trust's contribution to the Clinical Negligence Scheme for Trusts increased by £5 million, reflecting a change in the way that contributions are calculated.

The Trust delivered £79 million planned efficiency savings in 2015-16, and will continue to drive down costs in future years as part of our plan to return to financial balance on a sustainable basis and to deliver surpluses that can be reinvested in service developments and our estate in support of the Trust's strategic vision.

Despite these efficiency savings, with expenditure increasing faster than income in 2015-16, the Trust moved from an underlying £18 million surplus in 2014-15 to an underlying £11 million deficit in 2015-16, a £29 million deterioration.

### Trends in activity, income and expenditure

Charts one to five show the trends in activity, income and expenditure.

Overall, completed patient spells increased by 5.2% (4.2% in 2014-15). Daycases again showed the largest increase at 9.2% (6.6% in

2014-15); elective inpatients increased by 2.6% (4.8% in 2014-15); non-elective inpatients increased slightly by 0.4% (also 0.4% in 2014-15). See Chart 1.

Outpatient activity increased by 6.2% (3.4% in 2014-15). New appointments showed an increase of 7.2% (3.2% in 2014-15); follow-up appointments increased by 5.7% (3.5% in 2014-15). See Chart 2.

A&E attendances increased by 4.6% (the comparable figure for 2014-15 was 4.9% when attendances in 2013-14 at Guy's – then a GP led service – are taken into account). See Chart 3.

Charts 4 and 5 show the trends in income and expenditure. The main changes that affect the increases in income and expenditure are described in the section above.

### Cash flow

The Trust began the financial year with £133 million of cash and cash equivalents. The majority of this cash is the result of surpluses from previous years and is earmarked for the Trust's capital programme.

During the year, cash balances reduced by £16 million to £117 million. For more details of the Trust's cash balances see note 24 to the accounts on page 126.

The reduction in cash during the year partly reflects the underlying deficit during the year and partly reflects other changes in the balance sheet.

In 2015-16, the Trust had a £6 million deficit from continuing operations compared with a £51 million surplus in 2014-15. This surplus includes £121 million of non-cash items (£42 million 2014-15).

The largest component in the year on year difference was a £47 million increase in the impairment charge. After adjusting for non-cash items, the net cash generated in 2015-16 was £115 million (£93 million 2014-15).

The Trust used £104 million for capital expenditure (£130 million 2014-15) – see below – and received £26 million in charitable donations (£12 million 2014-15) – see below.

In 2015-16 net new loans and repayments (including dividend payments) amounted to a £28 million outflow (£34 million inflow 2014-15).

Table 3 sets out the changes in cash flow.

In summary, when non-cash items are excluded, the Trust generated £8 million more cash in 2015-16 than in 2014-15; capital expenditure was £26 million lower, while donations to fund capital expenditure were £15 million higher. The most significant change was in financing with a large net outflow in 2015-16 compared with a net inflow in 2014-15 – a net change of £62 million.

Full details can be found in the Consolidated Cash Flow Statement in the Annual Accounts on page 105.

### 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 2015-16, the Trust spent £27 million from charitable grants on capital projects, and also received £7 million in charitable contributions towards revenue expenditure.

## Capital expenditure

In 2015-16, the Trust spent £94 million on property, plant and equipment (£120 million 2014-15) and £10 million on intangible assets – mostly software and other IT – (£11 million 2014-15).

The capital programme is funded from a combination of the Trust's own internally generated resources, surpluses generated in previous years, charitable donations and loans from the Department of Health.

## Capital loans

A significant portion of the Trust's capital programme is funded from loans provided by the Department of Health (previously the Independent Trust Financing Facility or ITFF). At the beginning of the financial year, the ITFF had agreed loans totalling £169 million, the final £9 million of which was drawn down during the year. During 2015-16, four further loans were agreed, totalling £100m.

## Revaluation of land and buildings

As part of the preparation of the annual accounts, we are required to assess the value of our land and buildings. This exercise is carried out each year at the end of the financial year. This year, the Trust asked the valuer (Gerald Eve) to consider the implications of valuing our land and buildings on an alternative site basis using the modern equivalent asset concept, which is in line with HM Treasury guidance.

This has led to a substantial downward revaluation in the net value of our land and buildings. The full impact on the income statement

Table 3: Cash flow

	2015/16 £ million	2014/15 £ million	Change £ million
Operating surplus/deficit	-6	51	-58
Net non-cash transactions	121	42	80
Net cash	115	93	22
Capital expenditure	-104	-130	26
Proceeds from sale of property plant and equipment	1	–	1
Financing	-28	34	-62
<b>Net change in cash</b>	<b>-16</b>	<b>-3</b>	<b>13</b>
Opening balance	133	136	2
Closing balance	117	133	16

is £154 million – a £51 million impact on the operating surplus for the year (see above) and a further net £103 million adjusted for within the statement of financial position and reflected below the operating surplus for the year on the Trust's income statement.

These changes – referred to as impairments – do not reflect any physical damage to our land and buildings, or loss of utility or any financial loss, and they have no implications for patient care.

More details can be found in note 16 to the accounts on page 121.

## External audit services

In 2015-16, the Council of Governors appointed KPMG to be our external auditors, following a tendering exercise. Their contract will run for three years, with an optional two year extension prior to retendering. For 2014-15, the previous financial year, our external auditors were Deloitte LLP.

KPMG's opinion on the financial statements of Guy's and St Thomas' Accounts can be found in the Annual Accounts on page 99.

KPMG received £115,000 in audit services fees in relation to

the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2016.

KPMG have served as the Trust's tax advisors for a number of years. Following a tendering exercise, the Trust reappointed KPMG to this role in 2015-16 on a three year contract with a two year extension. In 2015-16, the Trust paid KPMG £279,000 for these services.

For more details, see note 5.2 to the accounts on page 113.

## Events since the end of the financial year

There have been no events since the end of the financial year which have a bearing on the analysis of the performance of the Trust.

## Identifying potential financial risks

In 2016-17, the Trust faces a number of financial risks which are listed below and then described in some detail individually with their agreed mitigating strategies:

- achieving the required efficiency savings for 2016-17;
- failure to secure an adequate contract with NHS England;

- the ability of our commissioners to afford forecast increases in activity levels;
- local authority funding reductions;
- the Trust's physical capacity to deliver activity to the required standards and activity levels;
- the costs of implementing the move towards seven-day services;
- delivering the Trust's commitments under the Sustainability and Transformation Fund.

### Efficiency savings for 2016-17

Broadly, the Trust plans to achieve an underlying break-even target in 2016-17.

As in previous years, this will involve substantial efficiency savings – some 8-9% of the Trust's cost base on which savings can be made. Two thirds of the efficiency savings have been identified. There is a risk that we do not identify additional efficiency savings, or that we cannot deliver the identified efficiency savings at the pace required.

To manage this risk, the Board has agreed to move proactively into internal financial 'turnaround' to build momentum and ensure targets are again delivered.

While the Board recognises that this must be led and delivered by senior Trust staff, these efforts will be supported by external expertise as required.

Turnaround will particularly focus on:

- ensuring an effective framework for the delivery and monitoring of the efficiency programme;

- a refreshed *Fit for the Future* programme;
- implementing the lessons of the Carter Productivity and Efficiency Review;
- implementing agency price caps and rules;
- further procurement efficiencies.

### Contract with NHS England

In 2016/17, the Trust expects to receive nearly 40% of its income from NHS England – mainly for specialist services, but also for dental, armed forces and public health services.

Ongoing negotiations with NHS England include:

- activity levels for specialist services;
- CQUIN funding;
- national waiting times targets.

If the contract negotiations cannot be successfully concluded we will seek mediation or arbitration.

### Commissioner affordability

While the Trust has agreed contracts with a number of local commissioners, progress with non-local commissioners has been slower. The main issue with non-local commissioners is a reluctance to fund activity growth in the contract.

Currently, commissioners do not appear to be able to fund the activity required to deliver national waiting times targets.

To manage this risk we expect to have full cost and volume contracts with commissioners, and we will expect all over performance to be paid.



## Local authority funding reductions

The Trust has been notified by Lambeth and Southwark local authorities that there is significant pressure on their public health budgets and that they require significant costs savings in 2016-17, and also in the subsequent two years.

The Trust has requested that they set out the scale of the savings required so that we can fully understand the risk to services.

Clinical services affected are now working in partnership with them to minimise the impact on service provision, service quality, population health and staff numbers. This particularly impacts sexual health, health visiting, school nursing and health promotion services.

## Capacity

The Board has identified five critical factors that affect our ability to deliver the activity levels forecast for 2016-17:

- **Workforce:** we need to recruit and retain sufficient staff to make optimum use of our facilities. The areas of particular focus are: theatres; nursing staff; critical care; district nursing; community rehabilitation teams; and clinicians in some of our highly specialised areas. Planned increases in NICU and children's critical care are similarly dependent on recruitment.
- **Capital schemes:** our plan for next year is predicated on the timely delivery of the following capital schemes affecting clinical services: new operating theatres, the redevelopment of the Emergency Department at St Thomas' and the

completion and opening of the new Cancer Centre at Guy's. Any delays may adversely affect our ability to sustain waiting time standards.

- **Occupancy levels:** all services are expected to operate at high levels of occupancy with implied productivity gains of 2-3%. This means that opportunities to exceed planned levels of activity are limited. Downside risks, such as disruption to normal activity, are much higher.

- **Urology and ENT:** these services are pivotal to meeting referral to treatment and cancer waiting time standards. They face particular challenges in treating increased volumes of patients.

- **Bed demand:** we have positive evidence of achieving efficiency in bed utilisation in 2015-16. The development of our @home and Enhanced Rapid Response community services has been critical. For example, we have managed a 37% increase in emergency admissions in over 75 year olds within our current bed capacity. We are consolidating these developments in 2016-17 with our commissioners' support and investment. However, continual pressures on social care provision are expected to further increase delayed transfers of care for medically fit patients who are ready to leave hospital, increasing pressures on beds.

## Cost of implementing the move towards seven-day services

Our Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator

(SHMI) performance are better than the national average, and we do not have a significant difference between weekday and weekend mortality performance. However, the Trust has made additional investment to support seven day services. For example, seven day endoscopy was introduced in 2015-16.

Affordability within the Tariff is a key constraint but our priorities for further investment include: radiology, to increase access to consultant-led diagnostic services such as MRI scans at weekends; a range of initiatives in critical care; further increases in the use of extended days and weekend operating lists for planned (elective) care; an increase in weekend obstetric cover; and further development of community services and services in patients' homes to reduce pressure on hospital services.

## The Sustainability and Transformation Fund

Funding secured under the Sustainability and Transformation Fund presents two risks:

- uncertainty about the additional costs of meeting the conditions attached to funding, including waiting times and CQUIN targets which may be threatened by other risks identified above;
- failure to fully meet all the conditions associated with the Sustainability and Transformation Fund, including performance trajectories and other conditions, which may mean that payment of up to £19.2 million is withheld.

# Performance analysis – sustainability and environmental

## Environmental impact performance indicators 2015/16

Area	2015/16	2014/15	% change		2015/16	2014/15	% change
<b>Finite resources</b>							
Water	548,651 m <sup>3</sup>	510,977 m <sup>3</sup>	7%	Water £	£937,874	£838,239	12%
Imported electricity	152,614 GJ	137,409 GJ	11%	Energy £	£10,236,200	£10,173,293	1%
Gas	642,986 GJ	523,914 GJ	23%				
CO <sub>2</sub> emissions from building energy use	54,133 tonnes	47,435 tonnes	14%				
<b>Waste</b>							
High temperature disposal	444 tonnes	410 tonnes	8%	Total waste cost £	£1,024,968	£961,059	7%
Alternative treatment (offensive waste)	1,556 tonnes	1,435 tonnes	8%				
Landfill waste	19 tonnes	15 tonnes	27%				
Recycling – by % of total	32%	30%					

The Trust remains committed to acting sustainably to minimise our environmental impact. Guided by our sustainability strategy, we have made significant progress with our aim to be one of the most sustainable healthcare organisations in the UK.

We have reduced our carbon emissions by 15% since 2007, exceeding the NHS target of a 10% reduction by 2015, and we remain on track to make further significant reductions. This progress is despite an increase in consumption in 2015/16 due to a significant increase in activity and operating hours. Through one of the most ambitious energy performance contracts (EPCs) in the NHS, the Trust is investing £10 million in energy saving initiatives across our hospitals. These initiatives will reduce carbon emissions by a further 11% when completed in 2018. This programme will improve the patient environment through better temperature controls and improved lighting. It will also deliver savings of £1.3 million each year.

Our award-winning water saving programme has reduced usage when compared with like for like activity through the elimination of leaks and the installation of water saving technology and controls. These changes are part of our ongoing partnership with Aquafund, a national water management scheme.

The Trust was awarded the Carbon Trust's Standard for Waste in 2015 in recognition of our work to reduce and correctly handle waste, receiving the highest score ever achieved. We currently recycle 32% of our waste (and 56% of our non-medical waste), and we continue to provide waste management training to our staff to improve this further.

Our used cooking oil is converted into biodiesel locally, and waste is transported by barge to local facilities and used to generate electricity. 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.

The Trust encourages staff to lead healthy, active lives and provides facilities for patients, staff and visitors who cycle to work. This year, the Trust has increased cycle parking at Guy's by 50% and at St Thomas' by 35%. We provide cycle maintenance and safety checks for staff, as well as bike marking and road awareness training.

## Equality and diversity

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

Our equalities objectives set out our priorities to drive improvements in patient care, staff experience and reduce inequalities for our diverse workforce and patient population.

We are legally required to consider whether our services meet the needs of people regardless of their age, disability, ethnicity, gender, race, religion or belief, and sexual orientation, in accordance with the Equality Act 2010 and our public sector equality duties.

This year, we will be setting new four-year equalities objectives, in consultation with staff and with local health partners and endorsed by the Board of Directors. These priorities aim to drive improvements in patient care, staff experience and reduce inequalities for our diverse workforce and patient population. These objectives will include:

- working in partnership with our local authorities, for example through Health and Well-being Boards;
- improving the provision of accessible information and the way that we communicate with patients;
- helping vulnerable people to participate in public life by widening access to employment and new skills;
- ensuring that our facilities and services are accessible to all who need to use them.

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

We also recognise the importance of respecting and protecting the human rights of our patients, staff and 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 2010, 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.

**Amanda Pritchard**

Chief Executive

25 May 2016



The majority of services in St John's Institute of Dermatology were recently moved to a specialist centre at Guy's Hospital. A lot of the patients treated in the new centre require input from different clinical specialities. By locating services together, healthcare professionals can collaborate closely, alongside academic and research teams, to improve patients' care and experience.



# 3

## Accountability report

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More than 50% of the care we provide is for people living in Lambeth and Southwark. Working with London Ambulance Service our @home service provides intensive medical care in people's homes so they don't have to go into hospital, or the service helps them to leave hospital sooner.

## Directors' report 2015-16

Guy's and St Thomas' has performed well both operationally and financially during 2015-16 which was another busy and demanding year. We have worked hard to balance high quality patient care with achieving our performance targets in a challenging financial environment.

The Trust continued to deliver excellent patient care, whilst driving forward quality and service improvements, including our ambitious capital programme, for the benefit of our patients. We have also maintained a strong financial position which has allowed us to continue to deliver our ambitious capital programme.

Our staff have worked hard to achieve national and local targets and measures and to comply with the requirements of our regulators, the Care Quality Commission and Monitor. We continue to work closely with our local clinical commissioning groups, with specialist commissioners and with our local Health and Well-being Boards in a rapidly changing external environment.

### Delivering high quality care

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

The Trust's services were assessed by the CQC in September 2015, and we were pleased to achieve an overall rating of 'Good'. This is a significant achievement given the size and complexity of the Trust, and is a tribute to the commitment and effort of staff across the organisation. The Trust was rated 'Outstanding' for caring services, and 'Good' for effectiveness, responsiveness, and being well-led.

We were delighted that Evelina London Children's Hospital and the Emergency Department (A&E) at St Thomas' were rated 'Outstanding'. Evelina London is the first

children's hospital in the country to receive an 'Outstanding' rating. The Emergency Department's 'Outstanding' rating is a significant achievement at a time when our A&E is busier than ever and staff are maintaining 24/7 emergency care during a major redevelopment project.

The CQC rated us as 'requires improvement' for safety and also highlighted three areas where the Trust needed to take action: consistently documenting venous thromboembolism (VTE) risk assessments in maternity; midwifery staffing levels in the Antenatal Day Assessment Unit (ADAU); and improving the effectiveness of governance links between surgical directorates. The Trust developed a detailed action plan to address these issues, most of which were completed by April 2016, and reported on at our Quality Summit.

Detailed action plans are also in place to respond to the additional recommendations made by the CQC in their inspection. These include improving the way that we assure safety, including through the consistent application of all five steps of the WHO surgical safety checklist and by consistently sharing the outcomes and learning from incidents.

The Trust continues to perform well in the Patient Led Assessments of the Care Environment (PLACE). Last year, we achieved a score of 99.75% for cleanliness, with the other elements measured also scoring strongly.

Sustaining operational performance against a wide range of national and local measures and Monitor's compliance framework remains an enormous challenge. It

requires a sustained effort from frontline staff and managers, and we work hard to support them, for example through weekly 'Safe in our Hands' briefings, monthly team briefings and the Trust's *Fit for the Future* programme, which brings together visible clinical leadership and improvements in quality, safety and efficiency.

In 2014-15, the Trust benefited from an external review of the performance and effectiveness of the Board, and this year we have implemented its recommendations to further enhance the Board's capability and culture. The Board has also assessed its compliance with the principles of the NHS Foundation Trust Code of Governance, including regular review of the make up and responsibilities of Board Committees and their terms of reference. Further details can be found in the Organisational Structure chapter on page 47 and in the full Compliance Statement on the Trust website.

The Trust's Quality and Performance Committee monitors the delivery of the Trust's quality priorities which have been developed in consultation with stakeholders from our local community. These are described fully in the quality report on pages 65 to 95.

The Committee also monitors the full range of clinical and non-clinical performance indicators which are reported monthly through the Integrated Quality and Performance Report (IQPR). This report is published on the Trust website and this, together with regular updates to 'Our Quality Story', ensures that we are open

and transparent about our performance. It is also scrutinised alongside the quality report by the Trust's external auditors as part of a rigorous assurance process.

We continue to work hard to reduce hospital infections and retain a sharp focus on quality, safety and clinical effectiveness, including through the objectives we have agreed with local stakeholders. These objectives are also informed by complaints and feedback that we receive from patients, families and carers.

We take complaints very seriously as they form a crucial part of our learning from patient feedback. We have received complaints related to clinical care and to other aspects of patient experience such as patient transport, catering and the attitude of staff.

This year, we have reviewed our principles for handling complaints to ensure that they reflect best practice and that complainants feel confident to speak up, knowing that they will be listened to. We know we can do more to improve the quality and timeliness of our complaint responses. In the coming year, we will continue to improve the management of complaints and have included this as a priority in our Quality Accounts.

The CQC inspection report, a wide range of performance measures and patient feedback, all provide valuable information about where and how we can improve care for patients. We use this information to drive improvement across the Trust, with close oversight from the Board of Directors and our Council of Governors.

## Our local and wider role

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

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

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 dental, 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. 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.

Evelina London Children's Hospital is developing a comprehensive

network of specialist children's services across south east England. By supporting expert care closer to home and improving access to our full range of specialist services, Evelina London will provide better care to children and young people, particularly those with complex clinical needs.

Until April 2016, the Trust was an active member of the London Cancer Alliance (LCA), working together with other providers in south and north west London to further develop high quality, integrated cancer services. Since the dissolution of the LCA, the Trust has played an instrumental role in the creation of an Accountable Clinical Network for cancer services in south east London, again with the ambition to improve care and outcomes for cancer patients.

Last year the Trust also continued to contribute to the work of Southwark and Lambeth Integrated Care (SLIC) – a partnership between local GP federations, trusts, clinical commissioning groups and our local authorities in Lambeth and Southwark, as well as people living in the two boroughs.

Set up in 2012, the four-year programme was supported by Guy's and St Thomas' Charity and brought together staff from health and social care, local residents and services users to improve the way that care is delivered.

For example, through the programme more than 3,000 people were able to remain independent in their own homes supported by the Trust's Enhanced Rapid Response and @home services, and many patients

benefited from improved care coordination and innovative falls prevention services.

The Trust continues to contribute to Lambeth and Southwark Health and Well-being Boards, which are responsible for overseeing the future planning of health and social care services for adults and children. More recently, we have been working closely with our local authorities in Lambeth and Southwark to address the challenges presented by the Government reductions in public health grants.

We work closely with Healthwatch in both boroughs and meet regularly to keep them informed of potential service changes and to discuss the Trust's progress in delivering our quality objectives.

In the last year, Healthwatch have used their powers to 'enter and view' services to observe and report on the delivery of care and the care environment. This year, Healthwatch Lambeth visited the Older Persons Unit at St Thomas' Hospital, while Healthwatch Southwark undertook a series of visits to the Emergency Department to learn about patients' reasons for attending the department and their experience of the service. All these visits were a positive experience and welcomed by the Trust.

The Trust did not conduct any formal public consultations on service changes during 2015-16 and there have been no significant variations to services that have required the Trust to consult our local Overview and Scrutiny Committees in the last year.



As part of the *Our Healthier South East London* initiative, and through other discussions with our commissioners, the Trust may be involved in public consultation about potential changes to sexual health and orthopaedic services during 2016-17.

The Trust has a strong commitment to involving patients, families and carers, as well as members of our Foundation Trust, in the delivery and development of services, and we believe the voice of patients should be ever-present in our organisation. We continue to implement our three-year patient and public engagement strategy.

Our Patient Insight Forum, a group of Foundation Trust members, patients and governors, continues to be very active, taking part in activities such as mystery shopping and our Patient Led Assessments of the Care Environment (PLACE).

At a service level, patients have helped to develop plans to introduce new video and telemedicine technology in the intensive care unit, and to support dermatology patients in self-management of their condition, but with rapid access to expert clinical advice when needed.

### System leadership

Further afield, the Trust has been providing support to Medway NHS Foundation Trust through a buddying agreement. Work has focused on improving clinical governance, clinical leadership, the medical pathway and professional nursing. This support will continue in 2016-17.

In September 2015, the Trust and Dartford and Gravesend NHS Trust successfully bid to be one of the acute hospital partnership vanguards for the 'NHS New Models of Care Programme'. This will generate one of the first Foundation Healthcare Groups, with the two trusts working together to improve healthcare services for patients in Dartford and Gravesend. The planned governance structure will enable clinical and corporate support services to be shared and provided across sites.

The Trust continues to play an active role in the *Our Healthier South East London* programme, and our Chief Executive has been asked to lead the development of the south east London Sustainability Transformation Plan, further demonstrating our active leadership and support for the wider health economy.

### King's Health Partners

The Trust remains a committed member of King's Health Partners, our Academic Health Sciences Centre (AHSC). Working closely with our colleagues at King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London, we use our combined clinical, research and educational strength and expertise to benefit our local communities and our patients nationally and internationally.

The 21 Clinical Academic Groups (CAGs), which are at the heart of King's Health Partners, continue to drive quality improvement, value and innovation. For example, this year we have made good progress in

delivering our strategies to tackle smoking and alcohol misuse. All hospital sites across the partnership are now smoke-free, with the university due to follow our lead shortly.

This year, we were delighted that King's Health Partners was awarded Comprehensive Cancer Centre status by the Organisation of European Cancer Institutes (OECI) in recognition of our collective excellence in patient care, research and training. We became only the third organisation in the UK to be given this status.

The King's Health Partners Mind and Body programme continues to drive improvement in integrating mental and physical health across the partnership. The IMPARTS programme to screen patients in outpatient clinics for depression and anxiety is now available in 28 services across Guy's and St Thomas' and King's College Hospital.

King's Health Partners' pioneering informatics work is supporting the connectivity of services across our AHSC. KHP Online, which links up electronic patient records across our three trusts, has been rolled out to primary care colleagues, connecting our trusts with local GP practices.

Now known as the Local Care Record, this allows clinicians across Lambeth and Southwark to see real-time patient information securely and quickly, and is supporting improved clinical decision making.

In October 2015, the AHSC partners began a process to explore how we might bring together our partnership's collective strength in a number of specialties to deliver

world-class patient care and research through the creation of a number of Institutes.

It is early days, but we believe that by working together with our local health and care partners to develop improved networks of care, we can deliver better care for patients, pioneering research, successful integration of mental and physical health, and greater value for money in the services that we provide.

Our research activities continue to grow. As a founding member of the South London NHS Genomic Medicine Centre, we are helping to deliver the ground-breaking 100,000 Genomes Project.

In the last year, all three AHSC trusts increased their number of clinical research studies, and Guy's and St Thomas' topped the London league table for the overall number of studies.

King's College London, our academic partner, is now ranked eighth in the world for clinical, pre-clinical and health in the Times Higher Education world rankings, building on the outstanding results achieved in the 2014 Research Excellence Framework.

Our shared education agenda has also been moving forward with the growth of the King's Health Partners Learning Hub. We have added over 30 online resources in the past year and the hub now offers staff across the partnership access to a wide range of free e-learning materials.

Overseas, the AHSC's Sierra Leone Partnership continues to work with partners to help rebuild the local health system following

the Ebola outbreak in West Africa. The partnership's crucial role in responding to the Ebola crisis has been recognised through a number of national awards, and we are immensely proud of our staff who volunteered to be part of the programme.

### Investing in our future

The Trust continues to make substantial capital investments in modern, high quality medical equipment to ensure patient safety, in IT systems to improve the efficiency of our services and in our buildings to enhance the environment for patients, visitors and staff.

It is heartening to hear positive feedback from local GPs in response to the introduction of the Local Care Record, which allows them to access electronic patient records in the Trust.

The 11 storey East Wing tower at St Thomas' has been given a new lease of life following a complete external refurbishment of the building using an innovative glazed facade that has both weatherproofed the building and improved its energy efficiency. It has also created two light and airy atria which are complemented by unique artwork, and added two new bed lifts to speed up patient movement between the intensive care units and wards in East Wing.

Last autumn, new admissions wards were opened on the ground floor as part of the Emergency Floor project. This has significantly improved the facilities for hundreds of patients every day who attend the hospital for emergency treatment. The programme of

work to develop the Emergency Floor continues and a new reception and treatment area will open in summer 2016.

We have completed the relocation of the St John's Institute of Dermatology to Guy's as part of an ambulatory centre for rheumatology, lupus and related diseases. Further investment has also been made in projects ranging from the installation of new MRI equipment at Guy's to the refurbishment of the historic chapel at St Thomas'.

Very good progress is being made on the new £160 million Cancer Centre at Guy's which will open to patients in autumn 2016. It will bring together the majority of cancer treatment and research for our patients. New, state-of-the-art radiotherapy and imaging equipment, combined with enhanced care, will ensure the best possible health outcomes.

In addition, the Trust will open a new Cancer Centre at Queen Mary's Hospital Sidcup in summer 2016, enabling many patients in south east London to receive radiotherapy and chemo-therapy closer to home.

The Evelina London Children's Hospital is seeing increasing numbers of patients every year, and we have begun a programme of work to increase our capacity. The new Emergency Floor has a dedicated children's short stay unit, and in the next year we will begin a major project to convert space currently used for offices into a new inpatient ward.

### Developing commercial partnerships

The Trust has a long tradition of innovation and we are committed to exploring commercial opportunities that will generate additional income to support the delivery of NHS services. We have one of the largest and most successful commercial teams in the NHS. A number of initiatives have progressed during the year, including:

- building a successful partnership with BOC Remeo to deliver satellite respiratory services;
- continuing to deliver our longstanding contract with the Ministry of Defence to provide a comprehensive range of hospital, primary and community health services to British Forces and their families in northern Europe, in partnership with the Soldiers, Sailors, Airmen and Families Association (SSAFA);
- developing our partnership with Diaverum to deliver renal services in south east London;
- developing our international programme, including ongoing work to support the development of healthcare services in Qatar.

The Trust has also developed a number of commercial organisations through which we can fully benefit from our intellectual property by capturing and developing innovations in patient care, including Cydar and Spot On. This year we formed Precision Diagnostic Analytics to support innovations in the use of ultrasound techniques in paediatric cardiology.

The Trust's wholly-owned subsidiary, GSTT Enterprises,

manages a company portfolio including Essentia Trading Ltd, our estates based consultancy company, as well as Viapath (through Pathology Services Ltd), our pathology joint venture with King's College Hospital and Serco. A full list of subsidiaries and interests in associates and joint ventures can be found in note 18 to the accounts on page 122.

## Board of Directors

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

In 2015-16, Board membership consisted of the following Executive Directors: Chief Executive (to September 2015) and Executive Vice Chairman, Ron Kerr; Chief Operating Officer, Acting Chief Executive (from October 2015) and Chief Executive (from 18 January 2016) Amanda Pritchard; Director of Finance, Martin Shaw; Medical Director, Ian Abbs; Chief Nurse and Director of Patient Experience and Infection Control, Eileen Sills; Director of Essentia (capital, estates and facilities), Steve McGuire; Director of Workforce and Organisational Development, Ann Macintyre; and Acting Chief Operating Officer (to cover maternity leave in April and May and from October 2015), Simon Steddon.

And the following Non-Executive Directors: Chairman, Hugh Taylor; Vice Chair, Diane Summers; Robert Drummond; Mike Franklin (to October 2015); Frank Nestle; Girda Niles; Priya Singh (from November 2015); Sheila

Better Payment Practice Code				
Measure of compliance	Year ended March 31 2016		Year ended March 31 2015	
	Number	£000	Number	£000
Total bills paid in the year	359,855	724,309	351,309	704,678
Total bills paid within target	280,039	532,342	246,460	480,773
Percentage of bills paid within target	78%	73%	70%	68%

Shribman; and Steve Weiner.

See pages 52 and 53 for biographies.

All of our Board of Directors meet the standards of the Fit and Proper Persons Test, there have been no declarations of interest which could be deemed to be a conflict of interest, and there have been no declarations of donations to political parties. Details of external directorships or other positions of authority held by the Directors of the Trust can be found in Note 29 (Related Parties) to the Annual Accounts.

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 on to the external auditors where appropriate.

The Trust complies with the requirement of the Better Payment Practice Code to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance against the code is set out in the table above.

The Trust meets the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health

and Social Care Act 2012) which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for other purposes. For full details see Note 1.3 to the Annual Accounts on page 106. Surpluses from other income that the Trust has received have been used to support the provision of goods and services for the purposes of the health service in England.

The directors confirm that the Trust complies 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.

**Amanda Pritchard**

Chief Executive

On behalf of the Board of Directors



Last year the Trust became the first in the UK to test all patients having a blood test in the Emergency Department routinely for HIV. Doctor and TV presenter Christian Jessen performed an HIV test on the Mayor of Lambeth to raise awareness of the importance of being tested.



# Remuneration report

## Chairman's Annual Statement

As the Chairman of the Remuneration Committee (the Committee), I am pleased to present our remuneration report for 2015-16.

A formal review of executive and senior management salaries was carried out during 2014-15 for the first time in six years, by independent management consultants, Hay Group. This review resulted in a prospective change to some executive salaries with effect from 1 April 2015. The Committee decided not to apply any cost of living increase to executive salaries for 2015-16. The last cost of living increase of 1% was applied with effect from April 2013.

During 2015-16, there have been a number of changes within the Trust's executive team. Sir Ron Kerr stood down from his role as Chief Executive of Guy's and St Thomas' NHS Foundation Trust with effect from 1 October 2015. On 1 October, Amanda Pritchard, previously Chief Operating Officer, became Acting Chief Executive and Accountable Officer and Dr Simon Steddon continued his role as Acting Chief Operating Officer. In January 2016, following a special meeting of the Council of Governors, Amanda Pritchard's appointment as Chief Executive and Accountable Officer was announced. Ron Kerr remains on the Trust's Board, in a part-time role, as Executive Vice Chairman, working closely with the executive team. These changes are reflected in the Annual Report on Remuneration.

I am pleased to confirm that during 2015-16, the Committee established the following Trust principles for the remuneration of senior managers:

### Very Senior Managers Pay Principles

The Trust is at a pivotal point in its development and is planning its future form and function to ensure effective leadership of the complex and growing organisation.

Strong leadership within the Trust has been identified as a key requirement to ensure safe, high quality, productive and compassionate care for our patients and local communities. Moreover, the Trust aspires to be the best NHS employer in the country, attracting and retaining motivated and talented staff.

With this in mind, the following key principles have been established for the pay of the Trust's senior managers so that the Trust is able to attract, motivate and incentivise top talent at this critical level of the organisation:

#### 1. Straightforward approach

The Trust's approach to pay for very senior managers will be simple, easy to understand and will stand up to scrutiny.

Appointment to the Trust's senior management will be on a fixed salary.

#### 2. Focus on base pay

While the focus is on base pay, the total remuneration package, including the value of pension benefits, will be considered, in particular versus the private sector.

Pension-related benefits accrued under the NHS Pension Scheme are the only non-cash element of senior managers' remuneration packages.

### 3. Focus on the market

The Trust is a large and complex organisation, when compared with other leading NHS multi-specialty academic healthcare organisations. The Trust recognises that it will be necessary to pay at the upper quartile of NHS salaries, when compared with similar organisations such as members of the Shelford Group (which represents ten of England's leading academic healthcare organisations) and similar private sector organisations. This will enable the Trust to attract and retain individuals with the appropriate experience to fulfil the Trust's senior managerial roles.

The Trust acknowledges that meeting these principles is likely to lead to a number of senior staff being paid more than £142,500. It is satisfied that this is justified.

Salaries will be formally reviewed every three years with annual interim reviews.

### 4. Focus on performance

The Trust's reward and performance systems are aligned with our values. A new performance development review system has been introduced for the Agenda for Change workforce that formally evaluates both what employees need to do and how they do it.

Consistent with this, the performance of the Trust's senior managers is managed through clear objective setting and regular performance reviews.

Pay will reflect the continuing value and sustained contribution of each individual senior manager. The Trust does not reward poor performance. While there is no current system for bonus payments, the Trust retains the option to withhold pay increases otherwise deemed appropriate if any aspect of a senior manager's performance has been lacking.

### 5. Focus on fairness

The Trust's pay system for senior managers will be evaluated and kept up to date to ensure that it delivers fair and consistent outcomes, eliminates discrimination, takes proper account of pay relativities across the Trust and meets the requirements of legislation.

### 6. Focus on sustainability

It is essential that the Trust's pay arrangements are affordable and sustainable, representing value for money to the Trust, based on both corporate and individual senior manager performance.

Finally, the Remuneration Committee will conduct an interim review of executive and senior management salaries in 2016-17, when consideration will also be given to a cost of living increase in light of the national 1% pay settlement, effective from 1 April 2016, awarded to the Agenda for Change and medical and dental workforce. There are currently no plans for changes to the Trust's remuneration policy for very senior managers in 2016-17.



**Sir Hugh Taylor**

Remuneration Committee Chairman  
25 May 2016

# Remuneration policy report 2015-16

## 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 all Non-Executive Directors.

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

$$\text{Salary} + \text{Pension} = \text{Total remuneration}$$

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

	Salary	Pension and Benefits
<b>Purpose and link to strategy</b>	<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 an individual's pension arrangements.</p>
<b>Operation</b>	<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 <i>Career Average Revalued Earnings</i> 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>
<b>Opportunity</b>	<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, the salary 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 2015-16 are set out in the single total figure table in the Annual Report on Remuneration.</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 <a href="http://www.nhsbsa.nhs.uk/pensions">www.nhsbsa.nhs.uk/pensions</a>. Details of the 2015-16 pension benefits of individual Executive Directors are available in the single total figure table in the Annual Report on Remuneration. Total pension entitlement for each Executive Director is available in the total pension entitlement table.</p> <p>A new external recruit will be eligible to join the NHS Pension Scheme. The main features of the 2015 Scheme include:</p> <ul style="list-style-type: none"> <li>• A Career Average Revalued Earnings (CARE) scheme with benefits based on a proportion of pensionable earnings each year during the individual's career</li> <li>• 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</li> <li>• Revaluation of active members' benefits in line with inflation, currently the Consumer Price Index (CPI) plus 1.5% per annum</li> <li>• A normal pension age at which benefits can be claimed without reduction for early payment linked to the state pension age</li> </ul> <p>In accordance with NHS Pension Scheme rules, the employer contribution rate is 14.3% from April 2015.</p>
<b>Performance measures</b>	<p>The overall performance of the individual is a consideration when reviewing salaries.</p>	<p>None.</p>

## Remuneration report

Salaries for senior managers are established and maintained taking the following elements into consideration the individual's role, experience and performance and independently sourced data for relevant comparable organisations. This includes consideration of salary levels at other members of The Shelford Group. Salaries for senior managers are formally reviewed every three years with annual interim reviews.

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' notice in the case of the Chief Executive.

The Trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

### 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 a 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.

### Annual Report on Remuneration 2015-16

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 Trust Development Authority.

### Remuneration Committee

The Remuneration Committee decides the pay, allowances and other terms and conditions of the Executive Directors and other senior managers, including directors' compensation in the event of early termination of contracts.

The Trust's Chairman is Chair of the Remuneration Committee and all Non-Executive Directors are members of the Committee.

Remuneration Committee membership and attendance 2015-16	
Name	Actual/Possible
Hugh Taylor	2/2
Robert Drummond	1/2
Girda Niles	1/2
Mike Franklin	1/1
Professor Frank Nestle	2/2
Priya Singh	1/1
Sheila Shribman	0/2
Diane Summers	2/2
Steve Weiner	1/2

The following individuals also attend the Remuneration Committee either regularly or as required:

Attendee	Regular attendee	Attends as required
Amanda Pritchard, Chief Executive	x	
Ann Macintyre, Director of Workforce	x	
Mark Hudson, Associate Director of Workforce		x
Catherine Briggs, Reward Manager		x

Other individuals may also be invited to attend Remuneration Committee meetings during the year. Executive Directors and other Committee attendees are not involved in any decisions, and are not present at any discussions regarding their own remuneration.

## Median Remuneration and Fair Pay Multiple

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:

Median Remuneration and Fair Pay Multiple		
	March 31 2016	March 31 2015
Highest paid director's total remuneration	£202,614	£253,267
Median total remuneration	£30,954	£34,651
Remuneration ratio	6.55	7.31

## Service contracts

The following table contains details of the service contracts in place during 2015-16 for Executive Directors:

Service contracts			
Executive Director	Date of service contract	Unexpired term	Notice period
Ian Abbs	Jan 2011	Open ended	6 months
Ron Kerr	Oct 2007	Open ended	3 months
Ann Macintyre	Nov 2009	Open ended	6 months
Steve McGuire	Apr 2003	Open ended	6 months
Amanda Pritchard	Apr 2012	Open ended	12 months
Martin Shaw	Oct 1998	Open ended	6 months
Eileen Sills	Feb 2005	Open ended	6 months
Simon Steddon	Oct 2014	Open ended	6 months



## Remuneration report

### Salary and benefits of senior managers

The following tables contain details of the salary and benefits of the Trust's senior managers in 2014-15 and 2015-16.

#### Single Total Figure 2015-16

Name	Title	Salaries and fees (bands of £5k) £000	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
<b>I. Abbs</b>	Medical Director and Director of Patient Safety	195–200	–	195–200
<b>R. Kerr *</b>	Executive Vice Chairman (from Oct 2015)	200–205	–	200–205
<b>A. Macintyre</b>	Director of Workforce and Organisational Development	150–155	22.5–25	170–175
<b>S. McGuire</b>	Director of Essentia	155–160	–	155–160
<b>A. Pritchard *</b>	Chief Executive (from Jan 2016)	180–185	27.5–30	210–215
<b>M. Shaw</b>	Director of Finance	155–160	2.5–5	160–165
<b>E. Sills</b>	Chief Nurse and Director of Patient Experience	170–175	5–7.5	180–185
<b>S. Steddon *</b>	Acting Chief Operating Officer (from Oct 2015)	100–105	–	100–105
<b>R. Drummond</b>	Non-Executive Director	15–20	–	15–20
<b>M. Franklin</b>	Non-Executive Director (until Oct 2015)	10–15	–	10–15
<b>F. Nestle</b>	Non-Executive Director	15–20	–	15–20
<b>G. Niles</b>	Non-Executive Director	15–20	–	15–20
<b>S. Shribman</b>	Non Executive Director	15–20	–	15–20
<b>P. Singh</b>	Non Executive Director (from 1 Nov 2015)	5–10	–	5–10
<b>D. Summers</b>	Vice-Chair	15–20	–	15–20
<b>H. Taylor</b>	Chairman	60–65	–	60–65
<b>S. Weiner</b>	Non-Executive Director	20–25	–	20–25

No senior manager received any taxable benefit, annual or long term performance bonuses in 2015-16 or 2014-15.

#### Single Total Figure 2014-15

Name	Title	Salaries and fees (bands of £5k) £000	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
<b>I. Abbs</b>	Medical Director and Director of Patient Safety	195–200	–	195–200
<b>R. Kerr</b>	Chief Executive	250–255	–	250–255
<b>A. Macintyre</b>	Director of Workforce and Organisational Development	145–150	–	145–150
<b>S. McGuire</b>	Director of Essentia	155–160	–	155–160
<b>A. Pritchard</b>	Chief Operating Officer (maternity leave from Oct 2014)	90–95	20–22.5	110–115
<b>M. Shaw</b>	Director of Finance	155–160	–	155–160
<b>E. Sills</b>	Chief Nurse and Director of Patient Experience	170–175	–	170–175
<b>S. Steddon</b>	Acting Chief Operating Officer (from Nov 2014)	90–95	–	90–95
<b>D. Dean</b>	Non-Executive Director (until June 2014)	5–10	–	5–10
<b>R. Drummond</b>	Non-Executive Director	15–20	–	15–20
<b>M. Franklin</b>	Non-Executive Director	15–20	–	15–20
<b>F. Nestle</b>	Non-Executive Director	15–20	–	15–20
<b>G. Niles</b>	Non-Executive Director	15–20	–	15–20
<b>S. Shribman</b>	Non Executive Director	15–20	–	15–20
<b>D. Summers</b>	Vice-Chair	15–20	–	15–20
<b>H. Taylor</b>	Chairman	60–65	–	60–65
<b>S. Weiner</b>	Non-Executive Director (from Jul 2014)	10–15	–	10–15

#### Pension Benefits of senior managers – 2015-16

Name/Title	Total accrued pension at age 60 at March 31 2016 £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 March 31 2016 £000	Cash equivalent transfer value at March 31 2015 £000	Real increase in cash equivalent transfer value during year £000	Cash equivalent transfer value at March 31 2016 £000
<b>A. Macintyre</b> Director of Workforce and Organisational Development	60	8	239	1,143	53	1,209
<b>A. Pritchard</b> Chief Executive (from Jan 2016)	36	9	142	423	33	461
<b>M. Shaw</b> Director of Finance	70	5	282	1,547	42	1,607
<b>E. Sills</b> Chief Nurse and Director of Patient Experience	68	6	271	1,241	40	1,296
<b>S. Steddon</b> Acting Chief Operating Officer (from Oct 2015)	32	0	127	491	1	500

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

\* In the Single Total Figure 2015-16 table on page 36 and the Pension Benefits table above we have used current job titles, although these have changed for Ron Kerr, Amanda Pritchard and Simon Steddon during the year. For an explanation of in year changes in responsibilities, see page 52 in the Organisational Structure chapter.

**Amanda Pritchard**

Chief Executive

25 May 2016



A patient on Husky Ward in Evelina London Children's Hospital.  
Last year we celebrated the 10th Birthday of Evelina London.

# 6

## Staff report

Last year, we employed around 15,000 staff, clinical and non-clinical, all of whom contribute to providing high quality patient care in our hospitals and across the local community. Our staff work hard to improve efficiency, to meet national and local quality and access targets, and to bring innovations in care to patients.

The majority of the Trust's staff are permanently employed clinical staff directly involved in delivering patient care. We also employ a significant number of scientific, technical and administrative staff who provide vital expertise and support. The table below provides a breakdown of our workforce.

### Staff numbers

Staff group	Permanently employed	Agency, Bank & seconded staff	Total March 2016
Administrative and estates	3,313	430	3,743
Ancillary staff	761	353	1,114
Medical and dental	1,805	66	1,871
Nursing, midwifery & health visiting staff	4,360	556	4,916
Nursing, midwifery & health visiting students	908	186	1,094
Scientific, therapeutic & technical staff	1,963	303	2,266
Social care staff	2	0	2
<b>Total</b>	<b>13,112</b>	<b>1,894</b>	<b>15,006</b>

The numbers above are the average number of staff (Whole Time Equivalent) employed at the Trust.

### Communicating with staff

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

We work hard to ensure all staff are aware of the issues affecting the organisation, such as ongoing changes to the NHS. The results of the 2015 national NHS staff survey demonstrate that the Trust has the highest level of staff engagement of any NHS provider in England. Staff engagement measures staff motivation, how involved staff are in change at work, and how likely they are to

recommend the Trust as a place to work, or receive treatment. During 2015-16 the Trust set up a Staff Engagement Steering Group, chaired by a Non-Executive Director, to give renewed direction to this work.

Our range of well-established communications channels include a monthly team briefing, a regular staff email bulletin and our intranet, GTi, which provides a central resource where staff can find policies, guidance and online tools. We hold regular face to face briefings on both clinical and management issues and produce a popular magazine, *The GiST*, for staff, patients and our Foundation Trust members.

We work closely with our staff representatives to ensure employees' voices are heard. The Joint Staff Committee meets

bi-monthly, acting as a valuable consultative forum. In addition, sub-groups have been established to look at policy and pay issues, and topics such as financial performance are regularly discussed.

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

### Staff survey

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

The staff survey in particular provides a valuable insight into the views of our staff, and during the last year the Trust has taken action to tackle concerns raised in the 2014 staff survey.

While the Trust scored well overall, it scored below the national average for *'staff feeling pressure to attend work when feeling unwell'*, and as a result a working group from Occupational Health, Staff Side and HR came together to revise the Sickness Absence Policy.

The *Speaking Up Campaign* helped address a need to improve *'staff receiving support from immediate managers'*. The Campaign engaged all managers to communicate new ways for staff to raise concerns.

A number of initiatives have also been taken to improve Trust's score on *'communication between senior*

*management and staff'*, including regular Executive Directors 'out and about' visits, 'It's your call' interviews connecting Executives and staff, and CQC and finance related drop in sessions where Executive Directors answered staff queries about the CQC inspection and our financial recovery programme.

In the 2015 survey, staff reported significant improvement in these areas.

This year, the Trust opted to invite all its staff to participate in the NHS staff survey. The areas of best and weakest performance are shown in the table on page 41.

The results for 2015 show that the Trust continues to perform well overall. Of the 29 key scores identified in the survey, the Trust was rated above average in 23 scores. On a scale of one to five, staff rated the Trust at 4.22 as a place they would recommend to work or receive treatment – well above the national average for staff in similar trusts, which is a score of 3.71.

We will continue to work with staff representatives to address issues raised by staff and to focus on key areas for improvement highlighted in the 2015 survey including:

- raising the response rate to the NHS staff survey;
- addressing concerns about equality in career progression;
- ensuring a focus on safety.

In addition to overall Trust survey results, directorates receive a breakdown of their scores so that they can develop local action plans to respond to the survey results in their area.



## Staff survey

	Trust	2015 National average	Trust	2014 National average	Trust improvement/ deterioration
Response rate	33%	41%	35%	43%	Deterioration
<b>Areas of best performance</b>					
Effective use of patient/user feedback	3.98*	3.65*	74%	56%	Question and scoring has changed
Staff recommending the Trust as a place to work or receive treatment	4.22*	3.71*	4.17*	3.67*	Improvement
Percentage of staff reporting good communication between senior managers and staff	42%	30%	34%	30%	Improvement
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.92*	3.71*	3.70*	3.54*	Improvement
<b>Areas of weakest performance</b>					
Percentage of staff experiencing discrimination at work in the last 12 months	14%	10%	19%	11%	Improvement
Percentage of staff working extra hours	75%	72%	70%	71%	Deterioration
Percentage of staff believing the Trust provides equal opportunities for career progression	84%	87%	84%	87%	No change
Percentage of staff reporting witnessing potentially harmful errors, near misses or incidents in the last month	30%	29%	35%	34%	Improvement

\*Scored out of 5

Note: In 2015 new comparator groups were introduced. Until 2014, the Trust was compared with other acute trusts. From 2015, the Trust was compared with other trusts providing both acute and community services.

## Equality and diversity

We serve diverse local communities in Lambeth and Southwark. This diversity is reflected in the profile of our patients and workforce, and brings many benefits. The Trust remains committed to providing services and employment opportunities that are inclusive across all strands of equality – age, disability, gender, ethnicity, race, religion and belief and sexual orientation – in accordance with the Equality Act 2010 and our public sector equality duties.

Our equality objectives have been developed in consultation with our staff and local health partners, and have been endorsed by the

Board of Directors. These objectives set out our priorities to drive improvements in patient care, staff experience and reduce inequalities for our diverse workforce and patient population.

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

The Trust continues to develop fair recruitment practices to ensure equal access to employment opportunities for all. We use the 'two tick' symbol on recruitment materials, signifying our positive attitude towards recruitment of

disabled people, and we continue to support disabled staff, including anyone who becomes disabled during their employment.

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

- a dyslexia support group to support staff with learning difficulties to develop their own coping strategies with training provided by the British Dyslexia Association;
- a strategy widening access to employment and skills to help homeless people and those with disabilities into jobs;

- an expanding range of apprenticeships involving teams and departments across the Trust;
- a growing work placement programme which was recognised by the Mayor's Fund for London as Work Experience Placement Provider of the Year 2015;
- a vibrant network to support lesbian, gay, bisexual and transgender (LGBT) staff – in 2015, the Trust was named as a healthcare leader by Stonewall, the charity which campaigns for LGBT equality;
- assistive technologies for staff who are sensory impaired, or have other learning difficulties.

Staff group	Gender		Total
	Male	Female	
Executive Directors	4	3	7
Other senior managers	102	167	269
Employees	3,572	10,417	13,989

Number of staff employed on March 31st 2016.

The Trust participates in the Department of Work and Pensions' Access to Work scheme. This scheme supports staff to return to work after a period of ill health or who have developed a disability. The Trust provides guidance to managers and all staff on the scheme and funding to make reasonable adjustments in the workplace. Our occupational health team also has a dedicated rehabilitation nurse manager to support staff who develop physical disabilities during their employment.

The Trust remains committed to providing equality of opportunity at all levels. The table above shows the breakdown of staff by gender at levels within the organisation.

### A safe working environment

We place a strong focus on health, safety and well-being and we are committed to providing a safe and supportive environment for staff, patients and visitors in our hospitals and community facilities.

The Trust induction programme delivers health and safety training to all staff. Staff also receive tailored training relevant to their role. In 2015, the Board approved a new health and safety strategy to ensure the effective management of non-clinical risk across the organisation. A new health and safety committee, chaired by the Director of Workforce, has been established to oversee the implementation of this strategy and will report progress to the Board.

We know that our staff value initiatives which support their health and well-being. We offer a wide range of opportunities for staff to get healthy at work through our '5 Ways to a Healthier You' programme. This year, we have extended the programme to offer additional support with nutrition and weight loss, self-referral physiotherapy, access to cognitive behavioural therapy for mental well-being and staff counselling via the Employee Assistance Programme. The Trust is now a 'no smoking' Trust and we provide support to staff through our smoking cessation services.

Our occupational health service remains one of the largest in the country, employing a multi-disciplinary team of doctors, nurses, safety specialists and administrative staff. It not only serves our staff but also has contracts to provide

Staff sickness absence		
	2015/16	2014/15
Total days lost	97,016	91,710
Total staff years	12,692	12,177
<b>Average working days lost (per WTE)*</b>	<b>8</b>	<b>8</b>

\*WTE = Whole Time Equivalent

The sickness absence figures are reported on a calendar basis, rather than the financial year. These statistics are published by the Health & Social Care Information Centre (HSCIC), using data drawn for January 2015 to December 2015 from the ESR national data warehouse. The latest publication, which covers up to December 2015, can be found on the website of the Health & Social Care Information Centre.

services to over 70,000 employees in local and national businesses. It was the first NHS hospital service to gain accreditation under the Safe, Effective, Quality Occupational Health Service (SEQOHS) scheme in 2011.

Our occupational health services include pre-employment screening, work-related health checks, vaccination and immunisation programmes and advice on reducing risks in the workplace. We also offer guidance to staff and managers to manage sickness absence and support return to work. The Trust has been a pilot for the Department of Work and Pensions Fit for Work scheme, trialling fast-track health assessment for staff experiencing long term sickness absence. The pilot is being evaluated to measure its benefit.

The Trust offers a flu vaccination programme to all staff. In 2014-15, over 6,500 staff received the vaccination, representing 58% of frontline staff. The programme was championed by senior managers and our Chief Nurse was a flu champion and peer vaccinator for the programme.

## Countering fraud and corruption

The Trust is committed to ensuring the best use of NHS resources. All staff have access to our counter fraud policy and procedure through the Trust-wide intranet and receive fraud awareness as part of the Trust induction programme. A counter fraud specialist works within the Trust's internal audit team to provide guidance and support to staff who raise concerns and conduct investigations.

## Agency staff

As part of a national initiative, we have made good progress in reducing the use of agency staff and in being compliant with NHS Improvement's agency 'cap' rates which set maximum pay levels for agency staff. We will continue to apply pressure to further reduce expenditure while still providing safe clinical care.

We have implemented procedures to monitor and report on agency spend and to reduce the number of breaches of the cap. Reported breaches are reducing weekly and we will continue to

develop plans to address this.

The Trust has seen a significant reduction in the amount spent on agency staff compared with previous years, and expects this to reduce further as agencies reduce their rates in line with the NHS Improvement rules.

Other initiatives, such as restrictions on using band 1 to 4 agency staff, have also delivered significant savings.

The majority of our temporary staff come through framework agencies. We are working directly with other agencies to renegotiate rates so these are compliant with the current and future capped rates, and we have amended our preferred supplier list accordingly.

Directorates that currently use temporary staff have also been developing local plans to minimise their reliance on temporary staff.

We regularly communicate with staff about temporary staffing controls and we have a governance structure in place to monitor cap breaches for agency and contractor staff, as well as compliance with maximum expenditure levels for nursing staff.

### 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 in 2015-16.

The Trust has needed to engage a number of contractors to support fixed term assignments in areas such as information technology and asset management on an off-payroll basis.

The number of contractors engaged is shown in the tables opposite where daily rates exceed £220 per day and the engagement has lasted longer than six months.

All the existing engagements outlined have been subject to an assessment as to whether assurance needs to be sought that the individual is paying the correct amount of tax. Where necessary,

assurance has been sought from the individual.

See opposite for details of the action that has been taken to obtain assurance from new off-payroll engagements.

### Expenditure on consultancy

Expenditure on consultancy in 2015-16 was £1,088,000.

## High paid off-payroll engagements

All off-payroll engagements where daily rates exceed £220 per day and the engagement lasted for longer than six months	
All off-payroll engagements at 31 March 2016, that exceed £220 per day and that have lasted for longer than six months	15
Number that have existed for between one and two years at the time of reporting	3
Number that have existed for between two and three years at the time of reporting	2
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	1
Please confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Yes

All new off-payroll engagements, or those that reached six months in duration, in 2015-16 where daily rates exceeded £220 per day and the engagement lasted for longer than six months	
Number of new engagements, or those that reached six months in duration in 2015-16	17
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	17
Number for whom assurance has been requested	17
Number for whom assurance has been received	11
Number for whom assurance has not been received*	6
Number that have been terminated as a result of assurance not being received	0

\*These are cases where an individual leaves after assurance is requested, but before assurance is received, or where the Trust is still waiting for information from the individual at the time of reporting.

### In any cases where, exceptionally

– the Trust has engaged staff without including contractual clauses allowing the Trust to seek assurance as to an individual's tax obligations;  
– or where assurance has been requested and not received, without a contract termination, please specify the reasons for this.

In no case has assurance been refused. Those who have not provided assurance to date have failed to respond, and action continues to obtain assurance from them.

Off-payroll engagement of Board members and/or senior officials with significant financial responsibility in 2015-16	
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility	0
Number of individuals that have been identified as Board members and/or senior officials with significant financial responsibility	67





Our security team were highlighted for their positive contribution to the Trust by the Care Quality Commission in their recent report following an inspection of hospital and community services in September. The Trust was rated as 'good' overall.

# Our organisational structure:

## Disclosures set out in the *NHS Foundation Trust Code of Governance*

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

It has a number of statutory duties, including appointing the Chairman and Non-Executive Directors, deciding on their remuneration as well as ratifying the appointment of the Chief Executive. The Council of Governors holds the Non-Executive Directors to account individually and collectively for the performance of the Board of Directors. The Council of Governors also receives the Trust's Annual Report and Accounts and the Auditor's Report, and contributes to the Trust's annual business planning process.

The Council of Governors runs a Membership Engagement and Development working group which facilitates Governors' consultation with their members. The Trust responds to ad-hoc requests and encourages the public to attend our Annual Public Meeting in September. The Council of Governors also runs a Service Strategy working group which is the main vehicle for the Trust to discuss plans with Governors.

This year the Council of Governors approved the appointment of the Chief Executive, Amanda Pritchard, in a meeting chaired by the Trust Chairman, Hugh Taylor.

The patient, public and staff members of the Council are elected from and by the Foundation Trust membership to serve for three years. They may stand for re-election for second and final term.

Elections for new governors in the public, patient and staff constituencies took place in

Spring 2015 with 14 places available in total. In addition some of the organisations we work most closely with nominate stakeholder governors: four new stakeholder governors were appointed in 2015.

There are 31 governors at the present time. During 2015-16, two governors received expenses totalling £128.50. See page 49 for a full list of governors.

### Code of Governance

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. It keeps its governance arrangements under regular review, including membership of Board Committees, their terms of reference and Board performance assessments. 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.

### Nominations Committee

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

This year, the Nominations Committee approved the reappointment of Girda Niles for a further term as Non-Executive Director from 31 December 2015. The Committee also appointed Priya Singh as Non-Executive Director to replace Mike Franklin from 1 November 2015. In addition, the Committee noted the replacement of Frank Nestle as the King's College London nominated Non-Executive Director by Reza Razavi from May 2016.

### Members of the Nominations Committee\*

Name	Role
John Chambers (from Oct 2015)	Staff Governor
Dawn Hill (until June 2015)	Patient Governor
Tom Hoffman	Public Governor
Hugh Taylor	Chairman
David Treacher (until June 2015)	Staff Governor
Warren Turner	Stakeholder Governor
Paula Young (from Oct 2015)	Patient Governor

\*The Nominations Committee is serviced by Peter Allanson, Trust Secretary and Head of Corporate Affairs.

### 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 23,138 members, of whom 4,198 are patient members, 5,673 are public members and 13,267 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.

This year, the Council of Governors Membership Engagement and Development working group, with the Strategy Director, undertook a voluntary membership survey which now forms the basis of our membership plan.

### Board of Directors

Our Board of Directors is made up of our Chairman, Hugh Taylor, seven other Non-Executive Directors and seven Executive Board Directors (eight from October 2015), including the Chief Executive, Ron Kerr, up to September 2015, with Amanda Pritchard as Acting Chief Executive from October 2015 and Chief Executive from 18 January 2016. 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; and
- promote effective dialogue between the Trust and the local communities we serve.

Membership is balanced, complete and appropriate. The Trust is confident that all of the Non-

Executive Directors are independent in character and there are no relationships or circumstances which are likely to affect, or could appear to affect, their judgment. We therefore have not appointed a senior independent director.

Mike Franklin's term of office came to an end of October 2015; he was replaced by Priya Singh. Amanda Pritchard returned from maternity leave in May 2015 and was Acting Chief Executive from October 2015 with her appointment as Chief Executive being approved by a special meeting of the Council of Governors on 18 January 2016. Simon Steddon acted as Chief Operating Officer during Amanda's maternity leave, Associate Chief Operating Officer from May to September 2015 and Acting Chief Operating Officer from 1 October 2015.

The Council of Governors appoint 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 Council of Governors' approval.

In September 2015, over 275 people attended our Annual Public Meeting, and heard about our performance during the year; had an opportunity to ask questions of the Board of Directors and the Council of Governors; and heard about our Older Persons Unit and the 'Hello My Name Is' initiative.

Details of external directorships or other positions of authority held by the Directors of the Trust can be found in Note 29 to the Annual Accounts.

## 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	3/4
Anita Campolini	July 2015	3/4
John Duncan	July 2015	2/3
Jonathan Farley	July 2015	3/3
Sue Hardy	July 2012 (until June 2015)	1/1
Dawn Hill	July 2012 (until June 2015)	1/1
Darren Oldfield	July 2015	3/3
David Spratt	July 2012 (until June 2015)	0/1
Giles Taylor	July 2015	2/3
Gail Thompson	July 2012 (until June 2015)	0/1
Paula Young	July 2013	4/4

Public governors	Elected from	Actual/possible attendance
Kevin Burnand	July 2015	3/4
Ken Hayes	July 2013	4/4
Tom Hoffman	July 2015	4/4
Yvonne Craig Inskip	July 2015	4/4
Kate Griffiths-Lambeth	June 2015	2/4
John Porter (Lead Governor)	July 2013	4/4
Barry Silverman	July 2015	3/4
Jenny Stiles	July 2013	4/4

Staff governors	Constituency	Elected from	Actual/possible attendance
Thelma Bangura	Community services	Sept 2014	2/4
John Chambers	Clinical	July 2015	3/3
Noreen Ging	Clinical	July 2012 (until June 2015)	1/1
Tony Hulse	Clinical	July 2015	3/3
Gyles Morrison	Non-clinical	July 2015	3/3
Sam Newman	Clinical	July 2015	3/3
David Treacher	Clinical	July 2012 (until June 2015)	1/1
Jeff Whitear	Non-clinical	July 2012 (until June 2015)	0/1
Bryn Williams	Non-clinical	July 2013	4/4

Stakeholder governors	Organisation	Appointed from	Actual/possible attendance
Jasmine Ali	Southwark Council	Oct 2014	2/4
John Balazs	Lambeth CCG	Dec 2015	1/1
Jo Champness (stepped down in June 2015 before the end of her term)	NHS England	July 2013	0/2
Robert Davidson	Southwark CCG	Dec 2015	0/1
Jane Fryer	NHS England	Oct 2015	1/1
Sue Gallagher (stepped down in September 2015 before the end of her term)	Lambeth CCG	July 2013	1/3
Prof Denise Lievesley (stepped down in May 2015 before the end of her term)	King's College London	July 2012	1/1
Robert Park (stepped down in September 2015 before the end of his term)	Southwark CCG	July 2013	2/3
Matthew Patrick	South London and Maudsley NHS Foundation Trust	Nov 2013	0/4
Jane Pickard (stepped down in May 2015 before the end of her term)	Lambeth Council	July 2013	0/1
Diane Rekow	King's College London	May 2015	1/3
Sue Slipman	King's College Hospital	Dec 2015	0/1
Warren Turner	London South Bank University	Sep 2014	3/4
Sonia Winifred	Lambeth Council	May 2015	2/3

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

### Audit Committee

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

It is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek any information it requires from staff. Last year, the Committee approved the internal and external audit work plans and received regular reports.

At its meeting in May 2015, the Committee reviewed the draft Annual Report and Accounts, including the 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 Board Assurance Framework and Risk Register, including those submitted to Monitor, and received reports on a number of topics including information governance, interims and consultants, internal audit and counter fraud performance. External auditors attend the Committee regularly, providing an opportunity for the committee to assess their effectiveness.

The Trust recently appointed a new external auditor, KPMG LLP, after a tender process overseen by a tender panel, including representation from the Council of Governors.

Board meeting attendance April 2015 – March 2016		
Name	Title	Actual/possible
Hugh Taylor	Chairman	8/8
Robert Drummond	Non-Executive Director	7/8
Mike Franklin (until October 2015)	Non-Executive Director	4/6
Frank Nestle	Non-Executive Director	4/8
Girda Niles	Non-Executive Director	4/8
Sheila Shribman	Non-Executive Director	5/8
Priya Singh (from November 2015)		2/2
Diane Summers (Vice Chair)	Non-Executive Director	8/8
Steve Weiner	Non-Executive Director	5/8
Ron Kerr (Chief Executive until Sept 2015)	Chief Executive/ Executive Vice Chair	7/8
Ian Abbs	Medical Director and and Director of Patient Safety	8/8
Ann Macintyre	Director of Workforce	6/8
Steve McGuire	Director of Essentia	6/8
Amanda Pritchard (Maternity leave until 11 May 2015, Acting CEO from October – CEO from 18 January 2016)	Chief Operating Officer/ Chief Executive	6/6
Martin Shaw	Director of Finance	7/8
Eileen Sills	Chief Nurse and Director of Patient Experience	6/8
Simon Steddon (To cover Amanda Pritchard's maternity leave until 11 May and from October 2015)	Acting Chief Operating Officer	8/8

Committee	Membership April 2015 – March 2016
<b>Adult Local Services</b>	Girda Niles (Chair), Ian Abbs, Ann Macintyre, Amanda Pritchard, Simon Steddon, Martin Shaw, Sheila Shribman, Eileen Sills, Diane Summers
<b>Audit</b>	Steve Weiner (Chair), Robert Drummond, Priya Singh (from Nov 2015), Diane Summers
<b>Cancer Services</b>	Hugh Taylor (Chair), Robert Drummond, Mike Franklin, Ron Kerr, Ann Macintyre, Frank Nestle, Sheila Shribman, Amanda Pritchard, Priya Singh (from Nov 2015), Simon Steddon, Diane Summers
<b>Children's Services</b>	Sheila Shribman (Chair), Ian Abbs, Amanda Pritchard, Simon Steddon, Diane Summers, Hugh Taylor
<b>Corporate Management</b>	Hugh Taylor (Chair), all Board members
<b>Quality and Performance</b>	Diane Summers (Chair), Ian Abbs, Ron Kerr, Ann Macintyre, Steve McGuire, Girda Niles, Amanda Pritchard, Martin Shaw, Sheila Shribman, Eileen Sills, Priya Singh (from Nov 2015), Simon Steddon, Hugh Taylor, Steve Weiner
<b>Remuneration</b>	Hugh Taylor (Chair), all Non-Executive Directors



The service contract was subject to Crown Commercial Services (CCS) ConsultancyOne National Framework Agreement standard terms and the Monitor Audit Code. A paper was presented to the Audit Committee on the outcome of the tender exercise, and the Council of Governors approved the appointment (in line with the Monitor Audit Code) of KPMG with effect from 1 December 2015.

All non-audit services provided by the auditor have been reviewed and reported to the Audit Committee as part of the appointments, audit planning and completion processes of the audit. The auditors have confirmed that they comply with APB Ethical Standards for each service provided and have reported in full on the steps taken to safeguard their independence and objectivity.

#### Audit Committee membership and attendance

Name	Actual/possible
Steve Weiner (Chair)	5/5
Robert Drummond	5/5
Priya Singh	1/1
Diane Summers	4/5

#### Remuneration Committee membership and attendance

Name	Actual/possible
Hugh Taylor (Chair)	2/2
Robert Drummond	1/2
Mike Franklin	1/1
Frank Nestle	2/2
Girda Niles	1/2
Sheila Shribman	0/2
Priya Singh	1/1
Diane Summers	2/2
Steve Weiner	1/2

## Remuneration Committee

The Remuneration Committee decides the pay, allowances and other terms and conditions of the Executive Directors and other senior managers, including directors' compensation on the event of early termination of contracts.

## 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 a year 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. This second meeting, attended by members of the Board, opens with a session reflecting on the business discussed and agreed by the Board.

Members of the Council of Governors attend Board Committees, apart from the Audit and Remuneration Committees.

Members of the Board attend meetings of the Council of Governors' working groups. In addition we have introduced 'accountability sessions' twice a year for the Governors to question the Board on a range of topics.

Should a disagreement arise between the Council of Governors and the Board of Directors, it would be referred to a panel consisting of the Chairman, the Chief Executive and two governors nominated by the Council of Governors. The Chairman would not participate in

the nomination of governors to this panel. The panel would use all reasonable endeavours to resolve any disagreement.

## Trust Management Executive

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

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

## The Management Executive has the following sub-committees:

- Cancer Centre 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



**Amanda Pritchard**  
Chief Executive and  
Chief Accountable Officer  
(from January 18 2016),  
Chief Operating Officer (to October  
2015)

Amanda Pritchard was appointed as Chief Executive on January 18 2016, having been Acting Chief Executive from October 2015. Prior to that she served as Chief Operating Officer at the Trust for three and a half years.

Amanda joined Guy's and St Thomas' from Chelsea and Westminster NHS Foundation Trust where she spent six years as Deputy Chief Executive having previously held a variety of senior strategic and operational management roles there, including Director of Strategy and Service Development.

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

Amanda has three children, the youngest of which was born at St Thomas' Hospital in 2014.



**Dr Ian Abbs**  
Medical Director

Ian 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 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 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.



**Sir Ron Kerr CBE**  
Chief Executive  
(to September 2015),  
Executive Vice Chair  
(from October 2015)

Ron joined Guy's and St Thomas' as Chief Executive in 2007. He stepped down on 1 October 2015 after 30 years in senior NHS leadership roles. Ron continues at the Trust as Executive Vice Chairman working closely with the executive team.

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 and Chief Executive of United Bristol Healthcare NHS Trust.



**Martin Shaw**  
Director of Finance

Martin 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 Finance Directors' Groups.



**Dame Eileen Sills DBE**  
Chief Nurse and Director  
of Patient Experience and  
Infection Control

Eileen 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, and a DBE in January 2015.

Eileen holds two visiting professorships, at King's College London and London South Bank Universities. She is also 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.



**Dr Simon Steddon**  
Acting Chief Operating  
Officer (until May 11 and  
from October 2015)

Simon is a graduate of King's College London and joined the Trust as a consultant renal physician in 2005, becoming clinical lead for the Renal and Transplant Unit in 2007.

Simon has a PhD from Queen Mary University of London and an MBA from Westminster Business School. He was appointed clinical director for renal and urological services in 2008 and joint-clinical director of abdominal medicine and surgery in 2010.

Simon served as Acting Chief Operating Officer until May 11 and from October 2015, covering Amanda Pritchard's maternity leave, period as Acting Chief Executive, and also during her substantive appointment as Chief Executive.

## Board of Directors – Non-Executive Directors



**Sir Hugh Taylor**  
Chairman

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.

Hugh chairs the Cancer Services, Corporate Management and 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.

Robert joined the Board in March 2013 and chairs the Commercial Assurance Board and Guy's and St Thomas' Enterprises Ltd. He also sits on the Audit, Cancer and Corporate Management Committees.



**Dr Sheila Shribman**  
Non-Executive Director

Sheila 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 Children's Services 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 strategic experience 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  
(to October 2015)

Mike Franklin has held roles as Commissioner and board member of the National Independent Police Complaints Commission (IPCC). He was previously a member of the TUC race relations committee and Vice-Chair of the Metropolitan Police Service Racial and Violent Crime Task Force Independent Advisory Group (IAG), set up following the Stephen Lawrence Inquiry.

Mike joined the Board in November 2007 and chaired the Workforce Committee. Mike completed his term as a Non-Executive Director in October 2015.



**Dr Priya Singh**  
Non-Executive Director

Priya was formerly an Executive Director at the Medical Protection Society and has a background in general practice. She brings substantial medico-legal, risk and strategic experience to her role on the Board.

Priya's career at the Medical Protection Society spanned more than 20 years and she was responsible for the provision of professional services to 290,000 doctors, dentists, and other health professionals around the world.

Priya joined the Board in November 2015.



**Diane Summers**  
Non-Executive Director  
(Vice Chair)

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 and Performance Committee.



**Steve Weiner**  
Non-Executive Director

Steve 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.





The national diagnostic epidermolysis bullosa laboratory provides skin biopsy and gene mutation analysis for patients with the inherited forms of skin fragility or blistering known as EB, one of the rare conditions treated at St John's Institute of Dermatology.



# Regulatory ratings report

2015-16	Annual Plan	Q1	Q2	Q3	Q4
Continuity of service rating	3	3	2	2	4
Governance rating	Green	Green	Green	Green	Under review

2014-15	Annual Plan	Q1	Q2	Q3	Q4
Continuity of service rating	4	4	4	4	4
Governance rating	Green	Green	Green	Green	Under review

## Continuity of service risk rating

At the start of the year the Trust planned for a continuity of service risk rating of 3 (the second lowest risk rating), reflecting a forecast outturn deficit.

During the year, actual performance fell below expectations in quarters two and three but was addressed by turnaround actions instigated by the Board of Directors.

By the end of the year, the Trust was able to exceed its financial plan, achieving a lower than expected deficit, and this in turn produced a continuity of service risk rating of 4, the lowest risk rating.

## Governance

During 2015-16 the Trust continued to experience challenging operating conditions and these are described more fully in the Performance report on pages 7 to 19.

The Trust has held regular meetings with the Regulator to describe the actions being taken to address these issues and also to explain the reasons for non-compliance, which have included a number challenges which are outside the Trust's direct control.

To date no regulatory action has been taken.

For details of our CQC rating, following our planned inspection in September 2015, see page 23.





We are committed to listening to and involving our patients. Last year we held an event in our maternity service to help staff put themselves in the shoes of the people they are caring for with the aim of improving the experience for families using the service.

# Statement of the Accounting Officer's responsibilities

## 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 Memorandum* issued by Monitor.

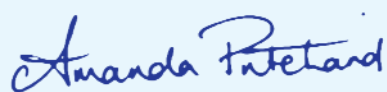
Under the NHS Act 2006, Monitor has directed Guy's and St Thomas' NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state 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 Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her 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*.



**Amanda Pritchard**

Chief Executive and Accounting Officer

25 May 2016

# Annual Governance Statement 2015-16

## 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 2016 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. Learning from Root Cause Analysis investigations directly feeds into our quality improvement programme including reality rounds, Schwartz rounds, safety huddles and safety alerts.

## 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 assessed as significant are monitored to ensure mitigating actions are undertaken to reduce risks 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 (CQC), 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 and Performance 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 2015-16 were set out in the Care Quality Commission's five domains of safe, effective, caring, responsive and well-led. Tools used include the ward accreditation scheme and leadership walkabouts, with input from our governors and the quality improvement team.

The Trust uses reality rounds, peer to peer and quality reviews to provide assurance on compliance with the core domains and evidence on best practice and high quality care.

In addition, the Trust monitors the contents of the Care Quality Commission's Intelligent Monitoring Report. Areas of concern are brought to the Trust Risk and Quality Committee for actions to be agreed and to the Quality and Performance Committee for review.

The Trust has undertaken an information assurance assessment of key indicators reported each month. The assessment assigns a weighted risk scoring to each indicator. Those with higher scores are subject to mitigating actions 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 a Deputy Medical Director, meets fortnightly to review progress across a range of process and quality indicators.

A full range of performance indicators are reported monthly to internal and external audiences through the Integrated Quality and Performance Report (IQPR), coupled with regular updates to 'Our Quality Story' on the Trust's website. High visibility and transparency of performance information acts as an additional assurance check on the quality of what is being presented.

## Information governance

The Trust's achieved a 'Satisfactory' rating in its self-assessment against the 2015-16 Information Governance Toolkit, the primary tool for information governance assurance.



All staff receive information governance training as part of corporate induction when joining the Trust. New online training assessments have been developed in 2015-16 for staff taking annual refresher training, and policies and guidance have been comprehensively reviewed in-year to ensure staff have access to up-to-date information.

An Information Asset Owner (IAO) is named for each department and specialty, with responsibility for managing information risks, supported by specialist information security staff. Registers of information assets, flows and uses are updated and reviewed quarterly, and risk reports are submitted to the Information Governance Committee and Audit Committee.

All information incidents are investigated, with "near misses" used as opportunities to improve processes and reduce risks. In 2015-16 two incidents were classified as Level 2 in the Information Governance Incident Reporting Tool, and reported to the Information Commissioner's Office. These incidents related to lost or stolen paperwork from a health professional working in the community and patient records temporarily lost in transit by a courier. Following the first incident, bespoke information governance training was developed and delivered to health professionals working within the relevant service. The second incident is currently under investigation – actions already taken include an examination of all recovered sheets and a review of working practices when using couriers.

Strategically, the Trust continues to develop its ambitious and successful programme of moving from paper to electronic health records, which represent both improved security as well as increased availability for patient care.

## Risks

**In year risks:** In-year risks to delivery of the Trust's objectives are recorded in detail in the Board Assurance Framework and corporate risk register which are monitored quarterly by the Board through the Audit Committee. A summary of significant risks within the Board Assurance Framework for 2015-16 is attached as Appendix 1 of the Annual Governance Statement.

## Future risks

The Board has identified future risks during a series of strategic risk planning activities. As with all NHS organisations, balancing the need to deliver high quality care in the context of increasing demand and acuity, whilst increasing productivity, is a continual challenge. This is against a backdrop of constraints on our ability to invest in additional physical and staffing capacity. We recognise that strategic and transformational change internally and across geographical health economies will be required to address the risks identified (see below). The principal strategic risks identified for 2016-17 are:

- delivering the level of efficiency increases and cost reduction within our extremely challenging financial plan;
- due to the complexity of the Trust, competing policy demands and internal factors, our quality governance and assurance systems may need to be reviewed regularly to ensure that they are able to meet future requirements;
- being unable to deliver the planned estate capacity increases in our five year capital plan due to the financial context, particularly in theatres and critical care. This may impact on our ability to deliver access standards in the short-term;
- being unable to invest capital to achieve our strategic ambitions, particularly in relation to information technology/digital transformation and the development of world-class children's services;
- a lack of commissioning clarity meaning we are unable to meet the changing needs of the populations we serve in an affordable way – particularly with respect to specialised services;
- commissioner affordability including: an inability to afford additional growth in patient demand putting additional pressure on our financial plan; reductions in funding from local authorities meaning we are unable to meet the population need for sexual

health, health visitors, the Family Nurse Partnership and health improvement services; and continual reduction in supporting social care provision resulting in the Trust being unable to achieve planned length of stay reductions;

- being able to recruit and retain sufficient workforce, particularly in theatres, Evelina London, nursing and other clinicians in some of our highly specialised areas;
- our services will operate at high levels of occupancy and capacity meaning that meeting unplanned patient demand, coping with disruption to services from neighbouring health sectors and hospitals and achieving planned waiting time standards, will be very difficult in the short and longer term;
- being unable to dedicate sufficient clinical and non-clinical leadership and management capacity to addressing the above points through strategic and transformational change.

The Trust recognises that addressing the risks identified will involve multiple partners working together across health and social care, and adapting our own internal arrangements so they are sufficiently agile to meet the challenges of working in complex and uncertain circumstances. In 2016-17 we will:

- play a key role in the delivery of strategic and transformational change through Sustainability and Transformation Plans including in South East London;
- undertake a review of our quality governance and assurance arrangements to ensure we can demonstrate that we are discharging our statutory responsibilities and that we are a learning organisation;
- continue to consider quality, safety and efficiency improvements in tandem, supported by our *Fit for the Future* programme which aims to improve productivity and efficiency whilst maintaining high quality care and a positive patient experience. Work streams include maximising utilisation of our facilities and equipment, reducing length of stay, and projects to meet the recommendations of the Carter Report;
- continue to focus on our internal Adult Local Services Programme which includes a number of priorities to drive the local health economy's integration vision for integrated care such as discharge management through our @home and Enhanced Rapid Response, community mobile working and reablement services. The Programme complements our work as part of the Southwark and Lambeth Strategic Partnership;
- seek to address issues relating to the sustainability of specific services across geographical areas through the development of Sustainability and Transformation Plans;
- work with partners to explore new sustainable organisational models including creating one of the first Foundation Healthcare Group models in an Acute Care Collaboration Vanguard with Dartford and Gravesham NHS Trust;
- explore whether we can develop models of delivery across networks to address the workforce risks which reflect national trends;
- continue to work closely with our commissioners to address the risks around commissioner affordability; and
- explore new capital funding models.

## Equality duties

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

The equality objectives are both patient and workforce facing in scope. All human resources (HR) policies are subject to an equality impact assessment (EIA). 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 are integral to Trust activity and will be refreshed this year to support the Trust's strategic objectives.

Equality impact assessments are an integral part of the Trust's Patient and Public Engagement toolkit. EIAs inform the engagement strategy when there is a transformation or change in service. This ensures the Trust proactively engages with seldom heard groups.

The Trust publishes Workforce Race Equality Standards annually. Disclosures in relation to staff engagement and the opportunities available to disabled employees are contained within the Performance Report and Staff Report (sections 2 and 5 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 2015-16 the Trust has continued to promote incident reporting across the organisation and we have seen an increase of 18% from the previous year, demonstrating a healthy reporting culture. The Trust's recent Care Quality Commission inspection report reflected good awareness of incident reporting.

A range of training programmes are in place, including at induction for all staff, for junior doctors and also for 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.

The electronic incident reporting system has been updated to include automatic feedback when an incident is investigated. Additional fields have been included to prompt staff to ensure the Duty of Candour process is followed. Training workshops on the Duty of Candour have been positively received by staff and will continue to be provided to raise awareness about being open when an incident occurs. In addition, leaflets have been produced for patients and staff to explain the process.

### Patient involvement in risk

The Trust's patient and 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.

The Trust Healthwatch Liaison Group meets quarterly to enable regular liaison and communication between the Trust and Local Healthwatch bodies in Lambeth and Southwark. This group identifies opportunities for the involvement of local Healthwatch 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 through its relevant working groups of proposed changes, including how potential risk to patients will be minimised.

## Compliance Statements

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

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

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

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 2008 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 has exceeded carbon reduction targets for 2015 by achieving a 15% reducing against a 10% target, and is on track to achieve its 34% reduction target by 2020 through an ambitious energy efficiency investment plan.

## 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.

The Board Assurance Framework sets out the principal risks to delivery of key priorities and overarching strategic priorities (corporate objectives). The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The Board Assurance Framework identifies the assurances available to the Board of Directors in relation to the achievement of the Trust's key objectives. The principal risks to the delivery of these objectives are mapped to key controls. The Board Assurance Framework supports the process for monitoring ongoing compliance with the requirements for registration set by the Care Quality Commission, with mapping of the regulations to strategic priorities. The Board of Directors plays a role in procurement as 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's Audit Committee has reviewed the Board Assurance Framework and at the end of 2015-16 the Board reviewed the key risks in detail and will repeat the exercise in the first half of 2016-17.

Each Board Committee has taken responsibility for monitoring the most serious risks relevant to its span of control.

## 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 2015-16, and to provide an opportunity for stakeholders to contribute to discussion about the choice of quality priorities for 2016-17. 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 consulted on with our stakeholders, and will be monitored by the Quality and Performance Committee.



For the annual Quality Report, the Trust employs the same information assurance processes as used in the monthly production of the Integrated Quality and Performance Report (IQPR).

Regular and transparent performance reporting to both internal and external audiences acts as an additional assurance check on the quality of the information in use. To this extent, the annual Quality Report is an extension of our monthly reporting processes. The IQPR is published as part of our Board Papers and accessible performance information is provided through 'Our Quality Story', both of which appear on the Trust's website.

A risk-based assessment of the information assurance associated with key indicators has helped determine the programme of audits undertaken by the Trust's Internal Audit department, with a strong emphasis on the collection and reporting of waiting time data.

For 2015-16, all three of the main waiting time performance measures – Referral to Treatment, Cancer and Accident & Emergency – will be subject to review by the Trust's external auditors, as part of the limited assurance opinion they provide for the annual Quality Report.

## 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 and Performance 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 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 IQPR 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 IQPR. 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 Audit 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 rely on them in arriving at their annual opinion. In addition to the planned programme of work, internal audit provide advice and assistance to senior management on control issues and other matters of concern. The internal audit team also provides an anti-fraud service to the Trust.

Internal audit work also 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 "I have considered all of the work conducted by internal audit staff during 2015-16, including audits undertaken during the year which related to the previous year's plan. I have also considered reactive and proactive work conducted by the Trust's Local Counter Fraud Specialist. This includes oversight of all internal audit reports, fraud investigations and personal conduct of specific projects during the year. In my opinion, with the exception of those areas in which limited assurance reports have been issued as reported to the committee during the year, the controls in those areas reviewed are adequate and effective. Where weaknesses have been identified these are being addressed by management and actions have been confirmed through follow up work by internal audit.

Compared to the previous year there has been a significant reduction in the proportion of audits which have received a limited or nil assurance rating, from 49% to 34%. This is a positive direction of travel and it should be noted that all of the Trust's key financial systems have received substantial assurance.

The Board is reminded of the need to ensure that agreed audit recommendations are implemented within appropriate timescales. In this regard I have a particular concern about progress against the recommendations made in August 2015 in the internal audit report on interims and consultants and in light of continuing high expenditure in this area. I intend to maintain a watching brief on this over the next six months to ensure that the programme to reduce reliance on agency staff remains on schedule.

I am satisfied that the Board Assurance Framework, as presented to the Audit Committee in 2015-16 over the course of the year is representative of the key risks faced by the organisation and that these are linked to the Trust's strategic objectives. I note that the TME risk sub group has been disbanded and, going forward, the Board will need to determine how it intends to review its operational and strategic risks."

In relation to quality assurance, I confirm that, in January 2016, the Trust has undergone an external assessment of internal audit and this was undertaken in accordance with the public sector Internal Audit Standards. The assessment found that Internal Audit generally conforms with the requirements. I confirm that I have monitored compliance with the standards and that, in my view, the department complies with those that are applicable to the public sector."

The Trust's Executive Directors and senior managers have provided the Board of Directors with reports on risk management, performance management and quality through the Quality and Performance and Audit Committees.

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

The Trust Risk and Quality Committee reports to the Trust Management Executive and the Quality and Performance Committee, its work on establishing a system for reviewing the Trust's clinical procedures and guidelines, contributing to maintaining the system of internal control.

A policy is in place which 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. The annual Quality Report includes detailed information about the Trust's participation in national and local clinical audits.

### Significant control issues in 2015-16

The Trust has identified no significant control issues during the year. It has identified and taken action to mitigate a number of risks, the most significant were as follows:

**Never Events:** This financial year has seen a rise in reported Never Events for the Trust. There were a total of 16 reported Never Events with a cluster occurring during quarter three. The reported incidents have been investigated and did not highlight a specific trend, but rather demonstrated a number of different factors leading up to the event. The Trust has responded openly and pro-actively with high-level leadership and frontline engagement. A Trust-wide action plan was developed which was signed off by our local Clinical Commissioning Group, who have been supportive of the work taking place. As part of the action plan, the Trust has reviewed its governance processes for managing Never Events. A communication strategy was put in place to target key staff groups and raise awareness by attending a Trust Management Executive summit, the Grand Round and other meetings, as well as through safety briefings and an 'Always Safe Campaign'. The Trust Safer Surgery Group is leading on implementing the National Safety Standards in Surgery and for Invasive Procedures, which is highly relevant as the Never Events occur in various settings and not only the operating theatre. Additionally, the Trust is working with the Centre for Applied Resilience and leads on Human Factors work to review the factors surrounding the Never Events, perform observational audits and focus on simulation training.

**Care Quality Commission standards:** The Care Quality Commission (CQC) undertook a scheduled inspection in September 2015. The Trust was rated as "Good" overall for the quality of its services but was rated as 'requires improvement' for safety and also required to take action in relation to three regulations which were found not to be met. The actions related to consistently documenting Venous Thromboembolism (VTE) risk assessments in maternity; midwifery staffing levels in the Antenatal Day Assessment Unit (ADAU); and effective governance links between surgical directorates. The Trust has sent a detailed improvement action plan to the CQC indicating actions already taken or to be taken. Actions include working towards creating a mandatory field for VTE assessment within a single electronic system, checking of staffing and activity levels twice daily on the ADAU to address any gaps; and the Trust's Surgical Safety Group, comprised of multi-disciplinary clinical leaders for all surgical specialities established in November 2015, to lead on addressing the governance issues. In addition, we will review our arrangements for learning and embedding lessons within the Trust.

**Financial Control:** 2015-16 presented a very challenging financial environment for the Trust, as it did for many acute NHS Trusts. Particularly challenging were the late changes to funding and other financial arrangements at the start of the financial year. Through the Trust's financial planning mechanisms, it was possible to determine that, as a consequence of these changes, it would be very difficult to achieve a surplus or to breakeven. Under the circumstances, the Board of

Directors felt obliged to plan for a £19m deficit and this plan was submitted to Monitor. Included within the plan was a detailed schedule of planned savings amounting to £93million – the largest savings target in the Trust's history. Progress towards the savings target was constantly monitored and reported to the Board of Directors, but initially proved difficult. In response, a Financial Recovery Group was formed under joint Operations and Finance control to reinforce the governance framework and provide proactive monitoring of the individual control targets. This proved effective and the Trust has been able to achieve the financial performance anticipated in the plan presented to Monitor at the start of the financial year.

**Accident & Emergency standard:** The Trust experienced a deterioration in our Accident & Emergency 4 hour wait performance in quarter two of 2015-16, due in part to a challenging physical environment as the transformation project at St Thomas' changed the internal layout of the emergency department during the year. The Trust was successful in receiving additional support from commissioners to implement schemes to help reduce the risk of patient delays, and worked with external partners to help improve the discharge arrangements for patients who did not need to be in an acute bed. The Trust also experienced significant increase in demand for emergency services in quarter four. The Chief Executive has led a star chamber approach with staff from adult and paediatric emergency services to help us understand themes and trends and deliver quick, material changes to improve emergency care for our patients. The Trust has further planned changes to the infrastructure during 2016-17 and, with the associated risk of winter pressures, has flagged a risk to compliance with the 4 hour target for quarters 3 and 4.

**Cancer waits:** The Trust is committed to achieving internal compliance with the 85% 62-day standard and has worked hard during 2015-16 to achieve this, including implementing additional urological robotic capacity. The Trust has worked with commissioners and acute partners in south east London to improve the time taken to treat cancer patients across all tumour groups with a new method for identifying patients who are likely to be referred to the Trust and clinically agreed, timed pathways for tumour sites. In seeking to achieve the Monitor target, the key remains the timeliness of inter-hospital transfers both within south east London and across south England. The Trust is committed to continuing current work to improve the timeliness of referrals, which will be supported by the creation of a new Accountable Clinical Network. The Trust also opens two new cancer centres during 2016-17 at Queen Mary Sidcup, Kent and on the Guy's Hospital site.

**Referral to treatment (RTT) standard:** During 2015-16 the Trust consistently achieved the 92% standard for incomplete pathways in the first half of the year, but struggled to achieve this consistently from December onwards, failing to achieve the standard in quarters 3 and 4. The Trust achieved an increase of 9% in elective and outpatient activity compared with 2014-15, but this has not kept pace with aggregate referral growth. The size of the Referral to Treatment list of patients rose during quarter 1 and quarter 3, and has since been maintained at the same level. The backlog of patients waiting over 18 weeks also rose during this period and, through the winter period, the Trust struggled to maintain the pace of bookings for these backlog patients, in part due to patient choice. The Trust has an action plan to improve performance and has set activity plans to deliver a further 8% increase in activity which will allow us to cope with 5% further growth in referrals. However, the referral growth rate is a key risk to the sustained delivery of the standards during 2016-17.

## 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.



**Amanda Pritchard**

Chief Executive  
25 May 2016

## Appendix 1: Board Assurance Framework Risk Summary at March 2016

### Short risk title and description:

<b>Patient experience:</b> Patient experience impacted by stresses on stable workforce, organisational change, performance pressure on clinical services and difficulties in staff adapting to new technologies
<b>Monitoring Board Committee:</b> Quality and Performance Committee
<b>Quality of care:</b> Deterioration in quality of care due to a mixture of factors including hospital running at capacity, increasing patient acuity and complexity and rising demand for services
<b>Monitoring Board Committee:</b> Quality and Performance Committee
<b>Finance:</b> Challenging financial environment resulting in the Trust not breaking even and substantial deficit which impacts on the quality and safety of services and fulfilment of strategic ambitions
<b>Monitoring Board Committee:</b> Corporate Management Committee
<b>Waiting times:</b> Failure to achieve key waiting time targets (A&E 4 hour wait, internal compliance with the cancer 85% 62-day standard, referral to treatment standard)
<b>Monitoring Board Committee:</b> Quality and Performance Committee
<b>Workforce:</b> Insufficient trained staff available to staff services to the detriment of safe clinical care as a result of factors including national shortages
<b>Monitoring Board Committee:</b> Corporate Management Committee
<b>Safeguarding:</b> Patient harm as a result of gaps in the effectiveness of systems for safeguarding and failing to learn the lessons from investigations e.g. Savile, Francis, Kirkup etc: reputational risk and risk of regulatory intervention
<b>Monitoring Board Committee:</b> Quality and Performance Committee
<b>Clinical strategy alignment:</b> Non alignment of the Trust's clinical strategy with those of local and national commissioners resulting in loss of income and competitiveness
<b>Monitoring Board Committee:</b> Trust Board
<b>Integrated care:</b> Trust unable to realise ambitions to secure fundamental improvements for Lambeth and Southwark service users through the integrated provision of acute and community health and social care
<b>Monitoring Board Committee:</b> Adult Local Services Committee
<b>Research:</b> Loss of research income and reputation as a result of failed research bids
<b>Monitoring Board Committee:</b> Trust Board
<b>Infrastructure:</b> The Trust's enabling infrastructure (IT, buildings) is not consistent with the demands of a modern healthcare service and is unable to transform care
<b>Monitoring Board Committee:</b> Corporate Management Committee
<b>Organisational transformation:</b> Transformation of the organisation to a world-class quality culture impeded through the external regulation and measurement expectations forcing the Trust to focus on a command and control culture
<b>Monitoring Board Committee:</b> Trust Board
<b>Health and social care economic stability:</b> Fragility of health and social care economy or other sector services adversely impacting demand for Trust services
<b>Monitoring Board Committee:</b> Corporate Management Committee
<b>Education:</b> Trust attracts fewer clinical students and trainees in the future leading to financial and reputational loss
<b>Monitoring Board Committee:</b> Quality and Performance Committee
<b>Organisational form:</b> Size and complexity of the organisation resulting in less agile decision making
<b>Monitoring Board Committee:</b> Trust Board
<b>Data Quality:</b> Lack of robust data quality
<b>Monitoring Board Committee:</b> Audit Committee





We have around 15,000 staff and their commitment underpins our success. We aim to develop all our staff so they are equipped to deliver high quality, efficient and effective services.

# 10 Quality report

## Statement on quality from the Chief Executive 2015-16

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:

- The Care Quality Commission inspection of our hospital and community sites in September 2015 led to an overall rating of 'Good', which is a significant achievement for an NHS organisation of our size and complexity. We were delighted that Evelina London Children's Hospital and the Emergency Department (A&E) at St Thomas' were rated 'Outstanding' – the first specialist children's hospital to receive this rating. The CQC also highlighted a number of areas where we must improve – see page 77 for details.
- we were very pleased to win the CHKS Top Hospitals Quality of Care Award 2016, a prestigious national award for excellence in high quality patient care;
- children and young people treated in Evelina London Children's Hospital, and their parents, were invited to have their say on the quality of their care by taking part in the CQC's national children's hospital survey. The results were published in July 2015 and showed that parents rated Evelina London significantly above the national average in four key areas, including parents feeling involved in their child's care and staff keeping parents informed of what was happening to their child;
- the national maternity survey published by the CQC in December 2015 highlighted improvements in our maternity care since the last survey in 2013 – we improved in eight out of 15 categories, including those relating to communication and the empathy of staff caring for women in labour, birth and on the postnatal ward;
- our innovative approach to providing psychological care for patients with skin disease won a prestigious *British Medical Journal (BMJ)* Award. Staff from St John's Institute of Dermatology at Guy's and St Thomas' were also named the BMJ's Dermatology Team of the Year 2016.

I am delighted that there is so much to be proud of in the CQC report, which was published in March 2016. The report reflects the compassion and dedication of our staff to providing high quality care for patients in our hospitals and in the community, and is full of examples of excellent practice. It was especially heartening that the CQC inspectors said that they 'found staff to be highly committed to the Trust and delivering high quality patient care'.

We are working with staff to address a small number of areas of the Trust rated as 'Requires Improvement': consistently documenting venous thromboembolism (VTE) risk assessments in maternity; midwifery staffing levels in the Antenatal Day Assessment Unit (ADAU); and improving the effectiveness of governance links between surgical directorates.

The report is a valuable source of information about where and how we can do better to provide high quality care for all patients but these areas for improvement should not overshadow what is overall a very positive report.



The Trust's action plan to tackle areas for improvement was discussed at our Quality Summit with the CQC, local stakeholders and patients' groups in April 2016 – and we look forward to implementing this action plan in full.

In May 2016 we will be launching 'Always Safe', a major patient safety campaign led by Medical Director Dr Ian Abbs to raise staff awareness of serious incidents and never events, and to get feedback from staff about how to improve safety. We aim to understand why the number of never events in the Trust has increased, and also to focus on 'near misses', so that we can learn lessons and share best practice across different parts of the organisation.

The Trust aims to have a positive ethos of encouraging staff to report incidents and we know we need to do better in terms of 'closing the loop' so that staff know the outcome of incident investigations, and what action must be taken as a result.

Last year our external auditors found some errors in the recording of dates in the 18 week referral to treatment incomplete pathway indicator. As a result we have introduced a number of additional controls. These have included regular departmental data quality audits; the creation of a detailed toolkit to improve awareness and understanding of the outpatient administration process; and improvements to the availability and frequency of training in referral management for existing and new staff.

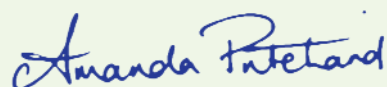
Two formal reviews carried out by our Internal Audit department have shown an improvement in processes and the accuracy of recording, though with a small residual level of errors. We are determined to ensure the highest standards are met and so will continue to work hard to drive out any remaining training or process issues in this area over the coming year.

We recognise the importance of visible leadership by our executive team and senior clinicians and managers in our clinical directorates. This was acknowledged in the CQC report.

This leadership is demonstrated on a regular basis, for example by our Chief Nurse Eileen Sills through her continuing commitment to Clinical Fridays and the 'Safe in Our Hands' forum. This weekly meeting allows quality and performance issues to be discussed and debated by staff in a 'no blame' environment.

In addition, the executive team comes together to lead a face-to-face Team Briefing session with all staff each month, and we all participate in regular Executive Director 'out and about' visits to various areas of the Trust to listen to staff.

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



**Amanda Pritchard**

Chief Executive

25 May 2016

## Our quality priorities for 2016-17

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 the year we continued to focus on ensuring that patients are at the heart of all that we do. Our work is supported by strong quality governance and assurance systems, which aim to increase the confidence of our patients, staff, and Trust Board and governors, as well as others who take an active interest in our work.

Our quality strategy for 2016-17 will help us to improve the provision of healthcare to our patients both in the community and in hospital settings, and also 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, together with the Trust's *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 2016-17. 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 2015-16, we met with our stakeholders to tell them about our progress in delivering our quality priorities for the year. In December 2015 we held a patient and public engagement event where stakeholders from across health and social care, our governors and our staff took part in a review of progress against our current quality priorities and worked in groups to identify areas to focus on in 2016-17.

A number of our 2015-16 priorities have been carried forward where it was recognised that they cover programmes of work that will take more than one year to deliver.

Staff have also helped to identify quality priorities through the Trust's business planning process, and all directorates have developed plans setting out how they will contribute to achieving these objectives.

### Our quality priorities for 2016-17

#### Patient safety

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

###### **We will achieve the 2016-17 CQUIN for the identification and treatment of sepsis**

This priority is being carried forward from 2015-16. It continues to be a priority to meet the 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.

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.

###### **We will ensure that all appropriate patients are assessed for risk of:**

###### **Dementia**

The care of people with dementia and delirium remains a Trust priority. Through assessment of risk our aim is to provide the best possible support and care for people with dementia, their families, and carers.

###### **Venous thromboembolism (VTE)**

It remains a priority for us to prevent health care acquired venous thromboembolism (VTE).

###### **We will demonstrate that we have embedded the five steps of the WHO surgical safety methodology**

It remains a priority for us to continually improve patient safety practice and prevent serious incidents and never events.

##### What success will look like

We will meet the targets in the national CQUIN on sepsis. We carried out a baseline audit in the last quarter of 2015-16. This will be reported in the first quarter of 2016-17 and will provide us with baseline performance. The audit looked at patients admitted through the Emergency Department, and at inpatients identified with sepsis and how we performed against two standards: giving antibiotics within 1 hour of sepsis being identified and reviewing the antibiotics prescribed on day 3.

We will achieve the improvement targets for 2016-17 for the Emergency Department and for inpatients. These will be agreed by the end of May 2016 and will be based on our performance in the 2015-16 audit.

We will implement our 3 year dementia strategy and continue to improve our performance in the assessment of dementia risk. We will screen patients over the age of 70 who are admitted through the Emergency Department for dementia risk and we will achieve this for 90% or more of these patients. Compliance of 90% or over will be seen for a minimum of two of the three elements of the screening tool.

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

Our WHO surgical safety checklist will show compliance at 95% or more for all five stages of the process.

## Clinical effectiveness

### Our quality priorities and why we chose them

#### **We will develop new clinical models that improve outcomes for patients through the use of electronic systems, including patient records.**

This quality priority builds on 2015-16 and involves a further phase in the standardisation of the recording of observations, decisions and prescriptions.

#### **We will reduce the number of obstetric anal sphincter injuries (OASIs)**

This quality priority is being carried forward from 2015-16 as we move into year two of the three year Sign Up to Safety programme.

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.

#### **We will continue to improve care for the deteriorating child**

This quality priority is being carried forward from 2015-16 as we move into year two of the three year Sign Up to Safety programme.

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.

### What success will look like

We will achieve the objectives for 2016-17 in the digital hospital programme implementation plan.

We will achieve the year two targets for the three year programme agreed at the Sign up to Safety Steering Group in May 2016.

The Sign up to Safety Steering Group will monitor the deliver of the plan to achieve the targets and report to the Trust Risk and Quality Committee on progress.

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## Patient experience

### Our quality priorities and why we chose them

#### **We will ensure that all our patients receive the fundamentals of care with a particular focus on nutrition and pain management.**

Having enough to eat and drink is a basic human right and when it comes to patients, good nutrition and hydration is essential to health and recovery from illness.

Our 'Nutritional Care' Strategy sets out our vision to provide our patients, their families, and carers and our staff high quality, nutritious food, drink or specialised nutrition across all our healthcare settings.

#### **We will continue to improve the Trust's response to complaints.**

We want to provide a complaints service based on the principles in 'My expectations for raising concerns and complaints' (Parliamentary Health Service Ombudsman and others) so that complainants are able to say:

'I felt confident to speak up and making my complaint was simple. I felt listened to and understood. I felt that my complaint made a difference.'

#### **We will continue to improve medicines management at the time of discharge.**

We want to reduce medication related problems at, or shortly after, patients leave hospital. This includes improving verbal and written communication with patients, carers and community health professionals.

Our goal is to reduce the harm associated with use of medicines when patients leave hospital.

### What success will look like

We will deliver the 2016-17 objectives in the implementation plan for the Nutritional Care Strategy. The plan will be monitored by the Nutrition Steering Group reporting to the Quality and Performance Committee.

We will deliver year two of the 'Complaints handling improvement plan'.

In particular we will achieve the targets for response times which are set out in our complaints triage framework.

We will achieve the year two targets for the three year programme agreed at the Sign up for Safety Steering Group in May 2016.

The Sign up for Safety Steering Group will monitor the delivery of the plan to achieve the targets and report to the Trust Risk and Quality Committee on progress.

# Statements of assurance from the Board of Directors

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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 2015-16 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 on our website [www.guysandstthomas.nhs.uk/resources/publications](http://www.guysandstthomas.nhs.uk/resources/publications).

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 2015-16 represents 100 per cent of the total income received for the provision of NHS services in 2015-16.

## Duty of Candour

The Trust has supported the implementation of the Duty of Candour by introducing an automatic prompt to the Trust's electronic incident reporting system. This reminds staff to follow the Duty of Candour process. We have also provided training for staff, which has been positively received, and this was complemented by an awareness raising campaign and information for patients.

## Sign Up to Safety

The Trust fully supports the Sign Up to Safety campaign. Its second year programmes have been incorporated into our quality priorities for 2015-16.

## Staff Survey – Workforce Race Equality Standard

Our most recent staff results, for 2015, show that 24% of staff reported experiencing harassment, bullying or abuse from other staff in the last 12 months (national average 24%). In the same survey, 84% of staff reported that they believe the Trust provides equal opportunities for career progression (national average 87%). We are working hard to improve performance in both these areas.

## 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 2015-16, we took part in 38 national clinical audits and four National Confidential Enquiries. By doing so we participated in 90.5% of national clinical audits and 100% of National Confidential Enquiries in which we were eligible to participate.

The national clinical audits and National Confidential Enquiries that we were eligible to participate in during 2015-16 are shown in the table on the following pages, together with those that we participated in and for which data collection was completed during 2015-16. 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 2015-16

Audit title	Participation	% of cases submitted
<b>Women and children's health</b>		
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%
Paediatric asthma	Yes	100%
Vital signs in children (care in emergency departments)	Yes	100%
Paediatric Pneumonia	Yes	100%
Child health clinical outcome review programme	N/A	N/A
<b>Acute care</b>		
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	56%
National Joint Registry (NJR)	Yes	97%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	62-75%
Emergency use of oxygen	Yes	100%
Non-invasive ventilation – adults	N/A	100%
Pleural sedation in adults (care in Emergency Departments)	Yes	100%
VTE risk in lower limb immobilisation (care in Emergency Departments)	Yes	100%
<b>Long term conditions</b>		
Chronic Obstructive Pulmonary Disease (COPD)	Yes	100%
Inflammatory bowel disease (IBD)	No	N/A
Renal replacement therapy (Renal Register)	Yes	100%
Rheumatoid and early inflammatory arthritis	Yes	Not yet available from audit supplier.
Diabetes (Paediatric) (NPDA)	Yes	Study ongoing.
Diabetes (Adult): National Diabetes Foot Care Audit (NDFA) & National Diabetes Audit	No	N/A
Diabetes (Adult): national diabetes inpatient audit	Yes	100%
Diabetes (Adult): national pregnancy in diabetes audit	Yes	Ongoing.
Adult asthma	Yes	90%
Complicated diverticulitis audit	No	N/A
UK Cystic Fibrosis Registry	N/A	We do not provide this service.
UK Parkinson's Audit	Yes	100%
<b>Older people</b>		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%

### Participation in national clinical audits 2015-16

Audit title	Participation	% of cases submitted
<b>Heart</b>		
Acute coronary syndrome or acute myocardial infarction (MINAP)	Yes	100%
National adult cardiac surgery audit (ACS)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	Ongoing.
Cardiac arrhythmia management (CRM)	Yes	Ongoing.
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	100%
Coronary angioplasty	Yes	100%
Heart failure (HF)	Yes	Ongoing.
National Vascular Registry	Yes	100%
Pulmonary Hypertension Audit	N/A	
<i>We are an outreach centre for the Royal Free Hospital who submit the data for this audit</i>		
<b>Other</b>		
Ophthalmology Audit: Adult cataract surgery	No	
Intermediate care	Yes	100%
<b>Cancer</b>		
Bowel cancer (NBOCAP)	Yes	100%
Lung cancer (NLCA)	Yes	100%
Oesophago-gastric cancer (NOGCA)	Yes	100%
Prostate cancer	Yes	Ongoing.
<b>Blood and transplant</b>		
National comparative audit of blood transfusion programme	Yes	100%
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	N/A	Service not provided.
Liver transplantation (NHSBT UK Transplant Registry)	N/A	Service not provided.

### National Confidential Enquiries 2015-16

Audit title	Participation	% of cases submitted
Sepsis	Yes	100%
Gastrointestinal haemorrhage	Yes	100%
Acute pancreatitis	Yes	100%
Mental health	Yes	Study still open figures not finalised.

The reports of 35 national clinical audits were reviewed during 2015-16 and we intend to take the following actions to improve the quality of the healthcare we provide:

### **Asthma**

The respiratory team at Evelina London Children's Hospital has developed new clinical guidelines, new personalised management plans, and new information for parents. Hospital staff are also working with community colleagues to improve the care of children with asthma outside hospital.

### **Bowel cancer**

The audit showed that our mortality and readmission rates are in line with national averages, and that we perform the largest number of major rectal cancer resections in London. The service will enhance its internal systems to increase coverage of the clinical dataset and submission.

### **Intensive Care National Audit and Research Centre Case Mix Programme**

The Trust compares favourably with national figures in most areas of the audit. In particular our Standardised Mortality Ratio is significantly lower than expected and the Trust performs well in the care of patients admitted with sepsis and pneumonia. The service will continue to monitor quarterly and annual reports for areas of improvement; all recommendations from the national report are currently met.

### **Congenital heart disease**

The audit flagged the Trust as an outlier for one surgical procedure; a full report was submitted to the audit, in line with the Department of Health's outlier policy, and a review by the two professional bodies who oversee the audit clinically concluded that no further action was required. The audit also found an upward trend in 30 day mortality over the previous 18 months and the service continues to review this. The service will work on implementing new software and staff training to allow capture of new dataset items.

### **Chronic Obstructive Pulmonary Disease (COPD) Audit**

An audit of pulmonary rehabilitation showed that we perform well in patients achieving a clinically meaningful improvement in exercise capacity (Trust 80%, national 57%) and for patients achieving a

clinically meaningful improvement in health status (Trust 87%, national 61%). There is a comprehensive action plan in place for areas identified as needing improvement, including working with our commissioners to review demand and capacity. We are also reviewing discharge processes to ensure all patients receive an individualised plan for ongoing exercise and updating standard operating procedures in conjunction with our partners at King's College Hospital and in the community.

### **Falls and Fragility Fractures Audit Programme**

The audit showed that the Trust performs the highest number of total hip replacements in England and that we perform well in time to surgery, length of stay and discharging patients back to their usual residence within 30 days. Areas for improvement are our reoperation rate and preventing pressure ulcers. The service is implementing an action plan to address these.

### **Inpatient falls**

The audit showed that we are performing better than the national average in most areas. Areas for improvement have been identified as measuring standing and lying blood pressure, monitoring medication that increases the risk of a fall, and providing a vision assessment for all patients. The Trust has a falls working group that is implementing an action plan to address these issues.

### **Irritable bowel disease**

We performed better than the national average for most domains of the audit and were judged excellent in giving patients access to specialist advice and reproductive health advice. We performed less well in patients accessing psychological support, and we do not have a dedicated gastrointestinal ward. The service is implementing an action plan to address these issues.

### **Lung cancer**

The Trust was significantly above average for patients who went on to have treatment following diagnosis. All patients are also discussed at the multi-disciplinary team meeting and we are above the national average

for patients receiving CT scans prior to their bronchoscopy, which is best practice. We were below average for the clinical nurse specialist being present at diagnosis. This may be a data collection issue which the team is investigating and we will take action to improve if necessary. The service is also working on data collection processes to mirror the new reporting schedule.

### **Mental health in the Emergency Department**

We were above the national average for risk assessing patients who have self harmed and for having an appropriate facility for the assessment of patients with mental health problems. We were also above the national average for recording a mental state examination but this is an area for improvement, as is ensuring that patients are reviewed within one hour of referral to the mental health team. The Emergency Department is implementing an action plan to address these issues.

### **Intermediate care**

Adult Community Services will review readmission rates and the reasons for readmission and will determine if there is potential to reduce length of stay. New processes are in place to improve data coverage for the audit.

### **Sepsis**

Our Emergency Department performed above the national average in a number of areas audited. However, overall performance has declined since the previous audit in 2011 and a comprehensive action plan is being implemented to address this.

### **Oesophago-gastric cancer**

Our 30 day and 90 day mortality rates following curative surgery were better than the national average and the 3rd lowest in the London Cancer Network. Our overall complication rate was the lowest in the network. Identification of appropriate cases and data completeness need to be improved and action is being taken to improve this.

### **Paediatric diabetes**

We achieved higher than the national average in five of the seven key care processes audited. We were also markedly better than the national average for children receiving structured education and for children offered psychological support. Our median HbA1c levels and the number of children achieving target HbA1c are worse

than the national average; this is most likely due to the characteristics of our local population, but action is being taken to improve this and to ensure that more children are screened for retinopathy and have foot examinations.

### **Assessing older people for cognitive impairment in the Emergency Department**

Our Emergency Department was above the national average for performing Early Warning System assessments and for sharing the findings with the admitting service. We achieved the national average for assessing cognitive impairment, but were below average for sharing assessment results with the patient's GPs. An action plan is being implemented to address this.

### **Stroke**

We were in the top 14% of trusts to achieve an 'A' rating for key indicator performance. We demonstrated organised and efficient use of speech and language therapy, high rates of early supported discharge, high rates of cognitive and nutritional assessment and an excellent palliative care model. We need to improve access to stroke unit care, length of stay, six month follow up, and access to psychology. A comprehensive action plan is being implemented to address these issues.

### **Trauma**

Our compliance rate has improved from 47% to 65% for this audit. We aim to achieve 80% for the next audit and our Emergency Department is working closely with the Trust's informatics team to improve data capture.

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## Local clinical audit

Reports of 273 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 and safety of our services:

### Acute

The Emergency Department is working with radiology to improve the time taken for computerised tomography (CT) scans to be performed and reported for patients who have suffered a head injury.

Our resuscitation teams have introduced 'huddle handovers' to improve the handover of patients and keep them safe when shifts change.

### Abdominal medicine and surgery

Our kidney transplant team has improved the way that they screen and risk stratify patients before transplant to reduce the risk of patients developing diabetes following their transplant.

Gastroenterology has introduced a new guideline for the treatment of patients admitted with alcoholic liver disease.

### Cardiovascular

Cardiac surgery has implemented a new pathway to identify and treat patients who are anaemic before surgery to improve the outcomes for patients post surgery.

Cardiology has improved staff training in placing electrodes for patients having an electrocardiogram (ECG) to reduce the potential for misdiagnosis.

### Children

The Paediatric Intensive Care Unit has developed new documentation and strategies to decrease the likelihood of airway management complications.

Paediatric orthopaedics have amended their documentation and handover processes to ensure that children with cerebral palsy who are having hip surgery have a particular blood test pre and post operatively. This reduces the risk of post surgical complications for these children.

### Children's community

Community paediatrics have established a weight resource area in the waiting room at Sunshine House community clinic and a healthy weight clinic for children following an audit of overweight and obese children.

Following a re-audit, community paediatrics have made further changes to ensure that families of children with ADHD have improved access to education programmes and better information leaflets.

### Clinical imaging and medical physics (CLIMP)

Diagnostic radiology have made changes to the protocol for MRCP scans to improve the diagnostic quality of the scans and to reduce the number of patients needing to be rescanned because of technical difficulties.

Diagnostic radiology has introduced formal teaching sessions for medical students on the radiation doses incurred by patients having diagnostic investigations. As future medical practitioners they will then be better able to inform their patients of the relative risks of investigations and avoid unnecessary exposure.

### Community audits

The Lambeth Early Intervention and Prevention Service is working with local GPs to ensure that all appropriate referral information is received and that patients receive timely and appropriate support.

Community physiotherapists have made changes to the way patients are screened and communicated with, and this has led to a 17% reduction in waiting times for physiotherapy.

### Dental

Oral medicine have introduced new standard operating procedures and improved information for patients being started on azathioprine.

Restorative dentistry are taking steps to improve the use of eye protection by patients and staff during procedures.

### Specialist Ambulatory Services

Dermatology has changed the way they allocate appointment slots to make better use of capacity and to improve patients' access to the service.

Child allergy has made changes to the way they manage children who are allergic to common drugs, such as ibuprofen and paracetamol, during drug challenge procedures, to make the process safer.



### Medical specialties

Diabetes and endocrinology have developed a training video, a smartphone app and an e-learning package for staff to improve the management of steroid induced hyperglycaemia.

### Oncology and haematology

Thoracic surgery has introduced a checklist for patients who need to be transferred from other hospitals for urgent surgery. This will reduce the chance of patients being transferred unsafely, which can lead to increased complications and mortality.

The palliative care team has made changes to the way strong pain killing medication is prescribed to achieve better pain relief for patients and better communication with the patient's GPs.

### Preoperative, critical care and pain (PCCP)

Anaesthetics have revised their local guideline and storage procedures to ensure that all staff are aware of the guidance on the treatment of local anaesthetic toxicity.

### Surgery

Orthopaedics and trauma has introduced a checklist, a discharge proforma and established a task force for patients who suffer a fractured neck of femur. This will ensure that we meet the standards set by the national hip fracture database.

### Therapies

Our physiotherapists have developed a new training tool and appointed a clinical champion to improve the way that patients who require rehabilitation following critical care are assessed.

Speech and language therapists have developed a new communication risk scale screening tool to help ensure that patients in intensive care are appropriately referred.

### Women's services

The gynaecology unit has improved the way that women are screened and treated to prevent venous thromboembolism.

Maternity services have redesigned care planning for women expecting twins or triplets to ensure the service meets national quality standards.

## Our participation in clinical research

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

We are part of King's Health Partners; one of six academic health sciences 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. 284 non commercial studies began in 2015-2016 and 99 commercial studies were also initiated.

Last year, over 31,000 patients took part in research which was approved by our research ethics committee. During 2015-16, over 1,100 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.

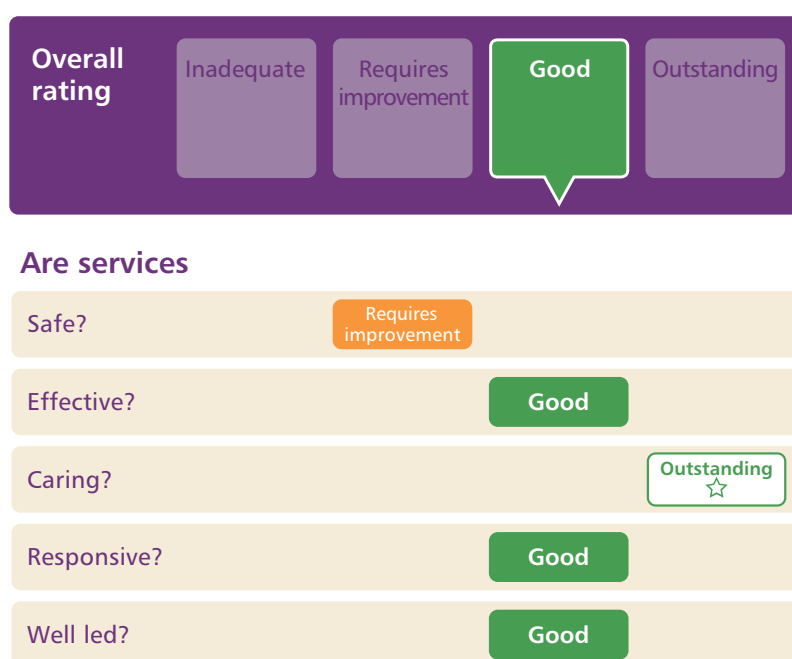
Guy's and St Thomas' and King's Health Partners are at the leading edge of national and international research. We managed over £50 million in research awards in 2015-2016 (National Institute Health Research).

## Statements from the Care Quality Commission

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

The CQC has not taken enforcement action against Guy's and St Thomas' NHS Foundation Trust during 2015-16.

The Trust's services were assessed by the CQC in September 2015, and we were pleased to achieve an overall rating of 'Good'. This is a significant achievement given the size and complexity of the Trust, and is a tribute to the commitment and effort of staff across the organisation. The Trust was rated 'Outstanding' for caring services, and 'Good' for effectiveness, responsiveness, and being well-led. We were rated as 'requires improvement' for safety.



We were delighted that Evelina London Children's Hospital and the Emergency Department (A&E) at St Thomas' were rated 'Outstanding'.

The CQC highlighted three areas where the Trust needed to take action: consistently documenting venous thromboembolism (VTE) risk assessments in maternity; midwifery staffing levels in the Antenatal Day Assessment Unit (ADAU); and improving the effectiveness of governance links between surgical directorates. The Trust developed a detailed action plan to address these issues, most of which were completed by April 2016, and reported on at our Quality Summit.

Action plans are also in place to respond to the additional recommendations made by the CQC in their inspection these include a number of ways in which we assure safety, including through the consistent application of all five steps of the WHO surgical safety checklist and by consistently sharing the outcomes and learning from incidents. To ensure delivery to the agreed timescales these are being monitored by the Trust Risk and Quality Committee reporting to the Quality and Performance Committee.

No special reviews or investigations by the CQC took place in 2015-16.

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

### Our CQUIN performance

In 2014-15 we secured 98.7 per cent of the CQUIN targets generating over £19.6 million of income. The Trust did not receive CQUIN payments in 2015-16 as we remained on the 2014-15 Tariff.

Our local incentive scheme (LIS) funding, which replaced CQUIN arrangements in some CCGs, totalled £4.75 million in 2015-16. This formed part of monthly contract payments. The Trust achieved 90% of the schemes in 2015/16.

### Our data quality

It is essential that we produce accurate and reliable data about patient care. For example, how we code a particular procedure or illness is important as it anonymously informs the wider health community about disease trends, as well as ensuring we 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 were addressed through an action plan, and this work continues to be part of the Trust's *Fit for the Future* programme. A steering group, chaired by a Deputy Medical Director, meets regularly to review progress across a range of process and quality indicators.

The Trust submitted records during 2015-16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published 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.

We achieved a 'satisfactory' (green) rating in our self-assessment against the 2015-16 information governance toolkit. This was an overall score of 74%.

### Clinical coding error rate

The Trust was not selected for a Payment by Results Pricing and Costing clinical coding audit by Monitor during 2015-16. Based on its quarterly internal audits of clinical coding, the Trust achieved a mixture of level 2 and level 3 standards, using the methodology set out in the Information Governance Toolkit Requirement 505.

The clinical coding error rate split by category was:

- primary diagnosis incorrect – 9%
- secondary diagnosis incorrect – 10%
- primary procedures incorrect – 9%
- secondary procedures incorrect – 6%.

# 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 our performance reflects that:

- the Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived;
- data is collated internally and then submitted on a monthly basis to Health and Social Care Information Centre (HSCIC) via the Secondary Uses Service (SUS). The SHMI is then calculated by HSCIC, with results reported quarterly on a rolling year basis;

	Oct 13 – Sept 14	Jan 14 – Dec 14	Apr 14 – Mar 15	July 14 – June 15	Oct 14 – Sept 15
SHMI	82.7	80.5	79.3	75.3	73.7
Banding	3	3	3	3	3
% Deaths with palliative care coding	40.8%	43.9%	46.7%	46.3%	47.2%

Source: HSCIC (data updated quarterly on a rolling basis)  
SHMI Banding 3 = mortality rate is lower than expected

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

## Patient reported outcome measures

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

We believe our performance reflects that:

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

Primary hip replacement – average health gain	2011-12	2012-13	2013-14	2014-15
<b>Guy's and St Thomas'</b>	<b>0.40</b>	<b>0.42</b>	<b>0.47</b>	<b>0.43</b>
National average	0.42	0.44	0.44	0.44
Highest	0.50	0.54	0.54	0.52
Lowest	0.31	0.32	0.31	0.33

Source: HSCIC

2014/15 data provisional. Final data not available until later in the year

Primary knee replacement – average health gain	2011-12	2012-13	2013-14	2014-15
<b>Guy's and St Thomas'</b>	<b>0.25</b>	<b>0.31</b>	<b>0.35</b>	<b>0.36</b>
National average	0.30	0.32	0.32	0.32
Highest	0.41	0.42	0.42	0.42
Lowest	0.18	0.21	0.21	0.20

Source: HSCIC

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 a 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 and Social Care Information Centre (HSCIC) is for 2013-14. Using data from the Healthcare Evaluation Data system we are able to access full year information for 2015-16, which also gives the national average performance and benchmarking data.

We believe our performance reflects that:

- the Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived;
- data is collated internally and then submitted on a monthly basis to Health and Social Care Information Centre (HSCIC) via Secondary Uses Service (SUS). This data is then used by the Healthcare Evaluation Data system to calculate readmission rates;
- data comparing to peers, and highest and lowest performers, is not available for the reporting period.

Readmissions	2014-15			2015-16		
	Under 16	16 and over	Total	Under 16	16 and over	Total
<b>Discharges</b>	16,074	72,908	<b>88,982</b>	15,179	67,010	<b>82,189</b>
<b>28 day readmissions</b>	656	6,160	<b>6,816</b>	617	6,045	<b>6,662</b>
<b>28 day readmission rate</b>	4.1%	8.4%	<b>7.7%</b>	4.1%	9.0%	<b>8.1%</b>

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

Our score for the five questions in the national inpatient survey relating to responsiveness and personal care are above the national average as shown below. The data is compared to peers, highest and lowest performers and our own previous performance as set out in the table below.

Patient experience	2011-12	2012-13	2013-14	2014-15
<b>Guy's and St Thomas'</b>	<b>69.7</b>	<b>71.4</b>	<b>73.1</b>	<b>71.4</b>
National Average	67.4	68.1	68.7	68.9
Highest	85	84.4	84.2	86.1
Lowest	56.5	57.4	54.4	59.1

Source: HSCIC \*The results for 2015-16 were not available at time of report.

## Staff recommendation to friends and family

The Trust has high levels of staff engagement and our results in both our Staff Survey and 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.

We believe our performance reflects that:

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

Staff recommendation	2012-13	2013-14	2014-15	2015-16
<b>Guy's and St Thomas'</b>	<b>82%</b>	<b>87%</b>	<b>85%</b>	<b>89%</b>
Average for acute*	60%	66%	68%	70%
Highest acute trust*	86%	94%	93%	93%
Lowest acute trust*	35%	40%	36%	46%

Source: [www.nhsstaffsurveys.com](http://www.nhsstaffsurveys.com)

\*All data from 2015-16 is for combined acute and community trusts, due to a change in the way results are reported.

## Patient recommendation to friends and family

We believe that patient recommendation to their friends and family is a key indicator of the quality of care we provide. Recommendations for inpatient and day case areas continue to be high and scores for A&E attendees have stabilised whilst maintaining a robust response rate.

We believe our performance reflects that:

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

Friends and Family Test	2014-15		2015-16	
Guy's and St Thomas'	A&E	Inpatient	A&E	Inpatient
Response rate	14.7%	37.6%	15.7%	30.4%
% would recommend	83.7%	96.9%	85.0%	95.6%
% would not recommend	8.6%	0.9%	8.2%	1.7%

Source: trust information system

## Infection control

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

We believe our performance reflects that:

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

Infection control	2012-13	2013-14	2014-15	2015-16
Guy's and St Thomas'				
Trust apportioned cases	48	43	51	51
Trust bed-days	314,389	319,441	321,749	324,000
<b>Rate per 100,000 bed-days</b>	<b>15.3</b>	<b>13.5</b>	<b>15.9</b>	<b>15.7</b>
National Average	17.4	14.7	15.1	–
Best performing trust	0	0	0	–
Worst performing trust	31.2	37.1	62.2	–

Source: Public Health England and trust information system  
2015-16 national data is not yet published

## 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, so different trusts may choose to apply different approaches and guidance when reporting, categorising and validating patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. These judgements may differ between professionals, and data reported by different trusts may therefore not be directly comparable.

We believe our performance reflects that:

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

Patient safety incidents	Apr 13 – Sep 13	Oct 13 – Mar 14	Apr 14 – Sep 14	Oct 14 – Mar 15
<b>Guy's and St Thomas'</b>				
Total reported incidents	5,835	6,107	7,146	6,929
Rate per 1,000 bed-days	8.7%*	9.1%*	45.3	41.8
National average (acute non-specialist)	8.0%	8.7%	36.4	40.4
Highest reporting rate	12.8%	14.9%	75.0	82.2
Lowest reporting rate	4.9%	4.6%	0.0	0.0

Source: HSCIC Note: From the April-Sep 14 period the NPSA is providing incidents per 1,000 bed days.

\*Previous periods show incidents per 100 admissions (ie as a percentage).

<b>Guy's and St Thomas'</b>				
Incidents causing severe harm or death	8	5	17	22
% incidents causing severe harm or death	0.1%	0.1%	0.2%	0.3%
National average (acute non-specialist)	0.3%	0.4%	0.5%	0.5%
Highest reporting rate	0.9%	0.1%	3.4%	5.2%
Lowest reporting rate	0.0%	0.0%	0.0%	0.1%

Source: HSCIC

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, although this remains significantly below the national average. 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. All serious incidents are investigated using root cause analysis methodology. We continue to work closely with commissioners and the National Reporting and Learning System (NRLS) to ensure that any changes made to incident classifications following a root cause investigation are reported to 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 which aim to improve the quality and safety of our services.

## Venous thromboembolism

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

Our clinical staff remain at the forefront of venous thromboembolism care nationally and internationally, including through clinical research and service development.

We believe our performance reflects that:

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

VTE assessments	2012-13	2013-14	2014-15	2015-16
<b>Guy's and St Thomas'</b>	94.2%	96.3%	97.1%	97.2%
National average	94%	96%	96%	–
Best performing trust	100%	100%	100%	–
Worst performing trust	87%	81%	88%	–

Source: HED and trust information system

2015-16 national data is not yet published

# Progress against priorities for 2015-16

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.

Last year we reported on a number of quality priorities in 2014-15 that were only partially achieved. We continue to work hard to address these and a number of actions, particularly the avoidance of never events, full compliance with the WHO surgical checklist and improving our complaints handling processes, remain priorities at the present time.

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

Patient safety		
Our quality priorities and why we chose them	What success will look like	How did we do?
<b>We will achieve the 2015/16 CQUIN for the identification and treatment of acute kidney injury (AKI).</b>	<ul style="list-style-type: none"> <li>We will track the percentage of patients with AKI whose discharge summary includes four key items: <ul style="list-style-type: none"> <li>stage of AKI</li> <li>evidence of medicines review</li> <li>type of blood tests required on discharge</li> <li>frequency of blood tests required on discharge</li> </ul> </li> </ul>	<p><b>We did not achieve this.</b></p> <ul style="list-style-type: none"> <li>Testing and sign off of the AKI algorithm suggested by NHS England was significantly delayed by the need to ensure compatibility with our systems. The plan is to roll this out in June/July 2016. Identifying patients with different stages of AKI on EPR will enable us to include information related to AKI stage and medicines review in the discharge letter.</li> <li>The intervention workstream of the National 'Think Kidneys' programme has developed a generic discharge template for patients with AKI. It includes information related to the type and frequency of blood tests required after discharge. We plan to work with our EPR and e-noting teams to adopt this discharge template.</li> </ul>
<b>We will achieve the 2015/16 CQUIN for the identification and treatment of sepsis</b>	<ul style="list-style-type: none"> <li>We will screen all appropriate patients for sepsis and rapidly initiate IV antibiotics for patients with suspected severe sepsis, red flag sepsis or septic shock.</li> <li>We will identify the number of patients who present to us with severe sepsis, red flag sepsis or septic shock and establish a baseline for those that receive intravenous antibiotics within one hour of presenting.</li> </ul>	<p><b>We achieved this.</b></p> <p>Audits in the Emergency Department are now routinely reported, the Acute Medical Unit audit has been completed and key areas of focus have been identified. Trustwide audit of sepsis alerts and an audit of unplanned critical care admissions with sepsis are underway.</p> <p><b>We achieved this.</b></p> <p>Our Site Nurse Practitioners and the Critical Care Response Team discuss response and implementation of sepsis alerts. We also have a tool to enable recording in electronic notes.</p>
<b>We will improve patient safety through the standardisation of how clinical decisions are described and recorded</b>	<ul style="list-style-type: none"> <li>We will roll out Medchart (EPMA) to Women's Services, Evelina London Children's Hospital and the Emergency Department.</li> <li>We will deploy e-noting to all inpatient areas by year end.</li> </ul>	<p><b>We achieved this.</b></p> <p>MedChart was deployed within NICU as planned in early December 2015. Medchart will not be deployed in the Emergency Department until we receive a software upgrade in mid 2016.</p> <p><b>We achieved this.</b></p> <p>Roll out to wards at Guy's was completed in May 2015. Roll out to the adult wards at St Thomas' has also been completed, and roll out to Evelina London Children's Hospital commenced in November 2015.</p>

## Patient safety

### Our quality priorities and why we chose them

### What success will look like

### How did we do?

#### Consolidate progress in core patient safety practices

- 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 Catheter Assisted Urinary Tract Infections (CAUTIs) across England
- We will continue and improve our record of excellence in managing the risk of venous thromboembolism (VTE).
- Our WHO surgical safety checklist will show compliance at 95% or more.
- Our audits will maintain or exceed the 2014/15 compliance of 91% with the falls risk assessment tool.
- We will have no never events.

#### We did not achieve this.

The target is zero Trust attributable MRSA bacteraemia (blood infections), we have had two. One occurred in Q1 and was found to have been unavoidable, the second in Q4 is under investigation at the time of reporting.

The target was 51 C.difficile EIA+ve cases, we had 51 cases, and of these 4 cases were the result of a lapse of care.

#### We did not achieve this.

We had four attributable grade 4 pressure ulcers, three occurred in patients being nursed in the community and one in a patient in our acute hospitals. All have been the subject of a full root cause analysis and were found to have been avoidable. Action plans to prevent recurrence have been implemented.

#### We achieved this.

We remain below the lower control limit and monthly sampling data suggests a continuing downward trend. Through our local Health Improvement Network, we have recently set up a collaborative with five other trusts to spread good practice across south London.

#### We achieved this.

We consistently meet the NICE guidance target to risk assess more than 95% of patients for risk of VTE within 24 hours of admission. We are also part of the NHS Exemplar Centre for our VTE management and performance.

#### We did not achieve this.

Following a fall in compliance to 81% in February 2015, an audit in August 2015 showed an improvement to 90%. A further audit in March 2016 showed compliance had fallen back to 84%. A Surgical Safety Group has been established to oversee all aspects of surgical safety, including use of the checklist and implementation of the new National Safety Standards for Interventional Procedures. New ways of more responsive monitoring using electronic systems are also being investigated so that more real time data on compliance with the checklist can be gathered.

#### We do not know if we achieved this.

The audit to determine compliance has not been carried out in 2015/16, it has been delayed by the need to use audit resource to carry out an audit of staff knowledge of the new falls pathway.

#### We did not achieve this.

During 2015/16 there have been 16 never events recorded; five related to retained foreign objects, one to a wrong implant, five to wrong site surgery, three concerned misplaced nasogastric tubes, one wrong route administration of medication and one mis-selection of a strong potassium containing solution.

The Trust has taken this very seriously; an action plan has been developed and agreed with commissioners and is being implemented. We held a never event summit in February 2016, with senior clinical staff and patient safety specialists. This was the formal launch of the Trust's campaign 'Always Safe' which aims to ensure that learning from root cause analyses is shared and embedded, helping to prevent further incidents.



## Clinical effectiveness

### Our quality priorities and why we chose them

### What success will look like

### How did we do?

#### Improve care for chronic obstructive pulmonary disease (COPD)

- We will improve the diagnosis of patients attending A&E with breathlessness.
- We will work with the Lambeth and Southwark COPD group to track progress and improve outcomes reported in national audits.
- We will ensure that patients admitted with COPD exacerbation receive a respiratory specialist opinion within 24 hours, 7 days a week.
- We will assess and manage acute and chronic breathlessness in line with Lambeth and Southwark breathlessness pathways and the London respiratory strategic clinical network guidance.
- We will complete roll out of smoking cessation advice across the respiratory care service.

#### We achieved this.

We have developed and appointed to a joint acute/community consultant role that mirrors the service offered at King's College Hospital. The postholder will develop our community service, whilst integrating with the acute service teams to improve early intervention and prevention of hospital attendance and admission. We are working closely with King's College Hospital and the respiratory network to ensure similar standards of care across local hospital services.

#### We achieved this.

We continue to collaborate and to engage in national and local audits to ensure compliance and the quality of our services. Latest national audit results demonstrate improved performance.

#### We achieved this.

The service has an integrated respiratory team that sees all patients admitted with COPD within 24 hours.

#### We partly achieved this.

Progress has been made with the integrated respiratory team and a respiratory core group, and we will continue this work in 2016 to deliver pathway requirements and guidance.

#### We achieved this.

We are compliant with NICE guidance for smoking cessation. We have a clinical lead for smoking cessation within the service. The Trust has become smoke free, and we have increased our campaign to improve our referral rate into smoking cessation services.

#### Reduce the number of obstetric anal sphincter injuries (OASIs)

- We will introduce a new clinical training programme for staff.
- We will achieve a 50% reduction in the rate of OASI at midwife led births from the 2014/15 rate by end of 2017/18.
- We will achieve a 25% reduction of OASI at obstetric led births from the 2014/15 rate by end of 2017/18.

#### We achieved this.

These targets form part of a three year programme, and the targets set for the first year have been achieved.

Data is now collected and analysed on a monthly basis. Monthly PEACHES e-mails are sent to all birth centre clinicians to highlight improvements to date.

Case reviews continue for each OASI and learning is fed back to staff.

## Clinical effectiveness

### Our quality priorities and why we chose them

### What success will look like

### How did we do?

#### Improving care for the deteriorating child

- We will achieve 100% compliance with the Paediatric Early Warning Score (PEWS).
- We will demonstrate increased use of the SBAR tool in escalations.
- We will reduce the incidence of failure to recognise/escalate the deteriorating child to 10%.
- We will achieve a 50% reduction in medication incidents resulting in harm.
- We will be using the Safety Thermometer in all paediatric inpatient areas.

#### We achieved this.

PEWS now fully in use across all designated clinical areas of Evelina London Children's Hospital with the planned exception of NICU and PICU.

#### We achieved this.

An audit of unplanned admissions to PICU showed 73% of admissions had an associated SBAR assessment where indicated. Implementation of PEWS on e-noting in May/June 2016 will include a mandatory alert to use the SBAR tool when any child fulfils the escalation criteria.

#### We achieved this.

Weekly PICU unplanned admission reviews demonstrate appropriate early recognition and escalation of clinical deterioration rose from 63% to 93% in the 6 months since introduction of 'safety huddles' and PEWS.

#### We have not yet achieved this three year target

Good progress has been made towards achieving the year three target. Prescribing improvement projects underway include improved training and assessment processes for new doctors.

The electronic medicine chart (MedChart) has been implemented across all planned areas in the Evelina London Children's Hospital.

Medication incident rates are difficult to interpret during transition to the MedChart system.

#### We achieved this.

This was successfully implemented in line with national guidance in August 2015.

### Patient experience

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

#### What success will look like

#### How did we do?

#### We will continue our focus on patients with dementia and their carers

- We will increase the percentage of nursing staff on the Older Persons' Unit who have received Tier 2 training to 85%. All other clinical areas will have a minimum of 25% trained staff.

#### We partially achieved this.

On two elderly care wards we achieved 85%, and Alexandra Ward achieved 81% level 2 training. All other clinical areas achieved 25% with the exception of Lane Fox, Albert Ward, the haematology day unit and Hedley Atkins Ward which achieved between 20 and 22%.

#### #hello my name is

- We will roll out #hello my name is to all staff across the Trust.
- We will see an improvement on the score for 2014-15 on the inpatient survey question 'Did you find someone on the hospital staff to talk about your worries and fears?'

#### We achieved this.

10,000 staff had badges by the start of September 2015 and a process is in place to order badges for new staff as routine.

#### We achieved this.

Qualitative evidence from local inpatient surveys, media sources and patient letters suggests that introduction of the badges has changed the way that staff speak to and engage with patients. Patients also report growing confidence in approaching staff. Areas where this has become apparent include day surgery and outpatients. In 2016 the Trust saw a 7% improvement in its score for the national survey question asking patients whether they had been able to find a member of staff to speak to if they had any concerns. This suggests that the campaign has been successful in raising patients awareness of who to ask and staff approachability.

#### Improving medicines management at the time of discharge

- 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.

#### We achieved this.

These targets form part of a three year programme, and the targets set for the first year have been achieved. An audit of medication related communications has been conducted and the results shared using the Trust's 'Safety Signal'. Work has been completed to identify types of drugs most frequently involved in safety incidents. A patient reference group has been formed in association with local HealthWatch. New draft discharge communication has been developed. Medication Administration Records have been introduced to patients' homes, with no further duplicate dose incidents reported since their introduction. We are working with King's College Hospital and our commissioners to produce a short medication summary for high risk patients that will assist community health professionals such as community pharmacists. We are exploring use of the Trust website for medicines management information for GPs and medicines advice for patients. We are working with community staff to better understand medicine problems when patients leave hospital and how to prevent them.

## Our performance against Monitor Risk Assessment Framework indicators

Monitor uses a number of national measures to assess access to services and outcomes, and 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 acquisitions (including: cases deemed not to be due to lapse in care and cases under review)	51	51 ●	13	19	6	13
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	92.3% ●	93.1%	92.3%	91.9%	91.8%
A&E access	95% A&E patients wait less than 4 hours	95%	92.8% ●	95.1%	93.3%	92.7%	90.2%
Cancer access initial appointments	Urgent cancer referrals seen within 2 week wait	93%	92.8% ●	93.3%	94.8%	93.6%	89.7%
	Symptomatic breast patients seen within 2 week wait	93%	95.0% ●	96.6%	95.0%	95.5%	92.5%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	69.4% ●	69.6%	67.8%	70.3%	69.9%
	% patients treated within 62 days from screening referral	90%	88.8% ●	87.0%	93.8%	92.6%	84.4%
	From diagnosis to first treatment within 31 days	96%	94.3% ●	94.4%	94.2%	94.7%	94.1%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	91.6% ●	92.2%	92.5%	90.5%	91.3%
	Chemotherapy treatments within 31 days	98%	98.7% ●	99.1%	99.1%	98.5%	98.1%
	Radiotherapy treatments within 31 days	94%	96.0% ●	96.7%	96.1%	95.8%	95.5%
Community care information completeness	Referral to treatment information completeness	50%	63.2% ●	64.7%	64.9%	60.4%	64.4%
	Referral information completeness	50%	85.5% ●	85.2%	85.6%	92.6%	76.0%
	Activity information completeness	50%	83.9% ●	78.7%	79.6%	93.0%	85.8%

In addition to these indicators, we certified compliance with the requirements to ensure that people with a learning disability can access health care. However following publication of the Independent Review of deaths of people with learning disabilities or mental health problems in contact with Southern Health NHS Foundation Trust\*, we will move to strengthen consistency and standardisation of practice across our hospital and community services.

\* Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

## 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.

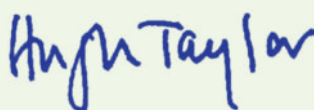
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

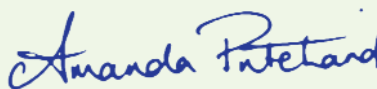
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 to March 2016
  - papers relating to quality reported to the board over the period April 2015 to March 2016
  - feedback from commissioners dated 20/05/2016
  - feedback from local Healthwatch organisations dated 20/05/2016
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015
  - the 2015 national patient survey published February 2016
  - the 2015 national staff survey published February 2016
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 11 May 2016
  - CQC Inspection Report dated 24 March 2016
- 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) as well as the standards to support data quality for the preparation of the Quality Report.

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  
25 May 2016



**Amanda Pritchard**, Chief Executive  
25 May 2016



## 2015/16 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 2016 (the 'Quality Report') and certain performance indicators contained therein.

#### Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the Indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge.

#### 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicator 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 supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance 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 and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners dated May 2016;
- feedback from governors during the presentation at the Governors Quality and Engagement Group May 2016;
- feedback from local Healthwatch organisations dated May 2016;
- feedback from Overview and Scrutiny Committee was requested on 10 May and followed up but has not yet not been received;
- 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 patient survey published February 2016;
- the latest national staff survey published February 2016;
- the 2015/16 Head of Internal Audit's annual opinion over the trust's control environment dated April 2016; and
- the latest CQC Inspection Report dated March 2016.

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.

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 the 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 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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.

### 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 indicator;
- 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; and
- 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.

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

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

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

### Basis for qualified conclusion

Our testing of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator identified the following:

- one case where there was insufficient supporting evidence available to evidence the stated pathway end date;
- two cases where the number of weeks on the pathway stated within the Patient Tracking List reports reviewed did not agree back to the supporting evidence; and
- one case where the pathway end date was incorrectly recorded as four days after the treatment date.

The Trust has referred to the issues identified in relation to the indicator on page 66 of the quality report and the actions planned to resolve these.

As a result of these issues, we are unable to give limited assurance on the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator included in the Quality Report for the year ended 31 March 2016.

### Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the other indicator in the Quality Report subject to limited assurance (A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge) has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

KPMG LLP

**KPMG LLP**

Chartered Accountants

London

25 May 2016

## Lambeth CCG statement on Guy's and St Thomas' NHS Foundation Trust 2015 Quality Accounts – on behalf of NHS Lambeth and Southwark Clinical Commissioning Groups and NHS England

1. It is useful to see the "how did we do" section for 15/16. This is helpfully set out and easy to read

2. Conversely, the document from page 14-27 is not easy to follow as doesn't seem to have much structure. It would be helpful if it was segmented better, e.g. into patient safety, experience and effectiveness

3. There is little/no evidence of community services in the document. It would be nice to see how this features in their priorities other than the national must do's e.g. PU 4, avoidable harms, etc

4. The areas GSTT have focused upon for 2016/17 cover CQUINs, SutS priorities and some locally set priorities. I don't recall the stakeholder event they refer to (December 2015) so am not able to comment on how well these reflect stakeholder's priorities raised. Whilst all seeming worthwhile the items don't reflect issues that have come up through SIs or CQRGs

5. The SHIMI looks as if it is at a suitable rate though it only covers half of 15/16 and some items (hips?) was an area raised by CQC. Is the first half of the year the only data available?

Finally the document doesn't summarise how stakeholders will be involved in the work going forward. Perhaps this would be useful as a closing statement?

**Anne Middleton,**

Assistant Director of Governance,  
NHS Lambeth Clinical Commissioning Group

20 May 2016

## Guy's and St Thomas' NHS Foundation Trust Quality Accounts 2015/16: Response from Healthwatch Lambeth and Healthwatch Southwark

This is a joint response to the Guy's and St Thomas' NHS Foundation Trust (GSTFT) Quality Account 2015/16 from Healthwatch Lambeth and Healthwatch Southwark because GSTFT services operate across these boroughs.

We appreciate the opportunity to comment on the quality of the services provided by GSTFT.

### Progress against Quality Priorities 2015-16

As an overarching theme, we encourage the Trust to review how 'success indicators' are set. We would like to see the Trust report on accurate measures of changes to safety, clinical effectiveness and patient experience that focus on outcomes rather than activities. This would support stakeholders to grasp how the activities translate into improvements to care quality.

### Patient Safety

**Standardised recording of clinical decisions:** we would require more information to understand if roll-out of a new system ensures uptake, and the degree to which the quality of recording is dependent on staff input.

**Core patient safety practices:** Only two of the seven core practices were achieved this year, though we recognise that targets of zero Trust-attributable MRSA, C-Difficile and pressure ulcers were missed narrowly. Of greater concern are the number of never events and the volatility in compliance with the WHO surgical safety checklist. The action plans outlined reassure us that the Trust is taking these issues seriously. Healthwatch encourage the Trust to find ways to empower patients to be active in supporting their own safety alongside stringent Trust procedures.

### Clinical Effectiveness

**Improve care for chronic obstructive pulmonary disease (COPD):** The narrative of progress provides insufficient detail to assess whether the success indicator was met.

**Obstetric anal sphincter injuries:** It would be useful for the Trust to explicitly report the actual achievement against the year one milestone of this three year plan.

### Patient Experience

**Medicines management at discharge:** We welcome the Trust's work to improve medicines management at discharge as this has been raised with us through our 'Going Home' project which tracks the experience of patients following their discharge from hospital. Healthwatch encourage the Trust to seek opportunities to involve patients in developing communication tools identified in its improvement programme, and are willing to support the process where appropriate.

### Quality Priorities for 2016-17

A number of quality priorities have been carried forward from last year and we welcome the continuing commitment to achieve these. As the Quality Account is a standalone document, transparency with regards to how priority areas were chosen would be helpful. It would also be useful to briefly outline key themes and success indicators from Trust-wide plans that are referred to within the report (e.g. Complaints Handling Improvement Plan, Sign up to Safety programme).

### Patient Safety

**Sepsis:** The Trust achieved its CQUIN in this area last year, but audit data suggests that overall performance has declined since 2011. We would like the Trust to outline its rationale for choosing sepsis over other potential CQUIN priorities, especially given that it did not achieve its CQUIN on acute kidney injury last year.

#### Assessment for risk of:

- **Dementia:** We support the commitment to ensuring all appropriate patients are assessed for risk of dementia. We assume that as part of this work, the Trust will be acting on audit findings which highlight the need to improve notification of GPs of the results of cognitive impairment assessments in the Emergency Department.
- **VTE:** As the Trust has at least a two-year record of excellence and achieved its goal in this area last year, it is unclear why it is being chosen as a

quality priority rather than areas of more concern revealed in the data e.g. COPD, paediatric diabetes foot and eye screening, stroke care, and trauma.

**Patient safety practice, preventing serious incidents and never events:** Given last year's results in this area, we agree that this is a priority. We advise the Trust to set and report against an indicator and target regarding the number of never events. As targets around healthcare-acquired infections and grade 4 pressure ulcers were not met last year, we would appreciate it if the Trust can confirm if these will be included in 2016/17 targets

### Clinical Effectiveness

We understand that the priorities of obstetric sphincter injuries, care for the deteriorating child and standardisation of recording of observation, decisions and prescriptions, are part of multi-year action programmes. A brief rationale as to why these have been chosen over other priorities would be helpful.

### Patient Experience

**Nutrition and pain management:** During PLACE visits we noted that the quality of food and drink provided to patients was good, with choice and variety, so it would be helpful if the Trust could highlight why nutrition is deemed to be a problem. It would also be useful if the rationale as to why pain management was chosen as a focus area could be provided, as this seems to be quite a separate issue.

**Complaints management:** We agree that complaints management is important. It would be useful if the Trust could provide some explanation as to whether this, and in particular complaint response times, are a noted problem, and to report a baseline.

### Participation in clinical audits

Given our keen interest regarding how the mental health needs of residents in our boroughs are being met, we welcome the Trust's achievement of above-average results regarding supporting patients with mental health needs in the Emergency Department. We look forward to learning more about progress towards ensuring that patients are reviewed within an hour of referral to the mental health team. The audit

data also suggests that psychological support provision could be improved in the areas of irritable bowel disease and stroke. As the importance of mental health and its interactions with physical health and self-management is increasingly recognised, we urge the Trust to consider how it can incorporate a focus on mental health in future quality priorities.

### Healthwatch Lambeth and Healthwatch Southwark

20 May 2016





Redevelopment of the East Wing at St Thomas' was completed in January. Parts of the building have been overclad with a glazed façade to weatherproof the building and improve its energy efficiency. Two new lifts have also been installed for critically ill patients who need to be transferred from the Emergency Department to the wards or intensive care in East Wing.

## Foreword to the accounts

These accounts, for the year ended 31 March 2016, 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, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.



**Amanda Pritchard**  
Chief Executive and Accounting Officer  
25 May 2016



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

## Opinions and conclusions arising from our audit

### Our opinion on the financial statements is unmodified

We have audited the financial statements of Guy's and St Thomas' NHS Foundation Trust for the year ended 31 March 2016 set out on pages 102 to 131. In our opinion:

- the financial statements give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2016 and of the Group's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

### Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

**Valuation and existence of land and buildings – Land £186.7 million (2014/15: £287.5 million) and Buildings (excluding dwellings) £620.3 million (2014: £635.4 million)**

Refer to page 9 (External Audit Report), page 107 (accounting policy) and page 118 (financial disclosures).

**The risk:** The Group is responsible for ensuring the valuation of land and buildings is correct, and for conducting impairment reviews that confirm the condition of these assets. As a result of the suggested accounting policies provided by Monitor, NHS providers typically achieve this by performing an annual review for impairment, a periodic desk top valuation (every three years) and a full valuation in not more than five yearly intervals. The asset valuation and impairment review processes are both estimates and therefore present a higher level of risk to the audit.

The Group undertook a full valuation of land and building assets in 2015/16. This valuation was completed by a Royal Institution of Chartered Surveyors (RICS) qualified individual.

The 2015/16 financial statements include £66.8 million for revaluation gains, and £217.9 million for impairments or revaluation losses. These have primarily been driven by the Group adopting an alternative site valuation methodology to measure a Modern Equivalent Asset value.

There are particular risks relating to the valuation and existence of the land and buildings valuation figures included within the financial statements.

**Our response:** In this area our audit procedures included:

- Confirmed the existence of the land and buildings through confirmation to land registry documents and also through observation across the Group estate.
- Reviewing the revaluation basis and considering its appropriateness. In doing so we drew on national benchmarks and engaged our property team experts to undertake an assessment of the revaluation.
- Assessing the qualifications, objectivity and expertise of the external valuer to perform the full revaluation exercise;
- Considering the terms of engagement of the valuer to check its consistency with the Group's accounting policies for property, plant and equipment, including the treatment of VAT in depreciated replacement cost valuations;
- Obtaining the instructions provided to the valuer and reconciling the list of properties to be valued to the asset register;
- Completed testing over the completeness and accuracy of the underlying data provided to the valuers to inform their valuation including re-measuring a sample of spaces across the estate;



- Undertaking work to understand the impact on the accounting of land and buildings in the financial statements in particular the split across the Revaluation Reserve and the Consolidated Statement of Comprehensive Income and determining whether they complied with the requirements of the Annual Reporting Manual; and
- Agreeing the appropriateness of any amendments made by management to the information received from the valuer before incorporation into the financial statements.

**Recognition of NHS and non-NHS income – Patient care income NHS £1,008.4 million (2014/15: £956.7 million) and patient care income non-NHS £53.6 million (2014/15: £41.1 million) and non-patient care income £277.7 million (2014/15: £292.1 million)**

Refer to page 11 (Audit Committee Report), page 106 (accounting policy) and page 112 (financial disclosures).

**The risk:** The main source of income for the Group is the provision of healthcare services to the public under contracts with NHS England, NHS Commissioners and other public bodies which make up 79.3% of income. For NHS related income the Group participates in the national Agreement of Balances (AoB) exercise which is mandated by the Department of Health (the Department), for the purpose of ensuring that intra-NHS balances are eliminated when the consolidation exercise takes place to report the Department's Consolidated Resource Account. The AoB exercise also identifies mismatches between income, expenditure, receivable and payable balances recognised by the Group and its counter parties at 31 March 2016.

Mismatches can occur for a number of reasons, but the most significant arise where the Group and its counterparties have not concluded the reconciliations of healthcare spells completed within the last quarter of the financial year, which have not yet been invoiced, or there is not final agreement over proposed contract penalties as activity data for the period has not been finally validated.

In addition to this patient care income the Group reported total income of £277.7m from other activities 20.7% of the total income, primarily through education and training, research and development, or other activities. Much of this income is through contracts with other NHS and non-NHS bodies under contracts that clearly indicate when income will be received; on delivery, milestones, or periodically. Therefore there is a greater risk that the income has not been recognised under the accruals basis, and instead on a cash basis. In particular some sources of income require independent grant confirmations which can impact the amount of the income the Group will actually receive.

We do not consider income to be at high risk of significant misstatement, or to be subject to a significant level of judgment. However, due to its materiality in the context of the financial statements as a whole income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

**Our response:** In this area our audit procedures included:

- Inspecting how the Trust manages the contracts with key commissioners and for the largest income recorded in your financial statements agree to the signed contracts, including the contract variations and seeking explanations from management that these had been agreed.
- In 2015/16 the Trust participated in the Agreement of Balances (AoB) exercise with other NHS organisations. We reviewed these third party confirmations from your commissioners and compared the values they are disclosing within their financial statements to the value of income captured in your financial statements. We sought explanations for any variances over £250k, and all balances in dispute.
- Reviewing the completeness and accuracy of the aged receivable balance and then re-performed the approach to impairing receivables and confirming that they were in line with the Groups accounting policies, and the judgement for the level of provision was appropriate.

- We reviewed the Trusts key contracts with their Education and Training contacts and Research and Development and reviewed the signed contracts for the agreed payment schedule, and confirmed to cash remittances.
- Reconciling the work reported as completed and evidence provided to partners as evidence that requirements for payments were met and hence income accrued.
- Carrying out testing of invoices within the income raised around the financial year-end to determine whether income had been recognised in the appropriate period.
- Considering the adequacy of disclosure about key judgement and degree of estimation involved in arriving at the estimate of revenue receivables and related sensitiveness.

## Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £24 million, determined with reference to a benchmark of income from operations (of which it represents 1.8%). We consider income from operations to be more stable than a surplus related benchmark.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £250,000, in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has five reporting components and all of them were subject to audits for group reporting purposes performed by the Group audit team at one location in London. These audits covered 100% of group income, deficit for the year and total assets. The audits performed for group reporting purposes were all performed to materiality levels set individually for each component as shown below:

- Guy's and St Thomas' NHS Foundation Trust: £24 million
- Guy's and St Thomas' Enterprises Ltd: £10,000
- GTI Forces Healthcare Ltd: £700
- Essentia Trading Ltd: £20,000
- Pathology Services: Ltd £500

## Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and Accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Group's performance, business model and strategy; or



- the Organisational structure/Governance section does not appropriately address matters communicated by us to the audit committee.

Under the Code of Audit Practice we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.
- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

#### **Respective responsibilities of the accounting officer and auditor**

As described more fully in the Statement of Accounting Officer's Responsibilities on page 57 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

#### **Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)**

A description of the scope of an audit of financial statements is provided on our website at [www.kpmg.com/uk/auditscopeother2014](http://www.kpmg.com/uk/auditscopeother2014). This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

#### **Respective responsibilities of the Trust and auditor in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources**

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

#### **Scope of the review of arrangements for securing economy, efficiency and effective in the use of resources**

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements

for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

#### **The purpose of our audit work and to whom we owe our responsibilities**

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, 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 Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.



**Neil Thomas**

for and on behalf of KPMG LLP, Statutory Auditor  
Chartered Accountants  
15 Canada Square  
Canary Wharf  
London E14 5GL

25 May 2016

## Consolidated statement of comprehensive income for the year ended March 31 2016

		March 31 2016 NOTE £000	March 31 2015 £000
Patient care income	3	1,062,640	997,778
Non-patient care income	4	277,690	292,078
<b>TOTAL INCOME</b>		<b>1,340,330</b>	<b>1,289,856</b>
Operating expenses	5.1	(1,346,568)	(1,238,579)
<b>OPERATING (DEFICIT)/SURPLUS</b>		<b>(6,238)</b>	<b>51,277</b>
<b>FINANCE COSTS</b>			
Finance income	10	397	463
Finance expenses	11	(4,818)	(3,973)
Public Dividend Capital dividend payable	28	(23,353)	(23,519)
<b>Net finance costs</b>		<b>(27,774)</b>	<b>(27,029)</b>
Corporation Tax	12	(475)	–
<b>(DEFICIT)/SURPLUS FOR THE YEAR</b>		<b>(34,487)</b>	<b>24,248</b>
<b>Other comprehensive (expense)/income</b>			
Impairments	16	(166,183)	(1,917)
Revaluations	17	63,278	48,992
Other reserve movements		–	(5)
<b>TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE YEAR</b>		<b>(137,392)</b>	<b>71,318</b>

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 (Expense)/Income		March 31 2016 £000	March 31 2015 £000
Total comprehensive (expense)/income as above		(137,392)	71,318
Less reserve movements in other comprehensive (expense)/income	a	102,905	(47,070)
<b>Total comprehensive (expense)/income before reserve movements</b>		<b>(34,487)</b>	<b>24,248</b>
Add back in year impairments and reversals of impairments included in (deficit)/surplus above (see note 16)	b	50,749	4,630
Other non-operating items	c	(310)	1,280
Less capital donations		(26,958)	(12,075)
<b>NET UNDERLYING (DEFICIT)/SURPLUS EXCLUDING ITEMS ABOVE</b>	d	<b>(11,006)</b>	<b>18,083</b>

- 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 consistently from year to year by the Board of Directors to monitor the Trust's financial performance.

# Statement of Financial Position as at March 31 2016

		GROUP		TRUST	
		March 31 2016	March 31 2015	March 31 2016	March 31 2015
	NOTE	£000	£000	£000	£000
<b>NON CURRENT ASSETS</b>					
Property plant and equipment	14	1,057,500	1,153,866	1,057,490	1,153,866
Intangible assets	15	41,787	41,313	41,787	41,313
Investments in associates (joint controlled operations)	18	71	71	500	500
Other Investments	18	74	–	–	–
Trade and other receivables	20.2	1,947	1,787	1,947	1,787
Other financial assets	21	–	3,500	6,686	5,688
<b>TOTAL NON-CURRENT ASSETS</b>		<b>1,101,379</b>	<b>1,200,537</b>	<b>1,108,410</b>	<b>1,203,154</b>
<b>CURRENT ASSETS</b>					
Inventories	19	21,326	19,893	21,326	19,893
Trade and other receivables	20.1	105,075	118,791	104,369	118,650
Other financial assets	21	3,500	–	–	–
Assets for sale and assets in disposal groups		800	–	800	–
Cash and cash equivalents	24	117,478	133,427	116,715	132,850
<b>TOTAL CURRENT ASSETS</b>		<b>248,179</b>	<b>272,111</b>	<b>243,210</b>	<b>271,393</b>
<b>CURRENT LIABILITIES</b>					
Trade and other payables	22.1	(149,124)	(142,785)	(149,403)	(142,805)
Tax payable	22.2	(15,323)	(14,078)	(14,908)	(14,030)
Other liabilities	22.3	(30,058)	(21,810)	(29,679)	(21,810)
Provisions	23.1	(1,803)	(3,414)	(1,803)	(3,414)
Borrowings	22.4	(9,508)	(6,519)	(9,508)	(6,519)
<b>TOTAL CURRENT LIABILITIES</b>		<b>(205,816)</b>	<b>(188,606)</b>	<b>(205,301)</b>	<b>(188,578)</b>
<b>NON-CURRENT LIABILITIES</b>					
Other liabilities	22.3	–	(329)	–	(329)
Provisions	23.1	(10,331)	(9,405)	(10,331)	(9,405)
Borrowings	22.4	(149,396)	(149,904)	(149,396)	(149,904)
<b>TOTAL NON-CURRENT LIABILITIES</b>		<b>(159,727)</b>	<b>(159,638)</b>	<b>(159,727)</b>	<b>(159,638)</b>
<b>TOTAL ASSETS EMPLOYED</b>		<b>984,015</b>	<b>1,124,404</b>	<b>986,592</b>	<b>1,126,331</b>
<b>TAX PAYERS' EQUITY</b>					
Public Dividend Capital		364,273	367,270	364,273	367,270
Revaluation reserve		292,785	396,007	292,785	396,007
Other reserves		743	743	743	743
Income and expenditure reserve		326,214	360,384	328,791	362,311
<b>TOTAL TAXPAYERS' EQUITY</b>		<b>984,015</b>	<b>1,124,404</b>	<b>986,592</b>	<b>1,126,331</b>

**Amanda Pritchard**

Chief Executive and Accounting Officer

25 May 2016

## Statement of changes in Taxpayers' equity

### GROUP 2015/16

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' Equity at April 1 2015</b>	367,270	396,007	743	360,384	<b>1,124,404</b>
Deficit for the year	–	–	–	(34,487)	<b>(34,487)</b>
Transfers to retained earnings on disposal of assets	–	(317)	–	317	–
Impairments	–	(166,183)	–	–	<b>(166,183)</b>
Revaluations	–	63,278	–	–	<b>63,278</b>
Public Dividend Capital received	5,947	–	–	–	<b>5,947</b>
Public Dividend Capital repaid	(8,944)	–	–	–	<b>(8,944)</b>
<b>Taxpayers' equity as at March 31 2016</b>	<b>364,273</b>	<b>292,785</b>	<b>743</b>	<b>326,214</b>	<b>984,015</b>

### GROUP 2014/15

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

### TRUST 2015/16

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' equity at April 1 2015</b>	367,270	396,007	743	362,311	<b>1,126,331</b>
Deficit for the year	–	–	–	(33,837)	<b>(33,837)</b>
Transfer to retained earnings on disposal of assets	–	(317)	–	317	–
Impairments	–	(166,183)	–	–	<b>(166,183)</b>
Revaluations	–	63,278	–	–	<b>63,278</b>
Public Dividend Capital received	5,947	–	–	–	<b>5,947</b>
Public Dividend Capital repaid	(8,944)	–	–	–	<b>(8,944)</b>
<b>Taxpayers' equity as at March 31 2016</b>	<b>364,273</b>	<b>292,785</b>	<b>743</b>	<b>328,791</b>	<b>986,592</b>

### TRUST 2014/15

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' equity at April 1 2014</b>	362,757	348,977	743	337,309	<b>1,049,786</b>
Surplus for the year	–	–	–	24,962	<b>24,962</b>
Transfer between reserves	–	(45)	–	45	–
Impairments	–	(1,917)	–	–	<b>(1,917)</b>
Revaluations	–	48,992	–	–	<b>48,992</b>
Public Dividend Capital received	4,513	–	–	5	<b>4,508</b>
<b>Taxpayers' equity as at March 31 2015</b>	<b>367,270</b>	<b>396,007</b>	<b>743</b>	<b>362,311</b>	<b>1,126,331</b>

## Consolidated cash flow statement for the year ended March 31 2016

	NOTE	March 31 2016 £000	March 31 2015 £000
<b>Cash flows from operating activities</b>			
Operating (deficit)/surplus from continuing operations		(6,238)	51,277
<b>Non-cash income and expense</b>			
Depreciation and amortisation	5.1	49,211	45,202
Impairments	16	54,305	6,913
Reversal of impairments	16	(3,556)	(2,283)
(Profit)/Loss on disposal	9	(310)	1,280
Non-cash capital donation		(84)	–
Decrease/(Increase) in trade and other receivables		13,044	(17,821)
(Increase) in inventories		(1,433)	(1,976)
Increase in other liabilities		7,919	630
Increase in trade and other payables		3,133	10,042
(Decrease) in provisions		(797)	(52)
Tax paid	12	(147)	–
Other movements in operating cash flows		(331)	89
<b>NET CASH GENERATED FROM OPERATING ACTIVITIES</b>		<b>114,716</b>	<b>93,301</b>
<b>Cash flows from investing activities</b>			
Interest received	10	397	463
Purchase of financial assets		(74)	–
Purchase of intangible assets		(10,064)	(9,634)
Purchase of property, plant and equipment		(94,349)	(120,486)
Proceeds from sale of property, plant and equipment		1,138	–
<b>NET CASH USED IN INVESTING ACTIVITIES</b>		<b>(102,952)</b>	<b>(129,657)</b>
<b>Cash flows from financing activities</b>			
Loans received from the Department of Health		9,000	59,975
Loans repaid to the Department of Health		(6,519)	(2,953)
Public Dividend Capital received		5,947	4,513
Public Dividend Capital paid		(22,493)	(23,817)
Interest paid on loans from ITFF	11	(4,703)	(3,812)
Public Dividend Capital repaid		(8,944)	–
<b>NET CASH GENERATED FROM FINANCING ACTIVITIES</b>		<b>(27,712)</b>	<b>33,906</b>
<b>Net (decrease) in cash and cash equivalents</b>		<b>(15,949)</b>	<b>(2,450)</b>
Cash and cash equivalents at April 1		133,427	135,877
<b>Cash and cash equivalents at March 31</b>	24	<b>117,478</b>	<b>133,427</b>

The cash flow 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 2015/16 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 will continue to provide the current service for the foreseeable future, as although contract negotiations are not yet complete in all cases they are confident the Trust will receive broadly the same level of funding for the next year as in the previous year (as evidenced by ongoing payments received in April and May) and the Trust starts the new financial year with a healthy cash balance. 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 three NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). The schemes are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each 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 schemes 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 (currently the Government Actuary's Department) 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 2016, is based on the valuation data as 31 March 2015, updated to 31 March 2016 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 payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed 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 1995 and 2008 sections of the Scheme are "final salary" schemes.

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. The 2015 scheme, which came into effect in April 2015, is a career average revalued earnings (CARE) scheme. Annual pensions are based on 1/54th of the annual reckonable pay per year of service uprated by CPI+1.5% for every year that they are a member of the Scheme. 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 pension benefits 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. This is a defined contribution, off Statement of Financial Position scheme. The number of employees opting in and the value of contributions is negligible.

## 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 2016 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. As at 31 March 2016 a valuation using an alternative site basis was carried out for the first time.

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.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

### Subsequent expenditure

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

### Depreciation

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

The Trust depreciates assets over the following ranges:

- Buildings, 4 – 40 years
- Plant and machinery, 2 – 20 years
- Transport equipment, 2 – 7 years
- IT hardware, 2 – 10 years
- Furniture and fittings, 5 – 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 ie:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

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

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

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

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

## 1.8 Intangible fixed assets

### Recognition

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

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

### Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

### Software

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

### Measurement

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

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

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

## Amortisation

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

The Trust depreciates intangible assets over the following ranges:

- Information technology, 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 102-Heritage Assets. Where there is an open market, such assets will be valued at market value, assets with no marketable value will be held at replacement cost.

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

Further information on the acquisition, disposal, management and preservation of the Trust's heritage assets as required by FRS 102 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. The Trust disposed of all its emissions credits during the year, which resulted in the release of the provision and the related deferred income that had originally been set up.

## 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the FIFO method.

## 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) and National Loans Fund (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, ie when receipt or delivery of the goods or services is made.

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

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

### De-recognition

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

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

### Classification and measurement

Financial assets are categorised as '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. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

## 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 1.37% (2014/15: 1.3%) 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 that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

### Provisions

A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities. The following discount rates as published by HM Treasury have been used in calculating the injury benefit provision: Short-term -1.55%, Medium-term -1.00% and Long-term -0.80%. Early voluntary retirement pension provision has been calculated by applying a 1.37% 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 1.37% (1.30% 2014/15) (See Note 1.20).

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year:

Change published	Published by IASB	Financial year for which the change first applies
<b>IFRS 11</b> (amendment) – acquisition of an interest in a joint operation	May 2014	Not yet EU adopted. Expected to be effective from 2016-17.
<b>IAS 16</b> (amendment) and <b>IAS 38</b> (amendment) – depreciation and amortisation	May 2014	Not yet EU adopted. Expected to be effective from 2016-17.
<b>IAS 16</b> (amendment) and <b>IAS 41</b> (amendment) – bearer plants	June 2014	Not yet EU adopted. Expected to be effective from 2016-17.
<b>IAS 27</b> (amendment) – equity method in separate financial statements	August 2014	Not yet EU adopted. Expected to be effective from 2016-17.
<b>IFRS 10</b> (amendment) and <b>IAS 28</b> (amendment) – sale or contribution of assets	September 2014	Not yet EU adopted. Expected to be effective from 2016-17.
<b>IFRS 10</b> (amendment) and <b>IAS 28</b> (amendment) – investment entities applying for the consolidation exception	December 2014	Not yet EU adopted. Expected to be effective from 2016-17.
<b>IAS 1</b> (amendment) – disclosure initiative	December 2014	Not yet EU adopted. Expected to be effective from 2016-17.
<b>IFRS 15</b> – revenue from contracts with clients	May 2014	Not yet EU adopted. Expected to be effective from 2017-18.
<b>Annual improvements to IFRS</b> – 2012-15 cycle	September 2014	Not yet EU adopted. Expected to be effective from 2017-18.
<b>IFRS 9</b> – financial instruments	July 2014	Not yet EU adopted. Expected to be effective from 2018-19.

## 2 Segmental reporting

The Trust operates as a single operating segment. The board of directors, led by the chief executive is the chief operating decision maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed.

Day-to-day financial control is devolved to:

- Eighteen 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. This report is made available to the public at the meeting and via the public website [www.guysandstthomas.nhs.uk](http://www.guysandstthomas.nhs.uk) – see the Board of Directors page.

## 3 Patient care income

### 3.1 Income from activities by source

	Year ended March 31 2016 £000	Year ended March 31 2015 £000
Clinical Commissioning Groups (CCGs)	546,358	513,555
NHS England	457,059	438,675
Other NHS and Government Bodies	5,575	4,491
DH – additional income for delivery of healthcare services	8,000	–
Non NHS:		
– Overseas patients (chargeable to patients)	3,492	3,314
– NHS injury scheme	1,080	921
– Other	41,076	36,822
	<b>1,062,640</b>	<b>997,778</b>

### 3.2 Income from activities by type

	Year ended March 31 2016 £000	Year ended March 31 2015 £000
Elective income	185,094	176,912
Non-elective income	115,645	113,227
Outpatient income	143,353	134,628
Other NHS clinical income	462,190	438,094
Accident and Emergency income	22,230	21,435
Private and overseas patient income	22,832	20,435
Community services	103,296	93,047
Additional income for delivery of healthcare services	8,000	–
	<b>1,062,640</b>	<b>997,778</b>

## 3.3 Patient care income

	Year ended March 31 2016 £000	Year ended March 31 2015 £000
Commissioner requested services	1,031,808	977,343
Non Commissioner requested services	22,832	20,435
Additional income for delivery of healthcare services	8,000	–
	<b>1,062,640</b>	<b>997,778</b>

Commissioner requested services include largely services from CCGs and NHS England.

## 3.4 Overseas visitor income

	Year ended March 31 2016 £000	Year ended March 31 2015 £000
Income recognised this year	3,492	3,314
Cash payments received in-year (relating to invoices raised in current and previous years)	826	1,064
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	2,560	2,234
Amounts written-off in-year (relating to invoices raised in current and previous years)	19	5,063

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. The Trust 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 2016 £000	Year ended March 31 2015 £000
Research and development	49,312	48,396
Education, training and research	78,044	81,386
Charitable and other contributions to expenditure and capital assets	34,875	22,065
Charitable and other contributions for capital assets (non-cash)	84	–
Non-patient care services to other bodies	27,464	22,052
Other income (see below)	78,130	94,182
Rental revenue from operating leases – minimum lease payments	2,310	7,531
Reversal of impairments of property, plant and equipment	3,556	2,283
Profit on disposal of fixed assets	316	–
Income in respect of staff recharges	3,599	14,183
	<b>277,690</b>	<b>292,078</b>

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 2016 £000	Year ended March 31 2015 £000
Services from NHS Foundation Trusts	14,239	13,961
Services from other NHS Trusts	3,818	3,565
Services from CCGs and NHS England	1,407	1,001
Services from other NHS bodies	5,225	4,490
Purchase of healthcare from non-NHS bodies	14,113	7,585
Executive Directors' costs	1,555	1,582
Non-Executive Directors' costs	197	203
Staff costs	729,693	705,972
Supplies and services – clinical	162,993	159,558
Supplies and services – general	10,472	10,293
Establishment	21,983	10,745
Research and development	114	130
Transport	15,599	13,988
Premises	78,481	62,677
Increase in bad debts provision	3,888	241
Change in provision rate	57	270
Drug costs	122,530	113,286
Rentals under operating leases	15,668	13,181
minimum lease payments		
Depreciation and amortisation	49,211	45,202
Impairments of property, plant and equipment	53,587	6,574
Impairments of intangible assets	718	339
Audit fees – statutory audit	124	134
Other auditor regulatory services	18	21
Other auditor remuneration	279	28
Clinical negligence	14,456	9,326
Consultancy costs	1,088	10,321
Internal audit cost	400	342
Redundancy	400	693
Early retirements	172	404
Special Payments recognised in pay costs	–	15
Other*	24,083	42,451
	<b>1,346,568</b>	<b>1,238,579</b>

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

### 5.2 Audit fees

	Year ended March 31 2016 £000	Year ended March 31 2015 £000
Audit services for statutory audit	92	104
Audit fee for subsidiary companies	8	8
Other auditor regulatory services	15	18
	<b>115</b>	<b>130</b>

Payments made to our Auditor for non-audit work in 2015-16 were £279k relating to taxation services. KPMG replaced Deloitte as the Trust's External Auditors in 2015-16.

### 5.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2015-2016 is £2million.

## 5.4 Operating leases

### Expenditure as Lessee

#### 5.4.1 Payments recognised as an expense:

	Year ended March 31 2016 £000	Year ended March 31 2015 £000
Minimum lease payments under operating leases recognised as an expense in the year	15,668	13,181

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 2016 £000	Year ended March 31 2015 £000
Within 1 year	16,292	15,862
Between 1 and 5 years inclusive	26,464	31,627
After 5 years	12,211	15,158
	<b>54,967</b>	<b>62,647</b>

### Income as Lessor

#### 5.4.2 Rental revenue:

	Year ended March 31 2016 £000	Year ended March 31 2015 £000
Rental revenue from operating leases – minimum lease receipts	2,310	7,531
	<b>2,310</b>	<b>7,531</b>

#### Future minimum lease receipts due:

	Year ended March 31 2016 £000	Year ended March 31 2015 £000
Within 1 year	2,202	1,451
Between 1 and 5 years inclusive	3,142	2,999
After 5 years	236	21
	<b>5,580</b>	<b>4,471</b>

## 6 2015-16 Salary and pension entitlements of senior managers

### A) Remuneration

Name	Title	2015-16 Salaries and fees £000	2015-16 Pension-related benefits £000	2015-16 Total £000
<b>Executive Directors</b>				
<b>I. Abbs</b>	Medical Director and Director of Patient Safety	199	–	199
<b>R. Kerr</b>	Executive Vice Chairman (from Oct 2015)	203	–	203
<b>A. Macintyre</b>	Director of Workforce and Organisational Development	150	24	174
<b>S. McGuire</b>	Director of Essentia	159	–	159
<b>A. Pritchard</b>	Chief Executive (from Jan 2016)	182	29	211
<b>M. Shaw</b>	Director of Finance	159	4	163
<b>E. Sills</b>	Chief Nurse and Director of Patient Experience	174	7	181
<b>S. Steddon</b>	Acting Chief Operating Officer (from Oct 2015)	103	–	103
<b>Non-Executive Directors</b>				
<b>R. Drummond</b>	Non-Executive Director	17	–	17
<b>M. Franklin</b>	Non-Executive Director (until Oct 2015)	10	–	10
<b>F. Nestle</b>	Non-Executive Director	17	–	17
<b>G. Niles</b>	Non-Executive Director	17	–	17
<b>S. Shribman</b>	Non Executive Director	17	–	17
<b>P. Singh</b>	Non Executive Director (from Nov 15)	7	–	7
<b>D. Summers</b>	Vice-Chair	17	–	17
<b>H. Taylor</b>	Chairman	60	–	60
<b>S. Weiner</b>	Non-Executive Director	20	–	20

Name	Title	2014-15 Salaries and fees £000	2014-15 Pension-related benefits £000	2014-15 Total £000
<b>Executive Directors</b>				
<b>I. Abbs</b>	Medical Director and Director of Patient Safety	199	–	199
<b>R. Kerr</b>	Chief Executive	253	–	253
<b>A. Macintyre</b>	Director of Workforce and Organisational Development	147	–	147
<b>S. McGuire</b>	Director of Essentia	159	–	159
<b>A. Pritchard</b>	Chief Operating Officer	91	21	112
<b>M. Shaw</b>	Director of Finance	159	–	159
<b>E. Sills</b>	Chief Nurse and Director of Patient Experience	174	–	174
<b>S. Steddon</b>	Acting Chief Operating Officer (from Oct 14)	93	–	93
<b>Non-Executive Directors</b>				
<b>D. Dean</b>	Non-Executive Director, Vice Chairman and Chairman of Audit Committee (until June 2014)	5	–	5
<b>R. Drummond</b>	Non-Executive Director	18	–	18
<b>M. Franklin</b>	Non-Executive Director	17	–	17
<b>F. Nestle</b>	Non-Executive Director	17	–	17
<b>G. Niles</b>	Non-Executive Director	17	–	17
<b>S. Shribman</b>	Non-Executive Director	17	–	17
<b>D. Summers</b>	Non-Executive Director	17	–	17
<b>H. Taylor</b>	Chairman	60	–	60
<b>S. Weiner</b>	Non Executive Director and Chairman of Audit Committee (from Jul 2014)	14	–	14

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 was a 'final salary' scheme until the 2015 Scheme came into effect and it is now a 'career average' 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 2015-16 and 2014-15, there were no taxable benefits or annual or long-term performance related bonuses.

Expenses paid to Executive Directors amounted to £1,368 in total. Total remuneration paid to directors in 2015-16 was £1,312k (£1,275k in 2014-15). No other remuneration was paid to directors in their capacity as directors. There were no advances or guarantees entered into on behalf of directors by the Trust. Employer contributions to the NHS Pension Scheme for the Executive Directors in 2015-16 totalled £105k (£108k in 2014-15). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was 4 in 2015-16 (and 1 in 2014-15).

### 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 2016	March 31 2015
Highest Paid Director's total remuneration	£202,614	£253,267
Median total remuneration	£30,954	£34,651
Remuneration ratio	6.55	7.31

### B) Pension benefits

Name	Title	Total accrued pension at age 60 at 31 March 2016 £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 2016 £000	Cash equivalent transfer value at 31 March 2015 £000	Real increase in cash equivalent transfer value during year £000	Cash equivalent transfer value at 31 March 2016 £000
<b>A. Macintyre</b>	Director of Workforce and Organisational Development	60	8	239	1,143	53	1,209
<b>A. Pritchard</b>	Chief Executive	36	9	142	423	33	461
<b>M. Shaw</b>	Director of Finance	70	5	282	1,547	42	1,607
<b>E. Sills</b>	Chief Nurse and Director of Patient Experience	68	6	271	1,241	40	1,296
<b>S. Steddon</b>	Acting Chief Operating Officer (from Oct 2015)	32	–	127	491	1	500

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

In the remuneration table at the top of page 114 we have used current job titles, although these have changed for Ron Kerr, Amanda Pritchard and Simon Steddon during 2015-16. For an explanation of in year changes in responsibilities see page 52 in the Organisational Structure chapter.

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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated

## 7 Employee costs and numbers

### 7.1 Employee costs (including executive directors)

	Permanently employed £000	Other £000	Year ended March 31 2016 Total £000	Year ended March 31 2015 Total £000
Salaries and wages	537,640	44,745	582,385	563,514
Social security costs	49,822	–	49,822	47,235
Employer contributions to NHSPA	67,209	–	67,209	62,119
Termination benefits	400	–	400	693
Agency and contract staff	–	56,141	56,141	57,708
<b>Total gross staff costs</b>	<b>655,071</b>	<b>100,886</b>	<b>755,957</b>	<b>731,269</b>
included in above:				
Costs capitalised as part of assets	(6,554)	(11,517)	(18,071)	(16,642)
less income netted off in staff costs	(5,838)	–	(5,838)	(6,023)
<b>Total staff costs</b>	<b>642,679</b>	<b>89,369</b>	<b>732,048</b>	<b>708,604</b>
<b>Analysed into Operating Expenditure (note 5.1)</b>				
Employee expenses – staff	640,327	89,366	729,693	705,972
Employee expenses – executive directors	1,555	–	1,555	1,582
Redundancy	400	–	400	693
Internal Audit Costs	397	3	400	342
Special Payments	–	–	–	15
	<b>642,679</b>	<b>89,369</b>	<b>732,048</b>	<b>708,604</b>

### 7.2 Average number of people employed

	Permanently employed number	Other number	Year ended March 31 2016 Total number	Year ended March 31 2015 Total number
Medical and dental	1,805	66	1,871	1,752
Administration and estates	3,313	430	3,743	3,551
Ancillary staff	761	353	1,114	1,052
Nursing, midwifery and health visiting staff	4,360	556	4,916	4,779
Nursing, midwifery and health visiting learners	908	186	1,094	1,074
Scientific, therapeutic and technical staff	1,963	303	2,266	2,255
Social care staff	2	–	2	2
	<b>13,112</b>	<b>1,894</b>	<b>15,006</b>	<b>14,465</b>

The numbers above are the average number of Whole Time Equivalents employed at the Trust.

### 7.3 Retirements due to ill-health

During 2015-16 there were 8 early retirements from the Trust agreed on the grounds of ill-health (7 in the year ended March 31 2015). The estimated additional pension liabilities of these ill-health retirements is £609k (£634k in 2014-15). 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 2016	Year ended March 31 2015
Number of cases	14	29
Cost of cases (£000)	413	1,066



## 8 Exit packages

### 8.1 Other compensation schemes – exit packages 2015-16

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000
	Number	£000	Number	£000	Number	£000
<£10,000	4	26	1	8	5	34
£10,001 – £25,000	3	50	1	12	4	62
£25,001 – £50,000	3	107	–	–	3	107
£50,001 – £100,000	1	63	–	–	1	63
£100,001 – £150,000	1	147	–	–	1	147
<b>Total</b>	<b>12</b>	<b>393</b>	<b>2</b>	<b>20</b>	<b>14</b>	<b>413</b>

### 8.2 Other compensation schemes – exit packages 2014-15

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000
	Number	£000	Number	£000	Number	£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
<b>Total</b>	<b>18</b>	<b>794</b>	<b>11</b>	<b>272</b>	<b>29</b>	<b>1,066</b>

### 8.3 Exit packages: other (non-compulsory) departure payments

	2015-16		2014-15	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Mutually agreed resignations (MARS) contractual costs*	–	–	8	172
Contractual payments in lieu of notice	–	–	2	84
Exit payments following Employment Tribunals or court orders	1	12	1	2
Non-contractual payments requiring Treasury approval*	1	8	1	14
<b>Total</b>	<b>2</b>	<b>20</b>	<b>12</b>	<b>272</b>

\* 2014-15 MARS payments were made to the value of £172k.

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.

## 9 Loss on disposal of non-current assets

<b>Loss on disposal of non-current assets is made up as follows:</b>	<b>Year ended March 31 2016 £000</b>	<b>Year ended March 31 2015 £000</b>
Loss on disposal of intangible fixed assets	–	(489)
Loss on disposal of plant and equipment	(5)	(791)
Profit on disposal of property, plant and equipment	315	–
	<u>310</u>	<u>(1,280)</u>

## 10 Finance income

	<b>Year ended March 31 2016 £000</b>	<b>Year ended March 31 2015 £000</b>
Interest on bank accounts	302	368
Interest on loans and receivables	95	95
	<u>397</u>	<u>463</u>

## 11 Finance expenses

	<b>Year ended March 31 2016 £000</b>	<b>Year ended March 31 2015 £000</b>
Capital loans for the Department of Health	(4,703)	(3,812)
Unwinding of discounts on provisions and other finance costs	(112)	(161)
Other	(3)	–
	<u>(4,818)</u>	<u>(3,973)</u>

## 12 Taxation

	<b>Year ended March 31 2016 £000</b>	<b>Year ended March 31 2015 £000</b>
<b>UK corporation tax</b>		
Adjustment in respect of prior years	147	–
Current tax payable on income at 20%	328	–
	<u>475</u>	<u>–</u>

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

None of the Trust's activities are subject to corporation tax.

However, the Trust's commercial subsidiaries are subject to corporation tax, the totals of which are recorded above.

## 13 Deficit attributable to the Trust

The Consolidated Statement of Comprehensive Income shows an operating deficit of £34,487k (2014-15 Surplus £24,248k) for the Group.

The operating deficit for the Trust was £33,837k (2014-15 surplus of £24,962k), 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 2016

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

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	IT hardware £000	Furniture and fittings £000	Total £000
<b>Cost or valuation at April 1 2015</b>	287,555	642,812	164,309	158,289	176	26,164	2,502	1,281,807
Additions purchased	–	1,620	69,795	77	–	1,304	12	72,808
Additions – donations of assets	–	–	–	–	–	–	84	84
Additions – assets purchased from cash donations/grants	–	489	25,172	12	–	8	–	25,681
Impairments – charged to operating expenses	–	(52,038)	(1,549)	–	–	–	–	(53,587)
Impairments – charged to the revaluation reserve	(101,993)	(63,881)	–	–	–	–	–	(165,874)
Reclassifications	–	58,378	(76,756)	10,106	–	9,716	–	1,444
Transfers to/from assets held for sale and assets in disposal groups	–	(800)	–	–	–	–	–	(800)
Revaluation	1,540	43,845	–	–	–	–	–	45,385
Disposal	(390)	(256)	–	(128)	–	–	(7)	(781)
<b>Cost or valuation At 31 March 2016</b>	<b>186,712</b>	<b>630,169</b>	<b>180,971</b>	<b>168,356</b>	<b>176</b>	<b>37,192</b>	<b>2,591</b>	<b>1,206,167</b>
<b>Accumulated depreciation at April 1 2015</b>	–	7,371	–	103,534	176	15,626	1,234	127,941
Provided during the year	–	23,944	–	14,329	–	3,799	232	42,304
Reversal of impairments credited to operating income	–	(3,556)	–	–	–	–	–	(3,556)
Revaluation	–	(17,893)	–	–	–	–	–	(17,893)
Disposals	–	–	–	(127)	–	–	(2)	(129)
<b>At March 31 2016</b>	<b>–</b>	<b>9,866</b>	<b>–</b>	<b>117,736</b>	<b>176</b>	<b>19,425</b>	<b>1,464</b>	<b>148,667</b>
<b>Net book value 2015/16</b>								
Purchased assets	121,849	454,846	146,316	42,410	–	17,597	603	783,621
Donated assets	64,863	165,262	34,655	7,679	–	88	524	273,071
Government granted assets	–	195	–	531	–	82	–	808
<b>Total at March 31 2016</b>	<b>186,712</b>	<b>620,303</b>	<b>180,971</b>	<b>50,620</b>	<b>–</b>	<b>17,767</b>	<b>1,127</b>	<b>1,057,500</b>

The reclassification line of Property, Plant and Equipment and Intangible Assets nets to zero across both notes. Additions to assets under construction may be moved between the tangible and intangible notes when assets are created causing an imbalance which nets to zero when both notes are viewed together.

A separate schedule for the Trust's property, plant and equipment has not been produced as the subsidiaries assets are considered immaterial.

In the year ended 31 March 2016, a valuation exercise was carried out on the Trust's properties by Gerald Eve, a firm specialising in Property valuations. The purpose of this exercise was to determine a fair value for Trust land and buildings as at 31st March 2016. 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 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."*

#### d) Impairments

Impairments are charged to the revaluation reserve to the extent that the revaluation reserve holds a previous revaluation surplus for that asset. Thereafter, they are charged to operating expenses.

## Property, plant and equipment – March 31 2015

### 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							Total £000
	Land £000	Buildings excluding dwellings £000	Plant and machinery £000	Transport equipment £000	IT hardware £000	Furniture and fittings £000		
<b>Cost or valuation</b>								
<b>At April 1 2014</b>	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 of 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)
<b>Cost or valuation</b>								
<b>At 31 March 2015</b>	<b>287,555</b>	<b>642,812</b>	<b>164,309</b>	<b>158,289</b>	<b>176</b>	<b>26,164</b>	<b>2,502</b>	<b>1,281,807</b>
<b>Accumulated depreciation</b>								
<b>At April 1 2014</b>	–	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)
<b>At March 31 2015</b>	<b>–</b>	<b>7,371</b>	<b>–</b>	<b>103,534</b>	<b>176</b>	<b>15,626</b>	<b>1,234</b>	<b>127,941</b>
<b>Net book value 2014/15</b>								
– 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
<b>Total at March 31 2015</b>	<b>287,555</b>	<b>635,441</b>	<b>164,309</b>	<b>54,755</b>	<b>–</b>	<b>10,538</b>	<b>1,268</b>	<b>1,153,866</b>

## 15 Intangible assets

### 15.1 As at March 31 2016

Group and Trust	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
<b>Cost April 1 2015</b>	3,778	43,678	20,383	1,202	69,041
Additions purchased/internally generated	–	1,048	7,702	–	8,750
Additions – grants/donations of cash	8	8	1,261	–	1,277
Impairments charged to operating expenses	–	–	–	(718)	(718)
Impairments charged to the revaluation reserve	–	–	–	(309)	(309)
Reclassification	1,034	15,755	(18,233)	–	(1,444)
Disposals	–	–	–	(175)	(175)
<b>Gross cost at March 31 2016</b>	<b>4,820</b>	<b>60,489</b>	<b>11,113</b>	<b>–</b>	<b>76,422</b>
Amortisation April 1 2015	1,421	26,307	–	–	27,728
Provided during the year	661	6,246	–	–	6,907
<b>Amortisation at March 31 2016</b>	<b>2,082</b>	<b>32,553</b>	<b>–</b>	<b>–</b>	<b>34,635</b>
<b>Net book value March 31 2016</b>					
Purchased assets at March 31 2016	2,385	27,021	9,974	–	39,380
Donated assets at March 31 2016	353	915	1,139	–	2,407
<b>Total at March 31 2016</b>	<b>2,738</b>	<b>27,936</b>	<b>11,113</b>	<b>–</b>	<b>41,787</b>

The reclassification line of Property, Plant and Equipment and Intangible Assets nets to zero across both Notes. Additions to assets under construction may be moved between the tangible and intangible Notes when assets are created causing an imbalance which nets to zero when both Notes are viewed together.

### 15.2 As at March 31 2015

Group and Trust	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
<b>Cost April 1 2014</b>	2,576	39,154	15,679	893	58,302
Additions purchased/internally generated	128	278	10,337	–	10,743
Additions government granted	–	–	690	–	690
Reclassification	1,074	4,735	(5,984)	–	(175)
Revaluations	–	–	–	309	309
Impairments charged to operating expenses	–	–	(339)	–	(339)
Disposals	–	(489)	–	–	(489)
<b>Gross cost at March 31 2015</b>	<b>3,778</b>	<b>43,678</b>	<b>20,383</b>	<b>1,202</b>	<b>69,041</b>
Amortisation April 1 2014	884	21,781	–	–	22,665
Provided during the year	537	4,526	–	–	5,063
<b>Amortisation at March 31 2015</b>	<b>1,421</b>	<b>26,307</b>	<b>–</b>	<b>–</b>	<b>27,728</b>
<b>Net book value March 31 2015</b>					
Purchased assets at March 31 2015	2,178	17,336	19,168	–	38,682
Donated assets March 31 2015	179	35	1,215	1,202	2,631
<b>Total at March 31 2015</b>	<b>2,357</b>	<b>17,371</b>	<b>20,383</b>	<b>1,202</b>	<b>41,313</b>



## 16 Impairments

	March 31 2016 £000	March 31 2015 £000
Charged to Statement of Comprehensive Income (SOCl):		
Impairments arising from professional valuation	(52,038)	(6,269)
Other impairments of property, plant and equipment	(1,549)	(305)
<b>Impairment of property, plant and equipment</b>	<b>(53,587)</b>	<b>(6,574)</b>
<b>Impairment of intangibles</b>	<b>(718)</b>	<b>(339)</b>
Total impairment charged to SOCI	(54,305)	(6,913)
Reversal of impairments	3,556	2,283
<b>Net impairment impact on SOCI</b>	<b>(50,749)</b>	<b>(4,630)</b>
Charged to Revaluation Reserve:		
Professional valuation impairments of land value	(101,993)	–
Professional valuation impairments of building value	(63,881)	(1,917)
Other intangible impairment charged to Revaluation Reserve	(309)	–
<b>Total impairments charged to Other Comprehensive Income</b>	<b>(166,183)</b>	<b>(1,917)</b>

The majority of the 2015-16 impairment charge relates to the property valuation.

Land and buildings were valued independently by Gerald Eve as at 31 March 2016 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 in impairment and Revaluation Reserve is summarised below.

	March 31 2016 £000	March 31 2016 £000	March 31 2016 £000	March 31 2015 £000	March 31 2015 £000	March 31 2015 £000
From professional valuation of land and buildings:	<b>Revaluation Reserve</b>	<b>SOCI</b>	<b>Total</b>	Revaluation Reserve	SOCI	Total
Increase in land value	1,540	–	1,540	33,065	–	33,065
Increase in building value	61,739	3,556	65,295	15,617	2,283	17,900
Impairments in land value	(101,993)	–	(101,993)	–	–	–
Impairments in building value	(63,881)	(52,038)	(115,919)	(1,917)	(6,269)	(8,186)
<b>Total movement</b>	<b>(102,595)</b>	<b>(48,482)</b>	<b>(151,077)</b>	<b>46,765</b>	<b>(3,986)</b>	<b>42,779</b>
Other valuation movements:						
Other impairments of property, plant and equipment	–	(1,549)	(1,549)	–	(305)	(305)
Increase in intangible value	–	–	–	309	–	309
Intangible impairment	(309)	(718)	(1,027)	–	(339)	(339)
	<b>(102,904)</b>	<b>(50,749)</b>	<b>(153,653)</b>	<b>47,074</b>	<b>(4,630)</b>	<b>42,444</b>

## 17 Revaluation Reserve movements

### Property, plant and equipment

	2015-16 £000	2014-15 £000
Revaluation Reserve at April 1	396,007	348,977
Impairments	(166,183)	(1,917)
Revaluations	63,278	48,992
Transfers to other reserves	(317)	(45)
<b>Revaluation Reserve at March 31</b>	<b>292,785</b>	<b>396,007</b>

### Non-Current assets held for sale

Ann Moss Way was classified as available for sale at a value of £800k. The sale of this property is expected to take place in 2016-17.

## 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 2016 are set out below. The accounting date of the financial statements for the subsidiaries is 31 March 2016 and for the joint ventures 31 December 2016. 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
<b>Subsidiary undertakings</b>			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
GTI Forces Healthcare Ltd <sup>1</sup>	UK	100%	Healthcare services
Pathology Services Ltd <sup>1</sup>	UK	100%	Healthcare services
Essentia Trading Ltd <sup>1</sup>	UK	100%	Healthcare services
<b>Associate and Joint Ventures</b>			
SSAFA GSTT Care LLP	UK	50%	Healthcare services
Viapath Group LLP <sup>1</sup>	UK	33%	Healthcare services
Viapath Services LLP <sup>1</sup>	UK	33%	Healthcare services
Viapath Analytics LLP <sup>1</sup>	UK	33%	Healthcare services
Spot on Diagnostics Ltd <sup>1</sup>	UK	30%	Healthcare services
Precision Diagnostic Analytics Ltd <sup>1</sup>	UK	25%	Healthcare services
King's Health Partners Ltd <sup>2</sup>	UK	25%	Healthcare services

<sup>1</sup> Not directly owned by Guy's and St Thomas' NHS Foundation Trust

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

### 18.1 Investments

	Investments in associates (and jointly controlled operations) 2015-16 £000	Investments other 2015-16 £000	Investments in associates (and jointly controlled operations) 2014-15 £000	Investments – other 2014-15 £000
Carrying Value at April 1	71	–	71	–
Additions	–	74	–	–
<b>Carrying value at March 31</b>	<b>71</b>	<b>74</b>	<b>71</b>	<b>–</b>

### 18.2 Aggregated amounts relating to joint ventures

	March 31 2016 £000	restated March 31 2015 £000
Current assets	5,187	5,039
Non-current assets	12,022	11,322
Non-current liabilities	(4,768)	(4,821)
Current liabilities	(10,605)	(10,599)
Group share – net assets	<u>1,836</u>	<u>941</u>
Revenue	53,212	57,517
Expenditure	<u>(52,312)</u>	<u>(56,423)</u>
Group share net profit	<u>900</u>	<u>1,094</u>

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 2016 £000	March 31 2015 £000
Group share of unrecognised losses	–	241

All figures are based on unaudited figures.

## 19 Inventories

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
Raw materials and consumables	21,326	19,893	21,326	19,893
	<u>21,326</u>	<u>19,893</u>	<u>21,326</u>	<u>19,893</u>

## 20 Trade and other receivables

### 20.1 Current

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
NHS receivables	45,597	45,581	47,940	45,581
Other receivables	48,363	42,003	45,617	41,983
Provision for impaired receivables	(25,617)	(22,729)	(25,614)	(22,729)
Prepayments	12,267	12,775	12,219	12,775
Accrued income	23,497	37,455	23,106	37,307
PDC dividend receivable	–	512	–	512
VAT and other tax receivable	968	3,194	1,101	3,221
	<u>105,075</u>	<u>118,791</u>	<u>104,369</u>	<u>118,650</u>

### 20.2 Non-current

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
Other receivables	1,947	1,787	1,947	1,787
	<u>1,947</u>	<u>1,787</u>	<u>1,947</u>	<u>1,787</u>

### 20.3 Provision for impaired receivables

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
At April 1	22,729	27,897	22,729	27,897
Increase in provision	3,888	241	3,889	241
Amounts utilised	(1,000)	(5,409)	(1,001)	(5,409)
At March 31	<u>25,617</u>	<u>22,729</u>	<u>25,617</u>	<u>22,729</u>

### 20.4 Ageing of trade and other receivables

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
0 – 30 days	48,253	38,009	48,253	37,989
30 – 60 days	11,562	11,476	11,562	11,476
60 – 90 days	6,799	16,928	6,799	16,928
Over 90 days	29,294	22,958	29,294	22,958
	<u>95,908</u>	<u>89,371</u>	<u>95,908</u>	<u>89,351</u>

### 20.5 Analysis of trade and other receivables

	GROUP	
	March 31 2016	March 31 2016
	£000	£000
	Impaired	Non-impaired
0 – 30 days	2,618	45,634
30 – 60 days	2,647	8,915
60 – 90 days	1,545	5,254
90 – 180 days	3,780	6,633
Over 180 days	15,027	3,854
	<u>25,617</u>	<u>70,290</u>

## 21 Other financial assets

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
<b>Non-current</b>				
Loan and receivables	–	3,500	6,685	5,688
	<u>–</u>	<u>3,500</u>	<u>6,685</u>	<u>5,688</u>

### Loans comprise:

Organisation	Loan £m	Interest Rate	Maturity Date
Viapath Group	3,500	Libor + 2%	Dec-16
Pathology Services Ltd (loan + accumulated interest)	1,623	Libor + 2%	Mar-18
Essentia Trading	562	Higher of cost of capital or Libor + 2%	Mar-19
Essentia Trading	500	Higher of cost of capital or Libor + 2%	Mar-20
Essentia Trading	500	3.50%	Mar-21
<b>Total Other Liabilities</b>	<b>6,685</b>		

## 22 Trade and other payables

### 22.1 Current

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
Receipts in advance	793	1,052	793	1,052
NHS payables – revenue	9,136	8,492	9,591	8,492
Trade payables – capital	23,937	19,831	23,937	19,831
Amounts due to related parties – revenue	9,840	9,169	9,841	9,169
Other trade payables	44,429	35,712	43,974	35,609
Other payables	2,188	1,869	2,168	1,869
Accruals	58,453	66,660	58,750	66,783
PDC dividend payable	348	–	348	–
	<u>149,124</u>	<u>142,785</u>	<u>149,402</u>	<u>142,805</u>

### 22.2 Current taxes payable

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
Other taxes payable including Social Security and VAT	15,323	14,078	14,909	14,030
	<u>15,323</u>	<u>14,078</u>	<u>14,909</u>	<u>14,030</u>

### 22.3 Other liabilities

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000
<b>Current</b>				
Deferred income	29,989	21,510	29,610	21,510
Deferred grants income	69	300	69	300
	<u>30,058</u>	<u>21,810</u>	<u>29,679</u>	<u>21,810</u>
<b>Non-current</b>				
Deferred income	–	329	–	329
	<u>–</u>	<u>329</u>	<u>–</u>	<u>329</u>

## 22.4 Borrowings

	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
Current	£000	£000	£000	£000
Capital loans from Department of Health	9,508	6,519	9,508	6,519
	<u>9,508</u>	<u>6,519</u>	<u>9,508</u>	<u>6,519</u>
	GROUP		TRUST	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015
Non-current	£000	£000	£000	£000
Capital loans from Department of Health	149,396	149,904	149,396	149,904
	<u>149,396</u>	<u>149,904</u>	<u>149,396</u>	<u>149,904</u>

Loans drawn down relate to loans from the Department of Health which have been fully drawn down. Details as follows:

- £80m – repayable over 25 years, of which £1.9m was repaid this year;
- £75m – repayable over 25 years of which £3.4m was repaid this year and £1.7m last year;
- £5m – repayable over 5 years of which £1.2m was repaid this year and £1.9m was repaid in prior years;
- The Trust drew down an additional £9m this year. Repayments for the loan will commence in 2016-17;
- The Trust has also negotiated further loans of £100m, draw down of which commenced in April 2016;

No security has been pledged against these loans.

These capital loans have been secured to support the Trust's ongoing plans to redevelop its two hospital sites and upgrade IT and other infrastructure.

## 23 Provisions for liabilities

### Group and Trust

#### 23.1 Overall provisions

	Current		Non-current		Total Provisions	
	March 31 2016	March 31 2015	March 31 2016	March 31 2015	March 31 2016	March 31 2015
	£000	£000	£000	£000	£000	£000
Pensions relating to other staff	807	836	7,301	7,937	8,108	8,773
Legal claims	834	352	–	–	834	352
Other	162	2,226	3,030	1,468	3,192	3,694
	<u>1,803</u>	<u>3,414</u>	<u>10,331</u>	<u>9,405</u>	<u>12,134</u>	<u>12,819</u>

#### 23.2 Changes in provisions

	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
As at April 1 2015	8,773	352	3,694	12,819
Arising during the year	346	750	1,938	3,034
Utilised during the year	(826)	(24)	(1,858)	(2,708)
Reversed unused	(266)	(244)	(670)	(1,180)
Unwinding of discount	120	–	(8)	112
Change in discount rate	(39)	–	96	57
<b>As at March 31 2016</b>	<b><u>8,108</u></b>	<b><u>834</u></b>	<b><u>3,192</u></b>	<b><u>12,134</u></b>

#### 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	807	834	162	1,803
Between one and five years	3,117	–	172	3,289
After five years	4,184	–	2,858	7,042
	<u>8,108</u>	<u>834</u>	<u>3,192</u>	<u>12,134</u>

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

£283m is included in the provision of the NHS Litigation Authority under legal claims at 31 March 2016 in respect of clinical negligence liabilities of the Foundation Trust (£132m at 31 March 2015).

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 2014 £000	Cash changes in period £000	At March 31 2015 £000	Cash changes in period £000	At March 31 2016 £000
Cash with the Government Banking Service	135,107	(2,413)	132,694	(16,196)	116,498
Cash at bank and in hand – commercial bank	771	(38)	733	247	980
	<u>135,878</u>	<u>(2,451)</u>	<u>133,427</u>	<u>(15,949)</u>	<u>117,478</u>

TRUST	At April 1 2014 £000	Cash changes in year £000	At March 31 2015 £000	Cash changes in year £000	At March 31 2016 £000
Cash with the Government Banking Service	135,107	(2,413)	132,694	(16,197)	116,497
Cash at bank and in hand – commercial bank	155	1	156	61	217
	<u>135,262</u>	<u>(2,412)</u>	<u>132,850</u>	<u>(16,136)</u>	<u>116,714</u>

## 25 Capital commitments

Commitments under capital expenditure contracts at the Statement of Financial Position date for the Group and the Trust were £52,047k, (£71,203k at 31 March 2015).

## 26 Events after the reporting date

There were no events after the reporting date.

## 27 Contingencies

	March 31 2016 £000	March 31 2015 £000
Contingent liability for other claims against the Group and the Trust	(100)	(137)
<b>Net-contingent liability</b>	<b>(100)</b>	<b>(137)</b>

All contingent liabilities recorded are in respect of Public and Employee liability cases as advised by the NHS Litigation Authority. This represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

## 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 2016 was £23,353k (14/15 £23,519k), based on the average relevant net assets of £792,063k.

## 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 Trust's biggest source of income in 2015-16 was £469m 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 NHS Bexley CCG, NHS Bromley CCG, NHS Greenwich CCG, NHS Lambeth CCG, NHS Lewisham CCG and NHS Southwark CCG from whom the Trust received £383.5m during 2015-16 for healthcare contracts (£378.5m during 2014-15). Additionally the Trust has received income from a large number of other CCGs including NHS Central London (Westminster), NHS Wandsworth CCG, Dartford, Gravesham and Swanley CCG and West Kent CCG. The Trust also received £78.8m from Health Education England.

The Trust recorded an income balance of £14.7m from King's College London in 2015-16.

The Trust has also received revenue and capital payments from a number of charitable funds, principally £19.8m is recorded in income from Guy's and St Thomas' Charity during 2015-16 (£14.1m in 2014-15). The balance for Guy's and St Thomas' Charity included within Other Receivables was £380k for March 31, 2016. Guy's and St Thomas' Charity is regarded as a related party.

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

Ron Kerr (Executive Vice Chairman), rents accommodation from the Trust at a commercial market rate as does Janet Powell, Director of Nursing for Evelina London Children's Hospital.

Hugh Taylor (Chairman) is a Trustee of the Macmillan Cancer Support, the Nuffield Trust and Cicely Saunders International: and the National Skills Academy for Health: all bodies which interact with the Trust from time to time.

Eileen Sills (Chief Nurse and Director of Patient Experience) is a Trustee of the Burdett Trust and chairs the Grant Committee. The Burdett Trust has continued to support the production of the Barbara's Story training pack which is distributed freely on request. Eileen held the part-time post of National Guardian for speaking up safely for 9 weeks, the post was hosted by the CQC. In addition, she is a 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, 2016 stood at £58.2m (£76.8m at March 31, 2015).

**Significant transactions (over £1m) with related parties include the following:**

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Ashford CCG	2,017	–	–	–
NHS Barking And Dagenham CCG	1,620	–	289	–
NHS Barnet CCG	2,761	–	96	–
NHS Bexley CCG	23,740	(47)	(1,329)	107
NHS Brent CCG	1,857	–	206	–
NHS Brighton And Hove CCG	1,768	–	486	–
NHS Bromley CCG	21,302	–	202	–
NHS Camden CCG	1,841	–	144	–
NHS Canterbury And Coastal CCG	2,947	–	198	–
NHS Central London (Westminster) CCG	13,119	–	1,422	–
NHS City And Hackney CCG	3,040	–	579	–
NHS Coastal West Sussex CCG	1,922	–	415	–
NHS Croydon CCG	7,324	–	638	–
NHS Dartford, Gravesham And Swanley CCG	10,354	–	355	–
NHS Ealing CCG	1,723	–	222	–
NHS East And North Hertfordshire CCG	1,373	–	69	–
NHS East Surrey CCG	1,499	–	23	–
NHS Eastbourne, Hailsham And Seaford CCG	1,621	–	122	–
NHS Enfield CCG	1,368	–	141	–
NHS Greenwich CCG	25,739	–	1,363	–
NHS Haringey CCG	2,069	–	511	–
NHS Hastings And Rother CCG	1,579	–	286	–
NHS Havering CCG	1,597	–	138	–
NHS Herts Valleys CCG	2,140	–	332	–
NHS High Weald Lewes Havens CCG	2,108	–	582	–
NHS Horsham And Mid Sussex CCG	1,464	–	467	–
NHS Islington CCG	1,970	–	88	–
NHS Kingston CCG	1,493	–	143	–
NHS Lambeth CCG	142,528	588	1,398	812
NHS Lewisham CCG	39,917	–	358	–
NHS Medway CCG	6,210	–	377	–
NHS Merton CCG	2,097	–	52	–
NHS Newham CCG	2,612	–	134	–
NHS North West Surrey CCG	1,901	–	54	–
NHS Redbridge CCG	3,848	–	839	–
NHS Richmond CCG	1,534	–	197	–
NHS Slough CCG	1,128	–	1,111	–
NHS South Kent Coast CCG	3,228	–	29	–
NHS Southwark CCG	130,436	620	1,365	591
NHS Surrey Downs CCG	2,238	–	25	–
NHS Sutton CCG	1,383	–	67	–
NHS Swale CCG	2,226	–	271	–
NHS Thanet CCG	2,220	–	158	–
NHS Thurrock CCG	1,105	–	43	–
NHS Tower Hamlets CCG	4,203	–	287	–
NHS Waltham Forest CCG	2,096	–	242	–
NHS Wandsworth CCG	13,258	(57)	159	–
NHS West Kent CCG	12,039	–	1,101	–
NHS West London (K&C & Qpp) CCG	2,256	–	547	–
NHS Basildon and Brentwood CCG	1,075	–	56	–
NHS Hammersmith and Fulham CCG	1,390	–	381	–
NHS Hounslow CCG	1,267	–	243	–
Great Ormond Street Hospital for Children NHS Foundation Trust	1,762	77	682	69
King's College Hospital NHS Foundation Trust	2,648	6,807	3,245	2,342
South London And Maudsley NHS Foundation Trust	1,475	3,109	1,353	471
Medway NHS Foundation Trust	1,766	4	259	71
St George's Healthcare NHS Foundation Trust	849	2,683	392	575

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
The Royal Marsden Hospital NHS Foundation Trust	319	3,446	275	50
NHS Litigation Authority	2	15,108	–	9
NHS Property Services	4,110	3,603	2,329	738
Community Health Partnerships	579	5,092	240	1,010
Hounslow and Richmond Community HealthCare NHS Trust	1,573	23	384	36
Lewisham and Greenwich NHS Trust	1,708	1,100	1,543	741
Total NHS England	469,440	1,647	22,547	3,737
Health Education England	78,744	120	410	3,403
Department of Health	49,969	(66)	165	–
Dartford and Gravesham NHS Trust	790	1,879	740	463
HM Revenue & Customs – VAT	–	–	968	15,323
HM Revenue & Customs – Other taxes and duties and NI contributions (Not PAYE or employee NI)	–	50,297	–	–
NHS Pension Scheme – (both employee and employer contributions o/s plus other invoiced charges)	–	67,209	–	10,057
NHS Blood and Transplant	306	5,235	10	391
Southwark London Borough Council	2,618	–	447	555
Lambeth London Borough Council	14,381	3,626	530	160
Northern Ireland Office	3,764	6	1,315	–

## 30 Financial assets and liabilities

### 30.1 Financial assets

	GROUP		TRUST	
	March 31 2016 £000	March 31 2015 £000	March 31 2016 £000	March 31 2015 £000
Denominated in £ Sterling	209,270	231,794	223,115	233,237
In other currencies, restated in £ Sterling	5,496	9,742	5,496	9,742
<b>Gross financial assets at March 31</b>	<b>214,766</b>	<b>241,536</b>	<b>228,611</b>	<b>242,979</b>

### 30.2 Analysis of financial liabilities

	GROUP		TRUST	
	March 31 2016 £000	March 31 2015 £000	March 31 2016 £000	March 31 2015 £000
Denominated in £ Sterling	319,372	309,148	320,440	309,169
<b>Gross financial liabilities at March 31</b>	<b>319,372</b>	<b>309,148</b>	<b>320,440</b>	<b>309,169</b>

### 30.3a Financial assets by category

	GROUP Loans and receivables £000	TRUST Loans and receivables £000
<b>As at March 31 2016</b>		
<b>Assets as per balance sheet</b>		
NHS debtors	50,672	50,712
Accrued income	23,497	23,106
Other debtors with related parties	31	31
Other debtors	45,205	56,976
Provision for doubtful debts	(25,617)	(25,613)
Other financial assets	3,500	6,685
Cash at bank and in hand	117,478	116,714
<b>Total at March 31 2016</b>	<b>214,766</b>	<b>228,611</b>
<b>At March 31 2015</b>		
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
<b>Total at March 31 2015</b>	<b>241,536</b>	<b>242,979</b>

### 30.3b Financial liabilities by category

	GROUP £000	TRUST £000
<b>Other financial liabilities</b>		
<b>At March 31 2016</b>		
<b>Liabilities as per balance sheet</b>		
NHS creditors	20,433	20,432
Other creditors	69,447	70,220
Accruals	58,454	58,750
Provisions under contract	12,134	12,134
Borrowings	158,904	158,904
<b>Total at March 31 2016</b>	<b>319,372</b>	<b>320,440</b>
<b>At March 31 2015</b>		
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
<b>Total at March 31 2015</b>	<b>309,149</b>	<b>309,170</b>

### 30.4 Fair values of financial assets at March 31 2016

	GROUP		TRUST	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Non-current trade and other receivables excluding non financial assets	1,947	1,947	1,947	1,947
Other	3,500	3,500	6,685	6,685
	<u>5,447</u>	<u>5,447</u>	<u>8,632</u>	<u>8,632</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	March 31 2015	TRUST	March 31 2015
	March 31 2016	£000	March 31 2016	£000
	£000	£000	£000	£000
Less than one year	148,334	149,840	138,132	149,861
Greater than one year	171,038	159,308	171,038	159,308
	<u>319,372</u>	<u>309,148</u>	<u>309,170</u>	<u>309,169</u>

### 30.6 Financial assets interest risk

GROUP				
Currency	Total	Floating rate	Non-interest bearing	Weighted average interest rate
	£000	£000	£000	
<b>At March 31 2016</b>				
Sterling	111,982	111,371	611	0.3%
Other	5,495	–	5,495	(0.5)%
<b>Gross financial assets</b>	<u>117,477</u>	<u>111,371</u>	<u>6,106</u>	
<b>At March 31 2015</b>				
Sterling	123,684	122,984	700	0.3%
Other	9,742	–	9,742	0.1%
<b>Gross financial assets</b>	<u>133,426</u>	<u>122,984</u>	<u>10,442</u>	
TRUST				
Currency	Total	Floating rate	Non-interest bearing	Weighted average interest rate
	£000	£000	£000	
<b>At March 31 2016</b>				
Sterling	111,363	111,371	(8)	0.3%
Other	5,351	–	5,351	(0.5)%
<b>Gross financial assets</b>	<u>116,714</u>	<u>111,371</u>	<u>5,343</u>	
<b>At March 31 2015</b>				
Sterling	123,107	122,984	123	0.3%
Other	9,742	–	9,742	0.1%
<b>Gross financial assets</b>	<u>132,849</u>	<u>122,984</u>	<u>9,865</u>	

### 30.7 Loan disclosure

	Current	Non current	Total	Weighted average interest rate
	£000	£000	£000	
<b>At March 31 2016</b>				
Fixed interest rate instruments	9,508	149,396	158,904	3.0%
<b>At March 31 2015</b>				
Fixed interest rate instruments	6,519	149,904	156,423	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 March 31 2016 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 £167k cash and cash equivalents at March 31 2016 (£156k at 31 March 2015) 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 as a result of assuities (£148k at 31 March 2015).

## 32 Losses and special payments

Losses	2015-16		2014-15	
	Cases	£000	Cases	£000
Cash losses	21	26	23	108
Stores losses	192	540	213	290
*Bad debts and claims abandoned	850	1,186	1,362	5,428
<b>Total losses</b>	<b>1,063</b>	<b>1,752</b>	<b>1,598</b>	<b>5,826</b>

Special payments	2015-16		2014-15	
	Cases	£000	Cases	£000
Ex gratia payments	41	22	40	32
<b>Total losses</b>	<b>41</b>	<b>22</b>	<b>40</b>	<b>32</b>

A debt of £316k with HMRC for prior years Tax and NI claims was written off in the year 2015-16.

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 lie in the Guy's Hospital site, on the land where the new Cancer Centre has been 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 (2014-2015: nil). There were no disposals of artefacts during either year.

## contacts

### **Chief Executive**

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

Amanda Pritchard, Chief Executive

Tel: 020 7188 0001

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

### **Patient Advice and Liaison Service (PALS)**

If you require information, support or advice about our services, contact:

PALS

Tel: 020 7188 8801 (St Thomas')

or 020 7188 8803 (Guy's)

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

### **Membership**

If you are interested in becoming a member of our NHS Foundation Trust, contact:

Tel: 020 7188 7346

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

### **Recruitment**

If you are interested in applying for a job at Guy's and St Thomas', contact:

The Recruitment Centre

Tel: 020 7188 0044

<http://jobs.gstt.nhs.uk>

### **Further information**

If you have a media enquiry or require further information, contact:

Anita Knowles, Director of Communications

Tel: 020 7188 5577

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