



Guy's and St Thomas'
NHS Foundation Trust

**Annual Report
and Accounts
2016-17**



Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2016-17

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, 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 15,300 staff, 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



The Inspiring Youth conference in August celebrated young people's involvement in improving patient care. Patient engagement helps shape the way that care is given at Evelina London and we hope it will inspire more young people to get involved with how their healthcare is delivered.

Contents

1	Chairman's statement	5
2	Performance report	7
3	Accountability report	21
4	Directors' report	23
5	Remuneration report	31
6	Staff report	39
7	Our organisational structure: The disclosures set out in the <i>NHS Foundation Trust Code of Governance</i>	47
8	Single oversight framework	55
9	Statement of the Accounting Officer's Responsibilities	57
10	Quality report	65
11	Annual accounts	97



A new statue honouring the Crimean War nurse Mary Seacole was unveiled in the gardens of St Thomas' Hospital in summer 2016.

Chairman's statement

The Trust has experienced another extremely busy year with rising demand for our services. Despite this pressure, our staff have shown a steadfast commitment to delivering high quality care and have continued to find new ways to improve services and increase efficiency.

We continue to receive positive feedback from patients about the quality of the services we provide in our hospitals and in the community. In March 2016, the Care Quality Commission reported on the inspection of our services and rated them as 'Good' overall.

Our staff consistently go the extra mile in caring for patients, exemplified in our monthly CARE Awards. Many were involved in our response to the terrorist incident on Westminster Bridge in March 2017. Their swift action and bravery was a credit to the Trust.

The Trust continues to experience significant growth in demand for our services. In common with other NHS organisations, 'front door' services including our Emergency Department (A&E) at St Thomas' came under significant pressure. The Emergency Floor redevelopment is increasing our capacity and, through our community services and partnership working, we are avoiding the need for patients to come into hospital wherever possible, for example by increasing support for patients in their own homes.

The Trust's specialist services continue to grow and innovate to remain at the leading edge of treatment and care. The new, state-of-the-art Cancer Centre at Guy's opened in autumn 2016. It brings most of our cancer care under one roof, alongside ground-breaking research and clinical trials, helping us to improve cancer treatments and outcomes.

The Trust is proud to take a leadership role locally and nationally. Our staff are helping to shape the development of the Sustainability and Transformation Plan for south east London.

With colleagues at Dartford and Gravesham NHS Trust, we are part of the national vanguard programme acute care collaborative. We are also

accredited by NHS Improvement as one of four trusts exploring how becoming a hospital group could benefit patients.

The Council of Governors continues to support the organisation to meet the needs of patients and provides constructive challenge to the Board in line with its statutory duties. This year, following elections, we welcomed new governors to the Council and thanked those who completed their terms of office.

The Trust draws strength 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 expertise to bear to improve care for our patients and to enable people to take a more active role in supporting their own health and well-being.

We remain grateful for the generous contribution of Guy's and St Thomas' Charity whose continued support enables us to deliver innovative patient care and research, as well as to improve our buildings and the environment. The Trust also benefits from close working relationships with our local MPs, 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 for me to thank Board colleagues for their continued support, particularly Robert Drummond, Frank Nestle and Diane Summers who stepped down this year.

I would also like to welcome Emma Duncan, Felicity Harvey, John Pelly and Reza Razavi who joined the Board as Non-Executive Directors, and our new Chief Operating Officer, Jon Findlay.



Sir Hugh Taylor, Chairman
24 May 2017



Excellence in education and training is at the heart of Guy's and St Thomas'. As part of King's Health Partners, one of the UK's six Academic Health Sciences Centres, and as teaching hospitals of international renown, we're committed to developing a healthcare workforce of the highest quality.

Annual Performance Statement from the Chief Executive

The Trust has again performed well both operationally and financially during 2016-17, although we have struggled to achieve national access targets.

From February 2016 onwards we experienced an exceptional and unexpected increase in demand for our services, with a 17% increase in referrals from GPs and a 14% increase in tertiary referrals from consultants at other hospitals. Growth in urgent GP referrals for suspected cancer followed a similar pattern.

While we continued to see growth throughout the year, the rate of referrals did plateau in the second half of the year. However, our overall waiting list grew by 10,000 during this time, and this has had a lasting effect on our ability to achieve the maximum referral to treatment time (RTT) and cancer access targets. We recognise the adverse impact this has on our patients and we are working hard to increase capacity so that we can treat patients as quickly as possible.

In common with other hospitals, our Emergency Department also experienced significant pressure throughout the year, and performance against the A&E target was made more difficult as we continue the major redevelopment of the Emergency Floor at St Thomas' which is due to complete in early 2018.

Our staff worked extremely hard to respond to these pressures, and remain focused on the delivery of high quality patient care, while also striving to achieve both performance and financial targets on a sustainable basis.

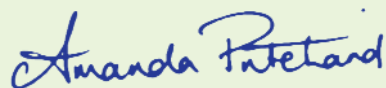
Despite these challenges, we have continued to progress many quality and service improvements, including our ambitious capital programme. We are pleased to have completed a number of major developments during 2016-17, most notably the opening of the new Cancer Centre at Guy's in the autumn of 2016, and these are described on page 27 in the Directors' Report.

At the start of the year we agreed a control total with NHS Improvement which required us to deliver a small underlying deficit of £2.4 million. Taking into account capital donations and impairments, this equated to a planned surplus of £24.8 million.

We are pleased to report that despite the extremely challenging financial climate across the NHS, we have exceeded our original financial plan by £38.2 million and delivered an underlying surplus of £35.8 million (or a surplus of £42.7 million once adjusted for capital donations and impairments).

This is a very positive achievement and a tribute to the considerable efforts and commitment of staff across the Trust. As well as delivering cost savings and efficiencies, we benefited from extra income for additional activity and incentive and bonus payments from the Sustainability and Transformation Fund which reflected our success in meeting our financial and performance targets and also exceeding our financial plan overall.

This strong financial performance will enable us to continue to invest in increased capacity and service improvements that benefit our patients.



Amanda Pritchard, Chief Executive
24 May 2017

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, cancer services at Guy's are a key strategic priority

for the Trust and King's Health Partners and we were delighted to open a new Cancer Centre in 2016.

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 15,300 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 2017-18, the Trust faces a number of financial risks which are listed below and then described in further detail on pages 14 and 15:

- achieving the required efficiency savings for 2017-18;
- failure to deliver our control total and secure Sustainability and Transformation Fund income;
- the ability of our commissioners to afford forecast increases in activity levels;
- the Trust's capacity to deliver activity to the required standards and activity levels;
- local authority funding reductions.

Operational risks

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

- our ability to deliver required activity levels in view of the sustained increase in demand for our services;
- a gap between funds for investment and our operational, transformation and strategic requirements;
- the ability to recruit and retain sufficient staff given current workforce pressures.

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 operational performance during 2016-17 reflected a very challenging external environment once again. Given this, we are extremely proud of the hard work of our staff as well as their continued determination to improve the care and experience of 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).

The overall number of attendances to our emergency services has continued to grow and there were numerous occasions where the emergency department recorded its busiest day. Daily attendances frequently exceeded 400, with the number of ambulances often exceeding 100 a day.

Work on a major transformation project to improve the whole of the Emergency Floor, continued to make good progress during the year, but has also meant that staff had to cope with significant temporary changes to the layout of our A&E and its associated wards. Despite this, they worked tirelessly to ensure patients were seen and treated as quickly as possible.

As demand for emergency services reached unprecedented levels across London, we were one of the better performing trusts against the target that 95% of patients should be diagnosed, treated and discharged within four hours, although it proved difficult to achieve the target. However, we did maintain one of the best perfor-

mance in the capital for ambulance handover times, ensuring that patients arriving in A&E with the most urgent medical needs received their treatment without delay.

After many years of planning, in autumn 2016 we opened the new Cancer Centre at Guy's and a further smaller cancer centre also opened at Queen Mary's Hospital in Sidcup in May 2017. While both centres will improve care for patients with a suspected cancer diagnosis, or requiring cancer treatment, a significant rise in the number of patients referred to us has made it difficult for us to achieve the national cancer access targets.

Continued efforts to improve timely access to care are reflected in the achievement of the standard to see urgent cancer referrals within 14 days towards the end of the year. However, we have continued to struggle to meet demand for specialist cancer treatments, particularly in some surgical specialties. As a result we have been unable to ensure that 96% of patients begin treatment within 31 days of a decision to treat, and 85% of patients are treated within 62 days of initial referral.

We recognise the impact that this has on our patients and we are redoubling our efforts to address this. We are increasing capacity so that we can treat more patients, and

we are working closely with our neighbouring hospitals who refer patients to us for specialist treatment.

In common with other specialist cancer centres, we often find it difficult to begin 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 are working with these hospitals to reduce unnecessary delays and also to tackle any shortcomings in our own processes.

We continue to meet the targets to begin radiotherapy and chemotherapy treatment within 31 days, and we have expanded access to these services through the opening of our new centres. We therefore expect to treat more patients and to meet these targets more consistently in future.

We experienced an unexpected and substantial increase in demand for planned (elective) care in 2016-17, considerably above the 5% growth rate that we had already planned for. As a result, an additional 10,000 patients were added to our waiting lists over and above the number we had planned to treat.

This sudden increase in demand has placed significant pressure on our services. The number of patients waiting more than 18 weeks for treatment has grown and it has

Performance report

Key performance indicators

		Performance		Quarterly Trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	<i>C.difficile</i> acquisitions (including: cases deemed not to be due to lapse in care and cases under review)	51	36 ●	13	8	8	7
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	90.4% ●	92.5%	90.6%	89.4%	89.3%
A&E access	95% A&E patients wait less than 4 hours	95%	88.1% ●	89.8%	89.2%	86.0%	87.5%
Cancer access initial appointments	Urgent cancer referrals seen within 2 week wait	93%	91.4% ●	90.5%	89.2%	91.5%	94.7%
	Symptomatic breast patients seen within 2 week wait	93%	90.2% ●	88.4%	90.9%	91.6%	89.8%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	66.9% ●	67.5%	67.9%	65.8%	66.5%
	% patients treated within 62 days from screening referral	90%	83.5% ●	92.0%	73.3%	79.2%	85.2%
	% patients treated within 31 days of decision to treat	96%	94.9% ●	94.6%	97.0%	94.5%	93.6%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	90.2% ●	88.9%	91.5%	91.3%	88.9%
	Chemotherapy treatments within 31 days	98%	97.6% ●	97.5%	98.3%	98.2%	96.5%
	Radiotherapy treatments within 31 days	94%	93.4% ●	96.4%	92.6%	94.7%	90.3%
Community care information completeness	Referral to treatment information completeness	50%	64.7% ●	64.4%	63.1%	69.0%	63.0%
	Referral information completeness	50%	76.0% ●	77.4%	76.1%	75.4%	74.9%
	Activity information completeness	50%	73.0% ●	75.8%	74.0%	71.1%	70.9%

proved impossible for us to achieve the referral to treatment target, that 92% of patients are seen within 18 weeks, during the last nine months of the year.

To address this we have worked collaboratively with our local clinical commissioning groups, GPs and local authorities to develop alternative services in the community and to ensure patients are referred to the most appropriate place for their treatment. There has been some positive impact in the last six months of the year, with the rate of referrals reducing and the size of our waiting list stabilising at around 60,000.

Internally, our clinical teams have focused on treating those patients who have waited the longest; they have also improved administrative processes, and increased capacity through additional evening and weekend clinics and operating lists.

Demand for children's services has followed a similar pattern and initiatives to tackle this have included the development of a new children's short stay unit to improve the flow of patients through the Emergency Department and a new procedure

room which has helped to meet the rise in demand for planned (elective) care.

Rising demand has also impacted adversely on our ability to ensure that 99% of patients requiring a diagnostic test receive this within six weeks. While we achieved this standard in August and November, it was not possible to do so consistently throughout the year. We have worked hard to improve our services in response to this, particularly in the second half of the year, and we hope the changes will enable us to achieve this standard consistently in the coming year.

Last year our community services began an exciting initiative to test and introduce a new model of community nursing based on the Dutch Buurtzorg model of self managed teams, initially in north Brixton.

As part of our commitment to improve care for patients nearing the end of their life, and their families and carers, we launched Pal@home, a 24 hour nursing service that brings together our adult community and palliative care teams.

We also opened six neuro-

rehabilitation beds for patients at the Pulross Centre, working in partnership with King's College Hospital who opened 14 beds in Orpington.

To improve care for older patients, we expanded our 'strength and balance classes' across Lambeth and Southwark and these services now form a key part of our falls prevention service. Meanwhile, our frailty unit is now open seven days a week and the Enhanced Rapid Response and @home teams are working well.

Reducing healthcare associated infections remains a key priority. Last year we saw an almost 30% reduction in cases of *C.difficile* and we were significantly below our external target, with only two cases identified as being the result of a 'lapse in care'.

Cases of MRSA bloodstream infections also remain low. We also continue to benchmark well against other large teaching trusts for levels of other reportable infections, and our levels of surgical site infections remain below the national average across a wide range of surgical specialties.

Performance analysis – financial

At the start of the year, the Trust had planned for a £2.4 million underlying deficit. The actual performance – a £35.8 million underlying surplus – represents an improvement of £38.2 million on the original plan. This was achieved through cost savings and efficiencies, non-recurrent action and extra income arising from additional activity, as well as incentive and bonus payments from the Sustainability and Transformation Fund to reflect our positive financial performance.

The underlying surplus is calculated before accounting for capital donations (£32.4 million) and impairments arising from the revaluation of land and buildings (£25.5 million). When these are taken into account, the operating surplus for the year was £42.7 million.

Our financial performance

At the start of the financial year, the Trust set a plan to achieve a £2.4 million underlying deficit. The underlying position is calculated before accounting for capital donations, sale of assets, and impairments (changes in the value of land and buildings). The underlying financial position is one of the key measures used by the Board of Directors to track the Trust's financial performance.

The Trust ended 2016-17 with a £35.8 million underlying surplus, which represents an improvement of £38.2 million against our financial plan. This resulted from increased income, savings and efficiencies, and the delivery of key targets that have allowed us to receive both the majority of our original Sustainability and Transformation Funding (STF) and significant incentive and bonus payments for exceeding our financial plan.

Cost Improvement Programme

At the start of the year, the Trust set a £73.7 million Cost Improvement Programme (CIP), reflecting the level of savings required to deliver our

financial plan, achieve national efficiency targets and treat an increased number of patients within the funding available from our commissioners.

This target was met through a range of efficiency measures and additional income. Local savings at a directorate level were complemented by Trust-wide savings, many of which were delivered through the *Fit for the Future* Programme to improve quality, safety and efficiency. In addition, changes to the way we value our buildings ensured depreciation and Public Dividend Capital dividend charges were significantly below plan.

Together, these actions enabled the Trust to exceed its planned Cost Improvement Programme by £19.4 million.

Sustainability and Transformation Funding

The financial plan included £19.2 million Sustainability and Transformation Funding (STF) from NHS Improvement which required us to achieve agreed financial and performance targets.

The funding received from the

original STF allocation was £17.5 million, against a maximum of £19.2 million. This reflects the achievement of our financial performance targets, but difficulty in consistently achieving the A&E target and some cancer waiting times targets.

A further incentive scheme, also part of the STF, was announced during the year. This provided additional funding to trusts that exceeded their financial plan and the Trust received an additional £18.7 million. At the end of the year, a further STF bonus of £1.7 million was also received, bringing total STF funding in 2016-17 to £38 million, £18.8 million above plan.

Performance against plan

Income exceeded our financial plan and extra activity was delivered at marginal cost, leading to favourable variances on income (£31.6 million) and expenditure (£6.6 million). This contributed to the positive shift in year from a planned £2.4 million deficit to an underlying surplus of £35.8 million.

Capital donations towards the

cost of our capital programme also exceeded the original expectations, set out in our financial plan, by £5.2 million as additional funding was secured during the year for new capital projects.

The annual revaluation of the Trust's land and buildings led to a £25.5 million impairment, which reflects changes in the basis of the valuation, but no physical loss in the functionality of the buildings or their ability to support patient care. This impairment was not included in the plan and represents a

technical accounting adjustment that is reflected in our final financial position.

Favourable variances in our underlying financial performance and increased capital donations were partially offset by the unanticipated impairment.

Once these adjustments (which we do not include in the underlying financial position used by the Trust Board to monitor performance during the year) have been reflected, the Trust achieved an overall surplus of £42.7 million,

£17.8 million ahead of the original plan for a £24.8 million surplus.

Cash flow

The Trust began the financial year with £117 million of cash and cash equivalents. The majority of the cash results from surpluses achieved in previous years and is earmarked for the Trust's capital programme. During the year cash balances increased by £23 million to £140 million. For details of the Trust's net cash balances, see note 25 in the annual accounts on page 128.

The increase in cash during the year partly reflects an operating surplus – after adding back non-cash items, operating activities generated cash of £92 million.

The Trust invested £105 million in infrastructure and drew down agreed loan funding – a net £35 million after servicing interest and Public Dividend Capital dividends. Full details can be found in the Consolidated Cash Flow Statement in the Annual Accounts on page 107.

Charitable funding

The Trust received £37.7 million from charitable sources during the year, £32.4 million of which consisted of donations towards capital expenditure and this funding came principally from Guy's and St Thomas' Charity.

Capital expenditure

In 2016-17, the Trust spent £88.7 million on property, plant and equipment (£98.6 million 2015-16). The Trust also spent £9.3 million on intangible assets, mostly software and other IT (£10.0 million 2015-16). The capital programme is

Table 1: Financial performance against plan

	2016/17 Plan £ millions	2016/17 Actual £ millions	Variance £ millions
Total income excluding capital donations	1,382.6	1,414.2	31.6
Expenditure excluding impairments	1,385.0	1,378.4	6.6
Underlying operating surplus/deficit	-2.4	35.8	38.2
Capital donations	27.2	32.4	5.2
Profits on sale of buildings	0.0	0.0	0.0
Impairments	0.0	-25.5	-25.5
Operating surplus	24.8	42.7	17.9

Table 2: Financial performance comparison

	2016/17 Actual £ millions	2015/16 Actual £ millions	Change £ millions
Total income excluding capital donations	1,414.2	1,313.0	101.2
Expenditure excluding impairments	1,378.4	1,324.0	54.4
Underlying operating surplus/deficit	35.8	-11.0	46.8
Capital donations	32.4	27.0	5.4
Impairments	-25.5	-51.0	25.5
Operating surplus/deficit for the year	42.7	-35.0	77.7

Table 3: Cash flow

	2016/17 £ million	2015/16 £ million
Operating surplus/deficit before finance and other costs	66.4	-6.5
Add back non-cash items	25.9	121.2
Net cash generated from operating activities	92.3	114.7
Investing activities	-104.6	-103
Financing	35.2	-27.7
Net increase / decrease in cash	22.9	-15.9

Trends in activity, income and expenditure

Chart 1: Completed patient spells

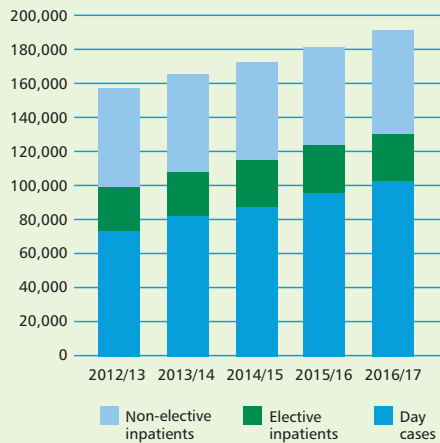


Chart 2: Consultant outpatient attendances

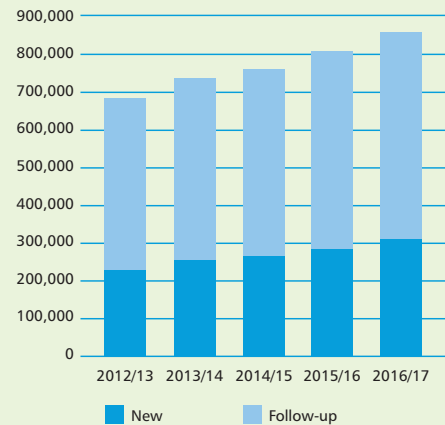
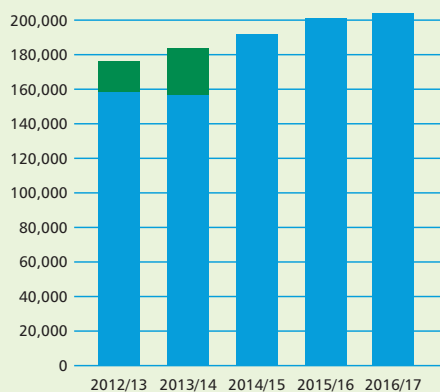


Chart 3: A&E attendances



During 2016-17, we saw in total 1,232,000 outpatients, 88,000 inpatients, 103,000 day case patients and 204,000 accident and emergency attendances. We also provided over 800,000 contacts in the community, bringing our total patient contacts in the year to 2.4 million.

- A&E attendances, including attendances at the urgent care centre at Guy's
- Shows attendances at the urgent care centre at Guy's when this service was managed by local GPs, not the Trust

Chart 4: Income £000s

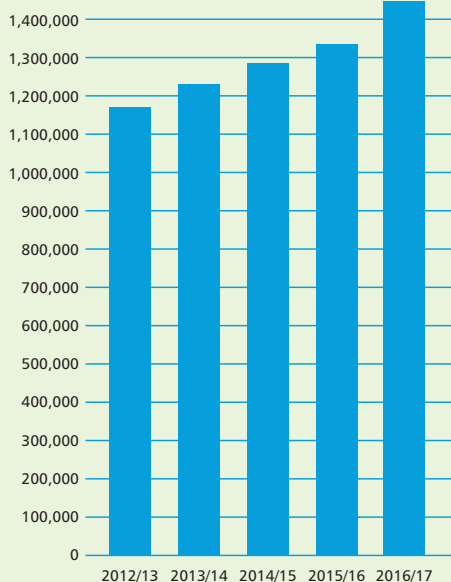
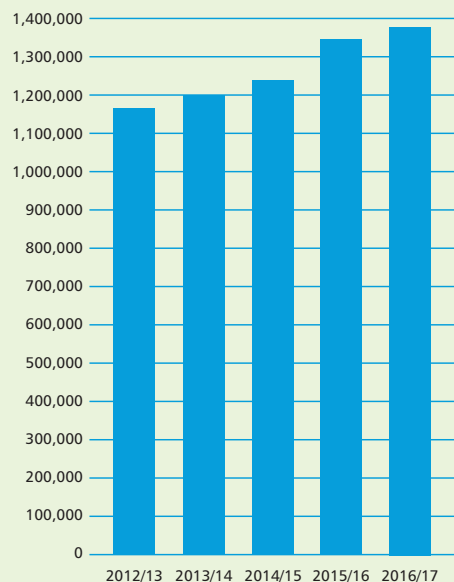


Chart 5: Expenditure £000s



funded from a combination of internally generated resources, surpluses generated in previous years, charitable donations and loans from the Department of Health.

Capital loans

A significant part 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 Independent Trust Financing Facility had agreed loans totalling £269 million, and the Trust had drawn down a net £158.9 million of these after repayments. During the year, the Trust drew down a further net £62.3 million (after repayments), bringing total borrowings to date to £221.2 million and leaving a further £27.7 million to be drawn down. See note 23.4 in the annual accounts on page 127 for more details.

A further £100 million loan has been agreed by the Independent Trust Financing Facility committee and this is currently awaiting confirmation from the Department of Health.

Revaluation of land and buildings

As part of the preparation of the annual accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of each financial year. This year, the full impact on the income statement is a charge of £25.4 million (£50.8 million 2015-16).

These charges, referred to as

impairments, do not reflect any physical damage to our land and buildings, loss of utility or financial loss, and they have no implications for patient care. More details can be found in note 15 to the accounts on page 122.

External audit services

KPMG received £115,000 in audit fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2017. KPMG has served as the Trust's tax advisor for a number of years. In 2016-17, the Trust incurred costs of £533,000 from KPMG for these services (£279,000 2015-16). For more details, see note 5.2 to the accounts on page 115.

Events since the end of the financial year

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

Identifying potential financial risks

In 2017-18, the Trust faces a number of financial risks. These include:

Commissioner affordability: although the Trust has agreed contracts with its principle commissioners these, in the main, do not include the full estimated costs of meeting national waiting times standards. We have agreed cost and volume contracts with these commissioners to mitigate our financial risk of over-performance.

However, if commissioners cannot afford to fund the in-year performance required to deliver

national waiting times, this poses a risk to our financial plan and our ability to meet our control total, and would therefore require discussion with NHS England and NHS Improvement.

Capacity: the Trust does not have sufficient capacity to deliver national waiting times standards, and the cost of outsourcing activity is greater than the cost estimates included in the financial plan. Plans to increase capacity remain an investment priority for the Trust.

Local authority funding reductions: the Trust will be affected by reductions in local authority funding for public health, including services such as health visiting and school nursing.

In addition, possible reductions to social services and care home provision may lead to delays in discharging patients from hospital, increased length of stay and associated costs.

Delivering required efficiency savings to support our financial plan: the Trust is required to deliver £77.7 million efficiency savings. This is more than 7% of the Trust's cost base on which savings can be made. There is a risk that we cannot identify sufficient efficiencies to fully address the financial challenge, or that we cannot deliver these at the required pace.

Failure to deliver our control total: if the Trust fails to achieve the performance trajectories agreed for A&E, the Trust will lose up to 30% of its Sustainability and Transformation Fund (STF) income, while failure to meet our financial target would mean the loss of all our STF money.

Capital planning

The Trust's capital programme has always underpinned delivery of our strategic ambitions. However, the availability of capital is now at odds with our operational and strategic requirements. We will need to continually balance multiple demands including:

- the urgent need for additional operating theatre and critical care capacity following a Board review of our five year demand and activity forecasts and to meet safety requirements.

With commissioner support, we are also investing in additional Emergency Department and ambulatory care capacity, as well as in community services to reflect significant increases in demand;

- maintaining our infrastructure to ensure we provide safe, compliant services;

- the need to invest capital and revenue in service transformation that will drive change and more efficient ways of working both internally and with partners as part of the south east London Sustainability and Transformation Plan; through the development of clinical networks and through the Trust's emerging group model. A particular need to invest in digital transformation and analytical capacity has also been identified;

- investing in our strategic ambitions and schemes with a favourable return on investment as part of our medium-long term plans.

In this context, we will:

Our capital priorities are set out below:	
Capital priority	Description
Theatres at both Guy's and St Thomas'	Urgent capacity requirement
Critical care and haemodialysis unit at St Thomas'	Urgent capacity requirement
Emergency Floor (emergency care pathway) Further Emergency Department expansion and creation of St Thomas' ambulatory unit	New build and service model for emergency care. This will pose short-term delivery issues in 2017. Additional capacity to manage recent demand increases
Ward improvements at both Guy's and St Thomas' Hospitals	Part of the CQC recommendations
Expansion of Evelina London Children's Hospital Children's Clinical Research Facility and Academic Institute	To accommodate growth of local and specialised children's services and to realise the first stage of our longer-term vision for Evelina London, including plans to develop research and academic activities
Medical equipment and infrastructure backlog	Annual replacement programme for high risk requirements
IT investment	Key infrastructure and IT enablers to drive greater efficiency and productivity
Faster IT programme and mobile working for community staff	To provide a modern IT infrastructure and greater opportunities for mobile/flexible working
Rare Diseases Centre	Create a national centre for people with rare diseases – externally funded
Orthopaedics joint venture	Work with a commercial partner to increase efficiency, capacity and quality to meet increasing demand
Expansion of oral medicine	To meet increasing demand and expand educational space
Pan-London ultra high field MRI research facility	Funded by the Wellcome Trust
Energy performance contract	To improve energy efficiency
PET (Positron Emission Tomography) redevelopment – phase 2	New imaging suite with two PET CT scanners
Cardiovascular Institute and Evelina London Institute development	Business case development

- continue to explore alternative funding sources;
- focus on making best use of our current infrastructure – linked to many of our *Fit for the Future* plans. Our ability to invest in new technology will be a major enabler or constraint;
- discuss options for properties that have been identified as surplus to our clinical service and estate requirements. This will be dependent on relevant consultation and partnerships with local authorities, clinical commissioning groups, community health partnerships, NHS Property Services and King's Health Partners.

Fit for the Future

Our refreshed *Fit for the Future* plan for the next two years builds on a strong platform and this Trust-wide programme has already supported directorates to deliver numerous quality, safety and efficiency improvements, including over £236 million savings since 2013.

There are high levels of staff engagement with the programme and our collective focus aims to create a culture of continuous improvement where 'everyone does improvement', and staff feel empowered to deliver change and transformation.

During the first three months of 2017-18 we will complete business cases for investment in three major transformation programmes under the *Fit for the Future* umbrella that aim to deliver significant cost and quality improvements over the next

three to five years:

- the Care Redesign Programme – to support evidence-based pathway redesign, engaging the whole multi-disciplinary team to optimise the way that services are delivered;
- the Digital Patient Journey – to drive improvements in administrative processes and consider how best to use new digital technologies to make our services more responsive to the needs of patients, referrers and staff;
- Transforming our Ways of Working – to create modern working environments that encourage flexible working and collaboration, while reducing our reliance on costly rented office accommodation.

In addition, we continue with 12 core workstreams, including improvements to clinical pathways. We also continue to invest in our staff through the *Fit for the Future Academy* to ensure they have the necessary skills to drive change.

Delivering the Carter recommendations

We continue to support NHS Improvement with the ongoing development and implementation recommendations of the Carter Review. Under the *Fit for the Future* umbrella, a number of projects have made significant progress this year including:

- the Nightingale Project – a nurse-led project to increase standardisation in our clinical

practices and ensure that patients receive safe, effective care delivered with the utmost kindness at all times;

- the TOHETI (Transforming Outcomes and Health Economics Through Imaging) programme to better use imaging technology to improve patient care;
- improvements in clinical coding to ensure that the Trust receives the correct income for the care delivered.

Procurement

The Trust is on track to meet the performance metrics set out in the Carter Review by October 2017 and we are already exceeding the target for purchase order compliance. The Trust's procurement transformation plan includes:

- an Amazon-style ordering system;
- an integrated supply chain in which the clinical supplies, medicines and estates and facilities are managed by a single team, removing duplication, releasing space, reducing inventory levels, and freeing up clinical time.

Performance analysis – sustainability and environmental

Environmental impact performance indicators 2016/17

Area	Acute hospitals 2016/17	2015/16	Trend 16/17 v 15/16	Community services 2016/17	2015/16	Trend 16/17 v 15/16
Water	562,321 m ³	548,651 m ³	2%	20,676 m ³	10,233 m ³	102%
Water cost	£1,009,270	£937,874	8%	£26,412	£28,236	-6%
Imported electricity	178,708 GJ	152,614 GJ	17%	2,136 GJ	4,859 GJ	-56%
Gas	655,768 GJ	642,986 GJ	2%	6,001 GJ	6,500 GJ	-8%
Energy cost	£9,107,242	£10,236,200	-11%	£146,201	£220,028	-34%
CO ₂ emissions from building energy use	54,620 tonnes	54,155 tonnes	1%	601 tonnes	1,008 tonnes	-40%
High temperature disposal	445 tonnes	444 tonnes	0%			
Alternative treatment (offensive waste)	1,599 tonnes	1,556 tonnes	3%			
Landfill waste	16 tonnes	19 tonnes	-16%			
Recycling by % of total	35%	32%	9%			
Cost of waste	£1,078,182	£1,024,968	5%			

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.

This year marks the start of the SAVE (Sustainable Actions delivering Valuable Efficiencies) programme at the Trust, which complements our wider *Fit for the Future* programme to support directorates to deliver savings through efficient use of resources and utilities. In its first months, SAVE has reduced water use in housekeeping, standardised supplies in the maintenance department and minimised waste in radiology, which, along with other initiatives, has saved over £75,000.

The Guy's Dental Institute was recognised in 2016 by the NHS Sustainability Day Awards for its initiatives to improve services, eliminate waste and engage staff and patients in a culture of continuous improvement. Their actions are saving the department

over £45,000 each year, and have laid the groundwork for the SAVE project to stimulate similar action across the Trust.

Helping our staff to keep well is embedded in our sustainability aims, and our approach is supported by the Trust's sustainable travel plan, approved in 2016. We support staff to travel actively by providing facilities for cyclists, monthly cycle maintenance sessions, tax-free cycle purchase schemes and fortnightly lunchtime walks which are open to all staff and patients.

The Trust carefully considers its impact as part of purchasing decisions and strategic decision-making. Sustainability is reflected in business plan development, as well as service tenders.

Last year the Trust was delighted to be awarded the Soil Association's Bronze *Food for Life* Award for its patient food, which is assured for quality, animal welfare and environmental sustainability.

Through one of the most ambitious energy performance contracts 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 also improve the patient environment through better temperature controls and improved lighting, and it will deliver savings of £1 million each year.

The Trust's award-winning waste team holds the Carbon Trust Standard for Waste, for which we received the highest score ever achieved, and the team has an enduring focus on eliminating waste at source, as well as finding innovative solutions to reuse waste and minimise our impact.

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.

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.

In 2016, the Board of Directors sponsored the development of revised equalities objectives. These objectives set out our priorities to drive improvements in patient care, staff experience and reduce inequalities for our diverse workforce and patient population. These objectives will include:

- improving the provision of accessible information and the way that we communicate with patients;
- ensuring that our facilities and service are accessible to all who need to use them;
- helping vulnerable people to participate in public life by widening access to employment and new skills;
- reviewing our patient and staff experience to ensure all groups have a good experience at Guy's and St Thomas';
- ensuring all groups of staff have equality of opportunity for career progression, and our senior management group reflects the diversity of the wider organisation and patient population.

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 aim to safeguard 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 provide many of our core information leaflets in an Easy Read format. A video-kiosk is also used to capture video and audio feedback.

It is important that our services and estate are fully accessible for patients, families and carers. The Trust has invested in a comprehensive accessibility audit to ensure we improve physical access for patients with disabilities, patients with sensory impairments and those who are frail or elderly. This work is supporting the development of a wider accessibility strategy.

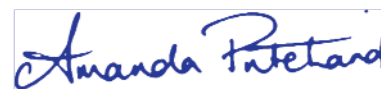
A multi-faith spiritual care team is available to support patients, and reflects the diverse faiths and beliefs of our local population.

Safeguarding training is given to all staff as part of the Trust's training programmes. This 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 Equality Act, 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 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
24 May 2017



The allergy service at Guy's and St Thomas' has become only the fourth centre in the world to be recognised as a Centre of Excellence for Allergy.

3

Accountability report

Directors' report	23
Remuneration report	31
Staff report	39
Our organisational structure: The disclosures set out in the <i>NHS Foundation Trust Code of Governance</i>	47
Single oversight framework	55
Statement of the Accounting Officer's Responsibilities	57



During 2016 our staff gave up some of their free time to use their skills and experience to help local people overcome barriers to employment as part of the Work Ready Programme.

Directors' report 2016-17

Guy's and St Thomas' has performed well both operationally and financially during 2016-17 which was another exceptionally busy and demanding year. Our staff continue to work 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, while driving forward quality and service improvements 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 exceptionally hard to maintain performance against national and local targets and to comply with the requirements of our main regulators, the Care Quality Commission and NHS Improvement. We continue to work closely with our local clinical commissioning groups, with specialist commissioners and with our local Health and Wellbeing 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'.

The CQC rated us as 'requires improvement' for safety and also highlighted three areas where the Trust needed to take action. The Trust developed and has implemented a detailed action plan to address these issues.

We continue to focus on a range of activities to improve and assure safety, including through the consistent application of the 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 99.4% for cleanliness, with the other elements measured also scoring highly.

Sustaining operational performance against a wide range of national and local measures and NHS Improvement'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.

The Board has continued to assess its compliance with the principles of the NHS Foundation Trust Code of Governance, including regular reviews 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 52 and in the full Compliance Statement on the Trust's 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 68 and 69.

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 and communications issues. We continue to work hard to improve the management of complaints, for example we need to do more to improve the quality and timeliness of our complaint responses.

Our 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

The Trust provides 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 England and London, as well as nationally and internationally, to improve services, 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 continue to 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, the new

Cancer Centre at Guy's and improvements to cancer services with partners across south-east London remain 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 continue to strengthen our position as a leader in genomics, imaging and regenerative medicine.

Evelina London Children's Hospital continues to develop 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.

The Trust continues to play a key role in the development of the Accountable Clinical Network for cancer services in south-east London, with a focus on improving care and outcomes for cancer patients.

We are an active member of the Southwark and Lambeth Strategic Partnership. The partnership brings together staff from health and social care, as well as local residents and service users through a Citizens' Forum and continues to build on the work of Southwark and Lambeth Integrated Care. This year, much of its work has focused on the development of local care networks.

The Trust contributes to Lambeth and Southwark Health and Wellbeing Boards, which are responsible for overseeing the

planning of health and social care services for adults and children. This year, we have worked closely with our local authorities in Lambeth and Southwark to engage patients in finding different ways to provide high quality services with reduced funding from the Government public health grant.

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. The Trust has provided Healthwatch with space in busy public areas to promote their work to patients and visitors.

Healthwatch has powers to 'enter and view' services to observe and report on the delivery of care and the care environment. In June 2016, Healthwatch Southwark published a report on a series of visits to the Emergency Department (A&E) at St Thomas' which were completed in February 2016. The report complimented the work of staff and made recommendations for how we could improve information for patients visiting the department. The Trust welcomed these visits and the valuable contribution that Healthwatch makes to the development of our services.

In response to a reduction in the public health grant, the Trust consulted patients and the public as well as key stakeholders on changes to sexual and reproductive health services in Lambeth and Southwark. As part of the consultation, Healthwatch in Lambeth and Southwark helped us to reach their

membership and understand the views of younger people who access these services.

The changes constituted a substantial variation of services, about which the local authority commissioners and the Trust consulted local Overview and Scrutiny Committees. We are using these changes as an opportunity to re-shape our services to ensure that we continue to fulfil our public health role and deliver the best possible care to our local population.

The Trust continues to play an active role in the *Our Healthier South East London* programme and Trust Chief Executive, Amanda Pritchard, has led the development of the south-east London Sustainability and Transformation Plan (STP) over the last year.

This five-year plan sets out how all the NHS organisations and local authorities in south-east London will work together to make services safer, affordable and consistently high quality. Trust staff are at the heart of the plan as we seek to establish sustainable services for our local population through greater collaboration.

As part of the *Our Healthier South East London* programme, and through discussions with our commissioners, the Trust expects to be involved in public consultations about potential changes to orthopaedic services and to public health services in 2017-18.

The Trust is committed to involving patients, families and carers, as well as members of the Foundation Trust, in the delivery and development of services. We have

continued to implement our three-year patient and public engagement strategy which will be reviewed in 2017-18 to ensure it continues to address the Trust's strategic priorities.

Over 50 Foundation Trust members joined staff teams as patient assessors for our Patient-Led Assessments of the Care Environment (PLACE) this year. The Trust was rated above the national average in five out of six categories including cleanliness, food and privacy.

System leadership

Throughout 2016-17 the Trust continued to provide 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 is a key part of our work to help the wider health economy, sharing practical solutions to help drive performance improvement and culture change. We were therefore delighted when the CQC decided to take Medway out of special measures in March 2017, reflecting the improvements made across the Trust.

We have continued to work with Dartford and Gravesham NHS Trust as part of the national vanguard programme acute care collaborative. This year, we were formally accredited by NHS Improvement as one of four trusts exploring how becoming a hospital group might benefit patients.

Through the vanguard programme with Dartford and

Gravesham, our clinical teams are exploring how closer working between our organisations can improve care for patients. We are testing this in three pilot areas – cardiology, vascular and children's services. We are delighted to have received a further £3 million of funding for 2017-18, allowing us to develop further improvements to care and services for our patients.

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.

A key priority for King's Health Partners remains the integration of mental and physical healthcare. The IMPARTS programme to screen patients in outpatient clinics for depression and anxiety is now available in more than 40 services across Guy's and St Thomas' and King's College Hospital, including award-winning work at the St John's Institute of Dermatology. We have also launched our innovative Three Dimensions of Care for Long-Term Conditions programme, which will provide holistic mind and body care for people with heart failure, COPD and hypertension.

Collectively, we have taken an active role in helping to develop the south-east London Sustainability

and Transformation Plan. This will enable us to maximise our partnership's strengths in a number of specialties, including cardiovascular, haematology, clinical neurosciences and child health. Our ambition is to deliver world-class patient care and research through the creation of a number of clinical academic institutes.

Our pioneering work to connect electronic patient records across our three NHS trusts and with primary care has gone from strength to strength and is allowing local clinicians to deliver safer, better care. 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.

Our research activities continue to grow. Our Experimental Cancer Medicine Centre was awarded Cancer Research UK Centre status in December 2016 in recognition of the excellence of the cancer research across our partnership. Renewal of the Centre and an increase in funding from Cancer Research UK and the Department of Health is providing substantial investment of £8.5 million in our cancer research and development programmes over five years.

King's Health Partners has two NIHR Biomedical Research Centres, which includes the Centre at Guy's and St Thomas' and these were awarded £130 million to continue their ground-breaking research into innovative treatments for patients over the next five years. Additionally, £11 million was received for Clinical Research

Facilities and a further £12 million for a medical imaging research centre.

In the last year, all three trusts within King's Health Partners increased their number of clinical research studies, and Guy's and St Thomas' topped the national league table for the overall number of participants in studies. As a founding member of the South London NHS Genomic Medicine Centre, together we are continuing to deliver the ground-breaking 100,000 Genomes Project.

The King's Health Partners Learning Hub meanwhile continues to support staff to develop through a wide range of free e-learning materials. There are now over 7,000 registered users accessing 90 different resources including training focused on the relationship between mental and physical health.

Overseas, our global health partnerships in Sierra Leone and Somaliland continue to support the development of sustainable health-care systems, and a new partnership venture in the Democratic Republic of Congo has been launched.

Investing in our future

The Trust continues to make substantial capital investments in innovative, high quality equipment and technology to help us deliver excellent patient care. We also invest in our buildings to enhance the environment for patients, visitors and staff.

The new £160 million Cancer Centre at Guy's opened in autumn 2016. Bringing most treatment and research together in a state-of-the-

art building will enable us to deliver more efficient patient care and provide greater capacity for radiotherapy. Patients and staff have been at the heart of the development of the Cancer Centre at Guy's. The Centre is the first in Europe to provide all radiotherapy treatment above ground level – a decision that will improve patients' experience and give them more access to natural light.

In addition, the Trust will open a new Cancer Centre at Queen Mary's Hospital, Sidcup in 2017, enabling many patients in south-east London to receive radiotherapy and chemotherapy closer to home.

We are continuing to progress the £20 million development of the Emergency Department (A&E) at St Thomas'. In August 2016, we opened the new Urgent Care Centre, where patients with less serious conditions are treated. Other changes include a new entrance and a new reception and initial assessment area, which opened in September 2016.

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. This year we have begun a major project to convert space previously used for offices into two new clinical areas – a cardiology ward and a critical care unit.

We continue to redevelop our PET imaging services through a joint venture with King's College London which will enable us to increase efficiency in patient treatments and to remain an international leader in molecular imaging.

We have also completed the restoration of St Thomas' Chapel, a Grade II listed chapel which dates back to 1870. The work, including repainting the interior of the chapel, restoring the artwork and improving the lighting and heating, was funded by Guy's and St Thomas' Charity and other donors.

During the summer of 2016 the Trust undertook a comprehensive review to assess the organisation's readiness and capacity to embrace digital technology. The findings of the review were discussed by the Board and its recommendations accepted.

The findings are being implemented through a detailed action plan and include: embedding the IT and digital function more firmly at the heart of the organisation; the appointment of a new Board level Director role responsible for digital and information technology; a refreshed digital strategy to ensure the Trust is well placed to benefit from digital technology in the years ahead; and plans to procure a new Electronic Health Record.

We are also investing in faster, more secure IT infrastructure, enabling us to introduce modern devices and software to support further mobile working and video calling. We will be the first NHS trust to upgrade to Windows 10.

New systems including eNoting are being introduced across the Trust, replacing paper records with digital notes and making the storage and retrieval of notes easier and more secure.

The roll-out of ePrescribing is enabling clinicians to prescribe and

order medication electronically, therefore reducing the risk of illegible or incomplete handwritten prescriptions. This year, we rolled-out ePrescribing for chemotherapy to the five hospitals that make up the Accountable Clinical Network for cancer services in south-east London.

Developing commercial partnerships

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

- 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 SSAFA, the Armed Forces charity;
- expanding our commercial education programme, for example; increasing the number of programmes for visiting professionals from three to 19;
- supplying pharmaceutical products to Fresenius Medical Care (UK) which are manufactured in our state-of-the-art pharmacy manufacturing unit at Guy's;
- developing retail services for patients and visitors in the new

Cancer Centre at Guy's.

The Trust continues to develop a number of commercial organisations so that it can benefit from intellectual property created through innovations in patient care. The Trust's wholly-owned subsidiary, GSTT Enterprise, manages a portfolio including:

- Essentia Trading Ltd, our estates and infrastructure company;
- Viapath, our pathology joint venture with King's College Hospital NHS Foundation Trust and Serco;
- Cydar, Spot On and a number of other spin off technology companies.

A full list of subsidiaries and interests in associates and joint ventures can be found in note 19 to the accounts on page 124.

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 2016-17, Board membership comprised of the following Executive Directors: Chief Executive, Amanda Pritchard; Director of Finance, Martin Shaw; Chief Medical Officer and Director of Patient Safety, 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; Acting Chief Operating Officer (to December 2016), Simon Steddon; Chief Operating Officer

(from January 2017) Jon Findlay.

And the following Non-Executive Directors: Chairman, Hugh Taylor; Diane Summers (Vice-Chair to June 2016); Sheila Shribman (Vice-Chair from June 2016); Robert Drummond (to December 2016); Emma Duncan (from August 2016); Felicity Harvey (from September 2016); Frank Nestle (to May 2016); Girda Niles; John Pelly (from January 2017); Reza Razavi (from May 2016); Priya Singh; 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 30 (Related Parties) to the Annual Accounts on page 129.

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

Better Payment Practice Code

Measure of compliance	Year ended March 31 2017		Year ended March 31 2016	
	Number	£000	Number	£000
Total bills paid in the year	341,733	726,335	359,855	724,309
Total bills paid within target	279,516	541,459	280,039	532,342
Percentage of bills paid within target	82%	75%	78%	73%

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 108. 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



In July 2016 Prince Harry visited Burrell Street Sexual Health Clinic where he took an HIV test to raise awareness of the importance of getting 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 2016-17.

There were no changes to the Trust's remuneration policy for very senior managers in 2016-17.

The Committee undertook the scheduled interim review of executive and senior management salaries at the start of 2016-17, taking into consideration the national 1% pay settlement applicable to the *Agenda for Change* and medical and dental workforce from 1 April 2016. The Committee approved a 1% cost of living increase to executive salaries with effect from April 2016. This followed two years without a cost of living increase for executives, the last such increase having been applied from April 2013. Owing to changes to UK pensions tax relief allowances from April 2016, the Committee approved a flexible approach, offering senior managers a choice between receiving the 1% increase as either consolidated into salary, and therefore pensionable, or as a non-pensionable salary supplement.

Following the appointment of Amanda Pritchard as Chief Executive and Accountable Officer in January 2016, there have been a number of changes to the Trust's executive team during 2016-17. In January 2017, Jon Findlay returned to the Trust as Chief Operating Officer, enabling Simon Steddon to move on from his role as Acting Chief Operating Officer to become Medical Director. These changes are reflected in the Annual Report on Remuneration. Also in January 2017, Ian Abbs became Chief Medical Officer and Director of Patient Safety for Guy's and St Thomas', with a focus on strategic issues, and both he and Eileen Sills became Deputy Chief Executive Officers.

Finally, as set out in the Trust's pay principles for very senior managers, the Committee will conduct its full three-yearly review of executive and senior management salaries in 2017-18. There are currently no plans for changes to the Trust's remuneration policy for very senior managers in 2017-18.



Sir Hugh Taylor

Remuneration Committee Chairman
24 May 2017

Remuneration policy report 2016-17

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
Purpose and link to strategy	<p>To provide a core reward for the role.</p> <p>Salary is set at a level appropriate to secure and retain the high calibre individuals needed to deliver the Trust's strategic priorities, without paying more than is necessary.</p>	<p>NHS Pension Scheme arrangements provide a competitive level of retirement income.</p> <p>Life assurance/death in service benefits may be provided as part of an individual's pension arrangements.</p>
Operation	<p>When determining salary levels, an individual's role, experience and performance, and independently sourced data for relevant comparator groups are considered.</p> <p>Executive Director salaries are inclusive of a 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>The NHS Pension Scheme is made up of the 1995/2008 Scheme and the 2015 Scheme. New Executive Directors are entitled to join the 2015 Scheme, which is a Career Average Revalued Earnings scheme.</p> <p>Where an individual is a member of the 1995/2008 Scheme and is subsequently appointed to the Board, he or she may remain a member of that scheme.</p>
Opportunity	<p>There is no formal maximum limit, however salary increases will ordinarily be in line with increases for the wider NHS workforce (not including incremental progression increases) as recommended by the NHS Pay Review Body.</p> <p>Increases may be higher to reflect a change in the scope of an individual's role, responsibilities or experience.</p> <p>Where a new Executive Director has been appointed to the Board on a salary lower than the typical Trust level for such a role, 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 2016-17 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 www.nhsbsa.nhs.uk/pensions. Details of the 2016-17 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"> • a Career Average Revalued Earnings (CARE) scheme with benefits based on a proportion of pensionable earnings each year during the individual's career • a build-up rate of 1/54th of each year's pensionable earnings with no limit on the number of years that can be taken into account. This is a higher build-up rate than the 1995/2008 Scheme • revaluation of active members' benefits in line with inflation, currently the Consumer Price Index (CPI) plus 1.5% per annum • a normal pension age at which benefits can be claimed without reduction for early payment linked to the state pension age. <p>In accordance with NHS Pension Scheme rules, the employer contribution rate is 14.3%.</p>
Performance measures	The overall performance of the individual is a consideration when reviewing salaries.	None.

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 2016-17

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 2016-17	
Name	Actual/Possible
Hugh Taylor	2 / 2
Robert Drummond	0 / 1
Emma Duncan	1 / 1
Felicity Harvey	1 / 1
Frank Nestle	1 / 1
Girda Niles	2 / 2
John Pelly	1 / 1
Reza Razavi	1 / 1
Sheila Shribman	2 / 2
Priya Singh	2 / 2
Diane Summers	1 / 1
Steve Weiner	2 / 2

Note: the second Remuneration Committee meeting of the year was via electronic circulation in February 2017.

Remuneration report

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	
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 2017	March 31 2016
Highest paid director's total remuneration	£252,500	£202,614
Median total remuneration	£30,542	£30,954
Remuneration ratio	8.27	6.55

The changes in the highest paid director's salary reflect the appointment of a permanent Chief Executive.

The calculation is based on full-time equivalent staff working for the Trust on March 31 2017. Where staff are part-time, their salaries have been annualised for the purposes of the median ratio calculation.

Service contracts

The following table contains details of the service contracts in place during 2016-17 for Executive Directors:

Service contracts			
Executive Director	Date of service contract	Unexpired term	Notice period
Ian Abbs	Jan 2011	Open ended	6 months
Jon Findlay	Dec 2016	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	6 months
Martin Shaw	Oct 1998	Open ended	6 months
Eileen Sills	Feb 2005	Open ended	6 months
Simon Steddon	Sept 2005	Open ended	3 months

Salaries of senior staff

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.

Salary and benefits of senior managers

The following tables contain details of the salary and benefits of the Trust's senior managers in 2015-16 and 2016-17.

Single Total Figure 2016-17

Name	Title	Salaries and fees (bands of £5k) £000	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
I. Abbs	Chief Medical Officer and Director of Patient Safety	200–205	–	200–205
J. Findlay	Chief Operating Officer (from Dec 2016)	40–45	12.5–15	50–55
R. Kerr	Executive Vice Chairman	115–120	–	115–120
A. Macintyre*	Director of Workforce and Organisational Development	160–165	37.5–40	195–200
S. McGuire	Director of Essentia	160–165	–	160–165
A. Pritchard	Chief Executive	250–255	195–197.5	445–450
M. Shaw	Director of Finance	160–165	37.5–40	195–200
E. Sills	Chief Nurse and Director of Patient Experience	175–180	27.5–30	200–205
S. Steddon	Acting Chief Operating Officer (until Dec 2016)	125–130	20–22.5	150–155
R. Drummond***	Non-Executive Director (until Dec 2016)	10–15	–	10–15
E. Duncan	Non-Executive Director (from Aug 2016)	10–15	–	10–15
F. Harvey	Non-Executive Director (from Sep 2016)	5–10	–	5–10
F. Nestle	Non-Executive Director (until May 2016)	0–5	–	0–5
G. Niles	Non-Executive Director	15–20	–	15–20
J. Pelly	Non-Executive Director (from Jan 2017)	0–5	–	0–5
R. Razavi	Non-Executive Director (from May 2016)	15–20	–	15–20
S. Shribman**	Vice-Chair (from Jun 2016)	15–20	–	15–20
P. Singh	Non-Executive Director	15–20	–	15–20
D. Summers	Vice-Chair (until Jun 2016)	0–5	–	0–5
H. Taylor	Chairman	60–65	–	60–65
S. Weiner	Chairman of the Audit Committee	20–25	–	20–25

No senior manager received any taxable benefit, annual or long-term performance bonuses in 2016-17 or 2015-16.

*The salaries and fees figure for 2016-17 includes a one-off, non-pensionable payment of £9,000 which was approved by NHS Confederation in recognition of work undertaken at a national level. **Sheila Shribman took on the role of Vice-Chair after Diane Summers stepped down.

***During the period that Robert Drummond was a Non-Executive on the Trust Board, he was also chair of the Guy's and St Thomas' Enterprises Ltd Board. He received £15K in relation to this role. His total remuneration over the period to December 16 from both roles was £28K.

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

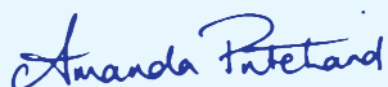
Remuneration report

Pension Benefits of senior managers – 2016-17

Name/Title	Total accrued pension at age 60 at March 31 2017 £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 2017 £000	Cash equivalent transfer value at April 1 2016 £000	Real increase in cash equivalent transfer value during year £000	Cash equivalent transfer value at March 31 2017 £000
A. Macintyre Director of Workforce and Organisational Development	62	11	249	1,209	92	1,301
A. Pritchard Chief Executive	50	29	174	488	167	655
M. Shaw Director of Finance	73	11	293	1,607	0*	0*
E. Sills Chief Nurse and Director of Patient Experience	70	9	280	1,296	85	1,381
S. Steddon Chief Operating Officer (until Dec 2016)	36	2	132	521	29	559
J. Findlay Chief Operating Officer (from Dec 2016)	45	1	171	734	22	820

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

* The NHS Pensions Agency (NHSPA) does not calculate a cash equivalent transfer value (CETV) once an individual reaches the scheme's normal retirement age (60).



Amanda Pritchard, Chief Executive
24 May 2017



In 2016 we gave flu vaccinations to 77% of frontline staff – more than 9,000 staff have been vaccinated this year.

6

Staff report

Last year, we employed around 15,300 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 and deliver the best possible care to our 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 2017
Administration and estates	3,455	335	3,790
Ancillary staff	797	344	1,141
Medical and dental	1,876	75	1,951
Nursing, midwifery & health visiting staff	4,512	531	5,043
Nursing, midwifery & health visiting learners	922	211	1,133
Scientific, therapeutic & technical staff	2,032	189	2,221
Social care staff	2	–	2
Total	13,596	1,685	15,281

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, engaging them in key developments, and keeping them informed of change across the organisation. We work hard to ensure that all staff are aware of both internal and external developments that may affect the organisation, such as financial pressures and changes in the wider NHS.

We place great importance on staff engagement as there is a positive correlation between this and staff motivation, commitment, involvement in change and ultimately a positive impact on the quality of patient care. The Trust was proud to achieve the highest score for staff engagement of any NHS provider in England for the second year running in the 2016 national NHS Staff Survey results. Throughout 2016/17, we also continued to

score highly in the quarterly Friends and Family Test, always achieving results significantly above the national average.

Our range of well-established communications channels include a monthly team briefing from the Chief Executive, a regular email bulletin to all staff, daily messages on all PC desktops and an extensive intranet where staff can find policies, guidance and online tools. The Trust's two-day corporate induction programme is a valuable source of information for new recruits.

We hold regular face-to-face briefings on both clinical and management issues, helping to engage staff who do not have regular access to computers, and the Knowledge and Information Centre at St Thomas' provides email and computer access for staff. Staff can

also download a staff app 'My GSTT' to their own mobile device, enabling them to access key Trust information anytime, anywhere. The Trust produces a popular magazine, *the GiST*, for staff, patients and our Foundation Trust members.

We work closely with the Chair of Staff Side and other staff representatives to ensure employees' voices are heard. The Joint Staff Committee meets bi-monthly, acting as a valuable consultative forum for key developments affecting staff, with sub-groups established to look at policy and pay issues. The Trust has six staff governors who contribute to the assurance and development of the organisation and represent staff members' views at Board level.

All staff are encouraged to voice opinions and make improvements in their areas. The Trust's transformation programme, *Fit for the Future*, engages staff in improving the quality, safety and efficiency of services and patient care. Last year more than 1,700 staff took part in a Trust-wide conversation which allowed local teams to explore how change happens and how we can accelerate the pace of positive change across the organisation.

Staff survey

We know that the quality and safety of our services depends on our staff, and that there is a strong link between positive staff engagement and patient experience and safety. We measure our success in terms of staff engagement and creating a good work environment through

the annual NHS Staff Survey and the Staff Friends and Family Test, which is undertaken three times a year. These survey and test results are closely monitored and discussed at the Trust Management Executive and Board meetings.

The staff survey results for 2016 were very positive and showed that for the second year running the Trust had the highest score for staff engagement of all NHS provider trusts in England. Our results were above average in 22 of the 32 key findings and below average in only four.

Although the Trust scored well overall, some areas require improvement. A working group, reporting to the Trust Management Executive, is reviewing the findings and taking action.

Long working hours may be linked to the high levels of engagement and to the commitment that staff have to the Trust and its patients. However, to ensure that excessive hours are not being worked and that staff are well rested, there are initiatives in place to improve ward processes and ensure handover takes place on time. We also recently launched the HALT campaign which encourages staff to take a break when they are 'hungry, angry, late or tired'.

The score for staff experiencing discrimination at work in the last 12 months includes discrimination by patients as well as by colleagues. The 'Keep our staff safe' campaign, launched in October 2016, aims to remind patients that the Trust's staff deserve to be treated well. The Trust continues to work to improve

relations between all staff, through promoting the Trust's values, including respecting others, and through training for managers.

Our score for the 'percentage of staff believing that the organisation provides equal opportunities for career progression or promotion' has been historically low, as it has in other London NHS trusts. We plan further action to address this.

The percentage of staff 'witnessing potentially harmful errors, near misses or incidents' is slightly higher than average. While this could be the result of greater awareness among staff about what constitutes harm we are not complacent. Alongside this, it is very positive to see that the Trust's scores are above average for the percentage of staff reporting incidents, the effectiveness of the procedures for doing so and staff feeling confident of reporting unsafe clinical practice.

We share learning and ideas for improving safety with staff through campaigns, email messages such as 'Safety signals' and our 'Quality matters' newsletter. The Trust monitors all incidents and near misses that are reported and analyses the causes so that we can learn lessons and take action.

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,

Staff survey

	2016/17 Trust	2016/17 National average	2015/16 Trust	2015/16 National average**	Trust improvement/ deterioration
Response rate	38%	40%	33%	41%	Improvement
Areas of best performance					
Effective use of patient/ service user feedback	3.95*	3.68*	3.98*	3.65*	No statistically significant change
Staff recommendation of the organisation as a place to work or receive treatment	4.2*	3.71*	4.22*	3.71*	No statistically significant change
Quality of non-mandatory training, learning or development	4.16%	4.07*	4.15*	4.04*	No statistically significant change
Staff satisfaction with the quality of work and care they are able to deliver	4.11*	3.92*	4.15*	3.94*	Deterioration
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.93*	3.73*	3.91*	3.71*	No statistically significant change
Areas of weakest performance					
Percentage of staff working extra hours	75%	71%	75%	72%	No change
Percentage of staff experiencing discrimination at work in the last 12 months	14%	10%	14%	10%	No change
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	83%	87%	83%	87%	No change
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	31%	29%	29%	29%	No statistically significant change
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	27%	26%	26%	27%	No statistically significant change

*Scored out of 5

**Combined acute and community trusts average

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 set out our priorities to drive improvements in patient care and staff experience which aim to 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 reports back on our performance. The Trust has in place a comprehensive plan to ensure better and fairer outcomes in

recruitment and progression, as well as ambitious targets to improve diversity in senior management, ensuring all staff have the opportunity to achieve their full potential.

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 people with disabilities, and we continue to support staff with disabilities, 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:

- an expanding range of apprenticeships involving teams and departments across the Trust;
- Unconscious Bias training, currently provided for all new starters, will be rolled out to all staff in 2017/18;
- 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;

- support for Black History Month to recognise and celebrate the diversity of our workforce;
- award-winning projects to support people with learning disabilities to gain access to employment;
- a partnership with McKinsey and Thames Reach to support formerly homeless people to gain employment;
- leading the London, Surrey and Kent Step Into Health programme which supports people from the armed forces to access employment opportunities in the NHS.

Staff group	Gender		Total
	Male	Female	
Executive Directors	5	3	8
Other senior managers	121	183	304
Employees	3,796	10,894	14,690
	3,922	11,081	15,002

Number of staff employed on March 31st 2017.

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 if they have developed a disability. The Trust provides guidance to managers and all staff about the scheme as well as 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 or long-term conditions during their employment.

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.

There have been significant changes to the external environment for health and safety, including the introduction of new guidelines on health and safety and corporate manslaughter from the Sentencing Council for England and Wales.

In 2016, the Trust improved governance arrangements for health and safety to ensure clear oversight by the Trust Management Executive and the Board. This included the publication of an

annual report and the establishment of a health and safety committee, chaired by the Director of Workforce, which meets monthly to manage key risks and which ratified a new health and safety policy. Strong links were maintained with Essentia and key partners including King's College London.

We have undertaken a number of initiatives to control or eliminate risk. Following an inspection by the Health and Safety Executive in February 2016, the Trust has implemented improvements to the management of sharps through an Executive-led sharps safety project group.

The Trust is compliant with its statutory obligations to manage

Legionella bacteria in water systems and manage asbestos risk.

Occupational health

Our occupational health service places a strong focus on health, safety and well-being for staff, patients and visitors. It remains one of the largest in the country, employing a multi-disciplinary team of doctors, nurses, safety specialists and administrative staff, serving our staff and over 70,000 employees in local and national businesses.

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 to support staff to return to work. This year we have improved our referral service for managers and staff, including the introduction of a managers' advice line. Staff can refer themselves directly to physiotherapy and dietetic services online.

The Trust offers a flu vaccination programme to all staff. In 2016-17, through a sustained campaign, we vaccinated 77% of frontline staff, (7,098 staff), exceeding the 75% CQUIN target set by the Department of Health. The programme was championed by our Chief Nurse and senior managers. Staff acting as peer vaccinators gave their time to run clinics and vaccinated over 3,000 colleagues.

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, extending 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. As a 'no smoking' organisation, the Trust provides support to staff through our smoking cessation services.

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 training 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

This year, the Trust has continued its focus on reducing the use of agency staff and remaining compliant with NHS Improvement's agency 'cap' which sets maximum pay levels for agency staff. We use robust procedures to monitor and report on agency spend and to reduce the number of breaches of the cap. Action plans are in place to continue to drive down costs while maintaining high standards of care.

The Trust has achieved significant reductions in the

Staff sickness absence		
	2016/17	2015/16
Total days lost	100,462	97,016
Total staff years	13,346	12,692
Average working days lost (per WTE)*	7.5	8

*WTE = Whole Time Equivalent

The sickness absence figures are reported on a calendar basis, rather than the financial year. These statistics are published by NHS Digital, using data drawn for January 2016 to December 2016 from the ESR national data warehouse. The latest publication, which covers up to December 2016, can be found on the NHS Digital website.

Employee costs (including executive directors)

	Permanently employed £000	Agency, bank and seconded staff £000	Year ended March 31 2017 Total £000	Year ended March 31 2016 Total £000
Salaries and wages	561,630	50,417	612,047	578,116
Social security costs	61,759	2,650	64,409	49,822
Employer contributions to NHSPA	69,657	1,642	71,299	67,209
Termination benefits	732	–	732	400
Temporary staff – external bank	–	4,643	4,643	4,269
Temporary staff – agency & contract staff	–	38,820	38,820	56,141
Total gross staff costs	693,778	98,172	791,950	755,957
included in above:				
Costs capitalised as part of assets	(8,551)	(5,155)	(13,706)	(18,071)
less income netted off in staff costs	(6,046)	–	(6,046)	(5,838)
Total staff costs	679,181	93,017	772,198	732,048
Analysed into Operating Expenditure				
Employee expenses – staff	676,353	93,017	769,370	729,693
Employee expenses – executive directors	1,721	–	1,721	1,555
Redundancy	732	–	732	400
Internal Audit Costs	375	–	375	400
	679,181	93,017	772,198	732,048

amount spent on agency staff compared with previous years, and we continue to develop plans to reduce this further. The Trust has been instrumental in driving forward a pan-London agreement to standardise rates for agency workers. This agreement ensures a consistent approach and supports us in managing the market rates for agency staff.

We continue to maintain a Trust-wide ban on using band 1 to 4 agency staff and have introduced a 'master vendor' approach for agency bookings of information technology staff which should lead to significant savings going forward.

Regular meetings take place with the directorates within the Trust with the highest agency

Exit packages

Staff exit packages

In 2016-17, a total of 12 exit packages were agreed in the year, all of which were compulsory redundancies. The total cost of these exit packages was £405,000. Summary information for 2016-17 and comparative information for 2015-16 is provided in the table below.

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16
<£10,000	3	4	1	1	4	5
£10,000 – £25,000	5	3	–	1	5	4
£25,001 – £50,000	–	3	–	–	–	3
£50,001 – £100,000	2	1	–	–	2	1
£100,001 – £150,000	–	1	–	–	–	1
£150,001 – £200,000	1	–	–	–	1	–
Total number of exit packages by type	11	12	1	2	12	14
Total resource cost £000	401	393	4	20	405	413

Exit packages: other (non-compulsory) departure payments

There were no non-compulsory departures which attracted an exit package in 2016-17. Summary information for 2016-17 and comparative information for 2015-16 is provided in the table below.

	2016-17		2015-16	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	–	–	–	–
Mutually agreed resignations (MARS) contractual costs	–	–	–	–
Early retirements in the efficiency of the service contractual costs	–	–	–	–
Contractual payments in lieu of notice	1	4	–	–
Exit payments following Employment Tribunals or court orders	–	–	1	12
Non-contractual payments requiring Treasury approval*	–	–	1	8
Total	1	4	2	20

expenditure to support them in reducing costs. Plans to reduce spending in other areas are reviewed and challenged at monthly performance review meetings.

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 2016-17.

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 2016-17 was £967,000.

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 2017, that exceed £220 per day and that have lasted for longer than six months	10
Number that have existed for less than one year at the time of reporting	2
Number that have existed for between one and two years at the time of reporting	4
Number that have existed for between two and three years at the time of reporting	4
Number that have existed for four or more years at the time of reporting	0

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 2016-17 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 2016-17	2
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	2
Number from whom assurance has been requested	0

On 6 April 2017, public bodies became responsible for collecting tax from those contractors subject to HRMC's IR35 rules; all those contractors listed above either brought their engagements to an end or were subject to a review to determine whether they were affected by the new rules and consequently no further assurance was sought.

Off-payroll engagement of Board members and/or senior officials with significant financial responsibility in 2016-17	
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	70



Staff from the amputee rehabilitation unit helped patient Syeda Mannan (centre) walk again after a catastrophic illness left her with both legs amputated above the knee.

Our organisational structure: disclosures set out in the NHS Foundation Trust Code of Governance

Our governors play a vital and active role 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 role 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.

And there is a Quality and Engagement Working Group which is a forum for the Trust and governors to discuss patient engagement, quality improvement and safety matters.

This year the Council of Governors approved the appointment of three new Non-Executive Directors, recommended by the Nominations Committee 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 a second and final term.

Elections for new governors in the public, patient and staff constituencies took place in Spring 2016 with eight places available in total. In addition, some of the organisations we work most closely with nominate stakeholder governors: two new stakeholder governors were appointed in 2016.

There are 31 governors at the present time. During 2016-17, two governors received expenses totalling £190.30. 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, Diane Summers' second term as Non-Executive Director came to an end in June 2016. The Nominations Committee recommended the appointment of Emma Duncan from 1 August 2016, Felicity Harvey from 15 September 2016 and John Pelly from 1 January 2017. They are each serving their first

Members of the Nominations Committee*

Name	Role
Heather Byron	Patient Governor
John Chambers	Staff Governor
Tom Hoffman	Public Governor
Hugh Taylor	Chairman
Warren Turner	Stakeholder Governor
Paula Young (until June 2016)	Patient Governor

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

term as Non-Executive Director. In addition, the Committee noted Robert Drummond's role change from Non-Executive Director to Non-Executive Advisor to the Board from 1 January 2017.

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 24,169 members, of

whom 4,013 are patient members, 5,581 are public members and 14,575 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 devised a membership strategy as part of the Trust's work to develop a membership that reflects the communities we serve.

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 September 2016), including the Chief Executive, Amanda Pritchard.

Its role is to:

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

Membership is balanced, complete and appropriate. The Trust is confident that all 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.

Reza Razavi replaced Frank Nestle in May 2016 and Diane Summers' term of office came to an end in June 2016; Robert Drummond stood down from the Board in December 2016. Sheila Shribman took over the role of Vice-Chair from June 2016. The resulting vacancies were filled by Emma Duncan (from August 2016), Felicity Harvey (from September 2016) and John Pelly (from January 2017).

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

In September 2016, over 200 people attended our Annual Public Meeting, and members, local people, patients, staff and other stakeholders heard about how we performed during the year; had an opportunity to meet and ask questions of the Board of Directors and the Council of Governors; and heard presentations about the Cancer Centre at Guy's, the community rehabilitation and falls services and the Trust's apprenticeship programme.

Details of external directorships or other positions of authority held by the Directors of the Trust can be found in note 30 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 2016	4/4
John Burns	July 2013 (until June 2016)	0/1
Heather Byron	July 2016	3/3
Anita Campolini	July 2015	2/4
John Duncan	July 2015	4/4
Jonathan Farley	July 2015	4/4
David Maurice	July 2016	1/3
Darren Oldfield	July 2015	4/4
Giles Taylor	July 2015	3/4
Paula Young	July 2013 (until June 2016)	1/1

Public governors	Elected from	Actual/possible attendance
Kevin Burnand	July 2015	4/4
Yvonne Craig Inskip	July 2015	3/4
Linda Goldsmith	July 2016	3/3
Kate Griffiths-Lambeth	July 2015	2/4
Ken Hayes	July 2013 (until June 2016)	1/1
Tom Hoffman	July 2015	4/4
James Palmer (replaced Barry Silverman until June 2018)	July 2016	3/3
John Porter (Lead Governor)	July 2016	1/1
Barry Silverman	July 2015 (until June 2016)	1/1
Jenny Stiles	July 2016	3/4

Staff governors	Constituency	Elected from	Actual/possible attendance
Thelma Bangura	Community	Sept 2014 (until Aug 2016)	3/4
John Chambers	Clinical	July 2015	3/4
Noreen Ging	Clinical (replaced Sam Newman until June 2018)	Feb 2017	0/0
Tony Hulse	Clinical	July 2015	3/4
Gyles Morrison	Non-clinical	July 2015 (until June 2016)	1/4
Sam Newman	Clinical	July 2015 (until Jan 2017)	3/4
Vicky Rogers	Non-clinical	July 2016	2/3
Bryn Williams	Non-clinical	July 2016	4/4

Stakeholder governors	Organisation	Appointed from	Actual/possible attendance
Jasmine Ali (stepped down in June 2016)	Southwark Council	Oct 2014	0/1
John Balazs	Lambeth CCG	Dec 2015	3/4
Robert Davidson	Southwark CCG	Dec 2015	2/4
Jane Fryer	NHS England	Oct 2015	0/4
Matthew Patrick	South London and Maudsley NHS Foundation Trust	Nov 2013	0/4
Lucilla Poston	King's College London	Jan 2017	1/1
Dianne Rekow (stepped down in December 2016)	King's College London	May 2015	1/3
Sue Slipman	King's College Hospital NHS Foundation Trust	Dec 2015	2/4
Warren Turner	London South Bank University	Sep 2014	2/4
Bill Williams	Southwark Council	June 2016	2/3
Sonia Winifred	Lambeth Council	May 2015	2/4

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

Head of Corporate Affairs
4th Floor, Gassiot House
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH
Tel: 020 7188 7346

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 2016, 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 NHS Improvement, and received reports on a number of topics including information governance, use of 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.

KPMG LLP has continued as the Trust's external auditors for the financial year 2016-17.

All non-audit services provided by the auditor have been reviewed and reported to the Audit Committee as part of the appointments, audit

Board meeting attendance April 2016 – March 2017

Name	Title	Actual/possible
Emma Duncan (from Aug 2016)	Non-Executive Director	2/3
Robert Drummond (until December 2016)	Non-Executive Director	4/5
Felicity Harvey (from Sep 2016)	Non-Executive Director	2/3
Frank Nestle (until May 2016)	Non-Executive Director	2/2
Girda Niles	Non-Executive Director	6/6
John Pelly (from Jan 2017)	Non-Executive Director	0/1
Sheila Shribman (Vice-Chair from June 2016)	Non-Executive Director	6/6
Priya Singh	Non-Executive Director	6/6
Diane Summers (Vice Chair until June 2016)	Non-Executive Director	2/2
Hugh Taylor	Chairman	6/6
Steve Weiner	Non-Executive Director	4/6
Ian Abbs	Chief Medical Officer and Director of Patient Safety	6/6
Jon Findlay (from Jan 2017)	Chief Operating Officer	1/1
Ron Kerr	Executive Vice Chair	5/6
Ann Macintyre	Director of Workforce	5/6
Steve McGuire	Director of Essentia	3/6
Amanda Pritchard	Chief Executive	6/6
Martin Shaw	Finance Director	6/6
Eileen Sills	Chief Nurse and Director of Patient Experience	6/6
Simon Steddon (until Dec 2016)	Acting Chief Operating Officer	5/5

Committee Membership April 2016 – March 2017

Committee	Membership April 2016 – March 2017
Adult Local Services	Girda Niles (Chair), Ian Abbs, Jon Findlay (from Jan 2017), Ann Macintyre, Amanda Pritchard, Simon Steddon (until Dec 2016), Sheila Shribman, Eileen Sills, Diane Summers (until June 2016)
Audit	Steve Weiner (Chair), Robert Drummond (until Dec 2016), John Pelly (from Jan 2016), Priya Singh, Diane Summers (until June 2016)
Cancer Services	Hugh Taylor (Chair), Robert Drummond (until Dec 2016), Emma Duncan (from Aug 2016), Jon Findlay (from Jan 2017), Felicity Harvey (from Aug 2016), Ron Kerr, Ann Macintyre, Frank Nestle (until May 2016), Amanda Pritchard, Reza Razavi (from May 2016), Sheila Shribman, Simon Steddon (until Dec 2016), Diane Summers (until June 2016)
Children's Services	Sheila Shribman (Chair), Ian Abbs, Jon Findlay (from Jan 2017), Amanda Pritchard, Simon Steddon (until Dec 2016), Diane Summers (until June 2016), Hugh Taylor
Corporate Management	Hugh Taylor (Chair), all Board members
Quality and Performance	Diane Summers (Chair until June 2016), Priya Singh (Chair from June 2016), Ian Abbs, Ann Macintyre, Jon Findlay (from Jan 2017), Steve McGuire, Girda Niles, John Pelly (from Jan 2017), Amanda Pritchard, Reza Razavi (from May 2016), Martin Shaw, Sheila Shribman, Eileen Sills, Simon Steddon (until Dec 2016), Hugh Taylor
Remuneration	Hugh Taylor (Chair), all Non-Executive Directors

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.

As a result of new rules from the National Audit Office, limiting the non-audit services that an external auditor can provide, by mutual agreement, the Trust will be seeking new external auditors for 2017/18.

Audit Committee membership and attendance

Name	Actual/possible
Steve Weiner (Chair)	3/3
Robert Drummond	2/2
John Pelly	1/1
Priya Singh	3/3
Diane Summers	1/1

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.

Remuneration Committee membership and attendance

Name	Actual/possible
Hugh Taylor (Chair)	2/2
Emma Duncan	1/1
Robert Drummond	0/1
Felicity Harvey	1/1
Frank Nestle	1/1
Girda Niles	2/2
John Pelly	1/1
Reza Razavi	1/1
Sheila Shribman	2/2
Priya Singh	2/2
Diane Summers	1/1
Steve Weiner	2/2

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 NHS Improvement. 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, they hold '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.

During the second part of the year, the Trust Management Executive reviewed its terms of reference, membership and ways of working and will propose changes to the Trust Board in 2017-18.

The Trust Management Executive has the following sub-committees:

- Cancer Centre Programme Board (to January 2017);
- Information Governance Committee;
- Investment Portfolio Board;
- IT Programme Board;
- Joint Pathology Committee;
- Professional Assurance Board;
- Research and Development Committee;
- Trust Risk and Quality Committee.

Our organisational structure

Board of Directors – Executive Directors



Amanda Pritchard
Chief Executive and
Chief Accountable Officer

Amanda was appointed as Chief Executive in January 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.

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.

She is the Senior Responsible Officer for the South East London Sustainability and Transformation Plan.

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



Dr Ian Abbs
Chief Medical Officer and
Director of Patient Safety

Ian became Medical Director in January 2011 and Chief Medical Officer in January 2017. 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.



Jon Findlay
Chief Operating Officer
(from January 2017)

Jon was appointed as Chief Operating Officer for Guy's and St Thomas' NHS Foundation Trust in January 2017.

Previously Jon was Chief Operating Officer and Deputy Chief Executive at Southend University Hospital NHS Foundation Trust, an Executive Director role he held since January 2014.

Before working at Southend, Jon was Director of Operations at Guy's and St Thomas' where he was responsible for operational performance and the strategic development of clinical services across the two hospital sites.

He has 14 years' experience working at director level in roles that have spanned clinical operations, service modernisation, performance improvement, human resources and workforce planning, as well as initiatives such as the National Patient Access Team and NHS franchising.



Sir Ron Kerr CBE
Executive Vice Chair

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.



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.

Ann is 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 leads Essentia, which provides the Trust with the majority of its non-clinical 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.



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 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' Group.



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.



Dr Simon Steddon
Acting Chief Operating
Officer
(to December 2016)

Simon is a graduate of King's College London and joined the Trust as a consultant renal physician in 2005.

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

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.



Emma Duncan
Non-Executive Director
(from August 2016)

Emma is the former deputy editor of The Economist and is current editor of that publication's sister magazine, 1843. She writes regularly for The Times and occasionally for a wide range of other publications.

She has been a Non-Executive Director of Lancashire Holdings Limited, a FTSE-250 insurance company, for six years, is a visiting fellow of Nuffield College, Oxford, and is a trustee of the George Orwell Trust.



Dr Felicity Harvey CBE
Non-Executive Director
(from September 2016)

Felicity has considerable senior leadership and strategic planning experience. She was director general for public and international health, until her retirement from the civil service in June 2016. Prior to that, she was director of the Prime Minister's Delivery Unit.

After qualifying in medicine in 1980 at St Bartholomew's Medical College, London, Dr Harvey completed an International MBA.

Her previous roles include private secretary to the Chief Medical Officer and Head of Medicines, Pharmacy and Industry Group at the Department of Health.



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.



John Pelly OBE
Non-Executive Director
(from January 2017)

John qualified as an accountant in 1978 and spent the early part of his career in the commercial sector.

He joined the NHS in 1990 as Finance Director of West Lambeth Health Authority, becoming Finance Director of Guy's and St Thomas' NHS Trust on the two hospitals' merger in 1993. John was subsequently Chief Operating Officer of Guy's and St Thomas' NHS Trust until he took up the position of Chief Executive of Queen Elizabeth Hospital NHS Trust in south London.

In 2008 he was appointed Chief Executive of Moorfields Eye Hospital NHS Foundation Trust, a position he held until his retirement from the NHS in November 2015.



Professor Reza Razavi
Non-Executive Director
(from May 2016)

Reza is Assistant Principal for Research and Innovation at King's College London. He is also Director of Research at King's Health Partners and a children's cardiologist at Evelina London Children's Hospital.

His research focus is on imaging and biomedical engineering related to cardiovascular disease. Reza helped to establish the Trust's cardiovascular MRI service and developed the world's first cardiovascular MRI cardiac catheterisation programme.



Dr Sheila Shribman
Non-Executive Director
and Vice-Chair
(from June 2016)

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 where she led the successful

integration of children's hospital, community and mental health services, working closely with the local authority.

Sheila chairs the Children's Services Committee.



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.

Priya joined the Board in November 2015 and chairs 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 multicultural teams.

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

Robert Drummond

Robert stepped down from his role as a Non-Executive Director in December 2016 to become a Non-Executive Advisor to the Board.

Professor Frank Nestle

Frank stepped down from his role as a Non-Executive Director nominated by our academic partner, King's College London, in May 2016 and is succeeded by Reza Razavi

Diane Summers

Diane stepped down from her roles as a Non-Executive Director and Vice-Chair in June 2016 after completing two full terms.



Catering staff have earned a prestigious award which recognises their work in preparing high quality, nutritious meals for patients, staff and visitors.

NHS Improvement's single oversight framework provides the framework for overseeing NHS trusts and identifying potential support needs. The framework looks at five themes:

- quality of care;
- finance and use of resources;
- operational performance;
- strategic change;
- leadership and improvement capability (well-led).

Based on information from these themes, trusts are segmented from 1 to 4, where '4' reflects those receiving the most support and '1' reflects those with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach, or suspected breach, of its licence.

The single oversight framework applied from quarter 3 of 2016/17. Prior to this, Monitor's risk assessment framework was in place. Information for the prior year and first two quarters of this year are not presented here as the basis of accountability was different.

Segmentation

NHS Improvement assigned a score of '2' to Guy's and St Thomas' NHS Foundation Trust and this reflects the Trust's position as at 7 March 2017. Current information is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on five measures which are scored from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the single oversight framework, our overall rating above is not the same as the overall finance score shown in the table below.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	2	1
Liquidity		1	1
Financial efficiency	Income and expenditure margin	2	1
Financial controls	Distance from financial plan	1	1
Agency spend		1	2
Overall score		1	1

The achievement of an overall score of 1 reflects the Trust's strong financial performance during the financial year 2016/17.

Agency spend

At the start of the financial year, NHSI suggested that it would be appropriate for the Trust to spend no more than £33.2 million on agency staff. The equivalent spend for 2015-16 was £49.0 million. During the year, the Trust spent £33.7 million on agency – exceeding the target by 1.3%.



Twenty fundraisers, each pledging £50,000 or more, flew across the River Thames on a zip wire from St Thomas' to raise more than £1 million for Evelina London. The money raised will go towards a £2.7 million Clinical Research Facility.

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 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 required by those Directions. 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 *Department of Health Group Accounting Manual* and in particular to:

- observe the Accounts Directions issued by NHS Improvement, 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* (and the *Department of Health Group Accounting 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 the *NHS Foundation Trust Accounting Officer Memorandum*.



Amanda Pritchard

Chief Executive and Accounting Officer

24 May 2017

Annual Governance Statement 2016-17

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, while 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 2017 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 the Always Safe campaign which provides Trust staff with information on incidents, 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 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 the Trust's overarching strategic 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 to 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.

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 are 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.

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 achieved a 'Satisfactory' rating in its self-assessment against the 2016-17 Information Governance Toolkit, the primary tool for information governance assurance. The Trust's declared score of 92% was an 18% improvement on the previous year's submission of 74%. All staff receive information governance training as part of corporate induction when joining the Trust. Training requirements have been reviewed during the year and are supported by comprehensive policies and guidance to ensure staff have access to up-to-date information.

An Information Asset Owner (IAO) with responsibility for managing information risks is named for each department, supported by specialist

information security staff. Registers of information assets, flows and uses are regularly updated and reviewed, 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 2016-17, six incidents were classified as Level 2 in the Information Governance Incident Reporting Toolkit, and reported to the Information Commissioner's Office (ICO). The first incident related to an email containing summary patient data which was sent insecurely to a contracted Trust supplier; bespoke information governance training was subsequently delivered to staff involved in the relevant service, including support to organisations from which the email originated.

The second incident involved the theft of recording equipment from a locked car belonging to a Trust community worker; the Trust worked with social services to identify and notify any patients potentially at risk from the data loss, and to establish additional protective measures on other equipment held and used by the Trust.

Four incidents related to data disclosed in error within large datasets, and a root cause analysis was conducted to identify common underlying factors and improvement actions to reduce the likelihood of recurrence. In all cases, the incidents were judged to be of minimal risk to patients. No action has been taken by the ICO.

One of the two serious incidents reported in the previous year, 2015-16, was downgraded to a near miss after the paperwork reported lost was subsequently found, with negligible risk of inappropriate access.

Risks

Major risks 2016-17

The key risks to delivery of the Trust's objectives are recorded in detail in the Board Assurance Framework and monitored quarterly by the Board or its committees. In 2016-17, the key risks with potential impact on achieving our objectives were:

- deterioration or variation in the quality of our services due to stresses on a stable workforce, organisational change, performance pressures, adapting to new technologies, increasing demand and patient complexity
- failing to deliver our financial plan due to the scale of the financial challenge facing the wider NHS
- a mismatch between our capacity and demand resulting in failure to achieve our activity and performance plans
- our ability to act on safeguarding issues impacted by an increasingly complex safeguarding environment
- inability to recruit to vacancies due to a range of factors including national shortages and industrial action
- insufficient capital to deliver our estates capacity plan with potential impact on staff and patient experience and ability to meet national targets
- our preparedness to harness digital technology to meet business needs and take advantage of transformative opportunities.

We have established controls or are implementing actions which may continue into 2017-18 to manage these risks, detailed in the Board Assurance Framework and summarised below.

- We regularly review and take action in relation to information which may indicate deterioration in the quality of our services, for example, patient surveys and complaints. In 2017-18, we will finalise our Quality Strategy to integrate the various aspects of quality improvement work in our organisation, and to set out clearly our vision for quality and how we will measure success against our goals.
- The Trust has delivered its financial plan for 2016-17. In 2016, we appointed a Board-level Director of Improvement to drive and lead major programmes of improvement work, and in 2017-18 we will continue, through our *Fit for the Future* programme, to identify and implement additional projects to improve quality, safety and efficiency.

- Led by our executive team and clinical directors, we have undertaken detailed analysis of key issues causing variation in our performance against national targets, implementing actions to address key capacity, flow and process issues.
- Our ability to meet national targets remains challenging in light of physical constraints and sustained rising demand. We will work within the South East London Sustainability and Transformation Plan (SELSTP) to address these challenges. In 2017-18, we will continue our internal work to improve patient pathways; completing the Emergency Care Pathway programme; establishing joint coordinators to facilitate and follow through patients referred into our cancer services; and seeking additional funding to invest in capital projects to improve our estates capacity.
- **Cancer waits:** the Trust is committed to achieving internal compliance with the 85% 62-day standard and has worked hard during 2016-17 to achieve this. However, our overall performance and our internal compliance deteriorated in quarter 3. As a result, we did not meet our trajectory in January 2017. We are establishing quality review meetings to cover all tumour groups; these will be clinically-led forums that will focus on identifying improvement opportunities and streamlining patient pathways. Alongside this, the administration of each part of the tumour pathways is being reviewed to ensure that there is complete clarity about who is responsible for each element of the administration that supports patients moving efficiently through the pathway. These controls will be in place by the end of quarter 4. In 2017-18, we expect to be compliant for internal referrals by the end of quarter 1. We are committed to continuing current work to improve the timeliness of referrals from south east London and across the south of England.
- **Accident and emergency standard:** the 4-hour wait performance has been challenging against a background of a continuing increase in overall attendances, the difficult physical environment due to the rebuild and the high number of patients attending with complex clinical requirements. Ambulatory pathways, including the frailty unit, acute assessment unit and the surgical assessment unit, have been key to improving flow through the emergency pathway and reducing demand on the capacity of the Emergency Department. In 2017-18, we plan to achieve 90% compliance by the end of quarter 2 and to achieve 95% by the end of quarter 4.
- We have a safeguarding team, training, and procedures in place as required by statute. We will be building a greater level of skill and awareness across the clinical workforce in 2017-18 to ensure we have sufficient capacity to deal with a sustained rise in activity within an increasingly complex safeguarding environment, and to facilitate proactive work.
- We have implemented a workforce strategy including approaches to recruitment and retention, and health and well-being, to mitigate the risk of workforce shortages.
- We have made good progress on our current five-year Capital Plan with most projects completed or progressing. The Independent Trust Financing Facility (ITFF) has agreed a loan for capital funding and we await national sign off for this in 2017-18 to enable us to increase clinical capacity.
- We reviewed our information technology arrangements and requirements and have begun to implement plans to ensure that we have an appropriate digital strategy and plans to support our business needs, and to take advantage of digital transformative opportunities.

Major risks 2017-18

As with all NHS organisations, balancing the need to deliver high quality care in the context of increasing demand and acuity, while increasing productivity, represents an ongoing challenge. This is against a backdrop of constraints on our ability to invest in additional physical and staffing capacity. The Board identified major risks for 2017-18 during strategic planning activities in year and will reconsider key risks which may impact on strategic objectives in

2017-18. We expect key risks to remain broadly the same but highlight the following as particularly significant due to their potential impact on our ability to achieve our objectives:

- our ability to deliver activity levels in view of the sustained increase in demand for our services. The final year of the building work to redevelop the Emergency Floor may impact on our ability to achieve A&E targets; and we also continue to struggle to deliver the 62-day cancer access target
- identifying and delivering the savings required to achieve our financial plan
- a gap between availability of money for investment (capital) and operational, transformation and strategic requirements
- workforce pressures across the healthcare system.

We recognise that strategic and transformational change internally and across geographical health economies will be required. We are developing our plans to address these risks as part of the wider NHS 'health economy' in Lambeth and Southwark and beyond, recognising that we treat both local people and patients who travel to our hospitals from further afield. Our plans form part of the South East London Sustainability and Transformation Plan (SELSTP) and we also play an important role in a number of clinical networks that join up services provided across several NHS trusts. In 2017-18 we will:

- work as part of the local healthcare system to manage demand and provide alternatives to hospital care, but other options, such as using private and voluntary sector providers, may be required
- continue with our *Fit for the Future* programme to improve quality, safety and efficiency, and work with NHS Improvement and NHS England to agree how we deliver services within the financial target (control total) they have set us
- develop our ambitions as a Foundation Healthcare Group Leader which will include developing new, integrated models of care and also making greater use of standardised approaches to care delivery that will help to improve quality and reduce cost.

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 relate to both our patients and workforce. All human resources policies are subject to an equality impact assessment. This is monitored at the Trust Joint Policy Forum. The Trust's equality objectives are in line with the requirements of the Public Sector Equality Duties to set four year objectives. The objectives 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. Equality impact assessments 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 6 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 2016-17, the Trust has continued to focus on the objective of increasing incident reporting across the organisation and we have seen a continued rise in incident numbers from the previous year, demonstrating a healthy reporting culture in which staff contribute to identifying risk and incidents. The majority of incidents reported are no harm/low harm incidents. The Trust's Care Quality Commission inspection report reflected good awareness of incident reporting and our commissioners have highlighted improvements in processes, structures and outcomes for the management of serious incidents including timeliness and quality of reports since January 2016.

In 2016-17, the Trust reduced the number of never events at the Trust by nearly 50% compared to 2015-16 when we had a high number of never events. Reduction of never events remains a key objective.

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. The feedback email to staff now also provides more information to help staff manage incidents.

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 Trust 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 works closely with patients and the public to ensure that any changes minimise the impact 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 Healthwatch in Trust activities. Healthwatch colleagues use these meetings to receive updates and comment on quality and risk performance reports.

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. The Emergency Preparedness, Resilience and Response (EPRR) team have developed risk-specific plans for inclement weather, heat wave, cold weather and flooding which may affect business continuity, and may occur as a result of climate change or as normal seasonal variance. These risk-specific plans are updated yearly or at any notification or assessment of risk change.

Sustainability and carbon reduction have been included, for governance purposes, into the Emergency Preparedness, Resilience and Response arrangements for the Trust. This is managed by the Trust sustainability team with EPRR response to specific risks such as heat wave, cold weather, flooding covered in EPRR risk-specific plans, managed by the EPRR team. The Trust has exceeded carbon reduction targets for 2015-16 by achieving a 15% reduction 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 auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not.

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

The emphasis of internal audit work is on risk management, governance and internal control processes. Individual assignments have also raised issues relating to economy, efficiency and effectiveness. Where scope for improvement, in terms of value for money, was identified during an internal audit review, appropriate recommendations were made and action plans were agreed with management for implementation.

Annual Quality Report

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

The Chief Medical Officer is the nominated Trust Executive for the Quality Report. The quality priorities have been developed in consultation with a wide range of stakeholders. During Always Safe Week in December 2016, contributions were sought from staff and patients and feedback was given on progress with the priorities for 2015-16. The draft priorities have been consulted on internally through the Quality and Performance Committee and the Operational Executive and their teams. The developing priorities have also been shared for comment with external stakeholders, local and national commissioners through the commissioners' quality meeting, the Governors through the Quality and Engagement Working Group and with our local Healthwatch teams. Delivery of the quality priorities for 2016-17 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 2016-17, two of the waiting time performance measures – referral to treatment and accident and emergency 4-hour wait – will be reviewed by the Trust's external auditors, as part of the limited assurance opinion they provide for the 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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee and the Quality 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 Integrated Quality and Performance report (IQPR) which 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 report is supplemented by more detailed briefings on any areas of adverse performance.

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection. The Integrated Quality and Performance Report is backed up by a cascade of more granular reports reviewed by Board Committees, monthly performance review meetings between the Chief Operating Officer and the directorates and individual services including analysis at individual practitioner level.

The internal audit plan includes a programme of reviews of key indicators and responds to the identification of any risks associated with information assurance. There is clear evidence of action taken to resolve audit concerns with follow-ups undertaken to assess performance improvement.

An assessment of the controls applicable to the key indicators is included as part of the Integrated Quality and Performance Report. Wherever possible, electronic systems are used to capture data allowing reports to be generated with minimal effort. This allows information to be traced to source and the information owners are held accountable for the validity of their information.

The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. The Board Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements.

Internal audit work to a risk-based audit plan, agreed by the Audit Committee, and covering risk management, governance and internal control processes, both financial and non-financial, across the Trust. The work includes 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 is found, recommendations are 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 as follows:

I have considered all of the work conducted by internal audit staff during 2016-17, 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.

There is a similar balance in assurance ratings in 2016-17 as compared to the previous year with just under a third of all reports receiving limited assurance. This is positive and it should be noted that all of the Trust's key financial systems have received a substantial assurance rating.

I am satisfied that the Board Assurance Framework, as presented to the Audit Committee in 2016-17, 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.

In relation to quality assurance, I confirm that, in January 2016, the Trust underwent an external assessment of internal audit and this was undertaken in accordance with the Public Sector Internal Audit Standards. The requirements for an external review every five years have been met and I have monitored compliance with the standards. 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 during 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, on 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 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.

Conclusion

A significant internal control issue has been identified concerning our ability to achieve two waiting time standards; the accident and emergency four-hour wait and the cancer 62-day wait. These two issues are described, together with action taken to manage them, in the 2016-17 risks on page 59.



Amanda Pritchard

Chief Executive

24 May 2017



88% of our patients rated the quality of care they receive at Guy's and St Thomas' as 7 out of 10 or higher, according to the results of the Care Quality Commission's national inpatient survey published in June 2016.

10

Quality report

Statement on quality from the Chief Executive 2016/17

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:

- 88% of our patients rated the quality of care they receive at Guy's and St Thomas' as 7 out of 10 or higher in the Care Quality Commission's annual national inpatient survey;
- we won the Quality of Care Award at the 2016 CHKS Top Hospitals Awards for our commitment to providing a high level of care for patients;
- more patients are involved in clinical research at Guy's and St Thomas' than any other NHS trust in England – investment in research leads to better treatments and improves the quality of patient care;
- an innovative project to help older people who are at risk of suffering a fall won a prestigious Health Service Journal (HSJ) Value in Healthcare Award – our community rehabilitation and falls team run more than 20 'strength and balance' exercise classes in Lambeth and Southwark;
- our allergy service has become only the fourth in the world to be awarded Centre of Excellence status by the World Allergy Organisation (WAO) due to leading-edge clinical care, research, education and training;
- our imaging services have been awarded ISAS (Imaging Services Accreditation Scheme) accreditation in recognition that patients consistently receive high quality treatment;
- our airline-style safety card, which is given to all inpatients when they are admitted to hospital with information about avoiding falls, blood clots and other problems, is now being used as far afield as Australia.

Over the last 12 months we have built on the foundations of our CQC report which was published in March 2016. We have also implemented a detailed action plan in response to the CQC's findings.

The CQC gave us an overall rating of 'Good' and their inspectors said that they 'found staff to be highly committed to the Trust and delivering high quality patient care'.

We recognise the importance of visible leadership by our Executive team which was recognised as a strength in our CQC report.

In May 2016 we launched 'Always Safe', a major new patient safety campaign led by our Chief Medical Officer, Dr Ian Abbs, to raise staff awareness of serious incidents and Never Events, and to encourage feedback from staff about how to improve safety.

The campaign has had an immediate impact and we are pleased to report fewer Never Events in 2016/17, while reinforcing our positive ethos of encouraging staff to report incidents. The World Health Organisation surgical safety checklist is used across all of our surgical services to ensure safe care.

Chief Nurse Eileen Sills continues to lead our weekly 'Safe in Our Hands' forum where quality and performance issues are discussed and debated by staff in a 'no blame' environment.

I personally led a Trust-wide 'Listening Exercise' in November and December 2016 called *Changing things for the better* during which managers led sessions with staff to encourage ideas to improve quality, safety and efficiency. More than 1,700 staff took part and we aim to learn from their feedback to ensure that ideas are turned into action.

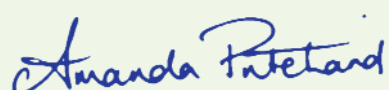
In addition, the Executive team comes together to lead a monthly face-to-face Team Briefing session open to all staff and we all participate in regular Executive Director 'out and about' visits to various areas of the Trust to listen to staff.

This year we launched The Nightingale Project, a new nurse-led project to ensure that patients receive safe, effective care delivered with the utmost kindness at all times. As part of this, simulation training is being used to establish a consistent, standardised approach to improve the quality of care for our patients and leave them feeling reassured and safe.

The impact of The Nightingale Project on the quality of care will be evaluated by King's College London and there is already interest from other NHS trusts.

Last year our external auditors found some errors in the recording of dates in the 18 week referral to treatment incomplete pathway indicator. 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.

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

24 May 2017

Our quality priorities for 2017-18

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, Trust Board and governors, as well as others who take an active interest in our work.

Our quality strategy for 2017-18 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 2017-18. 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 2016-17, we met our stakeholders to tell them about our progress in delivering our quality priorities for the year. This included monthly quality monitoring meetings with our commissioners and quarterly meetings with both Lambeth and Southwark Healthwatch. Internally we monitored progress against the quality priorities through the Quality and Performance Committee.

In December 2016, during 'Always Safe' week, we held drop by sessions in public areas at both St Thomas' and Guy's to give patients and their families, as well as staff, an opportunity to hear about progress against our quality priorities and to ask them how they would like us to prioritise quality improvement in 2017-18.

A number of priorities were identified for consultation. They included some of the 2016-17 priorities that will take more than one year to deliver. Information from clinical outcomes, incident reporting and complaints was also used to identify areas for improvement, along with national and local improvement programmes. The draft priorities were shared with commissioners, Healthwatch, our governors, the Trust Management Executive and directorate management teams. Having gathered their comments, the final priorities for 2017-18 were agreed by the Quality and Performance Committee in April 2017.

Quality priorities are embedded in the Trust's business planning process, and directorates have developed local plans to demonstrate how they will contribute to the achievement of our quality objectives.

Our quality priorities for 2017-18

Patient safety

Our quality priorities and why we chose them

We will continue to improve the identification and treatment of sepsis

This priority is being carried forward from 2016-17. It continues to be a priority to meet the national CQUIN goals to reduce the impact of serious infections. The aim is to ensure the timely identification and treatment of sepsis and a reduction of clinically inappropriate antibiotic prescription and use. 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 cause 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 increase staff confidence in the use of mental capacity assessments and Deprivation of Liberty Safeguards

Our CQC inspection report made a number of recommendations relating to application of the Mental Capacity Act and Deprivation of Liberty Safeguards. The Trust has undertaken a programme of work to ensure that staff are familiar with the mental capacity assessment process, and are confident about using it and recording the outcome of their assessment. This has included a link practitioner programme, extending training programmes and increasing communication on the subject to all staff.

In 2017-18 we will continue to embed learning about the MCA and DoLS and ensure that we support our staff with increased access to the senior safeguarding team to enable them to support patients who lack capacity to make decisions about some or all parts of their treatment and care.

We will improve the safety of invasive procedures with the development of Local Safety Standards for Invasive Procedures (LocSSIPs); these will be based on the national standards (NatSSIPs)

The Trust has successfully implemented the World Health Organisation's surgical safety checklist for invasive procedures carried out across the Trust. In 2017-18 we will build on this and develop Local Safety Standards for Invasive Procedures to further improve the safety of our patients.

What success will look like

We will meet the 2017-18 national CQUIN goals for the identification and treatment of sepsis.

- Screening of 90% of inpatient and Emergency Department patients combined.
- Treatment within 1 hour of inpatient and Emergency Department patients combined.
- Reduction in antibiotic use.

Staff will say they feel confident in the application of the Mental Capacity Act.

We will deliver the 2017-18 safeguarding adults audit programme.

We will achieve an 85% positive response to audit and reality round questions in our hospital and community services assessed as 'likely' to care for patients who lack capacity.

We will see fewer incidents with harm in patients undergoing an invasive procedure.

LocSSIPs will be in use for all identified invasive procedures.

Clinical effectiveness

Our quality priorities and why we chose them

We will embed the first phase of The Nightingale Project in key clinical areas to reduce variation in care

The Nightingale Project was set up to reduce variation through standardisation of working practices. The initiative started with a focus on arrangements in the first hour of a shift, a mid-shift huddle and the last hour of a shift. All wards are moving towards full implementation of these principles. Throughout 2017-18 phase two will focus on aspects of the environment, including making changes to meal times.

We will reduce the number of falls with harm

During 2016-17 we have seen an increase in falls with harm and the number of frail, elderly patients in the Trust is also increasing. We will continue to work to reduce the risk of falls and to reduce the harm caused by falls, recognising that our population is more frail and the risk of falls is increasing and will continue to increase.

The RCP National Falls Audit (2015) showed an average number of falls per 1,000 occupied bed days (OBDs) of 6.63. In the same year Guy's and St Thomas' reported 3.82 falls per 1,000 occupied bed days. The national average for falls with harm in the 2015 audit was 0.19 per 1,000 OBDs, at Guy's and St Thomas' it was 0.06 per 1,000 OBDs. We will assure ourselves that all no harm falls are being reported to ensure that we learn from these no harm events.

What success will look like

Phase one of the project will be embedded with a reduction in variation in practice on the wards and increased standardisation.

We will see improvement against metrics linked to The Nightingale Project in our local patient surveys.

We will be in the highest quartile for staff satisfaction and ability to speak up.

All patients at risk of falling will have a multi-factorial and ongoing assessment; identified risks will be mitigated to reduce the likelihood of a fall occurring.

We will be assured that all no harm falls are reported and see a reduction in the total number of falls per 1,000 occupied bed days.

Clinical effectiveness

Our quality priorities and why we chose them

We will carry out mortality reviews of patient deaths that happen while patients are under our care, and implement a consistent process to ensure any opportunity to learn from these events is identified.

In their document, 'Learning, Candour and Accountability', the Care Quality Commission recommends the development of a single framework on learning from death to complement the Serious Incident Framework. The Trust will work towards embedding this framework and will ensure that reviews of deaths are consistent and include patients with learning disabilities.

What success will look like

We will build on our existing systems and implement a consistent process for review of the death of any patient in our care. This will be evidenced through audit of a sample of death reviews drawn from the information collected on the Datix database.

Patient experience

Our quality priorities and why we chose them

We will ensure our patients receive the fundamentals of care with a particular focus on pain and nutrition management

This priority is carried forward from 2016-17 and builds on our audit work. 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, as well as our staff, with high quality, nutritious food, drink or specialised nutrition across all our healthcare settings.

What success will look like

Patient surveys will demonstrate that patients receive appropriate support at mealtimes to meet their nutritional needs and preferences.

Audit of healthcare records will demonstrate that all patients have an ongoing and comprehensive assessment of their pain with a plan of care in place that is continuously evaluated in conjunction with the patient.

We will consider how consent is taken to ensure a consistent approach

While we demonstrate good performance when we audit the consent process, there have been a small number of complaints and incidents that show that consent has not always been fully informed. This has generally arisen when there is a very low likelihood of potentially serious consequences occurring. The area shown to be weakest in our consent audits is evidence of information being provided to patients about the risks and benefits of their procedure.

We will see an improvement in performance against the questions concerning provision of information in the consent audit tool.

We will improve communication with patients to ensure we meet the Duty of Candour

Clinical teams are generally good at talking to patients and their families and carers at the time when something goes wrong, but there is scope to ensure this is embedded and consistent through ongoing awareness raising and training.

Audit will demonstrate that we are meeting the requirements of Duty of Candour and are communicating with patients and their families at the time of an incident, then following up with a letter covering the discussion and what will happen next.

We will deliver training in the duty of candour to 1,593 staff.

We will improve what happens when patients contact the Trust by telephone

Information from PALS enquiries and complaints shows that patients often have a poor experience when contacting the Trust by telephone. The Governors' Quality and Engagement Working Group has also identified this as an area that requires improvement.

By September 2017 there will be a plan in place setting out how telephone communication by patients into the Trust will be improved. The plan will have outcome measures and improvement against these measures will be demonstrated by the end of 2017-18.

Statements of assurance from the Board of Directors

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

A review of our services

During 2016-17 Guy's and St Thomas' provided 60 NHS services, and 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.

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 2016-17 represents 100 per cent of the total income received for the provision of NHS services in 2016-17.

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. In 2017-18 we have made improving the timeliness of communication with patients and their families one of our quality priorities.

Sign Up to Safety

The Trust fully supports the Sign Up to Safety campaign. The progress made in the second year of these programmes is reported later on pages 86 to 88 where we report on progress against our quality priorities for 2016-17.

Staff survey – Workforce Race Equality Standard

Our most recent staff survey results shows that 24% of staff reported experiencing harassment, bullying or abuse from other staff in the last 12 months (national average 23%). While this figure is similar to that in other trusts, we are working hard to tackle this issue. We have a Promoting Dignity and Respect Policy and a Bullying and Harassment Procedure, a mediation scheme for staff and an employee assistance helpline. Our managers are also trained to create a productive work environment for all staff.

In the same survey, 83% of staff reported that they believe the Trust provides equal opportunities for career progression (national average 87%), and this remains below average. During 2016-17 we ran career road shows and introduced more support to help staff develop their career prospects, including through mentoring and help with CV writing. We continue to work hard to identify new ways to address this important problem.

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 2016-17, we took part in 40 national clinical audits and six National Confidential Enquiries. By doing so we participated in 95% 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 2016-17 are shown in the table on the following pages, together with those that we participated in and for which data collection was completed during 2016-17. 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 2016-17

Audit title	Participation	% of cases submitted
Women and children's health		
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric intensive care (PICANet)	Yes	100%
Paediatric Pneumonia	Yes	Data collection ongoing to April 2017
Acute care		
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry (NJR)	Yes	97%
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%
Asthma (paediatric & adult) care in the emergency department	Yes	100%
Severe Sepsis and Septic Shock – care in emergency departments	Yes	100%
Long-term conditions		
Chronic Obstructive Pulmonary Disease (COPD)	Yes	100%
Inflammatory Bowel Disease (IBD)	No	To participate in 2017/18
Renal replacement therapy (Renal Registry)	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Yes	No data submission required in 2016-17
Diabetes (Paediatric) (NPDA)	Yes	100%
National Diabetes Inpatient Diabetes Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
Diabetes (Adult) Footcare Audit	Yes	50%
Adult Asthma	Yes	100%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP):	Yes	91%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Dementia	Yes	100%

Participation in national clinical audits 2016-17

Audit title	Participation	% of cases submitted
Heart		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
Adult Cardiac Surgery Audit (ACS)	Yes	100%
Cardiac Arrest Audit (NCAA)	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	100%
Coronary Angioplasty/Percutaneous Coronary Interventions	Yes	100%
Heart Failure	Yes	100%
National Vascular Registry	Yes	100%
Pulmonary Hypertension (Pulmonary Hypertension Audit)	We are an outreach centre for the Royal Free Hospital who submit the data for this audit	
Cancer		
Bowel cancer (NBOCAP)	Yes	65%
Lung cancer (NLCA)	Yes	100%
Oesophago-gastric cancer (NAOGC)	Yes	47%
Head and Neck Cancer	Yes	Data collection ongoing to Nov 2017
Radical Prostatectomy	Yes	100%
National Prostate Cancer Audit	Yes	67%
Blood and transplant		
National Comparative Audit of Blood Transfusion programme	Yes	100%
Other		
Ophthalmology Audit: Adult cataract surgery	No	Unable to participate as our IT system is incompatible with the audit data requirements. Plans in place to participate in 2017-18
Percutaneous Nephrolithotomy	Yes	100%
Stress Urinary Incontinence	Yes	100%
Elective Surgery (PROMs Programme)	Yes	50%

National Confidential Enquiries 2016-17

Audit title	Participation	% of cases submitted
Acute pancreatitis	Yes	100%
Mental health	Yes	100%
Acute non invasive ventilation	Yes	100% cases excluded
Chronic neurodisability	Yes	Study still open figures not finalised
Young people's mental health	Yes	Study still open figures not finalised
Cancer in children, teens and young adults	Yes	Study still open figures not finalised

The reports of 30 national clinical audits were reviewed during 2016-17 and we intend to take the following actions to improve the quality of the healthcare we provide:

Adult cardiac surgery

Audit data shows our risk-adjusted mortality is within the accepted range.

Our cardiothoracic surgeons continue to undertake a rolling 12 month mortality review every three months which is shared with relevant staff. Individual surgeon mortality is risk-adjusted to allow comparison with UK figures every three months and a set of triggers are in place (approved by our patient safety group) to detect any deterioration in performance at the earliest opportunity. We also monitor 'reopening' rates as well as transfusion rates, exceeding nationally mandated requirements.

Congenital heart disease (paediatric cardiac surgery)

Audit data shows that the Trust is the third largest centre in the UK for the number of surgical procedures performed and the fifth largest congenital heart disease centre overall. Our data quality index was 99.2% and the Trust is routinely used by the National Congenital Heart Disease audit as an exemplar site for new data managers.

The team is planning to develop a more robust method for capturing consent for external review.

Falls and fragility fractures audit programme

The Trust performs well against most audit criteria and in particular admitting patients to an orthopaedic ward within four hours; performing surgery within 24 hours; and mobilising patients out of bed the day after surgery. We also perform well on patients being able to return to their home within 30 days. Previous audit data showed that our adjusted 30 day mortality had risen above the 95% confidence limit. Actions put in place have reduced this figure back to within acceptable limits in the last audit.

Heart failure

The Trust has favourable outcomes in almost all domains of the audit. One area identified for improvement is low numbers of patients referred for cardiac rehabilitation. Changes have been made to our

treatment pathways and we have begun to see an increasing number of patients referred.

Intensive care national audit, case mix programme

The audit shows that the standardised mortality ratio for all of our services is better than the expected level and that all areas perform significantly better than the national average in relation to key delivery of care indicators. The Trust has a higher rate of unplanned readmissions to critical care following step down than the national average. There is evidence that some of these readmissions may be preventable so our critical care team has developed a quality improvement project which aims to reduce preventable, unplanned readmissions to within the audit target within 12 months and to eliminate preventable unplanned readmissions within two years.

Paediatric intensive care audit

Audit results show that the Trust performs better than the national average for retrievals, staffing levels, standardised mortality ratio and unplanned extubations. Our readmissions to paediatric intensive care within 48 hours of discharge, while within control limits, are higher than the national average. All unplanned readmissions are now reviewed by a multi-disciplinary team to improve this.

National comparative audit of blood transfusion programme

This audit showed that the Trust has good adherence to appropriate platelet thresholds for transfusion, and generally better practice than nationally. However, the audit showed that, where more than one platelet pool has been transfused there has sometimes been the lack of a clear rationale for this and there has been a lack of testing of increment prior to administering the second pool. The Trust's transfusion practitioners are working with ward staff to promote best practice in all blood transfusions.

Sentinel stroke national audit programme

This was an audit of how we organise our stroke services and the Trust met all eight of the relevant key

indicators in the audit. The Trust is in the top 16% nationally for the service it provides. We need to expand seven day working to include our occupational therapy teams and we need to improve our engagement with social services. Our stroke service has developed an action plan to address both these points.

Cardiac rhythm management devices

This audit showed that the Trust meets the minimum numbers for training and implants to ensure that the appropriate skills are maintained and that the service remains safe and viable. The data shows that we are just below the national average for physiological implants and the service is monitoring this through quarterly audits locally.

National vascular registry

Our vascular surgeons achieve excellent outcomes for infrarenal aortic aneurysm surgery and the Trust is one of the top three trusts in the country with an overall mortality rate that is half the national average. However, we need to improve our referral to treatment time for patients with an abdominal aortic aneurysm. Our median time was 70 days in the last audit (nationally 60-90 days) and should ideally be below 56 days. Work is underway to standardise our pre-operative pathway and a pathway co-ordinator will be appointed to improve this.

Bowel cancer audit

The Trust's performance is in line with the national average but we submit less data to the audit than we would like. The service is bidding for a dedicated data manager to manage this for future audit cycles.

National diabetes inpatient audit

The 2015 audit showed that there has been a marked improvement in the quality of inpatient diabetes care. In particular 'good diabetes days' have increased and the Trust is now in the top quartile of trusts (previously in the third and fourth quartiles). Medication errors and inappropriate use of sliding scale have also been reduced. We need to increase the number of patients having foot checks and the results of the audit have been used to modify our Trust wide 'ThinkGlucose' quality improvement programme.

National diabetes in pregnancy audit

The Trust's results compare very favourably to nationally reported data. We need to improve the uptake of preconception care for women with type 2 diabetes and an action plan is in place to deliver this.

Rheumatoid and early inflammatory arthritis

Following the latest audit report we have established a dedicated clinic to start patients on disease modifying antirheumatic drugs so that treatment can begin as soon as possible. We have amended our clinic structure so that early arthritis patients can be seen more promptly. We are transferring our rheumatoid arthritis database onto the Trust's electronic noting system as this will allow prompts and reminders when patients' annual reviews are due.

Neonatal intensive and special care

Audit data suggests that the Trust has above average central line associated infection rates. Local concern is that many cultures are contaminants, with no clinical or inflammatory correlate, so we plan to review and improve culture technique.

Percutaneous nephrolithotomy

The latest audit report shows that we are a very high volume centre and that our patients have larger stones and are more complex than the national average. The number of our patients who need a transfusion is about one third of the national average. The audit results do not suggest any action is required but our surgeons are embracing novel techniques such as mini-PCNL which we hope will lead to reduced length of stay in the future.

Major trauma

Following review of the national audit report, our Emergency Department (A&E) has undertaken further local audit of patients with an injury severity score over 15 (major trauma) and their outcomes. The audit showed that patients are appropriately managed and appropriate services are available at this trauma unit to manage these patients. We are currently reviewing our spinal pathway as part of the trauma service at the Trust.

Renal replacement registry

As a result of the audit, the service has reviewed and aims to increase capacity for peritoneal dialysis (PD). Dedicated PD surgical and medical leads have been put in place and the patient pathway has been amended to increase referral rates for PD.

Lung cancer

Audit data showed that the Trust is one of the largest lung cancer centres in the country and our 30 day and 90 day survival rates are in line with the national average. Our average length of stay is slightly above

the national average and, although this may be because of the complexity of the cases referred to us, we have introduced an enhanced recovery programme and hope to see improvements in length of stay in future audits.

Asthma

This audit showed that we provide good care to patients who present with an acute exacerbation of asthma. We intend to enhance this by working with our IT department to produce an electronic asthma care bundle and by liaising better with primary care to ensure patients are appropriately followed-up post discharge.

Local clinical audit

Reports of 289 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 medicine

In elderly care, our junior doctors conducted an audit to assess the quality of pre-employment shadowing provided to new incoming foundation year one (FY1) doctors. They were looking for opportunities to improve the handover process between incoming and outgoing FY1 doctors. Incoming junior doctors are now provided with up-to-date speciality specific information to improve the changeover.

The Emergency Department undertook an audit of patients presenting with suspected sub-arachnoid haemorrhage to ensure that they receive treatment in line with recommendations from the National Confidential Enquiry into patient outcomes and death.

Cardiovascular

An audit of patients with diabetes attending for vascular surgery showed poor adherence to Trust guidelines for pre-operative diabetic medication and prolonged pre-operative fasting times. Audit data also showed some patients experienced poor diabetes control following surgery which can lead to poor wound healing and is a risk for infection. The team is implementing an action plan to address these, that should lead to better outcomes and a better experience for these patients.

An audit of perioperative urinary catheterisation showed that the team had reduced the number of patients given urinary catheters (an infection risk) by 15%.

Children's services

The Trust's neonatology team undertook an audit of suspected infections in babies and propose to introduce 'point of care' testing which will lead to a better experience for families, reduced use of antibiotics and improved patient flow through the department.

An audit of antibiotic use in general paediatrics showed that dosing recommendations in use did not always provide the desired steady state target concentration. 22% of patients audited did not meet the desired target. The team has developed improved guidelines to ensure that more patients reach the desired target level.

Children's community services

The community paediatric team audited the recommendations made at health assessments for looked after children. Following the audit, changes were made to the paperwork used and training updates provided to staff to ensure that all relevant checks are carried out and the results recorded.

The community nutrition and dietetics team audited the training that they provide to stakeholders and made changes to ensure that they can better support families with children under five with healthy eating. The audit was also an opportunity to enhance partnership working with the service and to support staff with maintaining healthy eating practices.

Clinical imaging and medical physics

Diagnostic radiology audited the timeliness of imaging reports. Timely image reporting facilitates early diagnosis and progresses patient management. Following the audit, the service is seeking to increase capacity to ensure that all images are reported as quickly as possible.

An audit of gynaecology ultrasound showed that whilst imaging was of consistently good quality with accurate reporting, there were some minor inconsistencies with some measurements. As a result the gynaecology ultrasound protocol has been refined and communicated to all staff.

Adult community services

Community midwives carried out an audit of carbon monoxide screening of antenatal patients (an indicator of smoking status) that showed too many women were not being routinely screened. A comprehensive action plan is in place that aims to ensure that 95% of antenatal patients are routinely screened.

Following an audit by physiotherapists at the amputee rehabilitation unit, a training programme was developed and key worker role created to ensure that patients' care meets best practice guidance and standards.

Dental services

Following an audit of documentation, oral medicine has successfully introduced new paperwork that has improved documentation of patch testing within the department. The service plans to perform further cycles of the audit to ensure standards are maintained and also plans to incorporate the record into the Dental Institute's electronic record.

Paediatric dentistry is making changes to the referral process to encourage referrers to include radiographs when sending their patients for treatment. This will improve the quality of care for patients and help to improve efficiency.

Gastrointestinal medicine and surgery

An audit in gastroenterology showed that many patients experienced long delays whilst attending for treatment with drug infusions. An action plan is in place to refine the pathway, reduce or eliminate delays between the stages on the pathway and to shorten the overall time that patients have to stay in the unit.

A re-audit of patients with acute pancreatitis has demonstrated that the changes put in place after the first audit have had some effect. The action plan has been refined to improve things further and ensure full compliance with national gastroenterology guidelines.

Medical specialties

An audit of the rapid access neurological clinic showed that the service has prevented approximately 105 hospital admissions in its first year of operation. The audit also showed that a small number (4%) of patients were waiting too long to be offered an appointment. Consultant triage of all referrals is being trialled and a re-audit will be conducted to look for improvements.

Nutrition and dietetics audited the use of naso-gastric tubes across the Trust and has made changes to the content and frequency of staff training to improve competencies.

Oncology, haematology and cellular pathology

The palliative care team audited adherence to national guidelines for the use of home oxygen therapy in palliative care patients. As a result changes were made to local guidelines and procedures. Re-audit has demonstrated that significant gains have been made and the team will conduct further audits to maintain compliance.

An audit of head and neck cancer treatment by clinical oncology has led to a refinement of planning target volume (PTV) margins, meaning safer treatment for patients.

Perioperative, critical care and pain

An audit by the anaesthetics department on the use of a high cost drug that is used to reverse anaesthetic neuromuscular block has demonstrated that the service could save more than £2,500 each year with no impact on patient care.

Specialist ambulatory services

Rheumatology conducted an audit of their biologic pathway that revealed numerous delays for patients and a number of steps in the pathway that were prone to error. Pathway mapping has been completed to improve this process and a virtual biologics clinic is being trialled. A re-audit will be carried out to check for improvement.

Fully completed and well written medical records contribute significantly to high quality, safe care. The

allergy service implemented an action plan following an audit that showed improvements were needed. Re-audit has demonstrated that the service now achieves 100% compliance with the standards for quality of documentation in medical records. The service plans to re-audit regularly to monitor ongoing compliance.

Surgery

Orthopaedics audited compliance with nutritional screening for patients with hip fractures and appropriate referral to dietitians. Results showed that not all patients were being screened on admission and not all patients who could benefit were being referred for dietetic input. An action plan is being implemented and a re-audit will be carried out to check for improvement.

Plastic surgery audited the care of patients with severe open lower limb fractures against national standards. A comprehensive quality improvement programme is being developed and the audit provides a useful baseline against which future quality gains can be measured.

Therapies

Speech and language therapists audited compliance with recommendations for patients requiring special diets because of swallowing difficulties. Not following these recommendations puts patients at risk of aspiration. The audit results showed that there is good compliance, but room for further improvement. An action plan that includes working with dysphagia link nurses, meal time co-ordinators, the catering department and ward based education for staff is being implemented.

Following an audit of annual foot reviews for patients with diabetes, our podiatrists are taking action to ensure that all patients are reviewed at least annually.

Transplant, renal and urology

The Trust's nephrology service audited the provision of peritoneal dialysis (PD). The audit showed that we do not yet meet the national target for referring patients for PD. Following the audit a formal PD pathway has been devised and implemented in our advanced kidney care clinic.

Women's services

Maternity services audited the detection and management of 'large for gestational age' infants. These infants are at increased risk of delivery complications. The results showed that rates of the recommended scanning regime were very high for women with diabetes (a risk factor for 'large for gestational age' infants) but were only moderate for obese women (also a risk factor). The service plans to amend Trust guidelines to include an additional third trimester scan for obese patients.

An audit in general gynaecology of cervical intra-epithelial neoplasia (abnormal cells on the cervix) found that not enough women were being treated conservatively and that not enough women with high grade dysplasia were being treated within the nationally set timescales. As a result, local guidelines have been adapted to include guidance about conservative approach of treating appropriate patients and treatment times are now routinely monitored via the colposcopy performance scorecard.

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 and is at the leading edge of national and international research.

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. 351 non-commercial studies began in 2016-17 and 126 commercial studies were also initiated.

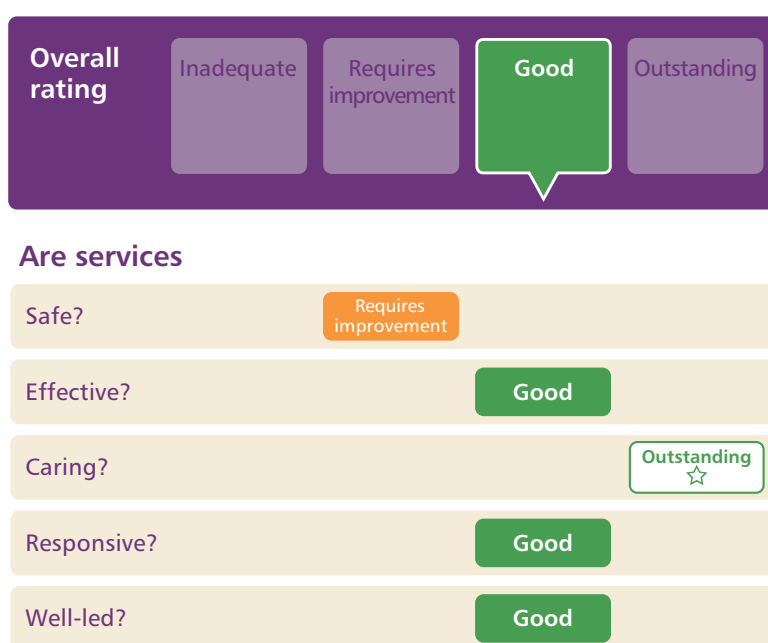
Last year, over 31,500 patients took part in research which was approved by our research ethics committee. During 2016-17, over 1,000 clinical research studies were active during the year. We used the nationally recommended systems and protocols to manage these studies and to ensure that the results are passed into practice in a timely and safe manner.

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 2016-17.

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 and in October 2016 the CQC met with us to review progress against the action plan. In December 2016, following submission of evidence, the CQC told us they were satisfied that the actions were complete.

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 have been monitored by the Quality and Performance Committee throughout 2016-17. A number of the recommendations concern ongoing programmes of work and will continue to be monitored through our governance and assurance framework.

No special reviews or investigations by the CQC took place in 2016-17.

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

Our CQUIN performance

The Trust did not receive CQUIN payments in 2015-16 as we remained on the 2014-15 tariff. In 2016-17 we secured almost all of the CQUIN targets generating over £20 million of income.

Our data quality

We place a very high priority on the accuracy and reliability of the descriptions of the care we provide. How we code a particular procedure or illness is important as it helps inform the wider health community about disease trends and enables us to assess the effectiveness of interventions.

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

The Trust continues to achieve high completeness scores on its external data flows. The percentage of records in the published Secondary Uses Service up to the end of January 2017 that included a patient's valid NHS number was 98.3% of inpatients, 98.4% of outpatients and 88.2% 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 99.9% of accident and emergency patients.

As community sites are still not required to upload data 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 the Department of Health in order to assess compliance.

We achieved a 'satisfactory' (green) rating in our self-assessment against the 2016-17 Information Governance Toolkit.

Clinical coding error rate

The Trust was not selected for a Payment by Results Pricing and Costing clinical coding audit by NHS Improvement during 2016-17. However the Trust has implemented quarterly internal coding audits in line with the Information Governance Toolkit Requirement 505. The Trust has achieved the highest level (Level 3) for the first time.

The clinical coding error rate split by category was:

- primary diagnosis incorrect – 5 per cent;
- secondary diagnosis incorrect – 4 per cent;
- primary procedures incorrect – 5 per cent;
- secondary procedures incorrect – 7 per cent.

National core set of quality indicators

In 2012 a statutory core set of quality indicators came into effect. 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 (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 the 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.

	Apr 14 – Mar 15	July 14 – June 15	Oct 14 – Sept 15	Jan 15 – Dec 15	Apr 15 Mar 16	July 15 – June 16
SHMI	79.3	75.3	73.7	74	76	76
Banding	3	3	3	3	3	3
% Deaths with palliative care coding	46.7%	46.3%	47.2%	47.5%	47.5%	49%

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 monitor closely mortality data by ward, speciality and diagnosis. Reviews of 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 the 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 on the next page.

Primary hip replacement – average health gain	2011-12	2012-13	2013-14	2014-15	2015-16
Guy's and St Thomas'	0.40	0.42	0.47	0.43	0.41
National average	0.42	0.44	0.44	0.44	0.44
Highest	0.50	0.54	0.54	0.52	0.54
Lowest	0.31	0.32	0.31	0.33	0.32

Source: HSCIC

Primary knee replacement – average health gain	2011-12	2012-13	2013-14	2014-15	2015-16
Guy's and St Thomas'	0.25	0.31	0.35	0.36	0.29
National average	0.30	0.32	0.32	0.32	0.32
Highest	0.41	0.42	0.42	0.42	0.40
Lowest	0.18	0.21	0.21	0.20	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 broadly consistent 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.

Clinicians regularly review the 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 2014-15. Using data from the Healthcare Evaluation Data system, we are able to access full year information for 2016-17, 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 the 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	2015-16			2016-17		
	Under 16	16 and over	Total	Under 16	16 and over	Total
Discharges	15,179	67,010	82,189	17,249	78,054	95,303
28 day readmissions	617	6,045	6,662	634	7,317	7,951
28 day readmission rate	4.1%	9.0%	8.1%	3.7%	9.4%	8.3%

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 consistent with 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	2015-16
Guy's and St Thomas'	69.7	71.4	73.1	71.4	77.3
National average	67.4	68.1	68.7	68.9	77.3
Highest	85	84.4	84.2	86.1	88
Lowest	56.5	57.4	54.4	59.1	70.6

Source: HSCIC

Staff recommendation to friends and family

The Trust has high levels of staff engagement and our results in both our Staff Survey and the 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	2016-17
Guy's and St Thomas'	82%	87%	85%	89%	89%
Average for acute*	60%	66%	68%	70%	68%
Highest acute trust*	86%	94%	93%	93%	95%
Lowest acute trust*	35%	40%	36%	46%	48%

Source: 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.

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 the Department of Health;
- data is compared to our own previous performance, as set out in the table on the next page.

Friends and Family Test	2014-15		2015-16		2016-17	
Guy's and St Thomas'	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	14.7%	37.6%	15.7%	30.4%	15.3%	23.6%
% would recommend	83.7%	96.9%	85.0%	95.6%	87.3%	97%
% would not recommend	8.6%	0.9%	8.2%	1.7%	7%	1.3%

Source: Trust information system

Infection control

The Trust continues to implement a range of measures 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	2013-14	2014-15	2015-16	2016-17
Guy's and St Thomas'				
Trust apportioned cases	43	51	51	36
Trust bed-days	319,441	321,749	324,000	331,097
Rate per 100,000 bed-days	13.5	15.9	15.7	10.9
National average	14.7	15.1	14.9	–
Best performing trust	0	0	0	–
Worst performing trust	37.1	62.2	66	–

Source: Public Health England and Trust information system

Patient safety incidents

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

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

There is no nationally established and regulated approach to the reporting and categorising of patient safety incidents, so different trusts may choose to apply different approaches and guidance when reporting, categorising and validating patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. These judgements may differ between professionals, and data reported by different trusts may 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 on the next page.

Patient safety incidents	Apr 14 – Sep 14	Oct 14 – Mar 15	Apr 15 – Sep 15	Oct 15 – Mar 16
Guy's and St Thomas'				
Total reported incidents	7,146	6,929	8,154	6,961
Rate per 1,000 bed-days	45.3	41.8	49.5	42.2
National average (acute non-specialist)	36.4	40.4	38.1	38.6
Highest reporting rate	75.0	82.2	74.7	75.9
Lowest reporting rate	0.0	0.0	18.1	14.8

Guy's and St Thomas'				
Incidents causing severe harm or death	17	22	21	22
% incidents causing severe harm or death	0.2%	0.3%	0.26%	0.3%
National average (acute non-specialist)	0.5%	0.5%	0.22%	0.46%
Highest reporting rate	3.4%	5.2%	2.39%	4.45%
Lowest reporting rate	0.0%	0.1%	0.03%	0.0%

Source: HSCIC

The number of patient safety incidents reported continues to reflect a positive culture for reporting all patient safety incidents, including near misses. The number and percentage of incidents resulting in severe harm or death has remained consistent, and remains below the national average, with the exception of the reporting period April to September 2015. 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 the 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	2013-14	2014-15	2015-16	2016-17
Guy's and St Thomas'	96.3%	97.1%	97.2%	96.6%
National average	96%	96%	96%	–
Best performing trust	100%	100%	100%	–
Worst performing trust	81%	88%	79.9%	–

Source: HED and Trust information system

Progress against priorities for 2016-17

The progress we have made in delivering our quality priorities for last year is set out in the following tables.

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

How did we do against last year's priorities?

Patient safety		
Our quality priorities and why we chose them	What success will look like	How did we do?
We will achieve the 2016-17 CQUIN targets for the identification and treatment of sepsis.	<ul style="list-style-type: none"> We will meet the national CQUIN targets on sepsis. We will achieve the improvement targets for 2016-17 for the Emergency Department and for inpatients. 	<p>Partially achieved.</p> <p>We achieved the Emergency Department target for treatment of severe sepsis, Red Flag Sepsis or septic shock. We administered intravenous antibiotics in an appropriate timeframe and reviewed the antibiotics within three days.</p> <p>We did not achieve the target for screening of inpatients who met the criteria for sepsis screening because the data needed to verify the screening of these inpatients was not available.</p> <p>The data for paediatric services is available and we met the target, with 100% of paediatric inpatients who met the criteria being screened.</p> <p>We did not achieve the target that 69% of inpatients with severe sepsis, Red Flag Sepsis or septic shock receive intravenous antibiotics within the appropriate timeframe and a review of antibiotics within 3 days. We achieved these standards for 61% of patients and are working hard to achieve this for more patients.</p>
We will ensure that all appropriate patients are assessed for risk of dementia	<ul style="list-style-type: none"> We will screen 90% of patients over the age of 70 who are admitted through the Emergency Department for dementia risk, with 90% compliance for two of the three elements of the screening tool. 	<p>We achieved this.</p> <p>This is one of the objectives in our dementia strategy, which has been successfully implemented across the Trust, and supports our aim to be a dementia friendly hospital.</p>
We will ensure that all appropriate patients are assessed for risk of venous thromboembolism (VTE)	<ul style="list-style-type: none"> We will continue and improve our record of excellence in managing the risk of VTE. 	<p>We achieved this.</p> <p>We have consistently met the NICE guidance target that we risk-assess more than 95% of patients within 24 hours of hospital admission.</p>
We will demonstrate that we have embedded the five steps of the WHO surgical safety methodology	<ul style="list-style-type: none"> Our WHO surgical safety checklist will show compliance at 95% or more for all five stages of the process. 	<p>We did not achieve this.</p> <p>We achieved compliance with three stages of the surgical safety checklist in 91% of cases, an improvement of 7% on the audit results in March 2016.</p> <p>A team briefing before the start of a theatre list and a team debriefing at the end of the theatre list are the other two components of the checklist. We achieved 92% compliance with team briefing before starting a list.</p> <p>Achieving compliance with the team debriefing has proved more challenging and work continues to improve performance against this component of the checklist.</p>

Clinical effectiveness

Our quality priorities and why we chose them

What success will look like

How did we do?

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

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

We made significant progress with our ongoing programme to become a digital hospital.

We have continued to develop and roll-out new content in our clinical information systems. Our e-Noting system has been enhanced for inpatient care and developed to support outpatient care. For example:

- We have improved our ability to identify and manage deteriorating patients.
- We have improved our ability to identify patients with devices such as intravenous cannulas and urinary catheters, supporting regular review of these devices and their removal when clinically appropriate.
- Outcomes from clinic visits are now entered directly into the e-Noting system, improving the flow of patients through our outpatient clinics.
- Data from the MedChart electronic-prescribing system is now available in e-Noting, enabling real time oversight of antibiotic prescribing and improved use of antibiotics across the Trust.

Other developments include:

- Working in partnership with Dr Doctor, we are now able to send details about appointments to a patient's smartphone, including text reminders.
- The Local Care Record is now available in all Lambeth, Southwark and Bromley GP practices, enabling greater sharing of clinical information with primary care colleagues.

Reduce the number of obstetric anal sphincter injuries (OASI)

- We will achieve the year two targets in our three year Sign Up to Safety action plan.
- 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 over three years.
- We will achieve a 25% reduction of OASI at obstetric-led births over three years.

We are on track to achieve these targets by the end of 2017-18.

From July to December 2014 the OASI rate for all vaginal births was 3.2%. In the period January to March 2017 the OASI rate had reduced to 2.8% of all births (midwife and obstetrician led).

PEACHES training was introduced for all midwives in January 2015 and the supporting training video has been presented at the Royal Society of Medicine. (PEACHES describes the actions needed to prevent OASI: P = position; E = extra midwife present at birth; A = assess the perineum; C = communication; H = hands on technique; E = episiotomy if required; S = slowly)

The video is also being used in multi-disciplinary training which started in April 2017.

Staff have also introduced an OASI risk assessment sticker for use in maternity notes, promoting the PEACHES actions, and lidocaine is now available in each birth room to support appropriate use of episiotomies.

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?

We will continue to improve care for the deteriorating child

- We will achieve the year two targets in our three year Sign Up to Safety action plan.
- We will maintain 100% compliance with the Paediatric Early Warning Score (PEWS).
- We will demonstrate increased use of the SBAR (Situation, Background, Assessment, Recommendation) tool in escalations.
- We will continue to reduce failure to recognise/escalate the deteriorating child.
- We will achieve a 50% reduction in medication incidents resulting in harm over three years.

We achieved this.

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

We continue to increase use of the SBAR tool, and reduce failures to identify deteriorating patients.

Good progress has been made in reducing medication incidents resulting in harm. Prescribing improvement projects include improved training and assessment processes for new doctors.

MedChart, our electronic prescribing system, has been implemented across all planned areas in Evelina London Children's Hospital.

Patient experience

Our quality priorities and why we chose them

What success will look like

How did we do?

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

- We will maintain and improve the nutritional status of every patient admitted to the Trust and communicate patients' needs appropriately on discharge by achieving the five goals in our nutritional strategy.

We achieved this.

- Every patient is weighed and undergoes nutritional screening on admission, and weekly thereafter during their hospital stay.
- Drug charts contain current and accurate weights for all inpatients.
- Every admitted patient has a nutrition care plan.
- Timely referrals are made when patients require nutritional support.
- Information relating to nutrition is included in all discharge documents.

The Malnutrition Screening Tool (MUST) is now available in electronic notes.

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

- We will introduce a triage tool, together with target times for responding to complaints based on their triage category.
- We will achieve the following targets for responses:
 - triage category green (20 days) – 75%
 - triage category amber (45 days) – 85%
 - triage category red (65 days) – 95%.

Partially achieved.

The triage system was introduced in May 2016. Complaints are assessed against a number of criteria and a target response time is then given to each complaint. The reasons for the time are also explained.

Limitations with the complaints database mean that it has not been possible to report on performance against each triage category as planned. An alternative weekly report has been provided to the senior management providing the percentage of complaints that have exceeded their triage category at a point in time.

In 2016-17 the Parliamentary and Health Service Ombudsman did not uphold any of our complaints that were investigated. This gives us reasonable assurance that the quality of investigation and the responses to complainants are of a high standard. However, we recognise that we need to do more to reduce the time taken to respond to complaints.

Patient experience

Our quality priorities and why we chose them

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

What success will look like

- We will achieve the year two targets in our three year Sign Up to Safety action plan.
- We will improve the information we provide to patients when they leave hospital to enable them to better understand and manage their medicines.
- We will continue our improvement programme to address staff communication issues and reduce errors associated with medicines when patients leave hospital.

How did we do?

We are on track to achieve these targets by the end of 2017-18.

An audit of medication-related communications has been conducted and the results shared using the Trust's 'Safety Signal'. Work has also been completed to identify the types of medicines most frequently involved in safety incidents.

We have reminded staff of the three-way check of a patient's discharge letter, contents of the drug bag, and the current inpatient prescription. Messages have been reinforced in the Medicines Safety newsletter, at the weekly Safe in our Hands briefing and in the Chief Nurse's Bulletin.

A checklist for discharge has been drafted, with stickers reminding staff to check for discharge medication in the fridge and controlled drugs from the Controlled Drugs cupboard.

We have seen improved patient satisfaction with medicines information in the National Inpatient Survey. Incidents about discharge medications continue to be reported but, they are either low harm or no harm incidents.

Our performance against NHS Improvement Single Oversight Framework indicators

NHS Improvement uses a number of national measures to assess access to services and outcomes, and to make an assessment of governance at NHS foundation trusts. Performance against these indicators acts 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	<i>C.difficile</i> acquisitions (including: cases deemed not to be due to lapse in care and cases under review)	51	36 ●	13	8	8	7
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	90.4% ●	92.5%	90.6%	89.4%	89.3%
A&E access	95% A&E patients wait less than 4 hours	95%	88.1% ●	89.8%	89.2%	86.0%	87.5%
Cancer access initial appointments	Urgent cancer referrals seen within 2 week wait	93%	91.4% ●	90.5%	89.2%	91.5%	94.7%
	Symptomatic breast patients seen within 2 week wait	93%	90.2% ●	88.4%	90.9%	91.6%	89.8%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	66.9% ●	67.5%	67.9%	65.8%	66.5%
	% patients treated within 62 days from screening referral	90%	83.5% ●	92.0%	73.3%	79.2%	85.2%
	% patients treated within 31 days of decision to treat	96%	94.9% ●	94.6%	97.0%	94.5%	93.6%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	90.2% ●	88.9%	91.5%	91.3%	88.9%
	Chemotherapy treatments within 31 days	98%	97.6% ●	97.5%	98.3%	98.2%	96.5%
	Radiotherapy treatments within 31 days	94%	93.3% ●	96.4%	92.6%	94.7%	90.3%
Community care information completeness	Referral to treatment information completeness	50%	64.7% ●	64.4%	63.1%	69.0%	63.0%
	Referral information completeness	50%	76.0% ●	77.4%	76.1%	75.4%	74.9%
	Activity information completeness	50%	73.0% ●	75.8%	74.0%	71.1%	70.9%

In addition to these indicators, we certified compliance with the requirements to ensure that people with a learning disability can access healthcare. We continue to strengthen consistency and standardisation of practice across our hospital and community services.

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.

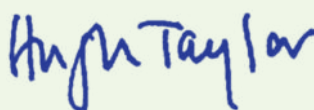
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality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

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

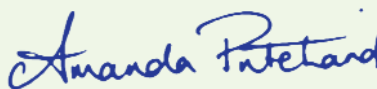
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016-17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2016 to March 2017
 - papers relating to quality reported to the Board over the period April 2016 to March 2017
 - feedback from commissioners dated 15 May 2017
 - feedback from local Healthwatch organisations dated May 2017
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2016
 - the 2015 national patient survey published June 2016
 - the 2016 national staff survey published March 2017
 - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017
 - 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 NHS Improvement'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
24 May 2017



Amanda Pritchard, Chief Executive
24 May 2017

2016/17 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 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 201 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.

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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 requirements for quality reports for foundation trusts 2016/17* ('the Guidance'); and

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17*.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

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

- board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners dated May 2017;
- feedback from governors, dated May 2017;
- feedback from local Healthwatch organisations dated May 2017;
- feedback was requested but not received from Overview and Scrutiny Committee;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated June 2016;
- the latest national staff survey, dated March 2017;
- Care Quality Commission Inspection, dated 24 March 2016
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2017.

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 2017, 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.

Limitations

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

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

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on pages 65 to 66 of the Trust's Quality Report, the Trust currently has concerns with accuracy of data. 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:

- three cases where the referral date or treatment date entered in the PAS system was not correct, one case where a referral letter could not be located so we could not conclude on the appropriateness of the clock start time; and

- two cases where patients who had received treatment were still included in the open pathways listing, and 1 patient that should not have been included on an 18 week pathway.

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 have concluded that we are unable to test sufficiently the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways indicators for the year ended 31 March 2017.

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 have come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the 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 the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP

Chartered Accountants
London

26 May 2017

Lambeth CCG statement on Guy's and St Thomas' NHS Foundation Trust 2016-17 Quality Accounts – on behalf of NHS Lambeth and Southwark Clinical Commissioning Groups and NHS England

Commissioners recognise the hard work going on in GSTT to improve systems and processes relating to the response to SIs and to effectively manage and reduce the number of never events whilst retaining a culture of candour and learning. The Quality Account is a high quality and well written document.

We look forward to working with GSTT in partnership next year to further improve quality.

Ann Middleton

Assistant Director of Governance
NHS Lambeth Clinical Commissioning Group

15 May 2017

Guy's and St Thomas' NHS Foundation Trust Quality Accounts 2015/17: Response from Healthwatch Lambeth and Healthwatch Southwark

This is a joint response to the Guy's and St Thomas' NHS Foundation Trust Quality Account 2016/17 from Healthwatch Lambeth and Healthwatch Southwark.

We welcome the opportunity to comment on the Quality Account and hope that our feedback as a 'critical friend' will support improvements both in the delivery and reporting of quality going forward.

General comments

To ease the comprehension of this report for lay readers, we suggest that the Trust report on its progress against this year's quality priorities before describing those for next year, as an understanding of past performance will help the public place a narrative of future plans into context.

Last year, we encouraged the Trust to take a standard approach to reporting by including a brief rationale for chosen priorities, success indicators and targets, and baseline measurements where available. Relevant annual targets from referenced Trust-wide strategies should be also provided. Due to inconsistent information, we are unable on occasion to comment on this year's progress or next year's ambitions.

The care of people with mental health is a priority issue locally and nationally. While the Trust is likely to have organisational plans to improve the parity of esteem between physical and mental health, we would advocate that it uses the Quality Account as a tool to draw attention and promote action on this area of work. We would be happy to work with you to find ways of including mental health as a future quality priority.

Progress against Quality Priorities 2016/17

Patient Safety

Sepsis: We note that the Trust achieved its Emergency Department targets; but fell short of its planned outcomes for adult inpatient treatment and was unable to verify screening achievements due to data issues. As the Trust will continue to work on this priority in 2017/18, it would be helpful to explain why adult inpatient data was not available and what measures it has put in place to address this situation.

Assessment for risk of dementia: Given that this priority is not being taken forward next year, it would be useful to know how the screening process for this target group has been embedded into practice in the Emergency Department. We would also welcome further commentary as to how the Trust is performing against its organisational Dementia Strategy.

Embedding the World Health Organisation (WHO) surgical safety methodology: We note that targets for this quality priority have not been met. With annual figures released by NHS England¹ showing that 6 of 7 'never events' at the Trust involved surgical cases, we would welcome an explanation as to why this quality priority is not being rolled forward to 2017/18.

Clinical Effectiveness

Using electronic systems to improve patient outcomes: The progress reported, especially around the enhancement of the Trust's e-Noting system sounds significant. We are unable to comment on the achievement as the intended objectives have not been outlined or reported against. We encourage the Trust to develop and report against 'patient outcome' indicators to demonstrate that changes in systems translate into improvements in care quality for patients.

Obstetric anal sphincter injuries: To increase transparency, we suggest that the Trust clearly states its planned target for 2016/17 and allows for comparison of data over time.

Patient Experience

Nutrition and pain management: Insufficient information regarding planned targets and implemented activities for this year leaves us unable to comment on progress in improving patients' nutritional status. Achievements regarding the pain management strand of this priority is absent.

Complaints management: As this year's target has not been met and there is recognition of a challenge with complaints response times, we urge the Trust to carry

this priority forward to 2017/18. We reiterate our suggestion from last year that the Trust report a baseline, provide data about current progress, and review the choice of performance indicators if it is unlikely that your IT infrastructure will support monitoring of the current measures.

Medicines management at discharge: We are pleased to see the progress on activities, and increasing patient satisfaction regarding medicines information.

Quality Priorities for 2017/18

Patient Safety

Sepsis: Last year's unmet targets regarding adult inpatient screening and treatment should be noted in the narrative, and recognising this as an issue, we request that the Trust report progress for the Emergency Department and inpatients separately, rather than as a combined indicator.

Mental Capacity Assessments (MCA) and Deprivation of Liberty Safeguards (DOLS): We are pleased to see this priority on increasing staff confidence to use MCAs and DOLs.

Clinical Effectiveness

Embedding the first phase of the Nightingale

Project: This initiative to reduce variation is welcomed, and we look forward to learning about outcomes for patients.

Mortality review of patient deaths: To ensure that the results of reviews lead to change, we suggest that the Trust include a performance indicator that allows measurement of how learning is embedded into practice.

Patient Experience

Nutrition and pain management: With regards to nutrition, the Trust should include progress and challenges to date, and specific indicators linked to the Trust-wide nutritional strategy. As before, we would like to learn more about the rationale for choosing pain management as a separate issue, with a description of current gaps in quality and areas for improvement.

Consent: We are pleased to see the inclusion of this priority as a direct consequence of the Trust acting on complaints and incidents data. We would advocate that the Trust include patient feedback/metrics as an additional success measure.

Duty of candour: It would be helpful if the Trust could explain which staff will be targeted with this training and why. Again, assuming that improving patient experience is the driver behind this priority, we'd like to see the Trust include patient feedback/metrics as a success measure..

Telephone contact of patients with the Trust: We look forward to seeing the improvement plan detailing analysis of strengths and gaps of the current system, and outcome measures that the Trust will work towards.

Healthwatch Lambeth and Healthwatch Southwark

May 2017



We welcomed our first patients to the new £160 million Cancer Centre at Guy's in autumn 2016.

Foreword to the accounts

'These accounts, for the year ended 31 March 2017, have been prepared by the Guy's and St Thomas' NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the NHS Act 2006 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
24 May 2017



Independent auditor's report

to the Council of Governors of Guy's and St Thomas' NHS Foundation Trust only

Opinions and conclusions arising from our audit

1. 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 2017 set out on pages 104 to 134. In our opinion:

- the financial statements give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2017 and of the Group's and Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual (GAM) 2016/17.

Overview

Materiality: Group financial statements as a whole £26m (2015/16:£24m)
1.9% (2015/16: 1.8%) of income from operations

Coverage 100% (2015/16:100%) of group assets, income and expenditure

Risks of material misstatement vs 2015/16

Recurring risks

1

Completeness, existence, valuation and rights / obligation of land and buildings and assets under construction



2

Completeness, existence and accuracy of NHS and non-NHS income and, in addition, valuation of receivables.



Key

◀▶ Risk level unchanged from prior year

2. 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, in decreasing order of audit significance, are in the table below. We have set out how we tailored our audit to address these risks in order to provide an opinion on the financial statements as a whole. This is not a complete list of all the risks identified by our audit.

	The risk	Our response
<p>Land and Buildings</p> <p>(£945.5 million; 2015/16: £807 million)</p> <p>Asset under Construction (AUC)</p> <p>(£79.1 million; 2015/16: £181 million)</p> <p><i>Refer to page 9 (Audit Committee Report), page 109 (accounting policy) and page 119 (financial disclosures).</i></p>	<p>Completeness, existence, valuation and rights / obligations of land and building assets and AUC:</p> <p>The most significant part of the Trusts' asset base is land and buildings. The GAM requires these to be held at fair value. Hospitals are usually valued as specialised assets as there is no active market for their sale. The GAM requires specialised assets to be valued on a modern equivalent asset basis, which calculates an estimate of the cost to replace the site and buildings based on an equivalent site and buildings.</p> <p>At 31 March 2016 the Trust had land and buildings with a total net book value of £807m, and £181m of Assets under Construction. The Trust completes a full valuation every year. We have determined this to be a significant risk due to the size of the balance, the level of judgement required to estimate the replacement cost, the complexity of measuring the replacement cost, and the assumptions applied by management in determining how the replacement asset would be constructed.</p> <p>In 2016-17 the new Cancer Treatment Centre has been completed and became fully available for patient use in September 2016. The Centre cost approximately £160m and the impact on the asset under construction and land and buildings balances will be significant.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Asset records: we obtained a copy of the asset base provided to the external valuers and reconciled this to the fixed asset register to assess the completeness of the valuation. — Trust's valuer: we assessed the qualification, objectivity and expertise of the Trusts external valuers, Gerald Eve and the district valuer, and the terms under which they were engaged by management to revalue the Trust's assets. — Property specialists: we considered the appropriateness of the revaluation basis. In doing so we drew on national benchmarks and engaged our property specialists to undertake an assessment of the revaluation. — Accuracy of assumptions: we re-measured a sample of spaces across the estate to ensure that these were accurate. — Impairment review: we considered how management had assessed the need for an impairment across its asset base either due to loss of value or reduction in future benefits; — Cancer Treatment Centre: we assessed the approach for recognising the new Cancer Treatment Centre, including the staggered completion, and lease of floors to third parties. — Rights/obligation: we tested that the Trust held the rights to a sample of land and buildings by agreeing land deeds with the Land Registry. — Application of the valuation: we assessed the appropriateness of any amendments made by management to the information received from the valuer before incorporation into the financial statements. — Useful lives: we considered the valuer's assessment of the useful lives the Trust applies across its land and buildings. — Revenue to capital transfer: we inspected a sample of revenue to capital transfers to confirm that they were appropriately capitalised.



	The risk	Our response
<p>NHS and non-NHS income and receivables</p> <p>Income: (£1,446.3 million; 2015/16: £1,336.8 million)</p> <p>Receivables: (£151.1 million; 2015/16: £107.0 million)</p> <p><i>Refer to page 10 (Audit Committee Report), page 108 (accounting policy) and page 114 (financial disclosures).</i></p>	<p>Completeness, existence and accuracy of NHS and non-NHS income, and valuation of receivables</p> <p>From 2016/17 onwards, transformation funding is being provided to NHS Foundation Trusts in order to support a return to financial stability. These funds are linked to the achievement of financial control targets agreed with NHS Improvement and trajectories for key operational performance indicators such as referral to treatment and four hour A&E waits. The Trust has a number of key cost and volume contracts which in turn lead to increased risks around revenue recognition with additional complexity relating to the PCS, CQUIN, and additional Sustainability Transformation Funding (STF).</p> <p>The Trust's income is trending upwards and is now forecast to reach £1.4bn. Income streams from non-clinical sources represent 21% of 2015/16 income. As a result, the Trust's income is less connected to commissioning and contract negotiations.</p> <p>In 2016/17 the Trust is potentially able to claim up to £19.2m of STF. Receipt is contingent on the achievement of the financial plan and agreed trajectories for three key performance indicators (A&E, referral to treatment, and 62 day cancer wait), that are measured on a quarterly basis. 70% of the STF is contingent on achievement of the financial plan and the remaining 30% can only be received if the performance standards have been met.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Contract agreement: we considered whether the Trust has signed contracts in place with commissioners worth over £18million and agreed a sample of income to these signed contracts. — Contract variations: we investigated a sample of contract variations, including the assumptions behind them, and sought explanations from management. — Contract monitoring: we inspected contract monitoring meeting minutes with the lead commissioners for confirmation from commissioners of activity levels and CQUIN. — Confirmations: we obtained a sample of third party confirmations from the Trust's commissioners and compared the values disclosed to ensure they were consistent with the Trust's disclosures. — Agreement of balances: we inspected the outcome of the agreement of balances exercise and sought explanations for variances > £250k. We also examined the basis for the Trust's disputes balances and bad debt provisions and reviewed the application and reasonableness. — Non-NHS Income: we inspected the contracts with a sample of organisations for non-NHS income for the Trust delivery of education and training, and research and development activity. — Disclosures: we considered the adequacy of disclosures about key judgement and degree of estimation involved in arriving at the estimate of revenue receivables and completed a sensitivity analysis.

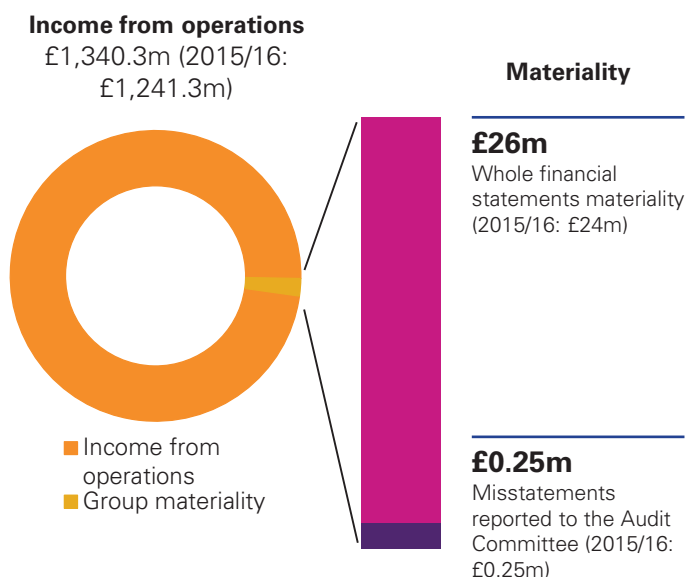
3. Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £26 million (2015/16: £24 million), determined with reference to a benchmark of income from operations (of which it represents approximately 1.9%). 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 (2015/16: £250,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group financial statements comprise the parent, Guy's and St Thomas' NHS Foundation Trust, and its subsidiaries.

The Group's five reporting components which were subject to audit for group reporting purposes were all performed to materiality levels set individually for each component (as shown above) by the Group audit team at one location in London. These audits covered 100% of Group income and expenditure for the year, and total assets.

The materiality stated is that deemed necessary to provide our opinion as to whether the accounts of the Group and Trust provide a true and fair view.



4. 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 2016/17; 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.

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

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified 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 financial statements taken as a whole is fair, balanced and understandable; or
- the Audit Committee's commentary on pages 48-51 of the Annual Report 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 2016/17, is misleading or is not consistent with our knowledge of the Group and Trust 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.

6. We have completed our audit

We certify that we have completed the audit of the accounts of Guy's and St Thomas' NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.



Scope and responsibilities

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 that 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. A description of the scope of an audit of financial statements is provided on our website at 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.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. 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. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General, 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. 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.

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

Chartered Accountants and Statutory Auditor
15 Canada Square, Canary Wharf, London, E14 5GL

26 May 2017



Consolidated statement of comprehensive income for the year ended March 31 2017

	NOTE	March 31 2017 £000	March 31 2016 £000
Patient care income	3	1,133,049	1,062,640
Non-patient care income	4	313,461	273,818
TOTAL INCOME		1,446,510	1,336,458
Operating expenses	5.1	(1,380,074)	(1,343,007)
OPERATING SURPLUS/(DEFICIT)		66,436	(6,549)
FINANCE COSTS			
Finance income	9	388	397
Finance expenses	10	(5,695)	(4,818)
Public Dividend Capital dividend payable	29	(19,552)	(23,353)
Net finance costs		(24,859)	(27,774)
(Losses)/gains in disposal of assets	8	(98)	311
Movement in fair value of Investment Property	17	1,090	–
Corporation Tax	11	93	(475)
SURPLUS/(DEFICIT) FOR THE YEAR		42,662	(34,487)
Other comprehensive Income/(Expense)			
Impairments	15	(10,161)	(166,183)
Revaluations	18	35,790	63,278
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		68,291	(137,392)

The notes on pages 108 to 134 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Note to Statement of Comprehensive Income/(Expense)		March 31 2017 £000	March 31 2016 £000
Total comprehensive income/(expense) as above		68,291	(137,392)
Less reserve movements in other comprehensive income/(expense)	a	(25,629)	102,905
Total comprehensive income/(expense) before reserve movements		42,662	(34,487)
Add back in year impairments and reversals of impairments included in surplus/(deficit) above (see note 15)	b	25,369	50,749
Other non-operating items	c	98	(310)
Less capital donations		(32,353)	(26,958)
NET UNDERLYING SURPLUS/(DEFICIT) EXCLUDING ITEMS ABOVE	d	35,776	(11,006)

- a. This is the total of the two items shown in Other Comprehensive Income.
- b. This is the total net impairments charged to expenditure (Note 15).
- c. This includes profit and losses on disposals of assets.
- d. Represents the primary view used by the Board of Directors to monitor the Trust's financial performance.

Statement of Financial Position as at March 31 2017

		GROUP		TRUST	
	NOTE	March 31 2017 £000	March 31 2016 £000	March 31 2017 £000	March 31 2016 £000
NON CURRENT ASSETS					
Property plant and equipment	13	1,107,297	1,057,500	1,107,289	1,057,490
Intangible assets	14	42,146	41,787	42,144	41,787
Investment property	17	1,169	–	1,169	–
Investments in associates (joint controlled operations)	19	71	71	1,450	500
Other investments	19	74	74	–	–
Trade and other receivables	21.2	2,152	1,947	2,152	1,947
Other financial assets	22	2,500	–	5,595	6,686
TOTAL NON-CURRENT ASSETS		1,155,409	1,101,379	1,159,799	1,108,410
CURRENT ASSETS					
Inventories	20	21,697	21,326	21,697	21,326
Trade and other receivables	21.1	149,095	106,404	149,295	105,698
Other financial assets	22	1,006	3,500	1,531	–
Assets for sale and assets in disposal groups	16	418	800	418	800
Cash and cash equivalents	25	140,391	117,478	138,565	116,715
TOTAL CURRENT ASSETS		312,607	249,508	311,506	244,539
CURRENT LIABILITIES					
Trade and other payables	23.1	(142,147)	(150,453)	(143,012)	(150,731)
Tax payable	23.2	(17,493)	(15,323)	(17,257)	(14,909)
Other liabilities	23.3	(22,308)	(30,058)	(22,308)	(29,679)
Provisions	24.1	(1,124)	(1,803)	(1,124)	(1,803)
Borrowings	23.4	(10,485)	(9,508)	(10,485)	(9,508)
TOTAL CURRENT LIABILITIES		(193,557)	(207,145)	(194,186)	(206,630)
NON-CURRENT LIABILITIES					
Provisions	24.1	(11,072)	(10,331)	(11,072)	(10,331)
Borrowings	23.4	(210,687)	(149,396)	(210,687)	(149,396)
TOTAL NON-CURRENT LIABILITIES		(221,759)	(159,727)	(221,759)	(159,727)
TOTAL ASSETS EMPLOYED		1,052,700	984,015	1,055,360	986,592
TAX PAYERS' EQUITY					
Public Dividend Capital		364,667	364,273	364,667	364,273
Revaluation reserve		317,614	292,785	317,614	292,785
Other reserves		743	743	743	743
Income and expenditure reserve		369,676	326,214	372,336	328,791
TOTAL TAXPAYERS' EQUITY		1,052,700	984,015	1,055,360	986,592

Amanda Pritchard

Chief Executive and Accounting Officer

24 May 2017

Statement of changes in Taxpayers' equity

GROUP 2016/17

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' Equity at April 1 2016	364,273	292,785	743	326,214	984,015
Surplus for the year	–	–	–	42,662	42,662
Impairments	–	(10,161)	–	–	(10,161)
Revaluations	–	35,790	–	–	35,790
Transfers to retained earnings on disposal of assets	–	(800)	–	800	–
Public Dividend Capital received	394	–	–	–	394
Taxpayers' equity as at March 31 2017	364,667	317,614	743	369,676	1,052,700

GROUP 2015/16

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2015	367,270	396,007	743	360,384	1,124,404
Deficit for the year	–	–	–	(34,487)	(34,487)
Transfers to retained earnings on disposal of assets	–	(317)	–	317	–
Impairments	–	(166,183)	–	–	(166,183)
Revaluations	–	63,278	–	–	63,278
Public Dividend Capital received	5,947	–	–	–	5,947
Public Dividend Capital repaid	(8,944)	–	–	–	(8,944)
Taxpayers' equity as at March 31 2016	364,273	292,785	743	326,214	984,015

TRUST 2016/17

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2016	364,273	292,785	743	328,791	986,592
Surplus for the year	–	–	–	42,745	42,745
Impairments	–	(10,161)	–	–	(10,161)
Revaluations	–	35,790	–	–	35,790
Transfer to retained earnings on disposal of assets	–	(800)	–	800	–
Public Dividend Capital received	394	–	–	–	394
Taxpayers' equity as at March 31 2017	364,667	317,614	743	372,336	1,055,360

TRUST 2015/16

	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2015	367,270	396,007	743	362,311	1,126,331
Deficit for the year	–	–	–	(33,837)	(33,837)
Transfer to retained earnings on disposal of assets	–	(317)	–	317	–
Impairments	–	(166,183)	–	–	(166,183)
Revaluations	–	63,278	–	–	63,278
Public Dividend Capital received	5,947	–	–	–	5,947
Public Dividend Capital repaid	(8,944)	–	–	–	(8,944)
Taxpayers' equity as at March 31 2016	364,273	292,785	743	328,791	986,592

Consolidated cash flow statement for the year ended March 31 2017

	NOTE	March 31 2017 £000	March 31 2016 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		66,436	(6,549)
Non-cash income and expense			
Depreciation and amortisation	5.1	47,071	49,211
Impairments	15	25,466	54,305
Reversal of impairments	15	(97)	(3,556)
Non-cash capital donation		–	(84)
(Increase)/Decrease in trade and other receivables		(40,802)	13,044
(Increase) in other assets		(6)	–
(Increase) in inventories		(371)	(1,433)
(Decrease)/Increase in other liabilities		(7,750)	7,919
Increase in trade and other payables		2,297	3,133
(Decrease) in provisions		(41)	(797)
Tax paid	11	(107)	(147)
Other movements in operating cash flows		196	(331)
NET CASH GENERATED FROM OPERATING ACTIVITIES		92,292	114,715
Cash flows from investing activities			
Interest received	9	388	397
Purchase of financial assets		–	(74)
Purchase of intangible assets		(11,036)	(10,064)
Purchase of property, plant and equipment		(95,095)	(94,349)
Proceeds from sale of property, plant and equipment		1,169	1,138
NET CASH USED IN INVESTING ACTIVITIES		(104,574)	(102,952)
Cash flows from financing activities			
Loans received from the Department of Health		72,288	9,000
Loans repaid to the Department of Health		(10,019)	(6,519)
Public Dividend Capital received		394	5,947
Public Dividend Capital paid		(21,993)	(22,493)
Interest paid on loans from ITFF		(5,475)	(4,703)
Public Dividend Capital repaid		–	(8,944)
NET CASH GENERATED FROM FINANCING ACTIVITIES		35,195	(27,712)
Net increase/(decrease) in cash and cash equivalents		22,913	(15,949)
Cash and cash equivalents at April 1		117,478	133,427
Cash and cash equivalents at March 31	25	140,391	117,478

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

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts all meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's Financial Reporting Manual (FRM) to the extent that they are meaningful and appropriate to the NHS. 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 the 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 DH GAM 2016/17.

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 two 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. Both 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 that scheme for the accounting period.

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

a) Accounting valuation

A valuation of 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 scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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. These

accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account their recent demographic experience), and to recommend 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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 and the number of employees opting in and the value of the contributions has been 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;
- the item has cost of 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, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, 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 2017 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 31st 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.

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, 2 – 62 years
- Plant and machinery, 2 – 20 years
- Transport equipment, 2 – 7 years
- IT hardware, 2 – 10 years
- Furniture and fittings, 5 – 15 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 GAM, 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 expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

De-recognition

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

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

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

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

Donated, government grant and other grant funded assets

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

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

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

1.8 Intangible fixed assets

Recognition

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

They are recognised only where it is probable that the future

economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Measurement

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

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

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

Amortisation

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

The Trust depreciates intangible assets over the following ranges:

- Information technology, 3 – 15 years
- Software licences and trademarks, 5 – 10 years.

1.9 Investment Property

Investment property, which is property held to earn rentals, is stated at its fair value at the balance sheet date, determined annually by independent professional valuers. Gains or losses arising from changes in the fair value of investment property are included in the Statement of Comprehensive Income for the period in which they arise. The cost of major renovations and improvements are capitalised and the cost of maintenance, repairs and minor improvements are recognised in the Statement of Comprehensive Income when incurred. On disposal of an investment property, the difference between the disposal proceeds and the carrying amount is recognised in profit or loss.

1.10 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 asset as required by FRS 102 can be found in Note 34.

1.11 Government and other revenue grants

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

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

1.14 Value Added Tax

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

1.15 Corporation tax

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

1.16 Other reserves

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

1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

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

translated using the spot exchange rate at the date of the transaction; and

- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

1.18 Financial assets and financial liabilities

Recognition

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

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

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

De-recognition

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

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

Classification and measurement

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

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

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

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: a loan to Viapath, current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

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

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

Foreign currency forward purchase contracts:

The Trust has foreign currency forward purchase contracts for Euros in order to gain greater budget certainty for its foreign currency expenditure obligations. These have been valued using IAS 39 – Financial Instruments.

The contracts are accounted for as derivatives initially at nil cost, and classified as Held for Trading financial instruments. Subsequently, open contracts are measured at fair value with movements in fair value being charged or credited to the Statement of Comprehensive Income. The fair value is measured as the difference between the currency's exchange rate at the date of valuation and the rate stipulated in the contract multiplied by the number of contracted units of currency.

Once each contract has been settled it is removed from the Consolidated Statement of Financial Position with any further gain or loss, calculated by comparing the contract proceeds translated at corporate rate of exchange at maturity with the purchase cost at the rate stipulated in the contract, taken to the Statement of Comprehensive Income.

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 0.24% (1.37% 2015/16) in real terms.

Clinical negligence costs

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

Non-clinical risk pooling

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

Commercial insurance

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

Contingencies

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

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

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

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.22 Losses and special payments

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

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

1.23 Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

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

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the Government implementation date for IFRS 16 still subject to HM Treasury consideration.

IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

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 -2.7%, Medium-term -1.95% and Long-term -0.80%. Early voluntary retirement pension provision has been calculated by applying a 0.24% 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 0.24% (1.37% 2015/16) (See Note 1.20).

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 who 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 web site 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 2017 £000	Year ended March 31 2016 £000
Clinical Commissioning Groups (CCGs)	605,134	546,358
NHS England	477,061	457,059
Other NHS and Government Bodies	5,122	5,575
DH – additional income for delivery of healthcare services	–	8,000
Non NHS:		
– Overseas patients (chargeable to patients)	3,964	3,492
– NHS injury scheme	1,503	1,080
– Other	40,265	41,076
	1,133,049	1,062,640

3.2 Income from activities by type

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Elective income	183,650	185,094
Non-elective income	118,674	115,645
Outpatient income	156,914	143,353
Other NHS clinical income	519,046	462,190
Accident and Emergency income	25,977	22,230
Private and overseas patient income	22,339	22,832
Community services	106,449	103,296
Additional income for delivery of healthcare services	–	8,000
	1,133,049	1,062,640

3.3 Patient care income

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Commissioner requested services	1,110,710	1,031,808
Non Commissioner requested services	22,339	22,832
Additional income for delivery of healthcare services	–	8,000
	1,133,049	1,062,640

Commissioner requested services are largely funded by CCGs and NHS England.

3.4 Overseas visitor income

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Income recognised this year	3,964	3,492
Cash payments received in-year (relating to invoices raised in current and previous years)	975	826
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	3,059	2,560
Amounts written-off in-year (relating to invoices raised in current and previous years)	926	19

4 Non-patient care income

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Research and development	52,571	49,312
Education, training and research	79,084	78,044
Charitable and other contributions to expenditure and capital assets	37,688	34,875
Charitable and other contributions for capital assets (non-cash)	–	84
Non-patient care services to other bodies	24,198	27,464
Sustainability and Transformation Fund income	37,958	–
Other income (see below)	74,663	78,130
Rental revenue from operating leases – minimum lease payments	3,248	2,310
Income in respect of staff recharges	4,051	3,599
	313,461	273,818

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 2017 £000	Year ended March 31 2016 £000
Services from NHS Foundation Trusts	17,519	14,239
Services from other NHS Trusts	4,401	3,818
Services from CCGs and NHS England	283	1,407
Services from other NHS bodies	4,746	5,225
Purchase of healthcare from non-NHS bodies	18,779	14,113
Executive Directors' costs	1,721	1,555
Non-Executive Directors' costs	197	197
Staff costs	769,370	729,693
Supplies and services – clinical	167,519	162,993
Supplies and services – general	8,408	10,472
Establishment	21,958	21,983
Research and development	235	114
Transport	15,834	15,599
Premises	77,937	78,481
Increase in bad debts provision	2,176	3,888
Change in provision rate	533	57
Drug costs	130,676	122,530
Rentals under operating leases	17,890	15,668
minimum lease payments		
Depreciation and amortisation	47,071	49,211
Impairments of property, plant and equipment	25,231	50,031
Impairments of intangible assets	138	718
Audit fees – statutory audit	5.2 120	124
Other auditor regulatory services	5.2 18	18
Other auditor remuneration	5.2 533	279
Clinical negligence	19,533	14,456
Consultancy costs	967	1,088
Internal audit cost	375	400
Redundancy	732	400
Early retirements	26	172
Other*	25,148	24,078
	1,380,074	1,343,007

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

5.2 Audit fees

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Audit services for statutory audit	92	92
Audit fee for subsidiary companies	8	8
Other auditor regulatory services	15	15
	115	115

Figures above exclude VAT.

Payments made or payable to our Auditor for non-audit work in 2016-17 were £533k relating to taxation and advisory services provided (2015-16 £279k).

The Fleming Latent VAT claim where the work was completed by the KPMG tax team between 2009-2014. The value of the work was agreed on a contingent basis as a percentage of the savings achieved from the Trust, resulting in an HMRC repayment of circa £1m–£1.8m. HMRC have accepted the claim in April 2017 and hence the fee is now due, but has not been billed or paid in the 2016/17 period.

5.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2016-17 is £2 million (2015-16 £2 million).

5.4 Operating leases

Expenditure as Lessee

5.4.1 Payments recognised as an expense:

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Minimum lease payments under operating leases recognised as an expense in the year	17,890	15,668

5.4.2 Future minimum lease payments:

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Within 1 year	18,186	16,292
Between 1 and 5 years inclusive	31,653	26,464
After 5 years	22,182	12,211
	72,021	54,967

5.4.3 Operating lease income:

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Rental revenue from operating leases – minimum lease receipts	3,248	2,310
	3,248	2,310

5.4.4 Future minimum lease receipts:

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Future minimum lease receipts due:		
Within 1 year	5,808	2,202
Between 1 and 5 years inclusive	20,909	3,142
After 5 years	81,192	236
	107,909	5,580

6 Employee costs and numbers

6.1 Employee costs (including executive directors)

	Permanently employed £000	Other £000	Year ended March 31 2017 Total £000	Year ended March 31 2016 Total £000
Salaries and wages	561,630	50,417	612,047	578,116
Social security costs	61,759	2,650	64,409	49,822
Employer contributions to NHSPA	69,657	1,642	71,299	67,209
Termination benefits	732	–	732	400
Temporary staff – external bank	–	4,643	4,643	4,269
Temporary staff – agency and contract staff	–	38,820	38,820	56,141
Total gross staff costs	693,778	98,172	791,950	755,957
included in above:				
Costs capitalised as part of assets	(8,551)	(5,155)	(13,706)	(18,071)
less income netted off in staff costs	(6,046)	–	(6,046)	(5,838)
Total staff costs	679,181	93,017	772,198	732,048
Analysed into Operating Expenditure (note 5.1)				
Employee expenses – staff	676,353	93,017	769,370	729,693
Employee expenses – executive directors	1,721	–	1,721	1,555
Redundancy	732	–	732	400
Internal audit costs	375	–	375	400
	679,181	93,017	772,198	732,048

6.2 Average number of people employed

	Permanently employed number	Other number	Year ended March 31 2017 Total number	Year ended March 31 2016 Total number
Medical and dental	1,876	75	1,951	1,871
Administration and estates	3,455	335	3,790	3,743
Ancillary staff	797	344	1,141	1,114
Nursing, midwifery and health visiting staff	4,512	531	5,043	4,916
Nursing, midwifery and health visiting learners	922	211	1,133	1,094
Scientific, therapeutic and technical staff	2,032	189	2,221	2,266
Social care staff	2	–	2	2
	13,596	1,685	15,281	15,006

The numbers above are the average number of Whole Time Equivalents employed at the Trust.

6.3 Retirements due to ill-health

During 2016-17 there were 12 early retirements from the Trust agreed on the grounds of ill-health (8 in the year ended March 31 2016). The estimated additional pension liabilities of these ill-health retirements is £598k (£609k in 2015-16). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

6.4 Analysis of termination benefits

	Year ended March 31 2017	Year ended March 31 2016
Number of cases	12	14
Cost of cases (£000)	405	413

7 Exit packages

7.1 Other compensation schemes – exit packages 2016-17

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	£000	Number	£000	Number	£000
< £10,000	3	19	1	4	4	23
£10,001 – £25,000	5	99	–	–	5	99
£25,001 – £50,000	–	–	–	–	–	–
£50,001 – £100,000	2	123	–	–	2	123
£100,001 – £150,000	–	–	–	–	–	–
£150,001 – £200,000	1	160	–	–	1	160
Total	11	401	1	4	12	405

7.2 Other compensation schemes – exit packages 2015-16

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	£000	Number	£000	Number	£000
< £10,000	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
£150,001 – £200,000	–	–	–	–	–	–
Total	12	393	2	20	14	413

7.3 Exit packages: other (non-compulsory) departure payments

	2016-17		2015-16	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Exit payments following Employment Tribunals or court orders	–	–	1	12
Contractual payments in lieu of notice	1	4	–	–
Non-contractual payments requiring HMT approval	–	–	1	8
Total	1	4	2	20

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

8 (Loss)/Profit on disposal of non-current assets

(Loss)/Profit on disposal of non-current assets is made up as follows:	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Profit on disposal of fixed assets held for sale	105	315
Loss on disposal of other property, plant and equipment	(455)	(5)
Profit on disposal of other property, plant and equipment	252	1
	<u>(98)</u>	<u>311</u>

9 Finance income

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Interest on bank accounts	300	302
Interest on loans and receivables	88	95
	<u>388</u>	<u>397</u>

10 Finance expenses

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
Capital loans for the Department of Health	(5,590)	(4,703)
Unwinding of discounts on provisions	(103)	(112)
Other	(2)	(3)
	<u>(5,695)</u>	<u>(4,818)</u>

11 Taxation

	Year ended March 31 2017 £000	Year ended March 31 2016 £000
UK corporation tax		
Adjustments in respect of prior years	(197)	147
Current tax payable on income at 20%	104	328
	<u>(93)</u>	<u>475</u>

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.

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 the 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
- Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

12 Surplus attributable to the Trust

The Consolidated Statement of Comprehensive Income shows a surplus of £42,662k (15/16 Deficit £34,487k) for the Group.

The operating surplus for the Trust was £42,745k (2015-16 operating deficit of £33,837k), and is included within the Statement of Comprehensive Income for the Group. As permitted by DH GAM, no separate Statement of Comprehensive Income is presented in respect of the parent.

13 Property, plant and equipment – March 31 2017

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

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	IT hardware £000	Furniture and fittings £000	Total £000
Cost or valuation								
At April 1 2016	186,712	630,169	180,971	168,356	176	37,192	2,591	1,206,167
Additions purchased	–	–	56,310	156	–	1,198	–	57,664
Additions – assets purchased from cash donations/grants	–	7,109	22,040	1,289	–	555	–	30,993
Impairments – charged to operating expenses	–	(24,780)	(548)	–	–	–	–	(25,328)
Impairments – charged to the revaluation reserve	–	(10,161)	–	–	–	–	–	(10,161)
Reclassifications	–	149,736	(179,656)	26,336	–	2,758	1,069	243
Transfers to/from assets held for sale and assets in disposal groups	(418)	–	–	–	–	–	–	(418)
Revaluation	31,968	(12,505)	–	–	–	–	–	19,463
Disposal	–	–	(5)	(26,499)	–	(1,944)	–	(28,448)
Cost or valuation At March 31 2017	218,262	739,568	79,112	169,638	176	39,759	3,660	1,250,175
Accumulated depreciation								
At April 1 2016	–	9,866	–	117,736	176	19,425	1,464	148,667
Provided during the year	–	18,937	–	14,260	–	5,201	218	38,616
Reversal of impairments credited to operating income	–	(97)	–	–	–	–	–	(97)
Reclassification	–	–	–	(25)	–	–	25	–
Revaluation	–	(16,327)	–	–	–	–	–	(16,327)
Disposals	–	–	–	(26,461)	–	(1,520)	–	(27,981)
At March 31 2017	–	12,379	–	105,510	176	23,106	1,707	142,878
Net book value March 31 2017								
Purchased assets	142,165	536,753	72,944	36,754	–	13,616	473	802,705
Donated assets	76,097	190,251	6,168	27,011	–	2,967	1,480	303,974
Government granted assets	–	185	–	363	–	70	–	618
Total at March 31 2017	218,262	727,189	79,112	64,128	–	16,653	1,953	1,107,297

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 2017, 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 31 March 2017. The valuation was conducted in accordance with the terms of the Royal Institution of Chartered Surveyors' (RICS) Valuation Standards.

a) Depreciated Replacement Cost (DRC)

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

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

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

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for the financial accounting purposes under IAS16 is

fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS 1.3 as:

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

c) Market Value (MV)

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

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

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.

13 Property, plant and equipment – March 31 2016

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

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	IT hardware £000	Furniture and fittings £000	Total £000
Cost or valuation								
At April 1 2015	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 – grants/donations	–	489	25,172	12	–	8	84	25,765
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
Revaluation	1,540	43,845	–	–	–	–	–	43,385
Transfers to assets held for sale	–	(800)	–	–	–	–	–	(800)
Disposal	(390)	(256)	–	(128)	–	–	(7)	(781)
Cost or valuation	186,712	630,169	180,971	168,356	176	37,192	2,591	1,206,167
At March 31 2016								
Accumulated depreciation								
At April 1 2015	–	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)
At March 31 2016	–	9,866	–	117,736	176	19,425	1,464	148,667
Net book value March 31 2016								
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
Total at March 31 2016	186,712	620,303	180,971	50,620	–	17,767	1,127	1,057,500

14 Intangible assets

14.1 As at March 31 2017

Group and Trust	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
Cost April 1 2016	4,820	60,489	11,113	–	76,422
Additions purchased/internally generated	328	1,991	5,595	–	7,914
Additions – grants/donations of cash	6	15	1,339	–	1,360
Impairments charged to operating expenses	–	–	(138)	–	(138)
Reclassification	510	5,203	(6,035)	–	(322)
Disposals	(42)	(5)	–	–	(47)
Gross cost at March 31 2017	5,622	67,693	11,874	–	85,189
Amortisation April 1 2016	2,082	32,553	–	–	34,635
Provided during the year	777	7,678	–	–	8,455
Disposals	(42)	(5)	–	–	(47)
Amortisation at March 31 2017	2,817	40,226	–	–	43,043
Net book value March 31 2017					
Purchased assets	2,548	25,509	11,152	–	39,209
Government granted assets	257	722	–	–	979
Donated assets	–	1,236	722	–	1,958
Total at March 31 2017	2,805	27,467	11,874	–	42,146

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.

14.2 As at March 31 2016

Group and Trust	Software licences £000	Information technology £000	Assets under construction £000	Other £000	Total £000
Cost April 1 2015	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
Reclassification	1,034	15,755	(18,233)	–	(1,444)
Impairments charged to operating expenses	–	–	–	(718)	(718)
Impairments charged to the revaluation reserve	–	–	–	(309)	(309)
Disposals	–	–	–	(175)	(175)
Gross cost at March 31 2016	4,820	60,489	11,113	–	76,422
Amortisation April 1 2015	1,421	26,307	–	–	27,728
Provided during the year	661	6,246	–	–	6,907
Amortisation at March 31 2016	2,082	32,553	–	–	34,635
Net book value March 31 2016					
Purchased assets	2,385	27,021	9,974	–	39,380
Donated assets	353	915	1,139	–	2,407
Total at March 31 2016	2,738	27,936	11,113	–	41,787

15 Impairments

	March 31 2017 £000	March 31 2016 £000
Charged to Statement of Comprehensive Income (SOCl):		
Impairments arising from professional valuation	(24,780)	(52,038)
Other impairments of property, plant and equipment	(548)	(1,549)
Impairment of property, plant and equipment	(25,328)	(53,587)
Impairment of intangibles	(138)	(718)
Total impairment charged to SOCI	(25,466)	(54,305)
Reversal of impairments	97	3,556
Net impairment impact on SOCI	(25,369)	(50,749)
Charged to Revaluation Reserve:		
Professional valuation impairments of land value	–	(101,993)
Professional valuation impairments of building value	(10,161)	(63,881)
Other intangible impairment charged to Revaluation Reserve	–	(309)
Total impairments charged to Other Comprehensive Income	(10,161)	(166,183)

The majority of the 2016-17 impairment charge relates to the property valuation.

Land and buildings were valued independently by Gerald Eve as at 31 March 2017 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 2017 £000	March 31 2017 £000	March 31 2017 £000	March 31 2016 £000	March 31 2016 £000	March 31 2016 £000
From professional valuation of land and buildings:	Revaluation Reserve	SOCI	Total	Revaluation Reserve	SOCI	Total
Increase in land value	31,968	–	31,968	1,540	–	1,540
Increase in building value	4,910	–	4,910	61,739	3,556	65,295
Impairments in land value	–	–	–	(101,993)	–	(101,993)
Impairments in building value	(10,161)	(24,780)	(34,941)	(63,881)	(52,038)	(115,919)
Reversal of previous impairments	–	97	97	–	–	–
Total movement	26,717	(24,683)	2,034	(102,595)	(48,482)	(151,077)
Other valuation movements:						
Other revaluation movements (Investment Property)	(1,088)	–	(1,088)	–	–	–
Other impairments of property, plant and equipment	–	(548)	(1,548)	–	(1,549)	(1,549)
Increase in intangible value	–	–	–	–	–	–
Intangible impairment	–	(138)	(138)	(309)	(718)	(1,027)
	25,629	(25,369)	260	(102,904)	(50,749)	(153,653)

16 Assets for sale

	March 31 2017 £000	March 31 2016 £000
Carrying value at April 1	800	–
Assets classified as available for sale in the year	418	800
Assets sold in year	(800)	–
Carrying value at March 31	418	800

Land at Bowley Close was classified as available for sale at a value of £418k (Ann Moss Way building, £800k 2015-16). The sale of the land is expected to take place in 2017-18.

17 Investment property

Investment property carrying values

	March 31 2017 £000	March 31 2016 £000
Carrying value at April 1	–	–
Fair value gains to Statement of Comprehensive Income	1,090	–
Reclassifications from PPE	79	–
Carrying value at March 31	1,169	–

In 2016/17 the Trust identified that the New Salomon Centre building should be valued as an Investment Property. The building is not held for its service potential, it is held to earn rentals, and therefore it should be valued under IAS 40 Investment Property. As a result of the change in valuation basis for the property, the value increased by £1,090k. Per IAS40, revaluation gains and losses are taken straight to the Statement of Comprehensive Income.

18 Revaluation Reserve movements

Property, plant and equipment

	March 31 2017 £000	March 31 2016 £000
Revaluation Reserve at April 1	292,785	396,007
Impairments	(10,161)	(166,183)
Revaluations	35,790	63,278
Transfers to other reserves	(800)	(317)
Revaluation Reserve at March 31	317,614	292,785

19 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 March 31 2017 are set out below. The accounting date of the financial statements for the subsidiaries is March 31 2017 and for the joint ventures December 31 2017. For the joint venture undertakings that have different accounting year-end dates, interim accounts to March 31 have been consolidated.

	Country of incorporation	Beneficial interest	Principal activity
Subsidiary undertakings			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
GTI Forces Healthcare Ltd ¹	UK	100%	Healthcare services
Pathology Services Ltd ¹	UK	100%	Healthcare services
Essentia Trading Ltd ¹	UK	100%	Healthcare services
Associates and Joint Ventures			
SSAFA GSTT Care LLP	UK	50%	Healthcare services
Viapath Group LLP ¹	UK	33%	Healthcare services
Viapath Services LLP ¹	UK	33%	Healthcare services
Viapath Analytics LLP ¹	UK	33%	Healthcare services
Spot on Diagnostics Ltd ¹	UK	30%	Healthcare services
Precision Diagnostic Analytics Ltd ¹	UK	25%	Healthcare services
King's Health Partners Ltd ²	UK	25%	Healthcare services

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

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

19.1 Investments

	Investments in associates (and jointly controlled operations) March 31 2017 £000	Other investments March 31 2017 £000	Investments in associates (and jointly controlled operations) March 31 2016 £000	Other investments March 31 2016 £000
Carrying value at April 1	71	74	71	–
Additions	–	–	–	74
Carrying value at March 31	71	74	71	74

19.2 Aggregated amounts relating to joint ventures

	March 31 2017 £000	March 31 2016 £000
Current assets	5,372	5,187
Non-current assets	11,377	12,022
Non-current liabilities	(3,166)	(4,768)
Current liabilities	(11,518)	(10,605)
Group share – net assets	<u>2,065</u>	<u>1,836</u>
Revenue	49,715	53,212
Expenditure	<u>(49,472)</u>	<u>(52,312)</u>
Group share net profit	<u>243</u>	<u>900</u>

As per accounting policy Note 1.2, the Group accounts for the joint ventures above are on an equity basis. The Group has no unrecognised losses (2015-16: £nil).

All figures in Note 19.2 are based on unaudited figures.

20 Inventories

	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Raw materials and consumables	21,697	21,326	21,697	21,326
	<u>21,697</u>	<u>21,326</u>	<u>21,697</u>	<u>21,326</u>

21 Trade and other receivables

21.1 Current

	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
NHS receivables	41,360	46,926	42,061	49,269
Other receivables	40,899	48,363	40,487	45,617
Provision for impaired receivables	(25,812)	(25,617)	(25,808)	(25,614)
Prepayments	10,610	12,267	10,608	12,219
Accrued income	76,975	23,497	76,719	23,106
PDC dividend receivable	2,093	–	2,093	–
VAT and other tax receivable	2,970	968	3,135	1,101
	<u>149,095</u>	<u>106,404</u>	<u>149,295</u>	<u>105,698</u>

21.2 Non-current

	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Other receivables	2,152	1,947	2,152	1,947
	<u>2,152</u>	<u>1,947</u>	<u>2,152</u>	<u>1,947</u>

21.3 Provision for impaired receivables

	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
At April 1	25,617	22,729	25,617	22,729
Increase in provision	2,176	3,888	2,172	3,889
Amounts utilised	(1,981)	(1,000)	(1,981)	(1,001)
At March 31	<u>25,812</u>	<u>25,617</u>	<u>25,808</u>	<u>25,617</u>

21.4 Ageing of trade and other receivables

	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Not past due date	50,376	48,253	48,684	48,253
Up to 3 months	8,988	11,562	8,988	11,562
In 3 to 6 months	3,948	6,799	3,948	6,799
Over 6 months	32,334	29,294	32,334	29,294
	<u>95,646</u>	<u>95,908</u>	<u>93,954</u>	<u>95,908</u>

21.5 Analysis of aged group trade and other receivables

	Impaired	Non-impaired	Impaired	Non-impaired
	March 31 2017	March 31 2017	March 31 2016	March 31 2016
	£000	£000	£000	£000
0 – 30 days	3,781	46,595	2,618	45,634
30 – 60 days	560	8,428	2,647	8,915
60 – 90 days	2,822	1,126	1,545	5,254
90 – 180 days	3,631	5,738	3,780	6,633
Over 180 days	15,018	7,947	15,027	3,854
	<u>25,812</u>	<u>69,834</u>	<u>25,617</u>	<u>70,290</u>

22 Other financial assets

Current	GROUP		TRUST	
	March 31 2017 £000	March 31 2016 £000	March 31 2017 £000	March 31 2016 £000
Loan and receivables	1,000	3,500	1,525	–
Forward contracts	6	–	6	–
	<u>1,006</u>	<u>3,500</u>	<u>1,531</u>	<u>–</u>
Non-current	GROUP		TRUST	
	March 31 2017 £000	March 31 2016 £000	March 31 2017 £000	March 31 2016 £000
Loan and receivables	2,500	–	5,595	6,685
	<u>2,500</u>	<u>–</u>	<u>5,595</u>	<u>6,685</u>

2016-17 Trust Loans comprise

Organisation	Current £000	Non-current £000	Interest rate	Maturity date
Viapath Group*	1,000	2,500	Libor + 2%	Dec 2019
Pathology Services Ltd (loan + accumulated interest)		2,020	Libor + 2%	Mar 2022
Essentia Trading	188	188	Higher of cost of capital or Libor + 2%	Mar 2019
Essentia Trading	125	250	Higher of cost of capital or Libor + 2%	Mar 2020
Essentia Trading	212	637	3.50%	Mar 2021
	<u>1,525</u>	<u>5,595</u>		

* The maturity date of the Viapath Group loan was extended from Dec 2016 to Dec 2019 during 2016/17.

Loans with Pathology Services Ltd and Essentia Trading Limited are removed from the Group Accounts following consolidation adjustments.

2015-16 Trust Loans comprise

Organisation	£000
Viapath Group*	3,500
Pathology Services Ltd (loan + accumulated interest)	1,623
Essentia Trading	562
Essentia Trading	500
Essentia Trading	500
	<u>6,685</u>

23 Trade and other payables

23.1 Current

	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Receipts in advance	1,025	793	1,025	793
NHS payables – revenue	7,337	10,465	7,337	10,920
Trade payables – capital	15,737	23,937	15,737	23,937
Amounts due to related parties – revenue	10,460	9,840	10,460	9,840
Other trade payables	32,537	44,429	33,137	43,974
Other payables	1,739	2,188	1,716	2,169
Accruals	73,312	58,453	73,600	58,750
PDC dividend payable	–	348	–	348
	<u>142,147</u>	<u>150,453</u>	<u>143,012</u>	<u>150,731</u>

23.2 Current taxes payable

	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Other taxes payable including Social Security	17,493	15,323	17,257	14,909
	<u>17,493</u>	<u>15,323</u>	<u>17,257</u>	<u>14,909</u>

23.3 Other liabilities

Current	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Deferred income	22,260	29,989	22,260	29,610
Deferred grants income	48	69	48	69
	<u>22,308</u>	<u>30,058</u>	<u>22,308</u>	<u>29,679</u>

23.4 Borrowings

Current	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Capital loans from Department of Health	10,485	9,508	10,485	9,508
	<u>10,485</u>	<u>9,508</u>	<u>10,485</u>	<u>9,508</u>

Non-current	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Capital loans from Department of Health	210,687	149,396	210,687	149,396
	<u>210,687</u>	<u>149,396</u>	<u>210,687</u>	<u>149,396</u>

Schedule of borrowing from the Department of Health

Date loan started	Date to be completed	Interest rate %	Amount of loan agreed March 31 2017 £000	Total repaid March 31 2017 £000	Amounts left to draw down March 31 2017 £000	Amounts outstanding March 31 2017 £000
Mar 2012	Mar 2037	2.85	80,000	5,592	–	74,408
Jun 2011	Jun 2036	3.27	75,000	8,513	–	66,488
Jun 2011	Jun 2017	1.05	5,000	4,375	–	625
Sep 2013	Nov 2023	1.95	9,000	1,125	–	7,875
Feb 2016	Feb 2041	1.9	25,000	510	–	24,490
Feb 2016	Feb 2041	1.9	14,000	–	–	14,000
Feb 2016	Feb 2041	1.9	33,768	–	11,752	22,016
Feb 2016	Feb 2031	1.38	27,232	–	15,961	11,271
			<u>269,000</u>	<u>20,115</u>	<u>27,713</u>	<u>221,173</u>

No security has been pledged against these loans.

All borrowing relates to capital loans have been secured to support the Trust's ongoing plans to redevelop its two hospital sites and upgrade IT and other infrastructure.

A further £100M has been agreed by the Independent Trust Financing Facility committee. This is currently awaiting clearance at the Department of Health.

24 Provisions for liabilities

Group and Trust

24.1 Overall provisions

	Current		Non-current		Total Provisions	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000	£000	£000
Pensions relating to other staff	792	807	7,275	7,301	8,067	8,108
Legal claims	257	834	–	–	257	834
Redundancy	32	–	–	–	32	–
Other	43	162	3,797	3,030	3,840	3,192
	<u>1,124</u>	<u>1,803</u>	<u>11,072</u>	<u>10,331</u>	<u>12,196</u>	<u>12,134</u>

24.2 Changes in provisions

	Pensions relating to other staff	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
As at April 1 2016	8,108	834	–	3,192	12,134
Arising during the year	194	197	32	798	1,221
Utilised during the year	(791)	(78)	–	(33)	(902)
Reversed unused	(77)	(696)	–	(120)	(893)
Unwinding of discount	112	–	–	(9)	103
Change in discount rate	521	–	–	12	533
As at March 31 2017	<u>8,067</u>	<u>257</u>	<u>32</u>	<u>3,840</u>	<u>12,196</u>

24.3 Expected timing of cash flows

	Pensions relating to other staff	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
Within 1 year	792	257	32	43	1,124
Between 1 and 5 years	3,142	–	–	178	3,320
After 5 years	4,133	–	–	3,619	7,752
	<u>8,067</u>	<u>257</u>	<u>32</u>	<u>3,840</u>	<u>12,196</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.

£314m is included in the provision of the NHS Litigation Authority under legal claims at March 31 2017 in respect of clinical negligence liabilities of the Foundation Trust (£283m at March 31 2016).

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

25 Analysis in changes of net cash

GROUP	At April 1 2015	Cash changes in period	At March 31 2016	Cash changes in period	At March 31 2017
	£000	£000	£000	£000	£000
Cash with the Government Banking Service	132,694	(16,196)	116,498	21,906	138,404
Cash at bank and in hand – commercial bank	733	247	980	1,007	1,987
	<u>133,427</u>	<u>(15,949)</u>	<u>117,478</u>	<u>22,913</u>	<u>140,391</u>
TRUST	At April 1 2015	Cash changes in year	At March 31 2016	Cash changes in year	At March 31 2017
	£000	£000	£000	£000	£000
Cash with the Government Banking Service	132,539	(16,208)	116,331	22,073	138,404
Cash at bank and in hand – commercial bank	311	72	383	(222)	161
	<u>132,850</u>	<u>(16,136)</u>	<u>116,714</u>	<u>21,851</u>	<u>138,565</u>

26 Capital commitments

Commitments under capital expenditure contracts at March 31 2017 for the Group and the Trust were £33,734k (£52,047k at March 31 2016).

27 Events after the reporting date

There were no events after the reporting date.

28 Contingencies

28.1 Overall provisions

	March 31 2017 £000	March 31 2016 £000
Contingent liability for other claims against the Group and the Trust	(104)	(100)
Net-contingent liability	(104)	(100)

Contingent liabilities recorded are in respect of Public and Employee liability cases and the Property Expenses Scheme 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.

28.2 Contingent assets and liabilities not required to be disclosed under IAS 37 but included for parliamentary reporting and accountability purposes - quantifiable

The Trust has entered into the following quantifiable contingent liabilities by offering guarantees, indemnities or by giving letters of comfort. None of these are a contingent liability within the meaning of IAS 37 since the likelihood of a transfer of economic benefit in settlement is too remote.

	March 31 2017 £000	March 31 2016 £000
Guarantees	1,314	–
	1,314	–

The £1.3M Guarantee relates to a Parent Company Guarantee to Essentia Trading Ltd.

29 Public Dividend Capital (PDC) dividend

The Trust is required to demonstrate that the PDC dividend payable is in line with the actual rate of 3.5% of average relevant net assets. The dividend payable relating to the period to March 31 2017 was £19,552k (2015-16 £23,353k), based on the average relevant net assets of £719,359k.

30 Related party transactions

Guy's and St Thomas' NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Trust has taken advantage of the exemption provided by IAS 24 'Related Party Disclosures', where the parent's own financial statements are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation. The debtor and creditor trading balances with the Group's joint ventures are presented in note 19.

The Trust's biggest source of income in 2016-17 was £526m 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 £420.9m during 2016/17 for healthcare contracts (£383.5m during 2015/16). 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 £79.6m from Health Education England.

The Trust recorded an income balance of £15.5m from King's College London in 2016/17 (£14.7m 2015/16).

The Trust has also received revenue and capital payments from a number of charitable funds, principally £28.1m is recorded in income from Guy's and St Thomas' Charity during 2016/17 (£19.8m in 2015/16). The balance for Guy's and St Thomas' Charity included within Other Receivables was £2.4m for March 31, 2017. 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: King's College Hospital NHS Foundation Trust, King's 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 and Neil Wigglesworth Deputy Director, Infection Prevention and Control.

Hugh Taylor (Chairman) is a Trustee of Macmillan Cancer Support, the Nuffield Trust and Cicely Saunders International and the National Skills Academy for Health: all bodies which interact which the Trust from time to time.

Ian Abbs sits on the Governing Bodies of Lambeth CCG and Southwark CCG representing King's Health Partners.

Eileen Sills is a Trustee of the Burdett Trust and chairs the Grant Committee. During 2016/17, the Burdett Trust has continued to support the production of the Barbara's Story training pack which is distributed freely on request. Eileen also holds the positions of visiting Professor at King's College London and London Southbank University.

The Council of Governors includes representatives from organisations that work closely with the Trust including Lambeth Council, Southwark Council, Lambeth CCG, Southwark CCG, NHS England, London South Bank University, King's College London, King's College Hospital Foundation Trust 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 receivables balance from all Department of Health Group bodies as at March 31 2017 stood at £97.4m (£62.4m at March 31 2016).

Significant transactions (over £1m) with related parties include the following:

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Ashford CCG	2,100	0	8	0
NHS Barking and Dagenham CCG	1,888	0	360	0
NHS Barnet CCG	2,674	0	0	57
NHS Basildon and Brentwood CCG	1,415	0	154	0
NHS Bedfordshire CCG	1,035	0	168	0
NHS Bexley CCG	24,368	9	2,495	0
NHS Brent CCG	2,017	0	64	0
NHS Brighton and Hove CCG	2,000	0	0	97
NHS Bromley CCG	22,575	33	0	106
NHS Camden CCG	2,398	0	559	0
NHS Canterbury and Coastal CCG	3,161	0	46	0
NHS Central London (Westminster) CCG	15,177	0	1,315	0
NHS Chiltern CCG	1,263	0	646	0
NHS City and Hackney CCG	2,941	0	150	0
NHS Coastal West Sussex CCG	1,981	0	105	0
NHS Crawley CCG	1,177	0	150	0
NHS Croydon CCG	7,639	0	12	0
NHS Dartford, Gravesham and Swanley CCG	11,486	0	527	0
NHS Ealing CCG	2,032	6	370	12
NHS East and North Hertfordshire CCG	1,630	0	114	0
NHS East Surrey CCG	1,700	0	80	0
NHS Eastbourne, Hailsham and Seaford CCG	1,491	0	0	54
NHS Enfield CCG	1,704	0	400	0
NHS Greenwich CCG	27,710	0	1,089	0
NHS Guildford and Waverley CCG	1,026	0	0	5
NHS Hammersmith and Fulham CCG	1,683	0	179	0
NHS Haringey CCG	2,509	0	265	0
NHS Harrow CCG	1,318	0	167	0
NHS Hastings and Rother CCG	1,955	0	87	0
NHS Havering CCG	2,027	0	449	0
NHS Herts Valleys CCG	2,538	0	240	0
NHS High Weald Lewes Havens CCG	2,305	0	194	0
NHS Horsham and Mid Sussex CCG	1,713	0	359	0
NHS Hounslow CCG	1,532	0	87	0
NHS Islington CCG	2,401	0	853	0
NHS Kingston CCG	1,882	0	175	0
NHS Lambeth CCG	166,155	(89)	1,695	193
NHS Lewisham CCG	43,732	511	870	0
NHS Medway CCG	6,832	0	233	0
NHS Merton CCG	2,599	0	0	245
NHS Mid Essex CCG	1,086	0	4	0
NHS Newham CCG	3,625	0	301	0
NHS North East Essex CCG	1,396	0	526	0
NHS North West Surrey CCG	1,918	0	0	15
NHS Redbridge CCG	3,525	0	260	0
NHS Richmond CCG	2,656	0	740	0
NHS South Kent Coast CCG	3,411	0	0	130
NHS Southwark CCG	136,405	116	2,117	354
NHS Surrey Downs CCG	3,114	0	304	0
NHS Sutton CCG	1,703	0	28	0
NHS Swale CCG	2,309	0	140	0
NHS Thanet CCG	2,741	0	206	0
NHS Thurrock CCG	1,203	0	73	0
NHS Tower Hamlets CCG	4,659	0	186	0
NHS Waltham Forest CCG	2,586	0	54	0
NHS Wandsworth CCG	14,284	0	454	25
NHS West Essex CCG	1,262	0	215	0
NHS West Kent CCG	12,555	0	202	0
NHS West London (K&C & Qpp) CCG	2,562	0	130	0
Dartford and Gravesham NHS Trust	2,230	2,085	1,443	655
Hounslow and Richmond Community Healthcare NHS Trust	1,683	25	77	60
Lewisham and Greenwich NHS Trust	2,050	794	2,032	429
NHS England	526,232	1,513	56,408	3,498
Health Education England	79,652	(78)	391	1
NHS Improvement	1,701	56	0	16
Department of Health	43,508	5	247	4

Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Litigation Authority	4	20,215	4	10
NHS Property Services	843	2,574	1,027	1,125
Community Health Partnerships	4	2,802	8	375
Great Ormond Street Hospital for Children NHS Foundation Trust	1,918	361	380	150
King's College Hospital NHS Foundation Trust	3,104	8,352	4,445	2,336
South London and Maudsley NHS Foundation Trust	1,460	2,701	975	570
The Royal Marsden Hospital NHS Foundation Trust	254	2,656	222	59
St George's Healthcare NHS Foundation Trust	999	3,572	467	843
Lambeth London Borough Council	10,156	214	321	332
Southwark London Borough Council	5,354	261	127	522
Northern Ireland Office	3,014	1	1,172	0
HM Revenue & Customs – Other taxes and duties and NI contributions (Not PAYE or employee NI)	0	64,316	0	17,493
HMRC VAT	0	0	2,970	0
NHS Pension Scheme (Own staff employers contributions only plus other invoiced charges)	0	71,299	10	10,460
NHS Blood and Transplant	302	4,757	51	790
Welsh Health Bodies – Public Health Wales NHS Trust	1,459	1	352	0

31 Financial assets and liabilities

31.1 Financial assets

	GROUP		TRUST	
	March 31 2017 £000	March 31 2016 £000	March 31 2017 £000	March 31 2016 £000
Denominated in £ Sterling	280,198	209,270	282,119	223,115
In other currencies, restated in £ Sterling	1,367	5,496	1,276	5,496
Gross financial assets at March 31	281,565	214,766	283,395	228,611

31.2 Analysis of financial liabilities

	GROUP		TRUST	
	March 31 2017 £000	March 31 2016 £000	March 31 2017 £000	March 31 2016 £000
Denominated in £ Sterling	374,491	319,372	375,355	320,440
Gross financial liabilities at March 31	374,491	319,372	375,355	320,440

31.3a Financial assets by category

	GROUP Loans and receivables £000	TRUST Loans and receivables £000
As at March 31 2017		
Assets as per balance sheet		
NHS debtors	41,360	42,061
Accrued income	76,975	76,719
Other debtors with related parties	–	–
Other debtors	45,145	44,732
Provision for doubtful debts	(25,812)	(25,808)
Other financial assets	3,506	7,126
Cash at bank and in hand	140,391	138,565
Total at March 31 2017	281,565	283,395
At March 31 2016		
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
Total at March 31 2016	214,766	228,611

31.3b Financial liabilities by category

	GROUP £000	TRUST £000
Other financial liabilities		
At March 31 2017		
Liabilities as per balance sheet		
NHS creditors	7,337	7,337
Other creditors	60,474	61,050
Accruals	73,312	73,600
Provisions under contract	12,196	12,196
Borrowings	221,172	221,172
Total at March 31 2017	374,491	375,355
At March 31 2016		
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
Total at March 31 2016	319,372	320,440

31.4 Fair values of financial assets at March 31 2017

	GROUP		TRUST	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Non-current trade and other receivables excluding non financial assets	2,152	2,152	2,152	2,152
Other	2,500	2,500	5,595	5,595
	4,652	4,652	7,747	7,747

As allowed by IFRS 7, short-term trade debtors and creditors measured at amortised cost may be excluded from the above disclosure as their book values reasonably approximate their fair values.

31.5 Maturity of financial liabilities

	GROUP		TRUST	
	March 31 2017	March 31 2016	March 31 2017	March 31 2016
	£000	£000	£000	£000
Less than 1 year	152,732	148,334	153,596	138,132
Greater than 1 year	221,759	171,038	221,759	171,038
	374,491	319,372	375,355	309,170

31.6 Financial assets interest risk

GROUP				
Currency	Total	Floating rate	Non-interest bearing	Weighted average interest rate
	£000	£000	£000	
At March 31 2017				
Sterling	139,024	137,356	1,668	0.1%
Other	1,367	–	1,367	-0.5%
Gross financial assets	140,391	137,356	3,035	
At March 31 2016				
Sterling	111,982	111,371	611	0.3%
Other	5,495	–	5,495	-0.5%
Gross financial assets	117,477	111,371	6,106	
TRUST				
Currency	Total	Floating rate	Non-interest bearing	Weighted average interest rate
	£000	£000	£000	
At March 31 2017				
Sterling	137,289	137,356	(67)	0.1%
Other	1,276	–	1,276	-0.5%
Gross financial assets	138,565	137,356	1,209	
At March 31 2016				
Sterling	111,363	111,371	(8)	0.3%
Other	5,351	–	5,351	-0.5%
Gross financial assets	116,714	111,371	5,343	

31.7 Loan disclosure

	Current	Non current	Total	Weighted average interest rate
	£000	£000	£000	
At March 31 2017				
Fixed interest rate instruments	10,485	210,687	221,172	2.6%
At March 31 2016				
Fixed interest rate instruments	9,508	149,396	158,904	3.0%

31.8 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with 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 and consequently makes Euro transactions. Overall the Trust deems that it is not exposed to significant exchange rate risk. However, to provide some certainty over Euro exchange rate gains and losses, the Trust has taken out Forward Currency contracts during 2016-17. As at 31 March 2017 there was one forward contract with a maturity date in 2017/18. This has been valued in accordance with IAS39 and deemed to have a value of £6k as at 31 March 2017.

During 17/18 the Trust is continuing to use forward contracts as a method of providing certainty over foreign exchange gains and losses.

Interest rate risk

The Trust borrows from Government for capital expenditure, subject to affordability as confirmed by NHS Improvement. 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 2017 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.

31.9 Forward Currency Contracts

As detailed in note 31.8, forward purchases of Euros have been used to hedge against foreign exchange risk.

Forward purchases contracts matured as follows:

	Euro Currency €000	Sterling Value £000	Unrealised Gains £000
Current Financial Assets			
Maturing in 2017-18	1,200	1,020	6
	1,200	1,020	6

32 Third party assets

The Trust held £198k cash and cash equivalents at March 31 2017 (£167k at March 31 2016) 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. £149k is held as client monies on behalf of tenants as a result of assuities (£148k at March 31 2016).

33 Losses and special payments

	Year ended March 31 2017	Year ended March 31 2017	Year ended March 31 2016	Year ended March 31 2016
	Cases	£000	Cases	£000
Losses				
Cash losses	16	51	21	26
Stores losses and theft	88	314	192	540
Fruitless payments and constructive losses	–	–	–	–
Bad debts and claims abandoned	725	2,023	850	1,186
Total losses	829	2,388	1,063	1,752
	Year ended March 31 2017	Year ended March 31 2017	Year ended March 31 2016	Year ended March 31 2016
	Cases	£000	Cases	£000
Special payments				
Ex gratia payments	22	7	41	22
Total special payments	22	7	41	22
Total losses and special payments	851	2,395	1,104	1,774

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.

34 Heritage assets note

Historic artefacts

The remains of a Roman boat lie in the Guy's Hospital site, beneath the new Cancer Centre. 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 (2015-16: nil). There were no disposals of artefacts during either year.

35 The Late Payment of Commercial Debts (interest) Act 1998

The Trust incurred £3k (nil 2015-16) in charges relating to the late payment of Commercial Debts.

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

Patient Advice and Liaison Service (PALS)

If you require information, support or advice about our services, contact:

PALS

Tel: 020 7188 8801 (St Thomas')

or 020 7188 8803 (Guy's)

Email: pals@gstt.nhs.uk

Membership

If you are interested in becoming a member of our NHS Foundation Trust, contact:

Tel: 020 7188 7346

Email: members@gstt.nhs.uk

Recruitment

If you are interested in applying for a job at Guy's and St Thomas', contact:

The Recruitment Centre

Tel: 020 7188 0044

<http://jobs.gstt.nhs.uk>

Further information

If you have a media enquiry or require further information, contact:

Anita Knowles, Director of Communications

Tel: 020 7188 5577

Email: communications@gstt.nhs.uk

www.guysandstthomas.nhs.uk

Guy's and St Thomas' NHS Foundation Trust
Guy's Hospital Great Maze Pond London SE1 9RT
St Thomas' Hospital Westminster Bridge Road London SE1 7EH
Tel: 020 7188 7188

www.guysandstthomas.nhs.uk