Guy's and St Thomas' NHS Foundation Trust

Public
Council of Governors Meeting

Wednesday 27th July 2022 at 6pm
Held virtually on MS Teams

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS
Wednesday 27th July 2022
6pm – 7.30pm, MS Teams

A G E N D A

1.	Welcome and apologies *Sir Hugh Taylor*	*Verbal*	*6.00pm*
2.	Declarations of interest	*Verbal*	-
3.	Minutes of previous meeting held on 27th April 2022	*Attached*	-
4.	Matters arising	*Verbal*	-
5.	Reflections on Board of Directors meeting *Sir Hugh Taylor*	*Verbal*	*6.05pm*
6.	GSTT Annual Report and Accounts *Steven Davies, Paul Dossett, Anita Knowles*	*Attached*	*6.30pm*
7.	Women's Health *Dr Jan Grace, Gina Brockwell*	*Presentation*	*6.50pm*
8.	Lead Governor Appointment *Jessica Dahlstrom*	*Verbal*	*7.10pm*
9.	Governors' Reports	*Attached*	*7.15pm*
	9.1 Lead Governor's Report *Heather Byron*		
	9.2 Quality and Engagement Working Group: meeting notes 28th June 2022 *John Powell*		
	9.3 Strategy, Transformation and Partnership Working Group: meeting notes 12th July 2022 *Placida Ojinnaka*		
10.	Any other business	*Verbal*	*7.25pm*

Date of next meeting: Wednesday 2nd November 2022 at 6pm – 7.30pm

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS

Wednesday 27th April 2022, 6pm – 7.30pm
Held virtually via MS Teams

Governors present:	Sarah Addenbrooke	Michael Bryan	Marianna Masters
	Evelyn Akoto	Mark Boothroyd	Margaret McEvoy
	Martin Bailey	Elfy Chevretton	Betula Nelson
	John Balazs	Marcia Da Costa	Trudy Nickels
	Victoria Borwick	John Hensley	Mary O'Donovan
	Heather Byron	Laura James	Placida Ojinnaka
	John Bradbury	Paula Lewis-Franklin	Mary Stirling
	Helena Bridgman	Leah Mansfield	Wisia Wedzicha
In attendance:	Hugh Taylor (Chair)	Alastair Gourlay	Jackie Parrott
	Ian Abbs	Richard Grocott-Mason	John Pelly
	Avey Bhatia	Felicity Harvey	Marian Ridley
	Edward Bradshaw	Joanna Johnson	Julie Screaton
	Ria Burnett	Javed Khan	Sheila Shribman
	Paul Cleal	Anita Knowles	Priya Singh
	Jessica Dahlstrom	Sarah Maskell	Elena Spiteri
	Steven Davies	Sally Morgan	Lawrence Tallon
	Jon Findlay	Jan O'Malley	Steve Weiner

1. Welcome and apologies

1.1. The Chair welcomed attendees to the meeting of the Council of Governors. Apologies had been received from Simon Friend, Reza Razavi and Simon Steddon and governors Jordan Abdi, Serina Aboim, Robert Davidson, Annabel Fiddian-Green, Sian Flynn, John Knight, Michael Mates, Rishi Pabary, Lucilla Poston, John Powell, Raksa Tupprasoot, Warren Turner, Rachel Williams, Tim Windle, Sonia Winifred and Christine Yorke.

2. Declarations of interest

2.1. There were no declarations of interest.

3. Minutes of the meeting held on 26th January 2022

3.1. The minutes of the previous meeting were agreed as an accurate record.

4. Matters arising

4.1. Three actions had been recorded at the last meeting, all of which had subsequently been completed. These actions were regarding:

- The circulation of written answers to all questions received from governors in advance of the meeting;
- A request from governors to provide further clarity from Grant Thornton about the diversity of its external audit team; and
- A request to review and potential reschedule the timing of the Strategy, Transformation and Partnerships Working Group meetings and their proximity to the public Board meetings.

5. Reflection on public Board of Directors meeting

5.1. A number of governors said they had found the research and development presentation at the Board of Directors meeting both interesting and inspiring. There was support for suggestions to increase the proportion of research in consultants' job plans, and for continued investment in digital technology to improve patient care. Some governors felt that the presentation had failed to emphasise the research collaborations in place between the Trust and its partners, including between Royal Brompton and Harefield hospitals and Imperial College Healthcare NHS Trust, and the importance of such collaborations in research outcomes.

5.2. One governor theorised that a reduction in public testing rates was contributing to lower numbers of positive COVID-19 cases in the community. The Chief Operating Officer agreed that the rate of testing had reduced, but that daily public health data from across south east London showed a clear downward trend in positive cases. This data was routinely reported to the Trust's infection, prevention and control team to help inform Trust policy. All patients admitted to the Trust's hospitals were tested for COVID-19 to triangulate external data.

5.3. Further clarity was sought about an email that governors had received from the Trust regarding its plans for the Evelina Expansion Programme. The change in plans had been necessitated by the timing of the availability of external funding; the change in approach would give the Trust greater control over the Programme and decisions taken by the organisation would be less dependent on external factors. It was emphasised that the Trust's commitment to developing Evelina London as a comprehensive children's hospital for children and their families from across south east England remains as strong as ever, and the ultimate ambition remains the same.

5.4. The Trust's long-term plans for Minnie Kidd House had not yet been decided, although a decision had been taken not to use it as an outpatient facility. One option was to use it for patients with short-term recoveries from diagnostics or ambulatory treatment. A suggestion was made that the building could be used for staff accommodation or potentially to support international nursing recruitment. In response to a question regarding the treatment of long waiters the Trust confirmed the number of patients waiting over 52 weeks; this number had been steadily falling over recent weeks, and the Trust was meeting its recovery trajectory for both 52-week and 104-week waiters.

5.5. In response to questions about how the Trust was dealing with staffing issues in acute areas, it was explained that good progress had been made in alleviating staffing pressures in critical care and the Trust was continuing to work hard to maintain sufficient numbers of staff in all other areas. Another governor raised a concern about

the findings in the Workforce Race Equality Standards (WRES) that showed Black, Asian and Minority Ethnic staff were significantly more likely than white staff to be subject to disciplinary action. An overview of the steps being taken by the Trust to address this, as part of the 'Just Culture' approach, was set out. The Trust was working closely with its Staff Side and trade union colleagues to make a real change in this area. More detail on this work would be provided to governors outside the meeting.

ACTION: JS

6. Patient communications/My Planned Care

6.1. The Council of Governors received a presentation on work the Trust was doing to continue to improve:

- Patient safety – with a focus on the clinical prioritisation process both within the Trust and across south east London; and
- Keeping patients informed – including through the 'My Planned Care' patient platform which included functionality that gives patients an indication of how long they may be waiting for treatment.

6.2. Further work was being undertaken to consider how the Trust could continue to improve communications with patients.

6.3. Governors thanked the presenters for providing more information about some important areas. In discussion there was consideration of the knock-on consequences on primary care for patients having to wait for appointments, diagnostics and treatment. There was also concern about the legacy of the pandemic in leading to more staff working from home and possible increased instances of being unavailable to respond to attempted contact from patients. It was agreed this was an area that governors would continue to explore collectively going forward.

7. Overseas visitors policy update

7.1. In previous meetings of the Council of Governors the Trust had been encouraged to call on the Government to suspend charging and data-sharing across the NHS in relation to undocumented migrants. The Trust's policy in this area was based on a statutory obligation to recover payment for the cost of services from patients who are not entitled to free healthcare. The Trust had sought to apply this policy humanely and would never refuse to provide urgent or emergency treatment based on an individual's ability to pay.

7.2. The Chief Financial Officer gave an update about the work that had been done by the Trust to explore this issue further; this had included testing internal compliance with the policy, seeking views from relevant teams across the organisation and collaborating with other NHS organisations in south east London. The Trust executive team had discussed the issue and was committed to ensuring the policy was applied fairly and consistently.

7.3. A number of governors gave their views about how the statutory obligations were impacting health and wellbeing within migrant communities, and extenuating health inequalities. It was acknowledged that the Trust had to balance competing obligations and that considerable judgement was needed in how the policy should be applied. A representative from the Lambeth and Southwark 'Patients not Passports' group voiced concerns about the pace of the Trust's response to governors' queries and requested information about the number of patients that were refusing treatment as a result of the policy to help demonstrate the impact on these individuals' health to the Government.

7.4. The Chair agreed that it was important to continue to focus efforts on this issue. It would be difficult for the Trust to accurately measure the clinical impact of the policy on its own, but it would seek to consider this with its partners in Lambeth Together. It was agreed that the issue would be taken forward by the Council of Governors Quality and Engagement Working Group in the first instance.

8. Nominations Committee: non-executive director appointments

Dr Sheila Shribman and Steve Weiner left the meeting for this item.

8.1. The Chair informed the Council of Governors that Paul Cleal, one of the Trust's Non-Executive Directors, had resigned from his role due to a change in his personal circumstances. The Chair thanked Paul for his significant contribution to the Trust. The Nominations Committee of the Council of Governors had been informed of Paul's decision and would be setting in train a process to appoint a successor.

8.2. The Chair informed the Council of Governors that the Nominations Committee had recommended the re-appointment of Dr Sheila Shribman as a Non-Executive Director of the Trust for a further 12 months. The importance of the work done by Dr Shribman in promoting the children's agenda at the Trust, including on the Evelina Expansion Programme, and, as Senior Independent Director, leading the process to find a new Chair, was highlighted.

8.3. In discussing the need to identify a successor to Steve Weiner, whose term at the Trust was due to end in July 2022, the Committee's attention had been drawn to the credentials of Ian Playford, currently a Non-Executive Adviser at the Trust and a former Non-Executive Director of Royal Brompton and Harefield NHS Foundation Trust. Ian had been 'interviewed' by the Nominations Committee earlier in April which led to the Committee unanimously recommending his appointment to the Council of Governors, with a view to succeeding Steve Weiner, as lead NED for oversight of the Trust's transformation and major programmes. However, the Committee had expressed a strong desire for the Trust to retain Steve's skills and experience for a further period, in particular so that he could continue to oversee the Apollo Programme and the Epic system 'go live' in April 2023.

8.4. In making these recommendations the Committee had therefore agreed there being an extended period of transition from Steve Weiner and Ian Playford as the Non-Executive Director with particular responsibility for oversight of the Trust's transformation and major programmes. There were questions from some governors

about the proposals, including about the cost implications of having both Ian Playford and Steve Weiner on the Trust Board. It was explained that, as Ian Playford was already a Non-Executive Adviser at the Trust, there would be no detrimental financial impact.

RESOLVED:

8.5. The Council of Governors approved:

- The reappointment of Dr Sheila Shribman as a Non-Executive Director for a further 12 months, to 13 June 2023;
- The appointment of Ian Playford as a Non-Executive Director for an initial term of four years; and
- The reappointment of Steve Weiner as a Non-Executive Director for a further 12 months, to 22 July 2023.

9. Nominations Committee: terms of reference and membership

9.1. The Nominations Committee terms of reference dates from September 2011 and had been refreshed to ensure it remained fit-for-purpose, particularly given its important role in supporting the appointment of a new Trust Chair. The Council of Governors received an overview of the main changes that had been made, including to introduce a defined period of time that members could serve on the Committee and clarify the arrangements for seeking new members.

9.2. In early 2022 two seats on the Nominations Committee lay vacant as a result of the departure of two governors from the staff and public constituencies of the Council of Governors. In January and February two elections had been run whereby all staff governors and all public governors were asked to nominate themselves to sit on the Committee. In each case only one self-nomination was received, from Dr Elfy Chevretton (staff) and Margaret McEvoy (public). In accordance with the Trust Constitution the Council of Governors was therefore now asked to approve these appointments.

RESOLVED:

9.3. The Council of Governors approved:

- The updated terms of reference for the Nominations Committee; and
- The appointments of Dr Elfy Chevretton and Margaret McEvoy to the Nominations Committee.

10. New Lead Governor appointment process

10.1. The Trust's current Lead Governor, Heather Byron, had been elected to the position in January 2020. Her second term as a governor would end on 22nd August 2022 and a new Lead Governor will be required. Governors received an overview of the process

for appointing a new Lead Governor which would be done at the next meeting of the Council of Governors in July 2022.

11. Chair succession approach

11.1. The Trust's Senior Independent Director confirmed that a decision had been taken to appoint a joint Chair for both the Trust and King's College Hospital NHS Foundation Trust. Odgers Berndtson had been appointed as headhunters and draft job descriptions for both the Chair and the Deputy Chair were being consulted upon. The final interviews would likely take place on 27th June 2022 and a senior external representative on the interview panel was being sought.

11.2. The first meeting of the Nominations Committee-in-Common with King's College Hospital NHS Foundation Trust was to be held the following Friday. This would largely focus on establishing the process to be followed. It was acknowledged that the timetable was tight, but assurance was provided that there would be sufficient time for candidates to meet relevant stakeholders as part of the process.

12. Governors' reports for information

12.1. The Council of Governors noted the Lead Governor's Report and the notes of the most recent meetings of the Quality and Engagement and Strategy, Transformation and Partnerships working groups.

13. Any other business

13.1. The next meeting was due to be held on 27th July 2022 and arrangements would be confirmed in due course. The governor away day had been scheduled for 14th June 2022.


NHS
Guy's and St Thomas'
NHS Foundation Trust
Annual Report
and Accounts
2021/22

Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2021/22

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 five of the UK's best known hospitals – Guy's, St Thomas', Evelina London Children's Hospital, Royal Brompton and Harefield – as well as community services in Lambeth and Southwark, all with a long history of high quality care, clinical excellence, research and innovation.

We are among the UK's busiest, most successful NHS 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 heart and lung, cancer and renal services.

Evelina London Children's Hospital at St Thomas' provides many specialist services, as well as general services for local children. Guy's is home to the largest dental school in Europe. Following a merger with Royal Brompton and Harefield in February 2021 we are one of the leading international centres for the treatment of cardio-respiratory disease.

We have a long tradition of clinical and scientific achievement and – as part of King's Health Partners – we are one of England's eight academic health sciences centres (AHSCs), 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, as well as many others.

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.

With around 23,500 staff, we are one of the largest employers locally. We aim to reflect the diversity of the 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.

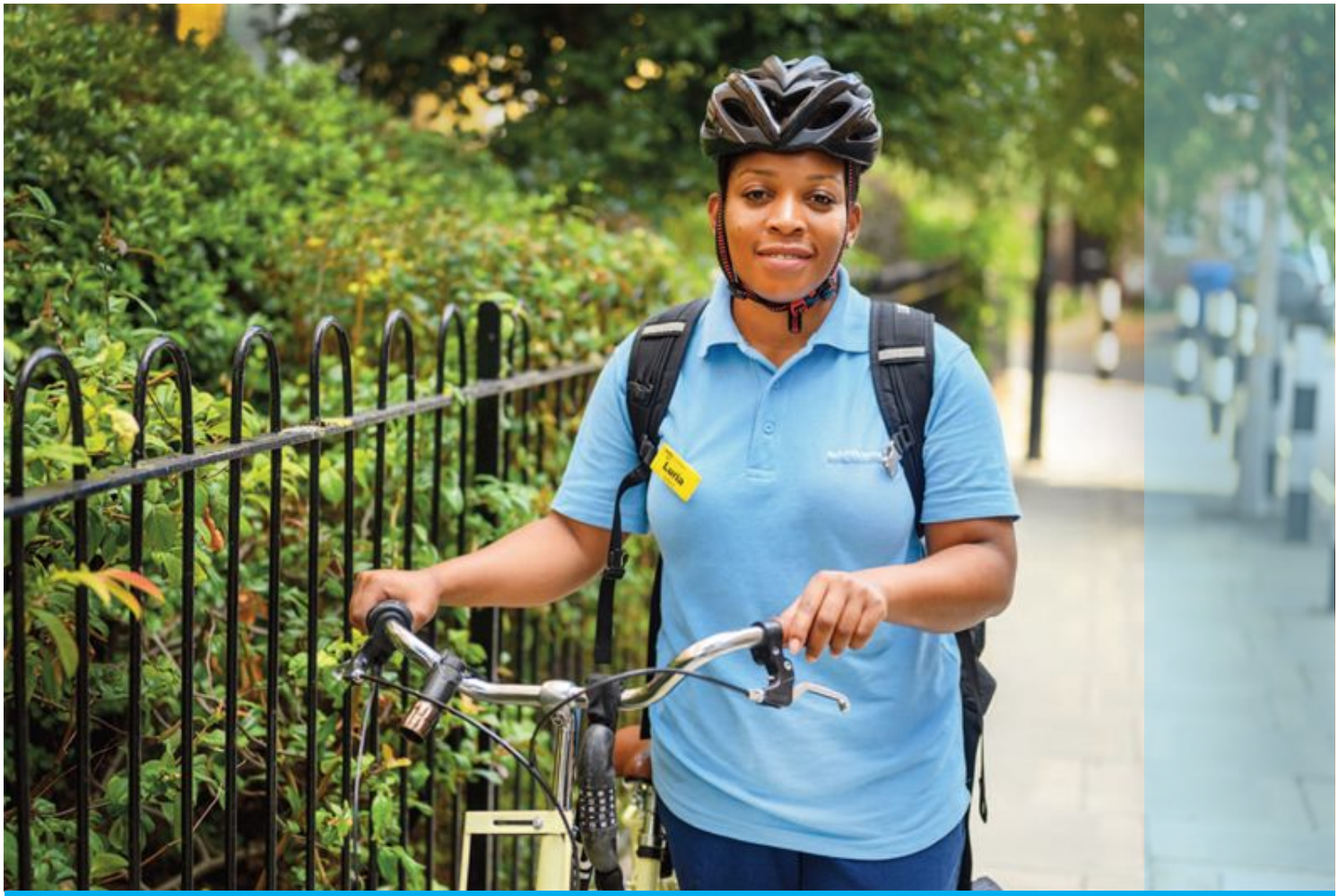
We strive to recruit and retain the best staff as the dedication and skills of our employees lie at the heart of our organisation and ensure that our services are high quality, safe and patient focused.

King's Health Partners is one of eight 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 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**

KING'S HEALTH PARTNERS

Pioneering better health for all



Our neighbourhood nursing teams are taking part in a pilot to enable nurses to reduce their journey times by cycling to patient visits, while also bringing about environmental and health and wellbeing benefits.

Contents

We employ around 23,500 staff, clinical and non-clinical, all of whom contribute to the delivery of high quality patient care in our hospitals and in our community services.

1 Chairman's statement

As I reflect on the past year, the COVID-19 pandemic has continued to dominate our lives and our hearts go out to all the individuals and families whose lives have been disrupted and above all, to those who have lost family and friends.

The pressures on the NHS, on Guy's and St Thomas' and on our staff remain substantial and we know that the impact of a pandemic spanning more than two years has been considerable. While the vaccine programme and new treatments have provided hope and some cause for optimism, the Omicron variant resulted in a rapid resurgence in infection rates which posed different challenges. We are also hugely aware of the many patients who are now waiting for NHS treatment, often facing waiting times that we all regard as unacceptable.

Our staff, clinical and non-clinical, have worked tirelessly to meet these challenges head on. Throughout this period we have worked collaboratively with our partners across London and beyond to care for the most vulnerable patients and to develop robust plans for the recovery of our services to pre-pandemic levels. This has included working with the Integrated Care Systems in both South East and North West London.

We remain focused on the disproportionate effect that COVID-19 has had on Black and other minority ethnic communities, in many cases amplifying existing health inequalities. As a Board we are determined to address these inequalities as we move forward. We have also continued to listen to the concerns raised by our staff and worked hard to engage with them on a range of issues, including views about the safety and efficacy of the COVID-19 vaccines.

We are grateful for the significant and continued support of Guy's and St Thomas' Foundation, which has helped to ensure that a generous health and wellbeing programme, including psychological support, is available to all staff.

I want to express my personal gratitude, and that of the Board, to each and every one of the staff in our hospitals and community services for their ongoing dedication and commitment to our patients and communities, and also for the way that they have supported each other through these difficult times.

The past year has seen a great deal of work to realise the benefits of our merger with Royal Brompton and Harefield hospitals which took place in February 2021. As well as bringing teams together to drive improvements in treatment for heart and lung disease, our specialist services have continued to save lives and been able to drive research while developing new services for those suffering from long COVID.

It has been hugely encouraging to see our 'Apollo programme', that will introduce a new electronic health record system and transform care from 2023, expanded to include both our Royal Brompton and Harefield sites and King's College Hospital NHS Foundation Trust. We have also continued to drive forward other elements of our ambitious capital development programme, including the building of a new children's day treatment centre that will open in 2022 and ambitious plans to further expand the Evelina London Children's Hospital. All these achievements remind me how very proud I am to be part of this exceptional organisation.

On behalf of the Board and as Chairman of the Council of Governors, I would like to record my thanks to our governors. Like others in the Trust, they have continued to adapt to new ways of working imposed on us by the pandemic, and have found new and creative ways to provide essential oversight of our efforts to provide the best possible care for the communities we serve.

Sir Hugh Taylor, Chairman
22 June 2022

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We are piloting a daily riverboat delivery service from the Trust Supply Chain Hub at Dartford into Guy's Hospital as part of plans to reduce our carbon footprint. The initiative forms part of a wider programme to support the Trust Sustainability Strategy.

2 Performance report

Annual performance statement from the Chief Executive

The COVID-19 pandemic has continued to present us with great challenges, as well as new opportunities, over the past year. It has affected us all, both in terms of our professional and personal lives.

Once again, our heartfelt condolences go out to those who have lost family, friends or colleagues. We also appreciate the impact that the pandemic continues to have in many other ways, including long waits for diagnosis or treatment and the pressure it has placed on staff.

The way our staff have continued to respond and step up therefore remains a source of huge inspiration, and I am extremely proud of their resilience and determination to provide the best possible care for our patients. It is also very positive to see that our survival rates for those admitted to critical care with COVID-19 have remained among the best in the UK, and we continue to share our experiences of treating these patients with others.

Ongoing peaks in the pandemic during the past year, particularly as a result of the rapid spread of the Omicron variant in December 2021, placed health services including at Guy's and St Thomas' under immense pressure. More patients required unplanned hospital treatment, at exactly the same time as we experienced unparalleled levels of staff sickness and absence.

Staff again redeployed to the areas and services needing them most, enabling us to meet the increased demand for medical treatment both on the wards and in critical care.

At the same time, we were proud to be asked to rapidly establish a new COVID Medicines Delivery Unit to provide the very latest treatments for COVID-19 to the most vulnerable people in South East London. Our team assessed over 3,000 patients in the first 6 weeks, preventing the need for hospital admission for those most at risk of serious illness from COVID-19.

Regrettably some patients experienced unavoidable late cancellation of their planned treatment or surgery at this time.

Throughout the year, we have worked extremely hard, with partners in South East London and beyond, to develop comprehensive plans to recover and restore services for patients whose primary health need is not COVID related. At Guy's and St Thomas' many of these patients are waiting for complex or life-saving treatment, and we continue to place their needs at the forefront of our minds.

Across the NHS there have been phenomenal efforts to restore planned care and diagnostic services to pre-pandemic levels, increasing face to face services for many, while retaining virtual consultations where appropriate. New ways of working,

Performance report

Annual performance statement

in both our hospital and community services, have developed rapidly over the past two years and will help us to increase the number of patients that we are able to treat in future.

Many patients have welcomed these changes, although we are very conscious of the need to listen to their experiences and to ensure that we retain a range of ways to access care so that this is equitable and does not disadvantage anyone, particularly our most vulnerable patients.

As we celebrated the first anniversary of our merger with Royal Brompton & Harefield NHS Foundation Trust in February 2021 we were able to reflect on the ways our clinical teams have worked together to improve care for patients.

Not only are we now the UK's largest provider of specialist respiratory care, including extracorporeal membrane oxygenation (ECMO) therapy for the very sickest patients, but our surgical teams have benefited from being able to access additional theatre and bed capacity at our new sites when this has been constrained at Guy's and St Thomas' hospitals. The warm welcome extended to colleagues has paved the way for further integration, including through management changes taking effect from April 2022.

We know the national emphasis on restoration and recovery will be a huge focus for the NHS over the next few years, and we are very aware of the sustained effort that will be required to bring our own waiting times back to acceptable levels in many specialties. We are also conscious of the considerable distress and anxiety that long waits for diagnosis and treatment place on patients, and their families and friends, often through personal experience.

Looking ahead, we welcome the opportunity to work collaboratively with our colleagues in the new Integrated Care Systems as we seek to tackle these challenges together and to improve care for the communities we serve.

The past year has also been characterised by ongoing medical breakthroughs and new knowledge about the best ways to treat and prevent the most severe disease arising from COVID-19.

Our clinical and research teams have continued to play a central role in this work, and we are proud that we continue to enroll so many patients into clinical studies and research as these offer the best hope for the future as we prepare for the possibility of new variants and coronaviruses worldwide.

Our future plans will also drive strategic change. We have wide ranging and ambitious plans that include the delivery of additional capacity through the expansion of our children's services provided by Evelina London, with the opening of a new Children's Day Treatment Centre later in the year. At Guy's we will open additional operating theatre capacity and progress exciting plans for an Orthopaedic Centre of Excellence.

In the community we are planning a new ophthalmology outpatient facility to serve patients from across south east London, while at Royal Brompton Hospital we recently opened a state-of-the-art Diagnostic Centre. Our Apollo Programme will deliver a new electronic health record that will transform every aspect of how we work.

Alongside the delivery of clinical services, we have continued to play a central role in the delivery of the COVID-19 vaccine and booster programme for patients, staff and our local communities across South East London.

The disproportionate impact of the pandemic on Black, Asian and other minority ethnic communities remains with us and has shone a spotlight on wider societal inequalities too. In response we have renewed our focus on equality, diversity and inclusion and we are determined that this extends to every aspect of how we support, engage and meet the needs of our patients, staff and the communities we serve. We recognise that we have more to do in all these areas, including to improve opportunities for career progression, remove discrimination and to build management capability and confidence.

Everything we do depends on the hard work and dedication of our 23,500 staff, and their health, safety and wellbeing is absolutely central to our work. I want to thank and pay tribute to each and every one of them.

Dr Ian Abbs
Chief Executive

Overview

Guy's and St Thomas' NHS Foundation Trust provides a full range of general and specialist hospital services, as well as community services for people in Lambeth and Southwark. The Trust was formed in 1993 from the merger of Guy's and St Thomas' Hospitals and the new Evelina London Children's Hospital was opened in 2005. In 2011 Lambeth and Southwark community services joined the Trust, and in 2021 we merged with Royal Brompton and Harefield to create one of the largest NHS organisations in the country.

As an NHS foundation trust, we are accountable to Parliament and regulated by Monitor, part of NHS Improvement. We remain part of the NHS and must meet national standards and targets. Our governors and members ensure that we are accountable and listen to the needs and views of our patients and communities.

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 and our Emergency Department.

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 providing 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 many of these services are colocated with research activities in the Guy's Cancer Centre which opened in 2016.

Royal Brompton and Harefield hospitals form the largest specialist heart and lung centre in the UK, which is also among the largest in Europe. We provide treatment for people with heart and lung disease, including rare and complex conditions.

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 (AHSCs), 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 aim to reflect the diversity of the local communities we serve and continue to develop new and existing partnerships with local people, patients, NHS organisations, local authorities, 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.

Key operational and financial risks

In common with all NHS organisations, we face continual challenges balancing delivery of high quality care with rising demand, the rising acuity of our patients, and the pressing need to increase both productivity and efficiency. We recognise the important role that strategic and transformational change, both internally and across our local health economy, will play as we address operational and financial risks.

As the impact of the pandemic appears to ease, it has left significant and unique operational and strategic challenges for the Trust, most notably around workforce resilience, the need to tackle growing waiting lists (elective recovery), and as a reult of considerable economic uncertainty.

The legacy of COVID-19 will continue to be felt across all our services, and threatens the achievement of the Trust's objectives. The principal strategic risks for the organisation in 2022/23 therefore remain much the same as for 2021/22, and the effectiveness of their controls and assurance will need to continue to be assessed in light of COVID-19.

A review of the Board Assurance Framework and principal strategic risks was undertaken in March 2022 and it was agreed to carry forward the same areas of strategic risk from 2021/22 for Board-level assurance. These are set out in detail on page 67 of the Annual Governance Statement.

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

Despite an extremely challenging environment, and rising demand for our services, we have worked exceptionally hard to deliver operational performance against key operational standards. This could not have been achieved without the dedication and hard work of our staff who have continued to ensure the best possible quality of care and experience for our patients throughout the pandemic and during each stage of recovery.

The Trust's performance is monitored against key national standards. In addition, our Board of Directors reviews progress against a range of internal and external metrics through our quality, financial and performance balanced scorecards.

As a result of the ongoing pandemic our focus has remained on treating as many patients as we safely can, both those with COVID and also those requiring diagnosis or care for other conditions.

Our emergency department had to make significant changes to ensure patients were kept safe and treated as quickly as possible in the most appropriate areas, with infection prevention measures maintained at all times.

The number of emergency department attendances fluctuated during the year and were generally lower during peaks in the pandemic. However, the health needs of patients presenting were generally higher, and this was reflected in the proportion of patients requiring admission. Despite some exceptionally busy periods, we have managed to sustain 4-hour performance at above 80% throughout the year. Staff have worked tirelessly in often difficult and stressful conditions to meet the needs of patients. This has included redeployment to those services under the greatest pressure at various stages during the pandemic.

Prior to the Omicron variant, progress against recovery plans was promising and in October and November 2021 we delivered 83% of outpatient activity, 82% of elective admissions and 103% of diagnostic activity, when compared to 2019/20 levels.

The delivery of this activity also had a positive impact on some of the Trust's key waiting time targets. In November, the Trust reported 87% of patients had received their diagnostic test within 6 weeks. This is a significant improvement compared to our May 2020 position, when just 35% patients received their diagnostic test within 6 weeks following the first wave of the pandemic. In addition, the number of patients waiting over 52 weeks for treatment had also reduced by 68% compared to March 2021.

However, our progress with

elective recovery – to reduce waiting times for diagnosis and treatment – was set back by the Omicron wave in December 2021. The Trust and other partners in the South East London Acute Provider Collaborative, had to reduce routine outpatient appointments and non-urgent surgery to ensure sufficient capacity for urgent and emergency care, including patients with COVID-19.

During this recent peak in the pandemic, we saw significant pressure on our general medical wards, alongside high levels of staff sickness, which required rapid changes to ward areas so they were able to meet the needs of patients with COVID-19.

Exceptional infection prevention and control measures have remained critical throughout, and although this limited our capacity to treat more patients, the safety of our patients and staff remains essential. The vigilance of staff and their ability to respond to changing circumstances has been an important factor in our operational performance during a very challenging year.

As COVID-19 infections again reduced, the Trust set 3 clear priorities:

- to maintain safe care pathways for patients requiring urgent or emergency care
- to ensure sufficient capacity to diagnose and treat high priority patients quickly
- to ensure our COVID vaccination and treatment service could meet demand from all eligible patients.

Staff have worked extremely hard to plan and deliver the recovery of all services, so that both patients who are the highest clinical priority and those who have been waiting the longest are seen as quickly as possible.

As a result, there has been a steady reduction in the number of patients waiting over 52 weeks. At 31 March 2022, there were 1,628 patients in this category, of which 56 patients had been waiting more than 104 weeks.

Our performance against the national cancer standards has been affected by the pandemic, although staff have worked tirelessly to maintain care for the most urgent patients throughout.

Cancer two-week wait referrals reduced significantly at the beginning of the pandemic. Referrals have fluctuated since, but by April 2021 they were exceeding the level a year earlier and were above pre-pandemic levels.

We have seen variation in demand between cancer specialties with particular pressures in the rapid diagnostic clinic and amongst patients presenting with breast, head and neck and upper gastrointestinal cancers.

As cancer referrals increased in the early part of the year, performance against the 62 day waiting time standard deteriorated, although referrals have stabilised since October and we are working hard to improve the timeliness of both diagnosis and treatment. At 31 March, 9% of cancer patients were waiting more than 62 days.

We continue to adapt how services for cancer patients are delivered, reducing the need for on-site appointments wherever possible. We have also continued to work closely with our neighbouring hospitals, local commissioners and the South East London Alliance Cancer Network to ensure equity of access. This has included mutual aid - both to manage two week wait referrals and to prioritise cancer patients requiring urgent surgery.

Throughout the year we have carefully prioritised theatre capacity within the Trust, and also moved work to alternative providers where patients have agreed to this. We recognise the need to increase capacity for the longer term given the very significant number of patients waiting for care across the NHS.

During this year we were able to open additional operating theatre capacity at Queen Mary's Hospital, Sidcup, where surgical teams from Guy's and St Thomas' work with our neighbouring trusts to carry out high volume, low complexity procedures. Working through the South East London Acute Provider Collaborative, this new facility is enabling us to increase operating capacity for patients across South East London.

Our performance against the national diagnostic standard, where 99% of patients should wait no longer than 6 weeks for a diagnostic test, unfortunately deteriorated during the Omicron wave of the pandemic in December and January.

However, in recent months we have worked hard to provide additional capacity, including

through the provision of mobile scanners and by using the private sector and in early 2022 we opened a new Diagnostic Centre at Royal Brompton Hospital.

In addition, we are working with our South East London partners to open diagnostic hubs and we have seen a sustained improvement in diagnostic performance since. At 31 March, 11% of patients were waiting more than 6 weeks from referral for a diagnostic test.

Wide ranging national recovery targets were published in December and we are working hard to achieve – and where possible exceed – pre-pandemic levels of activity as quickly as we safely can.

During the past year, our role in the ongoing delivery of COVID-19 vaccinations and boosters to staff, patients and our local communities has continued to be a key priority. We've delivered almost 900,000 vaccines, and more than 20,000 of our staff took up the offer of vaccination.

As the lead provider for the Our Healthier South East London vaccination programme, the Trust was responsible for the training and management of staff at a number of vaccine centres across South East London in addition to running up to six centres at any one time on our hospital sites. Our focus on meeting demand for vaccines, including through a range of outreach programmes, ensured that everyone who was eligible had access to a vaccine or booster.

Alongside our hospital services, we provide a wide range of care in the community, including in people's own homes across Lambeth and Southwark.

During the past year we have continued to implement new models of service delivery, including neighbourhood nursing and urgent response services where we work closely across health and social care to provide integrated multi-disciplinary teams that best meet patients' needs.

We also continued to provide a number of community based services in response to the pandemic, including support from our hospital@Home service; direct community referrals to treat severe COVID-19; and early hospital discharge for patients with COVID-19. Together, these initiatives have helped to reduce the need for hospital care and also the time that patients spend in hospital if they are admitted.

Our dedicated children's services are provided in the community as well as the Evelina London Children's Hospital, with some specialist cardiac and respiratory services provided at Royal Brompton Hospital. These services have remained exceptionally busy during the past year, and the children's emergency department, located alongside the adult service at St Thomas', has experienced some of its busiest days ever. We have also treated over 400 children with the rare form of COVID known as PIMS-TS, and our specialist teams remain at the forefront of work to understand and treat this rare, but serious condition.

Our heart and lung services at Royal Brompton and Harefield continue to play an important role in the North West London Integrated Care System, working closely with other Trusts and providing a dedicated heart attack centre at Harefield Hospital. We also provide many highly specialist services for patients from around the country.

Since the merger in February 2021, our clinical teams have been working increasingly closely together across the Trust as we focus on recovery and in particular how best to reduce waiting times for the most seriously ill patients, including those with heart conditions.

Performance analysis – financial

The Trust has recorded a deficit of £1.2 million. After adjusting for capital donations, impairments, depreciation on donated assets, donated inventory and other technical adjustments, we ended the year with a small surplus of £0.2 million against the £5.5 million surplus control total agreed with NHS England. This was another challenging year across the NHS and the Trust remained subject to an emergency financial regime, including the introduction of the Elective Recovery Fund, as it continued to respond to the COVID-19 pandemic alongside the national priority to recover services to pre-pandemic levels.

Following our merger in February 2021, our accounts include figures from Royal Brompton and Harefield hospitals as follows: 2 months (February and March) in 2020/21 and a full year in 2021/22.

Our financial performance

The Trust has remained subject to the emergency financial regime introduced to support the national response to the pandemic. The Trust plan was a surplus of £5.5 million, before technical adjustments such as capital donations, depreciation on donated assets and valuations. It was also assumed that we would continue to access the same COVID-19 and 'top up' payments that were available in the previous financial year.

The key national priority was the restoration of planned (elective) care and cancer treatment to broadly pre-pandemic activity levels and additional funding was made available through the Elective Recovery Fund to support this. Trusts would receive this funding if they achieved activity levels at 85% of 2019/20 levels from July, and the target was later increased to 95%.

The Trust's financial plan assumed receipt of £21.2 million from the Elective Recovery Fund, with an increase in expenditure of £15.7 million, to deliver the necessary volume of activity.

Performance against plan

Given the extremely difficult operational and financial environment across the NHS, including interruption to services arising from the further wave of COVID-19 associated with the Omicron variant, the Trust was unable to achieve the £5.5 million surplus, but did however achieve a small surplus against the control total of £0.2 million at the year end.

Including all technical adjustments, not taken into account as part of the control total calculation, the Trust results show a deficit of £1.2 million. The total adjustments for donations, depreciation on donated assets and valuations were a deduction of £15.1 million, £1.6 million greater

Financial performance against plan	Plan £'000	Actual £'000	Variance £'000
Total surplus \ (deficit)	(1,841)	**(1,163)**	678
Capital Donations	6,128	**12,890**	6,762
Impairment movements	0	**8,432**	8,432
Depreciation on Donated Assets	(13,478)	**(15,081)**	(1,603)
Donated Inventory	0	**(6,032)**	(6,032)
Other technical adjustments	0	**(1,582)**	(1,582)
Control total	5,509	**210**	(5,299)

than plan. Capital donations of £12.9 million were £6.8 million above plan. Technical adjustments for impairments were as follows: annual revaluation of land and buildings £8.4 million; donated inventory £6 million; other technical adjustments £1.6 million.

The control total is a measure of the financial performance before a number of technical adjustments as shown in the table above. This is the main financial measure against which Trust financial performance is viewed by our regulator.

Following these adjustments, the Trust reported a surplus of £0.2 million.

Cost Improvement programme

At the start of the year, the Trust set a £31.9 million Cost Improvement Programme target, 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.

The ongoing pandemic had a considerable impact on operational performance through the year and, while a significant proportion of planned cost improvements were achieved, at £15.7 million they were below the original target.

Elective Recovery Fund

The financial plan assumed that the Trust would receive £21.2 million from the Elective Recovery Fund. While the Trust did not fully achieve the target of 95% of elective activity against the 2019/20 baseline, it did secure funding of £26.9 million.

Cash flow

The Trust began the financial year with £321 million of cash and cash equivalents. The majority of the cash reserve results from surpluses achieved in previous years and is earmarked for the Trust's ambitious capital programme.

During the year, cash balances reduced by £100 million, to £221 million. For details of the Trust's net cash balances, see note 24 in the Annual Accounts on page 112. These changes during the year are the result of movements in working capital and investment in property.

The operating surplus after adding back non-cash items resulted in £112 million of net cash generated from operating activities. The Trust spent a net £168 million on investments, including £181 million purchasing intangible assets and property, plant and machinery, and receipts of £13 million in capital donations. A net £44 million was paid in loans and Public Dividend Capital dividends and draw downs. Full details can be found in the statements of cash flows in the annual accounts on page 85.

Charitable funding

The Trust received £18.4 million from charitable sources during the year, £13 million of which consisted of donations towards capital expenditure which principally came from Guy's and St Thomas' Foundation.

Capital expenditure

In 2021/22, the Trust spent £125.9 million on property, plant and equipment (£98.5 million in 2020/21). The Trust also spent £47 million on intangible assets, mostly software and other information technology (£50 million in 2020/21). The capital programme is funded from a combination of internally generated resources, surpluses generated in previous years, charitable donations and loans from the Department of Health and Social Care.

Capital loans

A significant part of the Trust's capital programme is funded from

loans provided by the Department of Health and Social Care. At the beginning of the financial year, the Trust had drawn down loans totalling £324 million. During the year, the Trust made principal repayments of £18.1 million and interest payments of £5.8 million, creating a cash outflow of £24 million.

At the year end, total borrowings equated to £229 million, including total repayments to date of £95.9 million. See note 22.7 in the Annual Accounts on page 110. In addition, the Trust began the year with commercial loans originally taken out by Royal Brompton & Harefield NHS Foundation Trust of £13.2 million. During the year an additional loan was drawn down for £30 million. All commercial loans were repaid by 31st March 2022.

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. In addition, some property, plant and equipment and intangible projects were impaired when projects were abandoned. This year, the full impact on the income statement is a benefit of £1.5 million (-£37 million in 2020/21).

In addition, impairments were charged to the revaluation reserve of £19.6 million (£22.8 million in 2020/21). Together the net impairment charge is £18.2 million (£59.8 million in 2020/21). These entries, 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 103.

External audit services

Grant Thornton received £232,000 in audit fees (excluding VAT) in relation to the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2022. In addition, the Trust paid a further £8,000 to Grant Thornton for their non-statutory audit work. For more details, see note 6.2 to the Accounts on page 97.

Events since the end of the financial year

On 13 June 2022, Essentia Trading Limited a 100% owned subsidiary of the Trust changed its name to Lexica Health and Life Sciences Consultancy Limited.

Identifying potential financial risks

In 2022/23, the Trust faces a number of financial risks. These include:

Delivering the required efficiency savings - the Trust is required to deliver £80.1 million efficiency savings. 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 a breakeven positon would potentially lead to regulatory intervention under the Single Oversight Framework.

Clinical income risk - the Trust is entering into contracts with commissioners which contain significant proportions of 'block' income and this presents a risk where activity levels run above those which are funded. In addition, the Trust has been set a target for elective recovery of services which it must achieve to access the Elective Recovery Fund.

Operational capacity - the Trust does not currently have sufficient capacity to deliver national waiting times standards and the cost of outsourcing activity may be greater than the cost estimates in the financial plan. Plans to increase capacity remain an investment priority.

Excess inflation costs - inflationary costs are running at significantly higher levels than those funded through contract uplifts. NHS England is preparing to release additional funding to cover excess inflation, however, the extent to which the funding meets these increased costs presents a significant risk.

Continued impact of the pandemic - it is anticipated that the financial risk associated with the pandemic is receding, with reduced levels of community infection and good uptake of the COVID-19 vaccine. However, a new variant or challenging winter has the potential to change this situation and we would look to NHS England to reintroduce financial support in this eventuality.

The Trust has a strong history of financial management and has delivered on its financial

Performance report

Trends in activity, income and expenditure

Chart 1: Completed patient spells

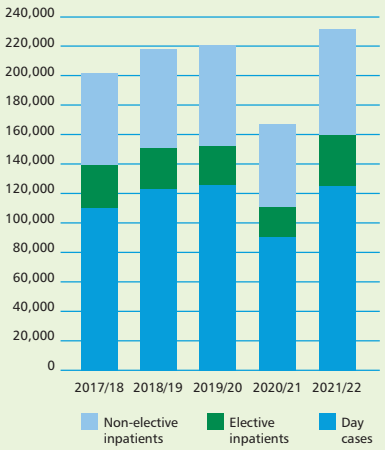


Chart 2: Outpatient attendances

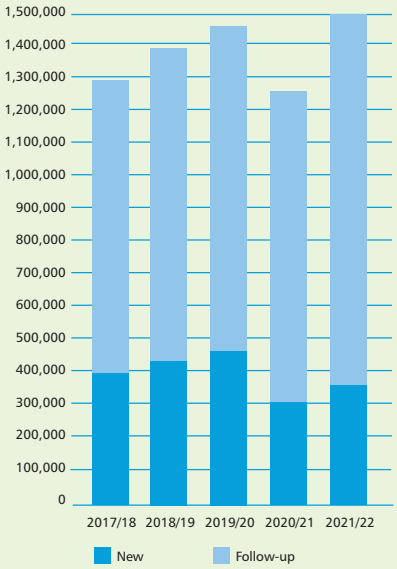
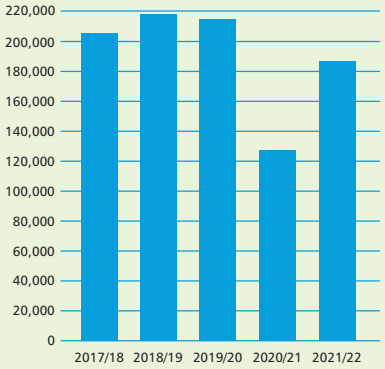


Chart 3: A&E attendances



During 2021-22, we saw in total 1,470,000 outpatients, 101,000 inpatients, 127,000 day case patients and 186,000 accident and emergency attendances.

We also provided over 641,000 contacts in the community, bringing our total patient contacts to 2.5 million.

Following our merger in February 2021, the charts include figures from Royal Brompton and Harefield hospitals as follows: 2 months of activity in 2020/21 and a full year of activity in 2021/22.

Chart 4: Income £millions

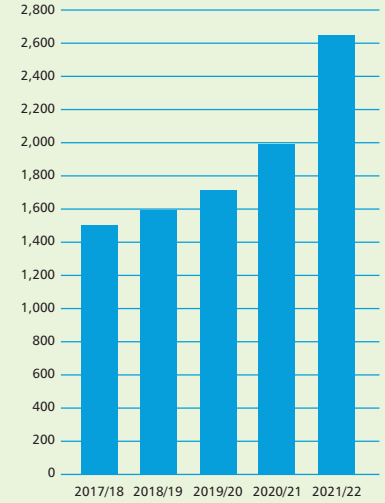
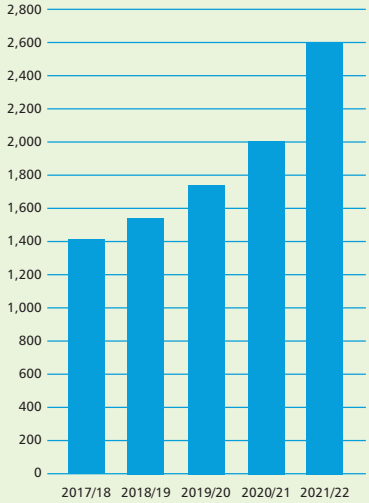


Chart 5: Expenditure £millions



obligations since its inception. As and when risks materialise, management action will be taken decisively and rapidly in mitigation.

Capital planning

The Trust's capital plan is balanced to ensure it both supports operational pressures and helps to meet the strategic ambitions of the Trust. The plan ensures best use of available capital resources within the confines of national expenditure limits. Our investment priorities are to:

- ensure continued provision of safe services across all specialties, ensuring high standards of care for patients and staff through the maintenance of infrastructure
- deliver additional capacity, particularly operating theatres and diagnostic services, needed to address increased demand following the COVID-19 pandemic
- pursue our ambitions to be a digitally enabled healthcare provider through investment in a new state-of-the-art electronic health record system that will transform models of care, improve patient experience and drive efficiency
- maintain our reputation for excellence in academic research, in partnership with King's College London and others
- support new ways of working at Guy's and St Thomas' and in partnership with other providers in south East London.

Demand for capital investment remains high, reflecting our ambition to constantly improve care for patients and invest in new technology, facilities, equipment and research. To best meet this demand we continue to:

- explore funding opportunities with our charity partners and through our commercial activities
- review our estate to identify any opportunities associated with property that is surplus to requirement, subject to the necessary consultation with partners and others.
- ensure that our existing infrastructure is fully utilised and supports maximum productivity.

Procurement

The Trust hosts a procurement shared service which also supports Lewisham and Greenwich NHS Trust, Great Ormond Street Hospital for Children and South London and Maudsley NHS Foundation Trusts.

During 2021/22 the team achieved £12.7m savings across the shared service through competitive tenders, product switches and inventory management.

The team won the urban logistics category at this year's Supply Chain Excellence Awards for its pilot of a river cargo service from the Trust's Supply Chain Hub at Dartford into Guy's Hospital. The initiative forms part of a wider programme to support the Trust's Sustainability Strategy. Other initiatives include a shift from single-use to reusable consumables, recycling medical devices and introduction of energy efficient copiers and printers.

Our capital priorities are set out below:

Capital priority	Description
Operating theatre capacity	Increase capacity through additional operating theatres and maintenance to deliver performance targets.
Medical equipment and infrastructure	Annual replacement programme for high risk items across our hospital and community sites.
Electronic health record system	A transformational programme to deliver new models of care, improve patient care and drive efficiency.
IT investment	Improve resilience of current IT systems and support improvements in clinical care and drive efficiency.
Expansion of Evelina London	Complete new day surgery centre and support increased capacity to meet demand and deliver new models of care.

Performance report

Performance analysis – sustainability and inclusion

Environmental impact performance indicators 2021/22

Following our merger with the Royal Brompton & Harefield NHS Foundation Trust we have combined full year figures for both 20/21 and 21/22 and these aggregate numbers are reflected in the tables below.

	Acute hospitals 2021/22	2020/21	Trend 2021/22 vs 2020/21	Community services 2021/22	2020/21	Trend 2021/22 vs 2020/21
Water (m^3)	**484,344**	515,650	-6%	**13,471**	11,512	17%
Water cost (£)	**946,936**	957,124	-1%	**39,219**	30,240	30%
Imported electricity (GJ)	**67,249,890**	51,147,250	31%	**1,822,871**	1,539,811	18%
Gas (GJ)	**193,726,099**	227,532,620	-15%	**1,585,909**	1,227,520	29%
Oil (GJ)	**263,568**	382,875	-31%	-	-	-
Energy cost (£)	**16,304,125**	13,572,089	20%	**364,177**	279,129	30%
CO2e (in tonnes) for building energy use	**49,830**	53,859	-7%	**678**	585	16%

Note. Fall in gas consumption largely due 7 month outage of combined heat and power (CHP) unit at Guy's. A fall in gas demand of 7,500kW for 4,500 - 5,000 hours equates to appproximately 35,000,000kWh (120,000GJ) in consumed gas.

Note. Increase in electricity consumption due to 7 month outage of CHP at Guy's. Loss of 3,000kW for 4,500 - 5,000 hours equates to appproximately 14,000,000kWh (50,000GJ) of generated electricity.

	Acute hospitals 2021/22	2020/21	Trend 2021/22 vs 2020/21
High temperature disposal (tonnes)	**572**	474	21%
Alternative treatment (offensive waste) (tonnes)	**2,148**	2,158	0%
Offensive Waste (tonnes)	**373**	222	68%
Landfill waste (tonnes)	**15**	10	50%
Recycling by % of total	**32%**	35%	-9%
Cost of waste (£)	**2,255,686**	2,392,442	-6%

Trust vehicle fleet 2021/22	Number in fleet	Miles per year	CO2e (in tonnes) per year
Core fleet (cars, vans and minibuses)	248	1,768,888	812
Salary sacrifice fleet (cars only)	183	1,375,637	271

Note. Calculations for core fleet based on average data values where data values not available. Salary sacrifice fleet calculations based on contracted miles per year. We currently have no meaningful date for our 'grey fleet' (private vehicles that employee's drive for business travel) although 161,000 miles were claimed via the expenses process.

Anaesthetic gases (volatile)	2021/22	2020/21	Trend 2021/22 vs 2020/21
Desflurane liquid (litres)	**7**	26	-72%
CO2e (in tonnes) from Desflurane	**27**	96	-72%
Isoflurane liquid (litres)	**195**	152	29%
CO2e (in tonnes) from Isoflurane	**149**	116	29%
Sevoflurane liquid (litres)	**853**	797	7%
CO2e (in tonnes) from Sevoflurane	**169**	157	7%
Total volume supplied (litres)	**1055**	974	8%
CO2e (in tonnes) from volatile anaesthetic gases	**344**	369	-7%

Note. CO2e is carbon dioxide equivalent - a term for describing different greenhouse gases in a common unit.

Sustainability

In June 2021 the Trust launched a new 10 year sustainability strategy which recognises the Trust's environmental impact and our responsibility to address this in the long term.

Our ambition is to be recognised as a leading NHS trust for sustainability locally, regionally and nationally, and by being at the forefront of delivering sustainable healthcare, we aim to actively protect our environment for our patients of today and tomorrow.

Our strategy considers both national and sector obligations, as well as our position as an anchor institution. We continue to work closely with the South East London Integrated Care System to deliver a joined-up approach to sustainability initiatives across the sector.

The Trust is committed to delivering a net zero health service and we are currently determining a range of metrics to enable us to track progress against our plans. As part of the Trust's carbon-zero ambitions, our target of reducing the use of desflurane anaesthetic gas in clinical practices by 80% (compared to 2018-19 levels) has been met ahead of the target date of May 2023.

We've completed a full review of our fleet of approximately 400 vehicles, enabling us to focus on tackling our biggest polluters. We've already met our target of having 85 electric or hybrid vehicles by May 2023, and have developed an electric vehicle charging infrastructure strategy. From June 2022 only ultra-low emissions vehicles will be on offer to staff through our Trust vehicle salary sacrifice scheme.

As part of our transition to a 'greener' fleet, we have provided e-cargo bike training and safety equipment to neighbourhood nurses taking part in a pilot at one of our community sites. The pilot is enabling nurses to reduce their journey times by cycling to patient visits, while also bringing about environmental and health and wellbeing benefits.

We continue to support active and sustainable travel amongst our staff and have opened a new staff bicycle storage unit at Guy's.

We hold 'bike marking' and bike maintenance sessions, bicycle auctions and provide a range of information to keep cyclists safe and promote enjoyable commutes.

We are committed to reducing the amount of food waste in our hospitals and, following a successful pilot at Guy's, we are working with South East London Integrated Care System to track food waste over a 24 month period in the St Thomas' and Royal Brompton central production kitchens and several wards. We hope the programme will lead to improvements at scale which can be shared more widely.

We continue to focus on reducing single-use plastic across our sites and have partnered with Brunel University London to assess sustainable alternatives to the more than 2,500 single-use plastic cubicle curtains used in the Trust each year.

The single-use plastics and sharps working groups are seeking to prevent 80,000 plastic sharps bins a year from being incinerated by switching to a reusable model.

Equality, diversity and inclusion

The Trust serves some of the most diverse communities of in the UK, as well as caring for patients from further afield. This diversity is also reflected in our staff and brings many benefits to our organisation that we are incredibly proud of. We are constantly striving to ensure that our services meet the needs of all people regardless of their age, disability, ethnicity, sex, religion or beliefs, gender reassignment, sexual orientation, pregnancy and maternity, and marriage or civil partnership, in accordance with the Equality Act 2010 and our Public Sector Equality Duty.

The past two years have been a difficult time for us all. Significantly, data has shown that people from Black, Asian and minority ethnic communities are disproportionately affected by COVID-19 and that the pandemic has increased existing health and social inequalities. We continue to create a safe space for colleagues to share their experiences and feelings, including in the response to the 'Black Lives Matter' movement and issues relating to race, racism and discrimination.

Since the Trust refreshed its equality, diversity and inclusion priorities in 2018/19 we have been working to embed these into day-to-day business. Our focus is to provide equitable access to service provision and delivery of care by driving improvements in patient care and staff experience and reducing inequalities and disparities for our diverse workforce and population. We continue to:

- review and improve the way we develop, design and deliver services to meet the needs of all of our staff and patients;
- analyse patient feedback, including from the Friends and Family Test, broken down by protected characteristics;
- work with patients and their carers to ensure they receive information and communication in their preferred format;
- ensure that our environment, facilities and services are accessible to all;
- work closely with local schools, colleges and organisations to raise awareness of career, learning and work experience opportunities at the Trust;
- ensure all staff have equality of opportunity for career progression and development by ensuring structural processes are equitable, transparent and free from bias and discrimination;
- build strong alliances with our staff networks;
- ensure our senior management reflects the diversity of our wider organisation.

The Trust has a duty to ensure all of its processes, practices and outcomes are fair for all and this work is supported and assured by the Trust's equality, diversity and inclusion team. We are also developing ways to analyse key performance metrics, such as waiting times, to highlight inequalities in access.

As part of our response to the COVID-19 pandemic we have carried out regular risk assessments to ensure we protect those who are most vulnerable, which has included staff from Black, Asian and other minority ethnic communities and those with long-term health conditions and disabilities.

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.

Our safeguarding team consists of separate adults' and children's teams which work closely with statutory bodies to provide support, guidance and decisions on all safeguarding issues. They also provide training to all staff as part of the Trust's wider training programmes. This includes Barbara's Story, our award-winning training film which raises awareness of dementia and the issues faced by vulnerable patients and their families. Our clinical areas have dementia and delirium leads and learning disabilities leads who champion, and work with colleagues to implement, best practice in their area. Supporting our most vulnerable patients, including those with learning difficulties and homeless people, has remained a priority during the pandemic.

The Trust provides a

comprehensive language and accessible support service to meet the communication needs of our diverse population. We were also the first Trust to roll out the 'sunflower' initiative to support patients and staff with hidden disabilities and the first to install state of the art 'changing places' facilities at Guy's and St Thomas' Hospitals.

Widening participation

The Trust has a strong commitment to its widening participation strategy, working with local schools and colleges, community groups and other partners to support young people from disadvantaged backgrounds into the workplace through initiatives such as the Department of Work and Pensions Kickstart programme, work experience and development opportunities for young people with autism. In response to the COVID-19 pandemic, we have adapted our approach, increasing virtual experiences and working with Southwark College and other partners to open an employability hub where we can showcase the opportunities available.

A multi-faith spiritual care team which reflects the diverse faiths and beliefs of our local population is available to support patients and staff. The team continues to work tirelessly to support patients, families and our staff as they cope with the ongoing impact of the pandemic.

Under the Equality Act 2010, employers are required to set out arrangements for how they meet specific employment duties. The Trust is committed to delivering against its responsibilities and collects a range of employment data to monitor and address diversity issues and inequalities, including through the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The results are published in an annual workforce monitoring report on our website and through reporting to NHS England and NHS Improvement.

The Trust has a number of vibrant staff networks which provide platforms to support an inclusive and compassionate culture and ensure that the lived experiences of staff are shared, along with other insights and innovation. 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 an assessment, we develop and implement an action plan to address this. Since 2018 the reporting data has also included information about our gender pay gap. For details see: gender-pay-gap.service.gov.uk as well as the Trust website.

Dr Ian Abbs
Chief Executive
22 June 2022

The surgical teams at Royal Brompton and St Thomas' have now carried out several major heart operations by sharing facilities across our hospital sites to reduce potential delays for patients arising from the pandemic.

3 Accountability report

We are proud to have led efforts to extend COVID-19 vaccinations and boosters to as many patients, staff and local people as possible. To date our teams have delivered almost 900,000 vaccinations.

4 Directors' report

Over the past year, across Guy's and St Thomas', we have continued to do everything possible to diagnose and treat as many patients as we safely can. This has involved both responding to the ongoing operational challenges of the COVID-19 pandemic whilst also maintaining services for patients without COVID-19, or for whom COVID-19 is not the primary reason for their treatment.

As ever, the hard work and dedication of our staff has been critical to this effort and we pay tribute to them. We recognise and appreciate how demanding this has been as the pandemic moved into its second year, leaving many staff emotionally and physically exhausted.

Throughout we have continued to work closely with our partners across the South East London health system, as well as new partners in North West London, offering mutual aid wherever possible. We are also proud to have led efforts to extend COVID-19 vaccinations and boosters to as many patients, staff and local people as possible.

We operated up to six vaccine hubs on our hospital sites at any one time and also supported vaccination in the community, including in schools. To date our teams have delivered almost 900,000 vaccinations and we thank all the staff, clinical and non-clinical, who have made this possible.

In December 2021, we were among the first trusts to establish a COVID Medicines Delivery Unit to offer new treatments to some of the most vulnerable patients, enabling many to avoid the need for hospital admission. Our clinicians and researchers have also remained at the forefront of clinical research to better understand the virus, and how to treat it, and we continue to be one of the largest recruiters to clinical trials.

The need to balance care for those with COVID-19 with that for patients with other, often serious or life threatening conditions has been at the forefront of our planning through the year, and we have worked extremely hard to maintain routine inpatient, outpatient and diagnostic services at close to pre-pandemic levels.

From early 2022, as the impact of the Omicron variant eased, we transitioned into what we hope will be a sustained period of recovery, allowing us to begin the huge task of tackling the growing waiting lists that will remain a devastating legacy of the pandemic across the NHS for the foreseeable future.

During 2021/22 we continued to be subject to the temporary financial regime which was introduced across the NHS to manage the pandemic and ensure resources were available when and where needed to deliver care for patients. As a result, we have maintained a secure financial position, and we have continued to deliver our ambitious capital programme where possible. In the final months of the year, we began the transition to the new financial and performance monitoring arrangements, working closely with our partners in the South East London Integrated Care System.

Data from the later waves of the COVID-19 pandemic continue to show that clinical outcomes at Guy's and St Thomas' remain extremely good, with some of the best survival rates in the UK for patients treated in our critical care units. We have also continued to treat some of the most seriously ill patients, many of whom are referred to us for extracorporeal membrane oxygenation (ECMO treatment), for which we are the country's largest provider.

The tragic loss of life throughout the pandemic remains a source of great sadness, and we extend our condolences to all who have lost friends and family. We also commend our staff for the significant sacrifices that they continued to make to ensure that we could provide the best possible, compassionate care. Many patients have been able to leave hospital and return to their loved ones, often receiving further care and ongoing support from our community teams or specialist Long COVID clinics. We are immensely grateful to staff for their flexibility and resilience, including if asked to redeploy to those areas under greatest pressure which, in the most recent wave of the pandemic, were our general acute wards as well as critical care units.

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 March and April 2019.

In our most recent inspections, we were pleased to maintain an overall rating of 'good' and that our community services for adults were rated as 'outstanding'. This was a significant achievement given the size and complexity of the Trust, and reflects the dedication of our staff. The Trust was rated 'outstanding' for caring services and for being well led, and 'good' for effective and responsive services.

It is disappointing that our rating for being safe remains 'requires improvement' as we have not had the opportunity for this to be re-inspected. While the inspection team commented positively on many factors that underpin safe care, including our staffing levels, they did find issues with a number of our processes and procedures which we have been working hard to address.

Royal Brompton and Harefield NHS Foundation Trust was last assessed by the CQC in October and November 2018, and rated as 'good'.

We continue to focus on a range of activities to improve and assure safety and this includes sharing the outcomes and learning from incidents. The Trust undertakes work to comply with national requirements on learning from deaths, and to ensure that such learning is used to improve care.

The Board has continued to assess its compliance with the principles of the NHS Foundation Trust Code of Governance, and has kept under review the makeup and responsibilities of its Board committees and their terms of reference. Further details can be found in the organisational structure chapter on page 51 and in the full Corporate Governance Statement on the Trust's website.

The Trust is committed to carrying out its business fairly, honestly and openly and has a zero tolerance commitment towards bribery which is set out in a Bribery Act statement on our website and enforced through the Trust Counter Fraud and Bribery Policy.

The Trust's Quality and Performance Committee continued to monitor the full range of clinical and non-clinical performance indicators and received regular updates on our response to COVID-19. These indicators and updates are reported monthly through the new integrated performance report, formerly the balanced scorecard. This report is published in Board papers on the Trust website ahead of each quarterly public board meeting which 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 this has been a key part of our pandemic response as we have learned more about COVID-19 and its transmission. We also retain a sharp focus on quality, safety and clinical effectiveness. We take complaints very seriously as they form a crucial part of our learning from patients. We continue to work hard to improve the management of complaints.

Our local and wider role

Our vision is to advance health and wellbeing as a local, national and international leader in clinical care, education and research. Our Trust strategy 'Together we care', sets out how we will achieve this.

The Trust provides community services within the boroughs of Lambeth and Southwark, a full range of local hospital services

primarily within south east London and a wide range of specialist services for local people and patients from across southern England and in many cases, nationally.

St Thomas' Hospital provides emergency services and a wide range of specialties including cardiovascular, respiratory, women's services, acute medicine and elderly care, critical care, gastro-intestinal medicine and surgery, plastic surgery and ophthalmology.

The Evelina London Children's Hospital is located at St Thomas' and provides a wide range of services from pre-birth, throughout childhood and into adult life to 120,000 children in Lambeth and Southwark and 1.6 million children in London, Kent, Surrey and Sussex through specialist clinical networks which include cardiac, renal, neurology and neonatology services. Evelina London also runs the South Thames paediatric intensive care retrieval service.

Guy's Hospital provides renal, urology and orthopaedic services, including complex surgery and many specialist services, to a wide population across South East London and beyond. It hosts the largest dental school in Europe and is also home to Guy's Cancer Centre which provides diagnosis and treatment for patients with many different types of cancer, including through radiotherapy, chemotherapy and surgery.

Royal Brompton and Harefield hospitals have been part of Guy's and St Thomas' since February 2021 and bring specialist clinical expertise and a strong academic track record in heart and lung disease to complement existing strengths in cardio-respiratory and critical care for both adults and children. These hospitals provide adult critical care, cardiology, cardiac and thoracic surgery and a range of other specialist cardiac services. The Royal Brompton Hospital provides specialist respiratory services for adults and also paediatric cardiac interventional and respiratory services, while Harefield Hospital hosts a heart attack centre serving north west London and also provides transplant services.

We provide community health services for adults and children across Lambeth and Southwark and some specialist services in Lewisham, allowing us to deliver seamless care for our patients. We deliver services in a variety of locations, including in GP practices, health centres, schools, community buildings and in patients' homes. We work in partnership with colleagues from across the local health economy, including other NHS organisations, local authorities, schools, primary care services and voluntary and community groups.

Engaging patients and the public

We work closely with Healthwatch organisations, keeping them informed of service developments and delivery of our quality priorities. Healthwatch have contributed to our pandemic response in a number of ways, including through participation in our Joint Programme for Patient, Carer and Public Involvement in COVID Recovery.

The Trust supports Healthwatch to undertake research. For example, Healthwatch Southwark has published a report, 'Waiting for Hospital Treatment', which has been shared widely and used to inform our work.

Healthwatch has powers to 'enter and view' healthcare premises to observe the delivery of services and the care environment. Due to the COVID-19 pandemic, they did not undertake any onsite visits during 2021.

The Trust was not required to undertake any formal public consultation exercises this year. However, the Trust kept local overview and scrutiny committees informed about developments and changes to services, including the closure of Minnie Kidd House and plans to expand Evelina London Children's Hospital.

The Trust's patient and public engagement team has continued to lead the Joint Programme for Patient, Carer and Public Involvement in COVID Recovery - a collaboration with King's College Hospital and other partners. It has published the findings of a survey undertaken by Ipsos MORI into patient and carer attitudes to accessing care during the pandemic. This work will enable patients, carers and local communities to work with staff to design and improve services that support patients waiting for treatment, who are accessing care virtually, or who are being treated for long COVID.

The Trust has also continued to involve patients, families and carers in our Apollo programme to

implement a new electronic healthcare record. A wide range of staff are working with a 50-strong panel of 'Patient Influencers' to drive key decisions, including about the design of the patient portal which will enable greater patient access to information about their care.

Throughout last year, we have continued to involve patients and carers in work to develop new strategies for our cancer and surgery services.

As part of King's Health Partners Cardiovascular and Respiratory Partnership, we have involved adults, young patients, families and carers in a series of events to explore how we can improve the way we provide, specialist heart and lung care.

We have also continued to involve young patients and families in our plans to expand the Evelina London Children's Hospital.

System leadership and partnership

The Trust is working within the Our Healthier South East London Integrated Care System and, since our merger with Royal Brompton and Harefield hospitals, with the North West London Integrated Care System where Royal Brompton and Harefield have played a key role in both the local pandemic response and in continuing to provide urgent planned care for non-COVID patients.

Our strong relationships with the London boroughs within which our hospital and community sites are located enable us to work together to support health, wellbeing, local employment, green sustainability plans and additional investment into the local communities.

As a provider of community services within Lambeth and Southwark we are active members of Lambeth Together and Partnership Southwark, working with GPs, the local councils and local community groups to join our services together and support our local communities' health and care needs. We also share learning and collaborate with other community service providers in south east London.

We are an active partner in the South East London Acute Provider Collaborative with King's College Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust which enables us to plan, co-ordinate and deliver services jointly across south east London.

The South East London Cancer Alliance, which the Trust hosts, also enables us to work collaboratively to deliver high quality cancer services across community, primary, and secondary care. As the largest provider of cancer care in London, our aim is to ensure that patients receive a timely diagnosis, high quality treatment and an excellent clinical outcome. In addition, Royal Brompton and Harefield hospitals are a member of the Royal Marsden Partners West London Cancer Alliance where we have been early implementers of a new low-dose CT screening programme to enable earlier diagnosis of lung cancer.

As a provider of specialised services for patients from across southern England and further afield we work closely with NHS England and NHS organisations across the country to plan and deliver care, and participate in a number of networks for specialised adult and children's services.

Guy's and St Thomas' is part of King's Health Partners, one of eight Academic Health Science Centres nationally which includes Guy's and St Thomas', King's College Hospital, South London and Maudsley NHS Foundation Trust and our shared university partner, King's College London. King's Health Partners are working on a number of programmes covering cardiovascular disease, diabetes, obesity and endocrinology, haematology, neurosciences, women and children's services and mind and body, all of which are bringing our combined expertise together to deliver world-class clinical care, research and education.

We work closely with King's College London to deliver under and post graduate education across multiple professions, and to enable the rapid translation of research into clinical practice to benefit our patients. The Royal Brompton and Harefield hospitals also work closely with Imperial College London and remain a founding member of the Imperial College Health Partners Academic Health Science Network.

In February Guy's and St Thomas' was awarded £11.8m from the National Institute for Health Research to support our Clinical Research Facility. This new funding will allow us to expand the volume of ground-breaking research we do and will benefit patients by giving them access to new treatment opportunities through clinical trials.

In addition, the reaccreditation process for our Biomedical Research Centre, where we work with our partners at King's College London to develop new treatments and drive research and innovation, is currently ongoing.

Guy's Tower is a major hub for research activity and boasts many specialist research facilities which continue to strengthen our position as a leader in advanced therapies, genomics and regenerative medicine. St Thomas' is a major 'med tech hub' and includes the London Medical Imaging and Artificial Intelligence Centre for Value-based Healthcare, which is funded by Innovate UK in partnership with King's College London.

The Trust is a key partner, along with our local authorities in Lambeth and Southwark and King's Health Partners, in the SC1 Innovation District which aims to transform healthcare by developing a world class health science innovation community in south central London, providing significant local, national and international benefits.

Guy's & St Thomas' Foundation, formally Guy's and St Thomas' Charity, is a key strategic partner. As an independent foundation they invest in a healthier society and seek to drive more equitable healthcare through their Impact on Urban Health programme. By supporting fundraising on behalf of the Trust they also help us to improve and transform services for patients, provide a comprehensive health and wellbeing programme for our staff and support many of our strategic ambitions.

In addition, we also work closely with the Royal Brompton and Harefield Hospitals Charity which funds innovative treatment, equipment and research at Royal Brompton and Harefield hospitals.

King's Health Partners

King's Health Partners is committed to the delivery of world-class research, education, and clinical practice for the benefit of patients, staff, students, and the wider community.

Last year it launched a new five-year plan – 'Delivering better health for all through high impact innovation' with four strategic themes:

- novel technologies, therapeutics and diagnostics;
- transforming system-wide quality improvement and outcomes;
- leading urban population health; and
- workforce innovation and sustainability.

The partnership also appointed a new Independent Chair, Professor Lord Ajay Kakkar who will work closely with the executive team.

King's Health Partners received £222 million in new awards and grants in 2020/21, and ongoing activities have contributed to almost 300 research papers and recruited more than 28,000 study participants across the partnership.

A new Advanced Therapies Accelerator opened in Guy's Tower in June, with £10 million funding from Research England, and a national Medical Research Council Gene Therapy Innovation Hub was established with partners LifeArc and the Biotechnology and Biological Sciences Research Council.

A new partnership with Nvidia was agreed that will enable clinical teams and researchers to access the UK's most powerful supercomputer for the application of artificial intelligence in healthcare, while a number of other major grants will enable use of artificial intelligence and robotics in the development of new surgical treatments.

Throughout this second year of the pandemic, King's Health Partners has worked closely with frontline clinical and academic staff, launching COVID-19 specific clinical guidelines and hosting 'Meet the Expert' and other online learning and engagement events that have attracted over 4,000 attendees.

The partnership also supported our response to the pandemic through the Life Lines project which has enabled 125,000 virtual visits connecting families with their loved ones in intensive care. As India's COVID-19 crisis hit, the team rapidly developed plans to use the same technology to connect clinicians there with their UK colleagues to share expert guidance and advice on topics such as breathlessness, palliative care and long COVID.

Meanwhile the COVID-19 Symptom Study using the Zoe App helped unearth powerful insights into the progress of the pandemic as new variants emerged. King's Health Partners continues to support education and training and

the KHP Online Leaning Hub attracted 16,000 active users over the past year, while the Clinical Academic Innovation workshop series welcomed almost 900 national and global attendees.

Investing in our future

We continue to invest significant capital in improving our estate, digital technology and medical devices to support the needs and expectation of our patients.

Despite the pandemic, we have continued with our ambitious plans for a new electronic health record system through the 'Apollo programme'. We are now in the implementation phase, with go live due in April 2023. The new system will span Guy's and St Thomas', Royal Brompton and Harefield hospitals and also King's College Hospital. In addition, our digital infrastructure programme is focused on key investments such as network replacement and our integration engine, ahead of this programme.

Our new Diagnostic Centre at Royal Brompton was completed during 2021, and allows us to provide state-of-the-art imaging services to help diagnose heart and lung disease. Investment in leading edge imaging technology also continues on the St Thomas' site and will create further capacity to meet growing demand and strengthen our research capabilities. Our longer term plans to increase orthopaedic theatre capacity at Guy's and to expand Evelina London Children's Hospital also continue to make good progress.

In the past year we have brought together our wide-ranging innovation, improvement and transformation capabilities (including computing, engineering, AI, digital, data analytics, private patients and international business development) to form a new Centre for Innovation, Transformation and Improvement (CITI). In collaboration with King's Health Partners, CITI will support our ambition to be internationally recognised for delivering better, faster and fairer healthcare.

Developing commercial partnerships

The Trust has a long tradition of innovation and business development, and continues to explore commercial opportunities that will generate additional income to support the delivery of NHS services. While the impact of the pandemic has been challenging, a number of initiatives have progressed during the past year including:

- ongoing managed service partnerships with: Johnson & Johnson Managed Services, Diaverum and Active Care Group (Remeo)
- expansion of our visiting professional programmes provided for doctors and nurses from overseas
- expansion of our industry preceptorship education programme
- switching, where possible, our services to online delivery
- discussions with leading global companies as part of our Strategic Industry Partners Programme
- recruitment of a network of clinical leads to support our consulting, innovation and private practice activities
- bringing together the combined commercial expertise of Guy's and St Thomas' and Royal Brompton and Harefield hospitals, including the management of our private patient services.

The Trust owns Guy's and St Thomas' Enterprises which independently manages the following fully or partially-owned companies:

- ETL, now Lexica Health and Life Sciences Consultancy Limited, our estates and infrastructure company.
- Viapath, our pathology joint venture with King's College Hospital NHS Foundation Trust. In the past year we successfully concluded our partnership with Serco and have welcomed Synlab UK & Ireland, the joint venture which provides pathology services for south east London
- a joint venture company with King's College London and King's College Hospital NHS Foundation Trust to accelerate 'medtech' initiatives with new start-ups and small and medium sized enterprises
- a number of spin-out technology companies, including Cydar and SpotOn.

A full list of subsidiaries and interests in associates and joint ventures can be found in note 18 to the Accounts.

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 2021/22, Board membership comprised the following executive directors: Chief Executive and Chief Medical Officer, Ian Abbs; Chief Nurse, Avey Bhatia; Chief Financial Officer (from January 2022) Steven Davies; Chief Operating Officer and Deputy Chief Executive, Jon Findlay; Chief Strategy Officer, Jackie Parrott (to November 2021); Chief People Officer, Julie Screaton; Chief Financial Officer, Martin Shaw (to December 2021); Medical Director, Simon Steddon; and Deputy Chief Executive, Lawrence Tallon.

The Board also comprised the following non-executive directors: Chairman Hugh Taylor; Paul Cleal; Simon Friend; Felicity Harvey; Javed Khan; Sally Morgan; John Pelly; Reza Razavi; Sheila Shribman; Priya Singh; and Steve Weiner. See pages 58-61 for biographies.

All of our Board of Directors meet the standards of the 'Fit and proper persons requirement'. The policy requires annual declarations to be made. There have been no declarations of donations to political parties. Details of external directorships or other positions of authority held by the directors of the Trust can be found in Note 29 to the Annual Accounts.

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditor, and members of the Board take all the necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate. The 'Better payment practice code' requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of the goods or a valid invoice, whichever is later. The total bills paid in the year has increased, and the percentage of bills paid within target has improved. Performance against the code is set out in the table below.

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.

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.

Ian Abbs
Chief Executive

Better payment practice code

Measure of compliance	Year ended 31 March 2022 Number	£000	Year ended 31 March 2021 Number	£000
Total bills paid in the year	**376,012**	**1,725,623**	288,703	1,181,203
Total bills paid within target	**324,892**	**1,372,164**	222,338	927,454
Percentage of bills paid within target	**86%**	**80%**	77%	79%

In light of the timing of the merger, prior year comparators only include 2 months of data from Royal Brompton and Harefield and 12 months of data from Guy's and St Thomas'. They have **not** been restated and are therefore not directly comparable with current year totals.

The Trust continues to invest in leading edge imaging technology to increase diagnostic capacity and strengthen our research capabilities. In early 2022 we opened a new diagnostic centre at Royal Brompton Hospital.

5 Remuneration report

Chairman's annual statement

As the Chairman of the Remuneration Committee, I am pleased to present our remuneration report for 2021/22.

There were no changes to the Trust's remuneration policy for very senior managers in 2021/22.

The committee approved a 3% cost of living increase to executive and senior managerial salaries with effect from 1 April 2021.

Chief Financial Officer Martin Shaw retired at the end of December 2021 and was replaced as Chief Financial Officer by Steven Davies, who had been the Trust's Director of Finance since 2018.

Sir Hugh Taylor
Remuneration Committee Chairman
22 June 2022

Remuneration policy report 2021/22

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:

Salary + Pension = 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	To provide a core reward for the role. 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.	NHS Pension Scheme arrangements provide a competitive level of retirement income. Life assurance/death in service benefits may be provided as part of an individual's pension arrangements.
Operation	When determining salary levels, an individual's role, experience and performance, and independently sourced data for relevant comparator groups are considered. Executive director salaries are inclusive of a high cost area supplement. Salary increases typically take effect from 1 April each year.	Executive directors are eligible to receive pension and benefits in line with the policy for other employees. Pension arrangements are in accordance with the NHS Pension Scheme. There is no cash alternative. The NHS Pension Scheme is made up of the 1995/2008 Section and the 2015 Section. New executive directors are entitled to join the 2015 Section, which is a career average revalued earnings scheme. Where an individual is a member of the 1995/2008 Section and is subsequently appointed to the Board, they may remain a member of that Section according to the Scheme rules.
Opportunity	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. Increases may be higher to reflect a change in the scope of an individual's role, responsibilities or experience.	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 2021/22 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.

	Salary	Pension and benefits
Opportunity	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. Salary adjustments may also reflect wider external market conditions. Salary levels for 2020/21 are set out in the single total figure table in the annual report on remuneration.	A new external recruit will be eligible to join the NHS Pension Scheme. The main features of the 2015 Scheme include: • 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. In accordance with NHS Pension Scheme rules, the employer contribution rate is 20.68%.
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 (which represents 10 of England's leading academic healthcare organisations). 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 either three or six months' notice.

The Trust's key workforce policies are held on the Trust intranet. These include Equality and Diversity and Recruitment and Selection policies which set out the process for ensuring fair employment, training and career development opportunities for individuals with protected characteristics. As referenced in the Equality, diversity and inclusion section of this report, see pages 20-21 and page 45. The Trust has a comprehensive plan to ensure better and fairer outcomes in access to learning and development, recruitment opportunities and career progression and development, as well as a 10-year plan to improve ethnic diversity in senior roles.

All 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.

Remuneration report

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 the recommendations of the NHS Pay Review Body and the Review Body on Doctors' and Dentists' Remuneration as reflecting 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 2020/21

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 NHS Improvement.

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 2021/22

Name	Actual / Possible
Hugh Taylor (chair)	3 / 3
Paul Cleal	3 / 3
Simon Friend	2 / 3
Felicity Harvey	3 / 3
Javed Khan	2 / 3
Sally Morgan	2 / 3
John Pelly	3 / 3
Reza Razavi	2 / 3
Sheila Shribman	3 / 3
Priya Singh	3 / 3
Steve Weiner	3 / 3

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

Attendee	Regular attendee	Attends as required
Ian Abbs, Chief Executive	x	
Julie Screaton, Chief People Officer	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.

Fair pay disclosures

Reporting bodies are required to disclose the relationship between the salary component of the highest-paid director in their organisation and the 25th percentile, median and 75th percentile salary component of the organisation's workforce.

The banded salary component of the highest-paid director in 2021-22 was £270,000-£275,000 (£260,000-£265,000 in 2020/21). The relationship to the salaries of the organisation's workforce is disclosed in the table below.

Fair pay disclosures

2021-22	25th percentile	Median	75th percentile
Salary component of total remuneration (£)	30,956	46,122	54,691
Pay ratio	8.73	5.86	4.94

The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.

The calculation is based on full-time equivalent staff working for the Trust on 31 March 2022. Where staff are part time, their salaries have been annualised for the purposes of the ratio calculation.

Based on the mid-point of the banded salary, the highest paid Director's salary has increased by 3.8% between 2020/21 and 2021/22. The percentage change in average employee salaries over the same period was an increase of 6.8%.

In 2021-22, one employee received remuneration in excess of the highest-paid director. In 2020-21, no employee received pay above that of the highest paid director. Salaries ranged from £17,000 to £288,000 in 2021-22. (£17,000 to £264,000 in 2020/21). Performance bonuses were not awarded during 2021-22.

The general increase in salaries results from the national pay uplift across Agenda for Change bands. Pay costs in 2021/2022 also include overtime, additional hours worked and selling of annual leave, all of which were affected by our response to the COVID-19 pandemic.

Service contracts

The following table contains details of the service contracts in place during 2021/22 for executive directors:

Service contracts

Executive director	Date of service contract	Unexpired term	Notice period
Ian Abbs	Jan 2011	Open ended	6 months
Avey Bhatia	Nov 2020	Open ended	3 months
Steven Davies	Jan 2022	Open ended	3 months
Jon Findlay	Dec 2016	Open ended	3 months
Jackie Parrott	Apr 2019	Open ended	6 months
Julie Screaton	Jun 2017	Open ended	3 months
Martin Shaw	Oct 1998	Open ended	6 months
Simon Steddon	Jul 2019	Open ended	6 months
Lawrence Tallon	Mar 2020	Open ended	3 months

Note: the differential in notice periods is as a result of a policy change by the Trust and not any agreements made on a personal basis with the postholder.

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 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 £150,000. It is satisfied that this is justified.

Remuneration report

Salary and benefits of senior managers

The following tables contain details of the salary and benefits of the Trust's senior managers in 2021/22 and 2020/21.

Single total figure 2021/22

Name	Title	Salaries and fees (bands of £5k) £000	Taxable benefits £000	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
I.Abbs*	Chief Executive and Chief Medical Officer	270-275	17	-	285-290
A.Bhatia	Chief Nurse	175-180	-	-	175-180
S. Davies	Chief Financial Officer (From 1 January 2022)	45-50	-	12.5-15	55-60
J.Findlay***	Chief Operating Officer and Deputy Chief Executive	170-175	-	115-117.5	290-295
J.Parrott****	Chief Strategy Officer (Until 30 November 2021)	105-110	-	30-32.5	135-140
J.Screaton***	Chief People Officer	170-175	-	52.5-55	225-230
M.Shaw	Chief Financial Officer (Until 31 December 2021)	130-135	-	-	130-135
S.Steddon	Medical Director	225-230	-	62.5-65	290-295
L.Tallon	Deputy Chief Executive	175-180	-	35-37.5	210-215
P.Cleal	Non-Executive Director	20-25	-	-	20-25
S.Friend	Non-Executive Director	20-25	-	-	20-25
F.Harvey	Non-Executive Director	20-25	-	-	20-25
J.Khan	Non-Executive Director	20-25	-	-	20-25
S.Morgan	Deputy Chair	60-65	-	-	60-65
J.Pelly	Chairman of the Audit and Risk Committee	20-25	-	-	20-25
R.Razavi	Non-Executive Director	30-35	-	-	30-35
S.Shribman	Non-Executive Director	20-25	-	-	20-25
P.Singh	Deputy Chair	25-30	-	-	25-30
H.Taylor**	Chairman	40-45	-	-	40-45
S.Weiner**	Non-Executive Director	20-25	-	-	20-25

***** I.Abbs was interim Chief Executive from August 2019 until he was appointed to the role permanently in September 2021. I.Abbs was not an NHS Pension scheme member for the year 2021-22. Taxable benefits relates to use of Trust accommodation during the Covid-19 pandemic.

A. Pritchard's secondment to NHS England / Improvement ended on 31 July 2021 when she became Chief Executive Officer of NHS England. Guy's and St Thomas' NHS Foundation Trust paid her salary during this period, but it was refunded by NHS England / Improvement and consequently does not appear in the 2021/2022 salary table.

****** H.Taylor is also the Chairman of King's College NHS Foundation Trust and Steve Weiner is also a Non Executive Director on the King's College Hospital NHS Foundation Trust.

******* J.Findlay and J.Screaton opted into the NHS Pension scheme during 2021-22

******** J.Parrott ceased to be a voting Board member from 1st December 2021

No senior manager received any annual or long-term performance bonuses in 2021-22

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

The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP

Single total figure 2020/21

Name	Title	Salaries and fees (bands of £5k) £000	Pension-relatedbenefits (bands of £2.5k) £000	Total (bands of £5k) £000
I.Abbs*	Chief Executive and Chief Medical Officer	260-265	-	260-265
J.Findlay***	Chief Operating Officer and Deputy Chief Executive	175-180	-	175-180
J.Parrott	Chief Strategy Officer	165-170	202.5-205	365-370
J.Screaton***	Chief People Officer	170-175	-	170-175
M.Shaw****	Chief Financial Officer	170-175	-	170-175
E.Sills***	Chief Nurse (Until August 2020)	50-55	-	50-55
A.Lynch	Chief Nurse (8 August 2020 to 1 November 2020)	20-25	5-7.5	30-35
A.Bhatia	Chief Nurse (from November 2020)	65-70	110-112.5	180-185
S.Steddon	Medical Director	215-220	105-107.5	325-330
L.Tallon	Deputy Chief Executive	165-170	40-42.5	205-210
P.Cleal	Non-Executive Director	15-20	-	15-20
F.Harvey	Non-Executive Director	15-20	-	15-20
J.Pelly	Chairman of the Audit and Risk Committee	15-20	-	15-20
R.Razavi	Non-Executive Director	15-20	-	15-20
P.Singh	Non-Executive Director	15-20	-	15-20
S.Shribman	Non-Executive Director	15-20	-	15-20
H.Taylor**	Chairman	45-50	-	45-50
S.Weiner**	Non-Executive Director	15-20	-	15-20
S.Friend****	Non-Executive Director	0 - 5	-	0 - 5
J.Khan****	Non-Executive Director	0 - 5	-	0 - 5
S.Morgan****	Non-Executive Director	10 - 15	-	10 - 15

***** I.Abbs was not an NHS Pension Scheme member for the year 2020-21. He is currently the interim Chief Executive whilst Amanda Pritchard is on secondment.
****** H.Taylor is also the Chairman of King's College NHS Foundation Trust and Steve Weiner is also a Non Executive Director on the King's College Hospital NHS Foundation Trust.
******* J.Findlay, J.Screaton and E.Sills were not NHS Pension Scheme members for the year 2020/21.
******** S.Morgan, S. Friend and J. Khan joined as Non-Executive Directors on 1st February 2021. Their salaries and fees disclosed above is for two months, February and March 2021.
********* M.Shaw's pension net annual increase did not result in a pension related benefits disclosure in 2020/21.
Salaries and fees includes payment for sold annual leave for I.Abbs, J.Findlay, J.Parrott, J.Screaton and M.Shaw.
No senior manager received any annual or long-term performance bonuses in 2021-22
As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.
The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP

2021/22 Salary and pension entitlements of senior managers

Name/Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash equivalent transfer value at 1 Apri 2021 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2022 £000
A. Bhatia Chief Nurse	0	10-12.5	65-70	155-160	1,183	119	1,334
S. Davies** Chief Financial Officer (from 1 January 2022)	0-2.5	0-2.5	35-40	70-75	534	9	601
J. Findlay**** Chief Operating Officer and Deputy Chief Executive	5-7.5	0-2.5	55-60	145-150	1,158	96	1,262
J. Parrott Chief Strategy Officer (to 30 November 2021)	0-2.5	0-2.5	70-75	195-200	1,556	46	1,655
J. Screaton**** Chief People Officer	2.5-5	2.5-5	60-65	160-165	1,269	73	1,359
M. Shaw* Chief Financial Officer (to 31 December 2021)	0	87.5-90	70-75	370-375	0*	0*	0*
S. Steddon Medical Director	2.5-5	2.5-5	60-65	125-130	1,037	62	1,128
L. Tallon** Deputy Chief Executive	2.5-5	0	15-20	0	148	15	181

***** The NHS Pensions Service Authority (NHSBSA) does not calculate a cash equivalent transfer value (CETV) for individuals over 60.
****** S.Davies pensions disclosure relates to January 2022 to March 2022 in line with his role as Chief Financial Officer
******* L.Tallon opted out of NHS Pension Scheme on 31/12/2021.
******** J.Screaton opted in to NHS Pension Scheme on 01/11/2021.
******** J.Findlay opted in to the NHS Pension Scheme on 01/03/2022.

J.Parrott ceased to be a Board member from 01/12/2021
I.Abbs was not an NHS Pension Scheme member for the year 2021/22 and there was no equivalent disclosure in 2020/21.
As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.
The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.

Ian Abbs
Chief Executive
22 June 2022

The NHS Staff Survey results show that 73% of staff said they would recommend the Trust as a place to work, compared to the national average of 58%.

6 Staff report

We employ around 23,500 staff, all of whom contribute to providing high quality patient care in our hospitals and in our community services. The majority of our staff are permanently employed clinical staff directly involved in delivering patient care. We also employ a significant number of non-clinical staff, including in our scientific, technical, Essentia, and administrative teams who provide vital expertise and support. The table below provides a breakdown of our workforce.

Staff group	Permanently employed	Agency, bank and seconded staff	Total 2021/22
Administration and estates	5,469	426	**5,895**
Healthcare assistants and other support staff	1,265	526	**1,791**
Medical and dental	2,986	214	**3,200**
Nursing, midwifery and health visiting staff	6,645	566	**7,211**
Nursing, midwifery and health visiting learners	1,182	492	**1,674**
Scientific, therapeutic and technical staff	3,528	151	**3,679**
Social care staff	4	-	**4**
Total average numbers	**21,079**	**2,375**	**23,454**

The numbers above show the average number of staff (Whole Time Equivalent) employed at the Trust.
The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.

Communicating with staff

The Trust is committed to involving staff in decision-making, engaging them in key developments, and keeping them informed of changes 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 our pandemic response and recovery, or changes in the wider NHS.

We place great importance on staff engagement as there is a positive correlation with the quality of patient care. In 2021/22, we continued to score highly in the annual NHS Staff Survey – see overleaf for details.

In November the Trust was proud to pick up the 'Best in-house team: internal communications' trophy at the 2021 Corp Comms Awards. We also collected the Grand Prix Award, recognising the depth and breadth of our communications work and the challenges we face on a daily basis.

Our range of well-established communications channels include regular briefings from the Chief Executive and senior leaders, with increased frequency during peaks of the pandemic, regular updates to all staff, daily messages on all desktops and laptops and an extensive intranet where staff can find policies, guidance and online tools. We produce a popular magazine, the GiST, and a monthly e-newsletter, the e-GiST for staff, patients and our foundation trust members.

Following our merger with Royal Brompton and Harefield hospitals we have begun the task of developing aligned communications channels. During the pandemic, we converted our usual face-to-face briefings to online sessions via Microsoft Teams which enabled us to directly reach many more staff, with as many as 3,000 colleagues joining at critical times. In addition, online question and answer sessions featuring a panel of experts have enabled us to engage staff in important issues

such as the COVID-19 vaccination programme, providing a forum for people to highlight any concerns and to get their questions answered.

We work closely with the chair of staff side and other staff representatives to ensure the voices of employees are heard. The joint staff committee meets quarterly, 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 from clinical, non-clinical and community teams who contribute to the development of the organisation and represent staff members' views at Board level.

Staff survey

The NHS Staff Survey is the largest annual workforce survey in the world and has been conducted every year since 2003. The 2021 survey was the first time that the survey questions were aligned to the NHS People Promise and the results are summarised under 7 new People Promise elements and 2 themes of staff engagement and morale. 2021 was also the first year that our survey results included responses from staff at Royal Brompton and Harefield hospitals following our merger in February, 2021.

As in previous years, our staff reported a positive experience of working for the Trust, and the results show there is much to be proud of at Guy's and St Thomas', particularly given the pressures presented by the COVID-19 pandemic.

Our response rate in 2021 was 47%, better than the national average at 46%. This was an area that we had committed to improving and it's reassuring that 10,200 staff took the time to complete the survey.

The Trust achieved above the national average in all 7 People Promise elements and in the staff engagement and morale theme scores, compared to our comparator group (acute trusts and combined acute and community trusts).

We continue to achieve high engagement scores and ranked fifth in the country on the overall staff engagement theme which includes the following:

- 73% of staff would recommend the Trust as a place to work, compared to a national average of 58%
- 87% of staff would recommend the Trust to a friend or relative as a place to receive care or treatment, compared to the national average of 76%. This is the highest score in London.

The Trust's score for the 'we are safe and healthy' people promise was 6.1, compared to the national average of 5.9, and we ranked second in London for staff agreeing that the Trust takes positive action on health and wellbeing. As part of our local questions, 94% of our staff said that they were proud to work at the Trust.

Results also indicate that best practice exists within our clinical groups and corporate directorates, with some scores at this level exceeding the best score nationally, including in our Essentia and workforce directorates.

For the second year running, the survey also included COVID-19 related questions to help understand the experiences of staff during the pandemic. Approximately 4,700 respondents indicated that they had worked in a COVID ward/area and these staff reported:

- more positive experiences than average in all 7 people promises and the 2 themes.
- scores for 'We are always learning' close to the best score nationally.
- scores for staff engagement equal to, or higher than, the rest of the Trust.

There were also a number of areas where the Trust scored less well and which we need to improve. We scored below the national average for diversity, equality and inclusion as well as for bullying and harassment. These findings are consistent with those from previous surveys and remain a priority for us.

The COVID-19 pandemic continues to have a significant impact on our staff and we are committed to responding to the key issues they raise.

We will respond to the survey results with action plans at both a Trust-wide and clinical group/corporate service level, and review these alongside other feedback from our staff throughout the year.

Follow up actions will be closely monitored through a range of workforce metrics which are reported to the Board, and updates will be shared with staff on a regular basis.

Staff survey scores

2021 staff survey scores, benchmarked against our comparator group (combined acute and community trusts)

	Trust score	Comparator group
Response rate	47%	46%
NHS People Promise element		
We are compassionate and inclusive	7.4	7.2
We are recognised and rewarded	6.0	5.8
We each have a voice that counts	7.0	6.7
We are safe and healthy	6.1	5.9
We are always learning	5.7	5.2
We work flexibly	6.2	5.9
We are a team	6.7	6.6
Theme		
Staff engagement	7.2	6.8
Morale	6.0	5.7

In 2021 the staff survey themes were restructured to align with the NHS People Promise. As a result it is not possible to make a direct comparison with previous years. Trust scores for the previous 3 years are below:

	2020		2019		2018	
	Trust score	National average	Trust score	National average	Trust score	National average
Response rate	41%	45%	41%	46%	41%	44%

	2020		2019		2018	
Themes	Trust score	National average	Trust score	National average	Trust score	National average
Equality, diversity and inclusion	8.6	9.1	8.7	9.1	8.7	9.1
Health and wellbeing	6.2	6.1	6.0	5.9	5.9	5.9
Immediate managers	6.9	6.8	7.0	6.9	6.9	6.8
Morale	6.3	6.2	6.3	6.1	6.2	6.1
Quality of care	7.8	7.5	7.9	7.5	7.8	7.4
Safe environment – bullying and harassment	7.9	8.1	7.9	8.0	7.8	8.0
Safe environment – violence	9.5	9.5	9.6	9.4	9.5	9.4
Safety culture	7.2	6.8	7.2	6.7	7.1	6.7
Staff engagement	7.5	7.0	7.5	7.0	7.4	7.0
Team working	6.8	6.5	6.9	6.6	6.8	6.6

We recognise that equality, diversity and inclusion is a key area for improvement arising from the staff survey and other feedback. Additional actions to improve the experience of our workforce include:

- creating equality, diversity and inclusion oversight groups within directorates with bespoke action plans and targets
- establishing the Positive Pathways leadership programme and career workshops for Black, Asian and other ethnic minority staff
- supporting career progression for staff with disabilities through the Calibre talent development and leadership programme

Continued overleaf

Staff report

Employee costs (including executive directors)

	Permanently employed £000	Agency, bank and seconded staff £000	Year ended 31 March 2022 Total £000	Year ended 31 March 2021 Total £000
Salaries and wages	**1,046,605**	**87,049**	**1,133,654**	907,463
Social security costs	**116,685**	**5,473**	**122,158**	95,271
Apprenticeship levy	**5,158**	**337**	**5,495**	4,334
Pension cost: employer's contributions to NHS pensions	**122,542**	**3,173**	**125,715**	100,256
Pension cost: employer contributions paid by NHSE on provider's behalf (6.3%)	**53,494**	**1,406**	**54,900**	43,761
Termination benefits	**108**	**-**	**108**	619
Temporary staff – agency and contract staff	**-**	**32,344**	**32,344**	21,947
Total gross staff costs	**1,344,592**	**129,782**	**1,474,374**	1,173,652
Included in above:				
Costs capitalised as part of assets	**(28,609)**	**(914)**	**(29,523)**	(12,452)
Less income netted off in staff costs	**(8,668)**	**-**	**(8,668)**	(9,149)
Total staff costs	**1,307,315**	**128,868**	**1,436,183**	1,152,051
Analysed into operating expenditure				
Employee expenses – staff and executive directors	**1,305,805**	**128,868**	**1,434,673**	1,150,929
Redundancy	**904**		**904**	619
Internal audit costs*	**606**		**606**	503
	1,307,315	**128,868**	**1,436,183**	1,152,051

The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.
*Internal audit costs are total costs incurred by the Trust. Income received in relation to providing internal audit services for other Trusts is recorded separately within other income and not netted off within staff costs.

- training over 400 staff as inclusion agents at all levels of the organisation
- developing a new e-learning module on holding wellbeing conversations to create a positive workplace culture
- establishing the psychological and spiritual wellbeing team to support staff
- increasing our pool of senior mentors and coaches to release the potential of staff within the Trust.

Speak up guardian

We are committed to creating a culture where everyone feels able and confident to voice opinions, suggest improvements and share ideas, as well as to raise concerns. Our 'Quality matters' newsletter provides a regular focus on quality and safety messages, and our 'Safety signals' emails share good practice, including learning from serious incidents.

The Trust's 'Showing we care by speaking up' initiative encourages all staff to speak up about concerns they may have about patient safety or the way the Trust is run. The initiative is led by the 'freedom to speak up' guardian, supported by a network of over 200 'speaking up' advocates across the Trust.

The guardian plays an active and visible role in raising awareness, developing staff and dealing with concerns, while ensuring that our governance processes for raising concerns are robust and effective.

The Trust continues to achieve an above-national-average score in the 'freedom to speak up index', which monitors 'speaking up culture' in the NHS including staff confidence about raising concerns.

The number of contacts, and their nature, are shared on a quarterly basis with the National Guardian's Office and published on their website.

Equality, diversity and inclusion

Staff group	Female	Male	Total
Employees	16,593	6,231	22,824
Executive directors	11	7	18
Other senior managers	163	145	308
Total	**16,767**	**6,383**	**23,150**

Number of staff employed on 31 March 2022.

We are proud to serve diverse communities locally and further afield. This diversity is reflected in the profile of our patients and workforce, and brings many benefits.

The Trust has a comprehensive plan to ensure better and fairer outcomes in access to learning and development, recruitment opportunities and career progression and development, as well as an ambitious 10-year plan to improve ethnic diversity in senior roles. We recognise we have more to do in this respect, as shown by our staff survey results and performance against the Workforce Race Equality Standard.

We are committed to supporting staff with long-term health conditions, those with a disability or who are neuro-divergent, including anyone who acquires a disability during their employment. The Trust promotes and supports the Department of Work and Pensions' 'Disability Confident scheme', which is designed to demonstrate how we recruit and retain people with disabilities, and how we ensure all our processes, training and culture enable staff to flourish.

The Trust supports a number of initiatives to widen access to learning and employment. These include:

- an award-winning apprentice recruitment programme and a programme to support apprentices with disabilities to gain placements;
- participating in the 'Step into health' programme which helps those leaving the Armed Forces to access employment opportunities in the NHS.
- reducing bias through diverse interview panels and a 'just culture approach' to all workforce investigations; and
- a successful reverse mentoring programme, aimed at creating safe spaces for staff to share personal equality and inclusion experiences with senior colleagues to enhance cultural competency and diversity of thought;
- interactive workshops and mandatory e-learning on beyond bias, impact of micro aggressions and incivilities, authentic allies and advancing cultural competence;
- vibrant lesbian, gay, bisexual and transgender (LGBT+), Black, Asian and minority ethnic, women, disability, and dyslexia staff networks;
- embracing Black History Month and promoting the legacy of Mary Seacole;
- the NHS rainbow badge initiative, which began at the Trust and gave staff a way to show that we support open, non-judgmental and inclusive care for all who identify as LGBT+.

Staff sickness absence

Staff sickness absence	
	2021/22
Total days lost	200,053
Total staff years	20,764
Average working days lost (per WTE)*	**10**

*WTE = Whole Time Equivalent

The sickness absence figures are reported on a calendar basis, rather than for the financial year.

These statistics are published by NHS Digital, using data drawn for January 2021 to December 2021 from the ESR data warehouse.

The latest publication, covering the year to December 2021, can be found on the website of NHS Digital.

Staff turnover

Staff turnover figures are published by NHS Digital using data drawn from the Electronic Staff Record data warehouse. The latest version, which covers the year to 2021, can be found on the NHS Digital website.

Safe working environment

The work of the health and safety team this year has again been dominated by our response to the COVID-19 pandemic, providing guidance and advice to help reduce the risk of transmission of the virus in the workplace and ensuring our staff are safe and able to carry out their roles. The team has worked closely with

occupational health and the infection, prevention and control specialists as well as clinical colleagues and the estates teams to review ventilation across the Trust and advise on the introduction of screens to reduce transmission of the virus.

The team has also provided technical expertise and training on the safe use of respiratory protective equipment including face fit testing for staff required to use FFP3 masks to perform their duties.

The manual handling team reinstated face-to-face training in June 2021, launching a new manual handling training programme to improve the quality and relevance of training across the Trust. During peaks in the pandemic the team supported high risk areas and the management of complex patients through bespoke training.

As part of the Trust's internal audit plan, the health and safety service was audited in 2021 to ensure it had implemented effective policies, procedures and processes to ensure a safe and healthy workplace, receiving an overall rating of *Substantial Assurance* for its work.

Occupational health service

The Occupational Health Service is one of the largest public sector services in the country and comprises a multidisciplinary team of doctors, nurses, health and safety specialists, psychologists, manual handling advisers, administrators and researchers. Delivering services both internally and to a variety of local and national organisations, it was the first NHS organisation to achieve Safe, Effective, Quality Occupational Health Service accreditation in 2011 and has maintained this ever since.

The service has remained pivotal in supporting the Trust's COVID-19 pandemic response and has played a key role providing expert advice; supporting the implementation of national guidance and developing advice for staff. Many guidance documents are shared locally and nationally with other trusts.

The team continues to provide an extended weekday and weekend service to ensure staff remain supported to work safely. It has also provided support to the Trust's COVID-19 and flu vaccination and asymptomatic testing programmes. Working closely with Trust clinical experts, staff side representatives and our spiritual care team, they participated in many webinars to support staff with anxieties about COVID-19 vaccinations including the proposed implementation of 'vaccination as a condition of deployment' following legislative changes in early 2022, which were subsequently reversed.

The health and wellbeing team developed a comprehensive programme of staff support throughout the pandemic and recovery phases, building on the Trust's 'Showing we care about you' programme. In addition, a staff self-referral pathway to access support for long COVID was introduced. Much work was done, working closely with the communications team, to promote the 'Showing we care about you' programme so that staff across the Trust were able to access resources, information and professional support.

The wellbeing programme included the recruitment, training and support of wellbeing champions to support colleagues. Other initiatives included rest and recharge zones, peer to peer wellbeing support and an expanded service to support the mental health and resilience of staff.

The occupational health research team continued to lead a programme of high quality and impactful research in the field of occupational medicine, working closely with other health research centres such as the National Centre of Excellence for Musculoskeletal Health and Work, government agencies and patient and public groups.

Trade union facility time

The following information is published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017. The relevant period is 1 April 2021 until 31 March 2022.

Table 1: relevant union officials	
Number of employees who were relevant union officials during the period	Full-time equivalent employee number
97	89.07

Table 2: percentage of time spent on facility time	
Percentage of employee time spent on facility time	Number of employees
0%	53
1%-50%	44
51%-99%	1
100%	0

Table 3: percentage of pay bill spent on facility time	
Total cost of facility time	£229,844
Total pay bill	£1,285,832,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Table 4: paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours, calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	21.46%

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 intranet and receive fraud awareness training through presentations and interactive "fraud chats".

The Trust has access to three counter fraud specialists who work within the Trust's internal audit team to provide guidance and support to staff who raise concerns, and to conduct investigations.

Agency staff

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. Pan London agreements have helped to reduce agency costs, while maintaining high standards of care, and we are at a stage where agency pay compares favourably with rates of pay for staff on our Staff Bank. Where breaches do occur, they mainly relate to nationally recognised shortage occupations, or are in response to exceptional requirements arising from our ongoing pandemic response.

Agency usage as a percentage of all temporary staffing usage is now at its lowest rate for many years, however there are still significant variances by staff group and we are continuing to work with London colleagues and the Workforce Alliance to reduce these.

Expenditure on consultancy

Expenditure on consultancy in 2021/22 was £4,650,000.

Staff report

High paid off-payroll engagements

Table 1: Off-payroll worker engagements as of 31 March 2022, earning £245 per day or greater	
Number of existing engagements as of 31 March 2022	27
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	7
for between two and three years at the time of reporting	6
for between three and four years at the time of reporting	3
for four or more years at the time of reporting	8

Table 2: All off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2022	27
Of which:	
Not subject to off payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	15
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	12
Number of engagements reassessed for consistency/ assurance purposes during the year end	7
Of which: number of engagements that saw a change to IR35 status following the consistency review	0

Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "Board members, and/or senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	9

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Off-payroll engagements

The Trust has a policy that all substantive staff are paid through the payroll. No executive Board members were engaged on an off-payroll basis in 2020/21.

On 6 April 2017, public bodies became responsible for collecting tax from those contractors subject to HMRC's IR35 rules; all contractors are subject to a review to determine whether they are affected by the rules. The number of contractors engaged as at 31 March 2021 is shown in the tables above where daily rates exceed £245 per day and the engagement has lasted longer than six months.

Staff exit packages

In 2021/22, a total of 24 exit packages were agreed in the year, 14 of which were compulsory redundancies. The total cost of exit packages was £1,247,000. Summary information for 2021/22 and comparative information for 2020/21 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	
	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21
<£10,000	0	3	3	0	3	3
£10,000 – £25,000	9	5	1	0	10	5
£25,001 – £50,000	2	2	1	0	3	2
£50,001 – £100,000	3	0	0	0	3	-
£100,001 – £150,000	0	1	3	0	3	1
£150,001 – £200,000	0	0	2	0	2	-
Total number of exit packages by type	**14**	**11**	**10**	**0**	**24**	**11**
Total resource cost £000	**437**	**310**	**810**	**0**	**1,247**	**310**

Exit packages: other (non-compulsory) departure payments

There were 11 elements of other departure packages agreed in 2021/22, totalling £810,000. Comparative information for 2021/22 is provided in the table below.

	2021/22 Payments agreed	Total value of agreements	2020/21 Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	7	780	-	-
Contractual payments in lieu of notice	1	16	-	-
Exit payments following Employment Tribunals or Tribunals or court orders	3	14	-	-
Total	**11**	**810**	**-**	**-**

The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.

We have ambitious plans to expand the Evelina London Children's Hospital. This includes opening a new children's day treatment centre in 2022.

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

The Trust benefits from a strong Board of Directors, whose wide-ranging experience underpins our continued success. Our governors also play a vital and active role in our work.

Operating model

The significant increase in the size and complexity of the Trust in recent years, and the further increase in scale as a result of the merger with Royal Brompton & Harefield NHS Foundation Trust in February 2021, meant that we needed to adapt the way in which we manage our organisation.

To enable us to balance operational delivery with our ambitious strategic agenda, we have made a number of significant changes to the way the Trust is structured to allow us to manage our operational services closer to the frontline whilst also maximizing the benefits of scale.

Following the merger, we established five closely-related clinical groups:

- Evelina London Women's and Children's Services
- Royal Brompton and Harefield
- Cardio-Respiratory and Critical Care
- Integrated and Specialist Medicine
- Cancer and Surgery.

In April 2022, we transitioned from five clinical groups to four, which saw the adult services at Royal Brompton and Harefield and the Cardio-Respiratory and Critical Care Clinical groups integrate, and children's services at Royal Brompton became part of Evelina London Women's and Children's Clinical Group.

These clinical groups have increasing responsibility for operational leadership and delivery of Trust strategy in their areas. Within each clinical group, clinical directorates remain at the heart of decision making and ensure strong clinical leadership.

These changes are designed to strengthen relationships with King's Health Partners and enable integration with cardio-vascular services at King's College Hospital NHS Foundation Trust. Clinical groups, and the directorates within them, will continue to be supported by our corporate services.

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, and 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 development, involvement and communication working group which facilitates governors' consultation with our members. The Trust responds to ad-hoc requests and encourages the public to attend our Annual Public Meeting.

The Council of Governors also runs a strategy, transformation and partnerships working group which is the main vehicle for the Trust to discuss its future plans with governors. There is a quality and engagement working group which is a forum where the Trust and governors discuss patient engagement, quality improvement and safety matters.

Our organisational structure

Governors are also involved in discussions about the Trust's strategy when these are considered at public meetings of the Trust Board and Council of Governors.

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

Some of the organisations we work closely with nominate partnership governors, and one new partnership governor was appointed in 2021/22.

The Trust's constitution requires us to have 43 governors. Elections were held for a number of these seats in spring 2022.

Governors received expenses totalling £50.15 during 2021/22. See page 53 for a full list of governors.

Code of Governance

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. It keeps its governance arrangements under regular review, including membership of Board committees, their terms of reference and Board performance assessments. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Nominations Committee

The Nominations Committee makes recommendations to the Council of Governors on the appointment and remuneration of the Chairman and non-executive directors, and considers the independent appraisal of the Chairman.

This year, the Council of Governors accepted the Nominations Committee's recommendation to offer Javed Khan a second term of four years as a non-executive director of the Trust, to February 2026.

Members of the Nominations Committee*

Name	Role
Heather Byron	Patient governor and lead governor
John Chambers (until July 2021)	Staff governor
Elfy Chevretton (from January 2022)	Staff governor
Annabel Fiddian-Green (to February 2022)	Public governor
John Hensley	Partnership governor (co-opted)
Margaret McEvoy (from February 2022)	Public governor
Hugh Taylor	Chairman
Warren Turner	Partnership governor

*The Nominations Committee is serviced by the Director of Corporate Affairs.

Our membership

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

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

Public – anyone aged over 18 who is living around Guy's and St Thomas' hospitals, Royal Brompton and Harefield hospitals, and the rest of England and Wales.

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

At 31 March 2022 the Trust had 37,666 members, of whom 7,624 were patient members, 8,391 were public members and 21,651 were 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 health seminars.

Council of Governors

Nominated lead governor: Heather Byron

Trust Board Directors attended every Council of Governors meeting.

Patient governors	Elected from	Actual/possible attendance
Victoria Borwick	July 2021	4 / 4
John Bradbury	July 2021	3 / 3
Michael Bryan	July 2021	2 / 3
Heather Byron **[lead governor]**	August 2019	4 / 4
John Knight	July 2019	3 / 4
Leah Mansfield	July 2021	3 / 3
Betula Nelson	July 2019	3 / 4
Trudy Nickels	July 2021	3 / 3
Placida Ojinnaka	July 2018	3 / 3
John Powell	July 2019	4 / 4
Mary Stirling	July 2018	4 / 4
Simon Yu Tan	July 2018 (until June 2021)	0 / 1
Christine Yorke	August 2019	3 / 4

Public governors	Elected from	Actual/possible attendance
Jordan Abdi	July 2021	3 / 3
Martin Bailey	July 2019	2 / 4
Elaine Burns	July 2018 (until June 2021)	0 / 1
Marcia Da Costa	July 2018	4 / 4
Annabel Fiddian-Green	July 2018	4 / 4
Paula Lewis-Franklin	July 2019	3 / 4
Marianna Masters	July 2021	2 / 3
Margaret McEvoy	July 2018	4 / 4
Samantha Quaye	July 2018 (until June 2021)	1 / 1
Sonia Winifred	July 2021	1 / 3
Peter Yeh	July 2018 (until June 2021)	1 / 1

Staff governors	Constituency	Elected from	Actual/possible attendance
Serina Aboim	Community	July 2021	1 / 3
Tahzeeb Bhagat	Clinical	July 2018 (to June 2021)	0 / 1
Mark Boothroyd	Clinical	July 2021	2 / 3
John Chambers	Clinical	July 2018 (to June 2021)	1 / 1
Elfy Chevretton	Clinical	July 2021	3 / 3
Sian Flynn	Non-clinical	July 2021	2 / 3
Tony Hulse	Clinical	July 2018 (to June 2021)	1 / 1
Laura James	Non-clinical	August 2019	3 / 4
Rishi Pabary	Clinical	July 2021	3 / 3
Raksa Tupprasoot	Clinical	July 2021	2 / 3

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

Chief of Staff and Director of Corporate Affairs
4th Floor, Gassiot House
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH

Partnership governors	Organisation	Appointed from	Actual/possible attendance
Sarah Addenbrooke	Royal Borough of Kensington and Chelsea Council	February 2021	2 / 4
Evelyn Akoto	Southwark Council	October 2020	2 / 4
John Balazs	Lambeth CCG	December 2015	4 / 4
Robert Davidson	Southwark CCG	November 2015	0 / 4
John Hensley	Hillingdon Council	February 2021	4 / 4
Jennifer Owen	South London and Maudsley NHS Foundation Trust	August 2020 (until August 2021)	2 / 2
Mary O'Donovan	South London and Maudsley NHS Foundation Trust	September 2021	2 / 2
Lucilla Poston	King's College London	January 2017	0 / 4
Ajay Shah	King's College London	February 2021 (until August 2021)	2 / 3
Warren Turner	London South Bank University	September 2014	2 / 4
Jadwiga Wedzicha	Imperial College London	February 2021	2 / 4
Timothy Windle	Lambeth Council	July 2020	4 / 4

Our organisational structure

Public Board meeting attendance April 2020 – March 2021		
Name	Title	Actual/possible
Ian Abbs	Chief Executive and Chief Medical Officer	4 / 4
Avey Bhatia	Chief Nurse	4 / 4
Paul Cleal	Non-executive director	3 / 4
Steven Davies	Chief Financial Officer (from January 2022)	1 / 1
Jon Findlay	Chief Operating Officer and Deputy Chief Executive	4 / 4
Simon Friend	Non-executive director	4 / 4
Felicity Harvey	Non-executive director	4 / 4
Javed Khan	Non-executive director	4 / 4
Sally Morgan	Non-executive director and Deputy Chair	4 / 4
Jackie Parrott	Chief Strategy Officer (to November 2021)	3 / 3
John Pelly	Non-executive director	3 / 4
Reza Razavi	Non-executive director	3 / 4
Julie Screaton	Chief People Officer	4 / 4
Martin Shaw	Chief Financial Officer (to December 2021)	3 / 3
Sheila Shribman	Non-executive director and Senior Independent Director	4 / 4
Priya Singh	Non-executive director and Deputy Chair	4 / 4
Simon Steddon	Medical Director	4 / 4
Lawrence Tallon	Deputy Chief Executive	4 / 4
Hugh Taylor	Chair and Non-executive director	3 / 4
Steve Weiner	Non-executive director	4 / 4

Committee	Membership April 2021 – March 2022
Audit and Risk	John Pelly (Chair), Paul Cleal (to July 2021), Simon Friend, Priya Singh, Steve Weiner
Finance, Commercial and Investment	Simon Friend (Chair), all Board members
Quality and Performance	Priya Singh (Chair), all Board members
Remuneration	Hugh Taylor (Chair), all other non-executive directors
Strategy and Partnerships	Hugh Taylor (Chair), all Board members
Transformation and Major Programmes	Steve Weiner (Chair), all Board members
Royal Brompton and Harefield Clinical Group Board	Sally Morgan (Chair), Simon Friend, Felicity Harvey, Avey Bhatia, Lawrence Tallon

Board of Directors

Our Board of Directors is made up of our Chairman, Hugh Taylor, ten other non-executive directors and seven executive directors including the Chief Executive, Ian Abbs. Its role is to:

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

Membership is balanced, complete and appropriate. The Trust is confident that all of the non-executive directors are independent in character and there are no relationships or circumstances which are likely to affect, or could appear to affect, their judgement.

During 2021/22 the Board's committees have been:

Audit and Risk – which supports an effective system of integrated governance, risk management and internal control across the Trust's activities, in support of the achievement of the Trust's objectives.

Finance, Commercial and Investment (from July 2021) – which monitors the financial performance of the Trust, its longer-term financial planning and oversees the development and implementation of the commercial strategy;

Quality and Performance – which monitors the overall quality and safety of services provided by the Trust and in-year operational performance.

Remuneration – which is responsible for setting and reviewing the remuneration of the executive team and other very senior managers.

Strategy and Partnerships – which considers the Trust's strategic, long-term plans and has oversight of the establishment of its major, strategic partnerships.

Transformation and Major Programmes – which monitors the Trust's major transformation and development work over the medium term, including the delivery of our estates and digital ambitions.

Royal Brompton and Harefield Clinical Group Board – which has delegated responsibilities and decision-making rights for the strategic and operational running of the services within Royal Brompton and Harefield Clinical Group.

Membership of the Remuneration and Audit and Risk Committees is limited to non-executive directors.

The Chairman evaluates, through appraisal, all non-executive directors and the Senior Independent Director undertakes an evaluation of the Chairman's performance.

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. The appointment, renewal or termination of a non-executive director's appointment is managed by the Council of Governors in a general meeting, advised by their Nominations Committee.

In September 2021 over 100 people attended our Annual Public Meeting, held virtually due to the COVID-19 pandemic, where members, local people, patients, staff and other stakeholders heard about how we have performed during the year. They had an opportunity to meet, and ask questions of the Board including about the work of our staff during the pandemic.

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

Audit and Risk Committee

The Audit and Risk 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.

The Trust has an in-house internal audit function which meets the requirements of the Public Sector Internal Audit Standards, providing independent and

objective assurance to the organisation.

The Audit and Risk Committee 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 June 2022 the Committee reviewed the draft Annual Report and Accounts and approved their submission to the auditors before being laid before Parliament.

During the year, the Committee also received updates about the Trust's Board Assurance Framework and received reports on a number of topics including information governance, cyber security, internal audit and counter fraud performance. Grant Thornton UK, the Trust's external auditors, attended the Committee regularly, providing an opportunity for the Committee to assess its effectiveness.

Audit and Risk Committee membership and attendance 2021/22

Name	Actual/possible
John Pelly [Chair]	6 / 6
Paul Cleal [until July 2021]	3 / 3
Simon Friend	6 / 6
Priya Singh	5 / 6
Steve Weiner	4 / 6

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 2021/22

Name	Actual/possible
Hugh Taylor [Chair]	3 / 3
Paul Cleal	3 / 3
Simon Friend	2 / 3
Felicity Harvey	3 / 3
Javed Khan	2 / 3
Sally Morgan	2 / 3
John Pelly	3 / 3
Reza Razavi	2 / 3
Sheila Shribman	3 / 3
Priya Singh	3 / 3
Steve Weiner	3 / 3

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. These are followed by a meeting of the Council of Governors which opens with a session reflecting on the Board meeting.

Governors attend the Quality and Performance, Finance Commercial and Investment, and the Transformation and Major Programmes Committee meetings, as well as the Royal Brompton and Harefield Clinical Group Board as participating observers. They then report back to their colleagues at the Council of Governors' working groups which are also attended by members of the Board.

In addition, 'accountability sessions' held twice a year allow governors to hold the Board to account for the Trust's performance.

Governors are invited to meet other members at the Annual Public Meeting.

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 Executive Committee

The Trust Executive Committee is the primary executive decision-making forum of the Trust.

The membership of Trust Executive Committee brings together executive board directors, Trust directors and clinical group directors. Its role is to:

- oversee the development and delivery of strategies, plans and policies that enable the Trust to achieve its strategic and operational objectives
- monitor and scrutinise quality of care, operational performance and financial performance, ensuring the Trust adheres to guidelines and meets all relevant standards
- support clinical groups to make operational decisions within their clinical services and with a clear focus on agreed priorities
- provide the Board of Directors with the assurance that the management of clinical and non-clinical services has been subject to scrutiny, and to ensure quality and safe services for patients.

The Trust Executive Committee has established a number of committees to enable it to discharge its functions more effectively. These committees are chaired by senior executive directors. The main committees of the Trust Executive Committee are set out below.

Strategic Finance Committee – oversees the Trust's financial performance and oversees the development and implementation of the Trust's financial strategy.

Strategy and Partnerships Executive Committee – supports the delivery of the Trust strategy by overseeing the delivery of the Trust's strategic objectives, enablers, key programmes of work and external relationships.

Transformation and Major Programmes Executive Committee – enables executive oversight of the effective delivery of the Trust's major programmes in accordance with agreed timescales and budgets. Its focus is on medium term delivery (18 months to three years).

Trust Operations Board – ensures our clinical services are safe, effective, caring, responsive and efficient by monitoring and scrutinising the performance of clinical services across the organisation, and making decisions on the coordination of resources in response to opportunities, pressures and risks.

Trust Risk and Assurance Committee – responsible for overseeing the management of risk and safety across the organisation, whilst ensuring that appropriate governance systems and processes are in place to monitor and deliver high quality, safe patient care.

Our organisational structure

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.

Before joining the Trust he was Permanent Secretary at the Department of Health, from which he retired in July 2010.

Hugh chairs the Remuneration Committee and the Strategy and Partnerships Committee as well as the Trust Board. He has also been the Chair of King's College Hospital NHS Foundation Trust since 1 March 2019. He is a resident of Southwark.

Baroness Sally Morgan
Non-executive director and Deputy Chair

Sally joined the Board in February 2021 having previously been a non-executive director and Chair at Royal Brompton & Harefield NHS Foundation Trust. She was made a life peer in 2001.

She has served as Minister of State in the Cabinet Office, Political Secretary to the Prime Minister and Director of Government Relations at 10 Downing Street, Chair of OFSTED and board member of the Olympic Delivery Authority. Sally is Master of Fitzwilliam College, Cambridge, a post she has held since 2019. Sally chairs the Royal Brompton and Harefield Clinical Group Board.

Dr Priya Singh
Non-executive director and Deputy Chair

Priya was formerly an executive director at the largest international professional indemnity organisation and has a background in primary care and legal medicine.

She brings substantial strategic, risk and safety experience to her role on the Board. She is Chair of the National Council for Voluntary Organisations (NCVO) and Chair designate of the Frimley Integrated Care Board.

Priya joined the Board in November 2015, was appointed Deputy Chair in 2021, and chairs the Quality and Performance Committee.

Simon Friend
Non-executive director

Simon joined the Board in February 2021, having previously been a non-executive director at Royal Brompton & Harefield NHS Foundation Trust since August 2017. Simon was a chartered accountant and partner at PricewaterhouseCoopers LLP (PwC), where his career spanned more than 30 years.

He has a depth of expertise in finance and audit, as well as a thorough understanding of governance across a range of sectors, technical rigor and board experience at the highest level. Simon is also a trustee at Jewish Care, a charity providing residential and day care facilities, a member of Council at the Royal Academy of Arts, non-executive director of Bevan Brittan LLP a national law firm, and a non-executive director of Otsuka Pharmaceutical Europe Limited. Simon chairs the Finance, Commercial and Investment Committee.

Paul Cleal OBE
Non-executive director

Paul has held leadership and advisory positions in a wide range of both public and private sector organisations, including many years spent as a partner at PricewaterhouseCoopers LLP (PwC).

Paul is currently a non-executive board member at Metropolitan Police and equality adviser to the board of the Premier League. He was awarded an OBE for his work promoting diversity and inclusion just before joining the Board in January 2020.

Dr Felicity Harvey CBE
Non-executive director

Felicity has considerable senior leadership and national and international 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, Felicity was Director of the Prime Minister's Delivery Unit. After qualifying in medicine in 1980 at St Bartholomew's Medical College, London, she completed an International MBA.

Since her retirement in 2016, Felicity became a member of the Independent Oversight and Advisory Committee for WHO Health Emergencies (IOAC) at its inception, and has been its Chair since 2018. She is also a Visiting Professor at the Institute of Global Health, Imperial College, London and a non-executive director of Mediclinic International plc, an international private healthcare services group, and of Halcyon Topco Ltd (Sciensus Group). Felicity joined the Board in September 2016.

Dr Javed Khan OBE

Non-executive director

Javed joined the Board in February 2021 having previously been a non-executive director at Royal Brompton & Harefield NHS Foundation Trust. Until recently, he was Chief Executive of the charity Barnardo's and is a leading figure in the UK public and voluntary sectors. Javed regularly advises government ministers, and is a high- profile contributor in the media and at national and international conferences.

Javed has also been a member of the advisory board for the Children's Commissioner for England and the governing body of Hounslow Clinical Commissioning Group. He is Chair designate of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and a member of the Government's Grenfell Recovery Taskforce.

John Pelly OBE

Non-executive director

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 merger of the two hospitals in 1993.

John was subsequently Chief Operating Officer of the 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. John joined the Board in January 2017 and chairs the Audit and Risk Committee.

Professor Reza Razavi

Non-executive director

Reza is Vice President and Vice-Principal of Research at King's College London (KCL), and served as Director of the Medical Engineering Centre of Research Excellence at KCL, funded by the Wellcome Trust and the Engineering and Physical Sciences Research Council, one of four such centres in the UK.

Reza is also a children's cardiologist at Evelina London Children's Hospital. He helped to establish the Trust's cardiovascular MRI service and developed the world's first cardiovascular MRI cardiac catheterisation programme. He also serves as Director of the London Medical Imaging and AI Centre for Value Based Healthcare funded by Innovate UK and Office for Life Sciences. Reza joined the Board in May 2016.

Dr Sheila Shribman CBE

Non-executive director and Senior Independent Director

Sheila was the Department of Health's National Clinical Director for Children, Young People and Maternity for seven years until March 2013.

She was a consultant paediatrician for more than 25 years and was Medical Director of Northampton General Hospital for 11 years where she led the successful integration of children's hospital, community and mental health services, working closely with the local authority. Sheila Chairs the Board of Evelina Women and Children's Clinical Group. She joined the Board in June 2013.

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 retired from his role as Global Controller and part of Unilever's finance leadership team in 2018.

He has extensive experience in making operational and commercial decisions involving large budgets and complex financial constraints, and in leading and developing multi-cultural teams. Steve joined the Board in July 2014 and chairs the Transformation and Major Programmes Committee.

Board of Directors – executive directors

Professor Ian Abbs

Chief Executive and Chief Medical Officer

Ian became Chief Executive in August 2019. He was appointed 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 the Trust's life science partnerships, and has been responsible for many aspects of the Trust's digital transformation and innovation agenda.

Avey Bhatia

Chief Nurse

Avey returned to the Trust as Chief Nurse in November 2020, having trained as a Critical Care nurse at St Thomas' in the early part of her career. Avey qualified in 1991 and her clinical experience includes theatres, general intensive care, coronary care and cardiothoracic nursing.

She became Chief Nurse and Director of Infection Prevention and Control at St George's University Hospitals NHS Foundation Trust in February 2017. Avey holds a postgraduate diploma in health services management and a Masters in Public Administration.

She is also Vice President of the Florence Nightingale Foundation and Honorary Vice President of The Nightingale Fellowship. She is the Trust's Director of Patient Experience, the executive lead for adults' and children's safeguarding and the executive lead for infection, prevention and control.

Steven Davies

Chief Financial Officer (From January 2022)

Steven was appointed as Chief Financial Officer in January 2022. He joined Guy's and St Thomas' in 2018 as Finance Director, leading the finance department, financial management for the Trust and delivering a number of key strategic developments. He has extensive experience of NHS revenue and capital, major projects, change management, contracts, partnerships and commercial activities.

He has worked in the NHS for over 20 years, initially joining the service on the national finance graduate scheme. Steven has worked for a number of NHS organisations in and around London, including Moorfields Eye Hospital NHS Foundation Trust where he was Chief Financial Officer and Deputy Chief Executive.

Jon Findlay

Chief Operating Officer and Deputy Chief Executive

Jon was appointed as Chief Operating Officer 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. He has many years' experience in director-level roles that span clinical operations, service modernisation, performance improvement, human resources and workforce planning.

Julie Screaton

Chief People Officer

Julie was appointed as Director of Workforce and Organisational Development in June 2017 and became Chief People Officer in 2018. Julie has wide ranging experience of leading workforce and organisational development teams in the NHS, having worked at regional and trust level.

In her previous position, as Regional Director, London and the South East for Health Education England, Julie was responsible for £1.4 billion of investment in education, training and workforce development across London, Kent, Surrey and Sussex.

Dr Simon Steddon

Medical Director

Simon has been the Trust's Medical Director since 2016 and became Executive Medical Director in 2019, having originally joined the Trust as a consultant renal physician in 2005. He became a Clinical Director in 2008 and served as the Trust's Chief Operating Officer from 2014 to 2016. He has a PhD from Queen Mary University of London and an MBA from Westminster Business School.

Lawrence Tallon

Deputy Chief Executive

Lawrence was appointed as Deputy Chief Executive in March 2020. Prior to joining Guy's and St Thomas' he was Director of Strategy, Planning and Performance at University Hospitals Birmingham NHS Foundation Trust.

Lawrence has held a wide range of healthcare leadership roles, both in the UK and abroad. He also worked at the Department of Health in the offices of both the Secretary of State and the NHS Chief Executive and was previously Managing Director of the Shelford Group.

Jackie Parrott

Chief Strategy Officer (To November 2021)

Jackie served as Chief Strategy Officer from April 2019 and has over 30 years' NHS experience. She joined Guy's and Lewisham Trust in 1991 as a general manager for women's services. When Guy's and St Thomas' merged she managed a wide range of specialist services including cancer, cardiothoracic and renal services.

Martin Shaw

Chief Financial Officer (To December 2021)

Martin joined the NHS in 1981 and West Lambeth Health Authority in 1983, where he held a variety of posts. He joined Guy's and St Thomas' as Business and Financial Planning Manager, before becoming Strategy Director and Projects Director. He was appointed Finance Director of the Trust in 1998 and made Chief Financial Officer in 2017.

Guy's and St Thomas' has the largest robotic surgery programme in the UK. We were the first Trust in London to adopt the new Versius robot, which has individual 'arms' that can be moved between hospital sites and departments to increase efficiency.

8 NHS System Oversight Framework

NHS England and NHS Improvement's NHS System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes:

- quality of care, access and outcomes
- preventing ill health and reducing inequalities
- finance and use of resources
- people
- leadership and capability.

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers 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.

Segmentation

NHS England and NHS Improvement assigned a score of '2' to Guy's and St Thomas' NHS Foundation Trust in March 2022. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England and NHS Improvement website.

Our commitment to the wellbeing of our staff ranges from wellbeing zones and an outdoor gym to psychological and spiritual support.

9 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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the *Department of Health and Social Care group accounting manual* and in particular to:

- observe the Accounts Direction 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 and Social Care 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
- confirm that 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 the NHS foundation trust's performance, business model and strategy, and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 them 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.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS foundation trust accounting officer memorandum*.

Ian Abbs
Chief Executive and Accounting Officer
22 June 2022

Annual governance statement 2021/22

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the 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 ending 31 March 2022 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Leadership of the risk process

As Chief Executive, I am responsible for overseeing risk management across all organisational, financial and clinical activities across acute and community services. All executive directors report to me and their performance is held to account through both individual and team objectives that also reflect the objectives of the Board.

The governance arrangements underpinning the Guy's and St Thomas' clinical group operating model are kept under regular review. Executive committees have been established to create clear accountabilities and leadership for managing risk, with alignment to Board committee structures. The Board continues to receive regular minutes, reports and assurance from each of its committees to demonstrate the Trust's capacity to handle risk. The Trust Board Assurance Framework aligns with national guidance and reflects assurance on the high-level strategic risks that are deemed the most significant through the year.

The Trust risk management policy, which I own as Chief Executive, was updated and ratified in late 2021 to reflect the new clinical group operating model. It sets out the accountability and reporting arrangements for risk management and the processes that maintain sound internal control. The policy aims to promote a positive culture towards the management of risk and provides clear, systematic approaches to ensure risk assessment is integral to all clinical, managerial and financial processes. A risk strategy is being developed in 2022 to reinforce the Trust's objectives in managing risk and embedding risk management into each of the clinical groups. The Medical Director carries responsibility for ensuring this policy is both implemented correctly and sufficiently effective. The Medical Director, in conjunction with the Chief Nurse, also holds responsibility for clinical governance and the appropriate monitoring of clinical standards.

The Chief Financial Officer oversees the adoption and operation of the Trust standing financial instructions and is the lead for counter fraud. All executive directors, clinical groups and directorate management teams have a leadership role in ensuring a strong risk management approach is operationally embedded in all aspects of the Trust's activities, both clinical and non-clinical, and that risk management is a core component of job descriptions of the Trust's senior managers.

Equipping staff to manage risk

Managers at all levels of the organisation have a responsibility to identify and manage their local risks and to promote an environment where proactive risk reporting identifies perceived or real threats to patient safety. Each clinical group and Essentia, as a delivery group, maintains a group risk register and oversees the management of risk within their respective directorates. Significant or unmanageable risks are escalated for inclusion in the corporate risk register, which is reviewed by the Trust Risk and Assurance Committee for escalation to the Trust Executive Committee.

Trust policies and procedures are authorised statements setting out how the Trust manages particular areas of risk and staff receive training commensurate with their role as part of policy implementation and assurance monitoring. The Trust has worked throughout the year to align existing Royal Brompton and Harefield policies and procedures with those already in place at the Trust. A risk-based approach was used to avoid confusion where policies are not fully aligned and where we must only have one policy, for example our 'risk management policy'. With the forming of the new Heart, Lung and Critical Care Clinical Group, encompassing clinical services from both Royal Brompton and Harefield and Guys' and St Thomas' hospitals, local policies and procedures will be further aligned in 2022.

The Trust learns from good practice through a range of mechanisms including clinical supervision, peer review, internal and external quality reviews, effective performance management, continuing professional development, clinical and internal audit, the application of evidence-based practice and reflective practice.

Learning from investigations such as root cause analyses feeds into our quality improvement initiatives, as well as Schwartz Rounds and our 'Safety connections' campaign. Safety stories are shared with the Trust Risk and Assurance Committee monthly and the Quality & Performance Board Committee. Safety stories and quality initiatives are cascaded throughout the organisation through governance meetings, the monthly 'Quality matters' newsletter, and safety signals, which includes key messages and examples of learning. Our quality committee framework enables clear escalation, discussion and monitoring of quality including identification and managing risks. For 2022, the Trust is working to embed the new Patient Safety Incident Response Framework from NHS England and NHS Improvement. This will involve a renewed incident response plan and incident investigation framework, where training will be provided to group leadership and governance teams to ensure delivery, alongside the use of specialist investigators.

Our internal audit department undertook an annual review of our risk and Board assurance frameworks (BAF) in early 2022. They rated the Trust's capacity and ability to handle risk as 'substantial' and made no significant recommendations. This is in addition to the Trust's annual risk management audit finding strong compliance with the Trust's risk management policy. This continued to be in line with the Care Quality Commission's (CQC) well-led inspection in 2019/20 which rated the Trust as 'Outstanding'.

During the year work was undertaken to identify the full range of the Trust's statutory and regulatory responsibilities and ensure that these were understood by staff and had clear executive ownership. This exercise also led to the development of a comprehensive forward plan

to ensure the Board and its committees are sighted on the Trust's compliance with these responsibilities and can take timely action where risks to compliance arise.

The risk and control framework

Risk management is guided by the risk management policy, but requires commitment, collaboration and participation from all members of staff. The Trust's overall vision is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system (principles, framework and process) in place which is underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust.

The process starts with systematic identification of risks which are then evaluated, graded and either managed locally (with risk control measures identified and implemented to mitigate the potential for harm), or escalated for possible inclusion in the clinical group risk register or corporate risk register. There are clear lines of accountability for the management of risks with an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/ de-escalation and challenge.

A risk management matrix with clear risk descriptors and tolerance levels is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and the Trust's appetite for risk is set within the boundaries of this risk evaluation. The Trust seeks to reduce risks to a level as low as reasonably practicable, however it is recognised that delivering healthcare carries inherent risks that can never be completely eradicated. The Trust recognises that a key factor in driving its priorities is to ensure that effective risk management arrangements are in place and embedded in the organisation's practices and processes. The Board and its committees are aligned to assure that there is independent and strategic focus on risk and assurance.

A serious incident assurance panel, chaired by the Deputy Medical Director or Director of Quality and Assurance meets monthly with multiple internal and external stakeholders to ensure detailed scrutiny of, and learning from incidents, as well as the early identification of emerging themes and associated organisational risks.

During 2021/22 we embarked on a review of our corporate governance structures following the merger with Royal Brompton & Harefield NHS Foundation Trust. Our arrangements provide the necessary support to deliver our operational priorities, improvement plans and strategic ambitions. This included a refreshed Executive committee structure to ensure optimal assurance and alignment to Board committees. A new scheme of delegation was created, providing corporate reporting from Royal Brompton and Harefield hospitals to the Trust Board in accordance with the organisation's clinical group operating model. The Trust Executive Committee continues to reinforce the importance of clinical leadership and oversees a number of supporting sub-committees.

The Board Assurance Framework sets out the principal risks to delivery of strategic objectives and the key controls and assurances available to the Board of Directors on management of these significant areas of risk. The Board Assurance Framework incorporates four tiers of assurance encompassing day-to-day management, performance and oversight of controls, internal objective assurance, and external independent assurance. It highlights nine areas in 2021/22 where the Board has limited or partial assurance despite significant management attention:

- maintaining operational performance with increasing patient demand that exceeds the Trust's capacity
- ensuring the Trust consistently delivers high quality care to patients
- improving or flexing its estate to meet the growing demand for care
- ensuring there are processes in place to meet its commercial ambitions
- managing the breadth and complexity of the organisation's strategic agenda
- operating in an uncertain environment where potential future legislative changes could impact the Trust's objectives
- working with local partners to improve health inequalities
- delivering the new complete electronic health record to support operational delivery
- alignment with local strategic partners to achieve integration

Each year the Board completes a formal strategic risk review to identify new or continued principal risks which might threaten the achievement of the Trust's strategy and assigns them to a lead executive director. These risks are taken forward for the new financial year and overseen through the Board Assurance Framework by the appropriate executive and Board committee.

For 2021/22, the Trust utilised many central control and assurance functions to ensure continued identification and evaluation of risk. These included:

- effective mechanisms in place to act upon national safety alerts and recommendations issued by all bodies such as the MHRA and NHS Improvement
- our performance management framework, including an Integrated Performance Report across all clinical groups
- analysis of patient experience, ward-level performance, incidents and complaints, monthly financial reporting and quality improvement activity
- assurances provided through the work of the Trust Risk and Assurance Committee and executive sub-committees across quality performance and risk
- learning from deaths, emergency preparedness and data security
- risk assessments and analysis of risk registers and the Board Assurance Framework
- assurance from the Quality and Performance Committee and the Audit and Risk Committee to the Board
- clinical audit, including national audits, audits arising from national guidance (for example from NICE), confidential enquiries and local audits related to patient safety and quality of care
- internal assurances through our internal audit department and independent, objective quality reviews within the quality and assurance team
- external regulatory and assessment body inspections and reviews including the Care Quality Commission (CQC), Royal Colleges, Postgraduate Deanery, Information Commissioner's Office and Health and Safety Executive reports
- self-assessment against the compliance framework and CQC registration requirements, including well-led reviews
- freedom to speak up guardian and guardian of safe working hours (for doctors in training).

Quality governance arrangements

Our quality governance framework is built upon the principles described within the eight domains of NHS Improvement's well-led framework and the Trust corporate governance statement.

Quality is deeply embedded in the Trust's overall strategy. Our refreshed organisational strategy 'Together we care' was developed in liaison with staff, governors and wider partners and approved by the Board in July 2018. The strategy reinforces the central importance of the Trust's values and has three overarching priorities: Patients, People and Partnerships. Work on delivery is managed and monitored under a 'Strategy into action' programme. In addition, the Trust's quality

strategy has entered its final year, focusing on delivering safe, effective care that provides a positive patient experience and a strong safety culture. The Board actively engages in quality of care with patients, the public, staff and other relevant stakeholders through a number of different mechanisms and forums.

Quality targets are linked to clinical groups and quality governance is delegated to each Group, with assurance reported quarterly to the Trust Risk and Assurance Committee and ultimately the Quality and Performance Board Committee. The Board receives the monthly Integrated Performance Report, with up-to-date information on key quality, safety and performance indicators including patient safety, patient experience and clinical effectiveness.

The Trust's Scheme of Delegation details decisions reserved for the Board and its committees. This has been reviewed as part of the overall governance review to align with devolved responsibilities of the clinical groups and was approved in February 2022.

We have established five closely-related clinical groups that will provide world-class care to the diverse communities that we serve, and will be supported by our corporate services. These clinical groups are:

- Cancer and Surgery
- Cardio-Respiratory and Critical Care
- Evelina London – Women's and Children's Services
- Integrated and Specialist Medicine
- Royal Brompton and Harefield.

In April 2022 we transitioned from five clinical groups to four which saw the adult services at Royal Brompton and Harefield and Cardio-Respiratory and Critical Care Clinical groups integrate into a new clinical group called Heart, Lung and Critical Care and the paediatrics services in Royal Brompton and Harefield Clinical Group transition into the Evelina London Women's and Children's Clinical Group.

Within each clinical group, clinical directorates remain the key building blocks of our success and will continue to ensure that strong clinical leadership remains at the heart of decision making at all levels of the Trust. The clinical groups require the autonomy to deliver quality services and meet their regulatory requirements. Each directorate has a Clinical Governance Facilitator and/or a Quality Improvement Projects Manager or Facilitator, in addition to the usual Clinical Lead and Senior Nursing team to support the quality and assurance work. In addition the clinical groups now have a dedicated Head of Patient Safety, Quality and Assurance and a Head of Corporate Governance to support the work. Each clinical group has an internal structure to oversee quality and safety which ultimately reports through existing structures up to Board level.

During 2021/22 Essentia, the in-house provider of capital, estate and facilities services across the Guy's and St Thomas' estate, was established as a 'delivery group' to distinguish it from the Trust's corporate functions and clearly align it with clinical groups as a provider of operational services. This will further devolve operational decision-making to a local level and improve the ability of the Trust Board to hold Essentia accountable for the provision of the infrastructure that has a direct impact on quality, safety and patient experience.

The governance arrangements underpinning the Trust operating model are kept under close review to ensure that issues and risks relating to quality of care are managed and where necessary escalated appropriately, and also to identify areas for improvement in executive or Board oversight of the performance of the clinical groups.

Assessing the quality of performance information

Our data-driven performance framework is used to monitor key performance indicators at directorate, clinical group and Trust level, with a monthly Integrated Performance Report collating trends, analysis and action plans for Board review and public scrutiny. A risk-based assessment of the data associated with key indicators helps determine the programme undertaken by the Trust's internal audit department and the quality of our information is also audited externally.

Assurance on compliance with the Health and Social Care Act 2008

The Trust is fully compliant with the registration requirements of the CQC. A range of mechanisms are in place to provide assurance of compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, as set out in the CQC's guidance for providers. These include a well-established programme of multidisciplinary quality visits to services, peer-to-peer reviews and directorate management self-assessments. These have, understandably, had to take different formats during the global pandemic and the team has adapted the methodology to use a table top reviews and systematic assurance triangulated through the Trust's corporate governance structure. The Trust underwent a full assurance review and re-registration of Royal Brompton & Harefield Hospitals in 2021 in order to meet registration requirements under the Health and Social Care Act 2008. The Trust has undertaken multiple provider engagement meetings with our CQC liaison team, providing assurance on our maternity services, emergency department, infection control and operational recovery during the pandemic.

The CQC carried out an unannounced inspection of our Emergency Department at St Thomas' Hospital in June 2021, notably to review mental health service provision in the department. No ratings were changed following the inspection, where the CQC noted the excellent care being provided despite the challenging circumstances around mental health beds nationally. The Trust remains rated as 'good' overall and rated 'outstanding' for well-led following its last full inspection in 2019/20.

Managing risks to data security

Cyber risk is formally included on the Trust corporate risk register with an action plan in place to ensure that appropriate cyber risk mitigations are deployed.

All staff receive data security training as part of their corporate induction upon joining the Trust, with annual information governance and information security training mandated for all staff. Training requirements are supported by comprehensive policies and guidance to ensure access to relevant and up-to-date information.

An information asset owner (IAO), with responsibility for managing information risks, is named for each key information asset and is supported by specialist information security and information governance staff. Registers of information assets, flows and uses are maintained, reviewed and updated in year.

The Trust's annual Data Security and Protection Toolkit submission to NHS Digital on 30 June achieved an assessment of 'Standards Not Met – Plan Agreed', reflecting the need to upgrade the Trust's Windows 10 IT environment. The Trust's IT team have subsequently submitted an approved plan for this to NHS Digital, along with quarterly progress updates. The current status for the Trust is 'Approaching Standards'. As the Windows 10 roll-out is not expected to be completed until the end of October 2022 it is anticipated that the Trust will not be able to achieve a full 'Standards Met' rating for the June 2022 Data Security and Protection Toolkit.

Managing risks from legacy IT systems

The Trust has a sizable technology debt in terms of the continued use of legacy IT systems. Delivery of the Trust's new electronic health record system (Epic) by April 2023 will address this risk. In the interim, a significant financial investment has been put in place to deliver a programme of work to fully replace or upgrade key Trust systems and infrastructure, including upgrades to the Trust's internal network and telephony systems, and deployment of an 'evergreen' Windows 10 capability.

The Trust has commenced a large scale technology programme to mitigate the most serious legacy risks and ensure the Trust's core infrastructure is stable and secure in order to leverage the benefits of the investment in the Epic software. The Strategic Network Programme is in delivery with the core communications rooms being upgraded with modern technology and addressing the 'black spots' in WiFi across the Trust; the Windows 10 Evergreen programme is starting to deploy the new Windows 10 operating system in April 2022 in readiness for the Epic go-live and the telephony replacement business case was approved in April 2022.

Information incidents

All information incidents and near misses are investigated and used as opportunities to improve processes and reduce risk. This is reinforced by information governance and information security awareness training that focuses on the need for safe processing and protection of personal and sensitive data.

In 2021/22, six information incidents within the Trust (including Royal Brompton and Harefield Hospitals) met the threshold for notification to the Information Commissioner's Office. Of these:

- Three incidents related to cyber events
- One incident related to physical premises break-in and paper records access
- One incident related to confused patient records
- One incident was recorded after inappropriate use of patient data by a member of staff at the Trust Vaccination Centre

Four of these incidents were closed with no further action required by the Information Commissioner's Office after their review. Feedback regarding the remaining two incidents (relating to cyber hacking of an employee's account and subsequent access to a shared folder, and the confused patient record) is awaited from the Information Commissioner's Office.

Major in-year risks 2021/22

The key risks to delivery of the Trust's strategic aims are recorded in detail in the Board Assurance Framework and monitored quarterly by the Board through its committees acting on its behalf. In 2021/22 the principal risks with potential impact on achieving our objectives were:

- the Trust may fail to deliver safe, high quality care to patients, or to maintain the health and safety of patients, staff and visitors across all sites in line with regulatory and national standards
- the Trust may be unable to ensure the resilience of its workforce by failing to maintain staff health and wellbeing, which will further undermine the Trust's ability to deliver services
- the Trust may be unable to successfully 'land' the implementation of the Trust's new electronic health record system due to the readiness of the technology, underpinning infrastructure, and workforce capability
- the Trust is required to manage a continuing pandemic and face future threats requiring emergency response, which may impact the Trust's ability to maintain services and recover in line with national and strategic demands
- the Trust may fail to deliver all its planned major programmes and projects, or fail on completion and integration of its major programmes, due to internal and external pressures
- the Trust may fail to align with local strategic partners to achieve integration which could result in the failure to deliver joint outcomes to improve health equality and fulfil our role as an anchor institution.
- the breadth and complexity of the Trust's strategic agenda, including an increasing number of strategic partnerships, could destabilise delivery of quality, finance and performance
- continued patient demand may significantly exceed the Trust's capacity and potentially its ability to provide safe and effective care to meet constitutional standards
- the Trust may be unable to improve and develop its estate to meet growing demand and the emerging operating model, particularly in the context of a rapidly changing national capital approval process
- the Trust may not achieve its ambition in relation to its commercial opportunities at the desired scale and pace without sufficiently robust governance and assurance processes
- the failure to recruit and retain staff and senior leaders with the right skills and behaviours may undermine the Trust's ability to deliver services in line with agreed quality standards and strategic priorities
- the Trust may be unable to maximise the opportunities arising from research and life sciences, and may fail to attract sufficient investment to remain a research industry leader
- the Trust may be unable to sustain financial efficiencies and secure sufficient income and/or capital for services curtailing its ability to deliver high quality care
- the Trust operates in a highly uncertain policy and legislative environment where the centralised national response and impending changes to NHS policy may negatively impact the Trust's aims, strategy and partnerships.

Major in-year risks 2022/23

As with all NHS organisations, we face continual challenges in balancing the delivery of high quality care with rising demand, rising acuity, rising rates of inflation and the need to increase both productivity and efficiency to meet challenging activity requirements. Successful implementation of the EPIC system from April 2023 will be critical in enabling the Trust to do this in the future. We recognise that strategic and transformational change internally and across our local health economy will be required to address any risks that we identify.

As the COVID-19 pandemic appears to subside, it has left significant and unique operational and strategic challenges to the Trust, most notably around workforce resilience, elective recovery and economic uncertainty. These challenges will be the same across the NHS and the country as a whole. The legacy of COVID-19 has been, and will continue to be, felt across all our services and threaten the achievement of the Trust's objectives.

The same principal strategic risks for the organisation in 2021/22 will therefore be carried forward into 2022/23, but the effectiveness of their controls and sources assurance will need to continue to be assessed in light of the challenges facing the Trust and ongoing developments. A full review of these risks will be undertaken by the Board in 2022/23.

NHS Improvement well-led framework

In 2021/22 the Trust has kept its corporate governance arrangements under review to ensure it meets the standards set out in the NHS Improvement well-led framework. This included the establishment of a new Finance, Commercial and Investment Board Committee to both monitor the Trust's financial performance and also to oversee and steer the Trust's response to the considerable financial challenges, uncertainties and opportunities that lie ahead. At an executive level, the Trust Operations Board was stood up in mid-2021, having been paused during the first wave of the covid-19 pandemic as the Trust moved to a critical incident mode. This forum is responsible for overseeing operational issues and performance across the clinical groups and corporate functions.

Significant work has been done to refine the governance arrangements within each of the Trust's clinical groups, to ensure

these complement the governance structures in place at an executive level and to ensure the clinical groups are able to discharge their increasing responsibility for operational leadership and for the delivery of Trust strategy in their areas.

Risks to foundation trust governance and corporate governance statement assurance

To assure itself of the validity of its corporate governance statement, as required under NHS Foundation Trust condition 4(8) (b), the Trust has assessed its compliance with the Code of Governance via its Audit and Risk Committee.

Embedding risk management and incident reporting

The ways in which risk management is embedded in the Trust is covered in the risk and control framework above. The Trust's overall vision is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system in place (principles, framework and process) which is underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust. The Trust has set the following risk management objectives to achieve this vision:

- Minimise the potential for harm to people (patients, staff and visitors) and protect everything of value (high standards of care, reputation, assets and finance) to a level as low as reasonably practicable.
- There are clear lines of accountability for the management of risks.
- All staff are competent and supported in the reporting and management of risks, and not blamed or seen as unduly negative for identifying these.
- There is an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/de-escalation and challenge.
- Inform policy, operational and strategic decisions by anticipating and responding to changing circumstances, and identifying risks and their potential impact.

All staff are encouraged to report incidents and near misses as part of an open and fair culture. During 2021/22, the Trust continued to have one of the best incidents reporting rates and low levels of harm despite the impact of COVID-19, indicating a positive safety reporting culture. Training is given to all staff at induction, including junior doctors, newly-appointed governance leads and newly-qualified nurses/midwives. The electronic incident reporting system gives feedback when an incident is investigated if the member of staff wishes to receive this.

Staff are prompted by the incident reporting system to follow the 'duty of candour' process, with duty of candour information and training widely available.

The Trust's commissioners have praised improvements in processes, structures and outcomes for the management of serious incidents, including the timeliness and quality of reports.

In 2021/22 however, the Trust reported seven 'never events'. This is an increase of three on the previous financial year and a key quality objective continues to be working towards a reduction in the number of 'never events' and will be taken forward in the Trust's patient safety incident response plan for 2022/23. All reported incidents are fully investigated to ensure the lessons are learnt and shared across the Trust. Any themes are identified, so that future recurrences can be prevented by coordinated work.

The Trust has robust controls in place to manage the risk of nosocomial (hospital-acquired) infections. These controls are reviewed regularly by the Trust's infection, prevention and control assurance committee to ensure they remain fit for purpose.

Equality, diversity and inclusion compliance

Control measures are in place to ensure that all obligations under equality, diversity and human rights legislation are complied with in line with the requirements of the Public Sector Equality Duties under the Equality Act 2010.

We recognise that we need to do more to reduce inequalities and disparities for our diverse workforce and population. The Trust has a comprehensive plan to address this, which includes:

- ongoing training on bias, micro-aggression, allies and building cultural competency
- continuous Trust-wide engagement on current issues and experiences including the impact of COVID-19 and mandatory vaccination as a condition of deployment (VCOD)
- maintaining strong alliances with our staff networks across the Trust
- an ambitious 10-year plan to improve ethnic diversity in senior roles
- ensuring all staff have equality of opportunity for career progression and development by ensuring structural processes are equitable, transparent and free from bias and discrimination
- reviewing and improving the way we develop, design and deliver services to meet the needs of all of our staff and patients
- analysing patient feedback, including from the Friends and Family Test, broken down by protected characteristics
- working with patients and their carers to ensure that our environment, facilities and communications are accessible to all.

We have established a reverse mentoring programme where executive directors are involved as mentees to create culture competency and confidence across the organisation.

The Trust publishes data from the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) annually and analysis is undertaken to inform local and Trust-wide improvement plans in collaboration with our staff networks representing our LGBT+, Black, Asian and minority ethnic, multicultural, disability and long-term condition and dyslexic/neurodiverse staff. Staff are encouraged to actively participate in all staff networks and broader activity such as the South East London women's leadership group, as well as through staff side colleagues. The Trust uses disclosures on protected characteristics to improve staff side engagement and experience, while ensuring opportunities are equitable, including meeting reporting requirements in relation to gender pay gap (sections 2 and 6 of the Annual Report). We will be looking at addressing other pay gap inequality beginning with an ethnicity report.

The Accessibility Steering Group ensures that the Trust is meeting the information and physical accessibility needs of patients and carers who are vulnerable or have physical and sensory disabilities, and that we are compliant with the Accessible Information Standard and Public Sector Equality Duty.

Equality impact assessments are an integral part of the Trust's patient and public engagement toolkit and inform the engagement strategy during any transformation or service change. They are required for all new Trust business cases and during all policy development, including those related to employment.

Public stakeholders' involvement in managing risk

The Trust's patient and public involvement policy and guidance ensures compliance with relevant legislation, and is described in 'Putting patients first: a policy for patient and public engagement and consultation'.

All departments, both clinical and non-clinical, are responsible for planning and undertaking patient and public involvement initiatives.

The Trust serves a diverse and dispersed community, which straddles a

number of boundaries. Given these complexities, there is a strong desire to work closely with the local community to provide coherent and effective services.

The Trust provides information and assurance to the public on its performance against its principal risks and objectives in a number of different ways including:

- Guy's and St Thomas' NHS Foundation Trust has approximately 37,000 members at the end of March 2021 following the merger with Royal Brompton & Harefield NHS Foundation Trust. These are represented by a Council of Governors that comprises public, staff and stakeholder governors
- the Council of Governors receives regular updates on the status of the Board objectives and uses this, along with the ratings by NHS Improvement and the CQC, to hold the non-executive directors to account for the performance of the Board
- involving (where necessary undertaking wider public consultation with) patients, carers and the public in developing new services and where key changes are proposed to existing services which may impact upon them
- the Council of Governors is informed of proposed changes, including how potential risks to patients will be minimised, through its relevant working groups
- the Trust has an agreed process to advise and engage with Southwark and Lambeth overview and scrutiny committees when there are proposed changes that may impact on service users
- the Trust Healthwatch liaison group meets quarterly to enable regular liaison and communication between the Trust and local Healthwatch bodies.

Compliance with developing workforce safeguards recommendations

The Trust Board approved a new 'People strategy' in April 2019 that sets out the workforce priorities and plans for the period 2019-2023, aligned with 'Together we care', the Trust's corporate strategy. As part of the annual business planning cycle, an annual workforce planning process is run to triangulate staffing with predicted activity levels and finance plans. Directorate-level plans are aggregated to form an overall Trust plan, with strategies and business cases to close potential workforce shortfalls considered through the relevant committees.

Workforce metrics are monitored regularly to ensure safe staffing levels. Local and Trust-wide strategies are in place to support the recruitment and retention of staff as well as to reduce our reliance on temporary staff. Longer-term workforce plans include the consideration and implementation of new roles, such as the physician associate and nursing associate roles within the appropriate governance frameworks. To ensure staff have the right skills commensurate with their role, a wide range of training and development is provided both Trust-wide and within directorates and clinical groups. Ongoing training requirements are monitored through annual appraisal and revalidation, performance development review and monthly statutory and mandatory training reports.

Staffing levels are reviewed regularly and e-rostering systems are in place for nursing and medical staff. Staffing levels are managed to ensure resources are deployed for optimum efficiency taking into account patient acuity. The Trust is compliant with Workforce Safeguards (NHSI 2018) which incorporates the National Quality Board standards. The Trust has a number of workforce controls in place to reduce reliance on agency staff; for example, local sign-off on the use of agency staff and restrictions on usage for specific groups and bands of staff, depending on safe staffing levels.

Key performance indicators are reviewed monthly at Trust, clinical group, directorate and cost centre level. The Trust regularly reviews 'Model Hospital' metrics with other trusts to ensure safe staffing levels and to benchmark workforce productivity, including skill mix and staff costs per weighted activity unit.

Compliance statements

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

The Trust has also published a separate up-to-date register of interests for the full Board of Directors and maintains a separate register of interests for the Council of Governors.

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.

The Trust has workforce control measures in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This includes Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Impact Assessments (EIA) and People Strategy objectives.

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust's 'Green plan' is its new Sustainability strategy (2021-2031) which was publicly launched in June 2021. This Strategy covers both climate change mitigation and adaptation, and complies with the 'net zero' statutory target set by the Climate Change Act 2008 and sector targets set in the 'NHS Net Zero' report. The Strategy comprises three strategic themes: 'Carbon zero', 'Connecting with nature' and 'Cycle of resources' and will be implemented through a series of management plans and governed through a Sustainability Steering Committee.

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

Key processes for efficient and effective use of resources

In normal circumstances the Trust ensures economy, efficiency and effectiveness through a variety of means, including:

- a robust pay and non-pay budgetary control system
- a suite of effective and consistently applied financial controls
- effective tendering procedures
- robust establishment controls
- annual external audit
- continuous service and cost improvement and modernisation.

The Trust benchmarks efficiency in a variety of ways, including through the national reference costs index and by use of national benchmarking data, Getting It Right First Time (GIRFT) and use of the 'Model Hospital' data sets. This is shared with directorates for use in business planning and to identify improvement opportunities.

The emphasis of internal audit work is on governance and internal control processes. Where scope for improvement is identified during

an internal audit review, appropriate recommendations are made for operational implementation. During this financial year the usual contract income payments have been replaced by a block payment system together with a cost reimbursement mechanism to provide financial stability and control during the COVID-19 pandemic.

Data quality and governance

The quality and assurance teams work closely with colleagues in the informatics function to ensure data provided to the Board is validated and accurate. Both teams have a variety of skills and expertise including analytics. This includes oversight by those with expertise in the relevant field; for example, the head of complaints would sign off any complaints data, ensure that correct processes have been applied to reporting the data from the system and that the data set is complete.

The quality and assurance teams collate data monthly from a variety of sources for the executive performance review meetings (PRM) and Integrated Performance Report. Primary sources include our local risk management system, which holds all incident, complaints, legal services, risks and safety alert databases. A senior clinical analyst validates the data and issues the PRM packs monthly to services, which feeds into the Integrated Performance Report for data accuracy, validity and alignment.

In some cases, data is owned by a governance committee, for example the acutely ill patients group is responsible for the collection and validation of data relating to the deteriorating patient and response times in relation to this. The group would also agree whether that data represented a good position or if improvement was needed, through assurance reporting to the executive.

The Trust has a number of policies and protocols which describe the desired outcome or key performance indicator (KPI) which assists the Trust Board in determining if they are assured by the data they are receiving. For example, the Trust's position relating to mortality outcomes is demonstrated by the Summary Hospital-Level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) which are benchmarked nationally to give Board members a clear picture of the Trust's performance in this area. A range of audits – internal and external – give assurance about the accuracy of data throughout the year.

The Trust has a Quality and Performance Committee where all data and information relating to quality of care and patient experience is reviewed.

The Trust employs rigorous information assurance processes in the production of the monthly Integrated Performance Report at both Clinical Group and Trust level, including local and Trust-wide validation of data and national benchmarking where available. The Integrated Performance Report is published as part of the Board papers and is available on the Trust's website.

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 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, the Audit and Risk Committee and the Quality and Performance Committee, and plans to address weaknesses and ensure continuous improvement of the system are in place.

Processes for maintaining and reviewing the system of internal control

The Board

While the COVID-19 pandemic continued to create significant operational challenges in 2021/22 the Board and its committees met regularly and kept arrangements for internal control under review through discussion and approval of policies and procedures and monitoring of outcomes agreed as indicators of effective controls.

Through its committees, the Board regularly reviews reports on operational performance, including the monthly Integrated Performance Report, which covers key national priority and regulatory indicators with additional sections devoted to safety, clinical effectiveness and patient experience. The report is supplemented by more detailed briefings on areas of adverse performance. The Integrated Performance Report is supported by more granular reports reviewed by Board committees, regular executive review meetings, and performance review meetings between the Trust executive team and each of the clinical group executive teams.

Audit and Risk Committee

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

Quality and Performance Committee and Trust Risk and Assurance Committee

The Quality and Performance Committee is a sub-committee of the Board of Directors and oversees the Trust's quality assurance agenda through monitoring and reviewing the quality, safety and performance of services against national standards.

The Trust Risk and Assurance Committee reports to the Trust Executive Committee, which, in turn, reports to the Quality and Performance Committee at the Trust Board. It ensures that appropriate governance systems and processes are in place to monitor any risk to the delivery of high quality, safe patient care, including review of the Trust's clinical procedures and guidelines. It works in tandem with the Trust Operations Board to ensure internal systems of control exist to oversee operational issues and performance across the clinical groups and corporate functions.

Internal audit

Internal audit works to a risk-based audit plan, agreed by the Audit and Risk Committee. Its remit covers 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 and Risk Committee.

Internal audit reports are also made available to the external auditors, who may use these to inform 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 includes 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 and counter fraud staff covering the period 1st June 2021 to the date of this opinion. Internal Audit set out a work plan in June 2021 and has completed 27 projects. This included eight reviews within Heart, Lung and Critical Care Clinical Group (previously Royal Brompton & Harefield NHS Foundation Trust), including in-depth reviews of the financial systems and payroll and pensions. These key systems are yet to be integrated with the wider Trust systems and controls were assessed and transactions processed were examined. In most cases the reviews were rated as 'substantial' assurance, with no material weaknesses. In addition, the Trust in the process of implementing a new finance system and a review of the User Acceptance Testing aspect found this area to be effectively managed.

There were changes and additions to the plan during the year with a number impacted by the ongoing COVID-19 pandemic. These were reported at the time to the Audit and Risk Committee. Primarily, this was due to management and staff unavailability within departments. Whilst the internal audit team, predominantly, worked remotely during the year, where necessary staff attended site to conduct audit/counter fraud work.

There were no limitations placed on the scope of internal audit work and the service operated in accordance with the Audit Charter.

I have also considered reactive and proactive work conducted by the Guy's and St Thomas' local counter fraud specialists. This includes oversight of all 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 control processes were changed, these were properly documented and authorised. Where weaknesses have been identified as a result of audit or counter fraud reviews these have or are being addressed by management and actions have been confirmed through follow up work by internal audit.

I am satisfied that the Board Assurance Framework contains the key risks faced by the organisation and that the Board and relevant responsible committee has effective oversight of the key risks.

I confirm that I have monitored compliance with the Public Sector Internal Audit Standards. In my view, Internal Audit complies with those standards that are applicable to the public sector. This compliance was further assured during the year by an independent external assessment, reported to the committee in September 2021. The overall finding from the assessment was: 'It is our opinion that the Shared Internal Audit Service's self-assessment is accurate and as such we conclude that they generally conform to the requirements of the Public Sector Internal Audit Standards."

Clinical audit

The Trust's Quality Improvement and Clinical Audit Committee (TQIaCAC) reports to the Trust Risk and Assurance Committee and the Quality and Performance Committee. TQIaCAC approves and monitors the annual quality improvement and clinical audit programme and ensures that the Trust participates in all appropriate national audits. External reviews, whether by regulators or invited peer reviews, are monitored through the Trust Risk and Assurance Committee, with an annual report on external review activity provided to the Trust Quality and Performance Committee.

Conclusion

To the best of my knowledge no significant internal control issues have been identified in 2021/22. I am confident that the internal control systems are operating well and that the work we have done to maintain and develop our risk management systems will help us to consolidate this position in the future. The Trust is committed to the continuous improvement of the processes of internal control and assurance. A review of the processes and systems that ensure the completeness, effectiveness and accuracy of the Trust's Board Assurance Framework and risk management processes by internal audit concluded that there is substantial assurance overall.

Ian Abbs
Chief Executive
22 June 2022

In March 2022 The Trust was awarded £11.8m by the National Institute for Health Research (NIHR) to support and expand our Clinical Research Facilities.

10 Annual accounts

Foreword to the accounts

These accounts, for the year ended 31 March 2022, 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.

Ian Abbs
Chief Executive and Accounting Officer
22 June 2022

Independent auditor's report to the Council of Governors of Guy's and St Thomas' NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Guy's and St Thomas' NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2022, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Consolidated Statement of Changes in Taxpayers Equity, Statement of Changes in taxpayer's Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2022 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the group and Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2021/22 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer [set out on page 65], the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2021/22, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

The Audit and Risk Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the group and Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit and Risk committee, concerning the group and Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the group and Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and any other fraud risks identified for the audit.. We determined that the principal risks were in relation to:
  - unusual journals, year-end journals, accrual journals, potential management bias in relation to accounting estimates, and critical judgements.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on unusual journals, as deemed appropriate by the audit team, year-end journals and accrual journals**;**
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations,Investment Properties, accruals both income and expenditure, provisions and allowance for doubtful debts;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to land and building valuations, Investment Properties, accruals both income and expenditure, provisions and allowance for doubtful debts**.**
- Assessment of the appropriateness of the collective competence and capabilities of the group and Trust's engagement team included consideration of the engagement team's;
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and Trust operates
  - understanding of the legal and regulatory requirements specific to the group and Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied 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 guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Guy's and St Thomas' NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

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 Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Signature: *Paul Dossett*

Paul Dosset, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

Date: 22nd June 2022

Consolidated statement of comprehensive income for the year ended March 31 2022

	NOTE	March 31 2022 £000	March 31 2021 £000
Operating income from patient care activities	3	**2,271,972**	1,632,297
Other operating income	4	**367,485**	367,069
TOTAL INCOME		**2,639,457**	1,999,366
Operating expenses	6.1	**(2,596,004)**	(2,004,561)
OPERATING SURPLUS/(DEFICIT)		**43,453**	(5,195)
FINANCE COSTS			
Finance income	9	**142**	43
Finance expenses	10	**(6,023)**	(5,682)
Public Dividend Capital dividend payable	35	**(29,237)**	(18,814)
Net finance costs		**(35,118)**	(24,453)
Other (losses)/gains	8	**(8,749)**	6,232
Share of profit of associates / joint ventures	18.1	**34**	979
Gains from transfers by absorption		**–**	286,937
Corporation tax (expense)	11	**(783)**	(1,601)
(DEFICIT)/SURPLUS FOR THE YEAR		**(1,163)**	262,899
Other comprehensive income/(expense)			
Impairments	15	**(19,601)**	(22,842)
Revaluations	17	**107,101**	18,216
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**86,337**	258,273

The notes on pages 86 to 117 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Note 12 includes the Trust's analysis of performance.

Statements of financial position as at 31 March 2022

		GROUP		TRUST	
	NOTE	**March 31 2022 £000**	March 31 2021 £000	**March 31 2022 £000**	March 31 2021 £000
NON-CURRENT ASSETS					
Property plant and equipment	13	**1,564,301**	1,415,301	**1,564,162**	1,415,133
Intangible assets	14	**132,939**	101,759	**132,939**	101,759
Investment property	16	**80,359**	90,190	**80,359**	90,190
Investments in joint ventures and associates	18.1	**1,345**	215	**2,050**	2,050
Other investments/financial assets	19	**146**	146	**9,667**	8,479
Trade and other receivables	21.2	**16,623**	15,595	**8,014**	7,159
TOTAL NON-CURRENT ASSETS		**1,795,713**	1,623,206	**1,797,191**	1,624,770
CURRENT ASSETS					
Inventories	20	**44,374**	44,652	**44,374**	44,652
Trade and other receivables	21.1	**172,836**	146,910	**169,196**	144,969
Cash and cash equivalents	24	**220,946**	323,800	**215,770**	318,167
TOTAL CURRENT ASSETS		**438,156**	515,362	**429,340**	507,788
CURRENT LIABILITIES					
Trade and other payables	22.1	**(375,104)**	(380,663)	**(372,543)**	(378,036)
Borrowings	22.3	**(21,099)**	(25,879)	**(21,099)**	(25,879)
Other liabilities	22.2	**(69,866)**	(39,532)	**(69,204)**	(39,297)
Provisions	23.1	**(4,211)**	(9,069)	**(4,211)**	(9,069)
TOTAL CURRENT LIABILITIES		**(470,280)**	(455,143)	**(467,057)**	(452,281)
NON-CURRENT LIABILITIES					
Borrowings	22.3	**(215,049)**	(245,750)	**(215,049)**	(245,750)
Provisions	23.1	**(14,761)**	(13,513)	**(14,702)**	(13,480)
TOTAL NON-CURRENT LIABILITIES		**(229,810)**	(259,263)	**(229,751)**	(259,230)
TOTAL ASSETS EMPLOYED		**1,533,779**	1,424,162	**1,529,723**	1,421,047
TAXPAYERS' EQUITY					
Public Dividend Capital		**561,526**	538,246	**561,526**	538,246
Revaluation reserve	17	**519,339**	431,839	**519,339**	431,839
Other reserves		**743**	743	**743**	743
Income and expenditure reserve		**452,171**	453,334	**448,115**	450,219
TOTAL TAXPAYERS' EQUITY		**1,533,779**	1,424,162	**1,529,723**	1,421,047

Ian Abbs
Chief Executive and Accounting Officer
22 June 2022

Statement of changes in taxpayers' equity

GROUP 2021/22	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2021	538,246	431,839	743	453,334	**1,424,162**
Deficit for the year	–	–	–	(1,163)	**(1,163)**
Impairments	–	(19,601)	–	–	**(19,601)**
Revaluations – property, plant and equipment	–	107,101	–	–	**107,101**
Public Dividend Capital received	23,280	–	–	–	**23,280**
Taxpayers' equity as at March 31 2022	**561,526**	**519,339**	**743**	**452,171**	**1,533,779**

GROUP 2020/21	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2020	374,670	358,429	743	378,405	**1,112,247**
Surplus for the year	–	–	–	262,899	**262,899**
Transfers by absorption: transfers between reserves	109,934	78,037	–	(187,970)	**–**
Impairments	–	(22,842)	–	–	**(22,842)**
Revaluations – property, plant and equipment	–	18,216	–	–	**18,216**
Public Dividend Capital received	53,642	–	–	–	**53,642**
Taxpayers' equity as at March 31 2021	**538,246**	**431,839**	**743**	**453,334**	**1,424,162**

TRUST 2021/22	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2021	538,246	431,839	743	450,219	**1,421,047**
Deficit for the year	–	–	–	(2,104)	**(2,104)**
Impairments	–	(19,601)	–	–	**(19,601)**
Revaluations	–	107,101	–	–	**107,101**
Public Dividend Capital received	23,280	–	–	–	**23,280**
Taxpayers' equity as at March 31 2022	**561,526**	**519,339**	**743**	**448,115**	**1,529,723**

TRUST 2020/21	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2020	374,670	358,429	743	380,980	**1,114,822**
Surplus for the year	–	–	–	257,209	**257,209**
Transfers by absorption: transfers between reserves	109,934	78,037	–	(187,970)	**–**
Impairments	–	(22,842)	–	–	**(22,842)**
Revaluations	–	18,216	–	–	**18,216**
Public Dividend Capital received	53,642	–	–	–	**53,642**
Taxpayers' equity as at March 31 2021	**538,246**	**431,839**	**743**	**450,219**	**1,421,047**

Statements of cash flows

	NOTE	GROUP March 31 2022 £000	GROUP March 31 2021 £000	TRUST March 31 2022 £000	TRUST March 31 2021 £000
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		**43,453**	(5,195)	**41,729**	(4,319)
Non-cash income and expenses					
Depreciation and amortisation	6.1	**82,234**	63,384	**82,172**	63,325
Impairments and reversals of impairments	15	**(1,449)**	37,045	**(1,449)**	37,045
Income recognised in respect of capital donations (cash and non-cash)		**(12,890)**	(5,928)	**12,890)**	(5,928)
(Increase)/decrease in trade and other receivables		**(23,870)**	80,032	**(22,169)**	70,632
Decrease/(increase) in inventories		**278**	(6,366)	**278**	(6,366)
Increase in other liabilities		**30,334**	18,291	**29,907**	18,349
Increase in trade and other payables		**756**	47,218	**821**	55,242
(Decrease)/increase in provisions		**(3,596)**	13,511	**(3,622)**	13,496
Corporation tax paid		**(1,620)**	(229)	**–**	–
Other movements in operating cash flows		**(1,464)**	(765)	**(2,278)**	(460)
NET CASH GENERATED FROM OPERATING ACTIVITIES		**112,165**	240,998	**112,498**	241,016
Cash flows from investing activities					
Interest received		**142**	67	**142**	67
Purchase of financial assets		**(1,125)**	(5,500)	**(1,325)**	(5,500)
Proceeds from settlements of financial assets		**30**	4,760	**320**	1,230
Purchase of intangible assets		**(46,956)**	(50,031)	**(46,956)**	(50,031)
Purchase of property, plant and equipment		**(133,784)**	64,576)	**(133,751)**	(64,569)
Proceeds from sale of property, plant and equipment		**422**	24	**422**	24
Receipt of cash donations to purchase capital assets		**12,890**	3,164	**12,890**	3,164
NET CASH USED IN INVESTING ACTIVITIES		**(168,381)**	(112,092)	**(168,258)**	(115,614)
Cash flows from financing activities					
Public Dividend Capital received		**23,280**	53,642	**23,280**	53,642
Movement in loans from the Department of Health and Social Care (DHSC)		**(18,133)**	(14,253)	**(18,133)**	(14,253)
Movement in other loans		**(13,170)**	(402)	**(13,170)**	(402)
Capital element of finance lease rental payments		**(1,151)**	–	**(1,151)**	–
Capital element of service concession payments		**(275)**	(263)	**(275)**	(263)
Interest paid on DHSC loans		**(5,864)**	(5,443)	**(5,864)**	(5,443)
Interest on other loans		**(64)**	(173)	**(64)**	(173)
Interest element on finance leases		**(66)**	–	**(66)**	–
Interest element of service concession obligations		**(128)**	(139)	**(128)**	(139)
Public Dividend Capital paid		**(28,400)**	(33,316)	**(28,400)**	(33,316)
NET CASH GENERATED FROM FINANCING ACTIVITIES		**(43,972)**	(347)	**(43,972)**	(347)
Net (decrease)/increase in cash and cash equivalents		**(100,187)**	128,559	**(99,731)**	125,054
Cash and cash equivalents transferred by absorption		**–**	53,326	**–**	53,326
Cash and cash equivalents at April 1		**321,134**	139,249	**315,501**	137,121
Cash and cash equivalents at March 31	24	**220,946**	321,134	**215,770**	315,501

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, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Transfers of functions from other NHS bodies

On 1st February 2021 Guy's and St Thomas' NHS Foundation Trust acquired Royal Brompton & Harefield NHS Foundation Trust, as approved by NHS Improvement on 23rd December 2020 under section 56A of the NHS Act 2006.

For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within income but not within operating activities. These adjustments are shown in the 20/21 figures, with the SOCI showing a transfer of £287m on 1st February 2021.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts were preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

The 20/21 income and expenditure figures only include 2 months worth of activity (February 21 and March 21) from Royal Brompton and Harefield clinical group. This contrasts with the 21/22 figures which now include a full 12 months worth of activity. There is no requirement to restate the comparators.

Accounting convention

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

Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.2 Basis of consolidation

The group financial statements consolidate the financial statements of the Trust and all of its subsidiary undertakings made up to the year ended 31 March 2022 and incorporate its share of the results of joint ventures and associates using the equity method of accounting.

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 have been consolidated in full into the appropriate financial statement lines and group financial statements have been prepared.

The 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. Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where differences are material. Inter-entity balances, transactions, unrealised profits arising from intra-group transactions and gains/losses are eliminated in full on consolidation.

In accordance with the DHSC GAM 2021/22 a separate Statement of Comprehensive Income for the parent (the Trust) has not been presented by the directors

All notes in the accounts refer to the Group. The Trust notes are included only where they are deemed to be materially different.

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 (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution is received from the associate. e.g. 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 trust 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.

1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Standard credit terms are 30 days and so payments are expected within one month after satisfying the performance obligations.

1.3.1 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

1.3.2 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

1.3.3 NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been provided, it receives notification from the Department of Work and Pensions' Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.3.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or 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.

Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Revenue from education and training

Health Education England provide funding to maintain education and training capacity, retain students on education and training programmes, and enable students to provide their skills to the NHS to support the response. Income is recognised in line with the requirements of IFRS 15. Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligation.

1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy 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

Most 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 for Health and Social Care 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. The contributions are charged to operating expenses as they become due.

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

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

a) Accounting valuation

A valuation of 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the Government Actuary Scheme has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS

Pension Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme. NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme. The employer's contribution rate in 2021/22 was 3% (2020/21: 3%).

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

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.

Measurement

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site and /or reduced site basis where this would meet the location and service requirements.

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 on assets on the Guy's and St Thomas' Estate.

Land and buildings (including Investment properties) 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 2022 land and buildings for the full Trust estate were valued by Gerald Eve. Comparative figures include: land and building assets for the Guy's and St Thomas' sites valued by Gerald Eve at 31 March 2021 and land and building assets for the Royal Brompton and Harefield sites valued by Montagu Evans as at 31 December 2020 with a subsequent valuer assessment confirming no material movements as at 31 March 2021. Enhancements to leasehold properties are valued at historic cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use, with subsequent revaluation on an annual basis.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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.

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

- Buildings, 1–50 years
- Plant and machinery, 1–20 years
- Furniture and fittings, 4–15 years.

Buildings and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the professional valuer. The Trust revalues 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.

Finance-leased assets are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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 expenditure.

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 from IFRS 5 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.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 useful 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 donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

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 when it meets the requirements set out in IAS 38 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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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.

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

- Information technology / Development expenditure 2–12 years
- Software licences and trademarks, 2–10 years.

1.9 Investment property

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held to generate a commercial return, or capital appreciation, or both are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

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 the notes to the financial statements.

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.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.14 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care.

This policy is available at *www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.*

In accordance with the requirements laid down by the Department of Health and Social Care (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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.15 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.

1.16 Corporation tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A)(3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non public sector source.

The tax expense on the surplus or deficit for the year comprises current and deferred tax due to the Trust's trading commercial subsidiaries. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided using the balance sheet liability method, providing for temporary differences between the carrying amounts of the assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not recognised on the taxable temporary differences arising on the initial recognition of good will or for temporary differences arising from the initial recognition of assets and liabilities in a transaction that is not a business combination and that affects neither accounting nor taxable profit.

Deferred taxation is calculated using rates that are expected to apply when the related deferred tax asset is realised or the deferred taxation liability is settled. Deferred tax assets are recognised only to the extent that it is probable that future taxable profits will be available against which the assets can be utilised.

1.17 Other reserves

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

1.18 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.

1.19 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

De-recognition

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

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

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expenses. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

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

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are estimated via a provision matrix that assigns differing percentages and timings in terms of categories of debt. These are based on an assessment of: past performance, current/future market and general economic conditions and any other considerations relevant to specific categories of debtor.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.20 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.20A The Trust as lessee

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 or IT hardware and a corresponding liability is recorded. The value at which they 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. 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 or hardware.

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

Operating lease payments are charged to operating expenses on a straight-line basis over the term of the lease. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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.

1.20B The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.21 Provisions and contingencies

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 rates effective for 31 March 2022 between the range of 0.47%to 0.66%. In calculating the early retirement and injury benefit provisions, the HM Treasury discount rate of minus 1.3% in real terms has been used.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the notes to the Statement of Comprehensive Income but is not recognised in the Trust's accounts.

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 NHS Resolution 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 NHS Resolution 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.

1.22 Third party assets

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

1.23 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.

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.

1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.25 Transfers of functions from other NHS bodies

On 1 February 2021 Guy's and St Thomas' NHS Foundation Trust acquired Royal Brompton & Harefield NHS Foundation Trust. For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within income but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IAS 8 requires that the impact of accounting standards that have been issued, but are not yet effective, is disclosed.

IFRS 16 leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease. This means that while the accounting for operating leases as a lessee will change, the Trust does not need to reassess whether an existing contract is or contains a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. The Trust has a significant property lease portfolio, including a number of peppercorn leases. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in

existing use or fair value, as valued by Gerald Eve. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust is well advanced in the implementation of IFRS 16 and continues to educate colleagues within the finance and procurement teams, and the wider Trust.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	188,225
Additional lease obligations recognised for existing operating leases	(159,159)
Net impact on net assets on 1 April 2022	**29,066**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(27,060)
Additional finance costs on lease liabilities	(1,254)
Lease rentals no longer charged to operating expenditure	23,515
Estimated impact on surplus/(deficit) in 2022/23	**(4,799)**
Estimated increase in capital additions for new leases commencing in 2022/23	**40,583**

For peppercorn leases, in line with DHSC Group Accounting Manual, the difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. This impact on reserves is estimated to be £29m.

The estimated impact on the Statement of Cashflows is not estimated to have a material impact and will be limited to classification changes only.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.28 Critical judgements in applying accounting policies

The Trust has made critical judgements in relation to the modern equivalent asset revaluation assumption as at 31 March 2022.

The Trust's valuers, Gerald Eve LLP, carried out a professional valuation of the modern equivalent asset (MEA) required to have the same productive capacity and service potential as existing Trust assets. Through discussion with Gerald Eve, the Trust has considered where its four principal hospitals could be theoretically relocated whilst still delivering the same service delivery. For Harefield, which is located in a reasonably economic location no specific alternative site assumption was made. For Guy's, St Thomas' and Royal Brompton, which are all located in very high value locations, the Trust and Gerald Eve continued to adopt the same hypothetical alternative site assumptions as previously, that is: for Guy's and St Thomas', a hypothetical alternative site located in the northern half of Lambeth; and for Royal Brompton, a hypothetical alternative site within the adjoining borough of Hammersmith & Fulham. Valuations have been prepared on the basis that the Trust cannot recover VAT on new non-domestic buildings but is able to recover VAT on professional fees associated with construction work. There are a number of additional assumptions that feed into the overall valuation such as gross internal area assumptions for the MEA.

The Trust has deemed that, apart from those involving estimations (see 1.29), no additional disclosures in relation to critical judgements are required with regard to significant effects on the amounts recognised in the financial statements when applying the Trust's accounting policies.

1.29 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.

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

1) Valuation of land and buildings

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis

The Trust seeks professional advice from its valuers annually in determining the value of its land and buildings. The Trust based the valuation of land and buildings in 2021/22 on the views of Gerald Eve for the combined Guy's and St Thomas' and Royal Brompton and Harefield sites. The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer exercised his professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact on the valuation. In 2020/21 Royal Brompton & Harefield NHS Foundation's estate was valued by Montagu Evans and the Guy's and St Thomas' estate by Gerald Eve.

Whilst the pandemic and measures taken to tackle COVID-19 continue to affect economies and real estate markets globally, at the valuation date property markets were mostly functioning again. The March 2022 valuation is not reported as being subject to material valuation uncertainty as defined by VPS and VPGA 10 of the RICS Valuation – Global Standards.

The net book value at 31 March 2022 of the Trust's property plant and equipment valued by professional valuers and reflected in these financial statements is £1,291,889k.

There are a number of inputs into the valuation model that could change in either direction such as land values, making it difficult to predict the future impact on the Trust's balance sheet. For illustrative purposes only, a 5% change in the net book value would adjust the balance sheet by approx. £64,594k. The impact of any movement would be split across the Statement of Comprehensive Income and Revaluation Reserve.

2) Investment Property

The Trust holds investment properties, including the Chelsea Farmers' Market. This site currently has planning permission for residential and retail development and was valued by Montagu Evans in 20/21 and by Gerald Eve as at 31 March 2022. There are a number of inputs into the valuation such as construction costs and property sale prices. The fair value of this property reflects the prevailing state of the market and economic conditions and can lead to significant swings year on year. As at 31 March 22, the valuation of Chelsea Farmers Market was £76.95m

(£83.75m 31 March 2021). This valuation reflects the safeguarding status for Crossrail 2 on the property, which has significantly depressed the site value. Should this safeguarding be removed in the future we would anticipate the valuation to increase by approximately 5%

The Trust makes a number of other estimates in its financial statements which are not considered to be subject to a material uncertainty.

2 Segmental reporting

The Trust's Operating Model during 21-22 has been based on five clinical groups: Evelina London Women's and Children's Healthcare; Integrated and Specialist Medicine; Cancer and Surgery; Cardio-Respiratory and Critical Care and; Royal Brompton and Harefield.

For the purposes of reporting however, the Trust currently operates as a single reportable operating segment, which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure in place during 21-22. 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 consolidated revenues and expenditure are fully reported and the overall financial and operational performance of the Trust is assessed.

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 Chief Financial Officer and Director of Finance to the agreed Board and Committee meetings during the year. This report is made available to the public at the quarterly Board meetings and via the public website of the Trust.

3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

3.1 Income from patient care (by source)

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
NHS England	**1,145,302**	798,591
Clinical Commissioning Groups (CCGs)	**1,048,409**	802,984
NHS Foundation Trusts	**3,909**	953
NHS Trusts	**780**	212
Local authorities	**10,811**	8,657
Department of Health and Social Care	**557**	6
NHS other (including Public Health England)	**5,071**	3,640
Non-NHS: private patients	**50,568**	15,135
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	**3,424**	4,251
Injury cost recovery scheme	**2,412**	(190)
Non-NHS: other	**729**	(1,942)
Total income from patient care activities	**2,271,972**	1,632,297
Of which:		
Related to continuing operations	**2,271,972**	1,632,297
Related to discontinued operations	**–**	–

3.2 Income from patient care (by nature)

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Acute services		
Block contract/system envelope income	**1,821,998**	1,360,606
High cost drugs income from commissioners (excluding pass-through costs)	**128,793**	21,441
Other NHS clinical income*	**46,596**	43,672
Community services		
Block contract/system envelope income	**131,312**	125,945
Income from other sources (eg local authorities)	**10,632**	8,704
All services		
Private patient income	**50,568**	15,135
Elective recovery fund	**26,911**	–
Additional pension contribution central funding**	**54,900**	43,761
Other income	**261**	13,034
	2,271,972	1,632,297

* For categories that fall outside of elective and non-elective inpatients, first and follow up outpatient, A&E and High cost drugs income categories these are included within other NHS clinical income.

** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

3.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Commissioner requested services	**2,214,839**	1,615,043
Non-commissioner requested services	**57,133**	17,253
	2,271,972	1,632,297

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

3.4 Overseas visitors (relating to patients charged directly by the provider)

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Income recognised this year	**3,424**	4,251
Cash payments received in-year	**892**	749
Amounts added to provision for impairment of receivables	**2,060**	2,864
Amounts written-off in-year	**796**	2,235

4 Other operating income (Group)

		Year ended March 31 2022 £000	Year ended March 31 2021 £000
Other operating income from contracts with customers:			
Research and development		**59,152**	51,082
Education, training and research		**71,848**	67,749
Non-patient care services to other bodies		**48,857**	24,081
Reimbursement and top up funding		**30,210**	108,523
Income in respect of staff recharges		**10,969**	6,862
Other income*		**107,876**	72,756
Other non-contract operating income:			
Research and development		**4,526**	983
Education and training – notional income from apprenticeship fund		**2,164**	1,392
Donated equipment from DHSC for COVID response (non cash)		**–**	2,764
Contributions to expenditure – receipt of equipment donated from DHSC for COVID response below capitalisation threshold		**–**	242
Contributions to expenditure – consumables (inventory) donated from DHSC group bodies for COVID response		**4,122**	16,549
Charitable and other contributions to expenditure and capital assets		**18,427**	5,844
Rental revenue from operating leases – minimum lease payments	6.4.3	**9,333**	8,203
Other non-contract income		**–**	38
		367,484	367,069

* Other income includes: £23m from clinical tests, £16m from external estate recharges and the remaining from catering, staff accommodation rentals, income from commercial activities, clinical excellence awards and other direct credits.

5 Additional income disclosures

5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end.	**34,022**	15,288

5.2 Transaction price allocated to remaining performance obligations

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
Within one year	**65,179**	34,022
Total revenue allocated to remaining performance obligations	**65,179**	34,022

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

6 Operating expenses (Group)

6.1 Operating expenses comprise:

	Note	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Purchase of healthcare from NHS and DHSC bodies		**409**	237
Purchase of healthcare from non-NHS and non-DHSC bodies		**58,720**	50,937
Staff and executive directors costs		**1,434,673**	1,150,929
Non-executive directors		**343**	239
Supplies and services – clinical (excluding drugs costs)		**303,122**	197,700
Supplies and services – general		**21,452**	19,018
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response		**10,154**	8,167
Inventories written down (consumables donated from DHSC group bodies for COVID response)		**–**	2,121
Supplies and services – general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold		**–**	242
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		**326,679**	178,935
Inventories written down (net including drugs)		**650**	874
Provisions arising / released in year		**166**	–
Consultancy		**4,650**	2,536
Establishment		**54,569**	36,985
Premises – business rates collected by local authorities		**12,695**	10,529
Premises – other		**147,510**	126,402
Transport – business travel only		**288**	41
Transport – other (including patient travel)		**26,344**	31,086
Depreciation	13.1	**66,927**	50,634
Amortisation	14.1	**15,307**	12,750
Impairments net of reversals	15	**(1,449)**	37,045
Credit loss allowance		**(6,663)**	4,431
Change in provisions discount rate		**75**	24
Audit services* – statutory audit		**232**	188
Other auditor remuneration (payable to external auditor only)		**–**	6
Internal audit – staff costs		**606**	503
Internal audit – non-staff		**23**	7
Clinical negligence – amounts payable to NHS Resolution (premium)		**33,165**	21,742
Legal fees		**5,875**	2,378
Insurance		**2,414**	1,946
Research and development – non-staff		**1,992**	2,260
Education and training – non-staff		**13,033**	3,003
Education and training – notional expenditure funded from apprenticeship fund		**2,164**	1,392
Operating lease expenditure	6.4	**23,528**	18,753
Redundancy cost (staff costs)		**904**	619
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis		**2,292**	1,859
Car parking and security		**2**	1
Hospitality		**777**	75
Other losses and special payments – non-staff		**574**	67
Other**		**31,802**	27,901
		2,596,004	2,004,561

* Audit services – statutory audit is net of VAT.

** Other operating expenses includes expenditure on commercial activities, NHS Blood and Transplant and Clinical Research Network expenditure.

6.2 Other auditor remuneration

Other auditor remuneration paid to the external auditor

Payments made to our auditor for non-audit work in 2021/22 were £8k relating to grant assurance services (2020/21 £6k). These fees are listed net of VAT.

6.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2021-22 is £2million (2020-21 £2million).

6.4 Operating leases

6.4.1 Operating lease expenditure:

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Minimum lease payments under operating leases recognised as an expense in the year	**23,528**	18,753

6.4.2 Future minimum lease payments*:

Future minimum lease payments due:	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Within 1 year	**26,552**	20,736
Between 1 and 5 years inclusive	**78,943**	66,710
After 5 years	**64,198**	58,703
	169,693	146,149

6.4.3 Operating lease income:

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Rental revenue from operating leases – minimum lease receipts	**9,333**	8,203
	9,333	8,203

6.4.4 Future minimum lease receipts:

Future minimum lease receipts due:	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Within 1 year	**8,522**	8,303
Between 1 and 5 years inclusive	**26,124**	27,356
After 5 years	**87,121**	92,831
	121,767	128,490

* IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases. For further detail on the impact this will have on the financial statements from 1 April 2022, refer to Note 1.27

7 Employee benefits (Group)

	Group	
	Year ended March 31 2022 Total £000	Year ended March 31 2021 Total £000
Salaries and wages	**1,133,654**	907,463
Social security costs	**122,158**	95,271
Apprenticeship levy	**5,495**	4,334
Employer contributions to NHSPA	**125,715**	100,256
Pension cost – employer contributions paid by NHSE on provider's behalf (6.3%)	**54,900**	43,761
Termination benefits	**108**	619
Temporary staff – agency and contract staff	**32,344**	21,947
Total gross staff costs	**1,474,374**	1,173,652
Recoveries in respect of seconded staff	**(8,668)**	(9,149)
Total staff costs	**1,465,706**	1,164,503
Of which:		
Costs capitalised as part of assets	**29,523**	12,452
Analysed into Operating Expenditure (note 6.1)		
Employee expenses – staff & executive directors	**1,434,673**	1,150,929
Redundancy	**904**	619
Internal audit costs*	**606**	503
Total employee benefits excluding capitalised costs	**1,436,183**	1,152,051

7.1 Retirements due to ill-health

During 2021-22 there was one early retirement from the Trust agreed on the grounds of ill-health (6 in the year ended March 31 2021). The estimated additional pension liabilities of this ill-health retirement is £137k (£262k in 2020-21). The cost of this ill-health retirement will be borne by the NHS Business Services Authority – Pensions Division.

* Internal audit costs are total costs incurred by the Trust. Income received in relation to providing internal audit services for other Trusts is recorded separately within other income and not netted off within staff costs.

8 Other gains and losses

	Group	
	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Loss on disposal of property, plant and equipment	**(102)**	(7)
Gain on disposal of property, plant and equipment	**51**	24
Gain on disposal of investments**	**–**	6,159
Loss recognised on return of donated COVID assets to DHSC	**(1,633)**	–
Total gain on disposal of assets	**(1,684)**	6,176
Fair value losses on investment properties	**(7,065)**	–
Gains on foreign exchange	**–**	56
Total other (losses)/gains	**(8,749)**	6,232

** Gain on disposal of investments in 20/21 relates to Pathology Services Limited disposing 51% of its investment in Viapath.

9 Finance income

	Group	
	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Interest on bank accounts	**146**	15
Interest on other investments / financial assets	**(4)**	28
Total finance income	**142**	43

10 Finance expenses

	Group	
	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Loans from the Department of Health and Social Care	**(5,778)**	(5,465)
Interest on other loans	**(64)**	(82)
Interest on finance lease obligations	**(67)**	–
Finance costs on service concession arrangements	**(128)**	(139)
Unwinding of discounts on provisions	**14**	9
Other finance costs	**–**	(4)
Total finance expense	**(6,023)**	(5,682)

11 Tax recognised in Statement of Comprehensive Income

	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Current tax expense		
Current year	**(197)**	(1,634)
Adjustments in respect of prior years	**(592)**	23
	(789)	(1,611)
Deferred tax expense		
Origination and reversal of temporary differences	**6**	10
	6	10
Total tax (expense) recognised in income statement	**(783)**	(1,601)

Tax recognised in other comprehensive income is £nil (2020/21 – £nil)
Tax recognised directly in equity is £nil (2020/21 – £nil)

Reconciliation of effective tax rate	Year ended March 31 2022 £000	Year ended March 31 2021 £000
Operating surplus before taxation – subsidiaries only*	**941**	5,689
Tax at standard rate of corporation tax in the UK 19%	**(191)**	(1,624)
Adjustments in respect of prior years	**(592)**	23
	(783)	(1,601)

* Liability for corporation tax generally arises from the activity of the commercial subsidiaries whose combined operating surplus before taxation is disclosed. In the prior year comparator (20/21), tax charge also includes tax arising on capital gains. The activities of the Trust do not incur corporation tax, see accounting policy note 1.16 for detailed explanation.

12 Trust performance – Notes to the Consolidated Statement of Comprehensive Income

		Group Year ended March 31 2022 Total £000	Year ended March 31 2021 Total £000
Total comprehensive (expense)/income per SOCI		**86,337**	258,273
Less reserve movements in other comprehensive income/(expense)		**(87,500)**	4,626
Total comprehensive (expense)/income before reserve movements		**(1,163)**	262,899
Add back in year impairments and reversals of impairments relating to market valuations included in surplus above (see note 15)	15.2	**(8,432)**	30,016
Gains from transfer by absorption*		**–**	(286,937)
DHSC capital equipment and inventory		**7,665**	(9,025)
Asset profit/loss on disposal adjustments in line with financial performance adjustment measurement		**(51)**	(6,176)
Capital donations		**(12,890)**	(3,164)
Add back depreciation on donated assets		**15,081**	12,613
Control Total Performance*		**210**	227

The adjusted financial performance is the primary view which is used by the Board of Directors in assessing the performance of the Trust.

* The Consolidated Statement of Comprehensive Income shows a deficit of £1,163k (20/21 Surplus £262,899k) for the Group. Prior year surplus included gains from the transfer of balances from Royal Brompton & Harefield NHS Foundation Trust of £286,937k. When valuation based impairments, depreciation on donated assets, adjustments for capital donations and I&E movements associated with centrally procured inventory are adjusted for, the total surplus for the Group is £210k.

As permitted by DHSC GAM, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The unconsolidated deficit relating to the Foundation Trust for the year ended 31 March 2022 was £2,104k (2020-21 surplus of £257,209k). The prior year surplus includes £286,937k of gains following the acquisition of Royal Brompton & Harefield NHS Foundation Trust.

13 Property, plant and equipment – March 31 2022

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	Dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	IT hardware £000	Furniture and fittings £000	Total £000
Cost or valuation at April 1 2021	**243,414**	**899,567**	**18,572**	**171,455**	**249,305**	**69,494**	**5,185**	**1,656,991**
Additions purchased	–	3,262	–	108,644	6,683	374	4	**118,967**
Additions – assets purchased from cash donations/grants	–	641	–	5,837	405	–	–	**6,883**
Impairments charged to operating expenses	(46)	(19,612)	–	(6,617)	–	–	–	**(26,275)**
Impairments charged to the revaluation reserve	(397)	(19,204)	–	–	–	–	–	**(19,601)**
Reversal of impairments credited to operating expenses	1,050	27,040	–	–	–	–	–	**28,090**
Revaluation	50,222	23,843	(328)	–	–	–	–	**73,737**
Reclassifications	–	103,208	394	(131,749)	24,414	6,230	372	**2,869**
Decognition – COVID equipment returned to DHSC	–	–	–	–	(1,633)	–	–	**(1,633)**
Disposal	–	–	–	–	(4,596)	(2,717)	–	**(7,313)**
Cost or valuation at March 31 2022	**294,243**	**1,018,744**	**18,639**	**147,570**	**274,578**	**73,380**	**5,561**	**1,832,715**
Accumulated depreciation at April 1 2021	–	20,977	199	–	161,510	55,526	3,478	**241,690**
Provided during the year		35,544	1,049		23,853	5,827	653	**66,927**
Revaluation	–	(32,159)	(1,205)	–	–	–	–	**(33,364)**
Disposals	–	–	–	–	(4,122)	(2,717)	–	**(6,839)**
Other								**–**
At March 31 2022	**–**	**24,362**	**43**	**–**	**181,241**	**58,636**	**4,131**	**268,414**
Net book value March 31 2022								
Purchased assets	211,963	774,005	17,930	142,839	73,103	12,375	1,430	**1,233,645**
Finance leased	–	–	–	–	1,993	1,886	–	**3,879**
On-SoFP PFI contracts and other service concession arrangements	–	2,731	–	–	241	–	–	**2,972**
Donated / Granted assets	82,280	217,646	665	4,731	16,998	483	–	**322,803**
Owned – equipment donated from DHSC and NHSE for COVID response					1,002	–		**1,002**
Total at March 31 2022	**294,243**	**994,382**	**18,595**	**147,570**	**93,337**	**14,744**	**1,430**	**1,564,301**

The reclassification line of Property, Plant and Equipment and Intangible Assets nets to zero across all 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 all 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.

Freehold and long leasehold properties occupied by the whole of the Guy's and St Thomas' NHS Foundation Trust estate were valued as at 31 March 2022 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. Freehold and long leasehold properties occupied by Guy's and St Thomas' NHS Foundation Trust were valued as at 31 March 2021 by Gerald Eve LLP. Buildings, land and dwellings that have transferred over from Royal Brompton & Harefield NHS Foundation Trust were valued at 31 December 2020 by an external valuer, Montagu Evans, a regulated firm of Chartered Surveyors. The valuations have all been prepared in accordance with the requirements of the RICS Valuation – Global Standards, the UK national standards, International Valuation Standards and IFRS. The valuations of specialised properties were derived using the Depreciated Replacement Cost (DRC) method, with other in-use properties reported on a Current Value in Existing Use basis. Further disclosures around the valuation are included in note 1.

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.

Property, plant and equipment – March 31 2021

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	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 2020	201,744	818,927	6,947	102,461	195,181	164	55,385	4,951	1,385,760
Transfers by absorption	25,056	126,329	11,091	41,229	69,349	-	15,234	–	288,288
Additions purchased	–	2,201	–	83,626	8,336	–	1,537	–	95,700
Additions – equipment donated from DHSC for COVID response (non-cash)	–	–	–	–	2,764	–	–	–	2,764
Additions – assets purchased from cash donations/grants	–	222	–	1,970	18	–	95	–	2,305
Impairments charged to operating expenses	–	(30,702)	–	(6,064)	(347)	–	–	–	(37,113)
Impairments charged to the revaluation reserve	(884)	(23,480)	(456)	–	–	–	–	–	(24,820)
Reversal of impairments credited to operating expenses	680	6	–	–	–	–	–	–	686
Revaluation	16,818	(20,250)	708	–	–	–	–	–	(2,724)
Reclassifications	–	29,295	283	(51,767)	17,601	–	4,068	234	(287)
Disposal	–	(2,982)	–	–	(43,597)	(164)	(6,825)	–	(53,568)
Cost or valuation at March 31 2021	**243,414**	**899,567**	**18,572**	**171,455**	**249,305**	**–**	**69,494**	**5,185**	**1,656,991**
Accumulated depreciation at April 1 2020	–	19,752	–	–	134,186	164	41,499	2,934	198,535
Transfers by absorption	–	2,132	2	–	53,220	–	13,647	–	69,000
Provided during the year	–	24,875	315	–	17,694	–	7,206	544	50,634
Impairments charged to the revaluation reserve	–	(1,861)	(117)	–	–	–	–	–	(1,978)
Revaluation	–	(20,940)	–	–	–	–	–	–	(20,940)
Disposals	–	(2,982)	–	–	(43,590)	(164)	(6,825)	–	(53,561)
At March 31 2021	**–**	**20,977**	**199**	**–**	**161,510**	**–**	**55,526**	**3,478**	**241,690**
Net book value March 31 2021									
Purchased assets	172,074	687,448	18,047	160,302	69,076	–	9,682	1,067	1,117,696
Finance leased	–	–	–	–	1,906	–	2,969	–	4,875
On-SoFP PFI contracts and other service concession arrangements	–	2,980	–	–	312	–	–	–	3,292
Donated / Granted assets	71,340	188,162	326	11,153	13,875	–	1,316	640	286,812
Owned – equipment donated from DHSC and NHSE for COVID response	–	–	–	–	2,626	–	–	–	2,626
Total at March 31 2021	**243,414**	**878,590**	**18,373**	**171,455**	**87,795**	**–**	**13,967**	**1,707**	**1,415,301**

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) 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.

Some assets that increased in value in 2021/22 had an impairment charge to income and expenditure in prior years. For these assets the increase in value resulted in a reversal of the impairment charge from prior years, creating a credit that is contained within the "impairments net of reversals" in the Statement of Comprehensive Income.

14 Intangible assets

14.1 As at March 31 2022

GROUP AND TRUST	Software licences £000	Information technology £000	Development expenditure £000	Assets under construction £000	Total £000
Cost April 1 2021	12,356	92,592	20,457	73,115	**198,520**
Additions purchased/internally generated	53	113	–	40,783	**40,949**
Additions – grants/donations of cash	10	5	–	5,992	**6,007**
Impairments charged to operating expenses	–	–	–	(366)	**(366)**
Reclassification	2,672	8,616	3,789	(15,180)	**(103)**
Gross cost at March 31 2022	**15,091**	**101,326**	**24,246**	**104,344**	**245,007**
Amortisation April 1 2021	10,062	75,179	11,520	–	**96,761**
Provided during the year	1,739	10,311	3,257	–	**15,037**
Amortisation at March 31 2022	**11,801**	**85,490**	**14,777**	**–**	**112,068**
Net book value March 31 2022	**3,290**	**15,836**	**9,469**	**104,344**	**132,939**
Purchased assets	3,202	14,854	9,469	97,798	**125,323**
Donated/granted assets	88	982	–	6,546	**7,616**
Total at March 31 2022	**3,290**	**15,836**	**9,469**	**104,344**	**132,939**

14.2 As at March 31 2021

GROUP AND TRUST	Software licences £000	Information technology £000	Development expenditure £000	Assets under construction £000	Total £000
Cost April 1 2020	6,844	90,548	–	27,619	**125,011**
Transfers by absorption	5,835	–	19,937	938	**26,710**
Additions purchased/internally generated	128	339	–	48,705	**49,172**
Additions – grants/donations of cash	–	7	–	852	**859**
Impairments charged to operating expenses	–	–	–	(618)	**(618)**
Reclassification	230	3,918	520	(4,381)	**287**
Disposals/de-recognition	(681)	(2,220)	—	–	**(2,901)**
Gross cost at March 31 2021	**12,356**	**92,592**	**20,457**	**73,115**	**198,520**
Amortisation April 1 2020	4,719	66,136	–	–	**70,855**
Transfers by absorption	4,859	–	11,198	–	**16,057**
Provided during the year	1,165	11,263	322	–	**12,750**
Reclassifications	–	–	–	–	**–**
Disposals/de-recognition	(681)	(2,220)	–	–	**(2,901)**
Amortisation at March 31 2021	**10,062**	**75,179**	**11,520**	**–**	**96,761**
Net book value March 31 2021	**2,294**	**17,413**	**8,937**	**73,115**	**101,759**
Purchased assets	2,203	16,504	8,937	71,661	**99,305**
Donated/granted assets	91	909	–	1,454	**2,454**
Total at March 31 2021	**2,294**	**17,413**	**8,937**	**73,115**	**101,759**

15 Impairments

15.1 Impairment of assets

	March 31 2022 £000	March 31 2021 £000
Impairments charged to operating surplus/deficit resulting from:		
Impairments arising from professional valuation	**(19,658)**	(30,702)
Reversals of impairments arising from professional valuation	**28,090**	686
Abandonment of assets in course of construction	**(6,983)**	(7,029)
Net impairment reversal/(charge) charged to expenditure	**1,449**	(37,045)
Impairments charged to revaluation reserve		
Professional valuation impairments of land value	**(397)**	(884)
Professional valuation impairments of building and dwellings value	**(19,204)**	(21,958)
Total impairments charged to revaluation reserve	**(19,601)**	(22,842)
Total net impairments	**(18,152)**	(59,887)
Impairments charged to operating expenses:		
Of which Departmental Expenditure Limit (DEL)	**(6,983)**	7,029)
Of which Annually Managed Expenditure (AME)	**8,432**	(30,016)
	1,449	(37,045)

15.2 Analysis of significant impairments

The majority of the 2021/22 net impairment relates to the property valuation.

Land and buildings across the full estate were valued independently by Gerald Eve as at 31 March 2022. 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 (SOCI).

Where the revaluation resulted in an increase in an asset's value, this increase was credited to the revaluation reserve unless it reversed a revaluation loss previously recognised in operating expenses, in which case it was credited initially to operating income and thereafter to the revaluation reserve.

The movement arising from the professional valuation can be summarised as follows:

	March 31 2022 £000 Revaluation reserve	March 31 2022 £000 SOCI	March 31 2022 £000 Total	March 31 2021 £000 Revaluation reserve	March 31 2021 £000 SOCI	March 31 2021 £000 Total
Impairments from professional valuation of land and buildings:						
Impairments in land value	**(397)**	**(46)**	**(443)**	(884)	–	(884)
Impairments in building and dwellings value	**(19,204)**	**(19,612)**	**(38,816)**	(21,958)	(30,702)	(52,660)
Reversal of previous impairments	**–**	**28,090**	**28,090**	–	686	686
Other impairments of property, plant and equipment	**–**	**(6,983)**	**(6,983)**	–	(7,029)	(7,029)
	(19,601)	**1,449**	**(18,152)**	(22,842)	(37,045)	(59,887)
Revaluations upwards from professional valuation to revaluation reserve						
Increase in land value to revaluation reserve	**50,222**	**–**	**50,222**	16,818	–	16,818
Increase in building value to revaluation reserve	**56,879**	**–**	**56,879**	1,398	–	1,398
	107,101	**–**	**101,101**	18,216	–	18,216
Total movement arising from from professional valuation	**87,500**	**8,432**	**95,932**	(4,626)	(30,016)	(34,642)

16 Investment property

Investment property carrying values

	GROUP AND TRUST	
	March 31 2022 £000	March 31 2021 £000
Carrying value at April 1	**90,190**	–
Transfers by absorption	**–**	90,190
Movement in fair value	**(7,065)**	–
Reclassifications to/from property, plant and equipment	**(2,766)**	–
Carrying value at March 31	**80,359**	90,190

Investment properties were transferred across to Guy's and St Thomas' as part of the assets transferred from Royal Brompton & Harefield NHS Foundation Trust. They were valued at 31 December 2020 by Montagu Evans, who also confirmed that there were no material movements between this time and 31 March 2021. Investment properties were valued by Gerald Eve as at 31 March 2022. Valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and International Financial Reporting requirements. The assets were valued by reference to the market conditions prevailing at the valuation date. Under IFRS13 this valuation is classed as a level 2 valuation (i.e. based on observable market data). The largest element of the Investment Property portfolio is the Chelsea Farmer's Market.

17 Revaluation reserve movements

Property, plant and equipment

	GROUP AND TRUST	
	March 31 2022 £000	March 31 2021 £000
Revaluation reserve at April 1	**431,839**	358,429
Transfers by absorption	**–**	78,037
Impairments	**(19,601)**	(22,842)
Revaluations	**107,101**	18,216
Revaluation reserve at March 31	**519,339**	431,839

18 Subsidiaries and interests in associates and joint ventures

The Guy's and St Thomas' principal subsidiary undertakings, associates and joint ventures as included in the Financial Statements at March 31 2022 are set out below. The accounting date of the financial statements for the subsidiaries, Collaborative Procurement Partnership LLP and KHP MedTech is March 31 2022 and for the remaining joint ventures December 31 2021. For the joint venture undertakings that have different accounting year-end dates, interim accounts to March 31 have been used.

	Country of incorporation	Beneficial interest	Principal activity
Subsidiary undertakings			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
Pathology Services Ltd[1]	UK	100%	Healthcare services
Essentia Trading Ltd[1]	UK	100%	Healthcare services
The Chelsea Private Hospital Ltd	UK	100%	Dormant
Associates and joint ventures			
The Institute of Cardiovascular Medicine and Science Ltd[3]	UK	50%	Healthcare services
KHP MedTech Innovations Ltd[1]	UK	30%	Healthcare services
Spot on Diagnostics Ltd[1]	UK	30%	Healthcare services
King's Health Partners Ltd[2]	UK	25%	Healthcare services
Collaborative Procurement Partnership (CPP) LLP	UK	25%	Healthcare services
Viapath Group LLP[1]	UK	24.5%	Healthcare services
Viapath Services LLP[1]	UK	24.5%	Healthcare services
Viapath Analytics LLP[1]	UK	24.5%	Healthcare services
SSAFA GSTT Care LLP[4]	UK	50%	Healthcare Services

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

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

[3] Since November 2011 Royal Brompton & Harefield NHS Foundation Trust had a 50:50 joint venture in The Institute of Cardiovascular Medicine and Science Limited ('ICMS'), a company limited by guarantee, with Liverpool Heart and Chest Hospital NHS Foundation Trust, being the other 50% holder. The founding partners each contributed £100,000 in total to the funding of ICMS including their original respective contributions of £50,000. Royal Brompton & Harefield NHS Foundation Trust had previously not reflected any surplus or deficit from ICMS's activities in its accounts as it deemed the impact to be immaterial. It is anticipated that this organisation will be dissolved during 2022-23.

[4] During 2021/22 it was formally agreed that SSAFA GSTT Care LLP would be wound up, following the cessation of British Forces Germany Health Service in previous financial years. The LLP appointed a voluntary liquidator and is in the process of finalising the steps of the members voluntary liquidation process.

18.1 Investments in joint ventures and associates

	GROUP	
	March 31 2022 £000	March 31 2021 £000
Carrying value at April 1	**215**	71
Additions	**1,126**	5,500
Share of profits	**34**	979
Profit distribution/dividends received	**(30)**	(3,530)
Disposals	**–**	(2,805)
Carrying Value at March 31	**1,345**	215

19 Other investments/financial assets

	GROUP		TRUST	
Non-current	**March 31 2022 £000**	March 31 2021 £000	**March 31 2022 £000**	March 31 2021 £000
Carrying value at April 1	**146**	146	**8,479**	3,146
Additions	**–**	–	**1,508**	5,653
Loan repayments	**–**	–	**(320)**	(320)
Carrying value at March 31	**146**	146	**9,667**	8,479

2021/22 Group other investments/financial assets

Organisation	**Current £000**	**Non-current £000**
Cydar Investments	–	146
	–	**146**

2021/22 Trust other investments/financial assets

Organisation	**Current £000**	**Non-current £000**	**Interest rate**	**Maturity date**
Pathology Services Ltd (loan + interest)	–	8,007	Base rate +2%	Mar 2029
Guy's and St Thomas' Enterprises Limited (loan + interest)	–	1,340	Base rate +2%	Dec 2029
Essentia Trading Ltd	–	320	3.50%	Mar 2024
	–	**9,667**		

Trust loans with Pathology Services Limited (PSL), Guy's and St Thomas' Enterprises Limited and Essentia Trading Limited are removed from the Group Accounts following consolidation adjustments.

20 Inventories

	GROUP AND TRUST	
	March 31 2022 £000	March 31 2021 £000
Drugs	**8,304**	7,851
Consumables and energy	**36,070**	36,801
	44,374	44,652

Inventories recognised in expenses for the year were £537,361k (2020/21: £368,457k). Write-down of inventories recognised as expenses for the year were £640k (2020/21: £2,995k).

In response to the COVID-19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £4,122k of inventory items purchased by DHSC (2020/21: £16,549k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

21 Trade and other receivables

21.1 Current

	GROUP AND TRUST	
	March 31 2022 £000	March 31 2021 £000
Contract receivables: invoiced	**96,217**	97,642
Contract receivables: not yet invoiced	**69,262**	60,568
Capital receivables	**6,025**	2,275
Allowance for impaired receivables	**(36,726)**	(46,870)
Prepayments	**22,379**	17,175
PDC dividend receivable	**1,931**	2,768
VAT and other tax receivable	**6,855**	8,185
Clinical pension tax provision reimbursement funding from NHSE	**100**	–
Other receivables	**6,792**	5,167
	172,836	146,910

21.2 Non-current

	GROUP AND TRUST	
	March 31 2022 £000	March 31 2021 £000
Contract receivables	**2,860**	1,916
Capital receivables	**8,609**	8,437
Clinical pension tax provision reimbursement funding from NHSE	**5,154**	5,242
	16,623	15,595

21.3 Allowances for credit losses

	GROUP AND TRUST	
	2021/22 Contract receivables and contract assets £000	**2020/21 Contract receivables and contract assets £000**
Allowances as at 1 April	**46,870**	34,188
Transfers by absorption	**–**	11,636
New allowances arising	**821**	6,075
Reversal of allowances	**(7,484)**	(1,644)
Utilisation of allowances	**(3,482)**	(3,385)
Allowances as at 31 March	**36,726**	46,870

22 Current liabilities

22.1 Trade and other payables

	GROUP AND TRUST	
	March 31 2022 £000	March 31 2021 £000
Trade payables	**81,516**	79,271
Capital payables	**47,621**	55,555
Accruals	**206,794**	193,570
Receipts in advance	**1,368**	15,303
Social security costs	**17,797**	16,420
Other taxes payable	**16,261**	15,716
Other payables	**3,747**	4,829
	375,104	380,663

22.2 Other liabilities

	GROUP AND TRUST	
Current	**March 31 2022 £000**	March 31 2021 £000
Deferred income: contract liabilities	**65,179**	34,022
Deferred grants	**55**	225
Lease incentives	**4,632**	5,285
	69,866	39,532

22.3 Borrowings

	GROUP AND TRUST	
Current	**March 31 2022 £000**	March 31 2021 £000
Bank overdrafts*	**–**	2,666
Capital loans from Department of Health and Social Care (DHSC)	**19,157**	19,244
Other loans (non-DHSC)	**–**	2,253
Obligations under finance leases	**1,669**	1,584
Obligations under PFI, LIFT or other service concession contracts (excluding lifecycle)	**273**	132
	21,099	25,879

	GROUP AND TRUST	
Non-current	**March 31 2022 £000**	March 31 2021 £000
Capital loans from Department of Health and Social Care (DHSC)	**209,973**	228,106
Other loans (non-DHSC)	**–**	10,917
Obligations under finance leases	**2,210**	3,445
Obligations under PFI, LIFT or other service concession contracts (excluding lifecycle)	**2,866**	3,282
	215,049	245,750
Total borrowings (current and non-current)	**236,148**	271,629

* Cash as at 31st March 2021 included a £2,666k one day 'book only' overdraft due to timing as funds were transferred between bank accounts.

22.4 Reconciliation of liabilities arising from financing activities 2021/22

GROUP	Loans from DHSC £000	Other loans £000	Finance leases £000	Service concession obligations £000	Total £000
Carrying value as at 1 April 2021	247,350	13,170	5,029	3,414	**268,963**
Cash movements:					
Financing cash flows – payments and receipts of principal	(18,133)	(13,170)	(1,151)	(275)	**(32,729)**
Financing cash flows – payments of interest	(5,864)	(64)	(66)	(128)	**(6,122)**
Non-cash movements:					
Application of effective interest rate	5,778	64	67	128	**6,037**
Carrying value at 31 March 2022	**229,131**	**–**	**3,879**	**3,139**	**236,149**

22.5 Reconciliation of liabilities arising from financing activities 2020/21

GROUP	Loans from DHSC £000	Other loans £000	Finance leases £000	Service concession obligations £000	Total £000
Carrying value as at 1 April 2020	226,880	–	–	3,677	**230,557**
Cash movements:					
Financing cash flows – payments and receipts of principal	(14,253)	(402)	–	(263)	**(14,918)**
Financing cash flows – payments of interest	(5,443)	(173)	–	(139)	**(5,755)**
Non-cash movements:					
Transfers by absorption	34,700	13,663	2,908	–	**51,271**
Additions	–	–	2,121	–	**2,121**
Application of effective interest rate	5,465	82	–	139	**5,686**
Carrying value at 31 March 2021	**247,350**	**13,170**	**5,029**	**3,414**	**268,963**

22.6 Finance lease obligations

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Liabilities that are due:		
– not later than one year	**1,669**	1,584
– later than one year and not later than five years	**2,126**	3,339
– later than five years	**84**	106
	3,879	5,209

The Trust has entered into finance lease arrangements for items of equipment.

22.7 Schedule of borrowings from the Department of Health and Social Care

Loan start date	Loan end date	Interest rate %	Total loan drawn down £000	Principal and accrued interest outstanding April 1 2021 £000	Loan principal repaid during 2021/22 £000	Loan principal outstanding March 31 2022 £000	Accrued interest at March 31 2022 £000	Total outstanding principal and interest at March 31 2022 £000
Jun-11	Jun-36	3.27	75,000	53,370	3,405	49,463	470	49,933
Mar-12	Mar-37	2.85	80,000	59,538	3,728	55,768	44	55,812
Sep-13	Nov-23	1.95	9,000	3,399	1,125	2,250	16	2,266
Apr-14*	Apr-29	2.54	30,000	20,631	2,400	18,000	205	18,205
Jun-15*	Jun-30	2.06	20,000	14,162	1,480	12,600	72	12,672
Feb-16	Feb-41	1.9	25,000	20,454	1,020	19,390	41	19,431
Feb-16	Feb-41	1.9	14,000	11,695	582	11,088	24	11,112
Feb-16	Feb-41	1.9	33,768	30,083	1,499	28,520	61	28,581
Feb-16	Feb-31	1.38	27,232	24,791	2,478	22,275	35	22,310
Nov-17	Nov-42	1.76	10,000	9,227	416	8,752	57	8,809
			324,000	**247,350**	**18,133**	**228,106**	**1,025**	**229,131**

* Loans transferred from Royal Brompton & Harefield NHS Foundation Trust. For disclosure purposes the full history of the loan has been disclosed, rather than just the movement since 1st February 2021.

No security has been pledged against these loans.

All borrowing relates to capital loans that have been secured to support the Trust's ongoing plans to redevelop its hospital sites and upgrade IT and other infrastructure.

22.8 Other loans

As part of the acquisition of Royal Brompton & Harefield NHS Foundation Trust on 1st February 2021, the following non DHSC loans transferred to Guy's and St Thomas' NHS Foundation Trust:

A £10m loan facility was granted by Barclays Bank PLC to fund the costs associated with fitting out and equipping the leased suite of private patient outpatient and diagnostic facilities at Wimpole Street. In January 2017, the £10m capital balance rolled into a 5 year amortising 'mortgage-style' loan facility, at an interest rate of 2.76%. Repayments commenced in January 2017 and by 31 March 2022 the balance was fully repaid.

A £40m bridging loan from HSBC Bank was taken out by Royal Brompton & Harefield NHS Foundation Trust in 2019/20 to fund construction of a new Imaging Centre. £10m was drawn down in 19/20 against the loan, and £30m during 21/22. The £40m loan was fully repaid by 31 March 2022.

A £10m Revolving Credit Facility, from HSBC Bank PLC which has a nil balance drawn down at 31 March 2022.

23 Provisions for liabilities

23.1 Overall provisions

GROUP AND TRUST

	March 31 2022 £000	March 31 2021 £000
Current		
Pensions: injury benefit	**81**	67
Pensions: early departure	**20**	46
Legal claims	**614**	243
Clininician pension tax reimbursement	**100**	–
Other*	**3,396**	8,713
	4,211	9,069

	March 31 2022 £000	March 31 2021 £000
Non-current		
Pensions: injury benefit	**1,737**	930
Pensions: early departure	**154**	128
Clinician pension tax reimbursement	**5,154**	5,242
Other*	**7,716**	7,213
	14,761	13,513

Total provisions	**March 31 2022 £000**	March 31 2021 £000
Pensions: injury benefit	**1,818**	997
Pensions: early departure	**174**	174
Legal claims	**614**	243
Clinician pension tax reimbursement	**5,254**	5,242
Other*	**11,112**	15,926
	18,972	22,582

23.2 Changes in provisions

	Pensions - injury benefits £000	**Legal claims £000**	**Pensions early departure £000**	**Clinician pension tax reimbursement £000**	**Other* £000**	**Total £000**
As at April 1 2021	997	243	174	5,242	15,926	**22,582**
Change in discount rate	75	–	–	–	–	**75**
Arising during the year	900	482	–	12	569	**1,963**
Utilised during the year	(125)	(16)	–	–	(2,128)	**(2,269)**
Reversed unused	(15)	(95)	–	–	(3,255)	**(3,365)**
Unwinding of discount	(14)	–	–	–	–	**(14)**
At March 31 2022	**1,818**	**614**	**174**	**5,254**	**11,112**	**18,972**

23.3 Expected timing of cash flows:

Timing of provisions	**Pensions - injury benefits £000**	**Legal claims £000**	**Pensions early departure £000**	**Clinician pension tax reimbursement £000**	**Other* £000**	**Total £000**
Within one year	81	614	20	100	3,396	**4,211**
Between one and five years	332	–	80	5,154	5,170	**10,736**
After five years	1,405	–	74	–	2,546	**4,025**
	1,818	**614**	**174**	**5,254**	**11,112**	**18,972**

*Other provisions largely consist of provisions for dilapidations.

As at 31 March 2022 £817m is included in provisions of NHS Resolution in respect of clinical negligence liabilities of Guy's and St Thomas' NHS Foundation Trust (£441m at March 31 2021).

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

24 Cash and cash equivalents movement

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	GROUP		TRUST	
	2021/22	2020/21	**2021/22**	2020/21
	£000	£000	**£000**	£000
At April 1	**323,800**	139,249	**318,167**	137,121
Transfer by absorption	**–**	53,326	**–**	53,326
Net change in year	**(102,854)**	131,225	**(102,397)**	127,720
At 31 March	**220,946**	323,800	**215,770**	318,167
Broken down into:				
Cash at commercial banks and in hand	**7,598**	7,034	**2,422**	1,401
Cash with the Government Banking Service	**213,348**	316,766	**213,348**	316,766
Total cash and cash equivalents as in SoFP	**220,946**	323,800	**215,770**	318,167
Bank overdrafts*	**–**	(2,666)	**–**	(2,666)
Total cash and cash equivalents as in SOCF	**220,946**	321,134	**215,770**	315,501

*Cash as at 31st March 2021 included a £2,666k one day "book only" overdraft due to timing as funds were transferred between bank accounts.

25 Contractual capital commitments

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Property, plant and equipment	**37,836**	52,327
Intangible assets	**59,240**	69,100
	97,076	121,427

26 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made. The Trust has no material contracts that would be reported under this category.

27 Events after the reporting date

On 13th June 2022, Essentia Trading Limited a 100% owned subsidiary of the Trust changed its name to Lexica Health and Life Sciences Consultancy Limited.

28 Contingencies

28.1 Contingent liabilities

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Contingent liability for claims	**(144)**	(152)
Net contingent liability	**(144)**	(152)

Contingent liabilities recorded are in respect of Public and Employee liability cases and the Property Expenses Scheme as advised by NHS Resolution. This represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

29 Related party transactions

Guy's and St Thomas' NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. It falls within the Department of Health and Social Care's (DHSC) consolidation boundary. DHSC is regarded as a related party. The DHSC is the parent department of the Trust. During the year Guy's and St Thomas' Foundation Trust has had a number of material transactions with the Department and with other entities for which the department is regarded as the parent Department as listed below:

- NHS Foundation Trusts
- NHS Trusts
- Department of Health and Social Care
- Public Health England
- Health Education England
- CCGs and NHS England
- Special Health Authorities
- Non-Departmental Public Bodies
- Other Department of Health and Social Care bodies

Per note 18, the Trust has four wholly owned subsidiaries. There are no material transactions between the Trust and its subsidiaries. Related party transactions were made on terms equivalent to those that prevail in arm's length transactions and are eliminated when preparing the group consolidated accounts.

The Trust works closely with its partners in King's Health Partners: King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and King's College London.

The Trust had a number of transactions with non consolidated charities with connections to the Trust. Details, along with other related parties, are included in the table below.

	Amounts due from related parties		Amounts owed to related parties	
	2021/22	2020/21	**2021/22**	2020/21
	£000	£000	**£000**	£000
Non-NHS Related party transactions				
Guy's and St Thomas' Charity	**1,842**	448	**–**	–
King's College London	**5,685**	5,602	**13,601**	3,810
Viapath*	**4,813**	959	**304**	1,359
Royal Brompton and Harefield Hospitals Charity	**153**	–	**95**	–

	Receipts from related party		Payments to related party	
	2021/22	2020/21	**2021/22**	2020/21
	£000	£000	**£000**	£000
Non-NHS Related party transactions				
Guy's and St Thomas' Charity	**6,256**	2,394	**17**	58
King's College Hospital	**25,679**	21,518	**28,962**	34,981
Royal Brompton and Harefield Hospitals Charity	**1,723**	638	**–**	–

* Includes transactions with Viapath Group LLP, Viapath Services LLP, Viapath Analytics LLP

A number of Board level staff held joint posts with King's College Hospital NHS Foundation Trust during 2021/22: Sir Hugh Taylor has been the interim Chair since March 2019, Beverley Bryant has been Chief Digital Information Officer since September 2019, and Steve Weiner has been a Non-Executive Director since March 2021.

Sir Hugh Taylor is Chair of the Health Foundation and Trustee of Cicely Saunders International. The Trust had no material transactions with these organisations.

Dr Ian Abbs sits on the Governing Bodies of Lambeth CCG and Southwark CCG representing King's Health Partners. Dr Ian Abbs is also a board member of Genomics NHS England and the Trust hosts a Genomics contract with GEL.

Alastair Gourlay is Trustee of the Florence Nightingale Museum which is a charity that operates from space in Gassiot House provided by the Trust free of charge. He also represents the Trust as a director of South Bank Employers Group (SBEG). The Trust pays an annual subscription to SBEG as a full member.

Since September 2020 Dr Felicity Harvey has been a NED at Sciensus (formerly 'Healthcare at Home'), a company (Halcyon TopCo Ltd), which provides services to GSTT as well as many other NHS Trusts, for the provision of medicines in the home of patients with long term conditions on expensive medicines. The Trust has recorded £10.7m of invoices from Healthcare at Home coded directly to Drug costs in Note 6, £22.8m coded as additions to inventory during the year and a year-end creditor of £54k.

Simon Friend is the Independent Non-Executive Director at Bevan Brittan LLP, who provide some legal and advisory services to the Trust. The Trust is showing £257k of expenditure with Bevan Brittan LLP during 2021-22 and a year-end creditor of £15k.

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 NHS 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' Hospital NHS Foundation Trust.

30 Financial assets and liabilities

30.1 Carrying value and fair value of financial assets

Group and Trust	Held at amortised cost March 31 2022 £000	Held at amortised cost March 31 2021 £000
Carrying values of financial assets as at 31 March		
Trade and other receivables (excluding non-financial assets) – with NHS and DHSC bodies	**67,578**	83,027
Trade and other receivables (excluding non-financial assets) – with other bodies	**85,461**	51,349
Other investments / financial assets	**1,491**	361
Cash and cash equivalents	**220,946**	323,800
Total carrying value of financial assets at 31 March	**375,476**	458,537

30.2 Carrying value and fair value of financial liabilities

Group and Trust	Held at amortised cost March 31 2022 £000	Held at amortised cost March 31 2021 £000
Carrying values of financial liabilities as at 31 March		
Loans from DHSC	**229,130**	247,350
Other borrowings excluding finance leases	**–**	15,836
Obligations under finance leases	**3,879**	5,029
Obligations under PFI, LIFT and other service concession contracts	**3,139**	3,414
Trade and other payables (excluding non financial liabilities) – with NHS and DHSC bodies	**25,832**	33,140
Trade and other payables (excluding non financial liabilities) – with other bodies	**286,336**	268,938
IAS 37 provisions which are financial liabilities	**11,726**	19,962
Total carrying values of financial liabilities as at 31 March	**560,042**	593,669

The carrying value and fair value of the financial assets and financial liabilities are not materially different.

30.3 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows.
This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group and Trust	
	March 31 2022 £000	March 31 2021 £000
In one year or less	**341,672**	342,989
In more than one year but not more than five years	**111,768**	131,068
In more than five years	**148,579**	167,789
	602,019	641,846

30.4 Loan disclosure

	Current	Non current	Total	Weighted average interest rate %
	£000	**£000**	**£000**	
March 31 2022				
Fixed interest rate instruments	**19,157**	**209,973**	**229,130**	2.43%
March 31 2021				
Fixed interest rate instruments	19,244	228,106	247,350	2.48%

30.5 Financial risk management

International Financial Reporting Standard (IFRS) 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by most 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 Foundation 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 Foundation 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 makes some purchases in foreign currency and these are converted to Sterling at the spot rate on the day of payment, and overall the Trust has minimal exposure to currency rate fluctuations.

Interest rate risk
Where appropriate, the Trust may borrow from Government and commercial sources, as disclosed in Note 22. The borrowings are for 1–25 years, in line with the life of the associated assets. Interest rates on the ITFF (Government) loans and Barclays loan from inception are fixed and interest rate on the bridging loan is variable. 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 2022 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk
Most of the Trust's operating costs are incurred under contracts with NHS commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital programme from its own resources and donations, and where necessary by accessing loans from government and commercial bodies.

31 Third party assets

Guy's and St Thomas' NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. These are split into the following:

£196k (£194k at March 31 2021) which relates to monies held by the Trust on behalf of patients.

£2,924k (£2,916k at March 31 2021) is held as client monies on behalf of tenants as a result of assurities.

These amounts have been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2022	31 March 2021
	£000	£000
Monies on deposit	**3,120**	3,110
Total Third Party Assets	**3,120**	3,110

32 Losses and special payments

	Group and Trust			
Losses	**Year ended March 31 2022 Cases**	**Year ended March 31 2022 £000**	Year ended March 31 2021 Cases	Year ended March 31 2021 £000
Cash losses	**10**	**29**	17	46
Stores losses, theft and other	**125**	**810**	108	931
Bad debts and claims abandoned	**1,080**	**1,714**	803	3,066
Total losses	**1,215**	**2,553**	928	4,043

Special payments	**Year ended March 31 2022 Cases**	**Year ended March 31 2022 £000**	Year ended March 31 2021 Cases	Year ended March 31 2021 £000
Ex gratia payments	**32**	**15**	35	29
Overtime corrective payments (nationally funded)	**1**	**968**		
Total special payments	**33**	**983**	35	29
Total losses and special payments	**1,248**	**3,536**	963	4,072

Of which cases of £300k or more:

Special Payment		
Overtime corrective payments (nationally funded)	**1**	**968**

The amounts quoted above are reported on an accruals basis but exclude provision for future losses.

The special payment over £300k relates to the cost of the combined overtime corrective payments – current and potential backpay claims to 31 March 21 linked to overtime pay entitlements in respect of holiday pay (the Flowers judgement). HMT approval was sought nationally by NHS England on employers behalf.

33 Heritage assets

Historic artefacts

The remains of a Roman boat lie in the Guy's Hospital site, beneath the 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 (2020-21: nil). There were no disposals of artefacts during either year.

34 The Late Payment of Commercial Debts (interest) Act 1998

The Trust incurred £2k (£3k 2020-21) in charges relating to the late payment of commercial debts.

35 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 2022 was £29,237k (2020-21 £18,814k).

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contacts

Chief Executive
If you have a comment for the Chief Executive, contact:
Ian Abbs, Chief Executive
Tel: 020 7188 0001

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

Tel: 020 7349 7715 (Royal Brompton)
or 01895 826572 (Harefield)
Email: pals@rbht.nhs.uk

Membership
If you are interested in becoming a member of our NHS Foundation Trust, contact:
Tel: 0800 731 0319
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
www.guysandstthomas.nhs.uk/careers

Further information
If you have a media enquiry or require further information, contact:
Anita Knowles, Director of Communications
Tel: 020 7188 5577
Email: communicationsteam@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

Evelina London Children's Hospital Westminster Bridge Road London SE1 7EH

Tel: 020 7188 7188

www.guysandstthomas.nhs.uk

www.evelinalondon.nhs.uk

Royal Brompton Hospital Sydney Street London SW3 6NP
Tel: 020 7352 8121

Harefield Hospital Hill End Road Harefield UB9 6JH
Tel: 01895 823 737

www.rbht.nhs.uk

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GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
WEDNESDAY 27 JULY 2022

Title:	**Lead Governor's Report**
Governor Lead:	**Heather Byron, Lead Governor**
Contact:	**Heather Byron**

Purpose:	For information
Strategic priority reference:	TO BUILD RESILIENT HEALTH AND CARE SYSTEMS WITH OUR PARTNERS
Key Issues Summary:	A report from the Lead Governor to acknowledge what the Governors have achieved over the last three months and to outline plans for the next three months.
Recommendations:	The COUNCIL OF GOVERNORS is asked to: 1. Note the Lead Governor's Report

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS

WEDNESDAY 27 JULY 2022

LEAD GOVERNOR'S REPORT

PRESENTED BY HEATHER BYRON

1. Welcome

Firstly, I want to Welcome our newly elected to their first Council of Governors meeting. As I mentioned in our April meeting, we had a very competitive process which has seen the majority of seats taken by new colleagues and I know we all welcome their involvement. Welcome and congratulations to everyone elected / re-elected in July.

Also a welcome to Ian Playford who is the Trusts most recently appointed NED – colleagues and I look forward to getting to know you better and working with you.

2. Chair Appointment

I wanted to take this opportunity to say a heartfelt thank you to everyone on the CoG and Nominations Committee for being so enthusiastic, positive and constructive throughout the Chair succession process. From submitting areas of scrutiny for candidates, sitting in stakeholder panels, the final appointment panel and the wider CoG ratification process, everyone really played their part in ensuring a fair and balanced process.

I know we are all very sad to see Sir Hugh leave us in the coming months but I am confident as a result of our very robust process, that Charles will be a strong successor and will help to govern and champion the Trust in the way we need. I'm personally sorry that I wont have the opportunity to lead the CoG under his Chair-ship, but know that my own successor and the rest of the CoG will build good relationships with Charles and benefit from his guidance and experience as I have under Sir Hugh.

Guy's and St Thomas' NHS Foundation Trust

3. Our Trust

Whilst the daily news may have moved away from Covid-19, we all remain acutely aware that Covid-19 is still very prevalent in the community with rises in numbers in a number of our communities. Whilst we may not be seeing the volume of critical admissions of the past, it is still a major factor in the Trusts daily considerations and juggle and want all of the staff across Clinical and non-Clinical roles to know that we remain grateful for all they are doing to increasingly return to 'normal' whilst also managing all around them.

With 'return to normal' in mind, I do want to remind colleagues that a new series of site visits have been announced and I strongly recommend that you get involved with these if you can. I understand that there is a backlog in Occupational Health slots preventing some of our new colleagues from being eligible from joining in which is frustrating, but we are looking at what we can do to accelerate those interested in a site visit through that process. Please reach out to Corporate Affairs if this relates to you.

4. Governors Away Day

I was so disappointed not to attend the Governor's Away day due to testing positive for Covid-19. I have heard a lot of positive feedback both on the presentations, breakout sessions and the ability to reconnect in person. It was really a wonderful opportunity for everyone to catch up and I'm glad that a number of our newly appointed Governors were also able to join us. Thank you to colleagues who facilitated the breakout sessions for us.

5. Lead Governor

I hope you have all received the communication from Corporate Affairs and will be submitting your vote for the new Lead Governor. We have 2 exceptional candidates for the post and we would be lucky to have either of them lead the CoG going forwards. I strongly encourage you to vote and to do so by sending the name of your selected candidate to via email (CorporateAffairs@gstt.nhs.uk) by **no later than 4pm on Tuesday 26th July**.

That leads me to close out my final LG update with a thank you. It has been a privilege to lead the GSTT CoG over the last 2+ years. The CoG has adapted, supported and been a critical friend to the BoD through some of the most challenging times and for that I am grateful to each of our (current and former) Governors. I hope that the changes we have made together over that period will continue to be effective and enhance how the CoG operates going forwards – whether that be our new hybrid working patterns, regular board

/ clinical group committee seat rotations or improved communications and more casual opportunity to meet and get to know NEDs. I have really enjoyed my 6 years with GSTT, the opportunity to get such insight to how the Trust operates and, in a very small way, being part of the governance of that.

Thank you to you all and all the very best for the future.

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
QUALITY AND ENGAGEMENT WORKING GROUP
TUESDAY 28 JUNE 2022

Title:	**Council of Governors Quality and Engagement Working Group Meeting Notes, 28 June 2022**
Governor Lead:	**John Powell, Working Group Lead**
Contact:	**Andrea Carney & Sarah Allen, Working Group Secretariat**

Purpose:	For information
Strategic priority reference:	TO TREAT AS MANY PATIENTS AS WE CAN, SAFELY
Key Issues Summary:	A report on the Working Group's discussion on the following: • Overseas Visitors Policy • Patient Safety Incident Response Plan • Quarterly reports for Patient Experience and Patient and Public Engagement • Patient Experience Priorities
Recommendations:	The GROUP is asked to: 1. Note the key discussion points at the Quality and Engagement Working Group meeting

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST

QUALITY AND ENGAGEMENT WORKING GROUP

TUESDAY 28 JUNE 2022

QUALITY AND ENGAGEMENT WORKING GROUP MEETING NOTES

PRESENTED FOR INFORMATION

1. Introduction

1.1. This paper provides notes from the Council of Governors Quality and Engagement Working Group meeting held via Microsoft Teams on Tuesday 28th June 2022.

This meeting was attended by: Sarah Allen (Head of Patient Experience), Victoria Borwick (Public Governor), Andrea Carney (Head of Patient and Public Engagement), Steven Davies (Chief Finance Officer, GSTT), Marcia De Costa (Public Governor), Mary O'Donavan (Governor), Sian Vincent Flynn (Staff Governor), Paula Franklin–Lewis (Public Governor), Naomi Good (Patient and Public Engagement Specialist), Jan O'Malley (Patients Not Passports Group), Leah Mansfield (Patient Governor), Sarah Maskell (Director of Equality, Diversity and Inclusion), Sarah Moore (Head of Finance), Margaret McEvoy (Public Governor), Trudy Nickels (Governor), Placida Ojinnaka (Patient Governor), Georgina Parker (Patient Feedback Facilitator), Ashley Parrott (Deputy Director of Quality and Assurance), John Powell (QEWG Chair), Elena Spiteri (Membership and Governance Coordinator), Mark Tsagli (Patient Experience Specialist), Sonia Winifred (Governor),

1.2.

Apologies were received from: Serena Aboim (Governor), Priya Singh (Non-Executive Director), Anna Grinbergs-Saull (Patient and Public Engagement Specialist).

2. Agenda Item 2: Notes from the last meeting

2.1. The notes were approved as an accurate record of the last meeting with the following correction.
Matters arising: Item 6 Action Governors were invited to join the workshop to consider the patient experience priorities, but none were able to attend. The Head of Patient Experience noted that Item 5a on the agenda would offer a further update.

3. Agenda Item 3: Overseas Visitors Policy

3.1. Steve Davies (Chief Finance Officer, GSTT) introduced the item and presented a summary of the paper and the actions recently agreed by the Trust Board and Trust Executive Committee, taking into consideration the requests from the coalition, #Patients, Not Passports, which included:

a) Implementing the actions highlighted from the GSTT assessment of the framework developed by Lewisham & Greenwich, which includes development and delivery of a training program led by the Overseas Visitors team for all patient-facing staff, which will be tailored for clinical and non-clinical roles.

b) Taking forward the request of the *#Patients, Not Passports* coalition to undertake an Equality Impact Assessment.

c) Carrying out a follow up assessment of the *Lewisham and Greenwich Framework* in December 2022 in order to ensure the recommended actions are followed up.

d) Increasing resource within the Overseas Visitors Team.

3.2. Jan O'Malley from the coalition, *#Patients, Not Passports,* was welcomed by the Chair, having joined the meeting upon the invitation of Sir Hugh Taylor, Chair, GSTT.

3.3. Discussion:

Jan O'Malley, a representative of the coalition #Patients, Not Passports welcomed the report as goes some way to addressing the concerns as outlined earlier in their letter. #Patients, Not Passports remain concerned about the following:

- The policy is generating a hostile environment and generating fear among local people.
- Examples of feedback from stakeholders were too few in the health inclusion report.
- Whether GPs views were sought. For example, a local GP reported to #Patients, Not Passports that there examples of patients refusing a referral to secondary care due to fear

3.4. Jan O'Malley raised further questions, including, whether:

- The trust continue to document concerns and would these be used in staff training?
- The report would be a public document?
- A public health impact assessment be undertaken
- There has been any research into other legal obligations of the trust and their professional duties and concerns about moral injury, duty to provide treatment judged to be non-urgent?
- Can the report include the commitments outlined in the GSTT 2020 annual report including the protection of human rights of our patients and those most vulnerable?
- What is the timescale for the completion of the Equality Impact Assessment and would this be used to evidence the harm to patients to government and serve to lobby for the end of data collection and charging?
- Can the Lewisham and Greenwich framework document be shared?
- Will the report be expanded to reflect all of the above?

3.5. The Chief Finance Officer outlined that the Trust is unable to make changes to Trust policy, which is governed by The National Health Service (Charges to Overseas Visitors) Regulations 2015.

3.6. The Trust remains politically neutral, as expected of all NHS bodies, and therefore cannot lobby national government.

Actions

3.7 The Director of Equality, Diversity and Inclusion agreed to forward a copy of the Lewisham and Greenwich framework and that it was anticipated that the Equality Impact Assessment would be completed by the end of December 2022.

3.8. An update would be provided to this group in 12 months' time, noting progress on the the action plan and staff training, which will take 9-12 months (approx.) to complete.

4. Agenda Item 4: Patient Safety Incident Response Plan

4.1. Ashley Parrott, Deputy Director of Quality and Assurance gave a presentation on the Patient Safety Incident Response Framework (2022) replacing the Safety Incident Framework (2015) which outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

4.2. The framework is aligned to the Patient Safety Strategy (2019) which applies to all NHS organisations not just NHS Trusts and provides a broader approach to incident management.

4.3. It aligns to 'Just Culture' which emphasises that mistakes are generally a product of system cultures, rather than solely brought about by a person or human error providing more transparency, support and engagement with those effected by patient safety incidents and includes patient safety partners which are roles that

patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

4.4. The framework serves to bring much more ownership at directorate and clinical group level with support from the central team freeing up time and capacity for deeper investigation and system wide action planning.

4.5. What we have done so far includes:

- Reviewing the culture and root cause of problems
- Data analysis looking into the last 3.5 years of incidents to review the common themes
- Developed a clear brief and project structure
- Development and recruitment of Patient Safety partners is underway
- Developed the Patient Safety Training Strategy
- Aligned processes, tools and techniques for the incident management process

4.6. Next steps are to:

- Further develop the response plan and incident plan and in terms of engagement work is underway to share learning from death reviews with groups like QEWG.
- Continue to focus on areas for improvement identified including for example consent for surgery.

4.7. Discussion:

- How are the impacts of investigations monitored and how do we know the right process is in place?

- Much work has been invested into identifying frequent incident themes, and going forward we plan to complete deeper dive investigations to develop a clear action plan around system level issues.
- Another area for development is to involve families and patients to generate more insight and indications are families appreciate this.

5. Agenda Item 5: Patient Experience and Patient and Public Engagement update

5.1. Patient Experience Report Q4 was shared in advance of the meeting. The Head of Patient Experience updated Governors on the following highlights:

5.2. National Maternity Survey

- Benchmarking against the national maternity results - not as good as was hoped. Women's experience was impacted during the pandemic as partners could not stay overnight. They missed the support and this lead to feelings of isolation.
- A number of areas for improvement were highlighted regarding communications, confidence and trust, cleanliness, choice regarding location of post-natal care.
- There is a draft action plan and improvement measures are now in place for example allowing 2 birthing partners in to the wards, enhanced pain relief post-caesarean section via self-management pumps.

5.3 National Cancer Survey

- We also took part in the National Voluntary Cancer Survey in 2020, which was not mandated due to the pandemic, however, GSTT opted in as we were keen to have a more comprehensive view of patients' experience which would complement local feedback initiatives including the experience of mobile blood services.

  Results showed GSTT strengths including talking with, not talking in front of patients, privacy and dignity, care planning, confidence in ward nurses and staffing levels demonstrating improvement since the last survey. Improvement seen in GSTT communications notably in free prescription and information provision.

5.4. Patient Involvement in Research

- Patients participating in research activity dropped as an impact of Covid, an area where GSTT is usually a positive outlier.

5.5. Friends and Family Test (FFT)

- FFT results for admitted care highlighted 95% positive experience however a there was a slight increase in poor scores for day surgery and waiting for surgery reflecting the operational pressures in those services.
- In our Outpatient services, patients continue to struggle to get through via telephone in timely way.
- In community services there are waiting challenges and access to transport for prosthetic patients is a highlighted issue.
- Patient transport positives scores were high in January and dropped for the remainder of the quarter. Response rate and negative score improved slightly in March.
- We are taking part in a pilot with Transport for London (TfL) enabling our transport teams to use the bus lanes and so some additional questions have been added to the Patient Transport survey to monitor this.
- Inpatients: Areas identified for improvement include; knowing who to contact if concerned after discharge - contact cards, increased noise at night – work needed to sustain improvement measures put in place.

5.6. Discussion:

- Governors noted it was good to see that improvements in the hospital menu are reflected in the maternity survey - an area important for patients' recovery.

6. Agenda Item 6: Patient Engagement Report

6.1. The Head of Patient and Public Engagement, presented highlights from the Patient Engagement Report.

6.2. There is a slow return face-to-face meetings however people are still cautious and the majority of activity is taking place virtually as an impact of the pandemic.

6.3. It is rewarding to begin to see emerging insights from the Joint programme for Patients and Carers in Covid Recovery, with the findings to be published in the autumn. The programme's findings have been driven by co-design with staff and patients (over 20 workshops have taken place) in the three areas:

- Virtual access to car (telephone or online) appointments
- waiting for treatment and managing your condition at home
- long COVID

6.4 Evelina London received entries from all ages for the Evelina Children's Day Treatment Centre Arts Competition and entries were shortlisted by staff and a young patient. The team will produce a report on the findings of the art competition.

6.5. Patient participation is to recommence in the 1:200 scale design of the building for the new Orthopaedic Centre for Excellence including:

- The ground floor outpatients department
- Welcome and departure areas
- Patient rooms

6.6. We have supported the development of a Patient and Public Engagement Plan for the Surgical Strategy and focused improvement work using experience-based co-design. Staff and patients have been working in partnership to create solutions for two work streams including waiting well and pre-operative assessment.

7. Agenda Item 7: Patient Experience Priorities

7.1 The Head of Patient Experience) outlined the process that was undertaken to develop the Patient Experience Priorities.

7.2 Multiple sources of patient experience data from all sites, including local and national surveys, themes from PALS concerns and complaints, mystery shopping reports and virtual appointments surveys were analysed to identify what matters most to our patients to arrive at the patient experience priorities.

7.3 The Patient Experience team led workshops to discuss key questions and asked groups to vote on the important priorities including how we better meet the needs of diverse communities and top 4 include;

- Improving experience of contacting the trust by telephone
- Informing patients of waiting times
- Treating patients with kindness and understanding
- Ensuring patients have the information they need to access care treatment and support / aftercare.

7.5 Next steps include:

- Sharing the proposed priorities with clinical groups.
- Review by the Chief Nurses Office
- Returning to this group to share the agreed patient experience priorities

8. Item 8: Governor Updates:

8.1 Governor Leah Mansfield noted that the Royal Brompton and Harefield services are part of the Heart, Lung and Critical Care clinical group, with the principle of ‘one team, multiple sites’ being at its core. A Strategic Review has been ongoing since Royal Brompton and Harefield services joined Guy’s and St Thomas’. The review has considered.

- Workforce sustainability
- Data and care models

- Population health models
- New models of care
- Harnessing our academic strengths
- Strong management teams
- Strong engagement with patients and the public

8.2 Areas which are doing well include waiting for treatment, and vascular care. There are structured action plans in place to help improve waiting times for cardiac care.

9. Agenda Item 8: Any other business

9.1 No other business was noted.

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS
STRATEGY, TRANSFORMATION AND PARTNERSHIPS WORKING WORKING GROUP
Tuesday 12th July 2022
5.30 – 7.00pm, held virtually via MS Teams

Governors in attendance:	Placida Ojinnaka (Chair) Sarah Addenbrooke Marcia Da Costa Roseline Nwaoba Alison Mould	Mary Stirling Jordan Abdi Leah Mansfield Sian Flynn
Trust staff in attendance:	Jackie Parrott Jack Root Claire WIlls Felicity Harvey	Robbie Coffin Elena Spiteri Amy Butterworth-Fernandes
In attendance:	Colin Kinloch and Catherine Hart, Guy's and St Thomas' Charity	

1. Welcome and Apologies

1.1. The Chair welcomed colleagues to the meeting of the Strategy, Transformation and Partnership Working Group (the Group).

1.2. Apologies had been received from John Hensley, Heather Byron, Margaret McEvoy, Warren Turner, John Clark, Lawrence Tallon, Lindsay Jones, and Steve Weiner

2. Declarations of Interest

2.1. There were no declarations of interest.

3. Review of the minutes of the previous meeting and review of the action log

3.1. The minutes of the previous meeting of the Group, held on Tuesday 5th April 2022, were approved as a true record. The action log was noted; all actions were in hand.

4. Sustainability Strategy Development

4.1. The briefing slides had been circulated to Group members prior the meeting.

4.2. The Group received supplementary papers:
- Sustainability Brochure
- Brunel GSTT Future Observatory
- Delivering a Net Zero NHS

4.3. The group received an overview of the Trust Sustainability Strategy, including:
- The timeline of the development of the sustainability strategy, starting prior to December 2020 and the current implementation phase.
- The engagement and consultation process.
- Strategic themes and areas, and phase 1 priority commitments.

- Current Sustainability Steering Committee membership
- Sustainability projects.

4.4. The Trust Sustainability Manager described the development of the strategy through staff and stakeholder engagement sessions and surveys, as well government and sector mandated guidance (Environment Bill, NHS net zero agenda and he NHS Long Term Plan etc). The strategy is separated into 3 key themes: Carbon Zero, Connecting with Nature, and Cycle of Resources. The themes are further subdivided into areas of focus and there are two enablers: Our People, and Our Approach.

4.5. As part of the approach, a steering committee was established which is now chaired by the Deputy Chief Executive Officer of the Trust, which reports directly to the Trust Executive Committee (TEC). The committee is made up departmental directors linked to the key themes of the strategy. The committee most recently reported to TEC on the progress against phase 1 priority commitments, of which 46% are on course for the target date of May 2023.

4.6. Sustainability projects were detailed under the 3 key themes:

- Carbon zero:
  - Reduction in desflurane anaesthetic gas.
  - Review of Trust vehicle fleet
  - Electronic Vehicle (EV) charging infrastructure strategy
  - Only ultra-low emission vehicles on offer to staff through salary sacrifice.
- Connecting with nature:
  - Pilot study to reduce food waste on waste – rolled out to 15+ wards over 24 months through ICS funding
  - Green screen along Westminster Bridge Road
  - Ivy pollution barrier along Lambeth Palace Road
  - Edible hedge along Gassiot House
- Cycle of resources:
  - Reduce single-use items & circular economy projects

4.7. During questions and discussion the following was highlighted:

- The “Glove or no Glove” campaign is designed to make clinicians think about which procedures actually require the use of gloves. The aim is to reduce waste of single use items. It was highlighted that the use of glove is a relatively new thing in care settings and infection control procedures can be followed to perform actions that keep patients safe and reduce single use waste.
- It was clarified that in the pilot study for the use of reusable sharps bins, the sterilisation procedure is performed off site by a contractor and not by ward staff. It was also noted that the design of the reusable sharps bins prevents needle-stick injuries and that they are more robust than the single use bins.
- The project to remove single use privacy curtains

5. Charity Update

5.1. The background paper had been circulated to Group members prior the meeting.

5.2. The Charity Relationship Manager was joined by the Director of Fundraising and the Trust Funding Director to provide an overview of the charity function, structure and activities. The Guy’s & St Thomas’ Foundation is the ‘parent’ of three charities that provide support to the Trust: Guy’s & St Thomas’ Charity, Evelina London Children’s Charity and Guy’s Cancer Charity. Also part of the family, is Impact on Urban Health which delivers the Foundation’s focus on improving the health of the local areas and provides understanding on how inequalities impact the population’s health.

5.3. The Foundation has a large endowment which funds the fundraising function of the Foundation, meaning that every penny raised provides benefit for the Trust. The fundraising team raise funds through major gifts, corporate sponsorship, community led activity, events, direct marketing, legacies (wills and donations) and grants.

5.4. Examples of funded activities include:

- Providing a staff 'supermarket' during the first COVID-19 wave to allow them to have access to basic provisions.
- Staff wellbeing resources.
- Four permanent rest and recharge areas.
- Inpatient toiletries, phone chargers, activity packs, etc.

5.5. During questions and discussion the following was highlighted:

- In the last year £14 million was raised by the fundraising team. The endowment allows the foundation to fund the fundraising, through employing staff, paying engagement and communication materials as well as providing the artwork which can be seen across the Trust.
- For each of the charities, there is a fundraising committee which is made up of colleagues from the relevant part of the Trust. The ideas that are presented to them come from colleagues at Trust, for example; the single use curtain project mentioned in Item 4 was an idea from members of GSTT staff.
- The RBH (Royal Brompton and Harefield Hospitals) Charity is independent from the Trust, and therefore set their own priorities. However, GST Foundation work together closely with the RBH Charity to ensure that fundraising activities complement each other and don't overlap. Charity funded work, like the wellbeing offering, is open to all staff at GSTT including those from RBH. The RBH Charity is undergoing a strategic review, and are meeting regularly with the GST Foundation to identify funding alignment and ways of working that complement each other.

6. Any other business

6.1. No items were raised.

The next meeting would be held on Wednesday 5th October 2022 at 5:30pm – 7pm.