Guy's and St Thomas' NHS Foundation Trust

Council of Governors Meeting

Wednesday 26th July 2023 at 6pm

Governors' Hall, St Thomas' Hospital

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS

Wednesday 26th July 2023, 6pm – 7.30pm
Governors' Hall, St Thomas' Hospital and MS Teams

A G E N D A

1.	Welcome and apologies *Charles Alexander*	*Verbal*	*6.00pm*
2.	Declarations of interest	*Verbal*	-
3.	Minutes of previous meeting held on 19th April 2023 and review of actions from previous meeting	*Paper*	-
4.	GSTT Annual Report and Accounts *Paul Dossett, Steven Davies*	*Paper*	*6.05pm*
5.	Children's Primary Treatment Centre *Jackie Parrott*	*Paper*	*6.25pm*
6.	Report from the Nominations Committee *Charles Alexander*	*Paper*	*6.45pm*
7.	Reflections on Board of Directors meeting	*Verbal*	
	• Chief Executive's report		*6.50pm*
	• Critical IT incident		*7.00pm*
	• Sustainability strategy		*7.05pm*
	• Other matters		*7.10pm*
8.	Governors' reports for information	*Papers*	*7.15pm*
	• Lead Governor's Report *John Powell*		
	• Quality and Engagement Working Group: meeting notes 27th June 2023 *Leah Mansfield*		
	• Strategy, Transformation and Partnership Working Group: meeting notes 4 July 2023 *Leah Mansfield*		
9.	Any other business	*Verbal*	*7.25pm*

Date of next meeting: Wednesday 18th October 2023 at 6pm – 7.30pm

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS

Wednesday 19th April 2023, 6pm – 7.30pm
Robens Suite, Guy's Hospital and MS Teams

Governors present:	Jordan Abdi	Alan Hall	Roseline Nwaoba
	Koku Adomdza	Peter Harrison	Lucilla Poston
	Victoria Borwick	Katherine Hamer	Placida Ojinnaka
	Michael Bryan	Emily Hickson	John Powell
	Elfy Chevretton	Leah Mansfield	Mary Stirling
	John Clark	Joanna McGillivray	Raksa Tupprasoot
	Marcia da Costa	Margaret McEvoy	Claire Wills
	Sian Flynn	Alison Mould	
In attendance:	Charles Alexander (Chair)	Steven Davies	John Pelly
	Ian Abbs	Jon Findlay	Ian Playford
	Sarah Austin	Richard Grocott-Mason	Reza Razavi
	Avey Bhatia	Felicity Harvey	Julie Screaton
	Edward Bradshaw (minutes)	Anita Knowles	Simon Steddon
	Miranda Brawn	Phil Mitchell	Sheila Shribman
	Members of the public and members of staff		

1. Welcome and apologies

1.1. The Chair welcomed attendees to the public meeting of the Council of Governors. Apologies had been received from Simon Friend, Javed Khan, Sally Morgan, Priya Singh, Lawrence Tallon and Steve Weiner and from the following governors: Mark Boothroyd, Serina Aboim, Sarah Addenbrooke, David Al-Basha, Nicola Clark, Ibrahim Dogus, Marianna Masters, Trudy Nickels, Rishi Pabary, Mary O'Donovan, Warren Turner, Wisia Wedzicha and Sonia Winifred.

2. Declarations of interest

2.1. There were no declarations of interest.

3. Minutes of the meeting held on 25th January 2023

3.1. The minutes of the previous meeting were agreed as an accurate record, subject to the inclusion of Tendai Wileman as being in attendance.

4. Surgical strategy programme update

4.1. The Council of Governors received a presentation about the work of a patient and carer steering group that had been established to improve the experience of patients and their families receiving surgical care at the Trust. Placida Ojinnaka, a patient governor, was co-chair of the steering group, and together with Trust staff she explained how and why the group had been created, its vision and objectives, and some of the key successes to date.

4.2. There was strong support from both governors and members of the Trust Board for the work done and for the genuine partnership approach that was evident. From feedback received to

date it was clear that the group had helped improve patient experience and connect patients more closely with the Trust's services. Following questions received there was discussion about how this work could dovetail with the MyChart portal being developed as part of the new Epic electronic health record system, the importance of ensuring that there were multiple ways for patients to engage with the Trust so as not to accentuate health inequalities, and also how the work could learn lessons from other sectors as well as health.

4.3. It was noted that the group's focus for 2023 was to expand on the work already underway as well as to start several new projects to continue to improve the way surgical services are delivered across the Trust. All involved were thanked for their work.

5. Report from the Nominations Committee

Felicity Harvey left the room for this item and rejoined the meeting for item 6.

5.1. In February 2023 the Nominations Committee had reviewed and evaluated the balance of skills, knowledge, experience and diversity of the Trust's current non-executive directors, as well as the end dates of those directors' terms, against the risks, challenges and opportunities the Trust is facing. As a result, the Committee decided to commence a process to identify non-executive directors to replace a number of those due to stand down from the Trust Board in 2023, as well as to support the re-appointment of an existing non-executive director and the appointment of a new Senior Independent Director for when the incumbent leaves the Board in June 2023.

5.2. The Chair gave an overview of the rationale for all four proposals, indicating these recommendations had been made unanimously by the Nominations Committee. Two members of this Committee also spoke in support of the proposals.

5.3. The Council of Governors also noted that, over the coming months, Professor Reza Razavi would step down from the Trust Board as the nominated non-executive director from King's College London, and a process would commence to identify his replacement.

RESOLVED:

5.4. The Council of Governors approved:

- The appointment of Dame Pauline Philip as a non-executive director at the Trust for four years from 1 July 2023 to 30 June 2027;
- The appointment of Professor Deirdre Kelly CBE as a non-executive director at the Trust for four years from 1 July 2023 to 30 June 2027;
- The re-appointment of Simon Friend as a non-executive director at the Trust for a further four years ending 31 July 2027; and
- The appointment of Dr Felicity Harvey as Senior Independent Director from 13 June 2023.

6. Reflections on the Board of Directors meeting

6.1. There were a number of questions about the recent waves of industrial action, where it was confirmed that, as yet, there was no definitive information about whether consultants would also vote to strike. It was also clarified that the Trust did not benefit from any cost savings from withholding pay from striking staff due to the costs involved in paying other clinical staff to cover shifts, and the need to pay administrative staff to work increased hours to cancel and reschedule patient appointments. There was discussion about the level of disruption caused by the strikes on a day-to-day basis.

6.2. Governors explored the Trust's operational performance and sought information about how the Trust was working with partners to continue to increase the volume of elective activity it delivered. Whilst there were a number of reasons why the Trust was behind some of its London peers in the percentage of value-weighted activity it had delivered in 2022/23, the Trust Chair assured the Council of Governors that there was an increasing sense of urgency in the Trust to address the things within its control to reach the planned target of 103% in 2023/24. In response to a query about activity reductions during Epic go-live in October, it was confirmed that, whilst this would differ by clinical specialty, the Trust had taken advice from Epic and other trusts about the extent to which activity would reduce during this period, and the overall impact on the Trust's aggregate activity for the year.

6.3. There was discussion about developments regarding the delegation of specialised commissioning to integrated care boards from April 2024, and how the Trust was working to mitigate the financial risks that would arise. It was agreed that an update on specialised commissioning, and the Trust's work, would be brought back to the next meeting.

ACTION: SD, JP

7. Governors' reports for information

7.1. 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. The Lead Governor congratulated Katie Hamer, who had been elected as Deputy Lead Governor in a pilot scheme until September 2023, and encouraged governors to put themselves forward for the vacancies that remained for governor observers on a number of Trust Board committees. Governors were also encouraged to attend the annual away day, being held in person on 12 May.

8. Any other business

8.1. A query was raised by some governors about the suitability of the Boardroom at Royal Brompton Hospital for governor meetings, due to perceptions that it was inaccessible. Corporate Affairs would look into this.

8.2. The next meeting was due to be held on 26th July 2023 and arrangements would be confirmed in due course.


NHS
Guy's and St Thomas'
NHS Foundation Trust
Annual Report
and Accounts
2022/23

Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2022/23

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 5 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, renal and orthopaedic 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. Together our services at Royal Brompton, Harefield and St Thomas' are renowned 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 8 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.

Our reputation for healthcare research and innovation includes the very latest developments in imaging, surgical robotics and artificial intelligence.

We have around 25,300 staff, making us 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 8 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

Michael Gold, a patient at our community-based Amputee Rehabilitation Unit, being cared for by lead physiotherapist Philippa Joubert and lead occupational therapist Sophie Cook.

Contents

Cheyenne Morgan is one of our community nurses who uses an electric bike to visit her patients as part of an initiative to reduce pollution and improve staff health and wellbeing.

1 Chairman's statement

It is a great privilege to have been appointed to the position of Chairman of Guy's and St Thomas' NHS Foundation Trust, as well as of King's College Hospital NHS Foundation Trust, a position I took up in December 2022. I'd like to extend my personal thanks to Sir Hugh Taylor for his many years of dedicated service as the Chairman of these two distinguished healthcare institutions.

The pressures on Guy's and St Thomas', and across the NHS as a whole, remain substantial. Many patients are now waiting for NHS treatment, often facing waiting times that we all regard as unacceptable. Considerable effort has been focused on the recovery of our planned (elective) services and, while good progress has been made in many areas, we know that we need to do more, particularly in those specialties where waiting times are the longest.

Our clinical and non-clinical staff have worked with great dedication, to meet these challenges head on. I want to express my gratitude, and that of the Board, to each and every one of the staff in our hospitals and community services for their ongoing commitment to our patients and the communities we serve, and also for the way that they continue to support each other.

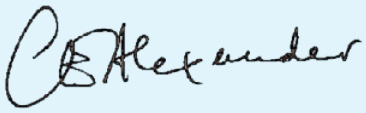
Throughout this period we have worked collaboratively with our partners across London and beyond to meet rising demand for care and to ensure equitable access. This has included working with our system partners and the newly constituted Integrated Care Systems in both south east and north west London. We look forward to developing these essential relationships further in 2023/24.

We are extremely proud of the diversity of both our patient and staff communities, but we know there is more that we need to do to make our organisation a truly inclusive and welcoming place for all. As a Board we are determined to understand and address the complex issues that can lead to inequality and exclusion and we have committed to a renewed focus on equity, diversity and inclusion in the year ahead.

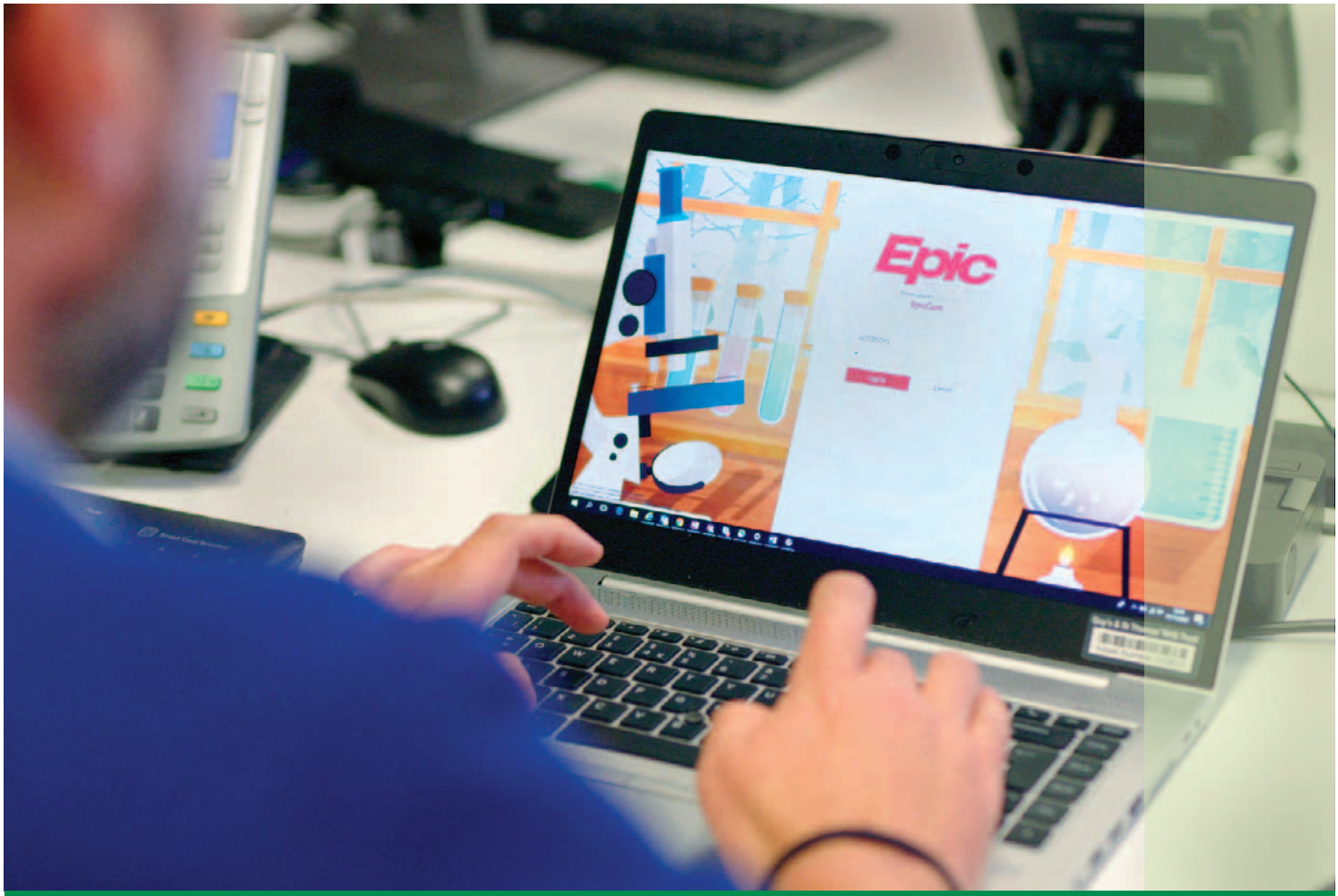
We are grateful for the significant and continued support of Guy's and St Thomas' Foundation, which continues to support our extensive staff health and wellbeing programme as well as initiatives to improve the experience of our patients and fund research, and I look forward to developing further this vital partnership in the coming years.

On behalf of the Board and as Chairman of the Council of Governors, I would like to record my thanks to our governors who provide essential oversight of our efforts to provide the best possible care for the communities we serve.

Finally I would like to welcome Ian Playford and Miranda Brawn who joined the Board as non-executive directors, and extend my thanks to Paul Cleal who stepped down from the Board this year.



Charles Alexander, Chairman
29 June 2023



Epic, our new single integrated electronic health record system is due to go live in October 2023 and will transform the experience of both patients and staff.

2 Performance report

Annual performance statement from the Chief Executive

It has been another challenging year, dominated by high demand for our services and complex operational pressures. Our staff have continued to work tirelessly to deliver safe, compassionate, high quality care to as many patients as possible.

We remain focused on the restoration and recovery of services following the COVID-19 pandemic, and although we have seen good progress in some areas, we have more to do to consistently deliver the required levels of operational performance against all the national standards.

We have finally been able to put certain aspects of the COVID-19 pandemic behind us, such as asymptomatic testing and some infection control measures, although we continue to feel the effect of the pandemic in many ways - not least in the number of patients waiting for diagnosis and treatment. We don't underestimate the considerable distress and anxiety that long waits and cancelled appointments place on patients and their families.

Despite the challenging context, our emergency department is consistently amongst the best performing in London and in the top 10 nationally. Work continues to ensure ambulance crews can hand over patients quickly and that all patients requiring emergency care can secure timely access to not only our own services, but also to appropriate mental health support when required.

Across the NHS there have been phenomenal efforts to restore planned (elective) care and diagnostic services to pre-pandemic levels, and we continue to work closely with our Integrated Care System partners, and the South East London Acute Provider Collaborative, to deliver equitable access to care and to reduce waiting times for treatment.

In the past year we have relentlessly focused on eliminating the cohort of patients waiting longer than 78 weeks for treatment, whilst also seeking to speed up access to diagnostic tests and treatment for all our patients. However, numerous periods of industrial action by key groups of staff have made it increasingly difficult to sustainably maintain progress with the recovery of our elective activity.

It is positive that improvements to the early stages of our cancer pathways have continued, and good progress has been made in reducing the backlog of patients waiting for cancer treatment. We recognise that we have more to do to achieve other cancer standards, including the 62 day maximum wait from referral for treatment to begin.

At an aggregate level it is also reassuring that we have seen outpatient activity return to pre-pandemic levels, and we continue to focus attention on increasing the number of new outpatients we can

Performance report

Annual performance statement

Overview

see in our clinics.

Despite the impact of industrial action, and critical IT outages during the summer and autumn, I am confident that we have set a good foundation on which to build going forward.

I very much regret the critical IT incident experienced in our own data centres during the heatwave last July as this had a devastating effect on our services, and therefore our patients and staff. I reiterate the full apology which I made at the time, and pay tribute to the expertise and dedication of our staff who ensured that no patients came to serious harm as a result of the outage.

We look forward to the significant opportunities that will be delivered by our Apollo Programme – a comprehensive new electronic health record system that will replace many of our clinical systems, improve the resilience of our IT infrastructure, and transform the experience of our patients and staff.

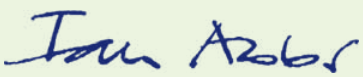
Our financial performance underpins all that we do, including our ability to invest in service improvements. The Trust agreed a 2022/23 target of breakeven with NHS England, and I'm pleased to report the year end position was a surplus of £13.1 million, after technical adjustments such as capital donations, depreciation on donated assets and valuations. The key national priority was on the restoration of planned (elective) care to exceed pre-pandemic activity levels and additional funding was made available to support this.

During the year, the Trust has renewed its focus on operational efficiency, and this will be given further momentum in 2023/24 as we respond to the changing financial regime nationally by implementing a wide ranging efficiency programme alongside our ongoing efforts to increase elective activity.

We have continued to invest in a number of service improvements for the benefit of our patients. The Trust's Capital Departmental Expenditure Limit (CDEL) allocation for 2022/23 was initially set at £111 million and later increased following agreement with South East London Integrated Care Board. Through careful financial management we met this new statutory requirement, reporting capital expenditure just below our CDEL allocation at the year end.

Our staff are our most precious asset and we have renewed our commitment to equality, diversity and inclusion with a specific focus on anti-racism in 2023. We are determined to create an environment where everyone truly feels that they belong, their voices are heard and their views are acted upon. We recognise that we have more to do in all these areas.

I want to thank and pay tribute to all the incredible staff who are at the heart of everything we do.



Dr Ian Abbs
Chief Executive

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 NHS Foundation Trust to create one of the largest NHS organisations in the country.

As an NHS foundation trust, we are accountable to Parliament and regulated by NHS England. As part of the NHS we 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 both general hospital services and 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 hospital teams work closely with our community services in Lambeth and Southwark, and serve both adults and children.

Our services at Guy's serve a wide population from across south London and further afield through a growing network of outreach clinics and satellite centres. These services include dental, renal, urology and orthopaedic services as well as cancer services, many of

which are provided in the Guy's Cancer Centre.

Royal Brompton and Harefield hospitals provide a wide range of specialist heart and lung services, and now work closely with our cardio-vascular services at St Thomas'. Together they form one of the largest centres specialising in the care of these patients in Europe.

Our services are closely involved in clinical and scientific research and, together with our partners, King's College Hospital, South London and Maudsley NHS Foundation Trusts and King's College London, we are part of King's Health Partners, one of 8 academic health sciences centres.

Guy's and St Thomas' is organised into 4 large clinical groups, and the Essentia delivery group, all of which are supported by corporate departments, as outlined in Chapter 7 'Our organisational structure.'

Our current Trust strategy 'Together we care' runs until the end of 2023, and work is underway to develop a new strategy, which will provide the strategic framework for the whole organisation to ensure we continue to provide the best possible care for patients now and in the future.

We also work closely to support the strategic priorities of our Integrated Care Board partners – particularly in south east London, but also in north west London and beyond – to deliver effective healthcare to the populations that we serve, improve health outcomes and reduce inequalities.

The Trust continues to work closely with the Integrated Care Boards to ensure compliance with capital limits, and utilisation of capital funds. The Trust supports the South East London Integrated Care Board in hosting capital funding for the Acute Provider Collaborative with a focus on digital diagnostics within South East London and also in delivering the Children's Day Treatment Centre through key funding initiatives such as the Targeted Investment Fund.

Our quality objectives and priorities are included in the Quality Report which is published on our Trust website.

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 eases, we still face significant and unique operational and strategic challenges for the Trust, most notably around the need to tackle growing waiting lists (elective recovery), manage the impact of ongoing industrial action, as well as the continued economic pressures due to a changing financial regime and constraints to capital funding.

A review of the Board Assurance Framework and principal strategic risks was undertaken in October 2022 which resulted in new strategic risks for Board-level assurance for 2023/24. These are outlined as the major in-year risks for 2023/24 set out on page 71 of the Annual Governance Statement.

In summary, the Trust's 4 main priorities and risks for 2023/24 are the safe implementation of the new electronic health record system, increasing levels of elective activity and operational productivity, controlling finances and improving delivery of efficiencies and supporting the workforce. In addition to these, and critical to core business, is the continued delivery of quality care.

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 report

Performance analysis – clinical

Despite an extremely challenging environment, and rising demand for our services, we have worked exceptionally hard to improve our performance and meet key operational standards. The impact of industrial action, as well as critical IT incidents affecting the Trust's services, have affected the speed at which we have been able to recover activity to pre-pandemic levels.

The Trust's clinical 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, providing vital insights into the quality and timeliness of care being received by patients.

As the impact of the COVID-19 pandemic has subsided, our focus this year has shifted to an intensive effort to restore planned (elective) care to pre-pandemic levels and to reduce waiting times for diagnostic tests and treatment, with a particular emphasis on those services where there is a backlog of patients who are waiting.

Staff across the Trust have continued to work with exceptional dedication and agility despite a number of unprecedented challenges, including sustained periods when both our hospital and community services were affected by IT outages and by ongoing industrial action.

The pressure on our emergency services has continued, with exceptionally high numbers of patients attending, particularly during the summer heatwave. In the winter months the number of children and young adults attending increased due to a rise in cases of Group A Streptococcus. A further challenge has been the often very complex needs of patients, including those presenting with severe mental health issues.

Despite this, the performance of our emergency services remains amongst the best nationally. At March 31 2023, our performance against the 4-hour standard was 77%, above the national target of 76%.

We have also focused on ensuring timely ambulance turnaround times to reduce delays for patients coming to hospital, and our community services play a vital role in both admissions avoidance and the prompt discharge of patients when they are ready to leave hospital.

During the past year we have continued to implement new models of service delivery in the community, including further development of our neighbourhood nursing teams and urgent response

services, which work across health and social care to provide integrated multi-disciplinary support that best meet the needs of local patients.

Throughout the year, our work to recover planned (elective) care has continued and we have made steady progress against our key objective, which is to treat more patients safely and sustainably.

By March 2023, the Trust had delivered an average of 97% of pre-pandemic outpatient activity levels, and 86% of planned (elective) admissions, when compared to 2019/20.

The speed at which we have been able to recover planned inpatient care has been affected by a number of issues, including capacity, particularly in our operating theatres and critical care. Addressing these issues remains a top priority, both through extended working hours and also targeted investment to open additional theatres and minimise the impact of essential maintenance.

Work to increase operating theatre efficiency has continued and national benchmarking data shows improved performance, with the Trust reaching 81% theatre utilisation rates for all surgical procedures. Innovative ways of working, such as high intensity theatre (HIT) lists, have also proved extremely successful.

We continue to use additional operating theatre capacity at Queen Mary's Hospital, Sidcup where surgical teams from Guy's and St Thomas' work with colleagues from neighbouring hospitals to carry out high volume, low complexity procedures.

We remain an active partner in the South East London Acute Provider Collaborative and together we have worked hard to increase day cases rates for surgical procedures, including for hernia repairs and gynaecology cases. Through shared waiting lists we have collectively worked hard to provide equitable access to treatment for our local population.

In north west London, teams at our Royal Brompton and Harefield hospital sites continue to work hard to meet the growing demand for both emergency and planned cardiac treatment and surgery, with an increase in complex cases following the pandemic.

Across our sites, we have welcomed the changes in infection prevention and control recommendations as these have allowed us to see more patients than during the pandemic. The safety of our patients and staff remains our priority and we are proud that our rates of infection, including for c-difficile and MRSA blood infections, remain relatively low and amongst the best in the country.

Our staff remain vigilant and focused on the continuing need to manage any increases in COVID-19, as well as to minimise the impact of other infections, such as influenza and norovirus, on our patients, staff and operational delivery. As part of the national High Consequence Infectious Diseases Network, we were also asked to respond to the mpox outbreak during 2022. While the number of cases nationally remained low, the complexity of the care required was significant, and placed an additional demand on key staff.

Across the NHS, reducing both the number of patients waiting and also tackling the longest waits for treatment, particularly for those patients who have waited over 78 weeks, has remained extremely challenging despite the extraordinary work of staff.

Despite our best efforts, at the end of April 2023 there were 83 patients waiting over 78 weeks for treatment against the revised national standard to eliminate these waits by the end of June 2023.

We continue to prioritise these patients, along with those waiting over 65 weeks, as we focus on the delivery of the national standard.

Throughout the year there has been a huge effort to reduce waiting times for cancer patients, and this has included work to transform processes and develop new models of care that aim to improve our performance against the national cancer standards.

This has included initiatives to ensure we meet, and wherever possible exceed, the maximum two-week waiting time standard for urgent referrals; consistently achieve the faster diagnosis standard (within 28 days); and also achieve the 62 days waiting time standard, although we recognise this remains especially difficult as we tackle the backlog of patients who have waited the longest.

Although cancer referrals have continued at above 2019/20 levels, from July onwards, performance against the two-week standard has

Performance report

steadily improved from, 84% of patients being seen within 2 weeks, to 95% in October. By March this figure had reduced slightly and was 90%.

Similar improvements have also been achieved against the faster diagnosis standard, and in November and December over 75% of patients either received a cancer diagnosis or were given the 'all clear' within 28 days. In March 2023 this increased to 77%.

Despite these welcome improvements to the early stages of the cancer pathway, we are very conscious that our performance against the 62 day standard remains a key challenge. At the end of March, the backlog of patients waiting over 62 days for treatment was 255 patients, reduced from a peak of just under 500 patients in September 2022. The focus on reducing the backlog and the impact of industrial action have led to a decline in performance against the 62 day standard, which was 49% in March, considerably below the national standard of 85%.

With our partners in the South East London Cancer Alliance, and working in partnership with our local commissioners, we are working hard to ensure equity of access to timely diagnosis and treatment for all cancer patients in south east London.

This includes reviewing the current Breast Screening Programme and working with local communities to better understand who this programme is failing to reach, including women in the West African community. Work is also underway to ensure equity of access to information about cervical screening in the Portuguese and Spanish communities and for transpeople and those who identify as non-binary.

The Trust has played a key role in the launch of the national Targeted Lung Health Checks programme, both in west and south London, enabling people aged between 55 and 75 years who have ever smoked to receive rapid access to a low dose CT scan if they are considered at high risk of lung disease. The programme aims to improve patient outcomes and reduce health inequalities.

Nearly 9,000 people have been invited for screening, almost 4,000 CT scans carried out and 60 lung cancer cases detected since the programme began.

The Trust has seen an increase in demand for diagnostic tests which has made it difficult to achieve the national standard that less than 1% of patients should wait longer than 6 weeks for a diagnostic test. The year end position is that 16% of patients are waiting over 6 weeks and we are working hard to reduce this with a particular focus on the longest waits.

We continue to invest in state-of-the-art imaging and diagnostic capacity across the Trust. Additional cardiac MRI capacity has been provided at Harefield, and the Diagnostic Centre at Royal Brompton Hospital, which opened in early 2022, and has increased capacity for echocardiography, CT scanning, cardiac MRI and bronchoscopy, including some highly specialised tests and procedures for which we are the only UK provider.

In December 2022, we also opened our new world-class medical imaging centre at St Thomas' Hospital which incorporates the latest artificial intelligence technology and clinical MRI scanners to improve patient care and support research.

Performance analysis – financial

The Trust has recorded a surplus of £24.7 million. After adjusting for capital donations, impairments, depreciation on donated assets, donated inventory and other technical adjustments, we ended the year with an Adjusted Financial Performance surplus of £13.1 million against the planned target of breakeven which was agreed with NHS England.

Across the NHS, during 2022/23 organisations moved out of the emergency financial regime that was introduced in response to the COVID-19 pandemic. Contracts with our commissioners were generally on a fixed-sum, or 'block-contract' basis, with indicative activity levels reflecting the number of patients to be treated. There was also a reduction in our level of income associated with the cost of responding to the pandemic.

Our financial performance

The Trust plan was to achieve a breakeven position, before technical adjustments such as capital donations, depreciation on donated assets and valuations. The key national priority was the restoration of planned (elective) care and for cancer treatment to exceed pre-pandemic activity levels. To support this, additional funding was made available through the Elective Services Recovery Fund. The Trust's plan assumed that if it achieved activity levels at 104% of 2019/20 activity, then it would receive £56 million from the Elective Services Recovery Fund to deliver this volume of care to patients.

Performance against plan

Whilst a number of services did achieve elective activity levels at or above 104%, this was not the case in aggregate across all Trust services. Factors influencing this included the speed at which services could be restored following the pandemic, the critical IT outage experienced by the Trust in July 2022 and the impact of industrial action that was taken in the final 4 months of the year. Given these challenges, and in line with national guidance, the Trust nevertheless received the full £56 million Elective Services Recovery Funding although discussions about this have continued with two Integrated Care Boards.

Despite the extremely difficult operational and financial environment across the NHS, once the technical adjustments which form part of the adjusted financial performance calculation are excluded, the Trust reported a surplus of £13.1 million at year end. The total adjustments for donations, depreciation on donated assets, valuations and donated inventory increased the overall position by £11.6 million, resulting in a final surplus of £24.7 million.

Capital donations of £4.6

Performance report

million were £4.4 million below plan; depreciation on donated assets, a change of £11.6 million, was £2.0 million above plan; while technical adjustments for impairments were as follows: annual revaluation of land and buildings £19.9 million and donated inventory £1.3 million.

Financial performance against plan	Plan £'000	Actual £'000	Variance £'000
Total surplus \ (deficit)	- 4,704	**24,696**	29,400
Less:			
Capital Donations	9,000	**4,613**	- 4,387
Impairment movements	0	**19,925**	19,925
Depreciation on Donated Assets	- 13,704	**- 11,655**	2,049
Donated Inventory	0	**- 1,289**	- 1,289
Adjusted Financial Performance	0	**13,102**	13,102

The Adjusted Financial Performance 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 £13.1 million.

Cost Improvement programme

At the start of the year, the Trust set a £46.2 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.

At year end, a significant proportion, £40.8 million, of the planned cost improvements were achieved. This was £5.4 million below plan.

Cash flow

The Trust began the financial year with £221 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 capital programme.

During the year, cash balances reduced by £90 million, to £131 million. For details of the Trust's net cash balances, see note 25 in the annual accounts on page 118. 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 £121 million of net cash generated from operating activities. The Trust spent a net £157 million on investments, including £165 million purchasing intangible assets and property, plant and machinery, and received £5 million in capital donations and £3 million in interest. A net £55 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 86.

Charitable funding

The Trust received £10 million from charitable sources during the year, £5 million of which consisted of donations towards capital expenditure which principally came from Guy's and St Thomas' Foundation.

Capital expenditure

In 2022/23, the Trust spent £116 million on property, plant and equipment (£126 million in 2021/22). The Trust also spent £42 million on intangible assets, mostly software and other technology information assets (£47 million in 2021/22). 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, with £229 million left outstanding for these loans in principal and interest.

During the year, the Trust made principal repayments of £18.1 million and interest payments of £5.4 million, creating a cash outflow of £24 million, and interest of £5 million was charged. At the year end, total borrowings equated to £211 million. See note 23.6 in the annual accounts on page 116.

Revaluation of land and buildings

As part of the preparation of the annual accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of each financial year. This year, the full impact on the income statement is a benefit of £19 million (£1.5 million in 2021/22).

In addition, impairments were charged to the revaluation reserve of £22 million (£20 million in 2021/22). Together the net impairment charge is £2 million (£18 million in 2021/22). 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 annual accounts on page 107.

External audit services

Grant Thornton received £253,000 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 £6,000 to Grant Thornton for their non-statutory audit work. For more details, see note 7.2 to the annual accounts on page 100.

Events since the end of the financial year

There were no events after the reporting date.

Identifying potential financial risks

In 2023/24, the Trust faces a number of financial risks. These include:

Delivering required efficiency savings - the Trust is required to deliver £92 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 position could 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 will lead to adverse income adjustments if not achieved.

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.

The Trust has a strong history of sound financial management and has delivered on its financial obligations since its inception. As and when risks materialise, management action will be taken decisively and rapidly in mitigation.

Continued impact of industrial action - unless resolved, continued industrial action will reduce activity and may impact on income if the Trust is unable to meet the targets it has been set for recovery.

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.

Given the Trust's strong history of sound financial management, as and when risks materialise, management action will be taken decisively and rapidly in mitigation.

Capital planning

The Trust's capital plan seeks to balance risk and delivery of strategic priorities over a 5 year period. It will do so by making best use of the capital and cash resources available over this period. The agreed plan is the outcome of a process involving clinicians,

Performance report

Trends in activity, income and expenditure

Chart 1: Completed patient spells

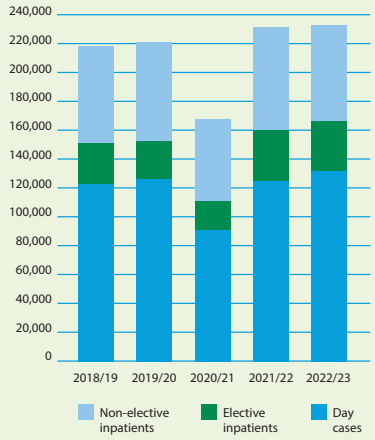


Chart 2: Outpatient attendances

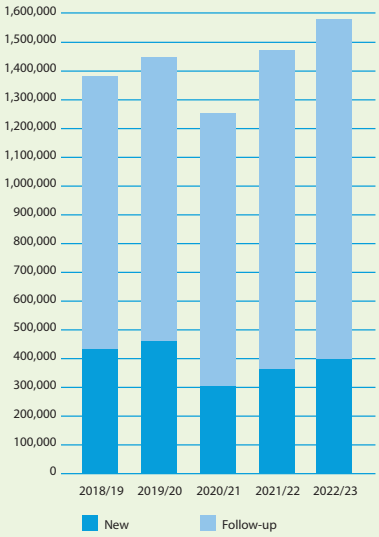
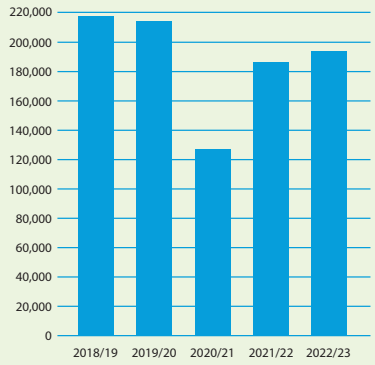


Chart 3: A&E attendances



During 2022/23, we saw in total 1,578,000 outpatients, 101,000 inpatients, 132,000 day case patients and 194,000 accident and emergency attendances.

We also provided over 629,000 contacts in the community, bringing our total patient contacts to 2.6 million.

Following our merger in February 2021, the charts include figures from Royal Brompton and Harefield hospitals for 2 months of activity in 2020/21 and for a full year of activity for 2021/22 and 2022/23.

Chart 4: Operating income £millions

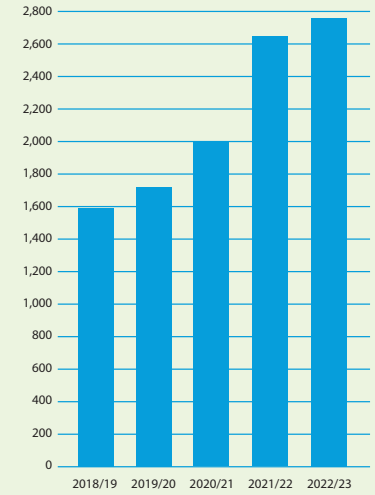
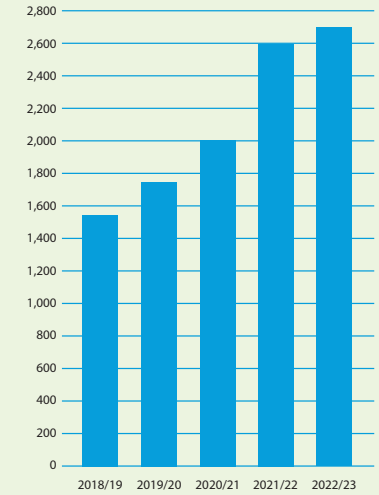


Chart 5: Operating expenditure £millions



clinical groups and the Trust Executive, and has considered the various demands for capital investment, resource availability and the underlying clinical and operational risks the investment will address.

In 2023/24 significant capital is committed to the delivery of key digital schemes, such as delivery of a new electronic healthcare record system, and other priorities that will help to increase capacity, such as the Children's Day Treatment Centre and new operating theatres on the Guy's Hospital site. Whilst the completion of these large schemes consumes significant capital, the Trust has also allocated increased capital for infrastructure resilience and regular replacement of vital equipment. A rolling programme of operating theatre maintenance and catheter laboratory replacement has also begun. This is in addition to the planned increase in funding for medical equipment and backlog maintenance over the next 5 years.

Demand for capital continues to exceed both internal resources and also the national expenditure limits which the Trust is set. The Trust therefore continues to carefully prioritise the allocation of available capital and to seek other sources of funding, either from national programmes, such as the Targeted Investment Funds, or by working with our charity partners.

Procurement

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

In the past year, the team achieved £13 million of savings across the shared service through competitive tenders, product switches and careful inventory management.

Performance report

Sustainability report

Environmental impact performance indicators 2022/23

	Acute hospitals 2022/23	2021/22	Trend 2022/23 vs 2021/22	Community services 2022/23	2021/22	Trend 2022/23 vs 2021/22
Water (m^3)	**578,923**	549,461	5%	**13,729**	13,471	2%
Water cost (£)	**1,189,159**	1,143,936	4%	**42,851**	39,219	9%
Imported Electricity (kWh)	**58,746,358**	82,634,727	-29%	**1,492,239**	1,822,871	-18%
Gas (kWh)	**195,480,190**	215,590,262	-9%	**1,410,117**	1,585,909	-11%
Oil (kWh)	**9,284,380**	437,068	2024%	-	-	-
Energy cost (£)	**29,610,669**	19,074,384	55%	**834,437**	364,177	129%
CO2e (in tonnes) for building energy use	**48,484**	56,819	-15%	**546**	678	-19%

Note. Oil consumption increased because temporary boilers are in use in some parts of Guy's Hospital; oil tanks were filled because of risk of interruption to gas supplies as a result of the conflict in Ukraine.

	Acute hospitals 2022/23	2021/22	Trend 2022/23 vs 2021/22
High temperature disposal (tonnes)	**559**	572	-2%
Alternative treatment (offensive waste) (tonnes)	**1,648**	2,148	-23%
Offensive Waste (tonnes)	**699**	373	87%
Landfill waste (tonnes)	**12**	15	-20%
Recycling by % of total	**36%**	32%	13%
Cost of waste (£)	**1,773,035**	2,255,686	-21%

Transport and Travel	2022/23	2021/22	Trend 2022/23 vs 2021/22
Core fleet (cars, vans and minibuses)			
Number in fleet	**248**	248	0%
Mileage	**2,178,084**	1,768,888	23%
CO2e (tonnes)	**917**	812	13%
Salary sacrifice fleet (cars only)			
Number in fleet	**215**	183	17%
Contracted mileage	**1,507,624**	1,375,637	10%
CO2e (tonnes)	**257**	271	-5%
Public transport (bus, tube and rail)			
Mileage	**364,462**	n/a	n/a
CO2e (tonnes)	**21**	n/a	n/a
Cycling			
Mileage	**4,966**	n/a	n/a
CO2e (tonnes)	-	n/a	271
Air travel			
Mileage	**1,053,454**	n/a	n/a
CO2e (tonnes)	**322**	n/a	n/a

Anaesthetic gases (volatile)	2022/23	2021/22	Trend 2022/23 vs 2021/22
CO2e (in tonnes) from Desflurane	**0**	27	-100%
CO2e (in tonnes) from Isoflurane	**25**	149	-83%
CO2e (in tonnes) from Sevoflurane	**11**	169	-93%
CO2e (in tonnes) from volatile anaesthetic gases	**36**	345	-89%

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

Note.

Core fleet: the total number of vehicles remained stable, but within that fleet we saw a decrease in pool cars and an increase in higher mileage patient transport vehicles. This led to an overall increase in mileage and CO2e emissions vs 2021/22.

Salary sacrifice fleet: despite an increase in the number of vehicles and mileage in this fleet vs 2021/22, CO2e emissions have decreased. This is due to a significant shift to electric vehicles within this fleet from 39% of the overall fleet in April 2022 to 58% in March 2023.

Grey fleet: the only data available for 2022/23 was expenses claims based on annual mileage of 330,000. No vehicle or fuel type data is currently available.

Miscellaneous Travel: the largest single contribution to 2022/23 travel expenses claims is recorded under Miscellaneous Travel. Payments filed under Miscellaneous Travel totalled £475,391.53, ranging from £1.55 to £10,000.00. Due to the lack of meaningful information on the nature of claims, including transport mode, this data has been omitted from the CO2e analysis. Further investigation into these payments is required to report more accurately on the Trust's carbon footprint from Scope 3 emissions in future years.

Performance report

Sustainability

Our 10 year sustainability strategy, launched in June 2021, recognises the Trust's environmental impact and our responsibility to actively protect our environment by providing sustainable healthcare. Our strategy considers both our national and sector obligations, as well as our position as an "anchor institution". We continue to work closely with our Integrated Care Systems to deliver a joined-up approach to sustainability initiatives across south east and north west London.

The Trust is committed to delivering a net zero health service as part of the Greener NHS Programme, and over the past year we have focused on three strategic themes where we can make the biggest difference: carbon zero, connecting with nature, and cycle of resources.

In 2022/23 our achievements against these themes include:

- 100% reduction in the use of desflurane anaesthetic gas in clinical practices. Using a bottle of desflurane has the same global warming effect as burning 440kg of coal.
- Over 1,000 miles travelled by our nurses on Trust e-bikes. This clean, active travel to visit patients at home is funded by Guy's and St Thomas' Charity.
- 0.5 tonnes (4%) less food waste per month at Royal Brompton Hospital thanks to improved quality of food, menu choices and better management processes.

Reducing emissions

We continue to encourage active and sustainable travel for patients and staff to reduce emissions, and we are working towards operating 'greener fleets', using electric vehicles, as well as supporting staff to work remotely where appropriate.

We also provide secure cycle parking as well as bike marking and maintenance sessions for our staff. From January 2023, only electric vehicles are available for staff to lease through our salary sacrifice scheme.

We are developing a new Green Travel Plan for all users of our hospital and community sites which will launch in spring 2023. Patients, visitors and staff were invited to have their say to ensure adequate facilities are in place to increase active, sustainable travel in our current and future estate, including cycling and walking.

Green space and biodiversity

We are enhancing our surroundings for patients and staff by increasing access to the national environment, encouraging active transport and improving air quality.

We have planted 400 trees at Harefield Hospital, thanks to a donation from the Woodland Trust. The recently installed Florence Nightingale Garden at St Thomas', supported by donations from Guy's and St Thomas' Charity and The Burdett Trust for Nursing, is home to 38 different species of plants, boosting biodiversity and attracting wildlife.

Reducing waste

We are reducing waste through a range of projects which focus on repair, reuse, recycling and innovation. Our reusable sharps bins have resulted in more than 1,000 such bins being reused over three months - realising a 2,000kg carbon saving. The pilot, taking place on wards at Guy's, St Thomas' and Evelina London hospitals, means that bins are collected, emptied, cleaned and returned ready to use again – up to 600 times.

Performance report

Equality, diversity and inclusion

Equality, diversity and inclusion

The Trust serves some of the most diverse communities 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 everyone 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.

We work hard to ensure all of our 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 continue to develop ways to collect and analyse key performance metrics to help us identify and address any inequalities experienced by our patients or staff.

The Trust undertakes equality and quality impact assessments to provide assurance that our policies, functions and services are fair and equitable. This helps to drive service level improvements, as well as partnership working with our communities and patients, to reduce inequalities which impact our patient population.

For our patients, we continue to:

- review and improve the way we design, develop and deliver both new and existing services to meet the needs of all patients, carers and staff;
- collect and analyse patient experience data and feedback, including through the Friends and Family Test, concerns received by our Patient Advice and Liaison Service and complaints and compliments analysed 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 improve social mobility by raising awareness of the 350 different careers within the Trust, as well as education and work experience opportunities.

For our staff, we continue to:

- work hard to offer all staff at all levels 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 developing staff networks to allow them to help shape, influence and critique our actions;
- create a safe space for staff to share their experiences and feelings, including issues relating to race, racism and discrimination;
- foster a compassionate and inclusive culture by looking after and valuing all staff;
- prioritise our commitment to ensure our senior management reflects the diversity of our wider organisation.

The Trust is committed to safeguarding all our patients, including the most vulnerable such as those with learning difficulties and those who are supported by our 'health inclusion' team. We participate in our local, multi-agency safeguarding boards which 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 service consists of separate teams for adults and children and they work closely with statutory bodies to provide support, guidance and decisions on all safeguarding issues. The teams 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, as well as specific training to support those with learning disabilities. 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.

The Trust provides a

comprehensive language and accessible support service to meet the communication needs of our diverse population. Our new website has been designed to ensure everyone can access the information they need, regardless of background, ability or needs. 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 - which have now been introduced at all our hospital sites.

We undertake comprehensive accessibility audits in all patient-facing areas and work hard to ensure that patients receive accessibility information to help them plan their visit before they arrive for an appointment.

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 all backgrounds into the workplace. This includes initiatives such as the Department of Work and Pensions Kickstart programme to deliver work experience and internships for young people with autism. We have seen a fourfold growth in a range of placements to help young people build experience and independence.

Under the Equality Act 2010, employers are required to set out arrangements for how they meet specific employment duties. The Trust is committed to fostering an equal and inclusive environment 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. We chair the London WRES Expert network bringing together organisations across London to work collectively to drive change. We also have a well-established reverse mentoring programme and we continue to develop and support cultural competence amongst our managers and leaders.

A multi-faith spiritual care team, reflecting the diverse faiths and beliefs of our local communities, is available to support patients and staff. The Trust celebrates its rich diversity through events, conferences and its vibrant staff networks, which provide important platforms to support an inclusive and compassionate culture; ensure that the lived experiences of staff are shared; and that staff can provide challenge, direction and innovation.

Dr Ian Abbs
Chief Executive
29 June 2023

The Trust developed a super-efficient but safe programme to maximise the number of patients treated using high intensity theatre lists – known as HIT lists. They focus on one type of procedure at a time, take place at weekends, and require careful planning to select suitable patients.

3 Accountability report

Ginny Wanjiro is a sister in the critical care unit at St Thomas' who has launched an initiative to care for the hair of patients from diverse backgrounds. The project is improving the care of some of the most unwell people in hospital and has received wide attention in the media.

4 Directors' report

Over the past year we have continued our focus on doing everything possible to return to pre-pandemic levels of activity, and to diagnose and treat as many patients as we safely can. We also continue to focus on our preparations to go live with a new electronic health record system later in 2023.

Teams across the Trust have worked tirelessly to return to, and exceed, pre-pandemic levels of planned care for inpatients, outpatients and diagnostic tests. Alongside this we remain focused on the needs of patients requiring urgent or emergency care, and continue to be amongst the best performing trusts nationally in meeting the 4 hour target in our Emergency Department.

We have continued to work closely with our partners across the south east London and the north west London health systems. Through the Acute Provider Collaborative in south east London we ensure equitable access to care for patients on the waiting list for high volume specialties such as ophthalmology, dental and orthopaedics.

As ever, the hard work and dedication of our staff has been critical to this effort and we pay tribute to them. We recognise how demanding this year has been with the impact of our ongoing recovery from the pandemic, combined with critical IT incidents and industrial action involving a number of unions, leaving many staff exhausted.

Despite this challenging context we've continued to deliver our strategic plans to adapt and improve our services to enable us to care for more patients. In December we opened our new world-class medical imaging centre at St Thomas' Hospital which incorporates the latest artificial intelligence technology with clinical MRI scanners to improve patient care and support vital research.

In addition our 'world-leading' Diagnostic Centre at Royal Brompton Hospital was officially opened by the Princess Royal in May. It provides the very latest in imaging technology to help diagnose cases of heart and lung disease.

We are proud we were able to rapidly adapt and extend our vaccination programme to deliver mpox and polio booster vaccinations, in addition to COVID-19 boosters. Our outreach vaccination teams have worked with partners across the south east London health system to ensure we were able to protect as many local people as possible, including hard to reach patient groups.

Our children's services at Evelina London Hospital have continued to develop our bespoke long COVID service and are now preparing for the opening this summer of the new Children's Day Treatment Centre.

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 last full inspection and assessment by the CQC was in March and April 2019.

We were pleased to have maintained 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. Royal Brompton and Harefield Hospital sites were last assessed by the CQC in October and November 2018, and remain rated as 'good' overall.

The CQC carried out an inspection of the Trust's maternity services at St Thomas' Hospital in September 2022. The service was rated 'Good' overall with positive findings and there were no changes to the Trust's overall CQC ratings as a result. It is disappointing that our maternity services were rated 'requires improvement' under the 'Safe' domain, and improvement actions are underway – specifically in relation to the triage process and the maternity assessment unit including both the environment and staffing.

As the Trust has not had a full well-led inspection or Trust-wide inspection since 2019, the Trust Board underwent an external mock well-led inspection in 2022 to aid in the Trust's readiness for a future inspection. We continue to focus on a range of actions to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, including a well-established programme of multidisciplinary quality visits, peer-to-peer reviews and a new ward accreditation scheme.

The Board has continued to assess its compliance with the principles of the Code of Governance for NHS provider trusts, 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 53 and in the Code of Governance published on the NHS England 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 elective recovery following the pandemic as well as preparations to implement a new electronic health record.

These indicators and updates are reported monthly through the integrated performance report. 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 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 and our Trust strategy 'Together we care', sets out how we plan to 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.

Evelina London provides comprehensive healthcare for children from before birth, throughout childhood and into adult life. Each year we care for more than 104,000 children and young people by providing hospital care and treatment at both our purpose-built children's hospital on the St Thomas' Hospital site and at the Royal Brompton Hospital.

We also care for families in our local communities of Lambeth and Southwark, and we provide an extensive range of specialist services for children with rare and complex conditions across our clinical networks, so that 1.7 million children from across south London, Kent, Surrey and Sussex can benefit from our expert care.

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 provide specialist care for patients with heart and lung disease, complementing existing strengths in cardio-respiratory and critical care for both adults and children at Guy's, St Thomas' and Evelina London. 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 children, and also children's interventional cardiology and cardiac surgery, while Harefield Hospital hosts a heart attack centre serving north west London and also provides transplant services.

We provide adult community health services across Lambeth and Southwark, and some specialist services in Lewisham, and work in partnership with colleagues from across the local health economy, including other NHS organisations, local authorities, primary care services and voluntary and community groups. This enables us to deliver care in a range of settings, including GP practices, health centres, schools, community buildings and in patients' own homes.

Engaging patients and the public

We value working closely with local Healthwatch organisations, who have continued to support our work through participation in our Joint Programme for Patient, Carer and Public Involvement in COVID Recovery. The findings of this work, involving 150 patients and staff, has now been published and considered long COVID, virtual access to care and the experience of waiting for treatment.

Through regular liaison meetings, Healthwatch is informed of service developments and delivery of our quality priorities. Healthwatch organisations also continue to share insights and feedback from their work with local people, which help to inform improvements in patient care.

Healthwatch organisations have the power to 'enter and view' healthcare premises to observe the delivery of services and the care environment. They did not undertake any onsite visits during 2022/23.

The Trust was not required to undertake formal public consultation exercises this year. However, the Trust was pleased to contribute to the Southwark Health Overview and Scrutiny Committee's interest in long COVID care and elective recovery.

In summer 2022, we undertook community engagement via the Lambeth Country Show to garner further insights on COVID recovery from people whose voices may be seldom heard in healthcare, and this work will continue to drive the design of our services.

Throughout last year, we have continued to involve patients and carers in work to put our cancer and surgery services strategies into action. We have involved young patients in our arts strategy for the new Children's Day Treatment Centre. Families have also helped us to make changes to how health visiting services are delivered, especially for those families who need our help the most during a child's early years.

Our heart and lung services at the Royal Brompton and Harefield hospitals have continued to involve young people with heart and lung conditions through their youth forum 'RBH Trailblazers'. This year the Trailblazers worked with clinical staff, to develop information videos to help young patients as they move from children's to adult services. Patients and staff also worked together to choose the art in the new Diagnostic Centre at Royal Brompton Hospital.

We continued to involve patients, families and carers in our Apollo programme to introduce a new electronic healthcare record.

Staff are working with the 50-strong panel of patient influencers to drive decisions about the design of the patient portal, MyChart, which will enable greater patient access to information about their care. The panel's insights have also helped to identify topics for inclusion in information resources that will support the use of MyChart.

Directors' report 2022/23

System leadership and partnership

The Trust is part of the South East London Integrated Care System and works with the North West London Integrated Care System via the Royal Brompton and Harefield hospitals.

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 in 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 work closely with other community services 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 primary care, community and hospital services. 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 continue to run the new low-dose CT screening programme to enable earlier diagnosis of lung cancer, with plans to further extend this across north west and south west London.

As a provider of specialist 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 specialist adult and children's services.

Guy's and St Thomas' is part of King's Health Partners, one of 8 Academic Health Sciences Centres nationally, which includes King's College Hospital and South London and Maudsley NHS Foundation Trusts and our shared university partner, King's College London.

King's Health Partners is 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 bring together our combined expertise to deliver world-class clinical care, research and education.

We also 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 work closely with Imperial College London, and remain founding members of the Imperial College Health Partners Academic Health Science Network.

Guy's Tower is a major hub for research activity and has many specialist research facilities which continue to strengthen our position as a leader in advanced therapeutics, genomics and regenerative medicine. St Thomas' is a major 'Medtech 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.

Following the de-designation of our National Institute for Health and Care Research Biomedical Research Centre in March 2023, we will be renewing our partnership strategy for the delivery of experimental medicine in south east London. This will include an ambitious new Experimental Medical Centre which will aim to maximise the impact of experimental medicine and translational research, and support the delivery of the best possible outcomes for patients. The centre has received generous support from Guy's and St Thomas' Foundation, as well as funding from King's College London and the Trust. Our intention is to broaden this partnership to include other partners, including King's College Hospital NHS Foundation Trust.

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.

The Trust continues to build its reputation for clinical innovation, as well as research, and is leading developments in many areas that directly improve the experience of patients, including advances in the use of robotic surgery, new imaging techniques and the use of artificial intelligence and computer technology to help identify those patients waiting for treatment who may require prioritisation.

Guy's & St Thomas' Foundation, formally Guy's and St Thomas' Charity, is a key strategic partner and the Trust is also its main beneficiary. As an independent foundation they invest in a healthier society and seek to drive more equitable healthcare through their Impact on Urban Health programmes. We work with them to identify where funding can enhance services for patients, provide a comprehensive health and wellbeing programme for our staff and support our strategic ambitions, particularly around innovative health research and patient experience.

The Foundation supports our 3 charities – Guy's & St Thomas' Charity, Guy's Cancer Charity and Evelina London Children's Charity – as well as fundraising. We also work closely with the Royal Brompton and Harefield Hospitals' Charity and a number of other charity partners.

King's Health Partners

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

It received £187 million in new awards and grants in 2022, and the number of research papers published by NHS clinicians increased by nearly 20% in the past year, reflecting significant activity related to COVID-19. Major awards included the King's Health Partners Experimental Cancer Medicine Centre being renewed for a further 5 years.

The partnership offers a range of education and training opportunities, including an online learning hub and events which were attended by more than 1,500 people in the past year - including an annual conference and inaugural population health conference.

5 Clinical Academic Partnerships focus on system-wide improvements to health outcomes. The partnership's flagship Mind & Body programme launched a new Quality Improvement Network that will use the expertise of 1,000 existing Mind & Body Champions to improve both physical and mental healthcare across south east London.

To drive better health locally, £1 million seed funding was invested to develop a joint programme with the Integrated Care System focused on population health and equity. Initial priorities include the Vital 5 – tackling tobacco dependency, alcohol, hypertension, obesity, mental health – as well as data science for population health management.

The partnership is an active member of the European University Hospital Alliance, and has developed further international partnerships with Aarhus University Hospital, and Sydney Health Partners to share best practice and foster excellence in research, clinical care and education.

Investing in our future

We have continued to invest significant capital in improving our estate, digital technology and medical devices to support the needs and expectations of our patients. A key focus has been on safely implementing the Trust's new electronic health record system through our 'Apollo Programme' whilst ensuring minimal disruption to the services that we provide.

The system is expected to go live later in 2023 jointly with King's College Hospital NHS Foundation Trust. A comprehensive implementation and training programme, as well as a number of associated digital infrastructure programmes, are underway and on track to support this. Once live, our new electronic health record will help transform the way we deliver care and empower our patients to get more involved in decisions about their health.

A new world-class medical imaging centre at St Thomas' Hospital was opened in December 2022 and incorporates the latest artificial intelligence (AI) technology with clinical MRI scanners to improve patient care and support research. The new facility will enable an additional 7,000 patients to undergo scans each year.

Directors' report 2022/23

A number of other major estates projects are currently underway and will increase inpatient capacity and improve the overall patient experience. Our longer-term estates plans to increase theatre capacity and expand our children's services also continue to be developed.

A range of innovative improvement projects are also being delivered through our Centre for Innovation, Transformation and Improvement (CITI), supporting our ambition to deliver better, faster and fairer healthcare.

Commercial Partnerships

The Trust has a long and successful tradition of innovation and business development, and continues to explore commercial opportunities that will generate additional income to support the delivery of NHS services. Despite a period of sustained pressure and operational challenges, 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)
- developing our global network and partnerships to expand international business development opportunities
- consolidating and enhancing the combined commercial expertise of Guy's and St Thomas' and Royal Brompton and Harefield hospitals, including the management of our private patient services.
- recruitment of a network of clinical leads to support our consulting, innovation and private practice activities.

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

- Lexica Health and Life Sciences Consultancy Limited, our estates and infrastructure company
- Synnovis (previously Viapath), our pathology joint venture with King's College Hospital NHS Foundation Trust and Synlab UK & Ireland
- KHP Ventures, 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, SpotOn and Zeus.

A full list of subsidiaries and interests in associates and joint ventures can be found in note 19 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 2022/23, Board membership comprised the following executive directors: Chief Executive , Ian Abbs; Chief Nurse, Avey Bhatia; Chief Financial Officer, Steven Davies; Chief Operating Officer and Deputy Chief Executive, Jon Findlay; Chief People Officer, Julie Screaton; Chief Medical Officer, Simon Steddon; and Deputy Chief Executive, Lawrence Tallon.

The Board also comprised the following non-executive directors: Chairman Hugh Taylor (to November 2022); Chairman Charles Alexander (from December 2022); Miranda Brawn (from January 2023) Paul Cleal (to June 2022); Simon Friend; Felicity Harvey; Javed Khan; Sally Morgan; John Pelly; Ian Playford (from May 2022); Reza Razavi; Sheila Shribman; Priya Singh; and Steve Weiner. See pages 60-62 for biographies.

Better payment practice code

Measure of compliance	Year ended 31 March 2023 Number	£000	Year ended 31 March 2022 Number	£000
Total bills paid in the year	**367,823**	**1,725,831**	367,012	1,725,623
Total bills paid within target	**238,423**	**1,139,301**	324,892	1,372,164
Percentage of bills paid within target	**65%**	**66%**	89%	80%

The total bills paid within the year has remained broadly consistent, although the percentage of bills paid within the target has deteriorated as a result of the impact of the IT outage that affected the Trust in summer 2022 and also changes to the financial reporting systems later in the year.

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 within the year has remained broadly consistent, although the percentage of bills paid within the target has deteriorated. Performance against the code is set and in the table on page 30.

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

In 2022 we opened the Mary Seacole Centre, a world-class medical imaging centre at St Thomas' Hospital incorporating the latest artificial intelligence technology with clinical MRI scanners to improve patient care and develop research breakthroughs.

5 Remuneration report

Chairman's annual statement

As the Chairman of the Remuneration Committee, I am pleased to present our remuneration report for 2022/23.

There were no changes to the Trust's remuneration policy for very senior managers in 2022/23.

The committee approved a 3% cost of living increase to executive and senior managerial salaries with effect from 1 April 2022.

There were changes to the executive team during 2022/23. Dr Simon Steddon, formerly Medical Director, was appointed as Chief Medical Officer following Professor Ian Abbs' appointment to substantive Chief Executive in September 2021.

During the year we welcomed two new non-executive directors onto our Board: Ian Playford, in May 2022, and Professor Miranda Brawn in January 2023.

I'd like to thank Paul Cleal who stepped down from the Board in June 2022 and Sir Hugh Taylor who was Chair and non-executive director until November 2022.

Charles Alexander
Remuneration Committee Chairman
29 June 2023

Remuneration policy report 2022/23

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 legacy membership and the 2015 Section for all from 01/04/2022. New executive directors are entitled to join the 2015 Section, which is a career average revalued earnings scheme.
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 2022/23 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 2022/23 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 on page 46 of this report. 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.

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 2022/23

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 2022/23

Name	Actual / Possible
Hugh Taylor (chair)	2 / 2
Charles Alexander (chair)	0 / 0
Miranda Brawn	0 / 0
Simon Friend	2 / 2
Felicity Harvey	2 / 2
Javed Khan	0 / 2
Sally Morgan	1 / 2
John Pelly	2 / 2
Ian Playford	2 / 2
Reza Razavi	2 / 2
Sheila Shribman	1 / 2
Priya Singh	1 / 2
Steve Weiner	1 / 2

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 total remuneration of the highest-paid director in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in 2022/23 was £285,000-£290,000 (£270,000-£275,000 in 2021/22). The relationship to the remuneration of the organisation's workforce is disclosed in the table overleaf.

Fair pay disclosures			
2022/23	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	35,855	44,748	55,057
Pay ratio	8.01	6.42	5.22

Fair pay disclosures			
2021/22	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	30,956	46,122	54,691
Pay ratio	8.73	5.86	4.94

The calculation is based on full-time equivalent staff working for the Trust on 31 March 2023. 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 remuneration, the highest paid Director's remuneration has increased by 5.5% between 2021/22 and 2022/23. The percentage change in average employee remuneration over the same period was an increase of 2.7%.

The difference in percentages is partly caused by the full year effect in 2022/23, of a pay change for the highest paid Director that was originally applied in mid-2021/22, following appointment to a substantive post.

In 2022/23 two employees received remuneration in excess of the highest-paid director. In 2021/22 one employee received remuneration in excess of the highest-paid director.

Remuneration ranged from £17,050 to £340,101 in 2022/23. (£17,000 to £288,000 in 2021/22).

The general increase in remuneration results from the national pay uplift across Agenda for Change bands. Pay costs in 2022/23 also include overtime, additional hours worked and selling of annual leave.

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

Service contracts

The following table contains details of the service contracts in place during 2022/23 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
Julie Screaton	Jun 2017	Open ended	3 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 2022/23 and 2021/22.

Single total figure 2022/23

Name	Title	Salaries and fees (bands of £5k) £000	Taxable benefits	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
I.Abbs*	Chief Executive	285-290	15	-	300-305
A.Bhatia	Chief Nurse	175-180	-	130-132.5	305-310
S.Davies**	Chief Financial Officer	190-195	-	37.5-40	230-235
J.Findlay	Chief Operating Officer and Deputy Chief Executve	200-205	-	280-282.5	480-485
J.Screaton	Chief People Officer	175-180	-	102.5-105	280-285
S.Steddon	Chief Medical Officer	245-250	-	222.5-225	470-475
L.Tallon***	Deputy Chief Executive	205-210	-	15-17.5	220-225
C.Alexander	Chairman (from 1 December 2022)	15-20	-	-	15-20
M.Brawn	Non-Executive Director (from 1 January 2023)	0-5	-	-	0-5
P.Cleal	Non-Executive Director (to 30 June 2022)	5-10	-	-	5-10
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	Non-Executive Director and Deputy Chair	50-55	-	-	50-55
J.Pelly	Non-Executive Director	20-25	-	-	20-25
I.Playford	Non-Executive Director (from 1 May 2022)	20-25	-	-	20-25
R.Razavi	Non-Executive Director	20-25	-	-	20-25
P.Singh	Non-Executive Director and Deputy Chair	30-35	-	-	30-35
S.Shribman	Non-Executive Director and Senior Independent Director	20-25	-	-	20-25
H.Taylor	Chairman (to 30 November 2022)	25-30	-	-	25-30
S.Weiner	Non-Executive Director	20-25	-	-	20-25

***** I.Abbs was not an NHS Pension scheme member for the year 2022/23.

****** S. Davies opted out of the NHS Pension Scheme in September 2022.

******* L.Tallon opted back into the NHS Pension scheme in January 2023. The Pension related benefits for the 3 months is nil effect.

Salaries and fees includes payment for sold annual leave for S.Steddon and L.Tallon.

H.Taylor was also Chairman of King's College Hospital NHS Foundation Trust until 30 November 2022, a role now fulfilled by Charles Alexander. Steve Weiner is also a Non-Executive Director at King's College Hospital NHS Foundation Trust.

No senior manager received any annual or long-term performance bonuses in 2022/23.

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 2021/22

Name	Title	Salaries and fees (bands of £5k) £000	Taxable benefits	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 Hospital NHS Foundation Trust and Steve Weiner is also a Non-Executive Director at 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 1 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 Trust remunerates its non-executive directors in excess of the guidelines in NHS England's Chair and Non-Executive Director remuneration structure (2019). Non-executive directors' terms and conditions are set and kept under regular review by the Council of Governors and reflect the scale and complexity of the Trust.

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

2022/23 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 2023 (bands of £5,000) £000	Cash equivalent transfer value at 1 Apri 2022 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2023 £000
S. Davies* Chief Financial Officer	2.5-5	0-2.5	40-45	75-80	601	35	668
S. Steddon Chief Medical Officer	10-12.5	20-22.5	70-75	150-155	1,128	210	1,401
L. Tallon** Deputy Chief Executive	0-2.5	0	15-20	0	181	12	204
A. Bhatia Chief Nurse	7.5-10	0-2.5	75-80	160-165	1,334	112	1,512
J. Screaton Chief People Officer	5-7.5	7.5-10	65-70	170-175	1,359	122	1,548
J. Findlay Chief Operating Officer and Deputy Chief Executive	12.5-15	30-32.5	70-75	180-185	1,262	295	1,622

***** S. Davies opted out of the NHS Pension Scheme in September 2022.

****** L. Tallon re-joined NHS Pension Scheme in January 2023.

I. Abbs was not an NHS Pension Scheme member for the year 2022/23 and there was no equivalent disclosure in 2021/22.

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

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

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

Ian Abbs
Chief Executive
29 June 2023

Facilities technician Roger Miantezilia is one of the 25,300 staff at Guy's and St Thomas'. We are proud that in the NHS Staff Survey 71% of staff said that they would recommend the Trust as a place to work, compared to the national average of 57%.

6 Staff report

We employ around 25,300 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 2022/23
Administration and estates	5,792	745	**6,537**
Healthcare assistants and other support staff	1,209	926	**2,135**
Medical and dental	3,102	436	**3,538**
Nursing, midwifery and health visiting staff	6,684	897	**7,581**
Nursing, midwifery and health visiting learners	1,139	584	**1,723**
Scientific, therapeutic and technical staff	3,506	256	**3,762**
Social care staff	5	–	**5**
Total average numbers	**21,437**	**3,844**	**25,281**

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 the performance of the Trust, and keeping them informed of changes across the organisation.

We work hard to ensure that our people are aware of both internal and external developments that may affect the organisation as well as 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 2022/23, we continued to score highly in the annual NHS Staff Survey – see overleaf for details. Our annual internal communications survey enables us to understand how effective our communications are and adjust our strategy accordingly.

Our range of well-established communication channels include regular briefings from the Chief Executive and senior leaders, topic or audience specific newsletters, daily messages on computer desktops and extensive intranets where staff can find policies, guidance and online tools.

In addition, online question and answer sessions enable us to engage with staff about important issues, such as industrial action and our Apollo programme, providing forums for people to highlight any concerns, get questions answered or share good practice.

Following our merger with Royal Brompton and Harefield hospitals we are continuing to align our Trust-wide communication channels. Our regular staff bulletin is now received by all staff and we've started work to deliver a new intranet Trust-wide.

We produce a popular magazine, the GiST, and a monthly e-newsletter, the e-GiST for staff, patients and our foundation trust members.

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

Staff report

established to look at policy and pay issues.

The Trust has 8 staff governors from clinical, non-clinical and community teams who contribute to the development of the organisation and represent colleagues' 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 2022 survey was the second year that these questions were aligned to the NHS People Promise.

As in previous years, our staff reported a positive experience of working for the Trust, and these results show how much there is to be proud of at Guy's and St Thomas', particularly given the extensive challenges currently facing the NHS.

The results are analysed against the national average for our comparator group which is 'acute and acute & community trusts'.

The response rate in 2022 was 41%, lower than the national average of 44% and lower than our 2021 response rate of 47%. Despite a decrease in the percentage of staff completing the survey, it is still reassuring that approximately 9,200 Trust staff took the time to have their say.

In 2022 the Trust achieved above the national average in all 7 People Promise elements and in the 2 themes of staff engagement and morale.

The staff engagement theme questions provide insight into the levels of motivation, involvement and advocacy of our staff. Our 2022 results once again show that our workforce is one of the most engaged, and Guy's and St Thomas' is ranked in the top 10 in the country for the overall staff engagement theme which are included in the table below:

The Trust's score for the 'we are safe and healthy' people promise was 6.0 compared to the national average of 5.9. We ranked second in London for staff agreeing that the Trust takes positive action on health and wellbeing and, as part of our local questions, 91% of our staff said that they were proud to work at the Trust and 93% of our staff said that they were aware of the organisation's values.

Results also indicate that best practice exists within our clinical groups and corporate directorates, with some scores even exceeding the best score nationally, including in our Essentia and People directorates. The Trust is committed to sharing best practice and promoting continuous improvement in all areas of the organisation.

In 2022, for the first time, organisations were encouraged to extend the NHS Staff Survey to 'bank only' staff and we opted-in as we were keen to hear from our bank staff about their experience of working at the Trust.

The response rate for our bank staff was 15%, with 500 completing the survey. The Trust's scores for this staff group were above the national average in all People Promises and themes, and the overall experience of bank staff compared very positively to that of substantive staff.

Question	National average	Trust score	Trust Ranking
Staff agreeing that the care of patients/service users is the organisation's top priority	74%	85%	Ranked third nationally and second best in London
Staff recommending the Trust to a friend or relative as a place to receive care or treatment	62%	82%	Ranked fifth nationally and second best in London
Staff recommending the Trust as a place to work	57%	71%	Ranked fourth nationally and second best in London

Areas for improvement

The Trust scored below the national average on 3 sub-scores including for diversity and equality. When comparing our results with our Shelford Group partners around the country, none of the London trusts met the national average in this area and we remain committed to improving our equality and diversity results as a priority.

In addition, we scored equal to the national average on 7 sub-scores. The Trust recognises the need for improvement in these areas and whilst we have started to feel the impact of some of the interventions introduced following previous surveys, more needs to be done at both a Trust and local level to really make a difference.

The Board remains dedicated to making significant improvements to address the areas of concern raised by our staff, and is committed to ensuring that the Trust is a welcoming, fair and inclusive place to work.

Over the last year we have introduced a number of initiatives, including:

Diversity and equality

- delivered a 'positive pathways' leadership programmes for Black, Asian and ethnic minority staff as well as for disabled and neurodivergent staff
- re-launched the professional coaching apprenticeships programme to support professional development of our staff
- implemented a workplace adjustment passport alongside a knowledge hub, open to all staff, to ensure support is provided to disabled, neurodivergent and staff with long term health conditions
- continued to grow our network of 200 inclusion agents across the organisation to support our equality, diversity and inclusion agenda.

Bullying and harassment

- delivered active bystander workshops to empower staff to call out poor behaviour
- provided a highly visible Freedom to Speak Up service across the Trust
- developed a Positive Behaviours Programme for our consultant body
- launched a Healthy Relationships toolkit to support leaders in creating a positive and inclusive team environment.

Health and wellbeing

- introduced 'wellbeing conversation' sessions for managers
- expanded the psychology team to improve local support and engagement for our staff
- delivered staff menopause clinics led by expert clinicians
- Healthy Eating Team launched an edible garden project for staff.

We are responding to the survey results by creating robust Trust-wide and local level action plans to drive positive change across the organisation. The results from the staff survey are reviewed in conjunction with other feedback gathered throughout the year and we regularly communicate the progress against our plans at Trust-wide team briefings and local forums, ensuring staff understand that their feedback is valued and acted upon.

The Trust continues to focus its efforts on improving the working experience of all staff, underpinning these efforts with a particular focus on equality, diversity and inclusion. Work to strengthen our inclusive culture, improve opportunities for career progression and further investment in our staff wellbeing offer include initiatives such as:

- a new People Manager Programme which will enable anyone with people management responsibilities to support the wellbeing, performance and careers of individuals in their teams
- refocusing our anti-racism strategy on improving the experience of Black, ethnic minority staff where our leadership teams work alongside middle managers to drive positive change.

Staff report

Staff survey scores

2022 and 2021 staff survey scores, benchmarked against our comparator group 'acute and acute & community trusts'

	Trust score 2022	Comparator group 2022		Trust score 2021	Comparator group 2021
Response rate	41%	44%		47%	46%
People Promise element					
We are compassionate and inclusive	7.3	7.2		7.4	7.2
We are recognised and rewarded	5.8	5.7		6.0	5.8
We each have a voice that counts	6.8	6.6		7.0	6.7
We are safe and healthy	6.0	5.9		6.1	5.9
We are always learning	5.6	5.4		5.7	5.2
We work flexibly	6.1	6.0		6.2	5.9
We are a team	6.7	6.6		6.7	5.9
Theme					
Staff engagement	7.1	6.8		7.2	6.8
Morale	5.8	5.7		6.0	5.7

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

Employee costs (including executive directors)

	Permanently employed £000	Agency, bank and seconded staff £000	Year ended 31 March 2023 Total £000	Year ended 31 March 2022 Total £000
Salaries and wages	**1,153,888**	**92,196**	**1,246,084**	1,133,654
Social security costs	**132,705**	**5,865**	**138,570**	122,158
Apprenticeship levy	**5,487**	**340**	**5,827**	5,495
Pension cost: employer's contributions to NHS pensions	**131,807**	**2,959**	**134,766**	125,715
Pension cost: employer contributions paid by NHSE on provider's behalf (6.3%)	**57,463**	**1,310**	**58,773**	54,900
Termination benefits	**526**	**–**	**526**	108
Temporary staff – agency/contract staff	**–**	**35,767**	**35,767**	32,344
Total gross staff costs	**1,481,876**	**138,437**	**1,620,313**	1,474,374
Included in above:				
Costs capitalised as part of assets	**(33,377)**	**(987)**	**(34,364)**	(29,523)
Less income netted off in staff costs	**(11,741)**	**–**	**(11,741)**	(8,668)
Total staff costs	**1,436,758**	**137,450**	**1,574,208**	1,436,183
Analysed into operating expenditure				
Employee expenses – staff and executive directors	**1,435,561**	**137,450**	**1,573,011**	1,434,673
Redundancy	**613**	**–**	**613**	904
Internal audit costs*	**584**	**–**	**584**	606
	1,436,758	**137,450**	**1,574,208**	1,436,183

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.

Staff report

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, the way the Trust is run or anything that affects their working life. The initiative is led by the 'Freedom to Speak Up' guardian, supported by a network of around 300 'speaking up' advocates across the Trust.

The guardian and advocates work together with local inclusion agents and wellbeing champions to provide an integrated and inclusive staff support network.

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 average score in the freedom to speak up metrics in the Model Hospital benchmarking.

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

Gender pay gap

Information about our gender pay gap is published annually and is available at gender-pay-gap.service.gov.uk as well as on the Trust's website.

Equality, diversity and inclusion

Staff group	Female	Male	Total
Employees	16,854	6,327	23,181
Senior managers	383	259	642
Executive directors	6	11	17
Total	**17,243**	**6,597**	**23,840**

Number of staff employed on 31 March 2023.

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. We recognise we have more to do to address inequalities across the Trust, as shown by our staff survey results and performance against the Workforce Race Equality Standard and Workforce Disability Equality Standard.

As a result we have refocused our staff equality, diversity and inclusion strategy into 5 key improvement areas which include: ending unfair treatment; understanding and including each other; fair employment processes; fair access to learning and development; as well as clear governance and accountabilities.

We are committed to supporting staff with long-term health conditions, those with a disability or who are neurodivergent, 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. We also offer internships for young autistic people.

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

- interactive workshops and mandatory training on bias, micro-aggression and incivility, authentic allies and advancing cultural competence;
- developing and empowering our vibrant LGBT+, multicultural, women's leadership, neurodiversity, disability and armed forces staff networks;
- increasing the numbers of inclusion agents to help raise awareness of best practice and offer peer to peer support on equality, diversity and inclusion issues;
- ensuring equality objectives are in place for all senior managers;
- reviewing and updating all people processes to eliminate bias and structural barriers;
- an award-winning apprentice recruitment programme and a programme to support apprentices with disabilities to gain placements;
- a fellowship programme to help address the gap in senior leaders from a Black, Asian or minority ethnic background;
- participating in the 'Step into health' programme which helps those leaving the Armed Forces to access employment opportunities in the NHS;
- a successful reverse mentoring programme which enables staff to share their experience with senior colleagues to enhance cultural awareness and understanding;
- working closely with partners such as Caretrade and The Prince's Trust to create more employment opportunities and training for young people.

The Trust follows good practice and takes all reasonable steps to prevent slavery and human trafficking as demonstrated in our Modern Slavery Act 2015 statement which is available on the Trust website.

Staff sickness absence

Staff sickness absence	2022/23	2021/22
Total days lost	232,799	200,053
Total staff years	21,556	20,764
Average working days lost (per WTE)*	**11**	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 2022 to December 2022 from the ESR data warehouse.

The latest publication, covering the year to December 2022, 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 2022, can be found on the NHS Digital website.

Safe working environment

Our health and safety service has been expanded to help support a positive health and safety culture whilst maintaining health and safety compliance across the organisation. The team works with our clinical and delivery groups, as well as corporate services, to facilitate the effective management of health and safety issues at all our sites.

A new in-house fit testing team was established to manage the Trust's response to the Department of Health and Social Care's Resilience principles for tight fitting respirators (FFP3 masks), ensuring our resilience for any future new respiratory viruses, and which proved beneficial in our response to the mpox (monkeypox) outbreak in May 2022.

We continue to respond to the health and safety lessons from the COVID-19 pandemic so that we can develop safer ways of working and improve the management of risk across the organisation.

Staff report

Occupational health service

Our occupational health service is one of the largest NHS based services in the country and comprises a multidisciplinary team of doctors, specialist nurses, health and safety specialists, wellbeing advisors, psychologists, manual handling advisers, administrators and researchers. The team delivers services both internally to the Trust and also commercially to a variety of local and national organisations. It was the first NHS organisation to achieve the Safe, Effective, Quality Occupational Health Service accreditation in 2011, and has maintained this accreditation ever since.

The service works closely with the infection prevention and control team to protect and support staff to stay safe and to minimise the risk of exposure to infectious diseases. It provides specialist advice to the Trust's vaccination and testing teams to support the delivery of effective staff flu and COVID-19 vaccination programmes.

The team provides training for managers to support them in managing sickness absence; enabling staff to remain or return to work with or without adjustments. They also work closely with the recruitment and onboarding teams and performance data is closely monitored and reported.

The dedicated health and wellbeing team continues to develop and improve the extensive staff health and wellbeing and benefits programme 'Showing we care about you' which is funded by Guy's and St Thomas' Charity. This includes self-referral for physiotherapy, dietitians, tobacco dependence support and referral to specialist psychological support. The programme includes a wide range of wellbeing training, and an employee assistance programme which provides counselling, manager's advice and financial support.

The psychology service was rapidly expanded during the pandemic and now has staff wellbeing psychologists embedded in all clinical and delivery groups. The team has specialist roles to support racial equity and works closely with the Trust's equality diversity and inclusion working groups to ensure staff have the best opportunities and support to enter the workplace and secure sustained employment.

The occupational health research team continued to deliver a research programme to improve the health outcomes and lives of the working-age population. With the London Centre for Work and Health, the team works in partnership with researchers and clinicians from different biomedical and allied health specialties and across different academic and NHS institutions in London and beyond.

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 2022 until 31 March 2023.

Table 1: relevant union officials	
Number of employees who were relevant union officials during the period	Full-time equivalent employee number
61	58.5

Table 2: percentage of time spent on facility time	
Percentage of employee time spent on facility time	Number of employees
0%	0
1%-50%	58
51%-99%	3
100%	0

Table 3: percentage of pay bill spent on facility time	
Total cost of facility time	£264,694.06
Total pay bill	£1,574,208,000
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	19.6%

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 intranets and receive fraud awareness training through presentations and interactive 'fraud chats'.

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

Further details on our approach to fraud and corruption and the Trust Bribery Declaration can be found on our webpage under statutory and strategy publications.

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 the agency rates of pay compare favourably with rates of pay on our Staff Bank.

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 our integrated care system, other London Trusts, and the Workforce Alliance to reduce these.

Expenditure on consultancy

Expenditure on consultancy in 2022/23 was £1,893,000.

Staff report

High paid off-payroll engagements

Table 1: Off-payroll worker engagements as of 31 March 2023, earning £245 per day or greater	
Number of existing engagements as of 31 March 2023	28
Of which, the number that have existed:	
for less than one year at the time of reporting	8
for between one and two years at the time of reporting	4
for between two and three years at the time of reporting	4
for between three and four years at the time of reporting	3
for four or more years at the time of reporting	9

Table 2: All off-payroll workers engaged at any point during the year ended 31 March 2023 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2023	28
Of which:	
Not subject to off payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	14
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	14
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.	7

* 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 2022/23.

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 2023 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 2022/23, a total of 20 exit packages were agreed in the year, 16 of which were compulsory redundancies. The total cost of exit packages was £613,000. Summary information for 2022/23 and comparative information for 2021/22 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	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
<£10,000	2	-	2	3	4	3
£10,000 – £25,000	9	9	1	1	10	10
£25,001 – £50,000	3	2	-	1	3	3
£50,001 – £100,000	1	3	1	-	2	3
£100,001 – £150,000	-	-	-	3	-	3
£150,001 – £200,000	1	-	-	2	1	2
Total number of exit packages by type	**16**	**14**	**4**	**10**	**20**	**24**
Total resource cost £000	**502**	**437**	**111**	**810**	**613**	**1,247**

Exit packages: other (non-compulsory) departure payments

There were 4 elements of other departure packages agreed in 2022/23, totalling £111,000. Comparative information for 2021/22 is provided in the table below.

	2022/23 Payments agreed	Total value of agreements	2021/22 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 court orders	3	110	3	14
Non-contractual payments requiring HMT approval (special severance payments)	1	1	-	-
Total	**4**	**111**	**11**	**810**

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

The Care Quality Commission (CQC) rated our maternity services good, following an inspection in September 2022. Pictured are maternity support worker Louise Samuel, new mum Karen Maxwell and baby George.

7 Our organisational structure: disclosures set out in the NHS 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.

In response to a significant increase in the size and complexity of the Trust in recent years, particularly following the merger with Royal Brompton & Harefield NHS Foundation Trust in February 2021, we introduced changes to the way we manage our organisation. During the year we continued to embed our clinical group operating model which allows us to manage our operational services closer to the frontline, whilst also maximising the benefits of scale. Our clinical services are now managed by four clinical groups:

- Evelina London Women's and Children's Services
- Heart, Lung and Critical Care
- Integrated and Specialist Medicine
- Cancer and Surgery.

These 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 continued strong clinical leadership.

In addition, the Essentia delivery group consists of our internal team responsible for capital, estates and facilities management, ensuring our buildings and non-clinical support services meet the needs of patients. A range of corporate services also provide Trust-wide support.

Council of Governors

The Council of Governors continues to play a vital role in the work of the Trust, representing the interests of our members and partner organisations and 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 approving 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 reviews our long-term strategy.

The Council of Governors holds regular 'informal' meetings and an annual away day in which governors assess their performance in discharging their statutory responsibilities and discuss ways in which to improve their impact and effectiveness.

The Council of Governors 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 also a quality and engagement working group which is a forum where the Trust and governors discuss patient engagement, quality improvement and safety matters.

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 two new partnership governors were appointed in 2022/23.

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 £3,750.32 during 2022/23. See page 55 for a full list of governors.

Our organisational structure

Code of Governance

The Trust has applied the principles of the NHS Code of Governance on a 'comply or explain' basis. In the few cases where the Trust has diverged from the recommended practice set out in the Code of Governance, it has made appropriate disclosures in this Annual Report and has provided explanations as to how its practices are consistent with the principle to which the provision in the NHS Code of Governance relates. The Trust keeps its governance arrangements under regular review, including membership of Board committees, their terms of reference and Board performance assessments. The NHS Code of Governance, most recently revised in October 2022, is based on the principles of the UK Corporate Governance Code.

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 recommendations to:

- appoint Charles Alexander as the new Chair in Common of the Trust and of King's College Hospital NHS Foundation Trust from 1 December 2022
- appoint Ian Playford as a non-executive director of the Trust from 1 May 2022
- appoint Miranda Brawn as a non-executive director of the Trust from 1 January 2023
- appoint Nilkunj Dodhia as a non-executive director of the Trust from 1 July 2023
- offer Sheila Shribman an extension of 12 months as a non-executive director of the Trust, to 12 June 2023
- offer John Pelly an extension of six months as a non-executive director of the Trust, to 30 June 2023
- offer Steve Weiner an extension of 12 months as a non-executive director of the Trust, to 22 July 2023, and
- offer Sally Morgan a second term of four years as a non-executive director of the Trust, to 31 December 2026.

The Trust engaged two external firms to aid with its identification and appointment of non-executive directors during the year. Odgers Berndtson supported the Trust in the appointment of Charles Alexander and Green Park undertook a similar role in the appointments of Miranda Brawn, who is now in post, and of Nilkunj Dodhia, who will join the Trust on 1 July 2023.

This year the Nominations Committee also reviewed and evaluated the balance of skills, knowledge, experience and diversity of the Trust's current non-executive directors, as well as the end dates of those directors' terms, together with the Trust's priorities, strategic ambitions and the key challenges it is facing.

Members of the Nominations Committee*

Name	Role
David Al-basha (from September 2022)	Patient governor
Charles Alexander (from December 2022)	Chairman
Heather Byron (to August 2022)	Patient governor
Elfy Chevretton	Staff governor
John Hensley (to January 2023)	Partnership governor
Margaret McEvoy	Public governor
Hugh Taylor (to November 2022)	Chairman
Warren Turner	Partnership governor

*The Nominations Committee is serviced by Trust's Corporate Affairs function.

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.

Council of Governors

Nominated lead governor: John Powell (from August 2022)

Trust Board Directors attended every Council of Governors meeting.

Patient governors	Elected from	Actual/possible attendance
Victoria Borwick	July 2021	6 / 6
John Bradbury	July 2021 (until March 2023)	4 / 6
Michael Bryan	July 2021	4 / 6
Heather Byron	August 2019 (until August 2022)	1 / 3
John Knight	July 2019 (until June 2022)	0 / 1
Leah Mansfield	July 2021	6 / 6
Betula Nelson	July 2019 (until June 2022)	1 / 1
Trudy Nickels	July 2021	4 / 6
Placida Ojinnaka	July 2018	5 / 6
John Powell (lead governor)	July 2019	4 / 6
Mary Stirling	July 2018	5 / 6
Christine Yorke	August 2019 (until August 2022)	1 / 3
David al Basha	August 2022	1 / 3
Nicola Clark	July 2022	1 / 3
Peter Harrison	July 2022	3 / 5
Joanna McGillivray	July 2022	3 / 5

Public governors	Elected from	Actual/possible attendance
Jordan Abdi	July 2021	4 / 6
Martin Bailey	July 2019 (until June 2022)	1 / 1
Marcia Da Costa	July 2018	2 / 6
Annabel Fiddian-Green	July 2018 (until June 2022)	0 / 1
Paula Lewis-Franklin	July 2019 (until June 2022)	1 / 1
Marianna Masters	July 2021	6 / 6
Margaret McEvoy	July 2018	6 / 6
Sonia Winifred	July 2021	2 / 6
Alan Hall	July 2022	4 / 5
Koku Adomza	July 2022	2 / 5
Katherine Hamer	July 2022	4 / 5
Alison Mould	July 2022	4 / 5
John Clark	July 2022	4 / 5

Staff governors	Constituency	Elected from	Actual/possible attendance
Serina Aboim	Community	July 2021	0 / 6
Mark Boothroyd	Clinical	July 2021	3 / 6
Elfy Chevretton	Clinical	July 2021	4 / 6
Sian Flynn	Non-clinical	July 2021	4 / 6
Laura James	Non-clinical	August 2019 (until August 2022)	2 / 3
Rishi Pabary	Clinical	July 2021	2 / 6
Raksa Tupprasoot	Clinical	July 2021	2 / 6
Rachel Williams	Non-clinical	August 2019 (until August 2022)	2 / 3
Claire Wills	Non-clinical	August 2022	5 / 5
Roseline Nwaoba	Non-clinical	August 2022	4 / 5

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

Trust Secretary
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	3 / 6
Evelyn Akoto	Southwark Council	October 2020 (until May 2022)	1 / 1
John Balazs	Lambeth CCG	December 2015 (until June 2022)	1 / 1
Robert Davidson	Southwark CCG	November 2015 (until June 2022)	0 / 1
Ibrahim Dogus	Lambeth Council	July 2022	0 / 4
John Hensley	Hillingdon Council	February 2021 (until February 2023)	4 / 6
Emily Hickson	Southwark Council	July 2022	3 / 5
Mary O'Donovan	South London and Maudsley NHS Foundation Trust	September 2021	1 / 6
Lucilla Poston	King's College London	January 2017	1 / 6
Warren Turner	London South Bank University	September 2014	4 / 6
Jadwiga Wedzicha	Imperial College London	February 2021	4 / 6
Timothy Windle	Lambeth Council	July 2020 (until June 2022)	0 / 1

Our organisational structure

Public Board meeting attendance April 2022 – March 2023		
Name	Title	Actual/possible
Ian Abbs	Chief Executive and Chief Medical Officer (until August 2022)	4 / 4
Charles Alexander	Chair and Non-executive director (from December 2022)	1 / 1
Avey Bhatia	Chief Nurse	4 / 4
Miranda Brawn	Non-executive director (from January 2023)	1 / 1
Paul Cleal	Non-executive director (until June 2022)	1 / 1
Steven Davies	Chief Financial Officer	4 / 4
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	3 / 4
Sally Morgan	Non-executive director and Deputy Chair	3 / 4
Ian Playford	Non-executive director	2 / 3
John Pelly	Non-executive director	4 / 4
Reza Razavi	Non-executive director	3 / 4
Julie Screaton	Chief People Officer	4 / 4
Sheila Shribman	Non-executive director and Senior Independent Director	3 / 4
Priya Singh	Non-executive director and Deputy Chair	4 / 4
Simon Steddon	Medical Director (until August 2022) Chief Medical Officer (from September 2022)	4 / 4
Lawrence Tallon	Deputy Chief Executive	4 / 4
Hugh Taylor	Chair and Non-executive director (until November 2022)	3 / 3
Steve Weiner	Non-executive director	3 / 4

Committee	Membership April 2022 – March 2023
Audit and Risk	John Pelly (Chair), Simon Friend, Priya Singh, Steve Weiner
Finance, Commercial and Investment	Simon Friend (Chair), John Pelly, Ian Playford, Reza Razavi, Steve Weiner, Ian Abbs, Avey Bhatia, Steven Davies, Jon Findlay, Lawrence Tallon
Heart, Lung and Critical Care Clinical Group Board	Sally Morgan (Chair), Simon Friend, Felicity Harvey, Avey Bhatia, Lawrence Tallon
Quality and Performance	Priya Singh (Chair), all Board members
Remuneration	Charles Alexander (Chair, from December 2022), Hugh Taylor (Chair, to November 2022), all other non-executive directors
Strategy and Partnerships	Charles Alexander (Chair, from December 2022), Hugh Taylor (Chair, from November 2022), all Board members
Transformation and Major Programmes	Steve Weiner (Chair), all Board members

At 31 March 2023 the Trust had 36,265 members, of whom 7,382 were patient members, 8,397 were public members and 20,486 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 popular and free-to-attend health seminars.

Board of Directors

Our Board of Directors is made up of our Chairman, Charles Alexander, eleven 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 has noted the criteria in the NHS Code of Governance which may impair, or could appear to impair, a non-executive director's independence. However the Trust is confident that all of the non-executive directors are independent in character, as they have consistently demonstrated objective and robust scrutiny and constructive challenge in their interactions at the Board, and there are no relationships or circumstances which are likely to affect, or could appear to affect, their judgement.

Non-executive directors at the Trust (excluding the Chair) are eligible for appointment for two four-year terms of office. This differs from the recommendation in the NHS Code of Governance that non-executive directors should be appointed and subject to re-appointment at intervals of no more than three years. The Trust Board of Directors and Council of Governors have taken the view that the scale and complexity of the Trust means non-executive directors need an extended period of time to understand the organisation and its activities before they can be fully effective in their roles. However, the Trust's Constitution, including the clause that stipulates the terms of office, is kept under regular review.

During 2022/23 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 – which monitors the financial performance of the Trust, its longer-term financial planning and oversees the development and implementation of the commercial and investment 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.

Heart, Lung and Critical Care Clinical Group Board – which has delegated responsibilities and decision-making rights for the strategic and operational running of the services within the Heart, Lung and Critical Care 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 appoint the non-executive directors in accordance with the Trust's

Our organisational structure

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 2022 almost 100 people attended our Annual Public Meeting where members, local people, patients, staff and other stakeholders heard about how we have performed during the year and had an opportunity to ask questions of the Board.

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 2023 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 2022/23

Name	Actual/possible
John Pelly [Chair]	5 / 5
Simon Friend	5 / 5
Priya Singh	4 / 5
Steve Weiner	4 / 5

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 2022/23

Name	Actual/possible
Hugh Taylor (Chair)	1 / 1
Charles Alexander (Chair)	1 / 1
Miranda Brawn	1 / 2
Simon Friend	2 / 2
Felicity Harvey	2 / 2
Javed Khan	0 / 2
Sally Morgan	1 / 2
John Pelly	2 / 2
Ian Playford	2 / 2
Reza Razavi	2 / 2
Sheila Shribman	1 / 2
Priya Singh	1 / 2
Steve Weiner	1 / 2

Working with the Council of Governors

The Board of Directors interacts regularly with the Council of Governors to ensure that it understands their views and those of our members.

Governors are invited to attend four public Board meetings a year. These are followed by a meeting of the Council of Governors which includes a session reflecting on the Board meeting.

Governors attend the Quality and Performance, Finance Commercial and Investment, and the Transformation and Major Programmes Board Committee meetings, as well as the Heart, Lung and Critical Care Clinical Group Board as 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 non-executive directors 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:

- set Trust values and oversee the establishment of an organisational culture that aligns with these values and which promotes equality, diversity and inclusion for patients and staff
- prioritise and allocate resources across clinical groups and corporate functions
- oversee the development and management of the Trust's external partnerships, locally, regionally and nationally
- oversee the development and delivery of strategies, programmes, 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 the development and implementation of the Trust's financial strategy.

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 makes decisions on the coordination of resources in response to opportunities, pressures and risks.

Trust Risk and Assurance Committee – oversees 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

Charles Alexander CBE
Chairman
(from December 2022)

Charles was appointed Joint Chairman of Guy's and St Thomas' and King's College Hospital NHS Foundation Trusts with effect from December 2022.

Charles has had a long and distinguished career working at board level across a number of different sectors, including very senior leadership roles at NM Rothschild and GE Capital Europe. He is Chairman of VIVID Housing, a leading housing association and housing development company in south England.

He is a strong supporter of the arts and has served as the lead non-executive director at the Department of Culture, Media and Sport. He spent 6 years volunteering with Trinity Hospice, providing support to patients and families at the end of life.

He was formerly Chair of both the Royal Marsden NHS Foundation Trust and the Royal Marsden Cancer Charity, roles he held between 2016 and 2022.

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 of Royal Brompton & Harefield NHS Foundation Trust. Sally 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 and she chairs the Heart, Lung and Critical Care 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 of Frimley Integrated Care Board.

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

Professor Miranda Brawn
Non-executive director
(from January 2023)

Miranda is a business expert, board advisor, investor and philanthropist across many sectors, with a career that spans financial service, law, charity and health.

Before joining the Bar of England and Wales as a barrister and senior banking lawyer, she worked as an investment banker.

She has served as an equality commissioner for Lambeth Council and is President and Board Chair of The Miranda Brawn Diversity Leadership Foundation. Miranda is a champion for diversity and inclusion, and also a Senior Visiting Fellow at the University of Oxford lecturing, mentoring and researching The Brawn Review on boardroom sustainability and inclusion.

Simon Friend
Non-executive director

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 joined the Board in February 2021, having previously been a non-executive director of Royal Brompton & Harefield NHS Foundation Trust, and chairs the Finance, Commercial and Investment Committee.

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. 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 is Chair of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and was previously Chief Executive of the charity Barnardo's. He regularly advises government ministers and recently led an independent review into government policy for a smoke-free England. Javed has also been a member of the advisory board for the Children's Commissioner for England and served as a member of the Government's Grenfell Recovery Taskforce. He joined our Board in February 2021 having previously been a non-executive director at Royal Brompton & Harefield NHS Foundation Trust.

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.

Ian Playford

Non-executive director

Prior to joining the Board in May 2022, Ian had been a non-executive director at Royal Brompton & Harefield NHS Foundation Trust.

He has over 30 years' experience as a senior executive across the public and private sector. His previous roles include interim chief executive at the Government Property Agency, where he managed the Government's warehouse and science estate.

He was also a group property director of Kingfisher PLC and has been a member of the board of HM Courts and Tribunals Service and the Queen Victoria Hospital NHS Foundation Trust in East Grinstead.

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. She joined the Board in June 2013 and chairs the Board of Evelina London Women's and Children's Clinical Group.

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 – non-executive directors

Sir Hugh Taylor

Chairman (to November 2022)

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 was also the Chair of King's College Hospital NHS Foundation Trust since 1 March 2019. Hugh stepped down from the Board in November 2022, shortly before the expiry of his final term as Chair.

Paul Cleal OBE

Non-executive director (to June 2022)

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. Paul stepped down from the Board in June 2022 as he was moving away from London.

Board of Directors – executive directors

Professor Ian Abbs

Chief Executive and Chief Medical Officer
(to August 2022)

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

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

Chief Medical Officer
(from September 2022)

Simon joined the Trust as a consultant renal physician in 2005 and became a Clinical Director in 2008 before serving as the Trust's Chief Operating Officer from 2014 to 2016. He was appointed as the Trust's Medical Director in 2016, and then Executive Medical Director in 2019. Simon took up his role as Chief Medical Officer in September 2022. 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.

In 2022 we held a virtual reality surgical training event allowing trainees to practice and develop their surgical skills in a safe simulated environment before they go into a real operating theatre.

8 NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

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 assigned Guy's and St Thomas' NHS Foundation Trust to segment 2 in March 2023. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-systemoversight-framework-segmentation/.

The London School of Paediatrics recently published its Trainee Doctor End of Post Survey results, which show the neonatal unit at Evelina London Children's Hospital is rated as the best in London for training experience. Pictured are Dr Paul Cawley, consultant neonatologist with Kiara Jackson and baby Kyrie.

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 England.

NHS England 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 England, 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
29 June 2023

Appendix 1: Annual governance statement 2022/23

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 2023 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Leadership of the risk management 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 strategic 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 minutes and assurances 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, sets out the accountability and reporting arrangements for risk management and the processes that maintain robust 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. As outlined in our risk management policy, the Chief Medical Officer carries responsibility for ensuring this policy is implemented correctly and is sufficiently effective. The Chief Medical Officer, in conjunction with the Chief Nurse, also holds responsibility for clinical governance and the appropriate monitoring of clinical standards, including morbidity and mortality. These functions are overseen by our executive sub-committee, the Trust Risk and Assurance Committee.

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 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. Our Audit and Risk Committee enables non-executive directors to provide objective oversight of our risk management function and leadership.

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 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 risks and staff receive training commensurate with their role as part of policy implementation. Work remains ongoing to align and embed existing Guy's and St Thomas' Trust policies with those from Royal Brompton and Harefield Hospitals following our merger in 2021/22. A series of strategic reviews have been completed to align operational teams and delivery. A risk-based approach is in place to ensure staff at respective sites can access the policy information and guidance they require to control areas of risk, for example health and safety policies or the Trust's risk management framework.

The Trust learns from good practice through a range of mechanisms including clinical supervision, peer review, effective performance management, continuing professional development, clinical audit, the application of evidence-based practice and reflective practice. These mechanisms are in place and embedded across our clinical and delivery groups.

Learning from investigations and root cause analyses feeds into relevant quality improvement initiatives, as well as Schwartz Rounds and our 'Safety connections' campaign. A patient or staff safety story linked to relevant agenda items is shared at each Quality and Performance Board Committee meeting. A 'Quality Matters' newsletter is published monthly for all staff and includes key messages and examples of learning. Our Serious Incident Assurance Panel meets monthly with clinical group attendance to share and discuss learning from adverse events and dissemination across the Trust. This committee reports into our Trust Risk and Assurance Committee for corporate and clinical assurance into the Trust Executive Committee. The Trust Risk and Assurance Committee also receives assurance from our patient experience, learning from deaths, health and safety, and patient safety committees for holistic oversight of learning and improvement.

Our internal audit department undertook their annual review of our risk management and board assurance frameworks in early 2023. They found the Trust's capacity and ability to handle risk was maintained at substantial assurance and made no significant recommendations. The Trust continues to annually audit its risk management framework policy effectiveness, which comes to the Audit and Risk Committee for noting. Internal audit maintains a robust annual audit plan and audit activity to provide objective, internal assurance to the Board on all manner of risk control such as Trust operations, performance and financial management.

Board and Board committee agendas continue to be structured around a comprehensive forward plan of reports that are closely linked to the Trust's statutory and regulatory responsibilities. This helps 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 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 directorate's, clinical group's or corporate (executive) risk register. The Trust utilises a risk register to oversee and manage operational risk across the Trust. This allows the central Quality and Assurance team to fulfil the role of Chief Risk Officer to monitor change in risk scores, as well as challenge non-moving risk within the system. Thematic reviews of risk types (for example clinical or patient safety) are undertaken periodically and reported to risk oversight committees for assurance on control (for example, high level clinical risks reported to the Trust's patient safety committee).

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 within the boundaries of the Trust's risk evaluation framework. The Trust seeks to reduce risks as far as possible; however it is recognised that delivering healthcare carries inherent risks that can never be completely eradicated. The Board and its committees are aligned to assure that there is independent and strategic focus on both risk and assurance.

A serious incident assurance panel, chaired by the Director of Quality and Assurance and the Deputy Medical Director for Safety and Clinical Effectiveness 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.

The Trust has effective mechanisms in place to act upon alerts and recommendations issued by all central bodies. The Trust has maintained 100% compliance with responding to national safety alerts issued through Central Alerting System.

During 2022/23 we continued to refine and embed our governance arrangements following the merger with Royal Brompton and Harefield Hospitals and our move to a group operating model. Our arrangements provide the necessary support to deliver our operational priorities, improvement plans and strategic ambitions. The Trust Executive Committee continues to reinforce the importance of clinical leadership and oversee a number of supporting sub-committees, all with corporate governance assurance lines to the Board. Our clinical groups continue to strengthen their internal governance arrangements within the Trust's corporate governance framework.

The Board Assurance Framework sets out the Trust's principal risks to achieving our strategic objectives and the key controls and assurances available to the Board of Directors on the management of these significant areas of risk. The Board Assurance Framework incorporates four tiers of assurance encompassing day-to-day operational controls, how we obtain performance oversight of these controls, our sources of internal objective assurance, and external independent assurance. It highlights the following areas where, at 31 March 2023, the Board had limited assurance despite significant management attention:

- delivering levels of activity in line with the Trust's plan
- the ability to deliver safe, high quality care to patients across all sites and services
- the ability to invest in infrastructure to mitigate risks to clinical services
- the implementation of the new Epic electronic health record system, and realisation of the opportunities to transform ways of working that this system can provide.

Key controls, assurances and actions on these risks include:

- our performance management framework, including performance dashboards and monthly Integrated Performance Report
- 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
- oversight from the Quality and Performance Board Committee, the Transformation and Major Programmes Board Committee and the Audit and Risk Committee, and reports from these committees to the Board
- clinical audit, including national audits, audits arising from national guidance (for example from NICE), confidential enquiries and local audits related to risk or patient safety
- assurances through internal audit, the Care Quality Commission (CQC), NHS England and NHS Resolution
- external regulatory and assessment body inspections and reviews including Royal Colleges, Postgraduate Deanery, Information Commissioner's Office and Health and Safety Executive (HSE) reports
- self-assessment against the compliance framework and CQC registration requirements
- quality assurance visits, including those led by executive directors, non-executive directors and governors
- freedom to speak up guardian and guardian of safe working hours (for doctors in training)
- steps taken to strengthen the Apollo programme governance at both executive and Board level, including the establishment of a Joint Oversight Committee in collaboration with King's College Hospital NHS Foundation Trust
- recruitment of Epic specialists into the Apollo programme team who have experience of deploying Epic in other NHS trusts.

Each year the Board completes a formal risk review to identify risks which might threaten the achievement of the Trust's strategy and assigns them to a lead executive director, as well as to the appropriate Executive and Board committees for management. This review was undertaken in October 2022 with the whole Board in a bespoke risk session, which resulted in new strategic risks on the Board Assurance Framework. These are outlined as the major in-year risks for 2023/24 later in this statement.

Quality governance arrangements

Our quality governance framework is built upon the principles described within the eight domains of NHS England's well-led framework and the five quality domains within the Care Quality Commission.

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 and measures are reviewed at clinical group level through performance meetings with Trust Executive Directors and the Clinical Group Executive Team. Summary data is provided in monthly performance reports for the Board and through Board sub-committees such as the Quality and Performance Committee. The monthly Board report includes up-to-date information on key quality indicators including patient safety, patient experience and clinical effectiveness.

The Trust's Scheme of Delegation details matters reserved for the Board and the responsibilities and accountabilities of its committees. Such matters include the approval of the Trust's strategy, approval of the Trust's annual operating and capital expenditure budgets, approval of changes in corporate structure, and the oversight of operations. All powers of the Trust which have not been retained as reserved by the Board of Directors shall be exercised on behalf of the Board by the Chief Executive, supported by other executive directors. The Scheme of Delegation also sets out the statutory responsibilities of the Council of Governors as required by the NHS Act 2006.

There are four clinical groups and one delivery group:

- Cancer and Surgery
- Heart Lung and Critical Care
- Evelina London – Women's and Children's Healthcare
- Integrated and Specialist Medicine
- Essentia delivery group

Each clinical group contains a number of clinical directorates reporting to them for assurance on quality, performance, workforce and finance. These have their specific leadership teams to ensure delivery. The corporate functions supporting and providing oversight and assurance for clinical group delivery are specific directorates with clear executive leads such as Finance, Workforce, Digital Technology and Information and quality and assurance as examples.

Trust quality committees are in place to monitor and review all elements of quality from complaints, incidents, risks, mortality as examples with clinical group representation to ensure full oversight.

Assessing the quality of performance information

Our revised and data-driven Trust integrated performance framework is used to monitor key performance indicators at directorate, clinical group and Trust level, with analysis and action plans provided 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.

Assurance on compliance with the Health and Social Care Act 2008

The Trust is fully compliant with the registration requirements of the CQC. The Trust maintains an up to date statement of purpose, reviewed and submitted regularly to the CQC; our latest CQC ratings are published online and link to our CQC licence RJ1 on the CQC's website. 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 quality rounds. Assurance on compliance with CQC regulations forms part of our existing quality assurance frameworks business as usual. Surveillance and assurance methods include mock well-led inspections, quality assessment frameworks, clinical audit, data analysis and policy effectiveness audits. Table-top review of information is also triangulated from the integrated performance reports, risk management data, staff experience and feedback, patient experience, complaints, and soft intelligence. The Trust's new ward accreditation scheme is now in progress to further develop quality assessment, assurance and oversight.

The CQC carried out an inspection of the Trust's maternity services in September 2022 at St Thomas' Hospital. The service was rated 'good' overall with positive findings and further improvement required under the safe domain. The Trust has not had a full well-led inspection and Trust-wide services inspection since 2019, which resulted in a 'good' overall rating with 'outstanding' for well-led. The Trust therefore commissioned Deloitte to undertake an external mock well-led inspection in 2022 to aid the Trust's readiness for CQC and the changing regulatory model – there is further detail about this later in this Annual Governance Statement. Improvement actions are being taken forward to further enhance the Trust's governance arrangements so we can continue to maintain our 'outstanding' rating for well-led.

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 , 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 England on 30 June 2022 achieved an assessment of 'Approaching Standards', reflecting the need to (a) complete mandatory information governance training for 95% of Trust employees; (b) upgrade the Trust's Windows 10 IT environment; (c) complete Multi-Factor Authentication rollout across the technical estate. Whilst these requirements are progressing, with quarterly updates to NHS England, some shortfall remains at the time of writing, and therefore the current status for the Trust remains at 'Approaching Standards'.

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 October 2023 will partially 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. A revised data centre strategy has been initiated following the outage in July 2022.

Information incidents

All information incidents and near misses are investigated and used as opportunities to improve processes and reduce risks. 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 2022/23, three information incidents within the Trust (including Royal Brompton and Harefield Hospitals) met the threshold for notification to the Information Commissioner's Office (ICO). Of these:

- one incident related to a significant internal IT system failure arising in July 2022
- one incident related to an externally-hosted IT national system failure (Carenotes and Adastra applications)
- one incident related to inappropriate access of patient data on the NHS spine portal by a member of staff.

All incidents have been closed by the ICO except the incident relating to Carenotes/Adastra. The ICO has asked for further clarification on the effects on the Trust of this incident. The answers have been provided and at the time of writing, we are awaiting ICO feedback.

Major in-year risks 2022/23 and in 2023/24

Major in-year risks 2022/23

The key risks to delivery of the Trust's strategic objectives are recorded in detail in the Board Assurance Framework and monitored at least quarterly by the Board or its committees acting on its behalf. In 2022/23 the key risks with potential impact on achieving our strategic objectives were:

- The Trust's activity and productivity levels may not be sufficient to recover in line with our strategic plans, which may impact our ability to provide safe and responsive care to patients and meet national strategic demands.
- The Trust may fail to deliver safe, high quality care to patients across all sites and services.
- The Trust may not successfully land the implementation of the electronic health record due to the readiness of the technology, underpinning infrastructure, and workforce capability and structure.
- The Trust is operating in a highly uncertain policy and legislative environment where the centralised national response and impending changes to NHS policy could negatively impact the Trust's aims, strategy and partnerships.
- 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 an integrated and comprehensive commercial strategy and robust governance.
- The Trust may fail to hire and retain staff and senior leaders with the right skills and behaviours which will undermine the Trust's ability to deliver services in line with agreed quality standards and strategic priorities.
- 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 maintain its current levels of research ambition and partnerships, and may fail to attract sufficient investment and income in order 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 our ability to deliver high quality care.
- The Trust may be required to manage future pandemics and face future threats requiring emergency response, which impacts 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 implementation of its major programmes, due to internal and external pressures.
- The Trust may fail to align with local strategic partners to achieve integration, in both south east and north west London, which could result in the failure to deliver joint outcomes to improve health equality, particularly access to services and employment, and fulfil our role as an anchor institution.

Major in-year risks 2023/24

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 new electronic health record system (Epic) in October 2023 will be critical in enabling the Trust to do this in the future. This remains an ongoing strategic priority for us and risks to delivering it remain on our Board Assurance Framework to keep sight of our controls and assurance managing these. We recognise that strategic and transformational change internally and across our local health economy will be required to address any risks that we identify. These operational and programmatic demands may reduce focus on the development and delivery of our strategic ambitions. We will continue to monitor and manage the risks that arise from the changing health economy landscape and across our estate at Guy's, St Thomas', Harefield and Royal Brompton hospitals as well as our community services.

The four main priorities and risks for 2023/24 are the safe implementation of the new electronic health record system, increasing levels of elective activity and operational productivity, controlling finances and improving delivery of efficiencies and supporting the workforce. In addition to these, and critical to core business, is the continued delivery of quality care.

A major cause of risk for 2023/24 remains the implementation of our new electronic health record system: Epic, through the Apollo programme. Given the scale of the task and risks associated, the Board made the decision to delay our implementation of Epic from April 2023 to October 2023 in order to safely deliver the programme. Therefore our Epic programme remains a key strategic priority where oversight of the risks arising from the programme and our failure to safely deliver it will be strengthened on our Board Assurance Framework into the financial year.

Elective recovery to clear backlog post COVID-19 remains an achievable but challenging risk for the Trust. Increasing demand for services, coupled with staffing and capacity challenges requires robust management and improvement in efficiency to reduce the backlog. The increase in productivity will reduce the time patients wait for treatment and will have a positive impact on the Trust's financial position.

The Trust's financial position and uncertainty around future funding is another cause of risk for 2023/24. In 2022 the Trust lost its bid as a Biomedical Research Centre with the National Institute for Health and Care Research which will impact the Trust in terms of investment and income later in 2023/24. Additionally, future changes to the specialist commissioning regime and allocation of capital departmental expenditure limits are likely to impact our ability to generate surpluses which may restrict future investment on strategic or operational objectives.

Supporting the workforce is critical for delivery of the Trust's priorities and will strengthen the Trust's ability to recruit and retain staff. The national situation for NHS organisations on recruitment and retention of staff is challenging and impacted further with industrial action reflecting the strength of feeling amongst many staff groups and professions.

The principal strategic risks for the organisation in 2023/24 therefore remain broadly the same as for 2022/23, but the effectiveness of their controls and assurance will need to be assessed in light of the current health and economic climate. A full review of the Board Assurance Framework and principal strategic risks was undertaken in October 2022 where it was agreed to carry forward the majority of strategic risks from 2022 for Board-level assurance into the next financial year. However, new strategic risks were identified in addition to these given the potential threats and causes of risk outlined above for 2023/24. These are that:

- operational and programmatic demands may reduce the focus on the development and/or delivery of the Trust's strategic ambitions
- the Trust may not fully realise the opportunities to transform ways of working based on the Epic implementation, and may not deliver the benefits set out in the business case
- changes to the specialised commissioning financial regime, in particular delegation, could have a significant financial impact on the Trust

- the availability of capital expenditure and our ability to generate surpluses may restrict future investment in our strategic and operational objectives.
- the Trust's and system priorities may not align, leading to uncertainty that hampers effective system working.

NHS England well-led framework

In 2022/23 the Trust has kept its corporate governance arrangements under review to ensure it meets the standards set out in the NHS England well-led framework.

Work continues to be undertaken to refine the governance arrangements within each of the Trust's clinical and delivery groups, to ensure these complement the governance structures in place at an executive level and to ensure the clinical and delivery groups are able to discharge their increasing responsibility for operational leadership and for the delivery of the Trust's strategic and operational objectives in their areas.

In 2022/23 the Trust commissioned Deloitte to undertake an external well-led review which concluded that the Trust exhibits many characteristics of a well-led organisation. In particular the review noted the unitary board operating to a high standard, depth in leadership, a clear strategic direction and a positive culture across the organisation. A number of recommendations were made about how to further strengthen leadership and governance across the organisation, particularly around the ongoing transition to a group model, although the review acknowledged the active considerations already underway in this area. The Trust is reflecting on these recommendations as part of the ongoing work to ensure the corporate governance arrangements are comprehensive, robust and underpin the group operating model.

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.

The external well-led review commissioned by the Trust during the year gave the Trust assurance that its corporate governance arrangements are fit for purpose and appropriate for the size and complexity of the organisation.

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.

All staff are encouraged to report incidents and near misses as part of an open and fair culture. The Trust has implemented mandatory training for level 1 national training on incident and safety management for all staff. Level 2 national training is required for managers across the Trust.

The electronic incident reporting system gives feedback when an incident is investigated if the member of staff wishes to receive this. The Trust purchased new risk management software in 2022/23 to ensure delivery of the new National Learning from Patient Safety Events incident reporting process. This new software provides the opportunity to revise processes to support the reporting and the new National Patient Safety Incident Response Framework.

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

During 2022/23, the Trust has continued to demonstrate a healthy incident reporting culture and remains one of the highest reporters of incidents within our cluster. The Trust has seen a continued rise in incidents reported compared with the previous year and the majority of incidents reported are of no, or low, harm. The Trust's commissioners continue to attend the Trust Serious Incident Assurance Panel where investigation reports are reviewed and discussed to ensure learning is shared and implemented. Actions following serious incidents are tracked and reported regularly on progress to completion.

Development with the new Patient Safety Incident Response Framework continues with commencement of training sessions, recruitment of Patient Safety Partners, full data analysis of trends and themes and the production of the response plan and a number of improvement plans completed to date.

In 2022/23, the Trust reported six 'never events' across the organisation. A continued reduction in this number remains a key objective. 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. One theme arising out of never events is the consistent and safe use of syringe drivers to deliver insulin in patients, with two never events and one near miss in the financial year. A diabetes and insulin quality improvement work stream has been established to oversee Trust-wide action and assurance in this area for 2023/24.

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 describes how the Trust will comply with relevant legislation, and is described in 'Putting patients first: a policy for involvement and consultation'. All departments, both clinical and non-clinical, are responsible for planning and undertaking patient and public involvement initiatives.

The Trust serves diverse and dispersed populations which straddle a broad geography. There is a strong desire to work closely with patients, families, carers and public stakeholders within and across geographies and communities.

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 had 36,265 members at the end of March 2023. These are represented by a Council of Governors that comprises patients, 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 England and the CQC, to hold the non-executive directors to account for the performance of the Board.
- Patients, carers and public stakeholders are involved 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 any 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 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's People Strategy sets out its workforce priorities and plans aligned with 'Together we care', the Trust's organisational 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. Clinical and delivery group 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 which incorporate 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 and cost centre level. The Trust regularly reviews 'Model Hospital' metrics 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 its 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 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 and continually reassesses the risk of underperformance against its obligations in order to optimise resource planning.

The Trust's 'Green plan' is its Sustainability strategy (2021-2031) which 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.

Equality, Diversity and Inclusion

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and inclusion are complied with. This includes Workforce Race Equality Standard Workforce Disability Equality Standard, Equality Impact Assessments and People Strategy objectives.

We recognise that we need to do more to address inequality and health inequalities and we have an extensive work plan, including:

- ongoing and mandatory training on bias, micro-aggression and civility, authentic allies and advancing cultural competency
- continuous Trust-wide engagement on current issues and listening to the experiences of our staff
- developing the maturity of staff networks and working together to co-create and action work across the Trust
- supporting clinical groups to embed inclusive practices and behaviours with associated action plans and accountability with clear governance by the Trust Board
- strengthening the numbers of Inclusion Agents across all directorates and teams to help raise awareness of best practice and offer peer to peer support and sign posting on equality, diversity and inclusion issues
- ensuring equality objectives are in place for senior managers
- an overhaul of people processes to eliminate bias and structural barriers
- ensuring all new policies, transformational work, or changes to buildings and space have completed an equality impact assessment.

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

Key processes for efficient and effective use of resources

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 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 including Datix, Sharepoint for policies, and local spreadsheets for topics such as NICE guidance compliance. A senior clinical analyst validates the data and issues the Trust Integrated Performance Report (IPR) pack to users.

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.

The Trust has a number of policies and protocols which describe the desired outcome or key performance indicator 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 and the Hospital Standardised Mortality Ratio 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 Board Committee where all data and information relating to quality of care and patient experience is reviewed, supported both by the standardised monthly IPR and other ad-hoc reports.

The Trust employs information assurance processes in the production of the monthly IPR, including local and Trust-wide validation of data and national benchmarking where available, including comparison against the Shelford Group average for all relevant metrics. The IPR is published as part of the Board papers and is available on the Trust's website.

Regular audits are undertaken of the quality of waiting list data, and themes as well as actions for services to improve are fed back and actioned through the formal monthly reporting cycles.

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 Board 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

The Board and its committees have 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 IPR, 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 IPR is supported by more granular reports reviewed by Board committees, regular executive review meetings, and performance review meetings between the Trust executive team and executive teams from each of the clinical and delivery groups.

Audit and Risk Committee

The Audit and Risk Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance and internal financial control within the Trust. The Committee has received 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 provides assurance through monitoring and reviewing the overall quality, safety and performance of services against national standards and the monitoring of in-year financial performance.

The Trust Risk and Assurance Committee reports to the Trust Executive Committee, which, in turn, reports to the Trust Board, and 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 risk management policies.

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 2022 to the date of this opinion. Internal Audit set out a work plan in June 2022 and has completed 27 projects. This included in-depth reviews of the financial systems for the Trust which migrated to the Oracle E-Business Suite (Cloud) system since June 2022. Whilst there were a number of challenges with the system implementation and the key financial systems for the former Royal Brompton and Harefield sites are yet to be integrated and moved to the new version of Oracle E-Business Suite, a review of controls found that transactions processing remained consistent with previous years and there were no significant or material control weaknesses.

There were changes and additions to the plan during the year. The impact of the IT system outage that occurred in summer 2022 caused significant disruption to Trust activities. The work of internal audit was also impacted. The Trust took commensurate steps and implemented business continuity plans accordingly. As part of the Trust's response, the Deputy Chief Executive led a lessons learned exercise and internal audit played a key role in this project. Whilst the impact of the outage was significant and the Trust has and will implement a number of measures to mitigate against such risks in future, I am satisfied that, although this was a significant control issue, the weaknesses identified do not undermine the whole control environment.

The integration of services since the merger is a key strategic objective for the Trust and at the request of management a review was undertaken of the Registration Authority function for the former Royal Brompton and Harefield sites. This review was given a 'nil' assurance rating on the basis that internal audit was unable to provide any level of assurance on controls and compliance with national requirements/ standards. Management took immediate steps to strengthen both the governance and controls in this area, including to fast track the integration of this service with the established function within the Trust's Data, Technology and Information (DT&I) directorate. There are a number of other areas, identified through internal audit reviews, where policies are yet to be fully adopted across the merged organisation. Management are aware of these and are working on various strategic reviews to ensure appropriate functions are fully integrated.

There were no limitations placed on the scope of internal audit work and the service operated in accordance with the Audit Charter, which was refreshed in February 2023.

I have considered all reactive investigations and proactive work conducted by the Trust's local counter fraud specialists. This includes oversight of all fraud investigations and personal conduct of specific enquiries during the year.

In my opinion, with the exception of those areas in which limited assurance reports have been issued as reported to the committee during the year, the controls in those areas reviewed are adequate and effective. Where weaknesses have been identified as a result of audit or counter fraud reviews, management have responded positively and recommendations have been 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 and compliance was independently assessed in 2021, which concluded '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 meets bimonthly with a focus on Clinical Groups to share the detail of the clinical audits they have completed and in progress. For the areas that do not sit directly into a clinical group they report assurance once a year on their clinical audit and quality improvement activity, such as the Chief Medical Officer's office.

Trust-wide priority audits are discussed at every committee meeting, based on a schedule developed from risks on the corporate risk register, changes to CQC or regulatory models, or if a theme is identified through quality assurance monitoring. National audit reports are shared back to the clinical groups and feedback collected from the participating clinicians on how and if we need to change the processes in the Trust from the Audits recommendations.

The Quality Improvement and Clinical Audit committee reports quarterly to Trust Risk and Audit Committee and focuses on clinical group assurance per report with an update of the published audits and reports from the Healthcare Quality Improvement Partnership and the National Confidential Enquiry into Patient Outcome and Death and the impact of work for the Trust. Each directorate within the clinical groups is encouraged to produce and deliver on its annual audit plan that must include relevant national audits and Trust wide audits, local audits that are critical for quality monitoring and assurance such as infection prevention, cleanliness and any other clinical audit the directorate identifies for quality monitoring.

A significant control issue was identified in July 2022 as a result of the failure of the Trust's data centres caused by extremely hot weather. The control issues were numerous and are set out in the Trust's published report which can be found on the Trust's website. The Trust, through the Trust Executive Committee and Audit and Risk Committee, continues to monitor the implementation of the actions required to prevent reoccurrence of the control failures.

Conclusion

To the best of my knowledge no other significant issues have been identified in 2022/23. 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.

Dr Ian Abbs
Chief Executive
29 June 2023

Royal Brompton and Harefield hospitals provide a wide range of specialist heart and lung services, and now work closely with our cardio-vascular services at St Thomas'. Together they form one of the largest centres in Europe caring for patients with these conditions. Pictured is surgical care practitioner, Edriel Santiago.

10 Annual accounts

Foreword to the accounts

These accounts, for the year ended 31 March 2023, 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
29 June 2023

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 2023, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Consolidated Statement of Changes in Taxpayer's Equity, the Statement of Changes in Taxpayer's Equity, the Statements 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 2022-23.

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 2023 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 2022-23; 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 2022-23 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 2022) 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.

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.

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.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report. 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.

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 themselves. 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 2022/23 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:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with NHS foundation trust annual reporting manual 2022/23; and
- based on the work undertaken in the course of the audit of the financial 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

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer set out on page 67, 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 2022/23, 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.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2022-23).
- We enquired of management and the Guy's and the St Thomas' 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 Guy's and St Thomas' 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 including investment properties;

  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement items.

- 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 expenditure recognition, and the significant accounting estimates related to land and building valuations.
- Our 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.

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.

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 2023.

We have nothing to report in respect of the above matter except on 21 June 2023 we identified:

- A significant weakness in the Trust's arrangements to deliver economy, efficiency and effectiveness in its use of resources in 2022/23.. This was in relation to Trust's having insufficient arrangements in place to deliver the savings target for 2023/24. We recommended that the Trust:
  - Develops a pipeline of savings scheme to deliver against the 2023/24 savings target.

- Continues to reassess the level of risk contained in the savings plan, how it can be mitigated, and communicated with the ICS if there is going to be a likely impact on its ability to deliver the overall financial plan for 2023/24.
- Ensures the savings programme is underpinned by robust assumptions, validated by staff delivering the CIPs and triangulated with other supporting plans.

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 January 2023. 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 Guy's and St Thomas' NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

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*

Name Paul Dosset, Key Audit Partner

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

London

Date: 29th June 2023

Consolidated statement of comprehensive income for the year ended March 31 2023

		March 31 2023	March 31 2022
	NOTE	**£000**	£000
Operating income from patient care activities	3	**2,464,371**	2,271,972
Other operating income	4	**314,145**	367,484
TOTAL INCOME		**2,778,516**	2,639,456
Operating expenses	7.1	**(2,706,904)**	(2,596,004)
OPERATING SURPLUS		**71,612**	43,453
FINANCE COSTS			
Finance income	10	**3,162**	142
Finance expenses	11	**(7,550)**	(6,023)
Public Dividend capital charge	35	**(37,668)**	(29,237)
Net finance costs		**(42,056)**	(35,118)
Other (Losses)	9	**(5,248)**	(8,749)
Share of profit of associates/joint ventures	19.1	**635**	34
Corporation tax (expense)		**(247)**	(783)
SURPLUS/(DEFICIT) FOR THE YEAR		**24,696**	(1,163)
Other comprehensive (expense)/income			
Impairments	15	**(21,624)**	(19,601)
Revaluations	17	**64,695**	107,101
Other		**1,929**	–
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**69,696**	86,337

The notes on pages 88 to 123 form part of these accounts. All revenue and expenditure is derived from continuing operations.

Note 12 includes the Trust's analysis of performance.

Statement of financial position as at March 31 2023

		GROUP		TRUST	
		March 31 2023	March 31 2022	**March 31 2023**	March 31 2022
	NOTE	**£000**	£000	**£000**	£000
NON-CURRENT ASSETS					
Property plant and equipment	13	**1,686,524**	1,564,301	**1,686,456**	1,564,162
Intangible assets	14	**157,171**	132,939	**157,171**	132,939
Right of use assets	16	**162,479**	–	**161,774**	–
Investment property	17	**75,134**	80,359	**75,134**	80,359
Investments in joint ventures and associates	19.1	**2,050**	1,345	**2,050**	2,050
Other investments/financial assets	20	**146**	146	**10,589**	9,667
Trade and other receivables	22.2	**7,911**	16,623	**7,911**	8,014
TOTAL NON-CURRENT ASSETS		**2,091,415**	1,795,713	**2,101,085**	1,797,191
CURRENT ASSETS					
Inventories	21	**48,015**	44,374	**48,015**	44,374
Receivables	22.1	**245,495**	172,836	**232,110**	169,196
Cash and cash equivalents	25	**130,760**	220,946	**125,918**	215,770
TOTAL CURRENT ASSETS		**424,270**	438,156	**406,043**	429,340
CURRENT LIABILITIES					
Trade and other payables	23.1	**(414,000)**	(375,105)	**(411,984)**	(372,544)
Borrowings	23.3	**(51,623)**	(21,099)	**(51,259)**	(21,099)
Other liabilities	23.2	**(68,547)**	(69,866)	**(68,006)**	(69,204)
Provisions	24.1	**(1,755)**	(4,211)	**(1,755)**	(4,211)
TOTAL CURRENT LIABILITIES		**(535,925)**	(470,281)	**(533,004)**	(467,058)
NON-CURRENT LIABILITIES					
Borrowings	23.3	**(301,673)**	(215,049)	**(301,188)**	(215,049)
Provisions	24.1	**(13,925)**	(14,761)	**(13,925)**	(14,702)
TOTAL NON-CURRENT LIABILITIES		**(315,598)**	(229,810)	**(315,113)**	(229,751)
TOTAL ASSETS EMPLOYED		**1,664,162**	1,533,778	**1,659,011**	1,529,722
TAXPAYERS' EQUITY					
Public Dividend Capital		**593,146**	561,526	**593,146**	561,526
Revaluation reserve	18	**564,338**	519,338	**564,338**	519,338
Other reserves		**743**	743	**743**	743
Income and expenditure reserve		**505,935**	452,171	**500,784**	448,115
TOTAL TAXPAYERS' EQUITY		**1,664,162**	1,533,778	**1,659,011**	1,529,722

Ian Abbs
Chief Executive and Accounting Officer
29 June 2023

Consolidated cash flow statement for the year ended March 31 2023

	NOTE	GROUP March 31 2023 £000	GROUP March 31 2022 £000	TRUST March 31 2023 £000	TRUST March 31 2022 £000
Cash flows from operating activities					
Operating surplus from continuing operations		**71,612**	43,453	**70,295**	41,729
Non-cash income and expenses					
Depreciation and amortisation	7.1	**98,025**	82,234	**97,616**	82,172
Impairments and reversals of impairments	15	**(19,293)**	(1,449)	**(19,293)**	(1,449)
Income recognised in respect of capital donations		**(4,613)**	(12,890)	**(4,613)**	(12,890)
(Increase) in trade and other receivables		**(70,879)**	(23,870)	**(69,742)**	(22,169)
(Increase)/Decrease in inventories		**(3,641)**	278	**(3,641)**	278
Increase in other liabilities		**5,154**	30,334	**5,275**	29,907
Increase in trade and other payables		**41,496**	756	**42,042**	821
(Decrease) in provisions		**(3,279)**	(3,596)	**(3,220)**	(3,622)
Corporation tax paid		**(645)**	(1,620)	**–**	–
Other movements in operating cash flows		**7,523**	(1,464)	**6,972**	(2,278)
NET CASH GENERATED FROM OPERATING ACTIVITIES		**121,460**	112,165	**121,691**	112,498
Cash flows from investing activities					
Interest received		**3,162**	142	**3,162**	142
Purchase of financial assets	19.1	**(675)**	(1,125)	**(875)**	(1,325)
Proceeds from settlements of financial assets	19.1	**605**	30	**895**	320
Purchase of intangible assets		**(41,640)**	(46,956)	**(41,640)**	(46,956)
Purchase of property, plant and equipment		**(122,883)**	(133,784)	**(122,869)**	(133,751)
Proceeds from sale of property, plant and equipment		**23**	422	**23**	422
Receipt of cash donations to purchase capital assets		**4,553**	12,890	**4,553**	12,890
NET CASH USED IN INVESTING ACTIVITIES		**(156,855)**	(168,381)	**(156,751)**	(168,258)
Cash flows from financing activities					
Public Dividend Capital received		**31,620**	23,280	**31,620**	23,280
Movement in loans from the Department of Health and Social Care (DHSC)	23.4	**(18,134)**	(18,133)	**(18,134)**	(18,133)
Movement in other loans		**–**	(13,170)	**–**	(13,170)
Capital element of lease liability repayments	23.4	**(29,334)**	(1,151)	**(29,334)**	(1,151)
Capital element of service concession payments	23.4	**(284)**	(275)	**(284)**	(275)
Interest paid on DHSC loans	23.4	**(5,444)**	(5,864)	**(5,444)**	(5,864)
Interest on other loans		**–**	(64)	**–**	(64)
Interest element of lease liability repayments	23.4	**(2,095)**	(66)	**(2,095)**	(66)
Interest element of service concession obligations	23.4	**(117)**	(128)	**(117)**	(128)
Public Dividend Capital paid		**(31,003)**	(28,400)	**(31,003)**	(28,400)
NET CASH GENERATED FROM FINANCING ACTIVITIES		**(54,791)**	(43,972)	**(54,791)**	(43,972)
Net (decrease) in cash and cash equivalents		**(90,186)**	(100,187)	**(89,852)**	(99,731)
Cash and cash equivalents at April 1		**220,946**	321,134	**215,770**	315,501
Cash and cash equivalents at March 31	25	**130,760**	220,946	**125,918**	215,770

Statement of changes in taxpayers' equity

GROUP 2022/23	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2022	561,526	519,338	743	452,171	**1,533,778**
Impact of implementing IFRS 16 on 1 April 2022	–	–	–	29,068	**29,068**
Surplus for the year	–	–	–	24,696	**24,696**
Impairments	–	(21,624)	–	–	**(21,624)**
Revaluations – property, plant and equipment	–	64,125	–	–	**64,125**
Revaluations – right of use assets	–	570	–	–	**570**
Other	–	1,929	–	–	**1,929**
Public Dividend Capital received	31,620	–	–	–	**31,620**
Taxpayers' equity as at March 31 2023	**593,146**	**564,338**	**743**	**505,935**	**1,664,162**

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**	**519,338**	**743**	**452,171**	**1,533,778**

TRUST 2022/23	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2022	561,526	519,338	743	448,115	**1,529,722**
Impact of implementing IFRS 16 on 1 April 2022	–	–	–	29,068	**29,068**
Surplus for the year	–	–	–	23,601	**23,601**
Impairments	–	(21,624)	–	–	**(21,624)**
Revaluations – property, plant and equipment	–	64,125	–	–	**64,125**
Revaluations – right of use assets	–	570	–	–	**570**
Other	–	1,929	–	–	**1,929**
Public Dividend Capital received	31,620	–	–	–	**31,620**
Taxpayers' equity as at March 31 2023	**593,146**	**564,338**	**743**	**500,784**	**1,659,011**

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**	**519,338**	**743**	**448,115**	**1,529,722**

Notes to the accounts

1 Accounting policies

1.1 Basis of preparation of the financial statements

NHS England 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 2022/23 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.

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 2023 and incorporate its share of the results of joint ventures and associates using the equity method of accounting. Subsidiary accounts have been prepared on a going concern basis.

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 2022/23 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. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. These are termed 'aligned payment and incentive' contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differs from the agreed level set in the fixed payments, the variable element either increases or reduces the income earned by the Trust at a rate of 75% of the tariff price.

Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria. Adjustments for actual performance are made through the variable element of the contract payments.

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 given, it receives notification from the Department of Work and Pension's 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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 actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS Pensions 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 2022/23 was 3% (2021/22: 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 2023 land and buildings for the full Trust estate were valued by Gerald Eve, which is consistent with the valuation at 31 March 2022. 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, 8-72 years
- Dwellings, 24-39 years
- Plant and machinery, 5-20 years
- IT hardware, 2- 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 GSTT'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.

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

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.20A The Trust as lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

1.20B The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

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

Income from operating leases is recognised on a straight-line basis or another systematic 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.

1.20C Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust is an intermediate lessor, classification of all continuing sublease arrangements has been reassessed with reference to the right of use asset.

2012/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

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 3% to 3.51%. In calculating the early retirement and injury benefit provisions, the HM Treasury discount rate of 1.7% in real terms has been used (prior year minus 1.3%).

Clinical negligence costs

The NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Resolution which in return settles all clinical negligence claims. Although the 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 the 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 the 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 the 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 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

1.26 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 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.

1.27 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 2023.

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 1.28), 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.

1.28 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 2022/23 and 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.

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 2023 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 2023 of the Trust's property plant and equipment valued by professional valuers and reflected in these financial statements is £1,375,066 (£1,291,889k 31 March 2022)

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. £68,753k. 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 Gerald Eve at 31 March 2023 and 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 23, the valuation of Chelsea Farmers Market was £71.73m (£76.95m 31 March 2022). 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

From 1 April 2022, the Trust's Operating Model was structured under four large clinical groups: Evelina London Women's and Children's; Integrated and Specialist Medicine; Cancer and Surgery and; Heart, Lung and Critical Care.

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 2022/2023. 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 activities (by source)

	Year ended March 31 2023 £000	Year ended March 31 2022 £000
NHS England	**1,336,555**	1,145,302
Clinical Commissioning Groups (CCGs)	**232,299**	1,048,409
Integrated care boards	**810,305**	–
Department of Health and Social Care	**–**	557
Other NHS providers	**5,817**	4,689
NHS other	**823**	5,071
Local authorities	**10,828**	10,811
Non-NHS: private patients	**62,655**	50,568
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	**2,766**	3,424
Injury cost recovery scheme	**507**	2,412
Non-NHS: other	**1,816**	729
Total income from patient care activities	**2,464,371**	2,271,972
Of which:		
Related to continuing operations	**2,464,371**	2,271,972
Related to discontinued operations	**–**	–

3.2 Income from patient care (by nature)

	Year ended March 31 2023 £000	Represented Year ended March 31 2022 £000
Acute services		
Income from commissioners under API contracts*	**1,824,460**	1,731,157
High cost drugs income from commissioners (excluding pass-through costs)	**246,470**	219,634
Other NHS clinical income**	**49,619**	46,596
Mental Health Services		
Income form commissioners under API contracts*	**1,625**	–
Community services		
Income from commissioners under API contracts*	**106,048**	131,312
Income from other sources (eg local authorities)	**11,021**	10,632
All services		
Private patient income	**62,655**	50,568
Elective recovery fund	**56,201**	26,911
Agenda for change pay award central funding***	**42,771**	–
Additional pension contribution central funding****	**58,773**	54,900
Other clinical income	**4,728**	261
	2,464,371	2,271,972

* Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National tariff payments system documentation.
www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

** 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.

*** In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.

**** 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.

Prior year income totals within Acute services have been represented from the 2021/22 audited accounts to ensure they are reported on a consistent basis with current year. The overall total remains the same.

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 2023 £000	Year ended March 31 2022 £000
Income from services designated as commissioner requested services	**2,396,627**	2,214,839
Income from services not designated as commissioner requested services	**67,744**	57,133
	2,464,371	2,271,972

3.4 Overseas visitors (relating to patients charged directly by the provider)

	Year ended March 31 2023 £000	Year ended March 31 2022 £000
Income recognised this year	**2,766**	3,424
Cash payments received in-year	**1,186**	892
Amounts added to provision for impairment of receivables	**2,194**	2,060
Amounts written-off in-year	**1,787**	796

4 Other operating income (Group)

	NOTE	Year ended March 31 2023 £000	Year ended March 31 2022 £000
Other operating income from contracts with customers:			
Research and development		**64,512**	59,152
Education, training and research		**78,311**	71,848
Non-patient care services to other bodies		**34,007**	48,857
Reimbursement and top up funding		**7,980**	30,210
Income in respect of staff recharges		**7,479**	10,969
Other income*		**97,066**	107,876
Other non-contract operating income:			
Research and development		**1,319**	4,526
Education and training – notional income from apprenticeship fund		**1,702**	2,164
Contributions to expenditure – consumables (inventory) donated from DHSC group bodies for COVID response		**2,578**	4,122
Charitable and other contributions to expenditure and capital assets		**9,791**	18,427
Operating leases – minimum lease receipts	6.1	**9,135**	9,333
Other non-contract income		**265**	–
		314,145	367,484

*Other income includes: £22m from clinical tests, £20m from facilities and services income, £6m from clinical excellence awards and the remaining from catering, staff accommodation rentals, income from commercial activities, 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 2023 £000	Year ended March 31 2022 £000
Revenue recognised in the reporting period that was within deferred income: contract liabilities at the previous period end.	**65,179**	34,022

5.2 Transaction price allocated to remaining performance obligations

	Year ended March 31 2023 £000	Year ended March 31 2022 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
Within one year (Note 23.2)	**68,290**	65,179
Total revenue allocated to remaining performance obligations	**68,290**	65,179

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 leases - Trust as Lessor

This note discloses income generated in operating lease agreements where GSTT is the lessor.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

6.1 Operating leases income (Group)

	Year ended March 31 2023	Year ended March 31 2022
Lease receipts recognised as income in year:	**£000**	£000
Minimum lease receipts	**9,135**	9,333
	9,135	9,333

6.2 Future lease receipts (Group)

	Year ended March 31 2023
Future minimum lease receipts due at March 31 2023:	**£000**
– not later than one year	**7,734**
– later than one year but not later than two years	**7,087**
– later than two years but not later than three years	**6,884**
– later than three years but not later than four years	**8,479**
– later than four years but not later than five years	**6,674**
– later than five years	**81,018**
	117,876

	Year ended March 31 2022
Future minimum lease receipts due at March 31 2022:	£000
– not later than one year	8,522
– later than one year and not later than five years	26,124
– later than five years	87,121
	121,767

7 Operating expenses (Group)

7.1 Operating expenses comprise:

	NOTE	Year ended March 31 2023 £000	Year ended March 31 2022 £000
Purchase of healthcare from NHS and DHSC bodies		**1,137**	409
Purchase of healthcare from non-NHS and non-DHSC bodies		**52,131**	58,720
Staff and executive directors costs		**1,573,011**	1,434,673
Remuneration of non-executive directors		**351**	343
Supplies and services – clinical (excluding drugs costs)		**329,387**	303,122
Supplies and services – general		**23,709**	21,452
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response		**3,815**	10,154
Inventories written down (consumables donated from DHSC group bodies for COVID response)		**52**	–
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		**333,389**	326,679
Inventories written down (net including drugs)		**1,238**	650
Provisions arising / released in year		**55**	166
Consultancy		**1,893**	4,650
Establishment		**42,866**	54,569
Premises – business rates collected by local authorities		**10,266**	12,695
Premises – other		**142,524**	147,510
Transport – business travel only		**581**	288
Transport – other (including patient travel)		**24,193**	26,344
Depreciation on property, plant and equipment and right of use assets		**86,899**	66,927
Amortisation	14.1	**11,126**	15,307
Impairments net of reversals	15	**(19,293)**	(1,449)
Credit loss allowance		**4,696**	(6,663)
Change in provisions discount rate		**(515)**	75
Audit services – statutory audit*		**253**	232
Internal audit – staff costs		**584**	606
Internal audit – non-staff		**2**	23
Clinical negligence – amounts payable to NHS Resolution (premium)		**32,031**	33,165
Legal fees		**1,994**	5,875
Insurance		**2,829**	2,414
Research and development – non-staff		**17,300**	1,992
Education and training – non-staff		**(38)**	13,033
Education and training – notional expenditure funded from apprenticeship fund		**1,702**	2,164
Expenditure on short term leases (current year only)		**2,034**	–
Operating lease expenditure (comparative only)		**–**	23,528
Redundancy cost (staff costs)		**613**	904
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis		**2,628**	2,292
Car parking and security		**18**	2
Hospitality		**371**	777
Other losses and special payments – non-staff		**(546)**	574
Other**		**21,618**	31,802
		2,706,904	2,596,004

* Audit services – statutory audit, the figure is net of VAT.

** Other operating expenses largely includes expenditure on commercial activities and NHS Blood and Transplant

7.2 Other auditor remuneration

Other auditor remuneration paid to the external auditor

Payments made to our auditor for non-audit work in 2022/23 were £6k relating to grant assurance services (2021/22 £8k). These fees are listed net of VAT.

7.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2022-23 is £2million (2021-22 £2million).

8 Employee benefits (Group)

	Group	
	Year ended	Year ended
	March 31 2023 Total £000	March 31 2022 Total £000
Salaries and wages	**1,246,084**	1,133,654
Social security costs	**138,570**	122,158
Apprenticeship levy	**5,827**	5,495
Employer contributions to NHS Pensions	**134,766**	125,715
Pension cost – employer contributions paid by NHSE on provider's behalf (6.3%)	**58,773**	54,900
Termination benefits	**526**	100
Temporary staff – agency and contract staff	**35,767**	32,344
Total gross staff costs	**1,620,313**	1,474,374
Recoveries in respect of seconded staff	**(11,741)**	(8,668)
Total staff costs	**1,608,572**	1,465,706
Of which:		
Costs capitalised as part of assets	**34,364**	29,523
Analysed into Operating Expenditure (note 7.1)		
Employee expenses – staff & executive directors	**1,573,011**	1,434,673
Redundancy	**613**	904
Internal audit costs*	**584**	606
Total employee benefits excluding capitalised costs	**1,574,208**	1,436,183

* 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.

8.1 Retirements due to ill-health (Group)

During 2022-23 there were 3 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended March 31 2022). The estimated additional pension liabilities of these ill-health retirements is £25k (£137k in 2021-22). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

9 Other gains and losses

	Group	
	Year ended	Year ended
	March 31 2023	March 31 2022
	£000	£000
Loss on disposal of property, plant and equipment	**(57)**	(102)
Gain on disposal of property, plant and equipment	**3**	51
Loss recognised on return of donated Covid assets to DHSC	**–**	(1,633)
Total (losses) on disposal of assets	**(54)**	(1,684)
Fair value losses on investment properties	**(5,225)**	(7,065)
Gains on foreign exchange	**31**	–
Total other (losses)	**(5,248)**	(8,749)

10 Finance income

	Group	
	Year ended	Year ended
	March 31 2023	March 31 2022
	£000	£000
Interest on bank accounts	**3,162**	146
Interest on other investments / financial assets	**–**	(4)
Total finance income	**3,162**	142

11 Finance expenses

	Group	
	Year ended March 31 2023 £000	Year ended March 31 2022 £000
Loans from the Department of Health and Social Care (see note 23.6)	**(5,349)**	(5,778)
Interest on other loans	**–**	(64)
Interest on lease obligations	**(2,096)**	(67)
Finance costs on service concession arrangements	**(117)**	(128)
Unwinding of discounts on provisions	**13**	14
Other finance costs	**(1)**	–
Total finance expense	**(7,550)**	(6,023)

12 Trust performance – Notes to the Consolidated Statement of Comprehensive Income

	Group	
	Year ended March 31 2023 £000	Year ended March 31 2022 £000
Total comprehensive income	**69,696**	86,337
Less reserve movements in other comprehensive income/(expense)	**(45,000)**	(87,500)
Total comprehensive income / (expense) before reserve movements	**24,696**	(1,163)
Add back in year impairments and reversals of impairments relating to market valuations included in surplus above (see note 15.1)	**(19,925)**	(8,432)
DHSC capital equipment and inventory	**1,289**	7,665
Asset profit/loss on disposal adjustments in line with financial performance adjustment measurement	**–**	(51)
Capital Donations	**(4,613)**	(12,890)
Add back depreciation on donated assets	**11,655**	15,081
Adjusted financial performance	**13,102**	210

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 surplus of £24,696k (21/22 Deficit £1,163k) for the Group. 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 £13,102k.

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The unconsolidated surplus relating to the Foundation Trust for the year ended 31 March 2023 was £23,601k (2021-22 deficit of £2,104k).

13 Property, plant and equipment – March 2023

13.1 Property, plant and equipment at 31/03/2023 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 2022	**294,243**	**1,018,744**	**18,639**	**147,570**	**274,578**	**73,380**	**5,561**	**1,832,715**
Reclassification of existing finance leased assets to right of use assets on 1 April 2022	–	–	–	–	(1,993)	(1,886)	–	**(3,879)**
Additions purchased	–	7,107	9	106,542	1,020	73	5	**114,756**
Additions – Assets purchased from cash donations/grants	–	–	–	620	169	–	3	**792**
Impairments charged to operating expenses	(752)	(9,622)	–	–	–	–	–	**(10,374)**
Impairments charged to the revaluation reserve	(15,570)	(6,054)	–	–	–	–	–	**(21,624)**
Reversal of impairments credited to operating expenses	–	31,194	–	–	–	–	–	**31,194**
Revaluation to revaluation reserve	–	35,558	1,310	–	–	–	–	**36,868**
Reclassifications	–	39,373	2,274	(51,404)	9,125	6,235	37	**5,640**
Disposals	–	(1,850)	–	–	(67,793)	(21,165)	(266)	**(91,074)**
Cost or valuation at March 31 2023	**277,921**	**1,114,450**	**22,232**	**203,328**	**215,106**	**56,637**	**5,340**	**1,895,014**
Accumulated depreciation at April 1 2022	–	24,362	43	–	181,241	58,636	4,131	**268,413**
Provided during the year	–	28,595	541	–	22,318	6,206	575	**58,235**
Revaluation to revaluation reserve	–	(26,674)	(583)	–	–	–	–	**(27,257)**
Disposals	–	(1,802)	–	–	(67,688)	(21,157)	(255)	**(90,902)**
At March 31 2023	**–**	**24,481**	**1**	**–**	**135,871**	**43,685**	**4,451**	**208,489**
Net book value March 31 2023								
Owned – Purchased	200,351	846,508	21,543	201,726	64,998	12,872	675	**1,348,673**
On-SoFP PFI contracts and other service concession arrangements	–	2,483	–	–	169	–	–	**2,652**
Owned – Donated / Granted	77,570	240,978	688	1,602	13,179	80	214	**334,311**
Owned – equipment donated from DHSC and NHSE for COVID response	–	–			888	–		**888**
Total at March 31 2023	**277,921**	**1,089,969**	**22,231**	**203,328**	**79,234**	**12,952**	**889**	**1,686,524**

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 2023 and 31 March 2022 by an external valuer, Gerald Eve LLP, 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.

13.2 Property, plant and equipment at 31/03/2022 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**
Derecognition – 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)**
At March 31 2022	**–**	**24,362**	**43**	**–**	**181,241**	**58,636**	**4,131**	**268,414**
Net book value March 31 2022								
Owned – Purchased	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**
Owned – Donated / Granted	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**

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 2022/23 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 2023

GROUP AND TRUST	Software licences £000	Information technology £000	Development expenditure £000	Assets under construction £000	Total £000
Cost April 1 2022	15,091	101,326	24,246	104,344	**245,007**
Additions purchased / internally generated	127	111	–	37,641	**37,879**
Additions – grants / donations of cash	–	–	–	3,761	**3,761**
Impairments charged to operating expenses	–	–	–	(632)	**(632)**
Reclassification	764	5,747	(59)	(12,092)	**(5,640)**
Disposals / Derecognition	(4,890)	(15,504)	(6,339)	–	**(26,733)**
Gross cost at March 31 2023	**11,092**	**91,680**	**17,848**	**133,022**	**253,642**
Amortisation April 1 2022	11,801	85,490	14,777	–	**112,068**
Provided during the year	1,561	7,080	2,485	–	**11,126**
Disposals / Derecognition	(4,885)	(15,504)	(6,334)	–	**(26,723)**
Amortisation at March 31 2023	**8,477**	**77,066**	**10,928**	**–**	**96,471**
Net book value March 31 2023	**2,615**	**14,614**	**6,920**	**133,022**	**157,171**
Purchased assets	2,479	13,956	6,920	122,712	**146,067**
Donated / granted assets	136	658	–	10,310	**11,104**
Total at March 31 2023	**2,615**	**14,614**	**6,920**	**133,022**	**157,171**

14.2 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)**
Disposals / Derecognition	–	–	–	–	**–**
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	–	**15,307**
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**

15 Impairments

15.1 Impairment of assets (Group and Trust)

	March 31 2023 £000	March 31 2022 £000
Impairments charged to operating surplus/deficit resulting from:		
Impairments arising from professional valuation (PPE)	**(10,374)**	(19,658)
Impairments arising from professional valuation (Right of Use Asset)	**(895)**	–
Reversals of impairments arising from professional valuation	**31,194**	28,090
Abandonment of assets in course of construction	**(632)**	(6,983)
Net impairment reversal charged to expenditure	**19,293**	1,449
Impairments charged to revaluation reserve		
Professional valuation impairments of land value	**(15,570)**	(397)
Professional valuation impairments of building and dwellings value	**(6,054)**	(19,204)
Total impairments charged to Revaluation reserve	**(21,624)**	(19,601)
Total net impairments	**(2,331)**	(18,152)
Impairments charged to operating expenses:		
Of which Departmental Expenditure Limit (DEL)	**(632)**	(6,983)
Of which Annually Managed Expenditure (AME)	**19,925**	8,432
	19,293	1,449

15.2 Analysis of valuation movements and impairments

The majority of the 2022/23 impairment transactions relate to the property valuation.

Land and buildings across the full estate were valued independently by Gerald Eve as at 31 March 2023. 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 2023 £000 Revaluation reserve	**March 31 2023 £000 SOCI**	**March 31 2023 £000 Total**	March 31 2022 £000 Revaluation reserve	March 31 2022 £000 SOCI	March 31 2022 £000 Total
From professional valuation of land and buildings:						
Impairments in land value	**(15,570)**	**(752)**	**(16,322)**	(397)	(46)	(443)
Impairments in building and dwellings value	**(6,054)**	**(9,622)**	**(15,676)**	(19,204)	(19,612)	(38,816)
Impairments in right of use assets	**–**	**(895)**	**(895)**	–	–	–
Reversal of previous impairments	**–**	**31,194**	**31,194**	–	28,090	28,090
Other impairments of property, plant and equipment	**–**	**(632)**	**(632)**	–	(6,983)	(6,983)
	(21,624)	**19,293**	**(2,331)**	(19,601)	1,449	(18,152)
Revaluations upwards from professional valuation to revaluation reserve						
Increase in value of right to use assets	**923**	**–**	**923**	–	–	–
Increase in land value to revaluation reserve	**–**	**–**	**–**	50,222	–	50,222
Increase in building and dwellings value to revaluation reserve	**64,125**	**–**	**64,125**	56,879	–	56,879
	65,048	**–**	**65,048**	107,101	–	107,101
Total movement to PPE arising from from professional valuation	**42,501**	**20,820**	**63,321**	87,500	8,432	95,932
Total movement to Right of Use assets from professional valuation	**923**	**(895)**	**28**	–	–	–

16 Leases – The Trust as a Lesee

This note details information about leases for which the Trust is a lessee.

The majority of lease arrangements where Guy's and St Thomas' NHS Foundation Trust is the lessee involve the leasing of buildings. Other lease arrangements involve the leasing of equipment and vehicles.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

16.1 Right of use assets 2022/23

	Property (land and buildings) £000	Plant and machinery £000	Transport Equipment £000	Information technology £000	Total £000	Of which: leased from DSHC group bodies £000
Valuation / gross cost at 1 April 2022	–	–	–	–	–	–
IFRS 16 implementation – reclassification of existing finance leased assets from PPE or intangible assets	–	1,993	–	1,886	**3,879**	**–**
IFRS 16 implementation – adjustments for existing operating leases / subleases	137,788	8,016	8,031	10,182	**164,017**	**51,566**
Additions	18,225	5,253	94	–	**23,572**	**–**
Impairments to operating expenses	(895)	–	–	–	**(895)**	**–**
Revaluations to revaluation reserve	294	(45)	–	(308)	**(59)**	**–**
Valuation/gross cost at 31 March 2023	**155,412**	**15,217**	**8,125**	**11,760**	**190,514**	**51,566**
Accumulated depreciation at 1 April 2022	**–**	**–**	**–**	**–**	**–**	**–**
Provided during the year	19,513	3,288	2,589	3,274	**28,664**	**4,138**
Revaluations to revaluation reserve	(629)	–	–	–	**(629)**	**–**
Accumulated depreciation at 31 March 2023	**18,884**	**3,288**	**2,589**	**3,274**	**28,035**	**4,138**
Net book value at 31 March 2023	**136,528**	**11,929**	**5,536**	**8,486**	**162,479**	**47,428**
Net book value of right of use assets leased from other NHS providers						**2,915**
Net book value of right of use assets leased from other DHSC group bodies						**44,513**
						47,428

16.2 Reconcilliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 23.

Group and Trust	**2022/23 £000**
Carrying value at 31 March 2022	**3,879**
IFRS 16 implementation – adjustments for existing operating leases	141,422
Lease additions	23,572
Interest charge arising in year	2,096
Lease payments (cash outflows)	(31,429)
Carrying value at 31 March 2023	**139,540**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

16.3 Maturity analysis of future lease payments at 31 March 2023

Group and Trust	Total	Of which leased from DHSC group bodies:
	March 31 2023 £000	March 31 2023 £000
Undiscounted future lease payments payable in:		
– not later than one year;	**33,646**	**4,368**
– later than one year and not later than five years;	**67,042**	**17,298**
– later than five years	**46,436**	**27,846**
Total gross future lease payments	**147,124**	**49,512**
Finance charges allocated to future periods	**(7,584)**	**(2,779)**
Net lease liabilities at 31 March 2023	**139,540**	**46,733**
Of which:		
Leased from other NHS providers		**2,930**
Leased from other DHSC group bodies		**43,803**
		46,733

16.4 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations unders leases the trust previosuly determined to be finance leases under IAS 17 at 31 March 2022.

Group and Trust	31 March 2022 £000
Lease liabilities	
– not later than one year;	1,669
– later than one year and not later than five years;	2,126
– later than five years	84
	3,879

16.5 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the Trust previously determined to be operating leases under IAS 17.

Group and Trust	2021/22 £000
Operating lease expense	
Minimum lease payments	23,528
Total	**23,528**

	31 March 2022
Future minimum lease payments due:	**£000**
– not later than one year;	26,552
– later than one year and not later than five years;	78,943
– later than five years	64,198
Total	**169,693**

16.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

Group and Trust	**1 April 2022 £000**
Operating lease commitments under IAS 17 at 31 March 2022	**169,693**
Incremental borrowing rate at 1 April 2022	**0.95%**
IAS 17 operating lease commitment discounted at incremental borrowing rate	**168,097**
Less:	
Commitments for short term leases	(29,063)
Irrecoverable VAT previously included in IAS 17 commitment	(24,547)
Commitments for leases that had not commenced as at 31 March 2022	(4,391)
Commitments for leases of low value assets	(9)
Other adjustments	
Differences in the assessment of the lease term	14,848
Finance lease liabilities under IAS 17 as at 31 March 2022	3,879
Other adjustments	16,487
Total lease liabilities under IFRS 16 as at 1 April 2022	**145,301**

17 Investment property

Investment property carrying values

	GROUP AND TRUST	
	March 31 2023 £000	March 31 2022 £000
Carrying value at April 1	**80,359**	90,190
Movement in fair value	**(5,225)**	(7,065)
Reclassifications to/from PPE	**–**	(2,766)
Carrying value at March 31	**75,134**	80,359

Investment properties were valued by Gerald Eve as at 31 March 2023. 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.

18 Revaluation reserve movements

Property, plant and equipment

	GROUP AND TRUST	
	March 31 2023 £000	March 31 2022 £000
Revaluation reserve at April 1	**519,338**	431,838
Impairments	**(21,624)**	(19,601)
Revaluations	**64,695**	107,101
Other	**1,929**	–
Revaluation reserve at March 31	**564,338**	519,338

19 Subsidiaries and interests in associates and joint ventures

The Guy's and St Thomas' principal subsidiary undertakings, associates and joint ventures as included in the Financial Statements at March 31 2023 are set out below. The accounting date of the financial statements for the subsidiaries, Collaborative Procurement Partnership LLP and KHP MedTech is March 31 2023 and for the remaining joint ventures December 31 2022. 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
Lexica Health and Life Sciences Consultancy Limited[1] (Formerly Essentia Trading Limited)	UK	100%	Healthcare services
The Chelsea Private Hospital Ltd	UK	100%	Dormant
Associates and joint ventures			
KHP MedTech Innovations Ltd[1]	UK	30%	Healthcare services
SpotOn Clinical Diagnostics Ltd[1]	UK	30%	Healthcare services
King's Health Partners Ltd[2]	UK	25%	Healthcare services
Collaborative Procurement Partnership LLP	UK	25%	Healthcare services
Synnovis Group LLP[1] (formerly Viapath)	UK	24.5%	Healthcare services
Synnovis Services LLP[1] (formerly Viapath)	UK	24.5%	Healthcare services
Synnovis Analytics LLP[1] (formerly Viapath)	UK	24.5%	Healthcare services

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

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

19.1 Investments in joint ventures and associates

	GROUP	
	March 31 2023 £000	March 31 2022 £000
Carrying value at April 1	**1,345**	215
Additions	**675**	1,126
Share of profits	**635**	34
Profit Distribution / Dividends received	**(605)**	(30)
Carrying Value at March 31	**2,050**	1,345

20 Other investments / financial assets

	GROUP		TRUST	
Non-current	**March 31 2023**	March 31 2022	**March 31 2023**	March 31 2022
	£000	£000	**£000**	£000
Carrying value at April 1	**146**	146	**9,667**	8,479
Additions	**–**	–	**1,242**	1,508
Loan repayments	**–**	–	**(320)**	(320)
Carrying value at March 31	**146**	146	**10,589**	9,667

2022/23 Group other investments / financial assets

Organisation	**Current £000**
Cydar Investments	146
	146

2022/23 Trust other investments / financial assets

Organisation	**£000**	**Interest rate**	**Maturity date**
Pathology Services Ltd (loan + interest)	8,305	Base rate +2%	Mar 2029
Guy's and St Thomas' Enterprises Limited (loan + interest)	2,284	Base rate +2%	Dec 2029
	10,589		

'Trust Loans with Pathology Services Limited (PSL) and Guy's and St Thomas' Enterprises Limited are removed from the Group Accounts following consolidation adjustments. Lexica Health and Life Sciences Consultancy Limited fully repaid its loan with the Trust during 22/23.

21 Inventories

	GROUP AND TRUST	
	March 31 2023	March 31 2022
	£000	£000
Drugs	**10,519**	8,304
Consumables and energy	**37,496**	36,070
	48,015	44,374

Inventories recognised in expenses for the year were £545,875k (2021/22: £537,361k). Write-down of inventories recognised as expenses for the year were £1,290k (2021/22: £640k).

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 2022/23 the Trust received £2,577k of inventory items purchased by DHSC (2021/22: £4,122k)

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.

22 Trade and other receivables

22.1 Current

	GROUP AND TRUST	
	March 31 2023 £000	March 31 2022 £000
Contract receivables: invoiced	**121,616**	96,217
Contract receivables: not yet invoiced	**112,919**	69,262
Capital receivables	**9,633**	6,025
Allowance for impaired receivables	**(40,422)**	(36,726)
Prepayments	**26,334**	22,379
PDC dividend receivable	**–**	1,931
VAT and other tax receivable	**3,736**	6,855
Clinical pension tax provision reimbursement funding from NHSE	**100**	100
Other receivables	**11,579**	6,792
	245,495	172,836

22.2 Non-current

	GROUP AND TRUST	
	March 31 2023 £000	March 31 2022 £000
Contract receivables	**2,638**	2,860
Capital receivables*	**–**	8,609
Clinical pension tax provision reimbursement funding from NHSE	**5,273**	5,154
	7,911	16,623

*Non-current capital receivable from prior year now treated as current.

22.3 Allowances for credit losses

	GROUP AND TRUST	
	2022/23 Contract receivables and contract assets £000	**2021/22 Contract receivables and contract assets £000**
Allowances as at 1 April	**36,726**	46,870
New allowances arising	**5,355**	821
Reversal of allowances	**(659)**	(7,484)
Utilisation of allowances	**(1,000)**	(3,482)
Allowances as at 31 March	**40,422**	36,726

23 Current liabilities

23.1 Trade and other payables

	GROUP AND TRUST	
	March 31 2023	March 31 2022
	£000	£000
Trade payables	**59,813**	65,957
Capital payables	**40,286**	47,621
Accruals	**251,582**	206,794
Receipts in advance	**1,314**	1,368
Social security costs	**18,343**	17,797
Other taxes payable	**17,444**	16,261
PDC dividend payable	**4,734**	–
Pension contributions payable*	**19,685**	15,559
Other payables	**799**	3,747
	414,000	375,104

*Newly disclosed category, prior year comparator re-analysed from trade payables

23.2 Other liabilities

	GROUP AND TRUST	
Current	**March 31 2023**	March 31 2022
	£000	£000
Deferred income: contract liabilities	**68,290**	65,179
Deferred grants	**257**	55
Other deferred income	**–**	4,632
	68,547	69,866

23.3 Borrowings

	GROUP AND TRUST	
	March 31 2023	March 31 2022
Current	**£000**	£000
Capital loans from Department of Health and Social Care (DHSC)	**19,062**	19,157
Lease liabilities*	**32,432**	1,669
Obligations under PFI, LIFT or other service concession contracts (excluding lifecycle)	**129**	273
	51,623	21,099
Non-current	**£000**	£000
Capital loans from Department of Health and Social Care (DHSC)	**191,839**	209,973
Lease liabilities*	**107,108**	2,210
Obligations under PFI, LIFT or other service concession contracts (excluding lifecycle)	**2,726**	2,866
	301,673	215,049
Total borrowings (current and non-current)	**353,296**	236,148

*The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 16.

23.4 Reconciliation of liabilities arising from financing activities 2022/23

GROUP	Loans from DHSC £000	Other loans £000	Lease liabilities £000	Service concession obligations £000	Total £000
Carrying value as at 1 April 2022	229,131	–	3,879	3,139	**236,149**
Cash movements:					
Financing cash flows – payments and receipts of principal	(18,134)	–	(29,334)	(284)	**(47,752)**
Financing cash flows – payments of interest	(5,444)	–	(2,095)	(117)	**(7,656)**
Non-cash movements:					
IFRS 16 implementation – adjustments for existing operating leases/subleases	–	–	141,422	–	**141,422**
Additions	–	–	23,572	–	**23,572**
Lease liability measures	–	–	–	–	**–**
Application of effective interest rate	5,349	–	2,096	117	**7,562**
Carrying value at 31 March 2023	**210,902**	**–**	**139,540**	**2,855**	**353,296**

23.5 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**

23.6 Schedule of borrowings from the Department of Health and Social Care

Loan start date %	Loan end date £000	Interest rate %	Total loan drawn down £000	Principal and accrued interest outstanding April 1 2022 £000	Principal repaid during 2022/23 £000	Interest paid during 2022/23 £000	Interest charge (I&E) for 2022/23 £000	Principal and accrued interest outstanding March 31 2023 £000
Jun-11	Jun-36	3.27	75,000	49,933	(3,405)	(1,590)	1,556	46,494
Mar-12	Mar-37	2.85	80,000	55,812	(3,728)	(1,559)	1,560	52,085
Sep-13	Nov-23	1.95	9,000	2,266	(1,125)	(38)	30	1,133
* Apr-14	Apr-29	2.54	30,000	18,205	(2,400)	(442)	415	15,778
* Jun-15	Jun-30	2.06	20,000	12,672	(1,480)	(251)	243	11,184
Feb-16	Feb-41	1.9	25,000	19,431	(1,020)	(365)	361	18,407
Feb-16	Feb-41	1.9	14,000	11,112	(582)	(209)	207	10,528
Feb-16	Feb-41	1.9	33,768	28,581	(1,499)	(538)	532	27,076
Feb-16	Feb-31	1.38	27,232	22,310	(2,478)	(300)	295	19,827
Nov-17	Nov-42	1.76	10,000	8,809	(417)	(152)	150	8,390
			324,000	**229,131**	**(18,134)**	**(5,444)**	**5,349**	**210,902**

***** Loans transferred from the Royal Brompton and 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.

24 Provisions for liabilities

24.1 Overall provisions

GROUP AND TRUST

	March 31 2023 £000	March 31 2022 £000
Current		
Pensions: injury benefit	**81**	81
Pensions: early departure	**20**	20
Legal claims	**389**	614
Clininician pension tax reimbursement	**100**	100
Other*	**1,165**	3,396
	1,755	4,211

	March 31 2023 £000	March 31 2022 £000
Non-current		
Pensions: injury benefit	**1,283**	1,737
Pensions: early departure	**137**	154
Clinician pension tax reimbursement	**5,273**	5,154
Other*	**7,232**	7,716
	13,925	14,761

Total provisions	**March 31 2023 £000**	March 31 2022 £000
Pensions: injury benefit	**1,364**	1,818
Pensions: early departure	**157**	174
Legal claims	**389**	614
Clinician pension tax reimbursement	**5,373**	5,254
Other*	**8,397**	11,112
	15,680	18,972

24.2 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 2022	1,818	614	174	5,254	11,112	**18,972**
Change in Discount Rate	(515)	–	–	(4,727)	–	**(5,242)**
Arising during the year	165	124	16	4,795	709	**5,809**
Utilised during the year	(90)	(29)	(34)	(57)	(2,243)	**(2,453)**
Reversed unused	–	(320)	–	–	(1,181)	**(1,501)**
Unwinding of discount	(14)	–	1	108	–	**95**
At March 31 2023	**1,364**	**389**	**157**	**5,373**	**8,397**	**15,680**

24.3 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	389	20	100	1,165	**1,755**
Between one and five years	1,096	–	80	236	6,046	**7,458**
After five years	187	–	57	5,037	1,186	**6,467**
	1,364	**389**	**157**	**5,373**	**8,397**	**15,680**

*Other provisions largely consist of provisions for dilapidations.

As at 31 March 2023 £486m is included in provisions of NHS Resolution in respect of clinical negligence liabilities of Guy's and St Thomas' NHS Foundation Trust (£817m at March 31 2022).

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

25 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	
	2022/23	2021/22	**2022/23**	2021/22
	£000	£000	**£000**	£000
At April 1	**220,946**	323,800	**215,770**	318,167
Net change in year	**(90,186)**	(102,854)	**(89,852)**	(102,397)
At 31 March	**130,760**	220,946	**125,918**	215,770
Broken down into:				
Cash at commercial banks and in hand	**6,020**	7,598	**1,178**	2,422
Cash with the Government Banking Service	**124,740**	213,348	**124,740**	213,348
Total cash and cash equivalents	**130,760**	220,946	**125,918**	215,770

26 Contractual capital commitments

	GROUP AND TRUST	
	31 March 2023	31 March 2022
	£000	£000
Property, plant and equipment	**24,611**	37,836
Intangible assets	**44,027**	59,240
	68,638	97,076

27 Contingencies

Contingent liabilities

	GROUP AND TRUST	
	31 March 2023	31 March 2022
	£000	£000
Contingent liability for claims	**(72)**	(144)
Net contingent liability	**(72)**	(144)

Contingent liabilities recorded are in respect of Public and Employee liability cases and the Property Expenses Scheme as advised by the NHS Resolution. This represents the best estimate of future liabilities based on available input from NHS professionals in the respective areas.

28 Events after the reporting date

There were no events after the reporting date.

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
- Public Health England
- Health Education England
- Integrated Care Boards and NHS England
- Special Health Authorities
- Non-Departmental Public Bodies
- Other Department of Health and Social Care bodies

Per note 19, 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 (invoiced) from related parties		**Amounts owed (invoiced) to related parties**	
	2022/23 £000	2021/22 £000	**2022/23 £000**	2021/22 £000
Non-NHS Related party transactions				
Guy's and St Thomas' Charity	**1,209**	1,842	**–**	–
King's College London	**12,297**	5,685	**5,402**	13,601
Synnovis*	**4,441**	4,813	**6**	304
Royal Brompton and Harefield Hospitals Charity	**7**	153	**95**	95

	Income from related party		**Expenditure with related party**	
	2022/23 £000	2021/22 £000	**2022/23 £000**	2021/22 £000
Non-NHS Related party transactions				
Guy's and St Thomas' Charity	**4,977**	6,256	**–**	17
King's College Hospital	**34,049**	25,679	**27,741**	28,962
Royal Brompton and Harefield Hospitals Charity	**1,252**	1,723	**–**	–

***** Includes transactions with Synnovis Group LLP, Synnovis Services LLP, Synnovis Analytics LLP

A number of Board level staff held joint posts with King's College Hospital NHS Foundation Trust during 2022/23: Sir Hugh Taylor was the interim Chair from March 2019 to November 2022, Beverley Bryant has been Chief Digital Information Officer since September 2019, Steve Weiner has been a Non-Executive Director since March 2021 and Charles Alexander has been Joint Chairman for both organisations since December 2022.

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.

Since September 2020 Dr Felicity Harvey has been a Non-Executive Director at Sciensus (formerly 'Healthcare at Home'), a company (Halcyon TopCo Ltd), which provides services to Guy's and St Thomas' as well as many other NHS Organisations for the provision of medicines in the home of patients with long term conditions on expensive medicines. The Trust has recorded £31.9m of invoices from Sciensus during 2022-23 (£33.5m 2021-22), being coded to 'Drugs' in Note 7. The Trust has a year-end creditor of £14k (£54k 2021-22).

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 £161k of expenditure with Bevan Brittan LLP during 2022-23 (£257k 2021-22) and a year-end creditor of £18k (£15k 2021-22).

The Council of Governors includes representatives from organisations that work closely with the Trust including Lambeth Council, Southwark Council, Royal Borough of Kensington and Chelsea Council, London South Bank University, and King's College London.

Aside from these transactions none of the other Board members, the members of the Council of Governors, members of the key management staff or parties related to them have undertaken any material transactions with Guy's and St Thomas' NHS Foundation Trust.

30 Financial assets and liabilities

30.1 Carrying value and fair value of financial assets

GROUP AND TRUST	**Held at amortised cost**	Held at amortised cost
	March 31 2023 £000	March 31 2022 £000
Carrying values of financial assets as at 31 March		
Trade and other receivables (excluding non-financial assets) – with NHS and DHSC bodies	**69,076**	67,578
Trade and other receivables (excluding non-financial assets) – with other bodies	**106,115**	85,461
Other investments / financial assets	**2,196**	1,491
Cash and cash equivalents	**130,760**	220,946
Total carrying value of financial assets at 31 March	**308,147**	375,476

30.2 Carrying value and fair value of financial liabilities

GROUP AND TRUST	**HELD AT amortised cost**	HELD AT amortised cost
	March 31 2023 £000	March 31 2022 £000
Carrying values of financial liabilities as at 31 March		
Loans from DHSC	**210,901**	229,130
Obligations under leases	**139,540**	3,879
Obligations under service concession contracts	**2,855**	3,139
Trade and other payables (excluding non financial liabilities) – with NHS and DHSC bodies	**30,181**	25,832
Trade and other payables (excluding non financial liabilities) – with other bodies	**259,238**	286,336
Provisions under contract	**8,325**	11,726
Total carrying values of financial liabilities as at 31 March	**651,040**	560,042

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 2023 £000	March 31 2022 £000
In one year or less	**347,957**	341,672
In more than two years but not more than five years	**175,419**	111,768
In more than five years	**171,698**	148,579
	695,074	602,019

30.4 Loan disclosure

	Current	Non current	Total	Weighted average interest
	£000	£000	£000	rate %
March 31 2023				
Fixed interest rate instruments	**19,062**	**191,839**	**210,901**	2.44%
March 31 2022				
Fixed interest rate instruments	19,157	209,973	229,130	2.43%

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 23. The borrowings are for 1 – 25 years, in line with the life of the associated assets. Interest rates on the ITFF (Govt) loans are fixed. 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 2023 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:

£186k (£196k at March 31 2022) which relates to monies held by the Trust on behalf of patients.

£2,929k (£2,924k at March 31 2022) 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 2023	31 March 2022
	£000	£000
Monies on deposit	**3,115**	3,120
Total Third Party Assets	**3,115**	3,120

32 Losses and special payments

	Group and Trust			
	Year ended March 31 2023	**Year ended March 31 2023**	Year ended March 31 2022	Year ended March 31 2022
Losses	**Cases**	**£000**	Cases	£000
Cash losses	**6**	**1**	10	29
Bad debts and claims abandoned	**1,178**	**2,989**	1,080	1,714
Stores losses, theft and other	**44**	**1,410**	125	810
Total losses	**1,228**	**4,400**	1,215	2,553

	Year ended March 31 2023	**Year ended March 31 2023**	Year ended March 31 2022	Year ended March 31 2022
Special payments	**Cases**	**£000**	Cases	£000
Ex gratia payments	**31**	**13**	32	15
Overtime corrective payments (nationally funded)	**–**	**–**	1	968
Special severance payments	**1**	**1**	–	–
Total special payments	**32**	**14**	33	983
Total losses and special payments	**1,260**	**4,414**	1,248	3,536

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 21/22 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 Treatment 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 (nil 2021/22). There were no disposals of artefacts during either year.

34 The Late Payment of Commercial Debts (interest) Act 1998

The Trust incurred £15k (£2k 2021/2022) 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 2023 was £37,668k (£29,237k 2021/22).

contacts

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Patient Advice and Liaison Service (PALS)
If you require information, support or advice about our services, contact:

PALS

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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
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GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
WEDNESDAY 26 JULY 2023

Title:	**Principal Treatment Centre for Children's Cancer**
Responsible executive:	**Jackie Parrott, SRO Paediatric Cancer**
Paper author:	**Jackie Parrott, SRO Paediatric Cancer**
Purpose of the paper:	• To give an overview of changes to children's cancer services in South London and Southeast England • To outline key aspects of Evelina London's proposal to NHS England
Main strategic priority:	TO TREAT AS MANY PATIENTS AS WE CAN, SAFELY; TO CARE FOR AND SUPPORT OUR STAFF; TO BUILD RESILIENT HEALTH AND CARE SYSTEMS WITH OUR PARTNERS
Key issues summary:	• Following a national review of Children's cancer services in 2019, and a newly developed service specification for Principal Treatment Centres in 2021, NHSE England (London Region) is preparing to consult the public on moving children's cancer services from the Royal Marsden Hospital (Sutton site) because it is unable to meet the new service specification. • Proposals were invited from providers who felt they met the service specification, and on the basis of a rigorous evaluation of the two proposals received from Evelina London and St George's University Hospital, both are being put forward for consultation. Following the options appraisal, Evelina London will be NHS England's (London) preferred option going into public consultation. • It is important that the Council of Governors are informed about the strength of our proposal and the process NHS England is following to support their final decision.
Paper previously presented at:	• N/A
Recommendation(s):	The COUNCIL OF GOVERNORS is asked to:

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	1. Note the background and the case for change. 2. Note and support NHSE's consultation process by providing feedback to them during consultation. 3. To be aware of the strengths of the Evelina London proposal.

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Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
WEDNESDAY 26 JULY 2023

1. Executive Summary

1.1. NHSE is planning a public consultation on proposals to relocate the children's cancer services currently provided at the Royal Marsden site at Sutton to an alternative provider which can meet the national service specification. The two options for children with cancer between the ages of 1 and 15 are, Evelina London – which is NHSE's preferred option going into public consultation – and St George's University Hospital.

1.2. The case for change has been developed over many years in response to significant engagement with clinicians, patients, and public stakeholders, captured in the 2021 service specification which mandates on-site intensive care and specialised children's services.

1.3. The Trust put forward a proposal in November 2022 which was recognised by independent, expert panels as providing the best option for clinical care and research. On the basis of this evaluation, the Trust's proposal will be the preferred option going into the public consultation.

1.4. Public consultation on both options is due to start in September and a wide range of views are being sought. We want to ensure that the Council of Governors is informed about the case for this change and the strength of the proposal submitted by the Trust.

2. Children's Cancer Services: Context and Case for Change

2.1. Principal Treatment Centres (PTCs) provide diagnosis, treatments, and coordination of highly specialised care for children aged 15 and under with cancer. There are 13 of them in England. The PTC provision for South London and the South East of England has been specifically considered as part of national reviews (including the Stevens Review in 2015).

2.2. Professor Sir Mike Richards' national review in 2019 specifically addressed the current PTC arrangements at the Royal Marsden and 'crucially the lack of a co-located level 3 PICU [which] presents an inherent geographical risk to patient safety. This risk can only ever be partially mitigated.' Following this review, in 2021, a new national service specification for Principal Treatment Centres was approved by NHS England after being developed and tested with patients, families, staff, and charities. It mandates that all PTCs must be on the same site as a paediatric intensive care unit (PICU) and other specialised children's services.

2.3. The PTC covering the catchment area of south London, Kent, Medway, most of Surrey, East Sussex, Brighton and Hove is provided by the Royal Marsden NHS Foundation Trust on the Sutton site, with St George's University Hospitals NHS Foundation Trust providing critical care and surgery for the PTC. The Royal Marsden does not have a paediatric intensive care unit on-site, which means that some children are transferred between the Sutton site and St George's Hospital in Tooting every year. Children are also transferred between the Sutton site and St Georges and other tertiary centres in London including King's College Hospital and Evelina London.

The case for change for the PTC for children with cancer living in south London and most of the southeast centres around five key points:

- **To eliminate hospital transfers for children who need intensive care**. Children with cancer can become very seriously ill during treatment and need to be transferred to intensive care – where these transfers of very sick children are to another hospital, risk is added to an already very difficult situation. Putting specialist children's cancer services on the same site as intensive care will eliminate these risks.
- **To help children avoid unnecessary and potentially distressing admissions to intensive care**. When they are on the same site, intensive care specialists can visit children on the cancer ward two or three times a day to see how they are, and discuss their care with the team looking after them. Cancer services in children's hospitals with intensive care on-site have fewer intensive care admissions for this reason.
- **To reduce distress and improve the experience for children and families**. With the PTC on the same site as specialist children's services as well as intensive care, most children with cancer will have more of their appointments, surgeries, and treatments in a place they already know (noting that not all transfers to specialist centres will be eliminated in this process).
- **To ensure the children's cancer centre is ready for the future**. Innovative cancer treatments may carry a greater risk of complications that require intensive care so can only be given at children's cancer centres on the same site as intensive care. This is the case, for example, for ground-breaking CAR-T treatment. Many more of these treatments are expected to become available in the next few years and at present, the PTC for children with cancer living in south London and most of the south east could not be commissioned to deliver these therapies.
- **It is a national requirement.** For all these reasons, it is a national requirement for specialist children's cancer services to be on the same site as intensive care. This is set out in the national service specification for Principal Treatment Centres which was approved by NHS England in 2021 after being developed with patients, parents, and professionals. The specification sets the standards for the service and must be enacted.

3. The Guy's and St Thomas' vision for the PTC

3.1. In November 2022, both Trusts submitted proposals to NHS England to become the new PTC for Children's Cancer in South London and the Southeast of England.

3.2. The vision for the PTC at Evelina London is that the Royal Marsden paediatric oncology team joins an environment that, as well as being clinically and academically world-class, is designed with children and their families in mind. The PTC at Evelina London would be co-located with teams who have an unparalleled depth of clinical and research expertise, in the only dedicated, purpose-built specialist children's hospital in the South Thames region, bringing the PTC in line with the leading centres worldwide, which are all located in specialist children's hospitals. Key aspects of the Evelina London proposal are set out in the appendix. Unique strengths include:

- Specialist children's services at a scale that is unmatched in the region, including regional services that are only provided at GSTT and already serve the PTC (i.e. cardiology and renal).
- Proven experience in managing complex paediatric clinical networks, including across the geography of the PTC and the children's cancer network, which will support the future delivery of care closer to home for the children of the region and will support education for the regional network.
- A model for transition to adult services, backed by many years of experience, recognised as excellent by experts.
- The breadth and scale of research at GSTT (including significant research portfolios in children's specialties, and in cancer in young people and adults); the potential for developing research opportunities in areas of strength at GSTT such as imaging and critical care, which the Royal Marsden does not currently focus on; and confidence that GSTT will open up further research opportunity and impact in experimental areas such as CAR-T and other immune therapies (with unrivalled infrastructure in advanced therapies).
- A clinical education team that will offer opportunities for development for paediatric specialist doctors and nurses, and already provides training in all hospitals in the regional cancer network, including RMH;
- A single electronic health record (Epic) which will be shared with King's College Hospital (KCH) and with clinicians able to access records through Epic at RMH, UCLH, and GOSH, transforming care and patient experience.
- Excellent patient experience. Evelina London was the only hospital in the region commended as a positive outlier in the most recent CQC Children and Young People's Experience survey for children aged 0-7, receiving higher feedback than peers, including notably for facilities for parents or carers staying overnight, communication and involvement in decisions around care, and play.
- A dedicated children's charity (Evelina London Children's Charity) that raises £3m p.a. for children's services and expects to raise much more for children's cancer.
- A widely accessible location, with excellent transport links and planned provision of free, dedicated parking for the PTC.

Facilities will include an inpatient ward (including rooms for bone marrow transplants), facilities to provide chemotherapy and other day-case procedures, and an outpatient department, co-located with Evelina London's existing children's facilities.

4. NHS England Process

4.1. A formal service reconfiguration and consultation process, run by NHS England (in this case, the London region), is required when moving a major service, to ensure all stakeholders have the opportunity to review and comment on the case for change, clinical model, and proposals.

4.2. NHS England has ensured that there has been patient and public engagement throughout, and has run a robust evaluation with specific criteria to evaluate each proposal, and final scores calculated.

4.3. The outcome of the evaluation was that **Evelina London scored 80.51% and St George's scored 75.27%**. Evelina London scored higher in 3 of the 4 domains, with the most significant differential in the clinical and research domains. Given both providers scored highly in the options appraisal process, the NHSE team will seek feedback on both options during public consultation. **Evelina London will be recognised as the preferred option going into the consultation** but the NHSE London team is keeping an open mind.

4.4. NHS England has undertaken an **Equality and Health Inequality Impact Assessment** (EHIA) as part of their process to assess the impact of the change in location of the current PTC and the implications of this change on patient travel arrangements, including travel time, the complexity of the journey (including parking), and cost. These are key issues that will need to be addressed under either option, and the Trust has provided detail of specific mitigations to address any potential negative impacts, including:

- Free, dedicated parking that will at least match the current provision at RMH.
- An updated patient transport service, including ringfenced capacity for Evelina London (including the PTC).
- Providing overnight accommodation, including on-site and in Ronald McDonald House (5-minute walk from Evelina London).
- Reimbursement for travel costs in line with national policies and best practice.

4.5. NHS England - London is adhering to a stringent assurance process throughout, and as part of this has presented outcomes, progress, and future plans to the London and Southeast Clinical Senate. Clinical Senate is an independent, non-statutory advisory body that is a source of strategic advice and guidance to commissioners and other stakeholders.

4.6. Extensive input from patients, families, staff, and children's cancer charities is being sought during the pre-consultation phase. This includes sharing information about the case for change, information on the public consultation, and ensuring that any materials used

during the consultation are accessible and that NHS England reaches as many people who may be affected by the change as possible and don't miss any stakeholders to engage in the process.

5. **Next Steps: Public Consultation**

5.1. A public consultation is a process that involves the public in providing their views and feedback on a proposal which will then be considered during the decision-making process. It is not a vote on the two options but feedback will influence the decision.

5.2. NHS England – London Region will be leading the public consultation for changes to children's cancer services. It is anticipated that the public consultation will launch in early autumn 2023 and run for 12 weeks. A decision is expected in early 2024.

6. Risks and Issues

There are a number of key risks and issues, including:

6.1. Timeline slippage has already occurred, with public consultation delayed from June to early autumn. There is a risk of further delay, with consequent delays to decision-making and the potential for elections and other external processes to introduce yet more delays.

Any delays to a final decision may cause uncertainty for patients, families, and staff, so it is important this is kept to an absolute minimum.

6.2. Meanwhile, the risks to the stability of the current PTC service grow as uncertainty continues and adds to the distress of families. Delays only increase these risks.

6.3. It is important that the public consultation is able to run in a fair and transparent way, based on factual and accurate information and materials, and it is, therefore, important that the risk of misinformation is managed closely throughout the process. Ensuring our stakeholders are aware of the facts and strength of the Evelina London proposal is important in this context.

7. Recommendations

The Council of Governors is asked to:

7.1. Note the background and the case for change.

7.2. Support NHSE's process and participate in the consultation process by providing feedback to NHSE on their proposals. Governors will be provided with details about how to do this as soon as this information becomes available

7.3. To be aware of the strengths of the Evelina London proposal when responding to the consultation or any questions you may receive from stakeholders.

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Guy's and St Thomas' NHS Foundation Trust

Appendix: Key Aspects of the Evelina London Proposal

- The service change will involve the transfer of the current RMH team, with recruitment and education to support the future development of the PTC service.
- Facilities will include an inpatient ward (including rooms for bone marrow transplants), facilities to provide chemotherapy and other day-case procedures, and an outpatient department, co-located with Evelina London's existing children's facilities.
- It has been agreed by all parties that a number of 'fixed points' are not in scope and will not change as a result of this process. These include care of under 1's at GOSH, liver surgery at King's College Hospital (KCH), and PICU at KCH, Evelina London, and St George's.
- The national service specification requires a number of services to be available on-site. Evelina London provides all of these services at scale. Evelina London also has on-site and at scale a number of services that are required to be 'readily available' and which are not available elsewhere, such as cardiac and renal – which are often needed by the sickest children. Evelina London already provides care to about 10% of the children in the children's cancer service.
- A further service that is required to be 'readily available' is neurosurgery. Regardless of where the new PTC is located, children requiring neurosurgery will be treated in the same way they are now, with approximately 70% - particularly those requiring the most complex interventions – being treated at KCH, with well-established processes and pathways in place to manage this. Evelina London and KCH already work as one team for children needing neurological services and KCH already provides some highly specialist neurosurgical procedures in Evelina London, clinical reviews for children on the wards, and on occasion emergency neurosurgical intervention. The remaining 30% of children needing neurosurgery will continue to be treated at St George's.
- Under both proposals, radiotherapy will be provided at UCLH (which aligns with the national direction of travel for consolidating radiotherapy services, with the introduction of proton beam therapy at two centres nationally – one being UCLH).

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Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
WEDNESDAY 26 JULY 2023

Title:	**Report from the Nominations Committee**
Responsible Executive:	**Charles Alexander, Trust Chair**
Author:	**Edward Bradshaw, Deputy Director of Corporate Affairs**
Purpose:	To provide updates on a number of matters within the Committee's remit
Strategic priority reference:	All strategic priorities
Recommendations:	The COUNCIL OF GOVERNORS is asked to: 1. Note this paper. 2. Approve the appointment of Cllr Ibrahim Dogus onto the Nominations Committee. 3. Approve the updated terms of reference for the Nominations Committee (Appendix 1).

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GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
WEDNESDAY 26 JULY 2023

1. Introduction

1.1. This Nominations Committee of the Council of Governors met on 12 June 2023 to consider a number of matters, and wishes to update the Council of Governors about these.

2. Nominations Committee membership

2.1. Warren Turner has been the partnership governor representative on the Committee for a number of years, but has now stood down from the Council of Governors following his departure from London South Bank University. The Trust's partnership governors were asked to identify a replacement from amongst themselves; Councillor Ibrahim Dogus from Lambeth Council was the only such individual who nominated themselves to become a member of the Committee and, as such, was directly appointed to the Committee.

2.2. The Council of Governors is asked to **approve** this appointment.

3. Nominations Committee terms of reference

3.1. At the previous meeting of the Committee there was discussion about the four members who sat on the Committee and whether this should be increased to reduce the risk of the Committee not being quorate if members were unavailable at short notice. Given the difficulty in identifying governors in all four constituencies to become members of the Committee (in the past two years, the current Committee members were the only ones who nominated themselves for the role) it is suggested that rather than add members, the Committee quorum is reduced from three members to two members. A small number of other updates have been proposed in addition. These are all set out in tracked changes in Appendix 1 and all were supported by the Committee.

3.2. The Council of Governors is asked to **approve** the proposed changes to the Nominations Committee terms of reference (Appendix 1).

4. Non-executive directors

4.1. The Nominations Committee also:

4.1.1. Noted and discussed an update regarding a potential successor to Professor Reza Razavi on the Trust Board;

4.1.2. Discussed the balance of skills, knowledge, experience and diversity of the Trust's current non-executive directors, plus their tenures, together with the Trust's priorities, strategic ambitions and the key challenges it was facing, and agreed that no steps would be taken to identify further non-executive directors to recommend for appointment to the Trust Board at this time.

4.1.3. Reviewed the terms and conditions for non-executive directors and, in particular, discussed the tenure, remuneration and allowances, and expected time commitment, and concluded that no changes should be proposed to the Council of Governors at this current time; and

4.1.4. Noted the process for appraisals of the non-executive directors, including the Trust Chair, in 2023.

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS
NOMINATIONS COMMITTEE
Terms of Reference

1. AUTHORITY

1.1 The Nominations Committee (the Committee) is constituted as a standing committee of the Council of Governors. The Committee is authorised by the Council of Governors to act within its terms of reference.

1.2 The Standing Orders of the Council of Governors, as far as they are applicable, shall apply to meetings of the Committee. In the event of conflict between the provisions of these terms of reference and the Standing Orders, the provisions of the Standing Orders shall take precedence.

1.3 The Committee has the authority to seek any information it requires from any employee of the Trust in order to perform its duties and to obtain external advice on any matters within its terms of reference.

2 PURPOSE

2.1 The purpose of the Committee is to be responsible for making proposals to the Council of Governors for:

- The appointment, reappointment, retention and removal of the Chair or Deputy Chair and non-executive directors;
- The remuneration, terms and conditions of service for the Chair and Deputy Chair and non-executive directors; and
- The oversight of the appraisal system for the Chair and Deputy Chair and non-executive directors.

2.2 In discharging these responsibilities the Committee will make recommendations to the Council of Governors; the Committee does not in itself have decision-making powers.

3 DUTIES

3.1 The Committee's general duties will be to:

- Consider the succession planning for the Chair, and non-executive directors, taking into account the challenges and opportunities facing the Trust, and the skills and expertise that are needed on the Board in the future;
- Make recommendations to the Council of Governors about the re-appointment of any non-executive director at the end of their specified term of office, having given due regard to their performance and ability to continue to perform adequately in the light of the knowledge, skills and experience required at the time re-appointment is to be made;
- Consider any matters relating to the potential removal of any non-executive director, including the Trust Chair, taking into account relevant legislation;
- Receive, on behalf of the Council of Governors, reports on the process and outcome of appraisal of the Chair and non-executive directors.
- Determine the remuneration of the Chair, and non-executive directors, taking into account guidance or requirements from regulatory bodies;
- Provide advice to the Council of Governors on levels of remuneration and associated terms and conditions for the Chair and other non-executive directors; and

- Receive reports on behalf of the Council of Governors on the process and outcome of appraisal for the Chairman and non-executive directors;

3.2 In relation to the appointment of non-executive directors the Committee will:

- Review the balance of skills, knowledge and experience of the existing non-executive directors in consideration of the role and the competencies required for a particular appointment;
- Seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates;
- Seek (using professional recruitment advisors or other third parties where appropriate) shortlist and interview such candidates as the Committee considers appropriate, having due regard to the principles of equality and diversity;
- Make recommendations to the Council of Governors as to potential appointments and advise the Board of Directors of those recommendations;
- Where necessary, seek professional advice and assistance from persons other than members of the Committee or of the Council of Governors in arriving at its recommendations; and
- Take up appropriate references as to suitability for appointment.

4 MEMBERSHIP & ATTENDANCE

4.1 The Committee will be chaired by the Trust Chair unless the Committee is discussing the appraisal, remuneration or appointment of the Trust Chair, in which case the Chair shall not be present during the discussion and the Committee shall be chaired as provided for by a deputy as set out in sections 3.14 and 3.15 of the Standing Orders of the Council of Governors.[1]

4.2 The other members of the Committee will be one governor from each of the governor constituencies in the Trust Constitution: staff, patient, public and partnership. Other members may be co-opted onto the Committee in certain situations, subject to the agreement of the Chair and all other Committee members.

4.3 Meetings of the Committee will be quorate with the Trust Chair or their nominated deputy and a minimum of two other members.

4.4 In accordance with section 8.1 the Director of Corporate Affairs and up to one other member of their team may be in attendance to facilitate and minute meetings of the Committee.

4.5 Other individuals may be invited to attend for all or part of any meeting, as and when required.

5 APPOINTMENT OF MEMBERS

5.1 Members of the Committee, other than the Trust Chair, will serve for a period of three years. They will be eligible at the end of that period for one further and final term.

5.2 When there is a vacancy on the Committee for a public, patient or staff governor representative, governors in that constituency will be asked to self-nominate themselves to stand for the seat by sending a short statement of suitability to the Trust's Corporate Affairs team. Where there is only one nomination, that individual will

[1] https://www.guysandstthomas.nhs.uk/resources/membership/trust-constitution.pdf

be appointed directly. Where there is more than one nomination, a private vote facilitated by Corporate Affairs will be held amongst the governors within that constituency. The Council of Governors will then be asked to approve the preferred candidate at a subsequent meeting or in correspondence.

5.3 When there is a vacancy on the Committee for a partnership governor representative, this individual will be appointed directly by the Trust Chair.

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held as and when required to enable the Committee to fulfil its duties.

6.2 The Committee may decide to take items by correspondence. In such cases, members will be given no less than three working days to respond, and the items will be formally noted at the following meeting of the Committee and recorded in the minutes.

6. REPORTING

6.1. The Committee shall report to the Council of Governors by means of reports setting out the matters discussed and the Committee's recommendations.

7. CONFIDENTIALITY

7.1. A member of the Committee shall not disclose any matter dealt with by, or brought before, the Committee without its permission until the Committee has reported on the matter to the Council of Governors or has otherwise concluded the matter.

7.2. Irrespective of the provisions of section 7.1, a member of the Committee shall not disclose any matter if the Committee or the Council of Governors resolves that it is confidential. Where a member is uncertain about releasing information, they should seek advice from the Director of Corporate Affairs.

8. AGENDA, PAPERS AND MINUTES

8.1. Corporate Affairs will provide administrative support to the Committee.

8.2. The agenda and supporting papers will be sent to Committee members and attendees no later than two clear days before the meeting.

8.3. The minutes of the proceedings of a meeting shall be drafted and submitted to members following the meeting, and issued for approval at the subsequent meeting.

9. REVIEW

9.1. These terms of reference will be reviewed and, if necessary revised, annually.

July 2023

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Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
COUNCIL OF NGOVERNORS
WEDNESDAY 26 JULY 2023

Title:	**LEAD GOVERNOR REPORT**
Responsible executive:	**John Powell, Lead Governor**
Paper author:	**John Powell, Lead Governor**
Purpose of paper:	For information
Main strategic priority:	All strategic priorities
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.
Paper previously presented at:	• Quarterly report for information only
Recommendation(s):	The COMMITTEE is asked to: **1. Note** the Lead Governor's report

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Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
TRUST EXECUTIVE COMMITTEE
WEDNESDAY 26 JULY 2023

1. The Covid-19 pandemic undoubtedly reformed working practices across the vast majority of organisations and industries, and of course the NHS took the brunt of the impact this global crisis had. We as a Council of Governors have also found ourselves in a very different place post-pandemic. As a voluntary force the demands of many day jobs have changed, necessitating therefore change in governor engagement with some aspects of the Trust. Out of any challenge, however, always comes an opportunity, and the recent governors' away day took full advantage.

2. A root and branch review of an organisation is never a bad thing from time to time, and that is exactly what the Council of Governors are now embarking on, to ensure we are operating most efficiently and effectively. Already we have restructured previously named 'informal' meetings to become "governor Briefing Sessions" with agendas to guide discussion on key current topics. This will in turn inform a new network of governor meetings and engagement which will dovetail onto the quarterly Board of Director and Council of Governor forums.

3. Governor responsibilities have also come under the spotlight, and we are acutely aware that we need to ensure our statutory responsibilities - including holding Non-Executive Directors to account - are discharged efficiently. It has therefore been decided to hold bi-annual meetings to inform the key areas in which governors will hold Non-Executive Directors to account. This will be achieved via visits, working group feedback, clinical reports and scrutiny of reports.

4. Within these forums we will identify themes from visits, pulling out ideas where governors can spearhead change. The first such meeting is already scheduled in September. We also want to ensure that members putting themselves up for election to the Council of Governors are clear on their potential responsibilities, and expected commitment should they be successful. An agreed 'Statement of Expectations' will be produced for candidates and will also be available to existing governors.

5. We are also of the view that the Membership Development, Involvement and Communication (MeDIC) working group could be resurrected with a refreshed purpose and terms of reference. The principle of adopting best practice from governors' experience as well as from other Trusts will be key to our strategy going forward. To this end I am already arranging to meet my opposite number, recently elected, at Kings. Other working groups including the QEWG and STPWG will also have their terms of reference

reviewed. Ensuring there are regular governor observers on Board committees and clinical/delivery group boards will also be prioritised.

6. Governors continue to carry out site visits - both to learn, identify where things are going well, as well as explore potential avenues for improvement. Alongside this Corporate Affairs have helped to establish a new governor training programme, driven by a series of monthly sessions on different subjects to help develop or refresh governors' understanding about some of the basic Trust functions and its structure.

7. On a completely different note, governors were impressed recently to learn that the Trust achieved the lowest Covid-19 mortality rate in the country, and indeed continues to command one of the lowest overall mortality rates across all services of all UK Trusts. We understand the Trust actual crude mortality rate is 1.8% - lower than the expected 2.5%, and lower than the national rate of 3.5%. Statistics can frequently expose shortcomings in an organisation - these figures clearly suggest this Trust has much to be proud of.

8. Finally my visit to the Guys Cancer Centre's "Celebration of Hope for Cancer Survivors' Day: as one such "survivor" of now 31 years (and counting) I am consistently in awe of the progress made in fighting this disease and the futuristic facilities and resources the Trust now possesses. I don't believe any other Trust in the country stages such an event, and my thanks and congratulations go to all involved in organising and presenting the day which even successfully grasped the attention and interest of my two young children 9 and 11!

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
QUALITY AND ENGAGEMENT WORKING GROUP
TUESDAY 27 JUNE 2023

Title:	**Council of Governors Quality and Engagement Working Group Meeting Notes, 27 June 2023**
Governor Lead:	**Leah Mansfield, 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 of the following: • Electronic healthcare record (Epic): Apollo staff training update • Quality and Engagement Working Group: 2023 work planning session continuation • Quarterly reports for Patient Experience and Patient and Public Engagement • Quality & Safety update
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

QUALITY AND ENGAGEMENT WORKING GROUP

TUESDAY 27 JUNE 2023

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 (QEWG) meeting held online on Tuesday 27 June 2023.

This meeting was attended by: Sarah Allen (Head of Patient Experience), Victoria Borwick (Public Governor), Michael Bryan (Patient Governor), Andrea Carney (Head of Patient and Public Engagement), Michaela Cashman (Deputy Director of Operations - Administrative and Pathway Safety) Nicola Clark (Patient Governor), Oliver Cook (Senior Lead for Quality and Compliance), Leah Mansfield (QEWG Chair), Marianna Masters (Public Governor), Jo McGillivray (Patient Governor), Alison Mould (Public Governor), Placida Ojinnaka (Patient Governor), Mark Tsagli (Patient Experience Specialist), Jo Turville (Director of Operations - Associate Director of Apollo), Claire Wills (Staff Governor), Philippa Yeeles (Patient and Public Engagement Specialist).

1.2. Apologies were received from: Elfy Chevretton (Staff Governor), Marcia De Costa (Public Governor), John Powell (Patient Governor) Mary Stirling (Patient Governor).

1.3. Leah Mansfield, Chair of the QEWG welcomed attendees and opened the meeting.

2. Agenda Item 2: Notes from the last meeting and matters arising

2.1. The notes were approved as an accurate record of the last meeting held on 28 March 2023.

2.2. The following incomplete actions from the March 2023 meeting were noted and will be carried forward:

- **Action 3.9**. Research on endometriosis: The Head of Patient Experience will follow this up and report back at the next meeting.
- **Action 5.2**: To seek information and clarification on the Trust's position regarding the use of Entonox.
- **Action 3.8**. To seek information (about arrangements for surgeons operating at other hospital sites) from the relevant team to provide governors with reassurance that concerns mentioned will not impact patient care.

3. Agenda item 3: Electronic healthcare record (Epic): Apollo staff training update

3.1. The Director of Operation - Associate Director of Apollo and the Deputy Director of Operations – Administrative and Pathway Safety gave a presentation to update governors on progress in the planning and delivery of training for the Trust's new electronic health record. See Annex A for a copy of the slides.

3.2. In discussion with governors the following points were noted:

- Training has switched from classroom delivery to pre-recorded and self-guided e-learning modules. This gives staff the freedom to carry out their online training when it best suits them and at their own pace.
- Face-to-face training is due to start in late July/early August and includes an end user proficiency assessment to obtain a system log-in.
- Initial feedback on the mandatory e-learning component of training is positive and an independent review of the e-learning element has been commissioned.
- Almost all of the trainers needed for the face-to-face component of training are in place - many were involved in the first training programme they already have the necessary credentials.

- Ensuring staff have access to the necessary training and support between now and go-live is key to building trust and confidence in the new electronic health record. For example, staff will have access to 'digital champions' and 'specialist clinical trainers' and there will be 'collaboration labs' for multi-disciplinary teams.
- Communications and engagement are also key to developing staff confidence and understanding that the new system will improve the delivery of care for both patients and staff.

Action: Apollo training programme: QEWG requested regular updates on the progress of staff training from the Apollo programme at future meetings.

4. Agenda Item 4: Quality and Engagement Working Group: determining our 2023-24 Workplan

4.1. The Chair referred governors to the paper for this item and reminded them of the outputs of the workshop held on 28 March and the survey that they had been asked to complete, to rank the themes that had emerged from the workshop.

4.2. The Head of Patient and Public Engagement noted that 9 governors had responded to survey and presented the results:

- Effective and clear communication – 6.63
- Interaction of My Chart with other healthcare apps - 6.25
- Training - 6.13

4.3. The group discussed the results and the further development of the group's work plan

4.4. Additional topic for inclusion in the plan

- In the survey, none of the recurrent themes that focussed on the Trust's strategic priority to 'treat more patients who need elective care', had been prioritised. However, PALS data highlights strong and growing concerns amongst patients about appointments that are being cancelled, difficulties rescheduling appointments and anxieties surrounding waiting for dates for appointments. Governors

agreed the work plan would include aspects of waiting and communications, as they relate to elective care, in addition to the topics prioritised by the survey.

- Governors noted examples:
- Appointment letters sometimes arrive after the date of an appointment and led to unintended Did Not Attends (DNAs), re-referrals etc. Processes need to be streamlined.
- Patients are unaware that they can reclaim the cost of a ULEZ charge for attending an appointment. Could this be included in the standard information in appointment letters or messages?
- Governors were interested to know how appointment processes worked - allocation, cancellations, rebooking, communications – and suggested doing a deep dive in this area at a future meeting.

4.5. Electronic Health Record: Effective and clear communication

- Jargon is used and is difficult for patients and carers to understand. For example, what are the differences between electronic health record, Epic, Apollo and MyChart? Need to minimise jargon and if it cannot be avoided, then provide clear explanations.
- A need to consider supporting people with a wide range of accessibility needs and providing information in accessible formats.
- Important to consider patients and carers who will not be using MyChart to communicate with the Trust and their clinicians. Need to ensure that we do not unintentionally worsen health inequalities. What can be done to support patients and carers to learn how to use MyChart?

4.6. Interaction of MyChart with other healthcare apps

- How will MyChart work with or alongside the NHS App or any other health related apps? Important to get the interoperability of apps and data sharing right. Risk having to use multiple apps for similar issues but with different healthcare providers. Will it be possible to cover all health needs through one app?
- Need to think through the links with pharmacy and ordering medication.

4.7. Next steps

Action: QEWG work plan: The Chair would work with the Head of Patient and Public Engagement and the Head of Patient Experience to draft a work plan for the coming year based on discussions at this meeting and the workshop in March. A draft plan will be brought to the next meeting.

5. Agenda Item 5a: Patient Experience Report (Q4 2022-23)

5.1. The Patient Experience Report Quarter 4 (January – March 2023) had been shared in advance of the meeting.

5.2. The Head of Patient Experience welcomed feedback from governors requesting the provision of a summary version of the Patient Experience report. A summary version is already presented to the Trust Risk and Assurance and Quality and Performance Committees and in future, this can be circulated to governors with the full report, giving governors the option to read one or both formats.

Action: Patient Experience Report: Both a summary version and the full report will be circulated to future QEWG meetings. Further feedback will be sought from governors.

5.3. In presenting the paper the Head of Patient Experience highlighted:

- Taken as a whole, the Friends and Family scores remain very positive.
- Waiting is evident as a major theme across all areas of care and delays are also a significant issue.
- Patient transport is now being provided by another contractor and there are some difficulties with the new system that are being addressed.
- Inpatients have been reporting some discomfort with overnight noise and dealing with the warmer weather. There is an opportunity to revisit and reinstate the ‘Noise at night’ project to address this.
- The volunteer service is benefiting from the implementation of a new database. For example, it has captured the involvement activities of 400+ volunteers in 100+ roles across the Trust who are generously donating an average of 1,500 hours of support per month.

5.4. In discussion, governors noted:

- Improvements to the telephone systems are needed. For example, the distress experienced by some patients and family members trying to contact the early pregnancy and acute gynaecology unit (EPAGU) but who were unable to get through to the unit or leave an answerphone message. Or the anxiety that some patients experience when they miss a call from the hospital and no message is left and no number is given to call back on.
- A query was raised about the increase in number of complaints recorded in the PALS report for Royal Brompton and Harefield hospitals. The Head of Patient Experience clarified that there had been marked increases in the number of patient concerns related to appointment delays and cancellations; information and communication and medical records
- The Call Handler Training project pilot is a great example of improvement work that is addressing some of the communication challenges faced by patients and administrators. The programme is helping administrators to better understand patients' perspectives and how to handle difficult conversation. Governors requested an update on this project at the next meeting.

Action: Communications with the early pregnancy and acute gynaecology unit (EPAGU): The Head of Patient Experience to request information from the Chief Midwife and team about work underway or planned to improve telephone communications with patients and family members.

Action: Call Handler Training: An update to be included in the next Patient Experience Report including reflections on the potential for wider roll out of the programme and possible funding sources.

6. Agenda Item 5b: Patient and Public Engagement Report (Q4 2022-23)

6.1. The Patient and Public Engagement Report Quarter 4 (January – March 2023) had been shared in advance of the meeting.

6.2. In presenting the paper the Head of Patient and Public Engagement highlighted:

- An event that Evelina London is planning to celebrate the opening of the new Day Treatment Centre in early July. It is an opportunity to thank the young people and their families involved in this project and for them to see how their involvement has shaped the look and feel of the new building.
- NHS England's pre-consultation phase on the Children and Young People's Cancer Principle Treatment Centre continues and it is now thought consultation will begin in September.
- Support continues for the involvement of patients who currently receive dialysis care in the Camberwell unit. Whilst patients are excited by the prospect of a new dialysis centre with much improved facilities, they have expressed some concerns about the new unit being staffed by the existing independent sector partner.

6.3. There were no questions or comments from governors.

7. Agenda Item 6: Quality and Safety Update

7.1. The Chair welcomed the Trust's Senior Lead for Quality and Compliance to their first QEWG meeting and invited them to present a progress update on the Trust's five quality priorities. See Annex B for a copy of the slides.

7.2. In presenting the paper the Lead for Quality and Compliance highlighted:

- Delivery of the action plan across all five quality priorities is currently on target.
- The Trust's annual Quality Accounts 2022/23 are due to be published on GSTT's website in the next couple of weeks. (The report can be accessed from here: Publications - Annual reports and accounts | Guy's and St Thomas' NHS Foundation Trust (guysandstthomas.nhs.uk)

7.3. In discussion, governors noted:

- Further clarity would be helpful in demonstrating how the five quality priorities relate to themes and learning that emerged from previous serious incidents, complaints, PALS, litigation etc. The Lead for Quality and Compliance explained that the priorities had been arrived at through a careful analysis of

existing data, a review of the previous year's priorities (as some priorities roll over) and the involvement of a wide range of stakeholders.

Action: Quality and safety update: Future reports to QEWG will make more explicit the connection between the themes and learning from data, and the current priorities, action plan and intended improvements.

8. Agenda Item 7: Governor Updates

8.1. **a) Transformation and Major Programmes Committee**

The governor representative in attendance highlighted the following from the committee meeting:

- An update on Children's Services included the Children's Hospital Programme.
- A timeline for the outline business case for the Orthopaedic Centre of Excellence was discussed.
- The early stages of a proposal to develop a London Diagnostic and Treatment Centre were noted by the committee and an outline business case will be brought back to a future meeting.
- The new cooling units/centre are now in place and operational at Guy's Data Centre.

8.2. **b) Quality and Performance Committee**

The governor representative in attendance highlighted the following from the committee meeting:

- An update on Apollo gave assurances about financial oversight and how risks are being managed.
- Children's Services were discussed, with updates on the Children's Hospital Programme and Evelina Expansion, and positive news about the Children's Day Treatment Centre opening in July 2023.
- A timeline for the outline business case for the Orthopaedic Centre of Excellence was presented. This would help with capacity challenges but is dependent on further Treasury engagement.
- The early stages of a proposal to develop a London Diagnostic and Treatment Centre were flagged to the committee and an outline business case will be brought back to a future meeting.
- The new cooling units/centre are now in place and operational at Guy's Data Centre.

8.3. **c) Heart, Lung and Critical Care Clinical Group Board**
No update was given.

8.4. **d) Cancer and Surgery**
No update was given.

9. Agenda Item 8: Any other business
In the absence of any other business, the Chair noted that the next meeting would be at 5.30pm on 26 September 2023, thanked everyone for attending and closed the meeting.

ACTIONS

3.2	**Apollo Training programme**: It was agreed that the Apollo programme would be requested to provide regular updates to governors on the staff training programme at future meetings.
4.7	**QEWG work plan:** It was agreed that the Chair would work with the Head of Patient and Public Engagement and the Head of Patient Experience to draft a work plan for the coming year based on discussions at this meeting and the workshop in March. A draft plan will be brought to the next meeting.
5.2	**Patient Experience Report:** Both a summary version and the full report will be circulated to future QEWG meetings. Further feedback will be sought from governors.
5.4a	**Communications with the early pregnancy and acute gynaecology unit (EPAGU):** The Head of Patient Experience to request information from the Chief Midwife and team about work underway or planned to improve telephone communications with patients and family members.
5.4b	**Call Handler Training:** An update to be included in the next Patient Experience Report including reflections on the potential for wider roll out of the programme and possible funding sources.
7.3	**Quality and safety update:** Future reports to QEWG will make more explicit the connection between the themes and learning from data to the current priorities, action plan and intended improvements.

Guy's and St Thomas' NHS Foundation Trust

Annex A

Copy of presentation from Item 3: Electronic healthcare record (Epic): Apollo staff training update

Apollo Training Update

27th June 2023

COUNCIL OF GOVERNORS
Quality and Engagement Working Group meeting

NHS
King's College Hospital
NHS Foundation Trust

NHS
Guy's and St Thomas'
NHS Foundation Trust

synnovis
A SYNLAB pathology partnership

Apollo
Delivering our electronic health record programme together.

Principles for the Unified Training Strategy following strategy refresh in February 2023

- The **quality** of training content and delivery is to be improved and not compromised.
- The **time** commitment required across both organisations to deliver and receive this training is to be reduced.
- One strategy for delivery for King's College Hospital Foundation Trust, Guy's and St Thomas' Foundation Trust & Synnovis
- Rule of **"no training, no access"**. Staff to pass an End User Proficiency Assessment before to attain their log-in, with full support to help them achieve this (via the Practice & Personalisation sessions).

Lessons Learned from GSTT Launch in February 2023

King's College Hospital NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
synnovis

Scheduling

A timetable without sufficient organisational input resulted in numerous change requests that could not be accommodated by the Apollo Training Team

Resourcing

Too few resources to support the volume of data correction, booking change requests, and general queries raised

Technical Landscape

The technical landscape underpinning was not fully understood by the Apollo Training Team

Technical Ask

The technical ask of users and trainers was under-estimated to run live virtual sessions

Quality

The quality of the training delivery was variable

Complexity

There was difficulty in communicating the complexity of the learning journey to end users

Apollo

Training Approach

Proactive booking support

Proactive Booking Support to address training allocation of tracks to learners before go live of e-learning release

Mandatory eLearning

Most learning delivered through **self-guided interactive eLearning**. Learners complete the recorded interactive training, broken into modules. Ability to learn at their own pace. The eLearning will be accessible off site

Learners Will Gain Access to the Epic Playground From Here!

Mandatory F2F learning and assessment

eLearning is followed by a **face-to-face learning session,** led by a trainer. Several components to sessions – learners complete an assessment, receive their log-in to the live system, and are shown how to personalise Epic screens. They can test the new devices such as Rovers and barcode scanners, where appropriate.

Extra optional learning to build your confidence

Extra optional learning to help build confidence - workshops to run throughout the summer giving staff a chance to explore and understand Epic in relation to their role, as well as ask any questions. These will be led by Digital Champions.

Training Feedback

- Commissioning independent evaluation of eLearning
  - Currently 3,172 of GSTT staff have started their elearning (8%)
  - Currently 6,387 of GSTT staff have booked their F2F training (28%)
- Initial feedback of eLearning release has been very well received, examples below:

I found it easy to navigate, the right length, just enough interactive moments to hold the attention, and relevant to day-to-day clinical practice. It was also narrated very well by familiar clinical voices, which also helps. I am now looking forward to the face to face session…… but I think it's important to highlight the very good work that colleagues are doing under highly pressured circumstances.
Consultant

I would like to stress that the training is much clearer / better than previous online sessions I had attended prior to Apollo launch date being moved
Deputy Clinical Lead

I started doing the e- learning this week and actually found myself enjoying it. The highly targeted sessions were focused on what I need as a clinician, easy to follow and the repetition where it occurred, useful to help me to learn how EPIC works and start to feel confident in using. I would really really encourage people to do (even if like me you have already done the F2F before) as this will I really think my transition to EPIC easier.
Dr Claire Lemer, Consultant in General Paediatrics and Service Transformation & Clinical Director Medicine Evelina London

Guy's and St Thomas' NHS Foundation Trust

Annex B

Copy of presentation from Item 6: Update on quality priorities for 2023/24

Guy's and St Thomas' NHS Foundation Trust

Quality and Engagement Working Group

Update on quality priorities for 2023/24

1) We will embed the new national patient safety incident response framework (PSIRF) and the patient safety incident response plan – On target for delivery

We will:	Q1 progress:
Monitor and deliver the individual improvement plans for each prioritised patient safety incident profile.	Improvement plans for each Trust priority incident within the patient safety incident response plan are currently being finalised for approval at TRAC.
Continuously monitor the changing data surrounding patient safety across the Trust to identify any changes that are needed.	Continuous monitoring of patient safety data will be achieved via horizon scanning, review of our live PSIRP, our new Local Risk Management Systems (LRMS) and our quarterly patient safety reports.
Analyse the safety culture survey results to inform the Trust's culture and any improvement work.	An initial analysis of the safety culture results has been completed and reviewed via the PSIRF Steering Group, with recommendations for further analysis prior to engagement with clinical groups.
Seek approval from the South East London Integrated Care Board to sign off our Patient Safety Incident Response Plan (PSIRP).	South East London Integrated Care Board have reviewed our PSIRP; the SEL ICB intend to begin the sign-off process in Q3 (2023) and have set up peer review session to aid sign-off in the interim.
Create a transition plan to embed the PSIRF, and associated incident management policy into the Trust.	A draft PSIRF implementation plan is in progress to support the transition from the serious incident framework to PSIRF.
Implement new ways of working to support the PSIRF.	A draft of the PSIRF implementation plan is in progress.
Set up quality improvement monitoring to proactively respond to areas where change is required.	A quality improvement tracker has been developed to support assessment and decision making for trust-wide resource, to be monitored via the Trust Quality Improvement and Audit Committee (TQIAC).

2) We will complete an in-depth quality assessment of ourselves against the new quality statements and domains – On target for delivery

We will:	Q1 progress:
Complete a quality assessment in every directorate within the clinical groups in quarters 1 and 2.	We have started reviewing our quality assessment toolkit to align with the new CQC single assessment framework and are meeting with clinical groups during July 2023 to develop directorate and service level engagement plans.
Identify key themes and trends and develop improvement plans in response to the top themes.	Analysis of the completed quality assessments will be undertaken to identify themes and trends.
Receive feedback on evidence against the Care Quality Commission's (CQC) new quality statements and domains.	Feedback from clinical groups will be aligned to CQC key questions, quality statements and evidence categories.
Compare the themes and trends across all clinical groups to identify cross cutting issues develop a trust-wide quality improvement programme and Trust audit priorities.	Outputs will be aligned with the trust quality improvement tracker and on-going work through the Trust Quality Improvement and Audit Committee (TQIAC)

3) We will develop and embed the Maternity Early Warning Score within the Trust for all maternity inpatients – On target for delivery

We will:	Q1 progress:
Develop an improvement plan to ensure Maternity Early Warning Score (MEWS) is safely rolled out with clear timelines for completion.	EPIC build has been signed off in June 2023; MEWS will be the default early warning score chart for maternity areas.
Develop e-learning and face to face training packages to ensure 100% compliance with MEWS processes and documentation.	MEWS is embedded in the annual face-to-face mandatory training for all maternity staff; e-Learning for Healthcare (HEE) published new e-learning for MEWS in June 2023 which will be reviewed against current training requirements.
Provide assurance through quality monitoring and audit via Trust wide safety committees such as our Acutely Ill Patient Group.	Assurance through quality monitoring and audit is provided via the Acutely Ill Patient Group and the group received an update in June 2023.

4) We will develop and embed a new sepsis working model in line with the recommended pathway – On target for delivery

We will:	Q1 progress:
Carry out an impact analysis of the new sepsis guidance through the Sepsis Working Group and deliver the new pathway across the Trust.	A new sepsis working model is currently being piloted in the Emergency Department, and feedback will be provided via the Sepsis Working Group.
Pilot and potentially implement sepsis trollies across the Trust to include all equipment for the treatment of sepsis and improve treatment for patients.	A six month pilot will be completed in September 2023 followed by a project evaluation; monthly data collection is on-going with feedback to points of contact on individual wards.
Monitor data and provide assurance through the Sepsis Working Group.	Sepsis data is presented monthly at the Sepsis Working Group.

5) We will improve patient experience through better communication and ease of contacting us at the Trust – On target for delivery

We will:	Q1 progress:
Launch ‘Call if Concerned’ across all our hospital sites to provide a phone number for relatives to call if they are unable to get hold of ward staff when concerned about patient care.	Call if Concerned was rolled out trust wide in March 2023, following a soft launch in January.
Respond to these calls within 6 hours having been to the ward and resolved any concerns where possible.	All calls are being responded to within this window of time.
Monitor the calls and concerns through the Acutely Ill Patient Group for assurance.	Feedback goes to the Acutely Ill Patient Group and is then presented quarterly at the Patient Safety Committee.
Develop a ‘contacting us’ continuous quality improvement project across the Trust to minimise the waiting times for patients contacting us by telephone.	A ‘Contacting Us’ continuous quality improvement project is underway, led by the Patient Experience Team.
Monitor the volume of patient queries and complaints received about difficulties contacting a clinical area.	The volume of queries and complaints is being monitored via complaints, PALS, and other patient feedback, included in the patient experience report.

NHS CONFIDENTIAL - Management

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
STRATEGY, TRANSFORMATION & PARTNERSHIPS WORKING GROUP
TUESDAY 04 JULY 2023

Title:	**Strategy, Transformation and Partnership Working Group (STPWG)**
Responsible executive:	**Leah Mansfield, Patient Governor**
Paper author:	**Jed Nightingale**
Purpose of paper:	For information
Main strategic priority:	Support and empower our workforce
Key issues summary:	A report on the Working Group's discussion on the following: • An update on the GSTT 2030 strategy development work • An overview of the Equality, Diversity and Inclusion (EDI) work currently being undertaken within the Trust
Paper previously presented at:	
Recommendation(s):	The COUNCIL OF GOVERNORS is asked to: 1. Note the key discussion points at the Strategy, Transformation and Partnership Working Group (STPWG)

NHS CONFIDENTIAL - Management

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
TRUST EXECUTIVE COMMITTEE
TUESDAY 04 JULY 2023

Governors in attendance: Leah Mansfield (Chair), Jordan Abdi, Victoria Borwick, Michael Bryan, John Clark, Marcia DaCosta, Sian Flynn, Alan Hall, Katherine Hamer, Margaret McEvoy, Joanna McGillivray, Roseline Nwaoba, Placida Ojinnaka, David Phoenix, Mary Stirling, Raksa Tupprasoot, Claire Wills

NEDs: Felicity Harvey

Trust staff in attendance: Jay Dungeni, Elizabeth Hubbard, Jed Nightingale, Jackie Parrott, Manal Sadik, Elena Spiteri

Apologies: John Powell, Lawrence Tallon, Steve Weiner

1. Welcome, introduction and apologies

1.1. The Chair welcomed everyone to the Strategy, Transformation and Partnership Working Group.

1.2. Apologies were noted.

2. Declaration of Interest

2.1. There were no declarations of interest.

3. Previous meeting report and matters arising

3.1. The minutes of the previous meeting of the Group, held on the 4th April 2023, were approved as a true record.

4. Equality, Diversity and Inclusion

4.1. Presentation slides were circulated prior to the meeting.

4.2. Jay Dungeni, Director of Equality, Diversity and Inclusion and Manal Sadik, Associate Director of Equality, Diversity and Inclusion, presented an overview on the work being undertaken surrounding equality, diversity and inclusion (EDI). This presentation included:

- EDI team aims and structure
- Context, legislation and current EDI data
- GSTT EDI vision and approach
- Focus on anti-racism

4.3. Manal Sadik outlined EDI at GSTT and the current context. EDI is at the heart of our values and GSTT's approach includes three pillars: patients, people, and widening participation with this presentation focusing on people. The EDI team aims to build capability, capacity and community of practice so that EDI becomes everybody's responsibility. To enable delivery, the EDI team structure is aligned to the Trust Operating Model. GSTT must maintain and ensure compliance with the Equality Act 2010, covering the nine protected characteristics. Progress is transparent through reporting requirements including reporting on the Gender Pay Gap, Workforce Race Equality Standards, and Workforce Disability Equality Standards.

4.4. Despite positive interventions regionally and locally, NHS staff still experience discrimination including racism, which requires behavioural and structural change to end. GSTT staff surveys show inequalities, such as higher numbers of staff entering formal disciplinary processes and higher numbers of reports of bullying or harassment for members of staff from ethnic minority backgrounds and members of staff with disabilities. We are working through all the recommendations put forward by Green Park following their cultural review to advance GSTT's approach and EDI maturity.

4.5. Jay Dungeni outlined his role as Director of EDI, supporting the organisation in an EDI reset. The new approach will include a combination of system and behaviour transformation changes, including a leader-ally approach. We will also set targets and monitor progress using data. Accountability will sit with directors and executives, with assurance and scrutiny during executive to executive performance review meetings. Governors can assist in driving tangible change, role modelling inclusive behaviours, and supporting leadership and management capability building and upskilling.

4.6. Aligned to national and London strategies, the vision for EDI includes 5 strategic objectives for the people pillar:

- Eliminate discrimination for all staff
- Foster an inclusive and compassionate culture
- Improve access to quality work through improved recruitment processes
- Advance social mobility by increasing equity of opportunity (development, progression and promotion)
  Visible governance and accountability (through leader-allyship that demonstrates inclusive behaviour, enforces equal opportunity, and promotes equity and fairness)

4.7. One of GSTT's priorities for EDI is to become an anti-racism organisation through addressing immediate challenges in experience, careers and culture. Jay Dungeni described anti-racism as being an active acknowledgement of the existence of racism and challenging views to begin the process of enacting change. Our approach to anti-racism includes investigating racial inequity using external and internal data, taking active steps to counteract racism by taking positive action or other targeted approaches, involving people who have been racially marginalised, measuring progress and accountability, and dedicating time and resources.

4.8. The following points were clarified during discussion:

- Intersectionality will be considered through data and engagement with staff networks to understand cumulative experiences. Specific challenges will be deliberately addressed through actions and behaviours.
- Widening participation aims to increase interest and access into NHS careers by a variety of means including school visits, community employability hub, the 'Discover Healthcare' website and a system-wide knowledge hub.
- GSTT has been chosen to participate in the Mayor of London's 'Design Lab' to benefit from best practice on EDI with a specific focus on inclusive recruitment and embedding anti-racism.
- Essentia have developed an EDI group called 'IDEA' (Inclusion, Diversity, Equality in Action) to deliver on their EDI objectives.
- We will be developing a range of tools alongside the current methods of statutory reporting and structures, to ensure we understand and hear from our staff that we have the right approach and actions in place to successfully improve staff experience.

4.9. The following points were clarified by Manal Sadik after the meeting:

- The Trust does not participate in positive discrimination. The Trust is more inclined to promote positive action, removing barriers that would make it harder for people to receive or access the same opportunities.
- The Trust collects metrics on disability, including disclosure rates across all bands, likelihood of being appointed from shortlisting, and entering capability processes. The EDI team are mapping intersectional impact where possible.
- The Trust will continue to raise awareness of the variety of careers within the NHS. Will work with partners to ensure clarity and ease of access to the various routes into health and career opportunities at all levels.

- Staff can access and/or seek support from a number of resources or people, including EDI officers, inclusion agents, health and wellbeing champions, staff psychologists, and the spiritual care team.

Actions:

- Manal to share the NHS EDI improvement plan, London Workforce Race Strategy, and information on widening participation
- Jay and Manal to return to STPWG to showcase developments on this work

5. GSTT 2030 Strategy Development

5.1. Presentation slides were circulated prior to the meeting.

5.2. The previous Guy's and St Thomas' strategy *Together We Care* was launched in 2018 as a five-year strategy. Since then, Guy's and St Thomas' has merged with Royal Brompton and Harefield and together we have launched our new Trust Operating Model. Our operating environment has significantly changed including the ongoing impact of the Covid-19 pandemic, the 2022 Health and Care Act, changes in payment mechanisms and limitations on capital expenditure, flat economic growth and productivity, and huge opportunities for digital and technological transformation, including the Trust new Electronic Health System due to launch in October.

5.3. The Trust strategy team is co-ordinating the development of the new multi-year organisational Trust strategy, called GSTT 2030. Clinical groups and Essentia have also been developing their refreshed Group strategies.

5.4. There are four phases for the development of the Trust strategy:

- Phase 1 (July – Sep 2022): Established governance, scope and key assumptions and parameters as well as reviewed qualitative and quantitative evidence to illustrate key themes and drivers for change.
- Phase 2 (Oct 2022 – Mar 2023): Initial focused discussions with the Trust Board and senior leadership to synthesise the key themes and priorities.
- Phase 3 (Apr – Sep 2023): Setting out difficult strategic choices facing the Trust and engaging with patients, staff and partners to develop the strategy.
- Phase 4 (Sep 2023 – Apr 2024): Further engagement as the strategy is finalised. The programme will then focus on launching the strategy in Spring 2024

5.5. In Phase 1, a comprehensive evidence review was undertaken. GSTT is starting from a historically strong position as a provider of high quality care and research. However, there are significant challenges locally and nationally, which include elective recovery and

performance (including cancer), staff recruitment and retention, and significant financial pressures.

5.6. Insights from Trust patient and public engagement activities as well as patient experience data have helped to identify important themes. These include clear communication and patient choice along all points of the patient journey, consistency and continuity of high-quality specialist care, fit for purpose and accessible hospital and community estates, support for patients who encounter barriers to accessing care, and addressing health inequalities and digital exclusion.

5.7. In Phase 2, a long-list of important strategic themes was developed, including people, technology, estates, finance, research and life sciences, EDI, data and analytics, patients and populations, partnerships, leader in healthcare, education, transformation and innovation, and sustainability.

5.8. As part of the Trust strategy, there will be a Trust-wide shared vision, values, and strategic framework

- Initial ideas for the vision have been developed and will be iterated through engagement.
- We have begun to coalesce around high-level areas to inform the Trust-wide strategic framework.
- We will refresh the Trust values post-merger through a parallel programme of work led by the Trust Organisational Development team.

5.9. The Trust's current context (e.g. limits on capital spend, national workforce shortages) means there will need to be choices on how to focus resources, including in capital investment, research, EDI, people, health innovations/therapies, changing our relationship with patients through technology, and population.

5.10. During discussions, the following points were clarified:

- There will be further opportunities for engagement with governors, senior leaders and other important groups. A more detailed plan will be worked through for all key groups, taking the Epic go-live date into account.
- A question was raised around whether the organisation will continue to promote the current clinical priorities and whether 'respiratory' is added to these, bearing in mind the merger with Royal Brompton and Harefield (RB&HT).
- The strategy needs to highlight the merger with RB&HT and the start of a new, integrated organisation that services a wide range of patients across multiple Integrated Care Systems.
- It is timely that the sign off of the strategy will not take place until after the launch of Epic.
- Parallel work to develop the Trust values post-merger will be very important and powerful.

Actions:

- GSTT 2030 evidence pack to be shared with this group after the meeting.
- Jackie and Elizabeth to return to STPWG to provide additional update(s) on this work.

6. Any other business

6.1. No items from other committees were raised by governors.

6.2. No other items were raised under 'any other business'.

The next Strategy, Transformation and Partnership Working Group meeting will be held on Tuesday 3rd October 2023 at 5:30pm-7pm.