NHS

Guy's and St Thomas'
NHS Foundation Trust

Annual Report and Accounts 2018/19

Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2018/19

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

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

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

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

We have a long tradition of clinical and scientific achievement and – as part of King's Health Partners – we are one of England's six academic health sciences centres (AHSCs), bringing together world-class clinical services, teaching and research. We work closely with our AHSC partners – King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London, our shared university partner.

We have one of the National Institute for Health Research's (NIHR) biomedical research centres, established with King's College London in 2007, as well as dedicated clinical research facilities.

We have around 17,100 staff, making us one of the biggest 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 only six AHSCs in England and brings together an unrivalled range and depth of clinical and research expertise, spanning both physical and mental health. Our combined strengths 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

The Duchess of Cambridge became Patron of Evelina London Children's Hospital in December 2018, ahead of its 150th anniversary in 2019.

Contents

In 2018 we celebrated the 70th birthday of the NHS.

1 Chairman's statement

Over the past 12 months the demands on staff across the Trust have been intense. Significant increases in emergency attendance, combined with ever more patients choosing to come to Guy's and St Thomas' for their care, as well as continued financial pressures have combined to make this an exceptionally busy year.

Nationally, Brexit has dominated the political landscape and presented additional challenges and uncertainty as we seek to maintain resilient services for our patients. We have also responded to the Long Term Plan for the NHS and published our own strategy – Together we care – which will ensure we remain stable and ambitious and continue to play a leadership role both in south east London and nationally.

In March and April, the Care Quality Commission (CQC) inspected our services and we now await the outcome. Our staff worked extremely hard to prepare for their visit and responded openly and honestly to the inspectors, demonstrating their commitment to delivering the highest quality care for all of our patients.

While there have been many challenges this year, there have also been many highlights.

The celebrations to mark the 70th anniversary of the founding of the NHS on 5 July were a heart-warming reminder of the values that inspired – and continue to inspire – this national institution and of the immense contribution the NHS, and all who work in it, continue to make to our lives.

In 2018 we marked the official opening of our new emergency department by HRH the Princess Royal and the opening of our new Rare Diseases Centre by the Countess of Wessex. Both projects have delivered new facilities which are improving the quality of the experience for patients and the working environment for staff.

We also had the honour of learning that HRH the Duchess of Cambridge had agreed to become Patron of Evelina London. This announcement has created a wonderful platform for the 150th anniversary of Evelina London, which we will celebrate throughout 2019.

This year, we led a successful consortium to create a new genetics laboratory hub for our region, and we have continued work, as King's Health Partners, with Royal Brompton and Harefield NHS Foundation Trust to create a new partnership that will revolutionise cardiovascular and respiratory services for our patients.

It was a privilege to participate in our Trust Care Awards and the Long Service Awards this year, both of which celebrate the outstanding professionalism of our staff and demonstrate just how much they care – about our patients, about their work and about each other.

The Trust continues to benefit greatly from close working relationships with local health and social care organisations, our local MPs, local authorities, the Metropolitan Police, and other employers in the area.

We are also grateful for the support of Guy's and St Thomas' Charity, whose generosity contributes so much to the development of the Trust's infrastructure, as well as supporting innovation in our services and improvements in staff welfare.

On behalf of the Board and as Chairman of the Council of Governors, I should like to record my thanks to all our governors, particularly those whose term of office came to an end this year – and to welcome new colleagues to the Council.

Following discussions with NHS Improvement, I have agreed to serve as interim Chair of King's College Hospital NHS Foundation Trust alongside my existing role. This in no way diminishes my commitment to Guy's and St Thomas'. As Chair of both organisations I will be promoting strategic alignment and collaborative working between our trusts and with partners in south east London for the benefit of patients and the local healthcare system.

Sir Hugh Taylor, Chairman
22 May 2019

On International Nurses' day, we recognised the first generation of 'Nightingale Nurses' for more than 20 years with a new professional award.

2 Performance report

Annual performance statement from the Chief Executive

The Trust has performed well both financially and operationally over the past 12 months. This is despite a relentless increase in demand for our services, and an extremely difficult financial climate across the NHS.

Throughout 2018/19, more and more patients chose to come to Guy's and St Thomas' for treatment, whether for emergency or planned care. Outpatient visits have also increased substantially, contributing to an overall increase of more than 200,000 in our total number of patient contacts during the year.

Our staff have worked incredibly hard to meet this challenge head on. They have maintained a focus on quality, safety and efficiency to ensure all of our patients get the best possible care at all times.

Inevitably, these increases in patient numbers have affected our ability to meet important national access standards.

Significant increases in cancer referrals from local and out-of-area GPs – up by more than 500 a month – have meant that meeting cancer access targets has proved difficult. Although we have been able to meet the 62 day standard for patients referred directly to us for much of the year, this has not been the case for those referred from other hospitals in south east London, and we are working extremely hard to address this.

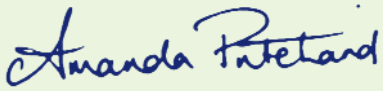
Our emergency department completed a major redevelopment programme during the year, which has improved the environment for both patients and staff. We have been seeing record numbers of patients throughout the year and, as a consequence, we have been unable to meet the four-hour maximum waiting time standard.

However, a range of initiatives, including innovative support in our community services, have enabled us to successfully maintain sufficient bed capacity for all patients needing inpatient care, and we have also been able to provide help to neighbouring trusts at key periods during the winter months.

At the start of the year we agreed a control total with NHS Improvement which required us to deliver a small underlying deficit of £3.3 million. Taking into account capital donations and impairments, as well as planned levels of Provider Sustainability Funding (PSF), this equated to a planned surplus of £20.8 million.

I am delighted to report that we have ended the year with a surplus of £31.4 million. This outcome is better than anticipated and £11.1 million ahead of our control total. This positive performance resulted from increased income, savings and efficiencies, and compensation from a property transaction. As a result, we not only received our planned PSF, but we also received additional incentive payments which contributed to our improved position.

As ever, the dedication and commitment of staff across the Trust was central to all our achievements this year, and we are delighted that our financial performance will allow us to invest in further improvements to our services in the year ahead.



Amanda Pritchard, Chief Executive
22 May 2019

Overview

Guy's and St Thomas' NHS Foundation Trust provides a full range of local hospital and community services for people in Lambeth and Southwark, as well as specialist care for patients from further afield. The Trust was formed in 1993 from the merger of Guy's and St Thomas' Hospitals. Evelina London Children's Hospital was opened in 2005 and in 2011, Lambeth and Southwark community services joined the Trust.

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

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

Our services at Guy's also serve a wide population from across south London and further afield through a growing network of outreach clinics and satellite centres. As well as dental, renal, urology and orthopaedic services, cancer services at Guy's are a key strategic priority for the Trust and King's Health Partners, with many services colocated with research activities in the dedicated Cancer Centre, which opened in 2016.

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

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

We have around 17,100 employees, making us one of the biggest 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, charitable bodies and GPs.

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

Financial risks

In 2019/20, the Trust faces a number of financial risks which are listed below and then described in further detail on page 14:

- achieving the required efficiency savings for 2019/20
- failure to deliver our control total and secure Provider Sustainability Fund income
- the ability of our commissioners to afford increases in activity required to deliver national waiting times
- the Trust's capacity to deliver activity to the required standards and activity levels
- reductions in local authority funding.

Operational risks

A number of operational risks, in addition to the financial risks above, which are described more fully in the annual governance statement, have also been identified.
These include:

- our ability to deliver required activity levels given the sustained increase in demand for our services
- our ability to deliver the national access standards, particularly the accident and emergency four-hour wait, the cancer maximum 62 day wait, the 18 week referral to treatment target and the diagnostic test six-week wait
- potential issues arising from delays to planned appointments or administrative issues associated with follow-up appointments.

The directors have reasonable expectations that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason the Trust continues to adopt the 'going concern' basis in preparing the accounts.

Performance analysis – clinical

Despite an extremely challenging external environment and rising demand for our services, we managed to maintain our operational performance against most of our key operational standards. This could not have been achieved without the dedication and hard work of our staff who continued to improve the quality of care and experience of the patients who use our services.

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

Our emergency floor transformation programme was completed this year. This was the culmination of four years of renovation and rebuilding work which has allowed us to deliver an emergency department designed specifically to improve both the experience for patients and the working environment for staff.

Although it was anticipated that the opening of the refurbished department would help us to meet the four-hour A&E target, the number of patients attending the department each day has continued to grow and we are now treating 50 patients a day more than we had planned for. Despite this, our staff continued to work tirelessly to ensure our patients are seen and treated as quickly as possible and we are now treating more patients than ever before within four hours.

This year also saw the expansion of our ambulatory and GP redirection services, which together with increased senior clinical cover in the evenings and at weekends, meant that we had sufficient beds for all patients who needed to be admitted to our hospitals, particularly during the winter months.

Demand for our emergency services reached unprecedented levels throughout the year.

We were also able to provide mutual aid to neighbouring hospitals at key periods during the winter months.

Infection control remains a priority for the Trust and we believe the vigilance of staff contributed to our excellent performance against our C.difficile target, and our ability to avoid bed closures and maintain capacity this winter.

Across the Trust over 12,000 staff received the flu vaccination. This includes 70.4% of frontline staff, which is slightly down on last year, although the total number of staff vaccinated increased.

During 2018/19 we experienced unparalleled growth in the number of cancer two-week wait referrals. These have increased by 555 a month since April 2018 and by over 1,000 a month since April 2017. The expectation is that two-week wait services are provided locally. However, we have seen a 13% increase in referrals from other parts of south east London and a disproportionate, 26% increase in out-of-area referrals. This is thought to be partly because the Trust was one of the first to introduce the electronic referral system (ERS) which makes it easier for GPs and patients to find out about and choose other providers, and partly because of capacity constraints or quality concerns elsewhere.

Although out-of-area GP referrals represent a relatively small proportion of our activity, the Trust, as a local and specialist provider, has to maintain an appropriate balance between secondary care activity which other hospitals could provide, and meeting the needs of complex tertiary patients, where there are fewer providers. Local commissioners and the Trust's Board have reluctantly supported proposals to temporarily close the electronic referral system for out-of-area GP referrals to a number of services to protect capacity for local patients and those needing the most specialist care.

During the year we introduced a number of changes to how we deliver our cancer services. This included significant investment in administrative support which meant we are better able to track and monitor patients to ensure they received the right care at the right time. Although we have been able to meet the 62 day standard

for patients referred directly to Guy's and St Thomas' for 10 months of the year, this has not been the case for those referred from other hospitals in south east London, and we are working extremely hard to address this.

We are working closely with our neighbouring hospitals to improve the shared service we are able to provide to cancer patients locally, and we have dedicated senior operational management support to drive improvements and also invested in additional diagnostic capacity.

The Trust continued to underperform against the 18 week referral to treatment (RTT) target, despite actions to improve our position. More patients are being treated within 18 weeks than last year but, despite this, the sheer volume of additional demand means that performance has still deteriorated.

There has been an 18.2% increase in GP referrals, set against a planned 5% increase, with a substantial jump in the number of referrals received from across and beyond London.

Overall, the Trust delivered a year-on-year increase in planned (elective) activity, with an impressive increase of 7.5% in the number of surgical procedures undertaken without any increase in theatre capacity.

Our outpatient activity also increased significantly and the Trust saw on average 2,827 more new outpatient referrals and 4,631 more follow-up patients a month compared with last year.

We struggled to consistently achieve the standard that 99% of patients receive their diagnostic test within six weeks, primarily due to problems with our administrative processes or insufficient capacity in some services.

The Trust continues to manage the impact of this increased demand on our administrative processes and is working hard to tackle potential risks to patient care arising from delays to planned appointments, or from patients failing to receive a follow-up appointment when required.

Demand for planned (elective), emergency and community children's services provided by Evelina London has remained high. The total number of children seen within national waiting time standards has increased but as the total number of patients accessing Evelina London services has also gone up, overall waiting times have remained similar.

A number of new initiatives, such as the introduction of a single point of access in health visiting and pathway redesign for children with the longest hospital stays have supported service improvements for patients and families. Additional inpatient facilities, including increased critical care capacity, and new mobile devices for community staff, will enable further improvements for both patients and staff.

Over the past two years Guy's and St Thomas' has been testing an approach to community nursing based on the Dutch neighbourhood nursing model known as Buurtzorg. We believe that this model offers benefits for patients, carers, staff, and the health and social care system. An early evaluation of the 'test and learn' pilots was very positive and we have now begun rolling out an adapted model across Southwark and Lambeth called 'neighbourhood nursing'.

The Trust is working with partners in Lambeth and Southwark to reduce unnecessary time spent in hospital. We are focusing on patients who have been in hospital for more than 21 days and who are medically fit for discharge but who have been unable to leave for non-clinical reasons.

The Trust is also working with local partners, including in the voluntary sector, to develop more joined up and locally-focused 'place-based care'. To support this project, we are leading an evaluation of the 'extensivist clinician', a new role which supports case management, and targeted care packages for patients with multiple long-term conditions.

The Lambeth reablement team has been held up as a model of best practice for the integration of health and social care. Lambeth Council has shown that the team has contributed to a reduction, from 11% to 4%, in the annual growth in spending on social care services in the borough.

Key performance indicators

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	C.difficile acquisitions (including: cases deemed not to be due to lapse in care and cases under review)	51	22 ●	3	6	4	9
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	88% ●	89%	89%	87%	88%
A&E access	95% A&E patients wait less than 4 hours	95%	87% ●	86%	88%	87%	87%
Cancer access initial appointments	Urgent cancer referrals seen within 2 week wait	93%	97% ●	97%	98%	97%	95%
	Symptomatic breast patients seen within 2 week wait	93%	95% ●	80%	100%	99%	100%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	72% ●	72%	71%	73%	71%
	% patients treated within 62 days from screening referral	90%	66% ●	86%	68%	64%	47%
	% patients treated within 31 days of decision to treat	96%	96% ●	94%	96%	96%	99%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	91% ●	82%	95%	91%	97%
	Chemotherapy treatments within 31 days	98%	99% ●	98%	98%	99%	99%
	Radiotherapy treatments within 31 days	94%	96% ●	94%	96%	96%	97%
Community care information completeness	Referral to treatment information completeness	50%	68% ●	71%	68%	66%	68%
	Referral information completeness	50%	95% ●	95%	95%	95%	95%
	Activity information completeness	50%	79% ●	80%	79%	78%	79%

Performance analysis – financial

At the start of the year we agreed a control total with NHS Improvement which required us to deliver a small underlying deficit of £3.3 million. Taking into account capital donations and impairments, as well as planned levels of Provider Sustainability Funding (PSF), this equated to a planned surplus of £20.8 million. We are pleased to report that despite the extremely difficult financial climate across the NHS, we ended the year £11.1 million ahead of our control total delivering a surplus of £7.8 million. This entitled us to bonus payments from the PSF and our final reported position is a surplus of £31.4 million.

Our financial performance

The Trust's control total, agreed with NHS Improvement, meant that we set a plan to deliver a £3.3 million deficit. After accounting for the depreciation charge on donated assets (-£11.9 million), the receipt of PSF funding (£31.1 million) and capital donations (£5 million), the Trust's planned surplus for the year was £20.8 million. The control total set by NHS Improvement was exceeded by £11.1 million. This performance resulted from increased income, savings and efficiencies and compensation from a property transaction, that have allowed us to receive a substantial element of the planned Provider Sustainability Funding (PSF) plus additional PSF incentive payments for exceeding our control total.

Cost Improvement programme

At the start of the year, the Trust set a £86.5 million Cost Improvement Programme (CIP), reflecting the level of savings required to deliver our financial plan, achieve national efficiency targets and treat an increased number of patients within the funding available from our commissioners. This target was met through a range of efficiency measures and additional income. Local savings at a directorate level were complemented by Trust-wide savings, many of which were delivered through the Fit for the Future programme to improve quality, safety and efficiency. Together, these actions enabled the Trust to achieve 98% or £84.8 million of the planned Cost Improvement Programme.

Provider Sustainability Funding

The financial plan included £31.1 million PSF baseline funding from NHS Improvement which required us to achieve agreed financial and performance targets. The funding received from the original PSF baseline allocation was £21.7 million, against a maximum of £31.1 million. This reflects the achievement of our financial performance targets, and a shortfall against the expected A&E trajectory. At the end of the year, the Trust received an additional £25.6 million of PSF incentive funding under this scheme. The additional PSF consisted of £13.6 million incentive PSF (finance) funding, £9.1 million incentive PSF (general distribution) and £2.8 million incentive PSF (bonus). PSF funding in 2018/19 totalled £47.3 million, £16.3 million above plan.

Performance against plan

By delivering a surplus of £7.8 million against our control total we ended the year £11.1 million ahead of plan, and £26.7 million favourable to our original plan when PSF is included. Capital donations towards the cost of our capital programme were £0.8 million less than the original expectations set out in our financial plan. The annual revaluation of the Trust's land and buildings led to a net £15.2 million impairment charge, which reflects changes in the basis of the valuation, but no physical change in the functionality of the buildings or their ability to support patient care. The impairment was not included in the plan and represents a technical accounting adjustment that is reflected in our final financial position. Variances in our underlying financial performance were partially offset by the reduced capital donations and the net impairment charge. Once these adjustments have been reflected, the Trust achieved an overall surplus of £31.4 million, £10.6 million ahead of the original plan for a £20.8 million surplus.

Cash flow

The Trust began the financial year with £134.8 million of cash and cash equivalents. The majority of the cash results from surpluses achieved in previous years and is earmarked for the Trust's capital programme. During the year cash balances increased by £9.3 million to £144 million. For details of the Trust's net cash balances, see note 25 in the Annual Accounts on page 138. The cash movement during the year is a result of movement in working capital. The operating surplus after adding back non-cash items resulted in £107.4 million of net cash generated from operating activities. The Trust spent a net £79.6 million on investing activities, which included £86 million purchasing intangible assets and property, plant and machinery, receipts of £4.1 million in capital donations and £0.9 million in interest. A net £18.5 million was paid in loan interest and Public Dividend Capital dividends and draw downs. Full details can be found in the Consolidated Cash Flow Statement in the Annual Accounts on page 117.

Table 1: Financial performance against plan

	Plan £000	Actual £000	Variance £000
Control total excluding PSF	(3,332)	7,784	11,116
Depreciation on donated assets	(11,937)	(12,642)	(705)
Core PSF	31,070	21,749	(9,321)
Incentive PSF (finance)	–	13,653	13,653
Incentive PSF (general distribution)		9,145	9,145
Incentive PSF (bonus)	–	2,797	2,797
Surplus including PSF	**15,801**	**42,486**	**26,685**
Capital donations	5,000	4,151	(849)
Impairments (market value)	–	(15,188)	(15,188)
Surplus for the year	**20,801**	**31,449**	**10,648**

Table 2: Financial performance comparison

	2018/19 £ million	2017/18 £ million	Change £ million
Income excluding capital donations and PSF/STF	1,547.0	1,439.8	107.2
Expenditure excluding impairments and sale of assets	1,551.8	1,450.6	101.2
Deficit excluding donations, impairments and PSF	**-4.8**	**-10.8**	**6.0**
Capital donations	4.2	12.4	-8.2
Impairments	-15.2	10.8	-26.0
PSF/STF	47.3	28.4	18.9
Surplus for the year	**31.4**	**40.8**	**-9.4**

Table 3: Cash flow

	2018/19 £ million	2017/18 £ million
Operating surplus before finance and other costs	59.4	66.5
Non-cash income and expense	48.0	14.2
Net cash generated from operating activities	**107.4**	**80.7**
Investing activities	-79.6	-66.9
Financing	-18.5	-19.4
Net increase / (decrease) in cash	**9.3**	**-5.6**

Charitable funding

The Trust received £9.9 million from charitable sources during the year, £4.2 million of which consisted of donations towards capital expenditure and this funding came principally from Guy's and St Thomas' Charity.

Capital expenditure

In 2018/19, the Trust spent £81.8 million on property, plant and equipment (£73.2 million 2017/18). The Trust also spent £12.2 million on intangible assets, mostly software and other IT (£8.6 million 2017/18). 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 Independent Trust Financing Facility had agreed loans totalling £279 million. During the year, the Trust drew down borrowing of £17.8 million and made principal repayments of £10.6 million, creating a net cash inflow of £7.2 million. At the year end, total

borrowings equate to £230.6 million, consisting of total repayments to date of £41.2 million, while a further £7.2 million is due to be drawn down in future years. See note 23 in the Annual Accounts on page 137 for more details. In addition to the £279 million of agreed loans, the Trust has agreement in principle from the Department of Health and Social Care for an additional loan of £90 million which is critical to addressing projected operational capacity constraints.

Revaluation of land and buildings

As part of the preparation of the Annual Accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of each financial year. In addition, some property, plant and equipment projects and intangible projects were impaired when projects were abandoned. This year, the full impact on the income statement is a charge of £15.2 million compared to a £10.8 million benefit in 2017/18. These entries, referred to as impairments, do not reflect any physical damage to our land and buildings, loss of utility or financial loss, and they have no implications for patient care. More details can be found in note 15 to the Accounts on page 132.

External audit services

Grant Thornton received £108,000 in audit fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2019. In addition, the Trust paid a further £8,000 to Grant Thornton for their quality audit work. For more details, see note 6.2 to the Accounts on page 126.

Events since the end of the financial year

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

Identifying potential financial risks

In 2019/20, the Trust faces a number of financial risks. These include:

Delivering required efficiency savings to support our financial plan: the Trust is required to deliver £68.4 million efficiency savings. This is more than 6% of the Trust's cost base on which savings can be made. There is a risk that we cannot identify sufficient efficiencies to fully address the financial challenge, or that we cannot deliver these at the required pace.

Failure to deliver our control total: if the Trust fails to achieve the target financial control total, the Trust will lose all of its Provider Sustainability Fund (PSF) income.

Commissioner affordability: although the Trust has agreed contracts with its principal commissioners these, in the main, do not include the full estimated costs of meeting national waiting times standards. We have agreed cost and volume contracts with these commissioners to mitigate the financial risk of over-performance. However, if commissioners cannot afford to fund the in-year performance required to deliver national waiting times, this poses a risk to our financial plan and our ability to meet our control total, and would therefore require discussion with NHS England and NHS Improvement.

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

Local authority funding reductions: the Trust will be affected by reductions in local authority funding for public health, including services such as health visiting, sexual health and school nursing. In addition, possible reductions to social services and care home provision may lead to delays in discharging patients from hospital, increased length of stay and associated costs.

Capital planning

Our capital investment plan is formulated to support operational challenges while ensuring there is sufficient investment to deliver our mid to longer-term ambitions which will require securing innovative funding sources to support delivery of our clinical and digital strategies. There are multiple pressures which require careful management to ensure scarce capital is invested wisely.

Our investment priorities are primarily centred around:

- additional theatre and imaging capacity
- maintaining our infrastructure (estate, IT and medical equipment

Trends in activity, income and expenditure

Chart 1: Completed patient spells

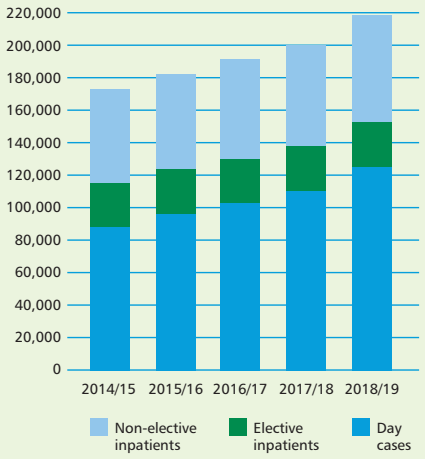


Chart 2: Outpatient attendances

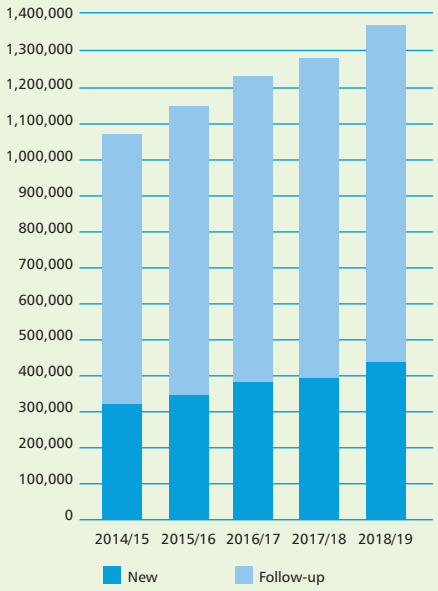
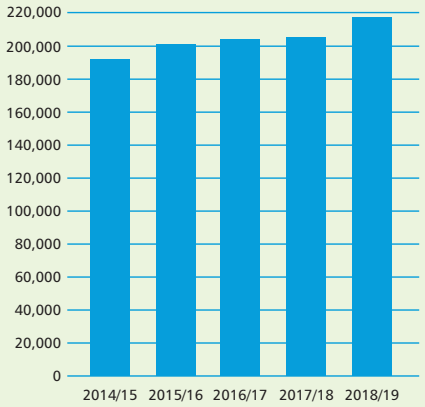


Chart 3: A&E attendances



During 2018/19, we saw in total 1,376,000 outpatients, 93,000 inpatients, 123,000 day case patients and 218,000 accident and emergency attendances. We also provided over 796,000 contacts in the community, bringing our total patient contacts to 2.6 million.

Chart 4: Income £millions

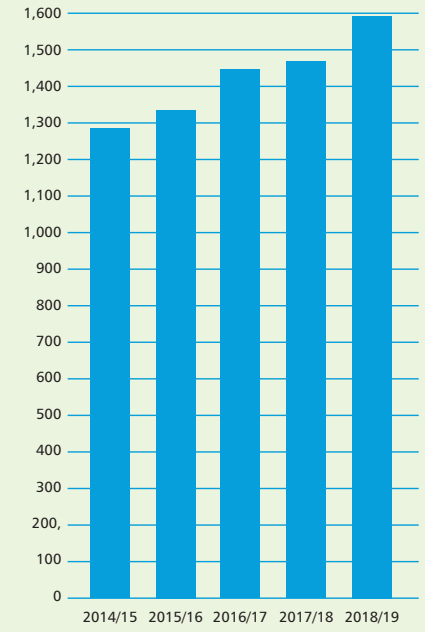
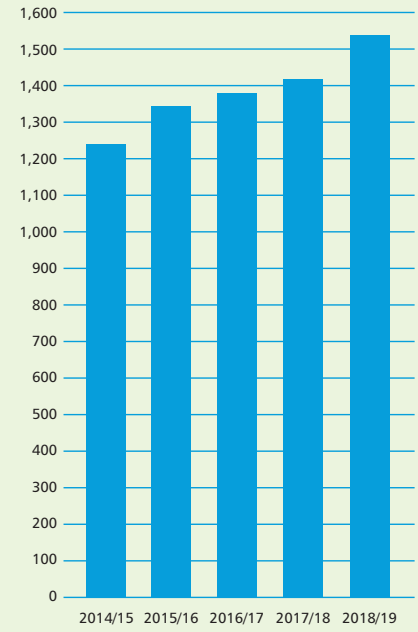


Chart 5: Expenditure £millions



to ensure we continue to provide safe and compliant services on our acute and community sites)

- the need to invest in improving clinical delivery models and ways of working, both internally and with partners including in the South East London Sustainability and Transformation Partnership (SELSTP), wider clinical networks and the Trust's Healthcare Alliance. This especially relates to investment in digital transformation and analytics
- investing in a patient centred electronic health record system that will transform models of care, reduce unwarranted variation and drive efficiency while improving patient experience and clinical outcomes
- investing in strategic ambitions such as the expansion of our paediatric services and, in partnership with Royal Brompton & Harefield NHS Foundation Trust, creating a global centre of excellence in heart and lung medicine and research in London
- in partnership with King's College London, continuing to invest in improving healthcare outcomes through pioneering academic research.

Our key capital priorities listed in the table opposite reflect these demands. In light of this context we will:

- continue to explore alternative funding sources, including reviewing our estate development strategy in partnership with King's

Our capital priorities are set out below:

Capital priority	Description
Theatres at both Guy's and St Thomas'	Urgent capacity requirement to meet demand and deliver performance targets.
Evelina London phase two development	Expansion of Evelina London to incorporate growth of existing services and new specialist services to become the regional specialist centre.
Medical equipment and infrastructure backlog	Annual replacement programme for high risk items and areas across our acute and community sites.
IT investment	Key infrastructure and IT enablers to drive improvements in clinical pathways while delivering greater efficiency and productivity.
Electronic health record	To enable the transformation of our model of care to one that is patient-centred and reduces unwarranted variation and cost.
Education and training centre	Business case being progressed between the Trust and King's College London to develop a leading centre for undergraduate and postgraduate teaching and simulation training.
Orthopaedics joint venture phase two	Working with our commercial partner to increase efficiency, capacity and quality to meet increasing demand in orthopaedic surgery.
North wing ward refurbishment	Investment to improve the ward environment to benefit patients and staff and to address the mechanical, electrical and infrastructure risks.
Patient-centric supply chain	Redesign supply chain processes and logistics across the SELSTP with the Trust acting as lead and proof of concept.
Relocation of cancer wards and teenage and young adult wards	Relocation of existing cancer wards at Guy's to improve patient experience and to support longer term site strategy for inpatient facilities.
Community properties rationalisation	Plans being implemented to consolidate community properties to improve patient pathway and experience in line with our integrated care strategy.
Cardiovascular and respiratory services in a partnership between King's Health Partners and Royal Brompton & Harefield NHS Foundation Trust	Business case in development. A united vision to create a global powerhouse for heart and lung medicine and research in London, providing the best possible patient care and experience.

College London, Guy's and St Thomas' Charity and Royal Brompton & Harefield NHS Foundation Trust, as well as exploring commercial opportunities. The Trust has agreement in principle from the Department of Health and Social Care for an additional loan of £90 million which is critical to addressing projected operational capacity constraints

- continue to access any central funding that may be made available to support system-wide programmes within the SELSTP. To date, the Trust has been successful in securing £10.5 million for an off-site supply chain hub
- focus on maximising utilisation of our current infrastructure which is linked to many of our Fit for the Future plans. Our ability to invest in technology will be a major enabler or constraint
- discuss options for potential properties identified as surplus to our clinical service and estate requirements. This will be dependent on relevant consultation and partnerships with local councils, clinical commissioning groups, community and mental health providers, NHS Property Services and King's Health Partners.

Fit for the Future/quality improvement

Our Fit for the Future plan continues to build on a strong platform which has been developed over the past six years. This Trust-wide programme has already supported directorates to deliver numerous quality, safety and efficiency improvements. There are high levels of staff engagement with the programme and our collective focus aims to create a culture of continuous improvement where 'everyone does improvement', and staff feel empowered to deliver change and transformation. This staff engagement will continue through the annual Fit for the Future week, our successful Dragons' Den competition and the Fit for the Future badge awards. These badges are presented at the monthly Team Briefing for staff who have gone the extra mile to implement an improvement in their area which has benefited staff, patients and their families.

In addition to this, the Trust has made a decision to boost its approach to quality improvement (QI). Building on our existing strengths, including Fit for the Future, we will create a single, shared system that maximises the pace of improvement across the organisation. A multi-professional implementation group is now working with directorates to put in place the key building blocks of the shared improvement system. Local QI team leaders and coaches will be trained and supported to deliver QI projects, and continue to access our Care Redesign programme, which has been expanded to incorporate 45 teams a year. Annual Trust-wide QI themes are currently being chosen to ensure effective alignment and focus.

Delivering the Carter recommendations

We continue to support NHS Improvement with the development and implementation of the recommendations of the Carter Review. We are pursuing both the specific recommendations and the wider use of benchmarking, including the 'model hospital portal', to inform our efforts. In particular:

- we have worked with clinical directorates to combine the model hospital tool with other sources of data to generate new insights
- we have created an opportunities 'heat map' to inform directorates and services about their improvement opportunities
- our Fit for the Future workstreams reflect the key drivers of productivity from the Carter agenda.

Through these initiatives we continue to deliver £15-20 million of efficiencies annually.

Procurement

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

The procurement department is ranked second out of 136 acute trusts in the latest NHS Improvement procurement league table which

uses model hospital benchmarking data to measure process efficiency and price performance.

In December 2018, £10.5 million was awarded from the 'Sustainability and Transformation Plan wave four estate transformation fund' to develop a new supply chain model. The project includes establishing an off-site consolidation centre to support public health by removing over 35,000 annual truck deliveries to the Trust. It will also support our SELSTP partners including King's College Hospital NHS Foundation Trust, Lewisham and Greenwich NHS Trust and Dartford and Gravesham NHS Trust.

Performance analysis – sustainability and environmental

Environmental impact performance indicators 2018/19

Area	Acute hospitals 2018/19	2017/18	Trend 18/19 v 17/18	Community services 2018/19	2017/18	Trend 18/19 v 17/18
Water	428,459 m^3	521,651 m^3	-18%	20,250 m^3	38,020 m^3	-47%
Water cost	£716,310	£860,844	-17%	£39,645	£82,430	-52%
Imported electricity	162,451 GJ	177,303 GJ	-8%	7,887 GJ	3,073 GJ	157%
Gas	668,628 GJ	708,340 GJ	-6%	6,253 GJ	7,760 GJ	-19%
Oil	660 GJ	10,617 GJ	-94%			
Energy cost	£11,731,464	£9,868,141	19%	£393,602	£283,383	39%
CO_2 emissions from building energy use	46,941 tonnes	53,401 tonnes	-12%	940 tonnes	886 tonnes	6%
High temperature disposal	445 tonnes	432 tonnes	3%			
Alternative treatment (offensive waste)	1,599 tonnes	1,609 tonnes	-1%			
Landfill waste	16 tonnes	20 tonnes	-20%			
Recycling by % of total	35%	37%	-5%			
Cost of waste	£1,144,120	£1,133,028	1%			

Trust energy consumption has decreased despite the inclusion of two additional properties in the reported figures this year. This is due to improvements in the energy infrastructure, including boiler upgrades and the introduction of more LED lighting.

Significant differences in water consumption figures are due in part to over-estimated usage at the end of 2017/18.

The Trust has a growing sustainability programme that continues to minimise our environmental impact. Guided by our sustainability strategy, we are viewed as a leader in sustainable healthcare and aim to be one of the most sustainable healthcare organisations in the UK.

Our SAVE programme (Sustainable Actions delivering Valuable Efficiencies) which aims to support directorates to deliver savings through efficient use of resources and utilities, has won an NHS Sustainability Award for staff engagement. 70% of our directorates are involved in the programme and are contributing to savings in excess of £200,000. Our sterile services team, in collaboration with Guy's Dental Institute, eliminated unnecessary plastic from procedure trays to achieve an annual saving of £21,000.

The Trust's 'Better Air Campaign' seeks to improve local air quality and improve health. We work with drivers to avoid idling engines and seek to avoid unnecessary journeys and deliveries to the Trust. We also aim to switch to people-powered, electric and hybrid vehicles, where possible.

Evelina Hospital School's staff and pupils have developed drawings as signs to designate clean air zones around the hospital and 'clean air maps' that help staff, patients and visitors find the healthiest route from major tube and bus stations to our hospital sites.

Helping our staff to stay active is embedded in our sustainability plans and our approach is supported by the Trust's sustainable travel plan. We continue to support staff to travel actively by providing facilities for cyclists and tax-free cycle purchase schemes as well as fortnightly lunchtime walks which are open to staff and patients.

The Trust carefully considers its impact on the environment when making purchasing decisions and in strategic decision making. Sustainability is reflected in business plan development, as well as service tenders.

Last year the Trust was delighted to win four awards at the NHS Sustainability Awards, including the overall NHS Winner for 2018. The Trust also won awards for staff engagement, waste minimisation and sustainable procurement.

Our energy performance contract delivers £1.25 million in savings and includes an ambitious LED lighting programme, which consumes on average 55% less energy, and has reduced lighting maintenance costs by 80%.

The Trust's award-winning waste team is now managing StockDoc, our Trust-wide furniture reuse platform, which delivered £100,000 worth of savings in 2018/19.

Equality, diversity and inclusion

The Trust serves the diverse local communities of Lambeth and Southwark, as well as caring for patients from further afield. This diversity is reflected in both the profile of our patients and staff, and brings many benefits.

We are constantly striving to ensure that our services meet the needs of all people regardless of their age, disability, ethnicity, gender, race, religion or belief, and sexual orientation, in accordance with the Equality Act 2010 and our public sector equality duties.

The Trust has this year refreshed its equality, diversity and inclusion priorities for 2018-2020 and is working to embed these into day-to-day business.

The objectives aim to drive improvements in patient care and staff experience, reducing inequalities for our diverse workforce and patient population.

These objectives include:

- improving the way we develop, design and deliver services to meet the needs of all of our patients, including our most vulnerable patients
- working with patients to ensure they receive information and communication in their preferred format, in line with the Accessible Information Standard
- ensuring that our environment, facilities and services are accessible to all
- helping people, including vulnerable people, to participate in public life by widening access to employment and new skills
- reviewing our patient and staff experience to ensure all groups of people receive a positive experience
- ensuring all groups of staff have equality of opportunity for career progression, and our senior management group reflects the diversity of the wider organisation and patient population.

The Trust has a duty to ensure all of its processes, practices and outcomes are fair for both patients and staff. This is monitored by the Trust's associate director of equality, diversity and inclusion, and through both local and statutory reporting.

The Trust also recognises the importance of respecting and protecting the human rights of our patients, staff and members. This is embedded as a core element in staff training, when designing processes and within our communications and decision making.

The Trust is committed to safeguarding all our patients, including the most vulnerable. We participate in our local, multi-agency safeguarding boards and aim to safeguard vulnerable people through a partnership approach. Care and treatment is provided to all patients with their consent, and for patients who cannot consent to treatment, care is provided in their best interests in accordance with the Mental Capacity Act 2005.

Our safeguarding team consists of separate adults and children's teams, which work closely with our statutory bodies providing support, guidance and decisions on all safeguarding issues. They also provide training to all staff as part of the wider Trust's training programmes. This includes Barbara's Story, an award-winning training film which raises awareness of dementia and the issues faced by vulnerable patients and their families. Each clinical directorate has a dementia and delirium champion and a learning disabilities champion who work with colleagues to implement best practice in their area. The Trust is also a member of the Dementia Action Alliance and is working with partners to provide better services for people with dementia, including through the creation of dementia-friendly communities.

The Trust provides a comprehensive language and accessible support service to meet the communication needs of our diverse population. The service provides interpreters for patients and their carers, patient information in other languages, as well as in other formats including easy read, Braille, large print and audio when required. We also offer web-based British Sign Language. Collaborative working between services has seen the roll out of 'communication aid' boxes and 'activity' boxes which consist of communication resources such as portable hearing amplifiers, magnifying sheets, white boards, symbols and images, and activity books to support patients with particular communication needs as well as patients with dementia.

It is important that our services and our buildings are fully accessible for patients, families and

carers. The Trust has invested in a comprehensive accessibility audit to ensure we improve physical access for patients with disabilities, patients with sensory loss and those who are frail or elderly. Accessibility information has been published on our website to inform patients and carers of our facilities prior to them attending their appointment. Patients can see what the area/department or ward looks like, and what facilities, for example, accessible toilets, flooring and lighting are available. This work is part of a wider accessibility strategy.

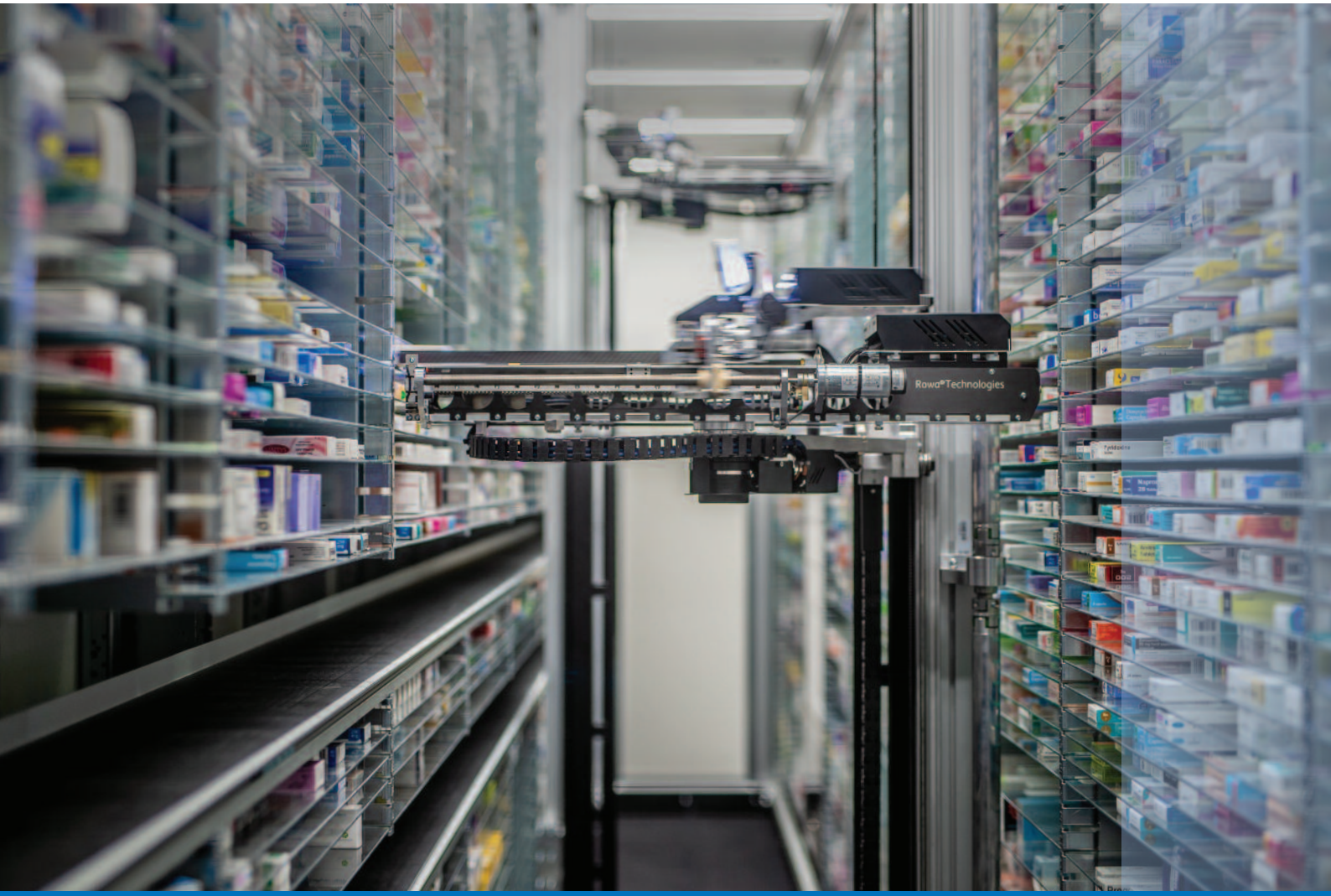
The Trust has supported many projects through its Widening Participation programme. These include: attending careers fairs in local schools and colleges, providing 700 work experience placements (126 for people from local communities) and supporting young people from severely disadvantaged backgrounds to undertake paid internships through partnerships with Lambeth College and the EY Foundation. We have also supported 260 members of the armed forces community through Step into Health, employing 11 people at Guy's and St Thomas' and helping a further 40 to secure employment in NHS organisations across London. We have supported 22 people who were homeless or in unstable/temporary housing through our Work Ready programme, 20 of whom went on to secure employment or education.

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

Under the Equality Act 2010, employers are required to set out arrangements for how they meet specific employment duties. The Trust collects a range of employment data to monitor diversity and inequalities, and publishes the results in an annual workforce monitoring report on our website and through reporting to NHS England.

The Trust undertakes equality impact assessments to provide assurance that our policies, functions and services are not discriminatory. When any remedial action is identified by the assessment, we develop and implement an action plan to address this. In 2018 the reporting data also included information about our gender pay gap for the first time.

Amanda Pritchard,
Chief Executive
22 May 2019



We opened a new pharmacy at Guy's Hospital providing a better environment for patients and, with the help of a new dispensing robot, allowing staff to deal with the 18,000 prescriptions they dispense each month more efficiently.

3 Accountability report

Rough sleepers in Southwark are the first in London to benefit from immediate, same day health checks and registration with a GP thanks to a project set up by specialist nurses from Guy's and St Thomas'.

4 Directors' report

Guy's and St Thomas' has performed well both operationally and financially during 2018/19 which was another exceptionally busy year. Our staff continue to work hard to balance high quality patient care with achieving our performance targets in a challenging financial environment, and against a backdrop of unprecedented demand for our services.

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

High quality care

Our staff have worked exceptionally hard to maintain performance against national and local targets and to comply with the requirements of our main regulators, the Care Quality Commission and NHS Improvement.

We continue to work closely with our local clinical commissioning groups, with specialist commissioners and with our local Health and Wellbeing Boards in a rapidly changing external environment.

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

The Trust's services were assessed by the CQC in September 2015, and we were pleased to achieve an overall rating of 'Good'. This was a significant achievement given the size and complexity of the Trust, and is a tribute to the commitment and effort of staff across the organisation. The Trust was rated 'Outstanding' for caring services, and 'Good' for effectiveness, responsiveness, and being well led. In March and April 2019, the CQC inspected our services again. We expect to know the results of that inspection later this year.

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

The Trust continues to perform well in the Patient-Led Assessments of the Care Environment (PLACE). Last year, we achieved a score of 99.7% for cleanliness, with the other elements measured also scoring highly.

Sustaining operational performance against a wide range of national and local measures, including NHS Improvement's compliance framework, remains an enormous challenge. It requires a sustained effort from frontline staff and managers, and we work hard to support them, for example through regular 'Safe in our hands' meetings, monthly team briefings and the Trust's Fit for the Future programme, which brings together visible clinical leadership and improvements in quality, safety and efficiency. A monthly Serious Incident Assurance Panel, chaired by a non-executive director, receives reports by clinicians on the outcome of investigations conducted in line with the Trust's serious incident framework.

The Board has continued to assess its compliance with the principles of the NHS Foundation Trust Code of Governance, and has reviewed the make up and responsibilities of its Board committees and their terms of reference. Further details can be found in the organisational structure chapter on page 51

and in the full Compliance Statement on the Trust's website.

Focus on quality

The Trust's Quality and Performance Committee monitors the delivery of the Trust's quality priorities which have been developed in consultation with stakeholders from our local community. These are described fully in the quality report on pages 74 and 75.

The committee also monitors the full range of clinical and non-clinical performance indicators which are reported monthly through the integrated quality and performance report (IQPR). This report is published on the Trust website and this, together with regular updates to 'Our Quality Story', ensures that we are open and transparent about our performance. It is also scrutinised alongside the quality report by the Trust's external auditors as part of a rigorous assurance process.

We continue to work hard to reduce hospital infections and retain a sharp focus on quality, safety and clinical effectiveness. Our quality priorities are also informed by complaints and the feedback that we receive from patients, families and carers. 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 and have made progress this year to improve the timeliness of our responses – but there is still more to do.

Our CQC report, a wide range of performance measures and patient feedback, all provide valuable information about where and how we can improve care for patients.

We use this information to drive positive change across the Trust, with close oversight from the Board of Directors and our Council of Governors.

Our local and wider role

The Trust provides a full range of local hospital services to people living in Lambeth, Southwark and surrounding boroughs as well as a wide range of specialist services for local people and patients from further afield.

We continue to collaborate across King's Health Partners and with organisations across south east England and London, as well as nationally and internationally, to improve services, research and education.

At St Thomas' we have one of the busiest emergency departments in London and provide a wide range of very specialist services and sub-specialties. The site is home to Evelina London Children's Hospital, as well as one of the largest intensive care units in the UK. We have many regional and national centres of excellence, including a major cardiovascular centre and a comprehensive range of women's and children's services, many of which benefit from being co-located on a single site.

During 2018 the Princess Royal opened our new emergency department, creating a dedicated emergency floor at St Thomas' which will enable us to provide a higher quality and more responsive service for local people. Our new Rare Diseases Centre was also

opened by the Countess of Wessex and will treat patients with rare conditions, such as epidermolysis bullosa, from all over the country. The Rare Diseases Centre was funded by Guy's and St Thomas' Charity, the charity DEBRA, the Four Acre Trust and the Photodermatology Charitable Trust.

Guy's Hospital continues to serve a wide population with dental, renal, urology and orthopaedic services, including complex surgery. It is also home to our Cancer Centre.

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

Guy's Tower is a major hub for research and includes a wide range of specialist facilities which continue to strengthen our position as a leader in genomics, imaging and regenerative medicine.

As part of our commitment to provide care closer to where people live, the Trust is participating in a number of specialised services networks and growing its own network of outreach clinics and satellite centres. This includes a cancer centre and a kidney treatment centre at Queen Mary's Hospital Sidcup. This means that patients don't always have to come into central London for treatment.

Evelina London Children's Hospital continues to develop a comprehensive network of specialist children's services across south east England, hosting the specialist paediatric network for the region. By supporting expert care closer to home and improving access to our full range of specialist services, Evelina London will provide better care to children and young people, particularly those with complex clinical needs.

We provide community health services for adults and children across Lambeth and Southwark, allowing us to deliver seamless care for our patients. We deliver services in a variety of locations, including in GP practices, health centres, schools, community buildings and in patients' homes.

We work in partnership with colleagues from across the local health economy – including local authorities and voluntary/community groups – to provide holistic care, and we are an active member of the Southwark and Lambeth Strategic Partnership. We continue to work across the partnership to identify opportunities for wider patient and public engagement.

We continue to work closely with Healthwatch in both boroughs and hold quarterly liaison meetings to keep them informed of potential service changes and to discuss progress in delivering our quality priorities. In addition, local Healthwatch bodies use these meetings to keep the Trust informed of their work programmes, which is an opportunity to share information across organisations to benefit public engagement.

In the third quarter of 2018, Healthwatch Lambeth began sending reports of patient feedback to the Trust. These reports are considered alongside other Trust patient experience data. By the end of 2018/19, Healthwatch had reported four patient feedback enquiries concerning Trust services between April and September 2018. We are working with Healthwatch Lambeth to ensure that we can make best use of these reports to support learning and continuous improvement.

Healthwatch have powers to 'enter and view' healthcare premises to observe the delivery of services and the care environment. Although neither local Healthwatch undertook visits during 2018/19, the Trust responded to Healthwatch Lambeth's report on their visits to our podiatry services as part of their 'Right for everyone' project, which focused on assessing the quality and accessibility of services for people with learning disabilities. The visit was undertaken in August 2017 and the report was published in May 2018.

The Trust continues to play an active role in Our Healthier South East London (OHSEL), the name for our local sustainability and transformation partnership (STP).

As part of OHSEL's plan to improve orthopaedic services, we continue to work with other providers in a South East London Orthopaedic Network. Consultant orthopaedic surgeon, Peter Earnshaw, is clinical lead for the network.

We have been actively involved in a number of engagement activities with staff and local people to explore plans for modernising services and improving health outcomes through the use of digital technology.

In November 2017, the Trust

announced a new 15-year partnership with Johnson & Johnson Managed Services to improve the efficiency of the procurement of medical devices, surgical instruments and implants. Over the next two years, the partnership will continue to support the development of a new Orthopaedics Centre of Excellence, providing additional theatres that will enable the Trust to respond to increasing demand for orthopaedic services. Patients continue to be involved in planning the design of the new centre.

The Trust was not required to undertake any formal public consultation exercises this year.

The Trust is committed to involving patients, families, carers and members in the delivery and development of services. For example, in February 2019, we and our partners held a series of patient engagement events to discuss potential changes to cardiovascular and respiratory services, including services currently provided at the Royal Brompton Hospital.

With the support of governors, members and staff we published an updated patient and public engagement strategy which continues to provide a framework for and supports the delivery of the Trust's organisational strategy, 'Together we care'.

More than 50 members and patients joined staff teams as patient assessors for our Patient-Led Assessments of the Care Environment (PLACE), visiting hospital and community services. The Trust scored above the national average in all six categories, including cleanliness, food and privacy.

The Trust scored above the national average – 85% compared with a national average of 78.9% – for a measure considering how well healthcare environments support the provision of care for people with dementia. In addition, this year the Trust scored slightly above the national average for a measure that considers how well the environment supports provision for people with a disability.

System leadership

Building on the success of the national vanguard programme acute care collaborative, on 1 April 2018 the Trust formally launched the Guy's and St Thomas' Healthcare Alliance with our founding member Dartford and Gravesham NHS Trust. This partnership – which is a collaboration between the organisations and not a new entity – is designed to drive benefits against four strategic aims: delivering consistently high quality care; developing our people; leveraging scarce resources; and embracing innovation.

The Healthcare Alliance also has a number of broader workstreams: leadership development (including clinical leadership); improvement capability; and staff training. And we have established major programmes to: embrace remote reporting of radiology scanning; maximise theatre capacity at Queen Mary's Hospital Sidcup; and to roll out the Trust's successful Nightingale Ward Programme at Dartford and Gravesham.

King's Health Partners

The Trust is proud to be part of King's Health Partners, our academic health sciences centre (AHSC). Working closely with our colleagues at King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London, our shared university partner. Together our ambition is to be a world-leading health organisation through the integration of research, education and patient care.

By working together, we combine our strengths to improve outcomes by delivering high impact research and innovation, world-class clinical care and internationally recognised education and training opportunities for the benefit of our patients, staff, students and partners.

We have made further progress this year in our partnership's work to join up the identification and treatment of mental and physical healthcare. Through the King's Health Partners 'Mind and Body Programme', with King's College Hospital, we have now screened more than 32,000 patients across 60 different clinics for signs of anxiety or depression alongside their physical health needs. We continue to deliver joined-up mental and physical healthcare through a range of programmes, including staff education and training.

More than 500 staff have signed up to be 'Mind and Body Champions', working as advocates for joining up mental and physical healthcare across our partnership. We are the first organisation in the country to offer 'mind and body'

care to people living with blood cancer, and the first where acute trusts have signed up to the Equally Well Charter – a new collaborative which is working to improve the physical health of people with a mental illness.

We are committed to improving outcomes by delivering care that is patient-centred, meets the needs of our population and is financially sustainable. Teams across our partnership are working to improve outcomes and care for patients and service users, with a particular focus on cardiovascular disease, orthopaedics, and depression in older adults. We are working with national and international partners as part of Vital 5, an innovative new approach to population health that aims to reduce health inequalities.

Building on the work in our clinical academic groups, our institutes and network programmes (cardiovascular, diabetes, obesity and endocrinology, haematology, neurosciences and women and children's health), we are bringing teams together to improve patient care, research and education. The benefits of this joint working are already being realised, for example, in our integrated heart failure service.

We are also working in a partnership between King's Health Partners and Royal Brompton & Harefield NHS Foundation Trust to develop plans that would revolutionise cardiovascular and respiratory services and research for the benefit of our patients.

Our research and innovation activities continue to grow. In 2018, all three trusts within King's Health Partners increased their number of clinical trials with 38,000 patients taking part in clinical studies, and we were awarded 'Major Centre' status by Cancer Research UK. We were also one of six sites in the UK to win a centre award from Innovate UK, bringing together our strengths in artificial intelligence and imaging with substantial investment from medical technology companies. The partnership's two biomedical research centres also continue to combine their significant expertise in physical and mental health to drive advances in research.

This year we received funding as part of a cross-London consortium to use data science and technology to make improvements in population health through the One London programme, which aims to bring all parts of the London health and social care system together to connect services and integrate care.

The King's Health Partners Learning Hub continues to support staff through a wide range of free e-learning materials. There are now more than 80 education resources available.

Overseas, our global health partnerships in Sierra Leone, Somaliland and the Democratic Republic of Congo continue to support the development of sustainable healthcare systems.

Investing in our future

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

During 2018/19, we completed the final phase of our emergency floor at St Thomas'. This will help us to meet the increasing demand for accident and emergency services from our local communities, ensuring that the more than 200,000 patients who visit the emergency department each year are cared for safely and efficiently in a brighter and more comfortable environment.

Evelina London Children's Hospital also sees increasing numbers of patients every year, and we continue to invest in improving facilities and services for children and young people while developing comprehensive plans to further increase capacity.

A major project to create two new clinical areas for children – a cardiology ward and a critical care unit – was substantially completed this year, as well as a new planned care ward and outpatient facilities.

During the year, we opened a new dialysis unit at St Thomas', enabling more patients to be treated in modern facilities.

Through our partnership with Johnson & Johnson Managed Services, we have opened an additional operating theatre and recovery suite at Guy's as a first step in the development of an Orthopaedics Centre of Excellence.

Developing our community services remains a priority with investment during the year to provide improved services at Dulwich Hospital.

We continue to invest in teaching, research and education facilities and a joint project between

the Trust and King's College London to create a new education and training centre at St Thomas' is progressing well.

Developing commercial partnerships

The Trust has a long tradition of innovation and is committed to exploring commercial opportunities that will generate additional income to support the delivery of NHS services and build on our key strengths in patient care, research and education.

A number of initiatives have progressed during the year, including:

- our partnership with Johnson & Johnson Managed Services to deliver an Orthopaedics Centre of Excellence
- our commercial education programme and events, with over 50 opportunities now in place for observerships and visiting professionals from overseas
- international consultancy and partnerships, with programmes across the Middle East, India and Asia
- private patient care, including our partnership with HCA at Guy's Cancer Centre and private patient services at St Thomas'.

This year we have begun the formal closure of our long-term partnership with the Ministry of Defence to provide hospital, primary and community health services to British Forces and their families in northern Europe. This follows Government plans to withdraw all UK troops from Germany by March 2020.

Better payment practice code

Measure of compliance	Year ended 31 March 2019 Number	£000	Year ended 31 March 2018 Number	£000
Total bills paid in the year	**334,766**	**724,028**	328,363	706,205
Total bills paid within target	**270,899**	**542,043**	264,914	520,279
Percentage of bills paid within target	**81%**	**75%**	81%	74%

The Trust's wholly-owned subsidiary, Guy's and St Thomas' Enterprises, manages its fully and partially owned companies, including:

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

A full list of subsidiaries and interests in associates and joint ventures can be found in note 19 to the Accounts on page 134.

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 2018/19, Board membership comprised the following executive directors: Chief Executive, Amanda Pritchard; Chief Financial Officer, Martin Shaw; Chief Medical Officer, Director of Patient Safety, and Deputy Chief Executive, Ian Abbs; Chief Nurse, Director of Patient Experience and Infection Control, and Deputy Chief Executive, Eileen Sills; Chief People Officer, Julie Screaton; and Chief Operating Officer, Jon Findlay.

And the following non-executive directors: Chairman, Sir Hugh Taylor; Sheila Shribman (Vice-Chair); Felicity Harvey; Girda Niles; John Pelly; Reza Razavi; Priya Singh; and Steve Weiner.

See pages 58 and 59 for biographies.

All of our Board of Directors meet the standards of the 'Fit and Proper Persons Requirement'. We have substantially overhauled this policy during the year, widening its scope to include those senior colleagues who attend the Board regularly. The revised policy also 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 31 (Related Parties) to the Annual Accounts on page 140.

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditor, and members of the Board take all the necessary steps to make themselves aware of relevant information and to ensure that this is passed on to the external auditors where appropriate.

The Trust complies with the requirement of the better payment practice code to pay all valid

invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Performance against the code is set out in the table 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 on page 118.

Surpluses from other income that the Trust has received have been used to support the provision of goods and services for the purposes of the health service in England.

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

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

Amanda Pritchard
Chief Executive
On behalf of the Board of Directors

Our simulation centre is one of the largest in the UK. We run regular simulated cardiac arrest scenarios to allow staff to practise their response.

5 Remuneration report

Chairman's annual statement

As the Chairman of the Remuneration Committee (the committee), I am pleased to present our remuneration report for 2018/19.

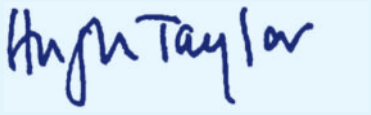
There were no changes to the Trust's remuneration policy for very senior managers in 2018/19.

Taking into consideration the national pay settlements agreed for Agenda for Change and medical and dental workforces, the committee approved a 1.5% cost of living increase to executive and senior managerial salaries with effect from 1 October 2018, following the settlement confirmed for medical consultants. We continued to offer the flexible approach of allowing senior managers the choice of accepting or declining the increase in pensionable salary.

The scheduled full review of executive and senior management salaries began in 2018/19 in conjunction with Korn Ferry Hay Group consultants, deferred from 2017/18. No changes to executive salaries were implemented in 2018/19 as a result of the review. The review will be completed early in 2019/20.

There was one change to the Trust's executive team during 2018/19. In March 2018, the committee approved a proposal to strengthen the senior management structure within the workforce directorate through the creation of a new role of Chief People Officer. Julie Screaton, Director of Workforce and Organisational Development, was confirmed as Chief People Officer from April 2018. Her salary was unchanged.

During the year, the committee considered the Trust's arrangements for meeting the NHS Fit and Proper Person Requirements. The Trust's arrangements were strengthened by the introduction of an updated policy and procedure covering an extended group of Trust posts that were agreed to be in scope of the national requirements.



Sir Hugh Taylor
Remuneration Committee Chairman
22 May 2019

Remuneration policy report 2018/19

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 Scheme and the 2015 Scheme. New executive directors are entitled to join the 2015 Scheme, which is a career average revalued earnings scheme. Where an individual is a member of the 1995/2008 Scheme and is subsequently appointed to the Board, he or she may remain a member of that scheme.
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. 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 2018/19 are set out in the single total figure table in the annual report on remuneration.	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 2018/19 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. 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 14.3%.
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 six months' notice.

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

Differences between remuneration for executive directors and other employees

The key difference between the remuneration of executive directors and other employees is that the fixed salary of executive directors is considered to be inclusive of a high cost area supplement, whereas for other employees this is a separate pay element.

When setting remuneration levels for the executive directors, the committee considers the prevailing market conditions, the competitive environment (in particular through comparison with the remuneration of executives at other leading NHS multi-specialty academic healthcare organisations of similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader Trust workforce.

In particular, the committee considers 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 2018/19

The remuneration and expenses for the Trust Chairman and non-executive directors are determined by the Council of Governors, taking account of the guidance issued by organisations such as the NHS Confederation and the NHS Trust Development Authority.

Remuneration Committee

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

The Trust's Chairman is chair of the Remuneration Committee and all non-executive directors are members of the committee.

Remuneration Committee membership and attendance 2018/19

Name	Actual / Possible
Hugh Taylor (chair)	3 / 3
Felicity Harvey	3 / 3
Girda Niles	3 / 3
John Pelly	3 / 3
Reza Razavi	2 / 3
Sheila Shribman	2 / 3
Priya Singh	3 / 3
Steve Weiner	3 / 3

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

Attendee	Regular attendee	Attends as required
Amanda Pritchard, Chief Executive	x	
Julie Screaton, Chief People Officer	x	
Catherine Briggs, Reward Manager		x

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

Median remuneration and fair pay multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The remuneration of the highest paid director compared to the median remuneration of the workforce was as follows:

Median remuneration and fair pay multiple		
	March 31 2019	March 31 2018
Highest paid director's total remuneration	£254,394	£252,500
Median total remuneration	£40,032	£38,805
Remuneration ratio	6.35	6.51

The calculation is based on full-time equivalent staff working for the Trust on March 31 2019. Where staff are part time, their salaries have been annualised for the purposes of the median ratio calculation. Individual staff remuneration ranged from £22,000 to £254,000 (2017/18, £20,000 to £252,000).

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

Service contracts

The following table contains details of the service contracts in place during 2018/19 for executive directors:

Service contracts			
Executive director	Date of service contract	Unexpired term	Notice period
Ian Abbs	Jan 2011	Open ended	6 months
Jon Findlay	Dec 2016	Open ended	6 months
Amanda Pritchard	Apr 2012	Open ended	6 months
Julie Screaton	Jun 2017	Open ended	6 months
Martin Shaw	Oct 1998	Open ended	6 months
Eileen Sills	Feb 2005	Open ended	6 months

Salaries of senior staff

The Trust is a large and complex organisation, when compared with other leading NHS multi-specialty academic healthcare organisations. The Trust recognises that it will be necessary to pay at the upper quartile of NHS salaries, when compared with similar organisations such as members of the Shelford Group (which represents 10 of England's leading academic healthcare organisations) and similar private sector organisations. This will enable the Trust to attract and retain individuals with the appropriate experience to fulfil the Trust's senior managerial roles.

The Trust acknowledges that meeting these principles is likely to lead to a number of senior staff being paid more than £150,000. It is satisfied that this is justified.

Salary and benefits of senior managers

The following tables contain details of the salary and benefits of the Trust's senior managers in 2017/18 and 2018/19.

Single total figure 2018/19

Name	Title	Salaries and fees (bands of £5k) £000	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
I. Abbs	Chief Medical Officer and Director of Patient Safety	205–210	–	205–210
J. Findlay*	Chief Operating Officer	160–165	–	160–165
A. Pritchard	Chief Executive	250–255	100–102.5	355–360
M. Shaw	Chief Financial Officer	160–165	–	160–165
E. Sills**	Chief Nurse and Director of Patient Experience	155–160	–	155–160
J. Screaton	Chief People Officer	160–165	255–257.5	420–425
F. Harvey	Non-executive director	15–20	–	15–20
G. Niles	Non-executive director	15–20	–	15–20
J. Pelly	Non-executive director	15–20	–	15–20
R. Razavi	Non-executive director	15–20	–	15–20
S. Shribman	Vice-Chair	15–20	–	15–20
P. Singh	Non-executive director	15–20	–	15–20
H. Taylor	Chairman	60–65	–	60–65
S. Weiner	Chairman of the Audit Committee	20–25	–	20–25

No senior manager received any taxable benefit, annual or long-term performance bonuses in 2017/18 or 2018/19.

* J. Findlay opted out of the NHS Pension Scheme on 31 July 2018.

** E. Sills took flexible retirement as at 31 December 2018.

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

Single total figure 2017/18

Name	Title	Salaries and fees (bands of £5k) £000	Pension-related benefits (bands of £2.5k) £000	Total (bands of £5k) £000
I. Abbs	Chief Medical Officer and Director of Patient Safety	200–205	–	200–205
J. Findlay	Chief Operating Officer	160–165	207.5–210	370–375
A. Macintyre	Director of Workforce and Organisational Development (until July 2017)	40–45	–	40–45
S. McGuire*	Director of Essentia (until Sep 2017)	320–325	–	320–325
A. Pritchard	Chief Executive	250–255	65–67.5	315–320
M. Shaw	Chief Financial Officer	160–165	22.5–25	185–190
E. Sills	Chief Nurse and Director of Patient Experience	175–180	5–7.5	185–190
J. Screaton	Director of Workforce and Organisational Development (from June 2017)	125–130	22.5–25	145–150
E. Duncan	Non-executive director (until Jul 2017)	5–10	–	5–10
F. Harvey	Non-executive director	15–20	–	15–20
G. Niles	Non-executive director	15–20	–	15–20
J. Pelly	Non-executive director	15–20	–	15–20
R. Razavi	Non-executive director	15–20	–	15–20
S. Shribman	Vice-Chair	15–20	–	15–20
P. Singh	Non-executive director	15–20	–	15–20
H. Taylor	Chairman	60–65	–	60–65
S. Weiner	Chairman of the Audit Committee	20–25	–	20–25

* Steve McGuire received a redundancy payment of £160k and payment in lieu of notice of £81k.

2018/19 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 2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2018 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2019 £000
J. Findlay* Chief Operating Officer	0	0	55-60	145-150	1,027	92	1,157
A. Pritchard Chief Executive	5-7.5	0	60-65	125-130	724	162	945
J. Screaton Chief People Officer	10-12.5	25-27.5	55-60	155-160	875	327	1,241
M. Shaw** Chief Financial Officer	0	0-2.5	75-80	235-240	0**	0**	0**
E. Sills*** Chief Nurse and Director of Patient Experience	0	0	70-75	220-225	1,498	0	0

* J. Findlay opted out of the NHS Pension Scheme on 31 July 2018. The figures reported in the above table are as of 31 July 2018, the date J. Findlay opted out of the NHS Pension Scheme.

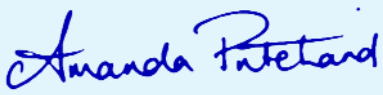
** The NHS Pensions Service Authority does not calculate a cash equivalent transfer value (CETV) for individuals over 60.

*** E. Sills took flexible retirement as at 31 December 2018. The figures reported in the above table are as of the retirement date of 31 December 2018.

I. Abbs, Chief Medical Officer and Director of Patient Safety, has opted out of the NHS Pension Scheme and therefore has no pension information disclosed above.

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.



Amanda Pritchard, Chief Executive
22 May 2019

77% of staff would recommend Guy's and St Thomas' as a place to work according the 2018 NHS Staff Survey.

6 Staff report

Last year, we employed around 17,100 staff, clinical and non-clinical, all of whom contribute to providing high quality patient care in our hospitals and across the local community. Our staff work hard to improve efficiency and deliver the best possible care to our patients.

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

Staff numbers

Staff group	Permanently employed	Agency, bank and seconded staff	Total 2018/19
Administration and estates	4,060	323	4,383
Healthcare assistants and other support staff	891	295	1,186
Medical and dental	2,062	192	2,254
Nursing, midwifery and health visiting staff	4,797	645	5,442
Nursing, midwifery and health visiting learners	980	286	1,266
Scientific, therapeutic and technical staff	2,433	121	2,554
Social care staff	1	–	1
Total	**15,224**	**1,862**	**17,086**

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

Communicating with staff

The Trust is committed to involving staff in decision-making, engaging them in key developments, and keeping them informed of change across the organisation.

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

We place great importance on staff engagement as there is a positive correlation between this and staff motivation, commitment, involvement in change and ultimately a positive impact on the quality of patient care. In 2018/19, we continued to score highly in both the NHS Staff Survey and in the quarterly Staff Friends and Family Test – see overleaf for details.

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

We hold regular face-to-face briefings on both clinical and management issues, helping to engage staff who do not have regular access to computers, and the Knowledge and Information Centre at St Thomas' and the new TechZone at Guy's provide email and computer access for staff, as well as help with a range of technical issues. We've introduced 'Big Conversation' sessions to ensure staff have a

forum to discuss important issues, how they are affected and what they can do to make improvements. The Trust produces 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 employees' voices are heard. The joint staff committee meets quarterly, acting as a valuable consultative forum for key developments affecting staff, with sub-groups established to look at policy and pay issues. The Trust has six staff governors who contribute to the assurance and development of the organisation and represent staff members' views at Board level.

All staff are encouraged to voice opinions, suggest improvements and share ideas, as well as raise concerns. Our 'Showing we care by speaking up' initiative encourages all staff to feel confident and able to speak up about any concerns they have about patient safety or the way the Trust is run. Our new 'Quality Matters' newsletter provides a twice monthly focus on important quality and safety messages for all staff, and our 'Safety Signals' emails share good practice, including learning from serious incidents. The Trust's transformation programme, Fit for the Future, engages staff in improving the quality, safety and efficiency of our services.

Staff survey

The NHS Staff Survey is the largest annual workforce survey in the world. This year 10 new themes were introduced, replacing the former set of 32 key findings. The new themes are scored on a scale of 0-10 where a higher score indicates a better result.

We know that patient and staff experience are intrinsically linked and that positive staff engagement leads to increased patient satisfaction. We measure our success in terms of staff engagement and creating a good work environment through the annual NHS Staff Survey and the Staff Friends and Family Test, which is undertaken three times a year. These survey and test results are closely monitored and discussed at the Trust Management Executive and Board meetings.

Our survey results remain positive, with a majority of our scores above those of our comparator group. The response rate to the 2018 survey was 41%, an increase of 5% compared with 2017 and now consistent with the national average, although we are keen to improve on this.

The Trust achieved the best score in our comparator category in three themes – staff engagement, safety culture and quality of appraisals.

We also had the highest score for staff engagement within our comparator group for the fourth consecutive year at 7.4. The Trust achieved above the national average in 6 out of 10 themes and equal to the national average in two themes. All Trust directorates scored above the national average for staff engagement.

The Trust was below average in two themes – equality, diversity and inclusion and bullying and harassment. These two areas are a priority for us to address going forward. Over the past year, we have introduced a range of measures to drive improvement.

- In 2018 we launched our 'Big Conversation' focussed on 'one team many perspectives' to create a Trust-wide discussion about what encourages a diverse and inclusive culture and to understand what we need to do to ensure everyone has a positive experience of working at the Trust. More than 3,000 employees took part and made individual and team pledges as part of their conversations.
- All executive directors now have a personal objective that supports the promotion of equality, diversity and inclusion within the Trust.
- As part of the Trust's 'Equality, diversity and inclusion vision' and two-year strategy, reverse mentoring and diverse recruitment panels were introduced to help promote equality in the workplace.

The Trust places an emphasis on the importance of personal development reviews (PDRs) and provides a range of training to support this. As a result, 89% of respondents to the Staff Survey stated that they had received an appraisal/PDR in 2018 compared with 84% the previous year. The Trust also achieved the best score nationally on quality of appraisals.

The Trust will continue with both a Trust-wide and directorate level approach to its response to the survey results and actions will also be monitored at both levels.

A high impact, Trust-wide approach to tackle

Staff survey

Scores for each indicator together with that of the survey benchmarking group (combined acute and community trusts) are presented below.

	2018		2017	
	Trust score	National average	Trust score	National average
Response rate	41%	41%	36%	43%

	2018		2017		2016	
Themes	**Trust score**	**National average**	**Trust score**	**National average**	**Trust score**	**National average**
Equality, diversity and inclusion	8.7	9.2	8.9	9.2	9.0	9.3
Health and wellbeing	5.9	5.9	6.1	6.0	6.2	6.1
Immediate managers	6.9	6.8	6.9	6.8	7.0	6.8
Morale	6.2	6.2	No information available (new theme in 2018)			
Quality of appraisals	6.2	5.4	6.2	5.3	6.2	5.4
Quality of care	7.8	7.4	7.9	7.5	8.0	7.5
Safe environment – bullying and harassment	7.8	8.1	8.1	8.1	8.1	8.2
Safe environment – violence	9.6	9.5	9.5	9.5	9.6	9.5
Safety culture	7.1	6.7	7.2	6.7	7.2	6.7
Staff engagement	7.4	7.0	7.5	7.0	7.6	7.0

bullying and harassment and equality, diversity and inclusion has been initiated and the action plan will be closely monitored.

The Trust offers leadership and development courses at all levels, a range of staff benefits and specific initiatives such as 'Showing we care about you' and 'Showing we care by speaking up', which aim to create a positive culture where all staff feel valued and receive the support they need.

Speak up guardian

At Guy's and St Thomas' we are committed to creating a culture where everyone feels able and confident to speak up. The Trust's 'Showing we care by speaking up' initiative was established in 2015 to encourage all staff to speak up about concerns they may have about patient safety or the way the Trust is run. The initiative is led by the 'freedom to speak up' guardian, supported by a large network of 150 'speaking up' advocates across the Trust.

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

Guy's and St Thomas' scores higher than the national average in the NHS Staff Survey in relation to staff feeling safe and confident raising concerns about unsafe clinical practice which demonstrates a positive speaking up culture.

During 2018/19, 197 contacts were made through the speaking up services. The number of contacts and their nature are openly and transparently shared on a quarterly basis with the National Guardian's Office and published publicly on their website.

Staff group	Gender		
	Female	Male	Total
Employees	12,058	4,224	16,282
Executive directors	4	3	7
Other senior managers	209	127	336
Total	**12,271**	**4,354**	**16,625**

Number of staff employed on 31 March 2019.

Equality, diversity and inclusion

We are proud to serve diverse local communities in Lambeth, Southwark and Lewisham. This diversity is reflected in the profile of our patients and workforce, and brings many benefits.

The Trust remains committed to providing services and employment opportunities that are inclusive across all strands of equality; age, disability, gender, ethnicity, race, religion and belief, sexual orientation, gender reassignment and pregnancy and maternity – in accordance with the Equality Act 2010 and our public sector equality duties.

Our equality, diversity and inclusion objectives set out our priorities to drive improvements in patient care and staff experience which aim to reduce inequalities for our diverse workforce and patient population. The associate director of equality, diversity and inclusion is responsible for monitoring progress against these priorities and regularly reports on our performance.

The Trust has in place a comprehensive plan to ensure better and fairer outcomes in recruitment and progression, as well as ambitious targets to improve diversity in senior management, ensuring all staff have the opportunity to achieve their full potential. We recognise we have more to do in this respect, as shown by our staff survey results.

We are committed to supporting staff with disabilities, including anyone who becomes disabled during their employment. The Trust participates in the Department of Work and Pensions' Disability Confident scheme, which is designed to actively demonstrate how we recruit and retain people with disabilities, and we aim to achieve the top level in the scheme of 'Disability Confident Leader' this year.

The Trust leads and participates in a number of projects and initiatives to widen access to employment and retain our staff. These include:

- an award-winning apprentice recruitment programme and a specific programme to support apprentices with disabilities to gain placements
- unconscious bias training, provided for all new starters, recruiting managers and frontline staff
- a reverse mentoring programme, allowing staff to share personal equality and inclusion experiences with senior staff including the Chief Executive
- vibrant networks to support staff including: lesbian, gay, bisexual and transgender (LGBT+); black and Asian minority ethnic (BAME); disability; and dyslexia
- support for Black History Month and promotion of the legacy of Mary Seacole, to recognise and celebrate the diversity of our workforce
- roll out of the rainbow badge initiative, giving healthcare staff a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as LGBT+
- updated recruitment and HR processes to reduce bias by introducing diverse panels for all senior interviews, and a new screening procedure prior to disciplinary processes being initiated
- award-winning projects to support people with learning disabilities to gain access to employment
- a partnership with McKinsey and Thames Reach to support formerly homeless people to gain employment
- leading the London, Surrey and Kent 'Step into Health' programme which supports people from the armed forces to access employment opportunities in the NHS.

Safe working environment

This year, the health and safety team has continued to focus on initiatives to improve the health and safety culture and manage risk across the Trust. We have delivered regular workshops and training sessions for staff on risk assessment and we have developed our support for staff through newly appointed health, safety and wellbeing champions. These colleagues assist frontline staff, giving them the knowledge and

Staff sickness absence		
	2018/19	2017/18
Total days lost	115,908	106,139
Total staff years	14,860	14,021
Average working days lost (per WTE)*	**8**	**8**

*WTE = Whole Time Equivalent

The sickness absence figures are reported on a calendar basis, rather than the financial year. These statistics are published by NHS Digital, using data drawn for January 2018 to December 2018 from the ESR data warehouse. The latest publication, which covers up to December 2018, can be found on the NHS Digital website.

Employee costs (including executive directors)

	Permanently employed £000	Agency, bank and seconded staff £000	Year ended March 31 2019 Total £000	Year ended March 31 2018 Total £000
Salaries and wages	**665,220**	**62,634**	**727,854**	655,581
Social security costs	**72,160**	**3,726**	**75,886**	70,132
Apprenticeship levy	**3,260**	**234**	**3,494**	3,237
Pension cost: employer's contributions to NHS pensions	**79,391**	**2,194**	**81,585**	76,089
Termination benefits	**654**	**–**	**654**	342
Temporary staff – external bank	**–**	**6,943**	**6,943**	6,573
Temporary staff – agency & contract staff	**–**	**21,462**	**21,462**	28,762
Total gross staff costs	**820,685**	**97,193**	**917,878**	840,716
Included in above:				
Costs capitalised as part of assets	**(18,192)**	**(1,303)**	**(19,495)**	(13,736)
less income netted off in staff costs	**(6,143)**	**–**	**(6,143)**	(6,960)
Total staff costs	**796,350**	**95,890**	**892,240**	820,020
Analysed into operating expenditure				
Employee expenses – staff and executive directors	**795,193**	**95,890**	**891,083**	819,219
Redundancy	**654**	**–**	**654**	342
Internal audit costs	**503**	**–**	**503**	459
	796,350	**95,890**	**892,240**	820,020

confidence to tackle health and safety risks at a local level or to report or escalate concerns in an appropriate and timely manner.

The Trust has a number of committees in place to provide assurance from the health and safety manager to senior management that health and safety risks are being managed effectively. The health and safety committee, chaired by an executive director, meets regularly and provides an annual report to the Board. This year, the reinvigorated biological safety committee oversaw the work under the Genetically Modified Organisms (Contained Use) Regulations 2014 and a new fire safety committee was formed.

The team has continued to work with key stakeholders and staff representatives to mitigate the risks from the use of sharp instruments in healthcare. We are also implementing the new Trust psychological health and wellbeing policy.

During the year, we have worked closely with community staff to understand the risk of musculoskeletal injury and improve staff safety in moving and lifting patients.

The Trust plays a leading role nationally in the approach to respiratory protection, providing

qualitative and quantitative testing of the fitting of protective face masks for frontline staff. This year we hosted a half-day symposium on respiratory protection for colleagues from Shelford Group trusts, attended by representatives from the Health and Safety Executive.

Occupational health

Our occupational health service is focused on the safety, health and wellbeing of our staff, patients and visitors. As one of the largest occupational health services in the country, we employ a multidisciplinary team of doctors, nurses, safety specialists, researchers and administrative staff. The team serves around 70,000 people including Trust staff, as well as employees in local and national businesses.

Our services include work-related health checks, pre-commencement screening, and vaccination and immunisation programmes. We advise on reducing risks in the workplace and promoting best practice in relation to good systems of work.

We offer guidance to staff and managers on maintaining wellness in the workplace and preventing ill health. We also provide advice and information to managers on managing sickness absence and how to support staff to remain in or return to work including with adjustments if required.

We offer a wide range of opportunities to support staff through our award-winning '5 ways to a healthier you' programme. The programme offers opportunities for staff to self-refer to receive nutritional and weight loss advice and support through our staff dietetics services, as well as access to physiotherapy and smoking cessation services. Specialist referral services include cognitive behavioural therapy for mental wellbeing, and advice, information and counselling through our Employee Assistance Programme. The Trust supports many local and national health and wellbeing initiatives through roadshows, promotions and educational events.

We provide advice to staff and managers when dealing with distressing events, ranging from local issues to major incidents.

The Trust offers an annual flu vaccination programme to all staff. This service is led by the occupational health team and championed by our Chief Nurse, senior managers and peer vaccinators.

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 2018 until 31 March 2019.

Table 1: relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
84	79.63

Table 2: percentage of time spent on facility time

Percentage of employee time spent on facility time	Number of employees
0%	57
1%-50%	26
51%-99%	1
100%	0

Table 3: percentage of pay bill spent on facility time

Total cost of facility time	£138,609.83
Total pay bill	£917,878,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Table 4: paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours, calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	21.13%

Exit packages

Staff exit packages

In 2018/19, a total of 13 exit packages were agreed in the year, 12 of which were compulsory redundancies. The total cost of these exit packages was £455,000. Summary information for 2018/19 and comparative information for 2017/18 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	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18
<£10,000	4	4	0	0	4	4
£10,000 – £25,000	2	4	0	1	2	5
£25,001 – £50,000	4	2	0	0	4	2
£50,001 – £100,000	1	2	1	1	2	3
£100,001 – £150,000	1	1	0	0	1	1
£150,001 – £200,000	0	1	0	0	0	1
Total number of exit packages by type	**12**	**14**	**1**	**2**	**13**	**16**
Total resource cost £000	**377**	**589**	**78**	**98**	**455**	**687**

Exit packages: other (non-compulsory) departure payments

One individual received a non-compulsory departure payment in 2018/19, receiving two elements to the package. Comparative information for 2017/18 is provided in the table below.

	2018/19		2017/18	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	1	25	1	81
Exit payments following Employment Tribunals or court orders	1	53	1	17
Total	**2**	**78**	**2**	**98**

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

Countering fraud and corruption

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

Agency staff

The Trust has continued its focus on reducing the use of agency staff and remaining compliant with NHS Improvement's agency 'cap' which sets maximum pay levels for agency staff. We use robust procedures to monitor and report on agency spend and to reduce the number of breaches of the cap. Action plans are in place to continue to drive down costs while maintaining high standards of care. Where breaches do occur, they are mainly attributed to nationally recognised shortage occupation groups.

We have continued to make significant savings in agency expenditure this year and have plans to reduce this spend further. The Trust has been working closely with other trusts locally and across London to support the effective management of temporary staffing spend and compliance with pan London maximum bank rates. This collaboration ensures consistency of approach and supports us in managing the market rates for agency workers and reducing agency spend.

We continue to maintain a Trust-wide ban on agency staff at Bands 1-4, and have introduced

High paid off-payroll engagements

All off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months	
Number of existing engagements as of 31 March 2019	7
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	3
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	4

All new off-payroll engagements, or those that reached six months in duration, in 2018/19, for more than £245 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	0
Of which:	
number assessed as subject to IR35	0
number assessed as not subject to IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year end	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of Board members, and/or senior officials with significant financial responsibility in 2018/19	
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.	6

additional workforce controls to restrict the use of administrative and clerical agency staff.

Regular meetings take place with teams that have the highest agency expenditure, to support them in reducing costs.

Expenditure on consultancy

Expenditure on consultancy in 2018/19 was £2,994,000.

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 2018/19.

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 new rules. The number of contractors engaged as at 31 March 2019 is shown in the tables above where daily rates exceed £245 per day and the engagement has lasted longer than six months.

We are working to reduce our impact on the environment by installing free water refilling stations.

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

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

Council of Governors

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

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

The Council of Governors runs a membership engagement, development and involvement working group which facilitates governors' consultation with our members. The Trust responds to ad-hoc requests and encourages the public to attend our Annual Public Meeting in September.

The Council of Governors also runs a service strategy working group which is the main vehicle for the Trust to discuss plans with governors. There is also a quality and engagement working group which is a forum for the Trust and governors to discuss patient engagement, quality improvement and safety matters. Governors are also involved in discussions about elements of the Trust's strategy when these are considered at meetings of the Trust Board and Council of Governors.

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

Elections to vacancies in the patient, public and staff clinician constituencies took place in 2018.

In addition, some of the organisations we work most closely with nominate stakeholder governors, and two new stakeholder governors were appointed in 2018.

The constitution currently requires us to have 31 governors. During 2018/19, one governor received expenses totalling £920.48. See page 53 for the full list of governors.

Code of Governance

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

Nominations Committee

Members of the Nominations Committee*

Name	Role
Heather Byron	Patient governor
John Chambers	Staff governor
Annabel Fiddian-Green	(Public governor) (from July 2018)
Tom Hoffman	Public governor (until June 2018)
Hugh Taylor	Chairman
Warren Turner	Stakeholder governor

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

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 its Nominations Committee recommendations to offer Steve Weiner a second term of four years as a non-executive director of the Trust, and, exceptionally, to invite the Chairman to serve a further two years beyond the end of his second term of office due to end in February 2019. This appointment will be subject to review by both parties in January 2020.

Our membership

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

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

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

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

We have 25,655 members, of whom 3,786 are patient members, 5,690 are public members and 16,179 are staff members.

Members receive regular mailings and are invited to our Annual Public Meeting, public meetings of the Board of Directors and Council of Governors and events such as our regular health seminars.

This year, the Council of Governors' membership engagement, development and involvement working group, has continued to implement the membership strategy as part of the Trust's effort to develop a membership that reflects the communities it serves.

Board of Directors

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

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

Membership is balanced, complete and appropriate. The Trust is confident that all of the non-executive directors are independent in character and there are no relationships or circumstances which are likely to affect, or could appear to affect, their judgement. We therefore have not appointed a senior independent director.

Following a review of Board performance undertaken by Praesta Partners in 2018, the Board has reviewed its operations and is introducing a refreshed suite of committees to support its work. This coincides with the establishment of a second strategic business unit (SBU), building on the success of the Evelina London SBU. The Integrated Care SBU brings together adult community, acute medicine and therapy services and provides opportunities to focus on new ways of working, including with our partners in Lambeth and Southwark, to improve care for local patients.

From 1 April 2019 the Board's committees will be:

Quality and Performance – which will monitor in-year performance across access and financial targets alongside the Trust's commitment to provide safe, high quality care to all our patients. It will also oversee the creation of the annual business plan.

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

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

Cancer Services – which will remain in place for the time

Council of Governors – Nominated lead governor: Devon Allison

Trust Board Directors attended every Council of Governors meeting.

Patient governors	Elected from	Actual/possible attendance
Devon Allison (lead governor)	July 2016	4/4
Heather Byron	July 2016	4/4
Jonathan Farley	July 2018	4/4
Williams Moses	July 2018	2/3
Placida Ojinnaka	July 2018	2/3
Giuseppe Sollazzo	Oct 2017	2/4
Mary Stirling	July 2018	2/3
Yu Tan	July 2018	3/3

Public governors	Elected from	Actual/possible attendance
Elaine Burns	July 2018	1/1
Marcia Da Costa	July 2018	3/3
Annabel Fiddian-Green	July 2018	3/3
Margaret McEvoy	July 2018	3/3
John Porter	July 2016	0/4
Samantha Quaye	July 2018	3/3
Jenny Stiles	July 2016	3/4
Peter Yeh	July 2018	1/3

Staff governors	Constituency	Elected from	Actual/possible attendance
Tahzeeb Bhagat	Clinical	July 2018	3/3
John Chambers	Clinical	July 2015	3/4
Tony Hulse	Clinical	July 2015	3/4
Anita Macro	Community	September 2017	1/4
Vicky Rogers	Non-clinical	July 2016	2/4
Bryn Williams	Non-clinical	July 2016	1/4

Stakeholder governors	Organisation	Appointed from	Actual/possible attendance
John Balazs	Lambeth CCG	December 2015	1/4
Robert Davidson	Southwark CCG	December 2015	1/4
Jacqui Dyer	Lambeth Council	June 2018	1/3
Jane Fryer	NHS England	October 2015	0/4
Alice Macdonald	Southwark Council	July 2018	0/3
Matthew Patrick	South London and Maudsley NHS Foundation Trust	November 2013	0/4
Lucilla Poston	King's College London	January 2017	1/4
Sue Slipman	King's College Hospital	January 2017	1/4
Warren Turner	London South Bank University	September 2014	2/4

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

Trust Secretary and Head of Corporate Affairs
4th Floor, Gassiot House
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH

Tel: 020 7188 7346

Board meeting attendance April 2018 – March 2019		
Name	Title	Actual/possible
Ian Abbs	Chief Medical Officer, Director of Patient Safety and Deputy Chief Executive	9/12
Eileen Sills	Chief Nurse, Director of Patient Experience and Infection Control, and Deputy Chief Executive	6/12
Jon Findlay	Chief Operating Officer	11/12
Felicity Harvey	Non-executive director	9/12
Girda Niles	Non-executive director	11/12
John Pelly	Non-executive director	12/12
Amanda Pritchard	Chief Executive and Chief Accountable Officer	12/12
Reza Razavi	Non-executive director	10/12
Julie Screaton	Chief People Officer	12/12
Martin Shaw	Chief Financial Officer	11/12
Sheila Shribman	Non-executive director	10/12
Priya Singh	Non-executive director	12/12
Hugh Taylor	Non-executive director	12/12
Steve Weiner	Non-executive director	10/12

Committee	Membership April 2018 – March 2019
Adult Local Services (closed March 2019. Replaced by Integrated Care Management Board from April 2019)	Girda Niles (Chair), Jon Findlay, Felicity Harvey, Amanda Pritchard, Martin Shaw, Julie Screaton, Eileen Sills, Hugh Taylor
Audit	Steve Weiner (Chair), John Pelly (Chair from February 2019), Girda Niles, Priya Singh
Cancer Services	Hugh Taylor (Chair), Ian Abbs, Jon Findlay, Felicity Harvey, Amanda Pritchard, Reza Razavi, Sheila Shribman, Eileen Sills
Corporate Management (up to December 2018)	Hugh Taylor (Chair), all Board members
Digital (up to December 2018)	David Perry (Chair, non-executive director adviser), Ian Abbs, Jon Findlay, Felicity Harvey, Amanda Pritchard, Eileen Sills, Priya Singh, Hugh Taylor, Steve Weiner
Quality and Performance	Priya Singh (Chair), all Board members
Remuneration	Hugh Taylor (Chair), all other non-executive directors
Evelina London Board	Sheila Shribman (Chair), Amanda Pritchard, Steve Weiner
Strategy and Partnerships (from February 2019)	Hugh Taylor (Chair), all Board members
Transformation and Major Programmes (from February 2019)	Steve Weiner (Chair), Ian Abbs, Martin Shaw, Hugh Taylor

being, continuing with its current remit of overseeing the strategic development of cancer services across the Trust and local network, and monitoring network operational performance.

Audit and Risk – which will review the establishment and maintenance of 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.

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

The membership of the Remuneration and Audit and Risk Committees is limited to non-executive directors. The Council of Governors will be invited to send two members to observe the work of the Quality and Performance, Transformation and Major Programmes and Cancer Services Committees.

The Chairman evaluates through appraisal all non-executive directors and the governors' Nominations Committee commissions an external evaluation of the Chairman's performance.

The Council of Governors appoints the non-executive directors in accordance with the Trust's constitution, which allows them to serve two four-year terms, extendable in certain circumstances by a further two years. The appointment, renewal and termination of a non-executive director is handled by the Council of Governors in a general meeting, advised by their Nominations Committee.

In September 2018, around 150 people attended our Annual Public Meeting, where members, local people, patients, staff and other stakeholders heard about how we have performed during the year; had an opportunity to meet and ask questions of the Board of Directors and governors; watched a film about our staff to celebrate the NHS 70th birthday; and heard presentations about our clinical services.

Details of external directorships or other positions of authority held by the directors of the Trust can be found in Note 31 to the Annual Accounts.

Audit Committee

Audit Committee membership and attendance 2018/19	
Name	Actual/possible
Steve Weiner (Chair)	4/4
John Pelly	4/4
Priya Singh	4/4

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

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 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. It also reviewed and revised its terms of reference.

At its meetings in May 2018 the committee reviewed the draft Annual Report and Accounts, including the quality accounts, and approved their submission to the auditors before being lodged in the library of the House of Commons. During the year, the committee also reviewed the Trust's Board Assurance Framework and Risk

Register, including those submitted to NHS Improvement, and received reports on a number of topics including information governance, use of interims and consultants, internal audit and counter fraud performance. External auditors attended the committee regularly, providing an opportunity for the committee to assess their effectiveness.

Grant Thornton UK were external auditors to the Trust and their appointment will be reviewed in 2019/20.

Remuneration Committee

Remuneration Committee membership and attendance 2018/19

Name	Actual/possible
Hugh Taylor (Chair)	3/3
Felicity Harvey	3/3
Girda Niles	3/3
John Pelly	3/3
Reza Razavi	2/3
Sheila Shribman	2/3
Priya Singh	3/3
Steve Weiner	3/3

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.

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. The Board meeting is followed immediately by a meeting of the Council of Governors. This second meeting, attended by members of the Board, opens with a session reflecting on the business discussed and agreed by the Board.

Members of the Council of Governors attend Quality and Performance and Transformation and Major Programmes Committee meetings as participating observers. These governors then report back to their colleagues using the three working groups they run.

Members of the Board attend meetings of the Council of Governors' working groups. In addition, they hold 'accountability sessions' twice a year for the governors to discuss a range of topics with the Board.

Governors are invited to meet other members at a series of health seminars run by the Trust through the year, as well as 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 Management Executive

The membership of the Trust Management Executive (TME) brings together executive board directors, Trust directors, clinical directors and other senior managers. This year, as part of the Trust's wider governance review, we have reviewed the Trust Management Executive, the most senior executive group below the Board, reinforcing its clinical leadership and establishing a number of supporting committees with specific responsibility for delivery of our objectives. Its role remains to:

- scrutinise draft plans and policies which would have implications across the Trust or for several parts of the Trust
- scrutinise reports on operational performance such as those on quality or risk
- scrutinise major investment proposals of over £1 million
- agree Trust-wide policies
- develop strategic plans and proposals for consideration by the executive team and the Trust Board
- consider matters where the support of clinical and managerial leaders is of critical importance
- consider matters which are of concern to a majority of the group.

The Trust Management Executive has established a number of committees to enable it to discharge its functions more effectively. These are led by senior, Board-level directors. Part of their remit is to receive reports from and monitor the work of a range of Trust committees. The committees report regularly to TME.

TME's committees are:

Trust Operations Board – receives reports from the following committees: Financial Operations; St Thomas' site; Guy's site; Cancer Action Board; A&E Action Board; Elective Action Board; Joint Pathology Board; and Trust Risk and Assurance.

Strategy and Partnerships Oversight Group – receives reports from other strategic committees and from all major strategic programmes.

Developing Our People Committee – receives reports from the following committees: Workforce Council; Education Council; Education Strategy Group; Employee Health and Wellbeing Group; Strategic Leadership Development Group; and Freedom to Speak Up Guardian.

Research and Development Committee – receives reports from the following committees: Biomedical Research Centre Executive; Clinical Research Facility Review Board; R&D Leads; Research and Governance Risk; Local Clinical Research Network Partnership Board; KHP Clinical Trials Operations Board; and KHP Clinical Trials Office.

Estates Committee – receives reports from the following committees: Estates Development Programme Board, CVIN/RBH Estates Matters; and Evelina London Children's Hospital Expansion Matters.

Strategic Finance Committee – receives reports from the following committee: Investment Portfolio Board.

Commercial Committee – receives reports covering all commercial projects and activities.

Transformation Improvement and Digital Committee – receives reports from the following committees: programme governance relating to the major improvement programmes including those directly and indirectly related to the current transformation and digital programmes.

Board of Directors – non-executive directors

Sir Hugh Taylor
Chairman

Hugh was appointed as Chairman of Guy's and St Thomas' in February 2011. He had a long and distinguished career in the civil service which included senior roles in the Department of Health and NHS Executive, the Cabinet Office and the Home Office.

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

Hugh chairs the Cancer Services, Strategy and Partnerships and Remuneration Committees as well as the Board. He is a resident of Southwark.

He was appointed interim Chair of King's College Hospital NHS Foundation Trust on 1 March 2019.

Dr Felicity Harvey CBE
Non-executive director

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

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

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

Felicity joined the Board in September 2016.

Girda Niles
Non-executive director

Girda is a local social business coach specialising in strategy for social businesses and those who want to make a social difference. She has extensive strategic experience in the community and voluntary sectors, social enterprise, financial management and training. Through her previous role as a non-executive director of Lambeth Primary Care Trust, she has a thorough understanding of how health and social care systems work.

Girda joined the Board in January 2012 and chaired the Adult Local Services Committee until March 2019. She now chairs the Integrated Care Board.

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 Guy's and St Thomas' NHS Trust until he took up the position of Chief Executive of Queen Elizabeth Hospital NHS Trust in south London.

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

John joined the Board in January 2017 and chairs the Audit and Risk Committee.

Professor Reza Razavi
Non-executive director

Reza is Vice President and Vice-Principal of Research at King's College London (KCL), and also Director of Research at King's Health Partners. He is 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 within the UK. Reza is also a children's cardiologist at Evelina London Children's Hospital.

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

Reza joined the Board in 2016.

Dr Sheila Shribman CBE
Non-executive director and Vice-Chair

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

She was a consultant paediatrician for more than 25 years and was Medical Director of Northampton General Hospital for 11 years where she led the successful integration of children's hospital, community and mental health services, working closely with the local authority.

Sheila joined the Board in June 2013 and chairs the Evelina London Board.

Dr Priya Singh
Non-executive director

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

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

Priya joined the Board in November 2015 and chairs the Quality and Performance Committee.

Steve Weiner
Non-executive director

Steve lives locally in Southwark. He has spent most of his career in finance with international consumer goods group, Unilever. He 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 multicultural teams.

Steve joined the Board in July 2014 and chaired the Audit Committee until the end of 2018. He chairs the Transformation and Major Programme Committee.

Board of Directors – executive directors

Amanda Pritchard
Chief Executive and Chief Accountable Officer

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

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

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

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

Dr Ian Abbs
Chief Medical Officer, Director of Patient Safety, and Deputy Chief Executive

Ian became Medical Director in January 2011 and Chief Medical Officer in January 2017. He joined the Trust as a consultant renal physician and honorary senior lecturer at King's College London in 1994 and has had a distinguished clinical and academic career, which has included a broad range of senior management positions.

In addition to his clinical work, Ian has played a key role in the development of the Trust's life science partnerships, and is responsible for many aspects of the Trust's significant digital transformation agenda.

Jon Findlay
Chief Operating Officer

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 across the two hospital sites.

He has many years' experience working in director level in roles that have spanned 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. Her role included providing support to eight Sustainability and Transformation Plans.

Martin Shaw
Chief Financial Officer

Martin joined the NHS in 1981. He joined West Lambeth Health Authority in 1983, where he held a variety of posts and was Deputy Director of Finance until 1993 when he joined Guy's and St Thomas' as Business and Financial Planning Manager, before becoming Strategy Director and Projects Director. He was appointed Finance Director of the Trust in 1998 and made Chief Financial Officer in 2017.

Dame Eileen Sills DBE
Chief Nurse, Director of Patient Experience and Infection Control, and Deputy Chief Executive

Eileen was appointed Chief Nurse in 2005. Having qualified as a registered nurse in 1983, Eileen has held a number of general management and senior nursing leadership posts in London. She was awarded a CBE in 2003 for services to nursing, and a DBE in January 2015.

Eileen holds two visiting professorships, at King's College London and London South Bank universities. She is also the Chair of the grant committee for the Burdett Trust for Nursing. Eileen has a national reputation for strong, visible, clinical leadership.

In 2018 we were rated above the national average in all six categories of the annual Patient-Led Assessment of the Care Environment (PLACE) programme.

8 Single oversight framework

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

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

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

Segmentation

NHS Improvement assigned a score of '1' to Guy's and St Thomas' NHS Foundation Trust for month 12, 2018/19 performance. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2018/19	2017/18
Financial sustainability	Capital service capacity	1	1
	Liquidity	1	1
Financial efficiency	Income and expenditure margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	1	1
Overall score		**1**	**1**

Agency spend

At the start of the financial year, NHS Improvement suggested that it would be appropriate for the Trust to spend no more than £27.4 million on agency staff. During the year (2018/19), the Trust spent £20.1 million on agency – 26% lower than the target.

We have ambitious plans to expand Evelina London Children's Hospital. Our current hospital building was opened in 2005, and since then, the number of children and young people we care for has more than doubled.

9 Statement of the Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Guy's and St Thomas' NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Guy's and St Thomas' NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Guy's and St Thomas' NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy, and
- prepare the financial statements on a going concern basis.

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 enable him/her to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Amanda Pritchard, Chief Executive and Accounting Officer

22 May 2019

Annual governance statement 2018/19

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the 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 2019 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Leadership of the risk process

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

The Trust Board Assurance Framework aligns with national guidance and reflects the high-level risks that are deemed the most significant through the year. The constitution of all Board committees has been reviewed, and new terms of reference approved, to ensure that our governance arrangements remain fit for purpose. The Board receives regular minutes and reports from each of these committees.

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 sound internal control. The policy aims to promote a positive culture towards the management of risk and provides clear, systematic approaches to ensure risk assessment is integral to all clinical, managerial and financial processes. The Chief Medical Officer carries responsibility for ensuring this policy is both implemented correctly and 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. 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 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.

Equipping staff to manage risk

Managers at all levels of the organisation have a responsibility to manage their local risks and to promote an environment where proactive risk reporting identifies perceived or real threats to patient safety. Each directorate maintains a risk register and key risks are escalated for inclusion in the corporate risk register, which is reviewed monthly.

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.

The Trust learns from good practice through a range of mechanisms including clinical supervision, reflective practice, peer review, effective performance management, continuing professional development, clinical audit and the application of evidence-based practice. Learning from investigations and root cause analyses feeds into relevant quality improvement initiatives, as well as Schwartz Rounds and our 'Safety Connections' campaign.

The risk and control framework

Risk management can be 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 corporate risk register.

A risk management matrix is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and the Trust's appetite for risk is set within the boundaries of this risk evaluation. The Trust seeks to reduce risks as far as possible, however it is recognised that delivering healthcare carries inherent risks that can never be completely eradicated. The workplan of the Board and its committees are aligned to assure that there is independent and strategic focus on risk and assurance.

A Serious Incident Assurance Panel, chaired by a non-executive director and attended by multiple internal and external stakeholders, meets monthly 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.

During 2018/19 we reviewed our governance arrangements to ensure they provide the necessary support to deliver our operational priorities, improvement plans and strategic ambitions. This includes refreshing our Board committee structure to ensure optimal assurance across each of these domains. The Trust Management Executive, the most senior executive group below the Board, has also been reviewed to reinforce the importance of clinical leadership and a number of supporting sub-committees with specific delivery portfolios have been established.

The Board Assurance Framework has been reviewed and refreshed over the past year and now incorporates four tiers of assurance. It highlights three areas where the Board has limited assurance (operational performance, digital infrastructure and the effects of a 'no-deal' Brexit) despite significant management attention. 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 oversight and assurance.

Controls and assurances include:

- our performance management framework, including performance dashboards and monthly integrated quality and 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 Patient Experience Committee (including learning from deaths, emergency preparedness and data security)
- risk assessments and analysis of risk registers and Board Assurance Framework.
- reports from the Quality and Performance Committee and the Audit Committee to the Board and quarterly reports to the Council of Governors

- 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, NHS Improvement, the NHS Litigation Authority and Patient-Led Assessments of the Care Environment (PLACE)
- external regulatory and assessment body inspections and reviews including Royal Colleges, Postgraduate Deanery and Health and Safety Executive (HSE) reports
- self-assessment against the compliance framework and CQC registration requirements
- quality walkabouts, 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).

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

Quality governance arrangements

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

Quality is deeply embedded in the Trust's overall strategy. Our refreshed organisational strategy 'Together we care' was developed in liaison with staff, governors and wider partners and approved by the Board in July 2018. The strategy reinforces the central importance of the Trust's values and has three overarching priorities: Patients, People and Partnerships. Work on delivery is managed and monitored under a 'Strategy into action' programme. In addition, the Trust's new quality strategy focuses on delivering safe, effective care that provides a positive patient experience. In the staff survey, the vast majority of our staff said that their role had a direct impact on patient experience and that we have a strong safety culture.

The Board actively engages in quality of care with patients, the public, staff and other relevant stakeholders through a number of different mechanisms and forums.

The Trust's quality report includes national and local priorities with measurable quality improvement targets and deadlines. Quality targets are linked to directorates and included in local business plans, with performance reported quarterly to the Quality and Performance Committee and ultimately the Board. The Board receives the monthly integrated quality and performance report (IQPR), with up-to-date information on key quality indicators including patient safety, patient experience and clinical effectiveness.

The Trust's Scheme of Delegation details decisions reserved for the Board and the responsibilities and accountabilities of its committees.

Evelina London is a strategic business unit (SBU), incorporating three clinical directorates, which allows it to operate with an increased level of autonomy. An additional SBU, Integrated Care, was established in April 2019 to bring enhanced leadership capacity and capability to one of our strategic priority areas.

Assessing the quality of performance information

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

There is a strong emphasis on the collection and reporting of waiting time data. Regular and transparent performance reporting to both internal and external audiences acts as an additional assurance check on data quality. For 2018/19, two of the waiting time performance measures (A&E and Cancer 62 day standard) will be reviewed by the Trust's external auditors, as part of the limited assurance opinion they provide for the quality report.

Assurance on compliance with the Health and Social Care Act 2008

The Trust is fully compliant with the registration requirements of the CQC. A range of mechanisms are in place to provide assurance of compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, as set out in the CQC's guidance for providers. These include a well-established programme of multidisciplinary quality visits to services, peer-to-peer reviews, a ward accreditation scheme and reality rounds.

In March 2018, the CQC made an unannounced inspection to one of the Trust's dialysis units following receipt of a patient complaint. The findings required a series of mitigating actions to be implemented and completed within timeframes agreed with the CQC, NHS Improvement and local commissioners.

Managing risks to data security

All standards of the 2018/19 Data Security and Protection Toolkit were met.

All staff receive information governance training as part of corporate induction on joining the Trust. Training requirements are supported by comprehensive policies and guidance to ensure access to up-to-date information.

An information asset owner (IAO), with responsibility for managing information risks, is named for each department 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.

Information governance

All information incidents and near misses are investigated and used as opportunities to improve processes and reduce risks. An information governance awareness campaign was launched in January 2019, focusing on the safe processing of personal data.

In 2018/19, two incidents were reported to the Information Commissioner's Office (ICO) and CQC. The first related to the disclosure of patient email addresses in a mailing list. An apology was provided to affected patients and a process review was undertaken within the relevant department. No action was taken by the ICO due, in part, to the actions taken by the Trust.

The second incident related to the inappropriate disclosure of a patient's letters to another patient. An apology was issued and the ICO's conclusions on the matter are awaited.

Major in-year risks 2018/19

The key risks to delivery of the Trust's objectives are recorded in detail in the Board Assurance Framework and monitored quarterly by the Board or its committees acting on its behalf. In 2018/19 the key risks with potential impact on achieving our objectives were:

- **Operational performance:** we identified a risk of deterioration in our position in relation to key national standards due to rising demand, constrained capacity and process issues.

  Cancer: performance against cancer waiting time targets has been variable. We worked hard to meet the 85% standard of referral to treatment within 62 days for patients with suspected cancer but were not able to achieve it, largely due to a significant rise in two-week wait referrals (average 1,400 to 2,300 per month). Additional capacity was commissioned in year where possible; eg across diagnostic modalities, but there was insufficient opportunity to increase capacity elsewhere to the level required, especially within specialist services. As a consequence, the Trust took the difficult decision to implement out-of-area referral restrictions across tumour groups where services could be provided by alternative local providers. The Trust continued to work closely with the south east London sector, providing senior operational support to improve shared pathways with neighbouring trusts and collaborating with south east London colleagues through our Accountable Cancer

Network (ACN) to improve the timeliness and quality of inter-trust transfers (ITT).

Urology and thoracic services have made significant pathway improvements and ENT has developed a very successful 'One stop' ambulatory model. Within imaging, PET, CT, and MRI have all reduced waiting times and maintained strong operational performance.

Of note, our compliance with the 62 day standard for patients starting their pathway at the Trust improved significantly during 2018 despite the growth in demand.

Accident and emergency: performance against the 4 hour standard continued to present a significant challenge. Activity in 2018/19 increased by 11%, equating to an average of an additional 50 patients attending each day. Acuity was also higher, with 9.1% more activity in majors and resus.

A considerable amount of work has been undertaken to keep pace with demand and ensure that patients receive safe care in a timely manner. Ambulance handover times have improved and we have avoided any breaches of the 12 hour wait target. We have changed a number of operational processes across the emergency floor and altered staffing to match acuity (including the appointment of five physician associates). Our critical care outreach team provides a rapid 24 hour response for deteriorating patients and 11 additional critical care beds have been opened.

We have worked with our commissioners on admissions avoidance, with several ambulatory and redirection pathways established to facilitate admission avoidance, including during evenings and at weekends.

In addition, the emergency department rebuild was completed, affording an opportunity to reconfigure the way we deliver services. For example, a redesigned ambulatory service now sees an average of 30 patients a day.

Referral to treatment: the Trust remained on target with the recovery trajectory for the first half of 2018/19, although a subsequent deterioration was driven by a significant increase in demand (up 18% and significantly above the 5% growth we had planned for). The Trust treated significantly more patients than in 2017/18, but was unable to deliver the additional activity required to meet the exceptional levels of demand that added approximately 9,000 patients to our waiting list during the year. The need for additional theatre capacity was a major issue, with plans to increase theatre capacity not materialising until 2019/20. Reducing the number of patients waiting over 52 weeks for treatment remains a key focus, but is proving challenging in some specialties.

Delayed appointments and lost to follow up: the Trust has identified a number of potential risks to patient care through delays to planned appointments and the potential for patients to be lost to follow up. These risks have been highlighted by a number of incidents. The Trust has worked to understand and take mitigating action for affected patients and improve the processes to manage future risk.

Considerable work has been completed and is ongoing. In all cases the work being undertaken, for example to address 'open referrals', will tackle data quality issues and improve follow up processes and workflow. Proactive measures have been put in place to address future risk and a new suite of KPI's have been introduced to ensure that the risk is mitigated and reduced appropriately. The Trust has created a robust improvement action plan which we are continuing to deliver in close collaboration with our lead CCG. There remains further work to do, mainly relating to concerns regarding the validation of data and until this is completed there remains potential risk within the system.

- **Governance and assurance systems:** ensuring our systems of governance are sufficiently robust to provide assurance on the delivery of high quality care. We continued to implement actions from our review of top level governance structures, establishing new Board and executive committees. We approved our five-year quality strategy, including ambitious quality goals with measurable objectives devolved to all levels of the organisation.
- **Workforce shortages:** the changing context within which we operate, organisational culture, and the potential for workforce shortages could all adversely impact on the availability of people and skills. A refreshed people strategy sets out how we will attract, retain and develop a diverse workforce and create a culture that promotes ongoing personal development and wellbeing.
- **Digital and technological maturity:** inability to invest and develop the digital and technological skills and infrastructure required to optimally support service delivery. An infrastructure portfolio was established setting out the projects and investments required to improve our maturity in this area over a three year period. Digital maturity and cyber security remain areas of concern and focus.
- **Brexit:** the risks of significant disruption to the supply of goods and services, in particular medicines and devices, as well as staff shortages in the event of a 'no-deal' Brexit. We have worked with local partners to mitigate risk within the South East London Sustainability and Transformation Partnership European Union Exit Planning Group.
- **Financial sustainability and income:** financial sustainability continues to be a challenge, but through robust financial controls and cost improvement plans we have ensured that we achieved our 2018/19 financial plan.
- **Research:** ensuring we have effective internal controls and work effectively with research partners to mitigate the risk of not delivering our research agenda. We have established the necessary structures and processes to comply with the research governance framework and achieve good recruitment into trials. The review of our Biomedical Research Centre's progress was positive.
- **Unplanned patient flows to the Trust:** the risk of financial or workforce instability in other healthcare providers creating an unplanned flow of patients that we are unable to treat in a timely manner. The Trust has worked in partnership with other providers and within the wider STP to address this, particularly with respect to cancer pathways (as outlined above).
- **Place-based care:** the Trust established an Integrated Care Strategic Business Unit (SBU) in April 2019 to mitigate the risk of poorly coordinated care across local patient pathways. The SBU brings 2,500 staff from adult community teams, therapies, acute medicine, specialist palliative care and discharge services together under a single operational structure to deliver more joined up care to our local population and to improve local partnership working. We are actively involved in 'Lambeth Together' and 'Partnership Southwark' and the establishment of the new SBU demonstrates the Trust's enthusiastic commitment to this agenda.
- **Leadership:** the Trust continues to develop its succession plan for its most senior managers, notably by appointing a C-suite of executives supported by a cadre of director-level colleagues. The Trust also established a number of talent programmes to target business critical roles and is now working on a more formal Talent and Succession Planning Strategy to coordinate these effectively. As part of the leadership development programme for 2019, we will provide a bespoke, high potential leadership programme for black and minority ethnic staff.
- **Commercial portfolio:** robust governance processes are required across our commercial portfolio to ensure alignment with both our strategic priorities and regulatory responsibilities. We have established an executive-led Commercial Committee with appropriate membership and Terms of Reference to further strengthen assurance in this area of the Trust's business.

Major risks 2019/20

As with all NHS organisations, we face continual challenges in balancing the delivery of high quality care with rising demand, rising acuity and the need to increase both productivity and efficiency. We recognise that strategic and transformational change internally and across our local health economy will be required to address any risks that we identify. The principal strategic risks for the organisation in 2019/20 remain the same as for 2018/19, but we have identified additional risks as follows:

- the breadth and complexity of the Trust's strategic agenda, including an increasing number of strategic partnerships, destabilise delivery of quality, finance and performance
- insufficient investment in the digital and technological infrastructure to support operational delivery and realise the benefits of the Trust's digital strategy to meet future medical advances, patient expectations, cyber security and data protection requirements
- changes in national policy, legislation and leaving the European Union with, or without, a deal negatively impact on the Trust's strategy, partnerships, investments and commercial activities
- the Trust is 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's commercial strategy fails to deliver the opportunities of a wide portfolio
- the Trust is unable to maximise the opportunities arising from research and life sciences, and does not have a robust data strategy to protect its commercial interests.

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 Committee.

The Board commissioned two reviews in 2018/19. Firstly, a comprehensive review from Praesta to address the question *'Does the Board do the right work, on the right agenda, with the right information and the right people operating the right culture?'* The second review by DCO Partners focused specifically on 'well-led' aspects of governance.

Praesta concluded that the Trust remained a consistently high-performing organisation with a unitary Board that was highly constructive and collegiate. Its role in the wider local health economy had increased the scope of the Board's work substantially, so its content and nature had necessarily changed over time. The degree of commitment demonstrated by directors was outstanding. The successful transition to a new CEO and the more recent structural moves towards a group and delegated structure were noted. The review encouraged the Board to strengthen both its formal and informal networks and to increase its visibility in the Trust. It also suggested that it gave more attention to horizon scanning, especially in terms of how new operating models, external benchmarking and collaborative relationships could affect strategy.

DCO Partners also concluded that the Trust was served by a high performing Board and that local stakeholders acknowledged its role as a system leader. It recommended ensuring that messages to staff and governors on vision, strategy and culture were always simple and clearly understood. It also highlighted the need to be open about any risks emerging from the Chairman's appointment as interim chair at King's College Hospital NHS Foundation Trust. The review encouraged the Trust to be confident about what it was good at, while being cognisant of weaknesses – including those inherent in the size and complexity of the organisation, such as the ability to maintain a consistent focus on the basics of high quality care.

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.

- Training is given to all staff at induction, including junior doctors, newly-appointed consultants and newly-qualified nurses/midwives.
- The electronic incident reporting system gives automatic feedback when an incident is investigated.
- 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 2018/19, the Trust has continued to demonstrate a healthy incident reporting culture and has seen a continued rise in incidents reported compared with the previous year. The majority of incidents reported are of no, or low, harm. The Trust's commissioners have praised improvements in processes, structures and outcomes for the management of serious incidents, including the timeliness and quality of reports.

In 2018/19, the Trust reported nine 'never events' and a 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. For example, a theme was identified around inconsistent follow up of diagnostic tests, causing the medical director to commission a programme of work to better describe the risk and establish mitigations in advance of a longer-term solution through an integrated electronic health record system.

Equality, diversity and inclusion

Control measures are in place to ensure that all obligations under equality, diversity and human rights legislation are complied with in line with the requirements of the Public Sector Equality Duties under the Equality Act 2010. We recognise that we need to do more to address equality, diversity and inclusion issues and we have agreed an extensive work plan, including the ongoing promotion of a Trust-wide conversation, equality objectives for senior managers, a reverse mentoring programme (all executive directors are involved as mentees) and enhanced recruitment processes to reduce unconscious bias. In addition, all relevant Trust policies are subject to an equality impact assessment monitored at the Trust Joint Policy Forum.

The Trust publishes data from the Workforce Race Equality Standard (WRES) annually and analysis is undertaken to inform local and Trust-wide improvement plans in collaboration with our BAME staff network and staff side colleagues. The Trust uses disclosures on protected characteristics to improve staff engagement and experience, while ensuring opportunities are equitable, including in relation to gender pay (sections 2 and 6 of the Annual Report).

The accessibility steering group ensures that the Trust is meeting the information and physical accessibility needs of patients and carers who are vulnerable or have physical and sensory disabilities, and that we are compliant with the Accessible Information Standard.

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 and consultation process ensures compliance with relevant legislation, and is described in Putting Patients First: A Policy for Involvement and Consultation. All departments, both clinical and non-clinical, are responsible for planning and undertaking patient and public involvement initiatives.

The Trust serves a diverse and dispersed community, which straddles a number of boundaries. Given these complexities, there is a strong

desire to work closely with the local community to provide coherent and effective services.

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

- Guy's and St Thomas' NHS Foundation Trust has approximately 25,000 members as at the end of March 2019. These are represented by a Council of Governors that comprises public, staff and stakeholder governors
- the Council of Governors receives regular updates on the status of the Board objectives and uses this, along with the ratings by NHSI and the CQC, to hold the non-executive directors to account for the performance of the Board
- consultation with the public is undertaken in developing new services and where key changes are proposed to existing services which may impact upon them
- the Council of Governors is informed of proposed changes, including how potential risk to patients will be minimised, through its relevant working groups
- the Trust has an agreed process to advise and engage with Southwark and Lambeth Overview and Scrutiny Sub-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 in Lambeth and Southwark.

Compliance with developing workforce safeguards recommendations

The Trust undertakes annual workforce planning as part of its business planning cycle to ensure triangulation with predicted activity levels and finance plans. Directorate-level plans are aggregated to form an overall Trust plan with strategies and business cases to close potential workforce shortfalls considered through the relevant committees.

Workforce metrics are monitored regularly to ensure safe staffing levels. Local and Trust-wide strategies are in place to support recruitment and retention of staff as well as reduce our reliance on agency staff. Longer-term workforce planning includes 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 organisational training and development is provided both at corporate and local induction. Ongoing training requirements are monitored through annual appraisal and revalidation, performance development review (PDR) and monthly statutory and mandatory training reports.

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

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

Compliance statements

The Trust has published an up-to-date register of interests for decision-making staff, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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 and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that it complies with its obligations under the Climate Change Act and adaptation reporting requirements.

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 through the Fit for the Future programme.

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

The emphasis of internal audit work is on governance and internal control processes. Where scope for improvement is identified during an internal audit review, appropriate recommendations are made for operational implementation.

Annual quality report

Quality report approach and information assurance

The directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended) to prepare quality accounts for each financial year.

NHSI has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporates the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. The annual quality report 2018/19 has been developed in line with relevant national guidance.

As in previous years the report sets out the priorities for the coming year which include patient safety, patient experience and clinical effectiveness indicators. The data owner for each indicator submits the required data to the quality team.

The Trust has a Quality and Performance Committee where all data and information within the quality report is reviewed. The Chief Medical Officer is the nominated Trust executive responsible for the quality report, which has been reviewed through both internal and external audit processes. Comments on the report are sought from local stakeholders, including commissioners, patient representatives, Overview and Scrutiny Committees and the Council of Governors.

For the annual quality report, the Trust employs the same information assurance processes as are used in the production of the monthly integrated quality and performance report (IQPR). To this extent, the annual quality report is an extension of our monthly reporting process. The IQPR is published as part of the Board papers and accessible

performance information is provided through 'Our quality story', both of which appear on the Trust's website.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Performance Committee, and plans to address weaknesses and ensure continuous improvement of the system are in place.

Processes for maintaining and reviewing the system of internal control

The Board

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 IQPR, which covers key national priority and regulatory indicators, including CQUIN targets, with additional sections devoted to safety, clinical effectiveness and patient experience. The report is supplemented by more detailed briefings on areas of adverse performance. The IQPR is supported by more granular reports reviewed by Board committees, regular executive review meetings, and performance review meetings between the Chief Operating Officer and the clinical directorates.

Audit Committee

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

Internal audit

Internal audit works to a risk-based audit plan, agreed by the Audit 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 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 staff during 2018/19, including audits undertaken during the year which related to the previous year's plan. I have also considered reactive and proactive work conducted by the Trust's counter fraud team. I have had oversight of all internal audit reports, fraud investigations and personally conducted a number of specific projects during the year.

During the year the Trust has been subject to a significant internal fraud with an estimated value of £216,000 for which a provision has been made within the accounts. Due to the internal involvement and their knowledge of the system, the normal controls which are in place were not, initially, effective. Once identified, management responded quickly and controls have been reviewed and strengthened. I am satisfied that management responded appropriately and acted quickly to identify the issue and remedy the control weaknesses.

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 and the specific fraud mentioned above, the controls in those areas reviewed are adequate and effective. Where weaknesses have been identified these are being addressed by management and actions have been confirmed through follow up work by internal audit."

Clinical audit

The Trust's newly established Quality Improvement and Clinical Audit Committee (TQIaCAC) reports to the Trust Management Executive and the Quality and Performance Committee. TQIaCAC approves and monitors the annual quality improvement and clinical audit programme and ensures that the Trust participates in all appropriate national audits. The annual quality report includes detailed information about the Trust's participation in national clinical audits.

Quality and Performance Committee and Trust Risk and Assurance Committee

The Quality and Performance Committee is a sub-committee of the Board and provides assurance through monitoring and reviewing the overall quality, safety and performance of services against national standards.

The Trust Risk and Assurance Committee reports to the Trust Management Executive, 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 guidelines.

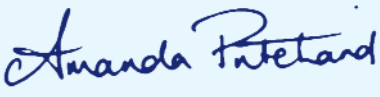
Conclusion

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.

In considering any significant internal control issues the following issue was recognised:

The Trust has identified a number of potential risks to patient care through delays to planned appointments and potential lost to follow up. While the Trust has created a robust improvement action plan, there remains further work to do, and until this is completed there is a known risk inherent within the system.

In relation to the fraud issue identified in the head of internal audit's opinion, controls have been strengthened through increasing awareness among staff of the internal fraud risk and the risk of payment diversion through email. Further processes have been put in place regarding bank account verification.



Amanda Pritchard
Chief Executive
22 May 2019

90% of our patients rated the quality of care they receive at Guy's and St Thomas' as 7 out of 10 or higher in the Care Quality Commission's annual adult inpatient survey.

10 Quality report

Statement on quality from the Chief Executive 2018/19

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

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

- 90% of our patients rated the quality of care they receive at Guy's and St Thomas' as 7 out of 10 or higher in the Care Quality Commission's adult inpatient survey
- we achieved the highest engagement score, for the fourth consecutive year, of all 'combined acute and community trusts' in the 2018 NHS Staff Survey. While we are not complacent, and are working to address areas where we need to improve, we are proud of this because we know that an engaged workforce has a positive impact on the quality of patient care
- we continue to have one of the lowest mortality rates in the NHS, a strong indicator of our relentless focus on quality and safety
- more patients are involved in clinical research at Guy's and St Thomas' than any other NHS trust in London – an important achievement as investment in research leads to better treatments and improves the quality of patient care
- we were rated above the national average in all categories of the annual Patient-Led Assessments of the Care Environment. Our results also showed that we had improved in five out of six scores compared with last year.

This year we published our new quality strategy, which sets out our ambitious quality improvement plans for the next five years. The strategy identifies four key quality themes – improving experience, preventing harm, reducing variation and continuous improvement – which are supported by 15 quality goals. Our aim is to deliver a culture of continuous and consistent improvement across our whole organisation.

Our staff are committed to providing safe, high quality care to our patients. Key to this is ensuring that we have a positive and supportive reporting culture and we learn and share lessons from serious incidents, never events and near misses.

This year we launched Quality Matters, a newsletter sent to all staff, which supports the sharing of best practice and lessons learnt across the Trust. Alongside this, we've introduced a new 'Learning from excellence' system for reporting and sharing excellent practice as well as recognising good work. We also developed a set of 'Fundamentals of care' standards which describe the quality of care that our patients can expect to receive as outpatients, inpatients and when cared for by us in the community, including in their own homes.

We encourage all our staff to 'speak up' if they have concerns about patient safety or the quality of care we provide and have a network of 150 'speak up advocates', a confidential email address and external phone line.

We also publish regular updates on our performance on the Trust's website in 'Our quality story'.

We recognise we don't always get things right and this year, we have significantly improved the speed with which we respond to complaints, ensuring that patients' concerns are addressed more quickly.

Our Chief Nurse, Eileen Sills, leads 'Safe in our hands', a forum where quality and performance issues are discussed and debated by staff in a 'no blame' environment.

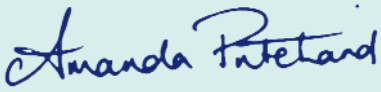
In addition, the executive team comes together to lead monthly face-to-face team briefing sessions open to all staff, and we all participate in regular executive director 'out and about' visits to various areas of the Trust to listen to staff.

In March and April Guy's and St Thomas' was inspected by the Care Quality Commission. The CQC team spent time in our hospitals and community services talking to staff, patients and their families and carers.

Right across the organisation, staff worked extremely hard to ensure that the CQC had a genuine opportunity to find out about the things we are most proud of as well as the things that we could do better.

We expect to know the results of the inspection later this year.

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



Amanda Pritchard
Chief Executive
22 May 2019

Our quality priorities for 2019/20

We aim to provide world-class clinical care, education and research that improves the health of the local community and of the wider populations that we serve. This ambition is reflected in our strategic objectives and is underpinned by our quality strategy and quality goals.

In February 2019 we published our five-year quality strategy which will help us to improve healthcare provision both in the community and hospital settings and also to mitigate any risks. Our view is that quality, safety and efficiency are intrinsically linked and are mutually beneficial. This principle underpins our quality priorities together with our Fit for the Future programme. The quality strategy is a central component of 'Together we care', the Trust's overall five-year strategy.

We have developed a set of quality priorities and ensured that these are embedded across the Trust through directorate business plans for 2019/20.

How we chose our priorities

Each year the Trust is required to identify its quality priorities. We consulted on both the quality strategy and annual quality priorities. The draft priorities were shared with commissioners, Healthwatch, our governors and corporate and directorate management teams. The final priorities for 2019/20 were agreed by the Trust's Quality and Performance Committee.

The chosen priorities support a number of the five-year quality goals detailed in our quality strategy as well as the following three key indicators of quality:

Patient safety – having the right systems and staff in place to minimise the risk of harm to our patients and being open and honest and learning from mistakes if things do go wrong.

Clinical effectiveness – providing the highest quality care with world-class outcomes while also being efficient and cost effective.

Patient experience – meeting our patients' emotional as well as their physical needs.

Progress to achieve our quality priorities will be monitored by quarterly reporting to the Trust's Quality and Performance Committee.

Our quality priorities for 2019/20

Patient safety

Our quality priorities and why we chose them	What success will look like
Mental health We will improve mental health care across the Trust and support for staff delivering care to these patients. This priority supports delivery of our quality goal to improve the care for our most vulnerable patients and their carers, including children and those living with dementia, a learning disability or mental health issues.	– We will finalise a mental health strategy, co-designed with our patients, staff and local partners. – We will launch the strategy by September 2019 with a mental health conference and Trust-wide communication plan. – We will identify and develop, through the strategy, key priorities for implementation. – We will implement the five identified projects, funded by the Lily Steiner legacy fund, focused on improving mental health across the Trust.
Sepsis We will improve our recognition and prompt treatment of sepsis. This priority supports delivery of our quality goal to reduce the impact of serious infections through effective treatment of sepsis and antimicrobial consumption and to reduce gram-negative infections.	– We will maintain our screening rate at over 90% for suspected sepsis. – We will increase this for patients who are administered IV antibiotic therapy within one hour of sepsis diagnosis to over 90%, from the current level of around 75%. – We will implement electronic tools within e-noting to facilitate appropriate screening and management of patients with suspected and proven sepsis. – We will continue to provide education and training to clinical staff on sepsis and its management, using the newly developed e-learning package. – We will continue to work towards reducing morbidity and mortality due to sepsis.
Learning from excellence We will continue to develop our 'Learning from excellence' programme to allow our staff to: • recognise good work • learn from excellent practice. This priority supports delivery of our quality goal to be a learning organisation.	– We will achieve at least five excellence reports each month. – We will use 'Learning from excellence' to identify examples of our system working at its best and use an 'appreciative enquiry' approach to organisational change (which focuses on strengths rather than weaknesses) to explore: • how this has happened • how to make it happen more.

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like
Surgical safety We will improve the use of local safety standards for invasive procedures (LocSSIPS) in all areas of the Trust where surgery, or other invasive procedures, take place. This priority builds on the achievements of our 2018/19 quality priority and supports delivery of our quality goal to reduce avoidable harm.	– We will establish a working party and appoint a lead to review all LocSSIPS currently in use. – We will establish a baseline of the use of electronic forms for invasive procedures in all Trust locations. – We will implement actions to address identified issues and implement monthly monitoring of LocSSIPS. – We will improve the completion of electronic documentation for invasive procedures by 20%.
Length of stay We will reduce the number of patients who remain in hospital for over 21 days. This priority supports delivery of our quality goal to improve the care for our most vulnerable patients and their carers, including children and those living with dementia, a learning disability or mental health issues.	– We will achieve a 40% reduction from the 2017/18 baseline of the number of beds occupied by patients staying over 21 days. (Note: the exact percentage figure subject to confirmation by NHSI.)
Delayed appointments We will work to ensure that patients have timely access to treatment and reduce unnecessary variation. This priority supports delivery of our quality goal to improve the processes and pathways underpinning patient access to our services.	– We will introduce an improved follow-up booking process across the Trust, offering patients a choice of appointment and the opportunity to self-book online. – We will continue to reduce the number of overdue un-booked follow-up appointments to 30% fewer than at the end of 2018/19. – At-risk open referrals will be actioned promptly to reduce the risk of patients being lost to follow up. Real-time reports will be available to all teams to monitor this. – We will see improvements in patient safety through a reduction in the number of serious incidents, compared with 2018/19, involving delayed appointments or patients lost to follow up. – Staff will be supported through enhanced training to improve data quality by getting administrative processes right first time.

Patient experience

Our quality priorities and why we chose them	What success will look like
End of life care We will ensure that patients and their carers are enabled to understand and participate in decisions about treatments and place of care when they are approaching the end of their lives. We will improve systems to support cross-sector sharing of information around preferences for treatment and place of care. This priority builds on the achievements of our 2018/19 quality priority and supports delivery of our quality goal to improve end of life care.	– We will conduct a survey of the carers of patients who died in hospital. Survey findings will inform our end of life care work plan. – We will test a link between 'Coordinate my care' and existing electronic systems and establish a baseline of use for future improvement. – We will test and launch written and digital patient resources developed as part of our 2018/19 'Let's talk' programme to support discussions relating to 'do not attempt cardiopulmonary resuscitation' (DNACPR) and treatment escalation planning. – We will deliver an e-learning module for staff to improve skills and confidence in treatment escalation planning. – We will continue to engage with the public including via 'Dying matters' week 2019.
Pain management We will ensure that our staff are appropriately trained in pain assessment and that patients have effective pain management from admission to discharge. This priority builds on the achievements of our 2018/19 quality priority and supports delivery of our quality goal to improve patient survey results, year on year, relating to pain management.	– We will maintain a central record of nursing staff who have completed pain assessment training. – We will update the online pain management tool used in the Trust, changing from the 'Abbey pain scale' to the more comprehensive and more up to date 'Bolton pain assessment tool'. – Patient surveys will show increased satisfaction with pain management. – We will undertake clinical audit to provide assurance that patients are receiving timely and appropriate assessment of their pain.
Age appropriate care All young people under our care who are transitioning from children's services into adult services will have a personalised care plan to allow smooth transition of care. This priority builds on the achievements of our 2018/19 quality priority and supports delivery of our quality goal to consistently deliver age and place-appropriate care.	– Each young person will have an appropriate transition care plan. – Patient experience surveys will demonstrate high levels of satisfaction with the transition period. – We will establish leads for 'Care of young people'. – We will scope how we can offer more support to all young people on adult wards. – We will improve our outpatient spaces for young people.

Progress against priorities for 2018/19

Patient safety

Our quality priorities and why we chose them	What success will look like	How did we do?
Surgical safety We will carry out a team debriefing following at least 75% of all operating theatre lists. Perioperative briefing and debriefing is known to improve patient safety and improve team culture of surgical teams and the efficiency of their work within the operating theatre. Perioperative briefing is already in place.	– We will have early awareness of issues that have been identified through the briefings, enabling prompt response and learning by theatres management. – We will see improvements in patient safety resulting from action on the briefings. – Staff will report high satisfaction with the contribution of the briefings to patient safety and team culture.	We partially achieved this. The electronic form for recording team briefing and debriefing is now on the Galaxy theatre system and has been rolled out across all theatre areas (with the exception of obstetric theatres). Feedback on compliance and real-time audit of performance, including trends and themes, has been presented at monthly surgical safety group (SSG) meetings since October 2018. The results of the January 2019 '5 steps to safer surgery' audit show an improvement in compliance with team debriefing for theatre areas (71%). Work is ongoing by the SSG to achieve the target of 75% compliance and feedback to the directorate specialties to address any concerns raised.
Mental health assessment We will undertake a brief mental health assessment on patients attending the emergency department with a known mental health condition, suspected mental health needs or where a patient's mental health deteriorates during admission, to ensure appropriate intervention. The emergency department has seen an increase in the number of individuals attending with mental health needs and recognises the requirement for prompt assessment and onward referral.	– There will be a 30% increase in the number of mental health assessments undertaken in the emergency department compared with 2017/18. – Timely referral to mental health services will be evident for those patients assessed as a priority. – Audit will demonstrate improvement in assessment and ongoing referrals.	We achieved this A new mental health board has been created and a new mental health lead has been recruited. Mental health assessments have increased by 41%. Mental health presentations to the emergency department are assessed by the clinical team within an hour of arrival and, if required, patients are referred to psychiatric liaison. The latest audit figures (February 2019) show that 82% of patients were seen within one hour of referral. The figure has not dropped below 80% since August 2018.
Medicines management We will reduce inappropriately omitted doses of critical medicines by 10%. If patients do not receive timely medication it can impact on the efficiency of the drug regime and their treatment plan.	– Audit will demonstrate a 10% reduction on data provided through the electronic systems, supported by qualitative data from incident reporting. – There will be improved visibility of critical drugs, for example those used to treat sepsis, infection, bleeding, long term conditions such as Parkinson's or diabetes. – We will have an improved system for follow-up of medicines on arrival on the ward and report an increase in the proportion of patients' own drugs brought into the Trust with London Ambulance Service.	We partially achieved this. A reduction of 10% of inappropriately omitted doses of critical medicines has been achieved. Changes have been made to MedChart to flag critical drugs, along with an instruction that these drugs should not be omitted without discussion with a prescriber. Administering staff are required to acknowledge that this instruction has been followed. These changes are initially for a number of drugs that the acutely ill patients group has identified as being involved in incidents leading to harm. This group will continue to work with the delayed and omitted medicines working group to expand this list. A working group has also been established in the emergency department, and a pharmacist appointed, to increase the number of patients bringing their own drugs into hospital.

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like	How did we do?
Radiology turnaround times We will ensure there is a timely report available to inform the patient treatment plan. Delays in turnaround times can impact on the patient treatment pathway and may lead to patient harm.	– We will deliver 14 day reporting on plain films and reduce the number of other images unreported for over one month. – Recruitment to essential positions will be completed. – Data will be captured on the radiology software system, CRIS, to enable regular monitoring to Trust management and commissioners.	We achieved this. Average plain film reporting has been reduced from 6.9 days to 4.9 days and the backlog of all other scans waiting over one month has been reduced by 34%. Recruitment to essential positions has been completed.
Theatre cancellations We will reduce 'on the day' patient theatre cancellations by the Trust and the number of patients cancelled more than once. Theatre cancellations by the Trust cause distress to the patient and their family and may lead to deterioration in their condition.	– Patients will be treated in a timely way and no more than 0.7% of patients will be cancelled on the day of surgery and the number of repeated cancellations will decrease. – We will undertake audit to demonstrate compliance with this priority.	We partially achieved this. On the day cancellations have been reduced from 1.15% to 0.85%. The overall cancellation rate is now 6.6% (target 7%). The theatre productivity group will continue to review reportable cancellations and will work with theatre teams to reduce them further over the coming year.
End of life care We will support patients and/or carers to understand and make choices about their treatment, consistent with the Mental Capacity Act 2005. Dignity and choice around end of life care are recognised as important to staff, individuals and their families.	– Patients will feel safe and confident about their care and enabled to make informed choices about when they are at the end of their life. – Audit of healthcare records and family feedback will demonstrate this has been achieved. – Staff will demonstrate through audit and patient/carer feedback that they feel confident in their skills to respond to patients approaching the end of their lives in a way that supports this.	We achieved this. Audit demonstrates that we consistently provide appropriate information to support patients and carers and that the Mental Capacity Act 2005 is appropriately applied when making decisions about treatment. Improved patient information has been developed and an e-learning package is being produced for staff. We launched the 'Second conversation' training for foundation year doctors and reached 3,000 members of the public in the first of a series of innovative public engagement events.

Progress against priorities for 2018/19

Patient experience

Our quality priorities and why we chose them	What success will look like	How did we do?
Complaints We will improve, by 30%, the response rate to complainants against each of the complaints handling triage categories. The Trust recognises the impact of delayed responses on complainants.	– By March 2019 the increased timeliness in complaints handling will be embedded against the triage categories. – Regular scrutiny through Trust committees of the improvement trajectory will provide evidence of sustained improvement. – Patients will report reduced delays in receiving responses.	We achieved this. Our overall complaints response rate has improved by 35% while the number of complaints opened and closed has increased.
Pain management We will ensure patients have effective pain management from admission to discharge. Feedback from patient surveys has identified that pain management could be improved.	– We will demonstrate through audit and patient experience surveys that patients are receiving timely and appropriate assessment of their pain; resulting in effective pain management.	We partially achieved this. The electronic pain tool and the electronic patient controlled analgesia and epidurals forms have been successfully rolled out and are in use across the Trust. Further audit and information gathering is planned to review compliance and gain assurance that these are embedded in practice.
Age appropriate care All young people under our care who are transitioning from children's services into adult services will have a personalised care plan to allow smooth transition of care. It is recognised that there is risk associated with transition from children's services to adult services.	– Each young person will have an appropriate transition care plan. – Patient experience surveys will demonstrate high levels of satisfaction with the transition period.	We partially achieved this. The 'Ready, steady, go' workshops have supported implementation of the process into services. We are now evaluating this. We have introduced a review of young people admitted to adult areas who are deemed vulnerable and we are now involved with their care, for example mental health, and safeguarding. We are working on a young people's area on Mountain Ward to provide dedicated facilities. This will be established in 2019/20. We have identified a hospital play therapist, a ward sister and shortly a matron to lead on this work renamed 'Care of young people in Guy's and St Thomas' project. The transition guidelines will become one guideline across Guy's and St Thomas'.

Statements of assurance from the Board of Directors

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

A review of our services

During 2018/19 Guy's and St Thomas' provided 102 hospital and community NHS services. A detailed list is available in the Trust's Statement of Purpose on our website **https://www.guysandstthomas.nhs.uk/about-us/publications/publications.aspx**

The Trust has reviewed data available on the quality of care in all of these services through its performance management framework and its assurance processes. The income generated by the services reviewed in 2018/19 represents 100% of the total income received for the provision of NHS services in 2018/19.

Participation in clinical audits and national confidential enquiries

A clinical audit aims to improve patient care by reviewing services against agreed standards of care and making changes where necessary. National confidential enquiries investigate an area of healthcare and recommend ways to improve it.

We are committed to participating in relevant national audits and national confidential enquiries to help assess the quality of healthcare nationally and to make improvements in safety and effectiveness.

During 2018/19, we took part in 54 national clinical audits and three national confidential enquiries. By doing so we participated in 92% of national clinical audits and 100% of national confidential enquiries in which we were eligible to participate.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2018/19 are shown in the table below. The information provided also includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in national clinical audits 2018/19

Audit title	Participation	% of cases submitted
Women and children's health		
Maternal, newborn and infant clinical outcome review programme	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	Data collection ongoing
Paediatric intensive care audit network (PICANet)	Yes	100%
Maternity and perinatal audit (NMPA)	Yes	97%
Paediatric diabetes	Yes	Not reported for this audit
Diabetes in pregnancy	Yes	100%
Feverish children (care in the ED)	Yes	100%
Paediatric asthma secondary care	Yes	100%

Participation in national clinical audits 2018/19

Audit title	Participation	% of cases submitted
Acute care		
Adult critical care (case mix programme – ICNARC CMP)	Yes	>95%
Emergency laparotomy audit (NELA)	Yes	Data collection ongoing
National joint registry (NJR)	Yes	98%
Major trauma: the trauma audit and research network (TARN)	Yes	82%
Bloodstream infections and C.difficile infections	Yes	100%
Vital signs in adults (care in the ED)	Yes	100%
VTE risk (care in the ED)	Yes	100%
Long-term conditions		
Chronic obstructive pulmonary disease (COPD)	Yes	100%
Adult asthma secondary care	Yes	Data collection ongoing
Pulmonary rehabilitation	Yes	Data collection ongoing
Inflammatory bowel disease (IBD)	No	Minimal engagement with the audit due to lack of resources and contract problems when company running the registry changed ownership. Patients currently being uploaded for the next quarter
Learning disability mortality review programme	Yes	100%
Core diabetes audit	Yes	100%
Diabetes foot-care audit	Yes	100%
Diabetes inpatient audit	Yes	100%
Early inflammatory arthritis	Yes	100%
Older people		
Fracture liaison service database	Yes	100%
Inpatient falls	Yes	100%
National hip fracture database	Yes	100%
Sentinel stroke national audit programme (SSNAP)	Yes	100%
Dementia	Yes	100%
Heart		
Myocardial ischaemia (MINAP)	Yes	100%
Adult cardiac surgery audit (ACS)	Yes	100%
Cardiac arrest audit (NCAA)	Yes	100%
Cardiac rehabilitation	Yes	100%
Congenital heart disease (paediatric cardiac surgery)	Yes	100%
Congenital heart disease (adults)	Yes	100%
Coronary angioplasty/percutaneous coronary interventions	Yes	100%
Cardiac audit programme	Yes	100%
National vascular registry	Yes	100%

Participation in national clinical audits 2018/19

Audit title	Participation	% of cases submitted
Cancer		
Bowel cancer (NBOCAP)	Yes	57%
Lung cancer (NLCA)	Yes	100%
Oesophago-gastric cancer (NOGCA)	Yes	100%
Radical prostatectomy	Yes	100%
National prostate cancer audit	Yes	100%
Breast cancer in older people	Yes	100%
Blood and transplant		
Use of fresh frozen plasma and cryoprecipitate in neonates and children	Yes	100%
Management of massive haemorrhage	Yes	100%
Other		
Ophthalmology audit: adult cataract surgery	No	We were not able to participate as our IT systems are incompatible with the audit supplier's requirements
Percutaneous nephrolithotomy	Yes	100%
Female stress urinary incontinence	Yes	100%
Cystectomy audit	Yes	100%
Nephrectomy audit	Yes	100%
Care at the end of life	Yes	100%
Non-invasive ventilation adults	Yes	Data collection ongoing
Intermediate care	No	Following a review of the data collection burden and value of the outputs, and with the agreement of our commissioners, the Trust did not take part in this round of the audit
Seven day hospital services self-assessment survey	Yes	N/A
Antibiotic consumption	Yes	100%
Antimicrobial stewardship	Yes	100%
Surgical site infection surveillance	No	The Trust has one of the most comprehensive surgical site infection surveillance (SSIS) programmes in England. We conduct high quality continuous surveillance and quality improvement in 11 surgical specialties with more in development. This audit was designed to identify levels of SSI and assess local practice in the absence of surveillance and quality improvement programmes such as are already in place at the Trust

Participation in national confidential enquiries 2018/19

Audit title	Participation	% of cases submitted
Acute bowel obstruction	Yes	100%
Pulmonary embolism	Yes	Study still open (91% to date)
Long-term ventilation	Yes	Study still open (76% to date)

National clinical audit

The reports of all national clinical audits published were reviewed during 2018/19 and we intend to take the following actions to improve the quality of the healthcare we provide.

National audit of adult cardiac surgery

The implementation of the specialist aortic dissection rota with King's College Hospital continues to deliver excellent results and was highlighted in the 'Getting it right first time' report. The specialist aorto-vascular team also has very good outcomes for the whole range of complex major aortic cases. The mitral surgery team has developed a multidisciplinary approach to the mitral valve with very high repair rates. The extent of our aorto-vascular practice is such that the nationally mandated dataset is not sufficient to allow us to monitor our practice in the detail we would like. We have therefore started to develop our own dataset and this should be in place by April 2019.

National audit of intensive care

The Trust has four critical care units; in three of these care is as good as or better than comparable units for all 11 quality indicators reported. For one unit, care is as good as or better than comparable units for 10 out of 11 of the quality indicators. The Trust already participates in a Public Health England sponsored quality improvement programme where every acquired bacteraemia is reviewed by a medical consultant with a specialist interest in infection control, and mini root cause analysis is undertaken to identify possible improvements. Cases and recommended actions are recorded on governance and quality improvement platforms within the department, and shared with the multidisciplinary team via email and electronic screens. We recognise that keeping a large number of staff informed about such important data is a challenge so we are developing a self-directed learning package to better inform and engage staff in audit metrics and quality improvement programmes.

National audit of inpatient falls

The latest results demonstrate a marked improvement from previous audits, with 5 out of 7 quality indicators achieved (previously 2 out of 7). Our falls prevention approaches are better than the national average and the Trust also has low rates of falls and falls with harm compared to the national average. We need to improve recording of standing and lying blood pressure and the Trust falls group is working with the e-noting team to achieve this. We have also implemented a workstream to enhance multidisciplinary working and documentation.

National hip fracture database

We have improved our achievement of the best practice tariff which is now at 60-100%. We need to do more to improve nutritional screening and to provide consistent pain relief in the emergency department. Quality improvement work includes: embedding data collection into routine practice; developing a pathway for nutritional assessment; new quick use packs and training around nerve block delivery; and multidisciplinary review of cases that missed the best practice tariff so feedback can be shared with the team.

National cardiac audit programme

Audit data shows excellent results for diagnostics and access to specialists and excellent mortality data. We need to increase the number of patients undergoing cardiac rehabilitation and we are working closely with the cardiac rehabilitation team to increase uptake.

National audit of oesophago-gastric cancer

We are one of the largest centres in the UK and have an outstanding 90 day mortality rate (0.3%). We need to improve our performance against the 62 day cancer treatment standard, and we are working closely with the South East London Accountable Cancer Network to improve service quality.

Local clinical audit

Reports of 184 local clinical audits were reviewed over the last year. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality and safety of our services.

Acute medicine

An audit of conscious sedation in the emergency department showed rates of pre-procedure assessment and documented consent, and procedures performed in resus were all well above the national average. Areas for improvement included providing written information to patients before discharge and documenting that vital signs had returned to normal prior to discharge. An updated discharge leaflet for procedural sedation has been produced, the sedation proforma has been updated, and simulation training has been provided for higher trainees in the emergency department.

Community adults

Malnutrition Universal Screening Tool (MUST) assessments are conducted to measure a patient's risk of developing malnutrition. An audit conducted by our community nurses showed that nutritional screening was below the standard required by national guidelines. The team will review the screening template, survey community nurses to understand the barriers to nutritional screening and investigate colocating the dietetics team with community nurses to provide support and enhance working relationships.

Children's services

Audits to improve perioperative fasting times showed that mean fasting time had been reduced from just under seven hours to just under two hours. The audit showed a continuing need for education of parents and allied healthcare professionals, especially with regard to high risk patients. New guidance will be developed and rolled out. A text reminder service will be introduced and the standardisation of all pre-op letters is in progress.

Critical care

An audit of prone positioning (patients laid on their front to aid ventilation) showed 68% overall compliance with guidance. Prone-specific observations will be added to the electronic patient record, an education and awareness programme will be launched to support the updated guidelines, and new observations will be developed.

Inpatient falls

The audit showed good compliance with falls risk assessments and a marked increase in compliance with regular reassessment. Staff knowledge of falls prevention and prevention equipment needs to be improved in some staff groups. The Trust falls lead and falls champions are following this up with professional forums and are reviewing falls training.

Surgical safety

Our annual audit of the five steps to safer surgery shows that compliance with team briefing and use of the WHO checklist remain high. Team debriefing in theatres has increased from 44% to 71%. The Trust surgical safety group is working with other areas, outside of theatres, where invasive procedures are carried out to ensure that these are fully compliant with the standards.

Therapies

An audit of patients with head and neck cancers found that there was unmet physiotherapy need among patients having non-surgical treatment. The physiotherapy service will be reviewed and a new pathway for non-surgical patients will be develop.

Women's services

An audit of women admitted with hyperemesis (severe vomiting in pregnancy) found that there was variation in dose and frequency of thiamine and that not all patients' weight loss was being quantified. The audit also highlighted that the Trust guideline no longer reflected the latest national guidance. The Trust guideline has been updated and an educational session arranged for staff to ensure that they are familiar with the latest guidance.

Our participation in clinical research

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

We are part of King's Health Partners – one of six academic health sciences centres in the UK. A wide range of research was carried out last year, some of which included the areas we specialise in such as allergy, genetics, women's health, cardiovascular disease and renal transplantation. 208 non-commercial studies began in 2018/19 and 106 commercial studies were also initiated.

Last year, over 18,600 patients took part in research which was approved by our research ethics committee. During 2018/19, over 1,500 clinical research studies were active during the year. We used the nationally recommended systems and protocols to manage these studies and to ensure that the results are translated into clinical practice in a timely and safe manner.

Our CQUIN performance

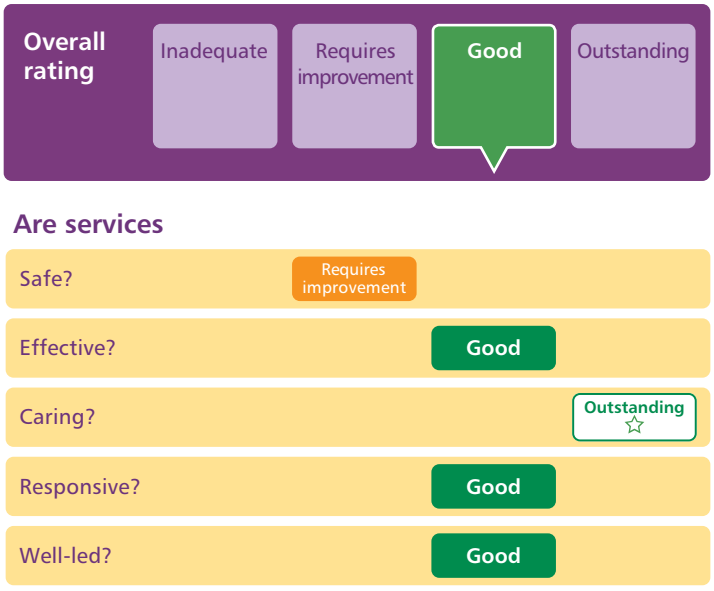
For 2018/19 our CQUIN targets were worth £20 million of income, and we are currently on track to achieve most of this as we have reached most of the milestones to date.

Statements from the Care Quality Commission

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

The CQC has not taken enforcement action against Guy's and St Thomas' NHS Foundation Trust during 2018/19.

The Trust's services were assessed by the CQC in September 2015, and we were pleased to achieve an overall rating of 'Good'. The Trust was rated 'Outstanding' for caring services, and 'Good' for effectiveness, responsiveness, and being well-led. We were rated as 'Requires improvement' for safety. We were delighted that Evelina London Children's Hospital and the emergency department (A&E) at St Thomas' were rated 'Outstanding'.



The CQC highlighted three areas where the Trust needed to take action: consistently documenting venous thromboembolism (VTE) risk assessments in maternity; midwifery staffing levels in the antenatal day assessment unit (ADAU); and improving the effectiveness of governance links between surgical directorates. The Trust developed a detailed action plan to address these issues and in December 2016, following submission of evidence, the CQC told us they were satisfied that the actions were complete.

Action plans were put in place to respond to the additional recommendations made by the CQC in their inspection about the ways in which we assure safety, including through the consistent application of all five steps of the World Health Organization (WHO) surgical safety checklist and by consistently sharing the outcomes and learning from incidents. A multidisciplinary surgical safety group chaired by the chief of surgery is now in place and meets regularly. It plays a key role in strengthening surgical governance arrangements, including improving the safety of all invasive procedures and sharing learning in a timely way across the Trust both between surgical specialties, and with areas not traditionally seen as theatre-type environments such as interventional radiology and cardiac catheter laboratories.

Key changes have been made to documentation and processes as a result of updated national guidance, never events and serious incidents to improve safety and effectiveness. This includes updates to the WHO checklist and the surgical count policy. An additional programme of work focused on team working is also planned in theatres to further improve safety. The last audit of the 'five steps to safer surgery' found that the checklist was carried out in full for 92% of patients undergoing a procedure in theatres, and further work is underway to embed its use.

The CQC undertook an unannounced visit to the Astley Cooper Dialysis Unit on 26 March 2018.

The Trust's initial action plan was revised in light of the further issues identified in the CQC report received on 30 May 2018. Key actions included providing infection control training to staff, environmental inspections, spot checks by the directorate management team, peer reviews of all dialysis units to ensure lessons learnt and actions are embedded across all areas, new guidelines for cleaning equipment, a focus on care planning, and continued involvement of patients and staff in the transport working group to ensure patients receive the best possible care. The action plan has been completed and is pending closure with the CQC.

Internal and external quality visits to the Astley Cooper Dialysis Unit, including by our commissioners, have been undertaken and confirmed that robust processes and procedures are in place to address issues including cleanliness, infection control and governance, while acknowledging some further work is required to embed cultural improvements.

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

Our data quality

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

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

The Trust continues to achieve high completeness scores on its external data flows. The percentage of records in the published Secondary Uses Service up to the end of February 2019 that included a patient's valid NHS number was 98.5% of inpatients, 99.1% of outpatients and 88.7% of A&E patients. These figures are similar to the previous year. The percentage of records which had the patient's valid GP registration code was 100% of inpatients, 100% of outpatients and 99.9% of A&E patients.

As community sites are still not required to upload data, only our hospital sites submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

Data security and protection toolkit

Good information governance means keeping the information we hold about our patients and staff safe. The 'data security and protection toolkit' (which has replaced the 'information governance toolkit') is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to the Department of Health and Social Care in order to assess compliance.

All standards were met in our self-assessment against the 2018/19 data security and protection toolkit.

Clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit during 2018/19 carried out by the Audit Commission.

Learning from deaths

Deaths at the Trust are recorded in line with the national approach using a DATIX mortality review module. This enables review and discussion at service and directorate morbidity and mortality meetings. A proportion of deaths also undergo a more detailed review.

Our 'learning from deaths' policy for identifying deaths for detailed case review is based on the framework set out in the National Quality Board's (NQB) publication 'National guidance on learning from deaths' published in March 2017 and was agreed with NHS Improvement.

Detailed case record review is undertaken using the Royal College of Physicians Structured Judgement Review (SJR) tool for any death meeting one of the defined categories below.

- Patients with learning disabilities, as part of the National Learning Disability Mortality Review (LeDeR) project.
- Patients with severe mental illness.
- Patients where concerns about the quality of care have been raised by the patient, families/carers and/or staff during or after the episode of care.
- Patients where the death was not expected, for example following certain elective procedures or low risk admissions or where the patients suffered a sudden unexpected cardiac arrest.

The Trust mortality surveillance group also agreed case record reviews should take place for:

- deaths in a particular service or specialty, or a particular diagnostic or treatment group where an 'alarm' has been raised either internally or externally
- deaths where learning will inform planned improvement work, for example we are currently focusing on cases where a death occurs in an individual who is known to be street homeless
- cases where there have been external concerns about previous care at the Trust
- a random sample of additional deaths – it has been agreed with NHS Improvement that the Trust will select these using the day of the week of the death.

Services and directorates may also undertake additional detailed case record reviews as part of their own mortality review processes and feed back the learning from these to the central team. In addition, while the Royal College of Physicians SJR tool and the NQB guidance on learning from deaths only relate to the episode of care where the death occurred, services and directorates may include previous episodes of care in their case review if they feel that this will add to the learning.

Paediatric and maternal or neonatal deaths are reviewed using the CDOP and MBRRACE tools respectively.

Sharing of learning

Learning from reviews of deaths, including those reviewed by detailed case record review, is discussed and shared through local service and directorate mortality meetings. Themes from these meetings are shared at the Trust mortality surveillance group, presented to the Trust Board and shared with NHS Improvement.

During the period April 2018 to March 2019:

	Q1	Q2	Q3	Q4	Total
Number of patients who died	268	229	292	180	969
Number of deaths subjected to case review or investigation	54 (20%)	69 (30%)	62 (21%)	47 (26%)	232 (24%)
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided	5 (2%)	4 (1.7%)	2 (0.7%)	N/A	N/A

Themes that have emerged from reviews of deaths at the Trust include: electrolyte and fluid management; medical history missed due to information being on old clinical letters; and the National Early Warning Score (NEWS) protocol not being fully adhered to. Actions to address these issues include: further teaching on fluid management for medical staff; ongoing NEWS training throughout the Trust, with regular audits; and further work to ensure patient records are reviewed and available.

The learning themes from detailed case record review and investigation across the Trust are summarised in the table overleaf.

Organisational learning	Actions/outcome
Access to end of life pain relief and symptom control medications	There was a delay to a patient receiving end of life medication. As a result, the Trust clinical guidelines on 'Omitted or delayed doses and stocking/availability of specific drugs list' is currently being reviewed and updated. Early specialist input in complex cases when appropriate has been identified as good practice.
Patient absence from ward and associated observation	A patient was regularly absent from the ward for prolonged periods of time, which made it difficult for the nursing staff to locate him throughout a shift and provide the required care and treatment outlined in the medical plan. A patient suffered an unwitnessed cardiac arrest as he was unobserved in a bathroom at the time. The patient was not immediately found, resulting in a delay to commencing CPR. A nursing shift change and a busy start to the night duty were identified as contributing factors. It is important for staff to identify acceptable time parameters for patients to be off the ward and ensure there is clear communication between the patient and the team caring for the patient.
Managing end of life care (EoLC) in the community setting	Patients are advised to go to hospital by district nurses but often decline. The patients are assessed as having capacity and are monitored closely by the district nurses and escalated to the GP. Learning followed the death of a patient with a community 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place. The patient known to palliative care and carers had been informed of the DNACPR order, but still called an ambulance when the patient was dying. Following an audit of all patients dying in the community, end of life community nurses have improved the written information given to patients and their families. The end of life duty nurse system is now set up so that patients and relatives can receive a quick response if there is an urgent need for a nurse.
Medical certification of cause of death (MCCD) completion and availability	Completed MCCDs are now scanned and available on the electronic patient record system. The Trust End of Life Committee approved the 'Care after death of adults in and out of the hospital' policy in October 2018. This outlines the expected timeframe for completion of an MCCD following a death and the escalation plan if the MCCD is not completed. This will be monitored and audited by the bereavement team and the Trust mortality surveillance group.
Managing end of life care (EoLC) in the inpatient hospital setting	Ongoing improvements to advance care planning particularly around choice of place of death. Progress made with embedding 'Coordinate my care' within the Trust's electronic patient records. Good use of EoLC, AMBER and DNACPR across specialties. A working group is being set up to look at cases where CPR is commenced on inpatients with a DNACPR order in place. New patient information and staff training is being made available about having conversations regarding DNACPR and escalation/ treatment decisions.

Seven day hospital services

We continue to work hard to implement seven day hospital services. The most recent audit shows that the Trust has achieved the required 90% compliance with the four priority standards two years ahead of the 2020 deadline.

Speaking up

In June 2015 the Trust launched its 'Showing we care by speaking up' initiative, putting in place a number of ways for staff to raise concerns about patient safety and the quality of care. These include a confidential email address, speaking up advocates and an external phone line. The service is managed by a full-time 'freedom to speak up' guardian who provides independent oversight supported by 150 speak up advocates within the directorates. Staff are encouraged to speak up and this is seen as a positive and valuable opportunity for improvement and learning. Guy's and St Thomas' scores higher than the national average in the NHS Staff Survey in relation to staff feeling safe and confident raising concerns about unsafe clinical practice which demonstrates a positive speaking up culture.

In line with national guidance, all contacts to the speaking up service are logged on a confidential database and data is submitted on a quarterly basis. Six-monthly reports are also submitted to the Trust's Quality and Performance Committee and an annual report is presented to a public Board meeting. The annual number of contacts is also published in the Trust's Annual Report on page 43.

Rota gaps

Junior doctors are allocated to the Trust by Health Education England (HEE). The Trust is an attractive place to work and train, and this is reflected in the fill rates for training posts. In the past year the Trust has averaged a fill rate of approximately 94% of training grade posts. Any unfilled posts are recruited to with local Trust grade posts. The Trust does not keep a central record of rota gaps, but there are no specialties that have consistent difficulties in recruiting to vacant positions. As we are dependent on HEE providing details of vacant posts, to manage the risk associated with late notification, we are piloting an electronic rostering system which aims to track vacancies and speed up recruitment when necessary.

National core set of quality indicators

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

For each indicator our performance is reported, together with the national average and the performance of the best and worst performing trusts where this data is available.

Mortality

The summary hospital level mortality indicator (SHMI) is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 100. A score below 100 denotes a lower than average mortality rate and therefore indicates good, safe care.

We believe our performance reflects that:

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

	Apr 15 – Mar 16	Jul 16 – Jun 17	Oct 16 – Sep 17	Jan 17 – Dec 17	Apr 17 – Mar 18	Jun 17 – Jun 18	Oct 17 Sep 18
SHMI	76	75	73	72	70	70	70
Banding	3	3	3	3	3	3	3
% Deaths with palliative care coding	47.5%	51.5%	50.6%	51.06%	50.94%	52.14%	53.3%

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

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

Patient reported outcome measures

Patient reported outcome measures (PROMs) measure quality from the patient perspective, and seek to calculate the health gain experienced by patients following one of four clinical procedures. We are reporting on patients who have had a hip replacement, knee replacement and varicose vein treatments where significant numbers of surveys were submitted. Hernia repair outcome data was not compared due to insufficient data for significance (defined as fewer than 30 cases) so these are not reported here.

We believe our performance reflects that:

- the Trust has a process in place for collating data on patient reported outcomes
- data is then sent to Capita on a monthly basis who collate and calculate PROMs scores and send it on to NHS Digital
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out below.

Primary hip replacement	2013/14	2014/15	2015/16	2016/17	2017/18*
Guy's and St Thomas'	**0.47**	**0.45**	**0.47**	**0.45**	**0.46**
National average	0.44	0.44	0.44	0.44	0.47
Highest	0.54	0.52	0.51	0.53	0.56
Lowest	0.31	0.33	0.32	0.30	0.39

Primary knee replacement	2013/14	2014/15	2015/16	2016/17	2017/18*
Guy's and St Thomas'	**0.31**	**0.29**	**0.31**	**0.30**	**0.29**
National average	0.32	0.32	0.32	0.32	0.34
Highest	0.42	0.42	0.40	0.40	0.42
Lowest	0.21	0.20	0.20	0.24	0.22

Varicose vein	2013/14	2014/15	2015/16	2016/17	2017/18*
Guy's and St Thomas'	**N/A****	**0.05**	**0.10**	**N/A****	**N/A****
National average	0.09	0.09	0.10	0.09	0.09
Highest	0.15	0.15	0.15	0.15	0.13
Lowest	0.02	-0.01	0.02	0.02	0.03

*2017/18 data is provisional and the latest available. ** Insufficient data (to date) for NHS Digital comparison.

Patients who have had these procedures are asked to complete a short questionnaire which measures their health status or health related quality of life at a moment in time. The questionnaire is completed before, and then some months after surgery, and the difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient.

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

Clinicians regularly review scores at a service and Trust level to ensure that what we learn from patient feedback is incorporated into our quality improvement programmes.

Readmission within 28 days of discharge

The most recent information available from NHS Digital was published in December 2013. Using data from the Healthcare Evaluation Data (HED) system in combination with local Trust digital systems, we are able to access full year information for 2018/19. The former provides national average performance rates, and the capacity to benchmark our performance against peers.

We believe our performance reflects that:

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

Readmissions	2016/17			2017/18			2018/19		
	Under 16	16 & over	Total	Under 16	16 & over	Total	Under 16	16 & over	Total
Discharges	17,249	78,054	**95,303**	18,186	78,656	**96,842**	18,752	82,077	**100,829**
28 day readmissions	634	7,317	**7,951**	813	7,416	**8,229**	992	8,268	**9,260**
28 day readmission rate	3.7%	9.4%	**8.3%**	4.5%	9.4%	**8.5%**	5.3%	10.1%	**8.5%**

Source: Trust information system

We continue to take the following actions to reduce the number of patients requiring readmission:

- the Trust Risk and Assurance Committee monitors readmissions on a monthly basis and identifies any areas where there is a trend or change which may be a cause for concern
- our elderly care team reviews all cases at multidisciplinary team meetings and is actively seeking to improve clinical practice
- we are also working with GPs and community teams to review patients who have been readmitted so that we can agree specific actions for these patients.

Patient experience

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

Patient experience	2013/14	2014/15	2015/16	2016/17	2017/18
Guy's and St Thomas'	**73.1**	**71.4**	**77.3**	**78.3**	**70.8**
National average	68.7	68.9	77.3	76.7	68.6
Highest	84.2	86.1	88	87.3	85
Lowest	54.4	59.1	70.6	66.1	60.5

Source: NHS Digital. Latest data available.

Staff recommendation to friends and family

The Trust has high levels of staff engagement and our results in both the NHS Staff Survey and our Friends and Family Test show that staff perception of the Trust's services continues to be high. We believe the willingness of staff to recommend the Trust as a place to be treated is a strong and positive indicator of the standard of care provided.

We believe our performance reflects that:

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

Staff recommendation	2014/15	2015/16	2016/17	2017/18	2018/19
Guy's and St Thomas'	**85%**	**89%**	**89%**	**88%**	**87%**
Average for combined acute/community trust	68%	70%	68%	69%	70%
Highest combined acute/community trust	93%	93%	95%	89%	90%
Lowest combined acute/community trust	36%	46%	48%	48%	49%

Source: www.nhsstaffsurveys

Patient recommendation to friends and family

We believe that patient recommendation to their friends and family is a key indicator of the quality of care we provide.

We believe our performance reflects that:

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

Friends and Family Test	2015/16		2016/17		2017/18		2018/19	
Guy's and St Thomas'	**A&E**	**Inpatient**	**A&E**	**Inpatient**	**A&E**	**Inpatient**	**A&E**	**Inpatient**
Response rate	15.7%	30.4%	15.3%	23.6%	21.9%	20.4%	19.8%	19.8%
% would recommend	85%	95.6%	87.3%	97%	83.8%	95.7%	85.6%	95.4%
% would not recommend	8.2%	1.7%	7%	1.3%	7%	1.6%	6.3%	1.6%

Source: Trust information system

Venous thromboembolism

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

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

We believe our performance reflects that:

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

VTE assessments	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Guy's and St Thomas'	96.3%	97.1%	97.2%	96.6%	95.4%	96.2%
National average	96%	96%	96%	96%	96%	96%
Best performing trust	100%	100%	100%	99%	99%	99%
Worst performing trust	81%	88%	79.9%	85%	86%	89%

Source: HED and Trust information system

Infection control

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

We believe our performance reflects that:

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

Infection control: C.difficile	2014/15	2015/16	2016/17	2017/18	2018/19
Guy's and St Thomas'					
Trust apportioned cases	51	51	36	27	22
Trust bed-days	321,749	324,000	331,097	338,235	343,750
Rate per 100,000 bed-days	15.9	15.7	10.9	7.9	6.4
National average	15.1	14.9	13.0	13.5	12
Best performing trust	0	0	0	0	0
Worst performing trust	62.2	66	82.7	92.75	80.5

Source: Public Health England and Trust information system

Patient safety incidents

The National Reporting and Learning System (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database and is designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission. To avoid duplication of reporting, all incidents resulting in severe harm or death are reported to the NRLS, who then report them to the Care Quality Commission.

There is no nationally established and regulated approach to the reporting and categorising of patient safety incidents, so different trusts may choose to apply different approaches and guidance when reporting, categorising and validating patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. These judgements may differ between professionals, and data reported by different trusts may not be directly comparable.

We believe our performance reflects that:

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

Patient safety incidents	Apr 15 – Sep 15	Oct 15 – Mar 16	Apr 16 – Sep 16	Oct 16 – Mar 17	Apr 17 – Sep 17	Oct 17 – Mar 18	Apr 18 – Sep 18
Guy's and St Thomas'							
Total reported incidents	**8,154**	**6,961**	**9,398**	**9,120**	**10,171**	**9,986**	**10,526**
Rate per 1,000 bed-days	**49.5**	**42.2**	**58.8**	**56.1**	**63.1**	**57.7**	**62.6**
National average (acute non-specialist)	38.1	38.6	40.2	40.9	42.8	42.5	44.5
Highest reporting rate	74.7	75.9	71.8	68.9	111.7	124	107.4
Lowest reporting rate	18.1	14.8	21.1	23.1	23.5	24.1	13.1

Guy's and St Thomas'							
Incidents causing severe harm or death	21	22	39	44	40	43	47
% incidents causing severe harm or death	0.26%	0.3%	0.4%	0.5%	0.4%	0.4%	0.4%
National average (acute non-specialist)	0.22%	0.46%	0.4%	0.44%	0.4%	0.3%	0.3%
Highest reporting rate	2.39%	4.45%	1.7%	2.1%	2.0%	1.5%	1.3%
Lowest reporting rate	0.03%	0%	0%	0%	0%	0%	0

Source: NHS Digital

The number of patient safety incidents reported continues to reflect a positive culture for reporting all patient safety incidents, including near misses. The number and percentage of incidents resulting in severe harm or death remains broadly consistent with the national average. All serious incidents are investigated using root cause analysis methodology. We continue to work closely with commissioners and the NRLS to ensure that any changes made to incident classifications following a root cause investigation are reported to the NRLS and that data provided to the NRLS is reviewed and validated against Trust data to ensure it is consistent.

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

Our performance against NHS Improvement Single Oversight Framework indicators

NHS Improvement uses a number of national measures to assess access to services and outcomes, and to make an assessment of governance at NHS foundation trusts. Performance against these indicators acts as a trigger to detect potential governance issues and we are required to report on most of them every three months.

Our performance against these indicators can be seen in the table below.

Key performance indicators

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Infection control	C.difficile acquisitions (including: cases deemed not to be due to lapse in care and cases under review)	51	22 ●	3	6	4	9
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	88% ●	89%	89%	87%	88%
A&E access	95% A&E patients wait less than 4 hours	95%	87% ●	86%	88%	87%	87%
Cancer access initial appointments	Urgent cancer referrals seen within 2 week wait	93%	97% ●	97%	98%	97%	95%
	Symptomatic breast patients seen within 2 week wait	93%	95% ●	80%	100%	99%	100%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	72% ●	72%	71%	73%	71%
	% patients treated within 62 days from screening referral	90%	66% ●	86%	68%	64%	47%
	% patients treated within 31 days of decision to treat	96%	96% ●	94%	96%	96%	99%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	91% ●	82%	95%	91%	97%
	Chemotherapy treatments within 31 days	98%	99% ●	98%	98%	99%	99%
	Radiotherapy treatments within 31 days	94%	96% ●	94%	96%	96%	97%
Community care information completeness	Referral to treatment information completeness	50%	68% ●	71%	68%	66%	68%
	Referral information completeness	50%	95% ●	95%	95%	95%	95%
	Activity information completeness	50%	79% ●	80%	79%	78%	79%

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

Statements

Statement of directors' responsibilities in respect of the quality report

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

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

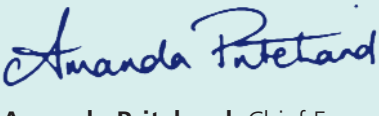
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2018/19 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to March 2019
  - papers relating to quality reported to the Board over the period April 2018 to March 2019
  - feedback from commissioners dated 13 May 2019
  - feedback from governors dated 31 March 2019
  - feedback from local Healthwatch organisations dated 13 May 2019
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11 October 2018
  - the 2017 national patient survey published June 2018
  - the 2018 national staff survey published February 2019
  - the head of internal audit's annual opinion over the Trust's control environment dated 8 May 2019
  - CQC inspection reports dated 24 March 2016 and 30 May 2018
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the quality report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Sir Hugh Taylor, Chairman
22 May 2019



Amanda Pritchard, Chief Executive
22 May 2019

Independent Practitioner's Limited Assurance Report to the Council of Governors of Guy's and St Thomas' NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Guy's and St Thomas' NHS Foundation Trust to perform an independent limited assurance engagement in respect of Guy's and St Thomas' NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2018 to 22 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 22 May 2019;
- feedback from commissioners dated 13/05/2019;
- feedback from governors dated 31/03/2019;
- feedback from local Healthwatch organisations dated 13/05/2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 11/10/2018;
- the national patient survey dated June 2018;
- the national staff survey dated February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 08/05/2019;
- the Care Quality Commission's inspection report dated 24/03/2016 and

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Guy's and St Thomas' NHS Foundation Trust as a body, to assist the Council of Governors in reporting Guy's and St Thomas' NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Guy's and St Thomas' NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary.

Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Guy's and St Thomas' NHS Foundation Trust. Our audit work on the financial statements of Guy's and St Thomas' NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Guy's and St Thomas' NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Guy's and St Thomas' NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Guy's and St

Thomas' NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose.

Our audits of Guy's and St Thomas' NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Guy's and St Thomas' NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
110 Bishopsgate
LONDON EC2N 4AY

22 May 2019

NHS Lambeth CCG and NHS Southwark CCG Joint Statement on Guy's and St Thomas' NHS Foundation Trust Draft Quality Accounts 2018/19

We thank the Trust for the opportunity to comment on the 2018/19 Quality Account. The draft Quality Account is comprehensive and reflects the positive work of the Trust to improve the quality of services and patient experience, which this year has included the development and launch of a five year Quality Strategy.

This year's Quality Accounts sets out how the Trust has progressed against the priorities for 2018/19 across both acute and community services. It is encouraging to see that a number of priorities were successfully achieved and some continue in 2019/20 with a different focus, which will build on the progress made. We recognise the improvements made in the use of 5 steps to surgical safety in theatre areas and the need to embed such improvements in non-theatre areas. We also acknowledge the improvement in complaints response times within the triage categories. Priorities that were partially achieved in 2018/19 have either been revised for 2019/20 or are being taken forward through other Trust processes, which commissioners will monitor through the Clinical Quality Review Group (CQRG).

The quality priorities chosen for 2019/20 identify a number of quality issues that have been discussed at the CQRG and seen as themes arising from serious incidents. These include delayed appointments, mental health care and surgical safety in non-theatre areas. The Quality Priorities also reflect areas identified through the Trust's learning from death reviews, such as end of life care. There are clear, measurable criteria to assess the achievement of these priorities with defined timescales for most priorities. We assume that for those without defined timescales, progress will be assessed in a year's time. A number of the Quality Priorities support various quality goals outlined in the Trust's Quality Strategy.

We acknowledge the significant work the Trust undertook following the CQC inspection report into the Astley Cooper Dialysis Unit. Commissioners have received regular updates at CQRG on progress in both the Astley Cooper Unit and how lessons learned have been implemented across all units. We look forward to further updates on embedding of cultural improvements.

However, we would like the Trust to consider how they plan to improve quality and the interface between organisations and services as part of Lambeth Together and the developing integrated care system. For example, how they plan to involve GPs in end of life care and reviews as this would also improve patient experience and provide safer, more effective care.

We recognise the Trust's new organisational wide and people strategies and highlight the importance of linking these to the Quality Strategy. We look forward to seeing progressive delivery of the Trust's Digital Strategy, acknowledging the impact digital systems have on the quality of services.

In addition to the agreed priority areas listed in the Quality Accounts we will continue to work together to assure the quality of services across the quality domains of patient safety, clinical effectiveness and patient experience. We look forward to working with the Trust and to see the Trust making progress against all its quality priorities during 2019/20.

Dr Rajive Mitra
Governing Body member and Chair of CQRG
13 May 2019

Guy's and St Thomas' NHS Foundation Trust Quality Accounts 2018/19: response from Healthwatch Southwark

We broadly support the priorities chosen and continued this year, several of which reflect fundamental areas of quality.

Delayed appointments are an area of frustration for patients with potential long term impact. Healthwatch Southwark (HWS) will be conducting its own engagement on referral to treatment times.

While it is positive that pain management tools have been rolled out, it appears that the goal of auditing experiences has not been met. This is disappointing given that pain management has been a quality focus for some years. It would be helpful to outline the challenges.

A continued focus on end of life care is appropriate given reviews noted on page 88. Detail on the audit mentioned on page 77 would be appropriate. It is not clear how each area of achievement so far aligns with the different elements of this priority, which is important as the goal is defined as 'achieved' yet is carried forward.

We would like to see more rationale for the goal on length of stay, and *how* the Trust intends to achieve this. This might be considered in tandem with rates of readmission (mentioned on page 91 but not compared with averages) and the quality of intermediate care services (not audited this year).

Positively, several of the priorities do include defined targets. It would be helpful to be more specific about what will constitute success in terms of pain management and age-appropriate care. Likewise, it would be helpful to include baselines for length of stay and delayed appointments (as is done for the sepsis target).

We are pleased to hear that the mental health strategy will be co-designed, and work to improve end of life care will be based on a carer survey. We hope that scoping of support for young people on adult wards will be done alongside young people themselves.

Priorities not rolled over

We particularly commend the progress made on radiology reporting. This is crucial to efficiency and it is reassuring that recruitment to essential posts is complete, given workforce challenges.

To build on the significant improvement in complaints response times, we would be interested to see PALS response times, as this is sometimes raised as an issue.

The 10% reduction in missed critical medicine doses was met; it would be helpful to see current figures to assess the remaining challenge.

It is positive that theatre cancellations on the day have reduced, though the target was not fully met. The report should comment on whether the Trust achieved its goal of reducing repeat cancellations.

Other data

The Trust is to be commended on excellent findings in some of the audits, and on its better-than-average mortality rates, national inpatient survey results, and staff recommendation levels.

We understand that higher-than-average rates of safety incidents may well reflect good reporting. However, it would provide reassurance to see detail on the breakdown.

As mentioned in previous years, we would also have liked to see themes identified in complaints, and information about referral to treatment times.

Healthwatch Southwark

13 May 2019

Guy's and St Thomas' NHS Foundation Trust Quality Accounts 2018/19: response from Healthwatch Lambeth

We welcome the Trust's continued focus in 2019/20 on reducing length of hospital stays and congratulate the Trust on the strides it has made in reducing the number of inpatient falls over the past year (page 83).

The Trust's next phase of plans for its **end of life care quality priority** are well considered and we look forward to our continued collaboration in the coming year with the Trust's end of life care lead through the Lambeth advance care planning consortium. We have been impressed by the dynamic approach the Trust has taken on this topic over the past year and appreciate the officer's energy, creativity and willingness to share her expertise in helping to engage Lambeth residents on Advance Care Planning.

However, we noted that Guy's and St Thomas' data on **patient safety incidents** over the seven-year period were higher than the national average and the second highest incident rate in 2018 (62.6, page 94).*

The GSTT plan to complete a co-produced **Mental Health Strategy and the new Mental Health Board** are also helpful developments. We would strongly urge the Trust to ensure that its own MH Strategy complemented and echoed the service developments and plans in Lambeth being taken forward by the Living Well Network Alliance, in particular, around improving experiences and outcomes for people especially those in contact with a number of different services. We are strongly supportive of cultural change across the mental health 'system' so that individuals experience more coordinated and continuity of care and support.

We note and support the ambition to reduce length of inpatient stay especially for vulnerable groups, such as people with mental health needs. However, in our experience this can sometimes compromise comprehensive and holistic discharge planning. **We would like to see the Trust develop closer links with mental health community resources in Lambeth** to ensure that those being discharged with mental health needs are well connected to support in the community. We would be keen to partner the Trust in any future work in this area.

We note the continued good performance in seeing people with mental health needs in A&E within one hour. **The increase in brief mental health assessments in A&E is also welcome**, however, it would be more helpful to understand the effectiveness of this policy if the number of people attending A&E with a mental health need was shown and the percentage of these who received a brief assessment. We would welcome more clarity about whether the definition of 'mental health' in this context, includes people with more common conditions such as depression and anxiety, (and therefore take into account possible impact of long A&E waits on individual's mental wellbeing) or if it solely focused on people likely to meet the criteria for secondary mental health services.

Catherine Pearson
Chief Executive
Healthwatch Lambeth
13 May 2019

** Guy's and St Thomas' has discussed this point with Healthwatch Lambeth and explained that the increase in reported incidents reflects the Trust's culture of openness and of encouraging staff to report all patient safety incidents and near misses. We await their response.*

Guy's and St Thomas' carries out more research studies than any other NHS trust in London and is in the top three trusts nationally.

11 Annual accounts

Foreword to the accounts

'These accounts, for the year ended 31 March 2019, have been prepared by the Guy's & St Thomas' NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Amanda Pritchard
Chief Executive and Accounting Officer

22 May 2019

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

Our opinion on the financial statements is unmodified

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 2019 which comprise the Consolidated Statement of Comprehensive Income, the Statement of Financial Position, the Group and Trust Statement of Changes in Taxpayers' Equity, the Consolidated Cash Flow Statement and notes to the financial statements, including significant Accounting Policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

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 2019 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; 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. 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 have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Grant Thornton

Overview of our audit approach

Financial statements audit

- Overall materiality: £30,000,000, which represents 1.95% of the group's gross operating costs (consisting of operating expenses and finance expenses);

- Key audit matters were identified as:
  - Additional NHS contract income from healthcare activities
  - Valuation of property

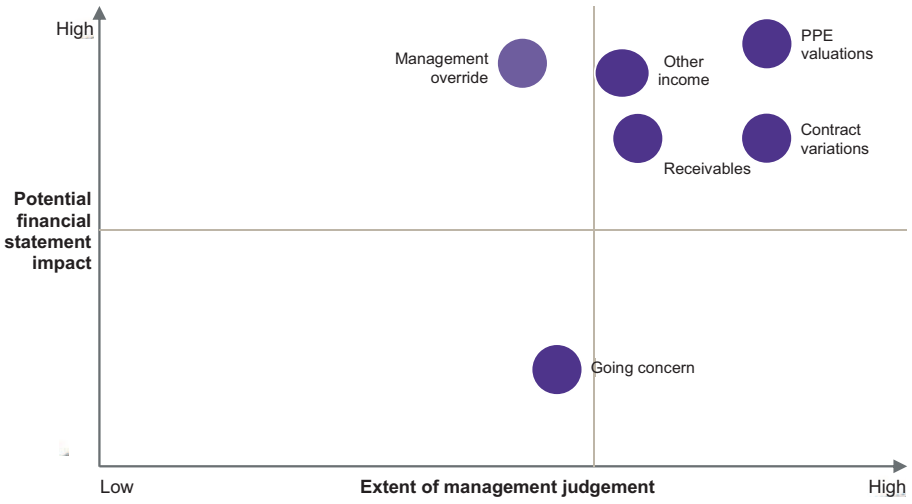
We performed a full scope audit of Guy's and St Thomas' NHS Foundation Trust and analytical audit procedures on the non-significant group components.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified 1 significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (see Report on other legal and regulatory requirements section).

Key audit matters

The graph below depicts the financial statement audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter – Group and Trust	How the matter was addressed in the audit – Group
Risk 1 Additional NHS contract income from healthcare activities Approximately 80% of the group's income is in relation to NHS contract income from healthcare activities. Healthcare activities provided that are	Our audit work included, but was not restricted to: • evaluating the group's accounting policy for recognition of income from healthcare activities for appropriateness and compliance with the Department of Health and Social Care Group Accounting Manual (GAM);

Key Audit Matter – Group and Trust	How the matter was addressed in the audit – Group
additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. We therefore identified the occurrence and accuracy of additional NHS contract income from healthcare activities as a significant risk, which was one of the most significant assessed risks of material misstatement.	• gaining an understanding of the group's system for accounting for income from healthcare activities and evaluating the design of the associated controls; • agreeing significant contract variations to correspondence with commissioners and NHS England, • where significant, agreeing contract variation values with commissioners to notifications received by the Trust from those entities; and • testing a sample of income from additional healthcare activity to signed contract variations, invoices, and other supporting documentation, such as correspondence from the Trust's commissioners confirming their agreement to pay for the additional activity. The group's accounting policy on Revenue Recognition is shown in note 1.3 to the financial statements and related disclosures are included. **Key observations** We obtained sufficient, appropriate audit evidence to conclude that: - the Trust's accounting policy for recognition of additional NHS contract income from healthcare activities complies with the GAM 2018/19 and has been properly applied; and - additional NHS contract income from healthcare activities is not materially misstated.
Risk 2 Valuation of Property The Trust revalues its property on a quinquennial basis with interim targeted valuations between to ensure that carrying value is not materially different from fair value. 2018/19 was valued under the targeted valuation method. This represents a significant estimate by management in the financial statements. We therefore identified valuation of property as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work; • evaluating the competence, capabilities and objectivity of the valuation expert; • challenging the information and assumptions used by the valuation expert to assess completeness and consistency with our understanding by comparison of valuations made by use of an auditor's expert. • testing a sample of valuation movements and associated reserve impacts. The group's accounting policy on Valuation of Property is shown in note 1.7 to the financial statements and related disclosures are included. **Key observations** obtained sufficient, appropriate audit evidence to conclude that: - the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimate were reasonable; and - the valuation of property disclosed in the financial statements is reasonable.

Our application of materiality

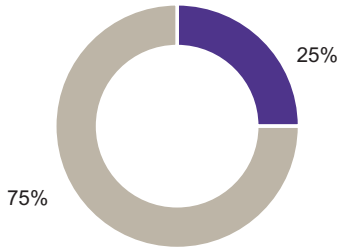
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

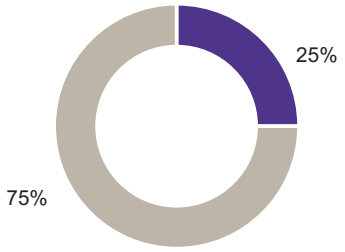
Materiality Measure	Group	Trust
Financial statements as a whole	£30,000,000 which is 1.95% of the group's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the group has expended its revenue and other funding. Materiality for the current year is higher than the level we determined for the year ended 31 March 2018 to reflect our view that the group audit is inherently less risky in our second year of audit as we now have a greater understanding of the Trust subsidiaries and their limited impact on the group.	£29,000,000 which is 1.88% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality	75% of financial statement materiality
Communication of misstatements to the audit Committee	£300,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.	£300,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Group



Overall materiality – Trust



■ Tolerance for potential uncorrected mis-statements ■ Performance materiality

An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the group's business, its environment and risk profile and in particular included:

- Evaluation of identified components to assess the significance of that component and to determine the planned audit response based on a measure of materiality and significance of the component as a percentage of the group's total gross revenue expenditure. A full scope, targeted or analytical approach was taken for each component based on their relative materiality to the group and our assessment of audit risk;
- Full scope audit procedures on Guy's and St Thomas' NHS Foundation Trust. The Trust's transactions represents more than 99% of the group's total income, more than 99% of its total expenditure and more than 99% of its total net assets;
- Gaining an understanding of and evaluating the group's internal control environment including its financial and IT systems and controls; and
- Analytical audit procedures on the group components:
  - Essentia Trading Ltd;
  - Guys' and St Thomas' Enterprises Ltd;
  - GTI Forces Healthcare Ltd; and
  - Pathology Services Ltd

which together represent 0.4% of the group's total net assets.

Other information

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

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

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group and Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit;
  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 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 meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2018/19 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.

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

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, 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 a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

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

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, 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 2018/19, 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 Trust's services to another public sector entity.

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

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

Report on other legal and regulatory requirements – Conclusion on 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 - 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 2019.

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

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risk	How the matter was addressed in the audit
Risk 1 Financial Sustainability Our initial risk assessment (at February 2019) identified that the financial position of the Trust remained challenging. The control total had been revised downwards and the attainment of the financial plans remained a significant challenge. In addition to this, there is uncertainty surrounding the potential impact of Brexit, which we considered throughout our assessment of the Trust's financial arrangements. We consider financial sustainability to be an inherently high risk in NHS bodies that are undertaking significant projects and savings targets as is the case with this Trust.	Our audit work included, but was not restricted to: ● The financial performance of the Trust during the 2018/19 financial year ● The Trust's arrangements for setting the 2019/20 budget ● The Trust's overall financial position in the context of the South East London STP ● The overall strength of the Trust's balance sheet and its ambitious capital plans **Key findings** Based on the work we performed to address the significant risks, we are satisfied that the Trust had proper arrangements in all significant respects to ensure it delivered value for money in its use of resources.

Responsibilities of the Accounting Officer

The 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 and to report where we have not been able to satisfy ourselves that it has done so. 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 on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

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

Use of our report

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

Paul Dossett

Paul Dossett Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

110 Bishopsgate, London, EC2N 4AY

22 May 2019

Consolidated statement of comprehensive income for the year ended March 31 2019

	NOTE	March 31 2019 £000	March 31 2018 £000
Operating income from patient care activities	3	**1,271,868**	1,185,469
Other operating income	4	**325,256**	293,569
TOTAL INCOME		**1,597,124**	1,479,038
Operating expenses	6.1	**(1,537,706)**	(1,412,553)
OPERATING SURPLUS		**59,418**	66,485
FINANCE COSTS			
Finance income	9	**892**	1,577
Finance expenses	10	**(5,799)**	(5,685)
Public Dividend Capital dividend payable	30	**(23,448)**	(20,631)
Net finance costs		**(28,355)**	(24,739)
Loss on disposal of assets	8	**(20)**	(884)
Share of profit of associates / joint ventures	19	**236**	–
Corporation tax income / (expense)	11	**170**	(38)
SURPLUS FOR THE YEAR		**31,449**	40,824
Other comprehensive income/(expense)			
Impairments	15	**(3,333)**	(208)
Revaluations	18	**14,249**	55,265
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**42,365**	95,881

The notes on pages 118 to 144 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Note to Statement of Comprehensive Income		March 31 2019 £000	March 31 2018* £000
Total comprehensive income as above		**42,365**	95,881
Less reserve movements in other comprehensive (expense)	a	**(10,916)**	(55,057)
Total comprehensive income before reserve movements		**31,449**	40,824
Add back in year impairments and reversals of impairments relating to market valuations included in surplus above (see note 15)	b	**15,188**	(10,758)
Less capital donations		**(4,151)**	(12,399)
Surplus including PSF		**42,486**	17,667
Less Provider Sustainability Fund (PSF) non recurrent	c	**(47,344)**	(28,370)
Deficit excluding donations, impairments and PSF	d	**(4,858)**	(10,703)

a. This is the total of the two items shown in Other Comprehensive Income.
b. This is the total net impairments charged to expenditure (Note 15).
c. This is the total PSF recognised as income.
d. Represents the primary view used by the Board of Directors to monitor the Trust's financial performance.

*The prior year figure has been represented to reflect the removal of PSF funding.

Statement of financial position as at March 31 2019

		GROUP		TRUST	
	NOTE	**March 31 2019 £000**	March 31 2018 £000	**March 31 2019 £000**	March 31 2018 £000
NON-CURRENT ASSETS					
Property plant and equipment	13	**1,229,593**	1,198,070	**1,229,443**	1,198,020
Intangible assets	14	**45,656**	44,857	**45,656**	44,857
Investment property	17	**–**	1,169	**–**	1,169
Investments in joint ventures and associates	19.1	**237**	71	**2,050**	2,050
Other investments/financial assets	22	**138**	1,368	**3,086**	4,898
Trade and other receivables	21.2	**2,260**	2,107	**2,260**	2,107
TOTAL NON-CURRENT ASSETS		**1,277,884**	1,247,642	**1,282,495**	1,253,101
CURRENT ASSETS					
Inventories	20	**21,957**	25,075	**21,957**	25,075
Trade and other receivables	21.1	**194,579**	158,294	**194,466**	157,715
Other investments/financial assets	22	**1,230**	1,270	**1,550**	1,270
Cash and cash equivalents	25	**144,057**	134,783	**141,661**	133,454
TOTAL CURRENT ASSETS		**361,823**	319,422	**359,634**	317,514
CURRENT LIABILITIES					
Trade and other payables	23.1	**(176,672)**	(156,820)	**(176,745)**	(157,198)
Other liabilities	23.2	**(30,451)**	(28,702)	**(30,100)**	(28,702)
Provisions	24.0	**(298)**	(698)	**(298)**	(698)
Borrowings	23.3	**(12,669)**	(12,085)	**(12,669)**	(12,085)
TOTAL CURRENT LIABILITIES		**(220,090)**	(198,305)	**(219,812)**	(198,683)
NON-CURRENT LIABILITIES					
Borrowings	23.3	**(218,810)**	(211,290)	**(218,810)**	(211,290)
Provisions	24.1	**(3,627)**	(6,227)	**(3,627)**	(6,227)
TOTAL NON-CURRENT LIABILITIES		**(222,437)**	(217,517)	**(222,437)**	(217,517)
TOTAL ASSETS EMPLOYED		**1,197,180**	1,151,242	**1,199,880**	1,154,415
TAXPAYERS' EQUITY					
Public Dividend Capital		**370,901**	367,328	**370,901**	367,328
Revaluation reserve		**383,587**	372,671	**383,587**	372,671
Other reserves		**743**	743	**743**	743
Income and expenditure reserve		**441,949**	410,500	**444,649**	413,673
TOTAL TAXPAYERS' EQUITY		**1,197,180**	1,151,242	**1,199,880**	1,154,415

Amanda Pritchard
Chief Executive and Accounting Officer

22 May 2019

Statement of changes in taxpayers' equity

GROUP 2018/19	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2018	367,328	372,671	743	410,500	**1,151,242**
Surplus for the year	–	–	–	31,449	**31,449**
Impairments	–	(3,333)	–	–	**(3,333)**
Revaluations – property, plant and equipment	–	14,249	–	–	**14,249**
Public Dividend Capital received	3,573	–	–	–	**3,573**
Taxpayers' equity as at March 31 2019	**370,901**	**383,587**	**743**	**441,949**	**1,197,180**

GROUP 2017/18	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2017	364,667	317,614	743	369,676	**1,052,700**
Surplus for the year	–	–	–	40,824	**40,824**
Impairments	–	(208)	–	–	**(208)**
Revaluations – property, plant and equipment	–	55,265	–	–	**55,265**
Public Dividend Capital received	2,661	–	–	–	**2,661**
Taxpayers' equity as at March 31 2018	**367,328**	**372,671**	**743**	**410,500**	**1,151,242**

TRUST 2018/19	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2018	367,328	372,671	743	413,673	**1,154,415**
Surplus for the year	–	–	–	30,976	**30,976**
Impairments	–	(3,333)	–	–	**(3,333)**
Revaluations – property, plant and equipment	–	14,249	–	–	**14,249**
Public Dividend Capital received	3,573	–	–	–	**3,573**
Taxpayers' equity as at March 31 2019	**370,901**	**383,587**	**743**	**444,649**	**1,199,880**

TRUST 2017/18	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2017	364,667	317,614	743	372,336	**1,055,360**
Surplus for the year	–	–	–	41,337	**41,337**
Impairments	–	(208)	–	–	**(208)**
Revaluations – property, plant and equipment	–	55,265	–	–	**55,265**
Public Dividend Capital received	2,661	–	–	–	**2,661**
Taxpayers' equity as at March 31 2018	**367,328**	**372,671**	**743**	**413,673**	**1,154,415**

Consolidated cash flow statement for the year ended March 31 2019

	NOTE	GROUP March 31 2019 £000	GROUP March 31 2018 £000	TRUST March 31 2019 £000	TRUST March 31 2018 £000
Cash flows from operating activities					
Operating surplus from continuing operations		**59,418**	66,485	**59,000**	66,854
Non-cash income and expense					
Depreciation and amortisation	6.1	**57,946**	53,047	**57,928**	53,042
Impairments and reversals of impairments	15	**15,756**	(10,143)	**15,756**	(10,143)
Income recognised in respect of capital donations (cash and non-cash)		**(4,151)**	(12,399)	**(4,151)**	(12,399)
(Increase) in trade and other receivables		**(36,403)**	(11,234)	**(36,869)**	(10,503)
(Increase)/Decrease in inventories		**3,118**	(3,378)	**3,118**	(3,378)
Increase in other liabilities		**1,749**	6,394	**1,398**	6,394
Increase/(Decrease) in trade and other payables		**12,789**	(2,809)	**12,485**	(3,066)
(Decrease) in provisions		**(3,003)**	(5,273)	**(3,003)**	(5,273)
Tax paid	11	**–**	(73)	**–**	–
Other movements in operating cash flows		**169**	36	**106**	9
NET CASH GENERATED FROM OPERATING ACTIVITIES		**107,388**	80,653	**105,768**	81,536
Cash flows from investing activities					
Interest received	9	**892**	1,577	**1,006**	1,681
Purchase of financial assets		**–**	(64)	**–**	(600)
Proceeds from settlements of financial assets		**1,342**	1,000	**1,662**	1,000
Purchase of intangible assets		**(12,166)**	(8,643)	**(12,166)**	(8,643)
Purchase of property, plant and equipment		**(73,860)**	(73,191)	**(73,741)**	(73,146)
Proceeds from sale of property, plant and equipment		**15**	34	**15**	34
Receipt of cash donations to purchase capital assets		**4,151**	12,399	**4,151**	12,399
NET CASH USED IN INVESTING ACTIVITIES		**(79,626)**	(66,888)	**(79,073)**	(67,275)
Cash flows from financing activities					
Public Dividend capital received		**3,573**	2,661	**3,573**	2,661
Movement in loans from the Department of Health and Social Care		**7,210**	2,203	**7,210**	2,203
Interest paid		**(5,736)**	(5,686)	**(5,736)**	(5,686)
Other interest		**(52)**	–	**(52)**	–
Public Dividend capital paid		**(23,483)**	(18,551)	**(23,483)**	(18,551)
NET CASH GENERATED FROM FINANCING ACTIVITIES		**(18,488)**	(19,373)	**(18,488)**	(19,373)
Net increase/(decrease) in cash and cash equivalents		**9,274**	(5,608)	**8,207**	(5,111)
Cash and cash equivalents at April 1		**134,783**	140,391	**133,454**	138,565
Cash and cash equivalents at March 31	25	**144,057**	134,783	**141,661**	133,454

Notes to the accounts

1 Accounting policies

1.1 Basis of preparation of the financial statements

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 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

The directors have a reasonable expectation that the NHS Foundation Trust will continue to provide the current service for the foreseeable future, as although contract negotiations are not yet complete in all cases they are confident the Trust will receive broadly the same level of funding for the next year as in the previous year (as evidenced by ongoing payments received in April and May) and the Trust starts the new financial year with a healthy cash balance. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.2 Basis of consolidation

The group financial statements consolidate the financial statements of the Trust and entities controlled by the Trust (its subsidiaries) and incorporate its share of the results of joint ventures and associates using the equity method of accounting. The financial statements of the subsidiaries are prepared for the same reporting year as the Trust.

The 'Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where differences are material.

All intragroup balances and transactions, including unrealised profits arising from intragroup transactions, have been eliminated in full on consolidation. 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.

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

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.

The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The exemption to include the Trust's Statement of Comprehensive Income as allowed by DHSC GAM 2018/19 has been applied 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.

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). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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.

1.3.1 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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.

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 it receives notification from the Department of Work and Pensions' Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation

claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.3.4 Revenue grants and other contributions to expenditure

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.

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, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.3.5 Other Income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments 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

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 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.

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:

Pension costs

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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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. The Department of Health and Social Care have recently laid scheme regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

In addition the Trust also operates a NEST scheme for staff not eligible for the NHS pension scheme. This is a defined contribution, off Statement Of Financial Position scheme and the number of employees opting in and the value of the contributions has been negligible.

1.6 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item has cost of at least £5,000; or
- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control

Valuation

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

Land and buildings are valued by an independent registered chartered surveyor on a regular basis and in accordance with Royal Institution of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect fair value. As at 31 March 2019 the land and building assets were revalued.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury adopts a standard approach to depreciated replacement cost valuations using a modern equivalent asset basis, and, where it would meet the location requirements of the service being provided, an alternative site can be valued. As at 31st March 2016 a valuation using an alternative site basis was carried out for the first time.

Properties in the course of construction are carried at cost. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value.

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.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates assets over the following ranges:

- Buildings, 2 – 60 years
- Plant and machinery, 2 – 20 years
- Transport equipment, 2 – 7 years
- IT hardware, 2 – 10 years
- Furniture and fittings, 5 –15 years.

Buildings and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the NHS Foundation Trust's professional valuer. The Trust adopts a policy of revaluing its estates on an annual basis. This has the impact that the useful life for buildings may vary subtly year on year.

Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating 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 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. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated, government grant and other grant funded assets

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

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

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

1.8 Intangible fixed assets

Recognition

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

They are recognised only where it is probable that the future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its

output, or, where it is to be used for internal use, the usefulness of the asset;

- adequate financial, technical and other resources are available to the Trust to complete the development and sale or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

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

Measurement

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

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

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

Amortisation

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

The Trust depreciates intangible assets over the following ranges:

- Information technology, 3– 10 years
- Software licences and trademarks, 5 – 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 solely to generate a commercial return 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 Note 35.

1.11 Government and other revenue grants

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

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the FIFO method.

1.13 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. At any time, 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, except for:

(i) donated assets (including lottery funded assets);

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility; and

(iii) any PDC dividend balance receivable or payable.

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

1.14 Value Added Tax

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

1.15 Corporation tax

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

1.16 Other reserves

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

1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

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

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

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

1.18 Financial assets and financial liabilities

Recognition

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

Financial liabilities 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 or assets measured at fair value through other comprehensive income, 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).

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.

1.19 Leases

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

1.19A The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The assets and liabilities are recognised at the commencement of the lease. Thereafter the assets are accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.19B The Trust as lessor

Finance leases

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

Operating leases

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

1.20 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

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.

1.21 Third party assets

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

1.22 Losses and special payments

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

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

1.23 Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

Provisions

A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to injury benefit liabilities. In calculating the injury benefit provision, the HM Treasury discount rate of 0.29% has been used.

Provision for impairment of receivables

Management will use their judgement to decide when to write-off revenue or to provide against the probability of not being able to collect debt.

Impairments and estimated asset lives

The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives.

Valuations of land and buildings

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See Note 1.7 for further details.

Key sources of estimation uncertainty

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) The use of estimated asset lives in calculating depreciation (See Note 1.7 and Note 1.8).

1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.25 Accounting standards that have been issued but have not yet been adopted

The following list presents a list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2018-19.

IFRS 16 Leases – Has been issued but is not being adopted in the FReM until 1 April 2020.
IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

*The European Financial Reporting Advisory Group recommended in October 2015 that the Standard should not be endorsed as it is unlikely to be adopted by many EU countries.

2 Segmental reporting

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive, is the chief operating decision maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed.

Day-to-day financial control is devolved to:

- Eighteen Clinical Directorates which are accountable to the Board of Directors via the Chief Operating Officer;
- Corporate and other support services accountable to the Board of Directors via the appropriate Executive Directors;
- Evelina London Strategic Business Unit accountable to the Board of Directors via the Chief Executive Officer.

The chief mechanism for financial management and control is a detailed budget report and forecast prepared at account code level each month. An aggregated summary budget is presented by the Director of Finance to the Board of Directors at each meeting. This report is made available to the public at the meeting and via the public website of the Trust.

3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

3.1 Income from patient care (by source)

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
NHS England	**572,060**	538,493
Clinical Commissioning Groups (CCGs)	**643,000**	601,513
NHS Foundation Trusts	**7**	264
NHS Trusts	**133**	98
Local authorities	**10,345**	11,689
Department of Health and Social Care	**11,236**	10
NHS other (including Public Health England)	**4,903**	6,019
Non NHS: private patients	**23,453**	21,485
Non NHS: overseas patients (non reciprocal, chargeable to patient)	**4,163**	3,767
Injury cost recovery scheme	**870**	687
Non NHS: other	**1,698**	1,444
Total income from patient care activities	**1,271,868**	1,185,469
Of which:		
Related to continuing operations	**1,271,868**	1,185,469
Related to discontinued operations	**–**	–

3.2 Income from patient care (by nature)

Acute services	**Year ended March 31 2019 £000**	Year ended March 31 2018 £000
Elective income	**220,579**	203,374
Non-elective income	**143,960**	131,031
Outpatient income	**68,452**	61,897
Follow up outpatient income	**98,245**	89,115
Accident and Emergency income	**29,128**	26,805
High cost drugs income from commissioners (excluding pass-through drugs)	**119,129**	113,344
*Other NHS clinical income	**432,396**	401,116
Community services		
Income from CCGs and NHS England	**104,583**	98,898
Income from other sources (eg local authorities)	**11,869**	12,944
All services		
Private patient income	**23,453**	21,581
AfC pay award central funding	**11,236**	–
Other income	**8,838**	25,364
	1,271,868	1,185,469

*For categories that fall outside of elective and non-elective inpatients, first and follow-up outpatients, A&E and high cost drugs income categories, these are included within Other NHS Clinical Income.

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 2019 £000	Year ended March 31 2018 £000
Commissioner requested services	**1,248,415**	1,163,888
Non Commissioner requested services	**23,453**	21,581
	1,271,868	1,185,469

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

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

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Income recognised this year	**4,163**	3,767
Cash payments received in-year	**1,451**	975
Amounts added to provision for impairment of receivables	**2,674**	2,955
Amounts written-off in-year	**2,991**	5,063

4 Other operating income (Group)

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Other operating income from contracts with customers:		
Research and development	**54,921**	54,317
Education, training and research	**72,807**	73,785
Non-patient care services to other bodies	**33,166**	25,979
Provider Sustainability Fund (PSF) / Sustainability and Transformation Fund (STF)	**47,344**	28,370
Income in respect of staff recharges	**5,259**	4,964
*Other income	**94,202**	80,928
Other non-contract operating income:		
Education and training – notional income from apprenticeship fund	**399**	190
Charitable and other contributions to expenditure and capital assets	**9,859**	70,663
Rental revenue from operating leases – minimum lease payments	**7,111**	7,373
Other non contract income	**188**	–
	325,256	293,569

*Other income includes: £17m from clinical tests, £13m from external estate recharges, £11m received from vacating properties early & the remaining from catering, staff accommodation rentals, income from commercial activities, clinical excellence awards and other direct credits.

5 Additional income disclosures

5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	Year ended March 31 2019 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	**28,702**

5.2 Transaction price allocated to remaining performance obligations

	Year ended March 31 2019 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
within one year	**20,820**
after one year, not later than five years	**–**
after five years	**–**
Total revenue allocated to remaining performance obligations	**20,820**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

6 Operating expenses

6.1 Operating expenses comprise:

	Note	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Purchase of healthcare from NHS and DHSC bodies		**295**	23,660
Purchase of healthcare from non-NHS and non-DHSC bodies		**26,889**	19,532
Staff and executive directors costs		**891,083**	819,219
Non-executive directors		**199**	221
Supplies and services – clinical (excluding drugs costs)		**186,250**	174,563
Supplies and services – general		**9,021**	8,945
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		**140,333**	132,271
Inventories written down (net including drugs)		**725**	404
Consultancy		**2,994**	1,410
Establishment		**20,861**	25,002
Premises – business rates collected by local authorities		**8,618**	10,576
Premises – other		**73,659**	73,529
Transport – other (including patient travel)		**17,044**	14,787
Depreciation		**46,971**	44,139
Amortisation		**10,975**	8,908
Impairments net of reversals		**15,756**	(10,143)
Credit loss allowance		**8,315**	6,683
Change in provisions discount rate		**(69)**	18
Audit services – statutory audit		**108**	108
Other auditor remuneration (payable to external auditor only)	6.2	**8**	8
Internal audit – staff costs		**503**	459
Clinical negligence – amounts payable to NHS Resolution (premium)		**19,156**	21,487
Legal fees		**1,282**	774
Insurance		**1,684**	651
Research and development – non-staff		**636**	269
Education and training – non-staff		**6,309**	6,032
Education and training – notional expenditure funded from apprenticeship fund		**399**	190
Operating lease expenditure		**11,010**	16,828
Early retirements – non-staff		**–**	582
Redundancy costs – staff costs		**654**	342
Hospitality		**65**	145
Other*		**35,973**	10,932
		1,537,706	1,412,553

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

6.2 Other auditor remuneration

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Other auditor remuneration paid to the external auditor		
Audit-related assurance services	**8**	8
Taxation and advisory services	**–**	–
	8	8

Payments made to our auditor for non-audit work in 2018/19 were £nil relating to taxation and advisory services (2017/18 nil).

6.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2018-19 is £2 million (2017-18 £2 million).

6.4 Operating leases

6.4.1 Operating lease expenditure:

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Minimum lease payments under operating leases recognised as an expense in the year	**11,010**	16,828

6.4.2 Future minimum lease payments:

Future minimum lease payments due:	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Within 1 year	**15,839**	17,597
Between 1 and 5 years inclusive	**44,722**	31,184
After 5 years	**44,883**	32,817
	105,444	81,598

6.4.3 Operating lease income:

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Rental revenue from operating leases – minimum lease receipts	**7,111**	7,373
	7,111	7,373

6.4.4 Future minimum lease receipts:

Future minimum lease receipts due:	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Within 1 year	**7,521**	6,786
Between 1 and 5 years inclusive	**25,982**	24,904
After 5 years	**107,524**	99,661
	141,027	131,350

7 Employee costs and numbers

7.1 Employee costs (including executive directors)

	Year ended March 31 2019 Total £000	Year ended March 31 2018 Total £000
Salaries and wages	**727,854**	655,581
Social security costs	**75,886**	70,132
Apprenticeship levy	**3,494**	3,237
Employer contributions to NHSPA	**81,585**	76,089
Termination benefits	**654**	342
Temporary staff – external bank	**6,943**	6,573
Temporary staff – agency and contract staff	**21,462**	28,762
Total gross staff costs	**917,878**	840,716
Recoveries in respect of seconded staff	**(6,143)**	(6,960)
Total staff costs	**911,735**	833,756
Of which:		
Costs capitalised as part of assets	**19,495**	13,736
Analysed into Operating Expenditure (note 6.1)		
Employee expenses – staff & executive directors	**891,083**	819,219
Redundancy	**654**	342
Internal audit costs	**503**	459
Total employee benefits excluding capitalised costs	**892,240**	820,020

7.2 Retirements due to ill-health

During 2018-19 there were 6 early retirements from the Trust agreed on the grounds of ill-health (8 in the year ended March 31 2018). The estimated additional pension liabilities of these ill-health retirements is £360k (£197k in 2017-18). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

8 Other gains and losses

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Loss on disposal of property, plant and equipment	**(33)**	(884)
Profit on disposal of property, plant and equipment	**13**	–
Total (losses) on disposal of assets	**(20)**	(884)

9 Finance income

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Interest on bank accounts	**800**	390
Interest on other investments/financial assets	**92**	74
*Other	**–**	1,113
	892	1,577

*Other: This relates to Interest received from HMRC for an historic VAT reclaim.

10 Finance expenses

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
Capital loans from the Department of Health and Social Care	**(5,744)**	(5,680)
Unwinding of discounts on provisions	**(3)**	(2)
Other finance costs	**(52)**	(3)
	(5,799)	(5,685)

11 Taxation

	Year ended March 31 2019 £000	Year ended March 31 2018 £000
UK corporation tax		
Adjustments in respect of prior years	**232**	35
Current tax payable on income at 20%	**(62)**	(73)
	170	(38)

None of the Trust's activities are subject to corporation tax. However, the Trust's commercial subsidiaries are subject to corporation tax, the totals of which are recorded above.

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of The Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private subject will be subject;
- Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

12 Surplus attributable to the Trust

The Consolidated Statement of Comprehensive Income shows a surplus of £31,449k (17/18 Surplus £40,824k) for the Group.

The surplus for the Trust was £30,976k (2017-18 surplus of £41,337k), and is included within the Statement of Comprehensive Income for the Group. As permitted by DHSC GAM, no separate Statement of Comprehensive Income is presented in respect of the parent.

13 Property, plant and equipment – March 31 2019

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

Group and Trust	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	IT hardware	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1 2018	229,242	815,470	95,595	158,207	164	41,813	3,749	1,344,240
Additions purchased	11,450	5,397	59,11	719	–	1,704	33	78,414
Additions – assets purchased from cash donations/grants	–	–	3,382	13	–	–	–	3,395
Impairments – charged to operating expenses	–	(20,625)	(29)	–	–	–	–	(20,654)
Impairments – charged to the revaluation reserve	(1,170)	(2,163)	–	–	–	–	–	(3,333)
Reversal of impairments credit to revaluation reserve	–	4,898	–	–	–	–	–	4,898
Revaluation	2,943	(8,656)	–	–	–	–	–	(5,713)
Reclassifications	630	34,525	(56,024)	17,358	–	5,060	–	1,549
Disposal	–	–	–	(260)	–	–	–	(260)
Cost or valuation at March 31 2019	**243,095**	**828,846**	**102,035**	**176,037**	**164**	**48,577**	**3,782**	**1,402,536**
Accumulated depreciation at April 1 2018	–	15,020	–	101,160	164	27,753	2,073	146,170
Provided during the year	–	22,308	–	17,604	–	6,717	342	46,971
Reclassification	–	–	–	–	–	(12)	–	(12)
Revaluation	–	(19,962)	–	–	–	–	–	(19,962)
Disposals	–	–	–	(224)	–	–	–	(224)
At March 31 2019	**–**	**17,366**	**–**	**118,540**	**164**	**34,458**	**2,415**	**172,943**
Net book value March 31 2019								
Purchased assets	162,915	595,467	87,140	39,605	–	10.907	278	896,312
Government granted assets	–	165	–	161	–	33	–	359
Donated assets	80,180	215,848	14,895	17,731	–	3,179	1,089	332,922
Total at March 31 2019	**243,095**	**811,480**	**102,035**	**57,497**	**–**	**14,119**	**1,367**	**1,229,593**

The reclassification line of Property, Plant and Equipment, Investment Property 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.

The freehold and long leasehold properties occupied by Guy's and St Thomas' NHS Foundation Trust were valued as at 31 March 2019 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuations were 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.

a) Depreciated Replacement Cost (DRC)

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

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

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

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for the financial accounting purposes under IAS16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS 1.3 as:

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

c) Market Value (MV)

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

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

d) Impairments

Impairments are charged to the revaluation reserve to the extent that the revaluation reserve holds a previous revaluation surplus for that asset. Thereafter, they are charged to operating expenses.

Some assets that increased in value in 2018/19 had an impairment charge to income and expenditure in prior years.

13 Property, plant and equipment – March 31 2018

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

Group and Trust	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	IT hardware	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation								
At April 1 2017	218,262	739,568	79,112	169,638	176	39,759	3,660	**1,250,175**
Additions purchased	–	3,133	56,023	22	–	2,013	9	**61,200**
Additions – grants/donations	–	142	11,585	141	–	118	1	**11,987**
Impairments – charged to operating expenses	–	(5,417)	(384)	–	–	–	–	**(5,801)**
Impairments – charged to the revaluation reserve	(208)	–	–	–	–	–	–	**(208)**
Revaluations	10,770	42,648	–	–	–	–	–	**53,418**
Reclassifications	–	35,396	(50,741)	9,942	–	2,032	79	**(3,292)**
Transfers to assets held for sale	418	–	–	–	–	–	–	**418**
Disposal	–	–	–	(21,536)	(12)	(2,109)	–	**(23,657)**
Cost or valuation								
At March 31 2018	**229,242**	**815,470**	**95,595**	**158,207**	**164**	**41,813**	**3,749**	**1,344,240**
Accumulated depreciation								
At April 1 2017	–	12,379	–	105,510	176	23,106	1,707	**142,878**
Provided during the year	–	20,663	–	16,876	–	6,234	366	**44,139**
Reversal of impairments credited to operating income	–	(16,175)	–	–	–	–	–	**(16,175)**
Revaluation	–	(1,847)	–	–	–	–	–	**(1,847)**
Disposals	–	–	–	(21,226)	(12)	(1,502)	–	**(22,740)**
Reclassifications	–	–	–	–	–	(85)	–	**(85)**
At March 31 2018	**–**	**15,020**	**–**	**101,160**	**164**	**27,753**	**2,073**	**146,170**
Net book value March 31 2018								
Purchased assets	148,599	588,846	81,887	35,213	–	9,764	353	**864,662**
Government granted assets	–	175	–	214	–	51	–	**440**
Donated assets	80,643	211,429	13,708	21,620	–	4,245	1,323	**332,968**
Total at March 31 2018	**229,242**	**800,450**	**95,595**	**57,047**	**–**	**14,060**	**1,676**	**1,198,070**

14 Intangible assets

14.1 As at March 31 2019

Group and Trust	Software licences £000	Information technology £000	Assets under construction £000	Total £000
Cost April 1 2018	6,101	74,888	13,495	94,484
Additions purchased/internally generated	378	888	10,144	11,410
Additions – grants/donations of cash	–	14	742	756
Reclassification	79	5,984	(6,443)	(380)
Disposals	(144)	–	–	(144)
Gross cost at March 31 2019	**6,414**	**81,774**	**17,938**	**106,126**
Amortisation April 1 2018	3,590	46,037	–	49,627
Provided during the year	653	10,322	–	10,975
Reclassifications	–	12	–	12
Disposals	(144)	–	–	(144)
Amortisation at March 31 2019	**4,099**	**56,371**	**–**	**60,470**
Net book value March 31 2019	**2,315**	**25,403**	**17,938**	**45,656**
Purchased assets	2,080	23,791	17,457	43,328
Government granted assets	86	337	–	423
Donated assets	149	1,275	481	1,905
Total at March 31 2019	**2,315**	**25,403**	**17,938**	**45,656**

The reclassification line of Property, Plant and Equipment, Investment Property 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 both notes are viewed together.

14.2 As at March 31 2018

Group and Trust	Software licences £000	Information technology £000	Assets under construction £000	Total £000
Cost April 1 2017	5,622	67,693	11,874	85,189
Additions purchased/internally generated	118	1,931	6,182	8,231
Additions – grants/donations of cash	5	24	383	412
Impairments charged to operating expenses	–	–	(231)	(231)
Reclassification	356	7,649	(4,713)	3,292
Disposals	–	(2,409)	–	(2,409)
Gross cost at March 31 2018	**6,101**	**74,888**	**13,495**	**94,484**
Amortisation April 1 2017	2,817	40,226	–	43,043
Provided during the year	773	8,135	–	8,908
Reclassifications	–	85	–	85
Disposals	–	(2,409)	–	(2,409)
Amortisation at March 31 2018	**3,590**	**46,037**	**–**	**49,627**
Net book value March 31 2018	**2,511**	**28,851**	**13,495**	**44,857**
Purchased assets	2,160	27,334	12,582	42,076
Government granted assets	156	530	–	686
Donated assets	195	987	913	2,095
Total at March 31 2018	**2,511**	**28,851**	**13,495**	**44,857**

15 Impairments

	March 31 2019 £000	March 31 2018 £000
Charged to Statement of Comprehensive Income (SOCI):		
Impairments arising from professional valuation including reversals	**(20,086)**	(5,417)
Reversals of impairments arising from professional valuation	**4,898**	16,175
Other impairments of property, plant and equipment	**(539)**	–
Other impairments of Asset under construction	**(29)**	(384)
Total impairments of property, plant and equipment charged to I&E	**(15,756)**	10,374
Impairment of intangibles	**–**	(231)
Net impairment impact on SOCI	**(15,756)**	10,143
Charged to Revaluation Reserve:		
Professional valuation impairments of land value	**(1,170)**	(208)
Professional valuation impairments of building value	**(2,163)**	–
Total impairments charged to Other comprehensive Income	**(3,333)**	(208)

The majority of the 2018/19 impairment reversal and charge relates to the property valuation.

Land and buildings were valued independently by Gerald Eve as at 31 March 2019 in line with the accounting policies. The valuation included positive and negative valuation movements. Revaluation losses were taken to the revaluation reserve to the extent there was a revaluation surplus. Any losses over and above the revaluation surplus were charged to the Statement of Comprehensive Income (SOCI).

The movement arising from the professional valuation can be summarised as follows:

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 2019 £000	March 31 2018 £000
Net impairments charged to operating surplus		
Loss or damage resulting from normal operations	**539**	–
Abandonment of assets in the course of construction	**29**	615
Other (arising from market valuations)	**15,188**	(10,758)
Total impairments and (reversals) charged to operating surplus	**15,756**	(10,143)
Total net impairments charged to revaluation reserve	**3,333**	208
Total impairments and (reversals)	**19,089**	(9,935)
Impairments charged to operating expenses:		
Of which Departmental Expenditure Limit (DEL)	**539**	615
Of which Annually Managed Expenditure (AME)	**15,188**	(10,758)

	March 31 2019 £000 Revaluation Reserve	March 31 2019 £000 SOCI	March 31 2019 £000 Total	March 31 2018 £000 Revaluation Reserve	March 31 2018 £000 SOCI	March 31 2018 £000 Total
From professional valuation of land and buildings:						
Increase in land value	**2,943**	**–**	**2,943**	10,770	–	10,770
Increase in building value	**11,308**	**–**	**11,308**	44,495	–	44,495
Impairments in land value	**(1,170)**	**–**	**(1,170)**	(208)	–	(208)
Impairments in building value	**(2,163)**	**(20,086)**	**(22,249)**	–	(5,417)	(5,417)
Reversal of previous impairments	**–**	**4,898**	**4,898**	–	16,175	16,175
Total movement	**10,918**	**(15,188)**	**(4,270)**	55,057	10,758	65,815
Other valuation movements:						
Other impairments of property, plant and equipment	**–**	**(29)**	**(29)**	–	(384)	(384)
Loss or damage resulting from normal operations	**–**	**(539)**	**(539)**	–	–	–
Intangible impairment	**–**	**–**	**–**	–	(231)	(231)
	10,918	**(15,756)**	**(4,838)**	55,057	10,143	65,200

16 Assets for sale

	March 31 2019 £000	March 31 2018 £000
Carrying value at April 1	**–**	418
Assets classified as available for sale in the year	**–**	–
Less assets no longer classified as held for sale, for reasons other than disposal by sale	**–**	(418)
Carrying value at March 31	**–**	–

17 Investment property

Investment property carrying values

	March 31 2019 £000	March 31 2018 £000
Carrying value at April 1	**1,169**	1,169
Reclassifications to Property, Plant and Equipment	**(1,169)**	–
Carrying value at March 31	**–**	1,169

The property which was rented to Lloyds pharmacy and Sainsbury's will be demolished and is no longer classified as an investment property. The land and building were reclassified as Property, Plant and Equipment and the building subsequently impaired.

18 Revaluation reserve movements

Property, plant and equipment

	March 31 2019 £000	March 31 2018 £000
Property, Plant and Equipment		
Revaluation reserve at April 1	**372,671**	317,614
Impairments	**(3,333)**	(208)
Revaluations	**14,249**	55,265
Revaluation reserve at March 31	**383,587**	372,671

19 Subsidiaries and interests in associates and joint ventures

The Guy's and St Thomas' principal subsidiary undertakings, associates and joint ventures as included in the consolidation at March 31 2019 are set out below. The accounting date of the financial statements for the subsidiaries is March 31 2019 and for the joint ventures December 31 2018. For the joint venture undertakings that have different accounting year-end dates, interim accounts to March 31 have been consolidated.

	Country of incorporation	Beneficial interest	Principal activity
Subsidiary undertakings			
Guy's and St Thomas' Enterprises Ltd	UK	100%	Holding company
GTI Forces Healthcare Ltd [1/3]	UK	100%	Healthcare services
Pathology Services Ltd [1]	UK	100%	Healthcare services
Essentia Trading Ltd [1]	UK	100%	Healthcare services
Associates and joint ventures			
SSAFA GSTT Care LLP	UK	50%	Healthcare services
Viapath Group LLP[1]	UK	33%	Healthcare services
Viapath Services LLP[1]	UK	33%	Healthcare services
Viapath Analytics LLP[1]	UK	33%	Healthcare services
Spot on Diagnostics Ltd[1]	UK	30%	Healthcare services
Precision Diagnostic Analytics Ltd[1]	UK	25%	Healthcare services
King's Health Partners Ltd[2]	UK	25%	Healthcare services
Collaborative Procurement Partnership (CPP) LLP	UK	25%	Healthcare services

[1] Not directly owned by Guy's and St Thomas' NHS Foundation Trust
[2] Limited by guarantee – no cash investment has been made, Guy's and St Thomas' NHS Foundation Trust holds 25% voting rights.
[3] A decision has been taken by the Guy's and St Thomas' Enterprises Limited Board and GTI Forces Healthcare Limited Board to close down GTI Forces Healthcare Limited during 19/20. The company has not traded for several years.

19.1 Investments

	Investments joint ventures and associates March 31 2019	Investments joint ventures and associates March 31 2018
	£000	£000
Carrying value at April 1	**71**	71
Sharing of profit from Joint Venture	**236**	–
Dividends received	**(70)**	–
Carrying value at March 31	**237**	71

20 Inventories

	GROUP AND TRUST	
	March 31 2019 £000	March 31 2018 £000
Raw materials and consumables	**21,957**	25,075
	21,957	25,075

21 Trade and other receivables

21.1 Current

	GROUP AND TRUST	
	March 31 2019 £000	March 31 2018 £000
Contract receivables: invoiced*	**113,543**	–
Contract receivables: not yet invoiced*	**86,317**	–
Capital receivables*	**12,353**	–
Trade receivables*	**–**	87,635
Accrued income*	**–**	80,545
Credit loss allowance	**(32,138)**	(27,056)
Prepayments	**6,350**	9,287
PDC dividend receivable	**48**	13
VAT and other tax receivable	**3,370**	2,097
Other receivables	**4,736**	5,773
	194,579	158,294

21.2 Non-current

	GROUP AND TRUST	
	March 31 2019 £000	March 31 2018 £000
Contract receivables	**2,260**	2,107
	2,260	2,107

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Accrued income in prior year included capital receivables, which have been separately split out in 2018/19.

21.3 Allowances for credit losses 2018/19

	GROUP AND TRUST	
	Contract receivables and contract assets £000	**All other receivables £000**
Allowances as at 1 April 2018 brought forward (before IFRS 9 and IFRS 15)	**–**	**27,056**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	**27,056**	**(27,056)**
New allowances arising	**8,315**	**–**
Utilisation of allowances	**(3,233)**	**–**
Allowances as at 31 March 2019	**32,138**	**–**

21.4 Allowances for credit losses 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	March 31 2018 £000
Allowances as at 1 April 2017	**25,812**
Increase in provision	**6,683**
Amounts utilised	**(5,439)**
Allowances as at 31 March 2018	**27,056**

22 Other investments/financial assets

Non-current	GROUP March 31 2019 £000	GROUP March 31 2018 £000	TRUST March 31 2019 £000	TRUST March 31 2018 £000
Carrying value at April 1	**1,368**	2,574	**4,898**	5,595
Additions	**–**	64	**58**	48
Current re-classified as non-current	**–**	–	**–**	525
Current portion of loans receivable transferred to current financial assets	**(1,230)**	(1,230)	**(1,870)**	(1,270)
Carrying value at March 31	**138**	1,368	**3,086**	4,898

Current	March 31 2019	March 31 2018	March 31 2019	March 31 2018
Loans receivable within 12 months transferred from non-current financial status	**1,230**	1,270	**1,870**	1,270
Loan instalment settled	**–**	–	**(320)**	–
	1,230	1,270	**1,550**	1270

2018-19 Group other investments/financial assets

Organisation	Current £000	Non-current £000	Interest rate	Maturity date
Viapath Group	1,230	–	Libor +2%	Dec 2019
Convertible loan notes	–	64		
Other investments	–	74		
	1,230	**138**		

2018-19 Trust other investments/financial assets

Organisation	Current £000	Non-current £000	Interest rate	Maturity date
Viapath Group	1,230	–	Libor +2%	Dec 2019
Pathology Services Ltd (loan + accumulated interest)	–	2,126	Libor +2%	Mar 2022
Essentia Trading Ltd	320	960	3.50%	Mar 2024
	1,550	**3,086**		

Loans with Pathology Services Ltd and Essentia Trading Limited are removed from the Group Accounts following consolidation adjustments.

23 Current liabilities

23.1 Trade and other payables

	GROUP AND TRUST March 31 2019 £000	GROUP AND TRUST March 31 2018 £000
Trade payables	**57,643**	49,966
Capital payables	**23,682**	15,733
Accruals	**71,649**	67,624
Receipts in advance	**1,248**	1,137
Other taxes payable	**21,160**	19,423
Accrued interest on other loans*	**–**	886
Other payables	**1,290**	2,051
	176,672	156,820

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 23.3. IFRS 9 is applied without restatement therefore comparatives have not been restated.

23.2 Other liabilities

	GROUP AND TRUST	
Current	**March 31 2019 £000**	March 31 2018 £000
Deferred income: contract liabilities	**20,820**	28,657
Deferred grants	**3,281**	45
Lease incentives	**6,350**	–
	30,451	28,702

23.3 Borrowings

	GROUP AND TRUST	
Current	**March 31 2019 £000**	March 31 2018 £000
Capital loans from Department of Health and Social Care (DHSC)*	**12,669**	12,085
	12,669	12,085

	GROUP AND TRUST	
Non-current	**March 31 2019 £000**	March 31 2018 £000
Capital loans from Department of Health and Social Care	**218,810**	211,290
	218,810	211,290
Total borrowings (current and non-current)	**231,479**	**223,375**

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 23.3. IFRS 9 is applied without restatement therefore comparatives have not been restated.

23.4 Reconciliation of liabilities arising from financing activities

Group	**Loans from DHSC £000**
Carrying value at 1 April 2018	**223,375**
Impact of implementing IFRS 9 on 1 April 2018	**886**
Cash movements:	
Financing cash flows – payments and receipts of principal	**7,210**
Financing cash flows – payments of interest	**(5,736)**
Non-cash movements:	
Interest charge arising in year	**5,744**
Carrying value at 31 March 2019	**231,479**

23.5 Schedule of borrowing from the Department of Health and Social Care

Date loan started	Date to be completed	Interest rate	Amount of loan agreed March 31 2019	Total repaid March 31 2019	Amounts left to draw down March 31 2019	Amounts outstanding March 31 2019	Accrued interest March 31 2019	Total borrowings and interest March 31 2019
		%	£000	£000	£000	£000	£000	£000
Mar 2012	Mar 2037	2.85	80,000	13,048	–	66,952	58	67,010
Jun 2011	Jun 2036	3.27	75,000	15,322	–	59,678	557	60,235
Jun 2011	Jun 2017	1.05	5,000	5,000	–	–	–	–
Sep 2013	Nov 2023	1.95	9,000	3,375	–	5,625	40	5,665
Feb 2016	Feb 2041	1.9	25,000	2,550	–	22,450	48	22,498
Feb 2016	Feb 2041	1.9	14,000	1,165	–	12,835	27	12,862
Feb 2016	Feb 2041	1.9	33,768	750	–	33,018	71	33,089
Feb 2016	Feb 2031	1.38	27,232	–	7,206	20,026	30	20,056
Nov 2017	Nov 2042	1.76	10,000	–	–	10,000	64	10,064
			279,000	**41,210**	**7,206**	**230,584**	**895**	**231,479**

No security has been pledged against these loans.

All borrowing relates to capital loans have been secured to support the Trust's ongoing plans to redevelop its two hospital sites and upgrade IT and other infrastructure.

The Trust has agreement in principle from the Department of Health and Social Care for an additional loan of £90 million which is critical in addressing the projected operational capacity constraints.

24 Provisions for liabilities

Group and Trust

24.1 Overall provisions

	Current		Non-current		Total Provisions	
	March 31 2019 £000	March 31 2018 £000	**March 31 2019 £000**	March 31 2018 £000	**March 31 2019 £000**	March 31 2018 £000
*Pensions: injury benefit	**43**	43	**751**	835	**794**	8,78
Legal claims	**243**	246	**–**	–	**243**	246
Other	**12**	409	**2,876**	5,392	**2,888**	5,801
	298	698	**3,627**	6,227	**3,925**	6,925

24.2 Changes in provisions

	Pensions – injury benefits £000	**Legal claims £000**	**Other £000**	**Total £000**
As at April 1 2018*	878	246	5,801	**6,925**
Change in discount rate	(69)	–	–	**(69)**
Arising during the year	16	113	–	**129**
Utilised during the year	(34)	(37)	(179)	**(250)**
Reversed unused	–	(79)	(2,734)	**(2,813)**
Unwinding of discount	3	–	–	**3**
As at March 31 2019	**794**	**243**	**2,88**	**3,925**

24.3 Expected timing of cash flows

	Pensions – injury benefits £000	**Legal claims £000**	**Other £000**	**Total £000**
Within one year	43	243	12	**298**
Between one and five years	171	–	1,240	**1,411**
After five years	580	–	1,636	**2,216**
	794	**243**	**2,888**	**3,925**

*The opening balance has been reanalysed to reflect updates to presentational requirements of the Department of Health and Social Care Group Accounting Manual. This change has involved, splitting out injury benefit provisions from the 'other' category.

Other provisions largely consist of provisions for dilapidations.

£382m is included in the provision of NHS Resolution under legal claims in respect of clinical negligence liabilities of the Foundation Trust (£332m at March 31 2018).

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

25 Analysis in changes of net cash

GROUP	At April 1 2017 £000	Cash changes in period £000	At March 31 2018 £000	Cash changes in period £000	**At March 31 2019 £000**
Cash with the Government Banking Service	138,404	(5,147)	133,257	8,158	**141,415**
Cash at bank and in hand – commercial bank	1,987	(461)	1,526	1,116	**2,642**
	140,391	(5,608)	134,783	9,274	**144,057**

TRUST	At April 1 2017 £000	Cash changes in year £000	At March 31 2018 £000	Cash changes in year £000	**At March 31 2019 £000**
Cash with the Government Banking Service	138,404	(5,146)	133,258	8,157	**141,415**
Cash at bank and in hand – commercial bank	161	35	196	50	**246**
	138,565	(5,111)	133,454	8,207	**141,661**

26 Contractual commitments

	GROUP AND TRUST	
	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	**9,737**	24,477
Intangible assets	**5,355**	1,330
	15,092	28,807

27 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made:

	GROUP AND TRUST	
	31 March 2019	31 March 2018
	£000	£000
Not later than 1 year	**1,306**	304
After 1 year and not later than 5 years	**16,269**	3,068
Paid thereafter	**29,196**	46,207
Total	**46,771**	50,207

Guy's and St Thomas' NHS Foundation Trust has entered in to a Managed Service Agreement with Johnson & Johnson Finance Ltd relating to the provision of managed orthopaedic theatre facilities. The contract commenced on 16 April 2018 and will last for 15 years from this date.

28 Events after the reporting date

There were no events after the reporting date.

29 Contingencies

29.1 Contingent liabilities

	GROUP AND TRUST	
	31 March 2019	31 March 2018
	£000	£000
Contingent liabilities for claims against the group and Trust	**(85)**	(88)
Net contingent liability	**(85)**	(88)

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

30 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 2019 was £23,448k (2017-18 £20,631k), based on average relevant net assets less average GBS cash balances totalling £669,931k.

31 Related party transactions

Guy's and St Thomas' NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. It falls within the Department of Health and Social Care's (DHSC) consolidation boundary. DHSC is regarded as a related party. The DHSC is the parent department of the Trust. During the year Guy's and St Thomas' Foundation Trust has had a number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department as listed below:

- NHS Foundation Trusts
- NHS Trusts
- Department of Health and Social Care
- Public Health England
- Health Education England
- CCGs and NHS England
- Special Health Authorities
- Non-Departmental Public Bodies
- Other Department of Health and Social Care bodies

The Trust has taken advantage of the exemption provided by IAS 24 'Related Party Disclosures', where the parent's own financial statements are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation.

The 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.

	Amounts due from related parties		Amounts owed to related parties	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Non-NHS related party transactions				
Guy's and St Thomas' Charity	**989**	1,842	**26**	–
King's College London	**8,979**	5,809	**6,110**	5,216
Viapath*	**3,377**	2,888	**2,130**	2,434
SSAFA GSTT Care LLP	**1,097**	1,380	**0**	1

	Receipts from related parties		Payments to related parties	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Non-NHS related party transactions				
Guy's and St Thomas' Charity	**10,724**	13,843	**98**	70
King's College London	**21,894**	18,553	**22,388**	11,873

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

	31 March 2019	31 March 2018
	£000	£000
Trust debtor with wholly owned subsidiaries		
Essentia Trading Ltd	**2,257**	879
GSTT Enterprises Ltd	**75**	106
Pathology Services Ltd	**2,128**	1
Trust creditor with wholly owned subsidiaries		
Essentia Trading Ltd	**1,107**	1,347
Trust income from wholly owned subsidiaries		
Essentia Trading Ltd	**912**	703
GSTT Enterprises Ltd	**104**	100
Pathology Services Ltd	**59**	50
Trust expenditure with wholly owned subsidiaries		
Essentia Trading Ltd	**4,660**	3,303

The subsidiaries are wholly owned by the Trust and the transactions are eliminated on consolidation.

Sir Hugh Taylor is Chair of the Health Foundation and Trustee of Cicely Saunders International. From 1 March 2019, Sir Hugh Taylor became interim Chair of King's College Hospital NHS Foundation Trust, all bodies which interact with the Trust from time to time.

Dr Ian Abbs sits on the Governing Bodies of Lambeth CCG and Southwark CCG representing King's Health Partners.

Dame Eileen Sills is a visiting Professor at King's College London and London Southbank Universities.

Janet Powell is renting an apartment from the Trust at a market rate.

Alastair Gourlay is Trustee of the Florence Nightingale Museum which is a charity that operates from space in Gassiot House provided by the Trust free of charge. He is also a Director of Southbank Employers Group and GSTT is a member of that organisation.

The Council of Governors includes representatives from organisations that work closely with the Trust including Lambeth Council, Southwark Council, Lambeth CCG, Southwark CCG, NHS England, London South Bank University, King's College London, King's College Hospital NHS Foundation Trust and South London and Maudsley NHS Foundation Trust.

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

32 Financial assets and liabilities

32.1 Carrying value and fair value of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group and Trust	**Held at amortised cost**
	March 31 2019 £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9	
Trade and other receivables (excluding non financial assets) – with NHS and DHSC bodies	**123,647**
Trade and other receivables (excluding non financial assets) – with other bodies	**63,590**
Other investments/financial assets	**1,439**
Cash and cash equivalents	**144,057**
Total at 31 March 2019	**332,733**

Group and Trust	Loans and receivables
	March 31 2018 £000
Carrying values of financial assets as at 31 March 2018 under IAS 39	
Trade and other receivables (excluding non financial assets) – with NHS and DHSC bodies	102,088
Trade and other receivables (excluding non financial assets) – with other bodies	46,929
Other investments/financial assets	2,709
Cash and cash equivalents	134,783
Total at 31 March 2018	286,509

32.2 Carrying value and fair value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group and Trust	**Held at amortised cost**
	March 31 2019 £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	
Loans from DHSC	**231,479**
Trade and other payables (excluding non financial liabilities) – with NHS and DHSC bodies	**17,154**
Trade and other payables (excluding non financial liabilities) – with other bodies	**137,110**
Provisions under contract	**3,925**
Total at 31 March 2019	**389,668**

Group and Trust	Loans and receivables
	March 31 2018 £000
Carrying values of financial assets as at 31 March 2018 under IAS 39	
Loans from DHSC	223,375
Trade and other payables (excluding non financial liabilities) – with NHS and DHSC bodies	11,789
Trade and other payables (excluding non financial liabilities) – with other bodies	124,471
Provisions under contract	6,925
Total at 31 March 2019	366,560

The carrying value and fair value of the financial assets and financial liabilities are not materially different.

32.3 Maturity of financial liabilities

Group and Trust	**March 31 2019 £000**	March 31 2018
In one year of less	**167,232**	149,043
In more than one year but no more than two years	**12,777**	12,376
In more than two years but no more than five years	**39,742**	39,688
In more than five years	**169,917**	165,453
	389,668	366,560

32.4 Loan disclosure

	Current	**Non current**	**Total**	**Weighted average interest rate**
	£000	**£000**	**£000**	**%**
March 31 2019				
Fixed interest rate instruments	**12,669**	**218,810**	**231,479**	**2.48%**
March 31 2018				
Fixed interest rate instruments	12,085	211,290	223,375	2.57%

32.5 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with the Clinical Commissioning Groups (CCG), and the way those CCGs are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS 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 Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has an operation overseas with British Forces in Germany and consequently makes Euro transactions. Overall the Trust deems that it is not exposed to significant exchange rate risk. However, to provide some certainty over Euro exchange rate gains and losses, the Trust has taken out Forward Currency contracts during 2018-19. All contracts matured during 2018-19.

Interest rate risk

The Trust borrows from Government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has limited exposure to credit risk. The maximum exposures as at March 31 2019 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds generated from free cash flow and donations. The details of our borrowing to fund capital expenditure is detailed in the Borrowings note.

33 Third party assets

The Trust held £227k cash and cash equivalents at March 31 2019 (£216k at March 31 2018) which relates to monies held by the Trust on behalf of patients. This has been excluded in the cash at bank and in hand figure reported in the accounts. £2,798k is held as client monies on behalf of tenants as a result of assurities (£2,792k at March 31 2018).

34 Losses and special payments

Losses	**Year ended March 31 2019 Cases**	**Year ended March 31 2019 £000**	Year ended March 31 2018 Cases	Year ended March 31 2018 £000
Cash losses	**3**	**250**	15	162
Stores losses and theft	**124**	**753**	87	414
Bad debts and claims abandoned*	**1,108**	**3,222**	1,022	5,391
Total losses	**1,235**	**4,226**	1,124	5,967

Special payments	**Year ended March 31 2019 Cases**	**Year ended March 31 2019 £000**	Year ended March 31 2018 Cases	Year ended March 31 2018 £000
Ex gratia payments	**27**	**15**	32	12
Total special payments	**27**	**15**	32	12
Total losses and special payments	**1,262**	**4,241**	1,156	5,979
Of which cases of £300k or more				
Store losses**	**1**	**301**	–	–

The amounts quoted above are reported on an accruals basis but exclude provision for future losses.

*Old debt of £2.9m for overseas visitors was written off in 2018/19.

**During the year £301k of obsolete cardiac stock was written off from inventory.

35 Heritage assets note

Historic artefacts

The remains of a Roman boat lie in the Guy's Hospital site, beneath the Cancer Centre. The artefact has been disclosed as a non-operational heritage asset. As well as being of significance in its own right, the artefact assists in interpreting and presenting our hospital to the public and provides a valuable research resource for heritage professionals. Subject to conditions not deteriorating, the Roman Boat will remain preserved in situ and thus will remain on the Trust's land. The ground conditions around the boat are subject to regular monitoring. Should conditions deteriorate to a certain level, then a decision will be taken to remove the boat. The Trust holds scheduled monument consent from the Department for Culture, Media and Sport.

The Trust does not consider that reliable cost or valuation information can be obtained for the Roman boat, and even if valuations can be obtained, the cost would be onerous compared with the additional benefits derived by the Trust and the users of the accounts. This is because of the nature of the asset held and the lack of comparable market values. The Trust therefore does not recognise this asset on its Statement of Financial Position.

Donated artefacts received during the year had a value of nil (2017-18: nil). There were no disposals of artefacts during either year.

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

The Trust incurred £2k (£nil 2017-18) in charges relating to the late payment of commercial debts.

37 Adoption of new accounting standards during 2018/19

37.1 Initial Application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £886k, and trade payables correspondingly reduced.

37.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Implementation of IFRS 15 has not had a material impact on the numbers reported by the Trust.

38 Accounting standards that have been issued but have not yet been adopted

IAS 8 requires entities to disclose an estimate of the impact of future accounting standards not yet adopted.

38.1 Impact of future accounting standards: IFRS 16

The Trust cannot yet assess whether the changes in IFRS 16 lease accounting will have a material impact on the Trust's 2020/21 accounts.

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