NHS

Guy's and St Thomas'
NHS Foundation Trust

Annual Report and Accounts 2019/20

Guy's and St Thomas' NHS Foundation Trust Annual Report and Accounts 2019/20

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 eight academic health sciences centres (AHSCs), bringing together world-class clinical services, teaching and research. We work closely with our AHSC partners – King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London, our shared university partner.

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 18,050 staff, making us one of the largest employers locally. We aim to reflect the diversity of the local communities we serve and continue to develop new and existing partnerships with local people, patients, neighbouring NHS organisations, local authorities and charitable bodies and GPs.

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

King's Health Partners is one of eight AHSCs in England and brings together an unrivalled range and depth of clinical and research expertise, spanning both physical and mental health. Our combined strengths drive improvements in care for patients, allowing them to benefit from breakthroughs in medical science and receive leading edge treatment at the earliest possible opportunity.

For more information, visit **www.kingshealthpartners.org**

KING'S HEALTH PARTNERS

Pioneering better health for all

Evelina London Patron, The Duchess of Cambridge, visited Sunshine House Children and Young People's Development Centre, one of the centres where Evelina London provides community services for families in Southwark.

Contents

In 2019 we launched a new role in our nursing team. The nursing associate will help bridge the gap between healthcare assistants and registered nurses. The role will also provide a route into graduate level nursing.

1 Chairman's statement

I would like to take this opportunity to pay tribute to the outstanding way in which staff across Guy's and St Thomas', in our hospitals and in the community, have responded to the Coronavirus (COVID-19) pandemic.

We have also been wonderfully supported in this crisis – and throughout the year – by Guy's and St Thomas' Charity and by the fundraising team.

I have seen, first hand, the determination and resilience of individuals and teams to overcome unprecedented organisational, professional and personal challenges in order to provide the best possible care for our patients. It has been both humbling and inspiring.

As we head into what promises to be a hugely significant period of change for the Trust and for our National Health Service as a whole, it is also incumbent on me to reflect on some of our achievements from the past year.

Building new relationships and nurturing existing partnerships have been recurrent themes. Joint appointments at Board level and the development of a Committee in Common have supported ever closer working between Guy's and St Thomas' and King's College Hospital NHS Foundation Trusts.

Working with colleagues across King's Health Partners (KHP) we have put in place plans to improve care and outcomes for people with cardiovascular and respiratory disease, including our proposals for an agreed merger with Royal Brompton and Harefield NHS Foundation Trust.

The reaccreditation of KHP as an academic health sciences centre will help ensure that we continue to align world-class academic research with world-class clinical practice to deliver improvements in the health of our local communities.

The launch of our new Integrated Care strategic business unit in April 2019, bringing together acute and adult community services, marks the beginning of the next phase of working in partnership across Lambeth and Southwark.

Alongside these developments we have also been engaged in progressing the emergent south east London Integrated Care System (ICS), focusing on a set of priorities to deliver better health, care and well-being.

As well as these organisational and system achievements, I have, over the past 12 months, been fortunate to participate in numerous examples of the Trust's commitment to its patients and its people: too many to list here. Some of the highlights for me were:

- events to mark the 150th anniversary of the founding of Evelina London Children's Hospital
- our commitment to the London Living Wage for all our staff, including contractors
- the positive outcome of our inspection by the Care Quality Commission, where we maintained our overall rating of 'good' and where our community services for adults were rated as 'outstanding', with the inspectors highlighting the dedication and passion of our staff.

I feel privileged to be associated with this organisation and the people who have made it – and who continue to make it – such an outstanding example of public service.

Finally, on behalf of the Board and as Chairman of the Council of Governors, I would like to record my gratitude to all our governors, especially those whose term of office came to an end this year, and to welcome new colleagues to the Council.

I would also like to thank Board colleagues for their continued support, to thank Girda Niles, who stepped down as a non-executive director this year, and to welcome Paul Cleal.

Sir Hugh Taylor, Chairman
10 June 2020

Our patients rated the overall experience of care they receive at Guy's and St Thomas' as 8.5 out of 10 in the Care Quality Commission's adult inpatient survey.

2 Performance report

Annual performance statement from the Chief Executive

Much of this year's Annual Report was prepared in the weeks before the impact of the Coronavirus (COVID-19) pandemic became known.

In keeping with requirements set out by NHS Improvement, we have retained as much of that information as possible without amendment.

However, we have also sought to provide some early reflections on the Trust's response to the pandemic.

While some sections of the Annual Report are necessarily limited to information available at the time of writing, we believe, taken as a whole, it provides as accurate a reflection as possible of our operational and financial performance in 2019/20.

The year 2020 will be remembered as a traumatic one for much of the world. Certainly, in its 72 years, the NHS has never known anything like it. We have been tested as never before, as a National Health Service, as a Trust and as individuals.

Many families, including among our own staff caring for the sickest patients, will have been deeply affected by the tragic loss of life.

Faced with this devastating pandemic, staff across Guy's and St Thomas' have demonstrated their ingenuity, their courage, and their commitment to our patients and to each other. I am so grateful for everything they have done.

We are living through an historic moment, which will clearly continue for some time. But I am sure already that we will be able to look back with pride at how the Trust, and every one of us in the NHS, stepped forward at this time of national crisis.

The beginning of the pandemic

The novel coronavirus, COVID-19, first emerged in Wuhan, China in late 2019 and spread quickly through parts of East Asia, the Middle East, Europe and North America, eventually touching most countries around the world in some way.

As soon as it became apparent that COVID-19 would not be contained within East Asia, the Trust was at the forefront of NHS efforts to respond to the virus. As one of four national centres for High Consequence Infectious Diseases (HCID), some of the first COVID-19 patients were admitted to St Thomas'.

On 12 March 2020, the Trust declared a critical site incident to initiate our well-rehearsed incident management protocols and procedures. At the time of writing, we continue to keep our governance processes under review to ensure they are appropriate to the ongoing situation. Temporary changes to our financial and procurement arrangements, considered essential to our pandemic response, are highlighted in the annual governance statement on page 68.

Putting patients first

Throughout the pandemic, we have remained true to our values and our overarching priority has been to keep our patients safe and to care for them as effectively and compassionately as possible.

In order to avoid potential exposure to the virus among our many patients with chronic

Annual performance statement

conditions, we reduced significantly the number who had to come to hospital for an outpatient appointment and converted as many appointments as possible to remote consultations using telephone or video software.

We worked rapidly with HCA Healthcare, which has hospital facilities at London Bridge, to open up their theatres for the treatment of NHS patients, so that we could carry on with the most clinically urgent surgery, including some cancer operations.

In order to cope with the dramatic increase in COVID-19 patients who needed critical care, we took rapid steps to increase capacity significantly. This included the extraordinary feat of relocating, within just two weeks, the paediatric intensive care unit to the sixth floor of the Evelina London Children's Hospital to free up space on the second floor for adult critical care. We also doubled the number of patients we could treat with extracorporeal membrane oxygenation (ECMO), a highly specialised technique to provide oxygen into the bloodstream when a patient's lungs cannot cope.

It is a very sad fact that COVID-19 is a new virus with a significantly higher mortality rate than pneumonia caused by seasonal influenza. We continue to monitor closely the outcomes of our critical care patients by age, gender and ethnicity, and to benchmark against national data. However, it is clear that our patients are receiving the best possible care, with the majority having positive outcomes.

We are very proud of how the team at St Thomas' cared for the Prime Minister when he was taken seriously ill with the virus, and that he was able to return to good health. At that moment, the Trust was in the global spotlight and managed the challenges this presented with exemplary professionalism, ensuring each and every one of our patients continued to receive the best possible care.

While the Trust has maintained access to other essential services at our hospitals and community sites during the pandemic, in common with the rest of the NHS, we witnessed a sharp reduction in the number of patients accessing services such as A&E and rapid diagnostics for possible cancer. We therefore took steps to publicise to our community the importance of patients continuing to seek help when they needed it.

Caring for our staff

As well as caring for our patients, it has been essential for us also to care for each other in these difficult times. The pandemic has placed extraordinary pressures on our 18,050 staff and they have responded commendably. This has been the most incredible team effort, with everyone playing their part, including thousands of staff who volunteered to be redeployed into different roles to directly support the effort to cope with COVID-19.

One of the most important and high profile issues of the pandemic response has been the provision of personal protective equipment (PPE). Our procurement and supply chain teams have worked tirelessly, teaming up with the Foreign and Commonwealth Office to source vital equipment and PPE internationally, chartering flights to bring essential medical equipment into the UK, and establishing a 3D printing factory to manufacture visors in our new supply chain hub at Dartford.

As a result, we have maintained a reliable supply of PPE in spite of the most intense global demand for those products. We have been able to keep our frontline clinical teams safe in our hospitals and community sites, and we have also provided supplies, through mutual aid, to other NHS trusts.

After an initial increase in sickness absence early on in the course of the pandemic, sickness levels among our staff have quickly returned to more normal levels. St Thomas' was a pilot site for staff testing for COVID-19 and we subsequently made viral testing available for all staff who displayed relevant symptoms.

The Trust introduced a range of innovations to support our staff at this time of personal and professional strain. This included free emergency supplies stores at both our main hospitals, and mobile drops at community sites, for groceries. We also opened health and wellbeing hubs across our sites where staff could rest and recharge. Psychological support has been made widely available to all staff, recognising that they have been working extremely hard, under great pressure, and often while coping with challenging circumstances in their personal lives as well as at work.

When social distancing measures were introduced, we enabled those staff who could do their jobs remotely to work from home, with the rapid roll out of new IT equipment and video software.

Support from our community

While Guy's and St Thomas' worked tirelessly to respond to the exceptional challenges presented by COVID-19, we could not have achieved so much without the overwhelming support of our wider community, including our patients, local people, governors, members, volunteers, businesses and other public bodies.

We received many generous donations to the fundraising campaign started by Guy's and St Thomas' Charity, and the national 'clap for carers and key workers' event every Thursday evening created a terrific weekly morale boost for our hard-pressed teams.

Local businesses contributed generously to support our staff, with items including food and skincare products for those wearing PPE during long shifts on the frontline. Technology companies donated equipment, software and expertise so that we were able to support families to 'virtually visit' their sick relatives for whom we were caring. We also received many other kind gifts and donations from around the world.

The London Assembly and Transport for London temporarily suspended the congestion charge so that more of our staff could travel to work without extra cost, while also maintaining essential public transport routes for key workers.

Planning for better times

At the time of writing, we believe we have passed the peak of the first phase of the pandemic. We have coped steadfastly in the face of such a challenge, maintaining high quality care for our patients and keeping our staff safe at work.

However, we expect to be managing a significant burden of COVID-related disease for a considerable time to come, as well as gradually increasing the number of consultations, tests and procedures we carry out for patients with other conditions. We therefore remain highly vigilant and in a state of readiness, carefully following the expert advice in case of further waves and peaks during the course of the pandemic.

Even as we are in its midst, we know we will get through this together and we are planning for better times. Our expert clinicians and scientists are directly involved in research into the virus, including optimal treatments for the disease it causes, and rehabilitation for the growing number of survivors.

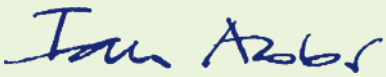
The destructive power of this awful disease has given rise to the most extraordinary energy and ingenuity within our organisation and our people. Necessity truly is the mother of invention.

When our patients and community needed us most, we have shown an incredible ability to innovate and to act dynamically. The emergence of this virus was not within our control, but the ways in which we have responded to it have shown the best in us.

While our values remain the same, the Trust will emerge from this pandemic a changed organisation, providing services in ways that are more innovative than before.

Many will inevitably bear psychological scars which will take time to heal. However, as we are increasingly able to reflect, we do so knowing that our staff were able to provide the best possible care to patients at the time they needed us most – and we will continue to support our staff across the Trust as life begins to return to a new normality.

I am immensely proud to work with such an inspiring group of people, and so grateful for everything they have achieved, and will continue to achieve in the months ahead.



Dr Ian Abbs
Chief Executive

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. 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 18,050 employees, making us one of the largest employers locally. We aim to reflect the diversity of the local communities we serve and continue to develop new and existing partnerships with local people, patients, neighbouring NHS organisations, local authorities, 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 2020/21, the Trust faces a number of financial risks which are listed below and then described in further detail on pages 15 and 17:

- continuing pressures of COVID-19
- achieving the required efficiency savings for 2020/21
- delivering our target financial trajectory and secure Financial Recovery Funding income
- the ability of our commissioners to afford increases in activity required to deliver national waiting times
- 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:

- continuing pressures of COVID-19
- 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 maximum six-week wait
- potential issues arising from delays to planned appointments and 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 have worked hard to maintain our operational performance against most of the 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 quality and performance balanced scorecards.

Following the completion of our emergency floor transformation programme in 2018/19, we have continued to work to improve our emergency services in 2019/20 by expanding a number of services on our emergency floor. These include our ambulatory/same day emergency care and GP redirection services. To help improve services, we have also increased the number of senior clinicians across the emergency floor during evenings and weekends.

In addition, we have introduced an evening rota for senior operational managers to support the emergency floor during weekday evenings. These changes have enabled us to have sufficient beds for all patients who needed to be admitted to our hospitals. It has also made it possible for us to provide mutual aid to neighbouring hospitals at key periods during the winter months.

Although it was anticipated that these initiatives would also help us to meet the maximum four-hour A&E waiting time target, the number of patients attending the department continued to grow through the year and this has affected our ability to achieve the standard. On a number of occasions we have experienced some exceptionally busy days. During these times, while staff have worked tirelessly to ensure our patients are seen and treated as quickly as possible, it has not always been possible to meet the standard.

As we are now seeing up to 600 patients on our busiest days, compared with around 400 patients a day just two years ago, we have implemented project 600. This initiative is designed to support our emergency floor and emergency services across the wider hospital when high numbers of patients attend A&E. The aim is to ensure that we are able to operate effectively and safely across the organisaiton when we are under exceptional pressure.

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

Across the Trust over 12,000 staff received the flu vaccination. This includes 77.6% of frontline staff, which is slightly up on last year.

During 2019/20 we have continued to see a high number of cancer two-week wait referrals. On average we have seen 2,300 patients in our two-week wait clinics each month, which is an increase of 100 urgent GP referrals per month compared to the number of referrals we received during 2018/19.

During the year we introduced a number of changes to how we deliver our cancer services which will also help us prepare for the new Faster Diagnosis Standard, which will be implemented nationally from April 2020. We have continued to work closely with our neighbouring hospitals, local commissioners and the South East London Alliance Cancer Network to improve shared services. We have continued to invest in dedicated senior operational management support to drive improvements and have invested in additional diagnostic and theatre capacity.

We continued to experience high levels of demand for our services during the year and this has made it difficult to consistently treat patients within the national

standard of 18 weeks. This means we still have patients waiting longer than 52 weeks for their treatment.

Although we agreed a challenging trajectory to reduce the number of 52 week plus waiters to zero by 31 March 2020, this has not proved possible in a number of specialties. The reasons for this are complex, but include pressure on operating theatre capacity and availability of surgeons in some specialties.

Addressing these issues on a sustainable basis remained of the highest priority, and included reprioritising theatre capacity and moving some procedures to alternative providers where patients are willing to accept this option. However, in response to the Coronavirus (COVID-19) pandemic we took the difficult decision in the first week of March to stop all non-essential activity, including treatment for many of these patients. Despite this, urgent elective activity, such as urgent cancer surgery, continued using capacity at London Bridge Hospital and in the HCA facilities in the Cancer Centre at Guy's.

Although out-of-area GP referrals have always represented a relatively small proportion of our activity, as a local and specialist provider, we must maintain an appropriate balance between local and specialist services so we can meet the needs of patients in south east London and those needing complex treatments that only a few hospitals can provide. Local commissioners and the Trust's Board have therefore reluctantly supported temporary restrictions to out-of-area referrals for some specialties during 2019/20.

This year, we have also struggled to consistently achieve the standard that 99% of patients receive their diagnostic test within six weeks. This was primarily due to an increase in demand for our endoscopy and imaging services and, although we have increased capacity, it has taken some time for these changes to have a positive impact and reduce waiting times.

Integrated local services

The Trust is working with partners in Lambeth and Southwark to develop place-based care systems. For example, Lambeth Together and Partnership Southwark are both bringing together key partners to focus on improving care for local people with multiple long-term conditions by anticipating their health needs and offering preventative interventions.

This emphasis on place-based working builds on the new community nursing model which we have developed locally. We believe that these new approaches to how teams are organised and managed offer benefits for patients, carers and staff, as well as 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 this model, known as 'neighbourhood nursing' across Southwark and Lambeth. This includes testing new roles such as the 'extensivist clinician' who supports case management, and targeted packages of care for those living with multiple long-term conditions.

We are also targeting extra support at patients who have been in hospital for more than 21 days and who are medically fit to leave but have been unable to do so for non-clinical reasons.

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 significant reduction – from 11% to 4% – in the annual growth in spending on social care services in the borough, and over 90% of people remain at home 90 days after leaving hospital.

Performance analysis – financial

At the start of the year we agreed a control total with NHS England and NHS Improvement which required us to deliver an underlying deficit of £8.4 million. Due to the additional cost pressures of the COVID-19 outbreak our control total was adjusted by £4.6 million, creating a new control total of £13 million deficit. However, when accounting for the planned levels of Provider Sustainability Funding (PSF), this equated to a planned surplus of £3.5 million.

We are pleased to report that despite the extremely difficult financial climate across the NHS, we ended the year £1.1 million ahead of our control total including PSF, delivering a surplus of £4.6 million. We were entitled to PSF for meeting all our financial targets. After accounting for technical capital items our final reported position is a deficit of £63.6 million.

Our financial performance

The control total set by NHS England and NHS Improvement was exceeded by £0.2 million. This performance resulted from increased income, savings and efficiencies. The Trust's adjusted control total of £13 million deficit, agreed with NHS England and NHS Improvement, and planned PSF of £16.4 million meant that we set a plan to deliver a £3.5 million surplus. After accounting for technical capital items, the depreciation charge on donated assets (-£13 million) and capital donations (£5 million), the Trust's planned deficit for the year was £4.6 million.

Cost Improvement programme

At the start of the year, the Trust set a £67.9 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 largely met through a range of efficiency measures and additional income. Local savings at a directorate level were complemented by Trust-wide savings, which were focused on improving quality, safety and efficiency. Together, these actions enabled the Trust to achieve 99% or £67.4 million of the planned Cost Improvement Programme.

Provider Sustainability Funding

The financial plan included £16.4 million PSF baseline funding from NHS England and NHS Improvement which required us to achieve agreed financial and performance targets. The planned funding was received. This reflects the achievement of our financial performance targets. In addition, PSF of £0.9 million was received in relation to the prior year and as a result, the total PSF funding in 2019/20 totalled £17.4 million, £0.9 million above plan for the year.

Performance against plan

By delivering a surplus of £4.6 million against our control total including PSF, we ended the year £1.1 million ahead of plan, and exceeded our adjusted control total by £0.2 million. Depreciation on donated assets was lower than planned. The Trust has received £44.9 million of charitable donations towards the Cancer Treatment Centre to date. We had hoped to fundraise more, and therefore our capital contribution to the scheme was increased in 2019/20. Capital donations towards the cost of our capital programme were less than the original expectations set out in our financial plan. As a result of these adverse movements, the capital donation figure for 2019/20 was negative (-£5.9 million).

The annual revaluation of the Trust's land and buildings led to a net £49.6 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 offset by the reduced capital donations and the net impairment charge. Once these adjustments have been

Table 1: Financial performance against plan

	Adjusted plan £000	Actual £000	Variance £000
Control total excluding PSF	(8,390)	(8,233)	157
COVID-19 eligibility adjustment	(4,568)	(4,568)	-
Adjusted control total performance	**(12,958)**	**(12,801)**	**157**
PSF	16,440	17,357	917
Control total performance including PSF	**3,482**	**4,556**	**1,074**
Technical capital items			
Depreciation on donated assets	(13,062)	(12,554)	508
Adjustment for capital donations and profit on sale of fixed assets	5,000	(5,908)	(10,908)
Impairments (market value)	-	(49,638)	(49,638)
(Deficit) for the year	**(4,580)**	**(63,544)**	**(58,965)**

Table 1a: Total control adjustment

	Original plan £000	COVID-19 eligibility adjustment £000	Adjusted plan £000
Control total excluding PSF	(8,390)	(4,568)	(12,958)
PSF	16,440	-	16,440
Control total including PSF	**8,050**	**(4,568)**	**3,482**
Depreciation on donated assets	(13,062)	-	(13,062)
Capital donations	5,000	-	5,000
(Deficit) for the year	**(12)**	**(4,568)**	**(4,580)**

Table 2: Financial performance comparison

	2019/20 £ million	2018/19 £ million	Change £ million
Income excluding capital donations and PSF	1,694	1,547	147
Expenditure excluding impairments and sale of assets	1,706	1,539	167
(Deficit) / surplus excluding depreciation on donated assets, capital donations, impairments and PSF	**(12)**	**8**	**(20)**
PSF	17	47	(30)
Surplus excluding donations and impairments	**5**	**55**	**(50)**
Depreciation on donated assets	(13)	(13)	-
Capital donations	(6)	4	(10)
Impairments	(50)	(15)	(35)
(Deficit) / surplus for the year	**(64)**	**31**	**(95)**

Table 3: Cash flow

	2019/20 £ million	2018/19 £ million
Operating surplus before finance and other costs	(36.2)	59.4
Non-cash income and expenses	154.5	48.0
Net cash generated from operating activities	**118.3**	**107.4**
Investing activities	(103.4)	(79.6)
Financing	(19.8)	(18.5)
Net (decrease) / increase in cash	**(4.8)**	**9.3**

reflected, the Trust achieved an overall deficit of £63.6 million, £59 million adverse from the plan for a £4.6 million deficit.

Cash flow

The Trust began the financial year with £144.1 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 decreased by £4.8 million to £139.3 million. For details of the Trust's net cash balances, see note 24 in the Annual Accounts on page 136. 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 £118.3 million of net cash generated from operating activities. The Trust spent a net £103.4 million on investing activities, which included £99 million purchasing intangible assets and property, plant and machinery, expenditure of £5.9 million in capital donations and £1.1 million in interest. A net £19.8 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 111.

Capital expenditure

In 2019/20, the Trust spent £81.1 million on property, plant and equipment (£81.8 million 2018/19). The Trust also spent £17.8 million on intangible assets, mostly software and other IT (£12.2 million 2018/19). 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 (ITFF) had agreed loans totalling £279 million. During the year, the Trust drew down borrowing of £11.8 million and made principal repayments of £7.2 million, creating a net cash inflow of £4.6 million. At the year end, total ITFF borrowings equate to £226.9 million, consisting of total repayments to date of £53 million. Further obligations for a service concession contract create total borrowing of £230.6 million. See note 22 in the Annual Accounts on page 133 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 in addressing the 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 £49.6 million (£15.2 million in 2018/19). 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 129.

Inventory

The Trust's inventory balance of £26.286 million is material to the Trust's accounts. The Trust is satisfied that its inventory balance is presented fairly in all material respects: the Trust maintains perpetual inventory systems for the majority of stock, including pharmacy, and stock is routinely counted in other areas. However, the restrictions on movement in the United Kingdom in March 2020 arising from the COVID-19 pandemic meant that the Trust was unable to perform its planned year end inventory counts, and the auditor has been unable to gain sufficient audit evidence from alternative procedures. The auditor has therefore been unable to complete the procedures required by auditing standards, and is required to issue a qualified opinion. We are aware that a number of trusts in the country are affected by the same issue in 2019/20 and we understand NHS Improvement will disclose the extent to which this has impacted the sector in its consolidated provider accounts when published later in 2020. The auditor's opinion on the financial statements remains unmodified in all other respects.

Please refer to note 1.24 in the Annual Accounts for critical accounting judgements and key sources of estimation uncertainty.

External audit services

Grant Thornton received £131,000 in audit fees in relation to the statutory audit of the Trust and the accounts of its subsidiaries to 31 March 2020. For more details, see note 6.2 to the Accounts on page 122.

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 2020/21, the Trust faces a number of financial risks. These include:

Continuing pressures of COVID-19: the impact of COVID-19 on the NHS led to a temporary cessation of the normal NHS payment system prior to the Trust concluding negotiations with its commissioners. For the early part of the 2020/21 financial year the level of funding that the Trust receives is determined and mandated by NHS England and NHS Improvement. The process has been set up with the aim of ensuring that, for the duration of these measures, each provider will receive sufficient

Trends in activity, income and expenditure

Chart 1: Completed patient spells

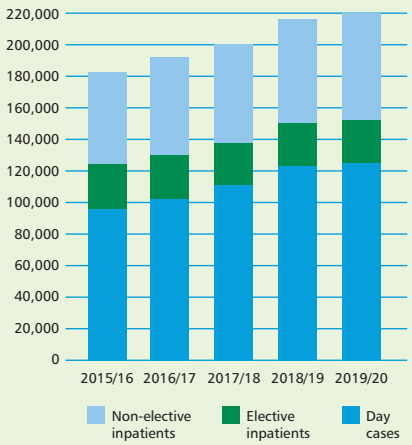


Chart 2: Outpatient attendances

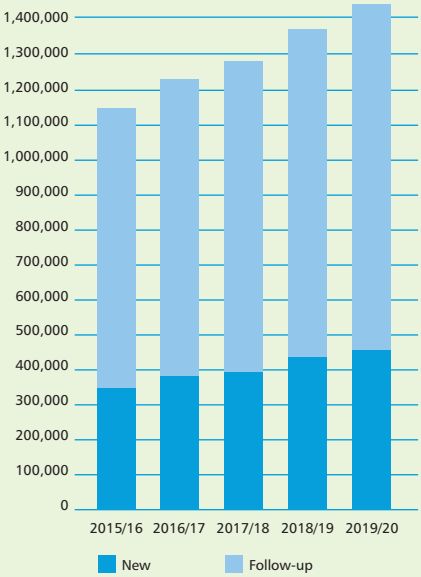
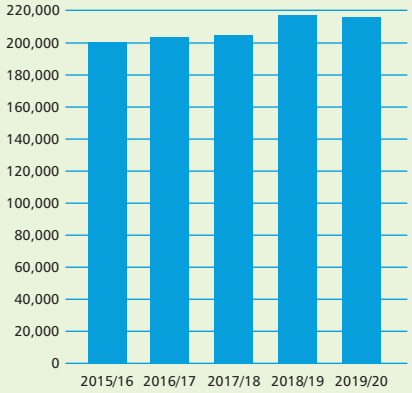


Chart 3: A&E attendances



During 2019/20, we saw in total 1,442,000 outpatients, 95,000 inpatients, 125,000 day case patients and 217,000 accident and emergency attendances.
We also provided over 769,000 contacts in the community, bringing our total patient contacts to 2.6 million.

Chart 4: Income £millions

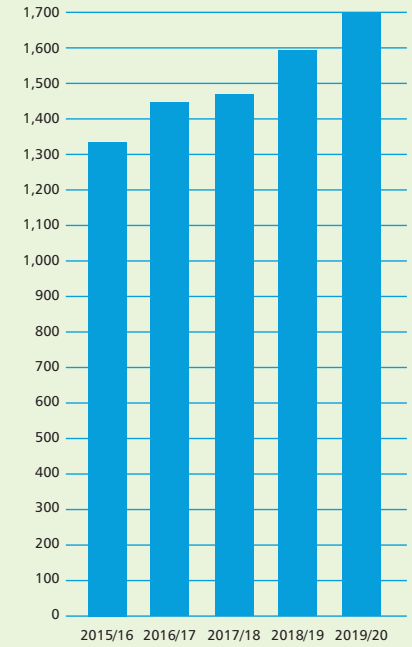
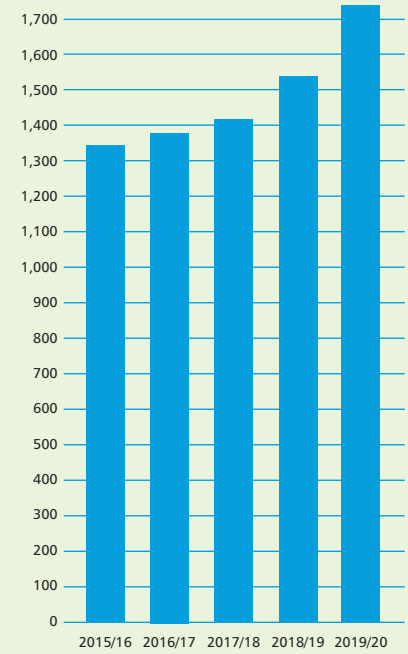


Chart 5: Expenditure £millions



income to break even.

Currently it is not clear what the financial regime will be after these interim measures, or what the requirements will be for the delivery of national standards. However, the Trust will work collaboratively with commissioners and providers in the local health economy to ensure that there is an appropriate level of funding for the delivery of services. Additionally, given the focus of the Trust has been on responding to the pandemic, the normal operational focus on efficiency scheme identification and delivery has not been in place. As the Trust suspended its usual business planning process in March 2020, there may be a period of financial uncertainty while the organisation seeks to return to normal ways of working. The Trust is also working to mitigate the financial control and cash flow risks related to COVID-19.

Delivering required efficiency savings in line with the financial plan: the Trust is required to deliver £68.4 million efficiency savings and to mitigate any further downsides. This is in excess of 6% of the Trust's cost base on which savings can be made. There is a risk that we do not identify efficiencies to fully address the financial challenge or that we cannot deliver them at the required pace.

Failure to deliver our target financial trajectory: if the Trust fails to achieve the target financial control total, the Trust will lose all of its Financial Recovery Funding income.

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 designed to support key operational challenges while ensuring there is also sufficient investment directed towards delivering 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 the 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) to ensure we continue to provide safe and compliant services on our hospital 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 Integrated Care System and wider clinical networks. This especially relates to investment in digital transformation and analytics
- investing in a patient-centred electronic health records system that will transform our models of care, reduce unwarranted variations and drive efficiency while improving patient experience and clinical outcomes
- investing in our strategic ambitions such as expansion of our paediatric services and, in partnership with King's Health Partners and Royal Brompton & Harefield NHS Foundation Trust, creating a global centre of excellence in heart and lung services and research in London
- in partnership with King's College London, continue to invest in improving healthcare outcomes through pioneering academic research.

Our key capital priorities, listed in the table overleaf, 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 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 essential to support the Trust's ability to meet the levels of demand during 2020/21
- continue to access any central funding that may be made available to support system-wide working
- focus on maximising utilisation of our current infrastructure which is linked to many of our plans. Our

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 a regional specialist centre.
Medical equipment and infrastructure backlog	Annual replacement programme for high risk items and areas across our hospital and community sites.
IT routine 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 for orthopaedic surgery.
North wing ward refurbishment	Investment to improve the ward environment to benefit patients and staff and to address mechanical, electrical and infrastructure risks.
Patient-centric supply chain	Redesign supply chain processes and logistics across the ICS with the Trust acting as lead and proof of concept.
Relocation of cancer wards and development of teenage and young adult facility	Relocation of existing cancer wards at Guy's to improve patient experience and to support longer-term site strategy for inpatient services.
Community property 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 partnership between King's Health Partners and Royal Brompton& Harefield NHS Foundation Trust	Business case in development to create a world-class centre for heart and lung services and research in London, providing the best possible patient care and experience.

ability to invest in technology will be a major enabler or constraint

- discuss options for any 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.

Procurement

The Trust hosts a procurement shared service, SmartTogether, 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 function is ranked 6th out of 136 acute trusts in the latest NHS Improvement 'Model Hospital' procurement league table released in February 2020. The league table measures price performance and process efficiency against national benchmarking data. The Trust is ranked in first place for price performance.

In August 2019, the Trust opened a supply chain hub in Dartford with the aim of consoli-dating up to 90% of inbound deliveries to release on-site space and improve local air quality.

The initiative is part of a wider South East London Integrated Care System (ICS) project led by the Trust, which also includes the expansion of automated inventory management systems and the establishment of a performance centre to optimise inventory systems across both clinical supplies and medicines and across the ICS.

Performance analysis – sustainability and environmental

Environmental impact performance indicators 2019/20

Area	Acute hospitals 2019/20	2018/19	Trend 19/20 v 18/19	Community services 2019/20	2018/19	Trend 19/20 v 18/19
Water	409,118 m^3	449,167 m^3	-9%	73,805 m^3	20,335 m^3	263%
Water cost	£715,028	£715,988	0%	£113,623	£39,853	185%
Imported electricity	137,936 GJ	162,451 GJ	-15%	7,790 GJ	7,892 GJ	-1%
Gas	711,876 GJ	672,730 GJ	6%	7,303 GJ	6,247 GJ	17%
Oil	0 GJ	660 GJ	-100%			
Energy cost	£10,989,939	£11,770,979	-7%	£411,881	£394,213	4%
CO_2 emissions from building energy use	46,264 tonnes	46,941 tonnes	-1%	927	940	-1%
High temperature disposal	471 tonnes	445 tonnes	6%			
Alternative treatment (offensive waste)	1,632 tonnes	1,599 tonnes	2%			
Landfill waste	14 tonnes	16 tonnes	-13%			
Recycling by % of total	26%	35%	-26%			
Cost of waste	£2,040,737	£1,144,120	78%			

Carbon emissions	Acute hospitals 2019/20	Community sites 2019/20
Imported electricity (GJ)	9,794	553
Gas (GJ)	36,470	374
CO2 emissions from building energy use (tonnes)	46,264	927

Significant differences in water consumption figures are due to charges carried over from 2018/19 and the inclusion this year of previously unavailable data from additional community sites.

Increased waste costs were, in large part, a result of the Trust having to instigate contingency arrangements for clinical waste collections after the existing supplier was placed into liquidation.

The Trust has a growing sustainability programme that continues to reduce 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.

Staff and pupils from the Evelina London Children's Hospital school have helped develop 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.

Equality, diversity and inclusion

The Trust serves the diverse 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, religion or belief, gender reassignment, sexual orientation, pregnancy and maternity and marriage or civil partnership, in accordance with the Equality Act 2010 and our public sector equality duties.

The Trust refreshed its equality, diversity and inclusion priorities last year and has been 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 population.

The objectives include:

- improving the way we develop, design and deliver services to meet the needs of all of our patients, including the most vulnerable
- 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 everyone's experience is positive
- working closely with local schools and colleges to raise awareness of career opportunities at the Trust, including opportunities for learning and work experience
- working closely with local organisations supporting residents to become 'work ready' and improve social mobility
- ensuring all groups of staff have equality of opportunity for career progression and development, and that our senior management reflects the diversity of the wider organisation and patient population
- ensuring there is no differential experience based on protected characteristics
- encouraging opportunities to hear the lived experience and voices of both patients and staff.

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

As part of our response to the COVID-19 pandemic we have carried out regular risk assessments to ensure we protect those who are most vulnerable, and this has included staff from black, Asian and minority ethnic groups.

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, through our Trust values and behaviours 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 statutory bodies providing support, guidance and decisions on all safeguarding issues. They also provide training to all staff as part of the Trust's wider training programmes. This includes Barbara's Story, 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 and lighting is available. A state-of-the-art 'changing places' facility was opened on the Guy's site in 2019, and another is being built on the St Thomas' site as part of a wider accessibility strategy.

Widening participation

The Trust has supported many projects through its widening participation strategy. These include: attending careers fairs in local schools and colleges, providing nearly 500 work experience placements supporting young people from disadvantaged backgrounds to undertake paid internships, and providing placements and paid employment to young people with autism. We are working closely with the University Technical College, Southwark College and Lambeth College to provide science, technology, engineering and mathematics (STEM) related employer engagement, career mapping and other opportunities. We have supported members of the armed forces community through the 'Step into health' initiative, 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 and NHS Improvement.

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. Since 2018 the reporting data has also included information about our gender pay gap.

Ian Abbs
Chief Executive
10 June 2020

We celebrated the huge success of the NHS rainbow badge scheme by taking a giant inflatable badge to the Pride celebrations in London.

3 Accountability report

We are committed to ensuring our staff feel valued and receive the support they need. Our 'Showing we care about you' programme offers a wider range of benefits and support to help staff with their personal, professional and family life.

4 Directors' report

Guy's and St Thomas' performed well operationally and financially during 2019/20, with the final weeks of the year devoted to a Trust-wide response to the exceptional demands of the Coronavirus (COVID-19) pandemic. Throughout, our staff have continued to work hard to balance high quality patient care with achieving our performance and financial targets, and they have been truly inspirational in their response to the pandemic. (See page 7)

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 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 March and April 2019. We were pleased to maintain an overall rating of 'good' and that our community services for adults were rated as 'outstanding'. This was a significant achievement given the size and complexity of the Trust, and is a tribute to the commitment and effort of staff across the organisation. The Trust was rated 'outstanding' for caring services and for being well led, and 'good' for effective and responsive services. It is disappointing that our rating for being safe remains 'requires improvement'. While the inspection team commented positively on many factors that underpin safe care, including our staffing levels, they did find issues with a number of our processes and procedures and we are determined to tackle these shortcomings.

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 99.6% 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 clinical meetings, monthly team briefings and the Trust's care redesign programme. This 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 outcomes 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 kept under review 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 Corporate Governance Statement on the Trust's website.

Driving positive change

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. These are reported monthly through the performance framework balanced scorecard, formerly the integrated quality and performance report. The scorecard 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 compliments, 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 to improve the quality and 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

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

The Trust provides 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.

At St Thomas' we have one of the busiest emergency departments in London and provide a wide range of specialised services and subspecialties. 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.

Guy's Hospital continues to serve a wide population with dental, renal, urology and orthopaedic services, including complex surgery. It is also home to the Cancer Centre at Guy's – one of the largest purpose-built cancer treatment centres in Europe.

During 2019 we continued our investment programme across the Trust. This included the completion of a new modular theatre at Guy's as part of the Orthopaedics Centre of Excellence, and the refurbishment of our critical care wards at St Thomas' providing improved facilities for patients and staff. We also installed a 'changing places' toilet at Guy's which provides dedicated facilities for people with disabilities or with learning difficulties.

The Trust plays a key role in the South East London Cancer Alliance and leads the South East London Accountable Cancer Network, 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 research facilities which continue to strengthen our position as a leader in advanced therapies, genomics and regenerative medicine. St Thomas' is a major 'medtech hub' and includes the new London Medical Imaging and Artificial Intelligence Centre for Value-based Healthcare funded by Innovate UK in partnership with King's College London.

We put patients first, and work with our partners to provide care closer to home, where it is safe to do so, particularly for specialised services where patients might otherwise have to travel into central London for treatment. Our network of outreach clinics and satellite centres includes a kidney treatment centre and cancer centre at Queen Mary's Hospital in Sidcup, renal

dialysis units in several locations across south east London, and the Bexley cardiology service. We participate in a number of networks for specialised adult and children's services, helping to improve quality and safety in south London and southern England.

We provide core community health services for adults and children across Lambeth and Southwark and some specialist services in Lewisham, allowing us to deliver seamless care for our patients.

We deliver services in a variety of locations, including in GP practices, health centres, schools, community buildings and in patients' homes. During 2019/20 we continued to roll out our neighbourhood nursing model for adults, where dedicated teams work across a smaller population with a maximum 20 minutes walking distance between patients, allowing more patient-facing time. We have also been developing our children's community nursing team and @Home services, providing proactive care for children with long-term conditions, while minimising admissions and hospital stays for those who are ill.

We work in partnership with colleagues from across the local health economy – including partner trusts, local authorities, schools, primary care and voluntary/community groups – to provide holistic care. In our local boroughs we are focusing on place-based care which includes further developing integrated services through our involvement in Lambeth Together and Partnership Southwark. We continue to work across the partnerships to identify opportunities for wider patient and public engagement, particularly in service development.

Engaging patients and the public

We work closely with Healthwatch in both boroughs and hold quarterly 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.

Healthwatch has powers to 'enter and view' healthcare premises to observe the delivery of services and the care environment. Although neither local Healthwatch undertook visits during 2019/20, the Trust responded to Healthwatch Lambeth's report (May 2019) on their visits to the Evelina London kidney transplant unit that took place in February 2019.

In January 2020, Healthwatch Southwark published a report on their research into experiences of unpaid carers in Southwark focusing in particular on the support they receive, the support they would like and the impact of their role on their health and wellbeing.

For the last three years the Trust has included a small number of 'carers priorities' with its patient experience priorities. The Trust welcomed the report and responded to the three recommendations that related to hospital services. We will continue to use the information to inform the review of our carers' priorities for 2020/21.

The Trust actively supports Healthwatch bodies to undertake research that supports their work programmes. This year Healthwatch Lambeth completed a perinatal mental health research project, which involved interviews with 18 mothers from Lambeth and 12 members of staff.

Healthwatch Southwark and the LGBT+ Network led a community survey to explore LGBT+ people's experiences of living in the borough, which included their experiences of accessing health services provided by Guy's and St Thomas' and King's College Hospital.

The Trust welcomes the insights and recommendations provided by these reports, which continue to inform improvements to care.

Patients continue to be involved in planning the design of the new Orthopaedics Centre of Excellence that will be developed as part of our partnership with Johnson & Johnson Managed Services. The partnership will provide additional theatres that will enable the Trust to respond to increasing demand for orthopaedic services, as well as improving the efficiency of the procurement of medical devices, surgical instruments and implants.

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

This year patients worked alongside staff in the procurement of the Trust's future electronic health record, participating in and providing feedback on demonstrations from vendors.

We and our partners also held a series of events, working together with patients, carers and representatives from charities to develop and evaluate our ambitious proposals for the future design and delivery of cardio-respiratory services, with the Royal Brompton Hospital. To date, some 500 patient-public stakeholders have been involved in this work.

In October, our Evelina London children's services held their annual 'Inspiring Youth Conference' to engage young patients in their physical and emotional health and wellbeing. Our young delegates heard from a range of guest speakers and learned about future research from a group of young scientists.

Over the last year we have continued to make good progress implementing the Trust's three-year patient and public engagement strategy. The objectives were reviewed and amended to ensure that patient and public engagement continues to support the delivery of the Trust's ambitious organisational strategy, 'Together we care'.

More than 30 Foundation Trust patient and public members 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.

Results also showed that the Trust had improved in five out of six scores compared with the last assessment, demonstrating our commitment to providing good food, high standards of cleanliness and facility maintenance, and support for patients with dementia or a disability.

The Trust is committed to involving patients in decisions about their care and treatment. This year, in partnership with the Association of Medical Royal Colleges, we launched a project called 'choosing wisely'. The aim of the project is to improve the quality of conversations between healthcare professionals and patients regarding the different treatment options available and patients' own preferences so that a joint decision can be reached about which treatment is best.

'Choosing wisely' is being piloted in knee surgery, dermatology and with older patients undergoing surgery, and early findings suggest the initiative is being well received.

System leadership and partnership

The Trust continues to play an active role in the South East London Integrated Care System, working with our partners to deliver a clinically and financially sustainable system for the future, taking collective action to improve outcomes and address health inequalities in our population.

In 2019, we took steps to deepen our longstanding relationship with King's College Hospital NHS Foundation Trust. We have committed to closer collaboration and strategic alignment, initially focused on a small number of priority areas where we believe we have the greatest opportunity to make progress.

We continue to collaborate across King's Health Partners and with organisations across south east England and London, as well as nationally and internationally. This includes contributing to the development of a partnership between King's Health Partners and Royal Brompton & Harefield NHS Foundation Trust, to revolutionise care and research for heart and lung patients across London and the south of England.

Guy's and St Thomas' continues to work closely with Dartford and Gravesham NHS Trust through the Guy's and St Thomas' Healthcare Alliance, for which 2019/20 is its second year of operation. The partnership is focused on delivering benefits against its four strategic aims: delivering consistently high quality care, developing our people, leveraging scarce resources, and embracing innovation.

Successes include rolling out the Nightingale Ward Programme at Dartford and Gravesham, and a collaboration in radiology reporting which has enabled clinicians to view scans across the two trusts, so streamlining the patient pathway.

King's Health Partners

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

Our partnership has a combined turnover of £3.8 billion, supports 42,000 staff, 36,000 students and delivers 4.2 million patient contacts a year.

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

Through five institutes (cardiovascular; women and children's health; neurosciences; haematology; and diabetes, obesity and endocrinology) we are working together to improve care for our patients. This includes: cardiovascular teams working jointly to reduce waiting times for patients needing surgery and improving patient survival rates, and haematology staff working as 'one team' to improve care for people with blood diseases, for example, by offering advanced therapies to deliver innovative new treatments.

In 2019, our partnership once again led the way in involving patients in research, with more than 57,000 patients taking part in clinical studies and each trust increasing the numbers of patients enrolled in clinical trials. We have also supported 120 NHS clinicians in winning professorial academic titles since 2014.

A three-year deal with global biopharmaceutical company UCB is bringing 15 researchers to work directly alongside academics to focus on early development and translational medicine, and we have led on major new developments in in the use of artificial intelligence (AI) to improve clinical care. This includes a £20 million initiative in AI and imaging, funded by UK Research and Innovation and industry partners.

Clinical academic groups continue to make breakthroughs in research, clinical care and education. Highlights include the development of unique ways to see images of the fetal heart through 3D reconstructions, while our cross-partner alcohol care team's innovative work is helping reduce pressure on busy emergency departments and improve support offered to patients.

We are working with our partners locally to develop the 'Vital 5', a new approach to help individuals, communities and organisations make simple changes that will have a major impact on health at both the individual and population level.

We have also made good progress with our 'Mind and Body Programme' to join up mental and physical healthcare. Almost 78,000 patients have been screened in 59 clinics to identify a range of physical and mental health needs and education and training has been provided to around 3,000 staff, including over 800 'mind and body champions.'

The King's Health Partners learning hub continues to support staff education and training through a wide range of free e-learning materials. There are now more than 85 education resources available and last year we launched a new, upgraded learning service.

Overseas, our global health partnerships in Sierra Leone, Somaliland, Zambia and Kongo Central continue to support the development of sustainable local healthcare systems.

We also continue to work with international colleagues to share our experiences and expertise as an AHSC. This year we have supported colleagues in Denmark, China, Singapore, Australia and Malaysia.

Investing in our future

The Trust works hard to achieve its financial targets as this allows us to continue to invest in our estate, technology and medical devices in order to improve patient care and clinical outcomes.

During 2019/20, improvements were made in infrastructure across our hospitals and community sites.

Capital investment was targeted at some of our older critical care facilities following the recent expansion of the service. This has helped to ensure that the environment for our most critically unwell patients remains safe, pleasant and supports positive patient outcomes. Catering facilities for patients, visitors and staff were also expanded on the Guy's site.

In partnership with King's College London, we installed the first 7 Tesla Magnetic Resonance Imaging (MRI) machine in London on the St Thomas' site. The scanner is part of a new clinical imaging facility which will have a special focus on diseases affecting babies and children.

To meet growing demand for our children's services, additional facilities have been completed this

year, including improved clinical research facilities for our young patients.

As part of our long-term plans, we are committed to expanding our specialist children's hospital with construction of a new building on the St Thomas' site, and have started the procurement process to select a development partner.

Our commitment to investment in digital technology remains a priority and is a key part of our Trust strategy. The introduction of a new electronic health record system will help us transform the way we deliver care, and empower our patients to become more involved in decisions about their health. It will replace many of the systems we currently use with a single, integrated solution. During 2019 we invited suppliers to take part in a competitive procurement process and we expect to appoint a preferred partner during 2020.

Developing commercial partnerships

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

A number of initiatives have progressed during the year including:

- our partnership with Johnson & Johnson Managed Services to create an Orthopaedics Centre of Excellence
- a new partnership with Diaverum for the delivery of community dialysis services across south east London and Kent
- expansion of our commercial education offer with over 70 visiting professional programmes now provided for doctors and nurses from overseas
- recruitment of a network of clinical leads to support our consulting, innovation and private practice activities.

At the request of the Ministry of Defence, we have extended our partnership with them to support the delivery of hospital, community and primary healthcare services for British Forces and their families in Germany and northern Europe until September 2020.

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

- 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 SpotOn.

A full list of subsidiaries and interests in associates and joint ventures can be found in note 18 to the Accounts on page 131

Better payment practice code

Measure of compliance	Year ended 31 March 2020 Number	£000	Year ended 31 March 2019 Number	£000
Total bills paid in the year	**348,344**	**786,294**	334,766	724,028
Total bills paid within target	**270,544**	**527,205**	270,889	542,043
Percentage of bills paid within target	**78%**	**67%**	81%	75%

Education and training for nurses and midwives

2020 is designated the 'International year of the nurse and midwife' in commemoration of the 200th anniversary of the birth of Florence Nightingale. As part of a range of activities to mark the occasion, the Trust is taking part in the 'Nightingale challenge' which asks every health employer around the world to provide leadership and development training for nurses and midwives.

The Trust has a well-established education and training programme for nursing staff and midwives. Our 'Nightingale Nurse Award', which is part of the Nightingale Academy at Guy's and St Thomas', was launched in 2016 to provide a platform for innovation, practice and service development in clinical nursing and midwifery. Since its inception, 230 nurses and midwives have successfully completed the award.

The Trust also supports the nursing associate programme which is designed to bridge the gap between health and care assistants and registered nurses. We currently have more than 120 funded apprentice nursing associate posts and are committed to increasing

these numbers over the next five years. We are implementing the nursing associate role alongside the development of our registered nurses and have a dedicated nursing workforce transformation team to facilitate this change.

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 2019/20, Board membership comprised the following executive directors: Chief Executive and Chief Medical Officer, Ian Abbs (from August 2019); Chief Operating Officer, Jon Findlay; Chief Strategy Officer, Jackie Parrott (from April 2019); Chief Executive, Amanda Pritchard (to July 2019); Chief People Officer, Julie Screaton; Chief Financial Officer, Martin Shaw; Chief Nurse, Director of Patient Experience and Infection Control, and Deputy Chief Executive, Eileen Sills; Medical Director, Simon Steddon (from August 2019); and Deputy Chief Executive, Lawrence Tallon (from March 2020).

And the following non-executive directors: Sir Hugh Taylor, Chairman; Sheila Shribman, Vice-Chair; Paul Cleal (from January 2020); Felicity Harvey; Girda Niles (to December 2019); John Pelly; Reza Razavi; Priya Singh (Executive Vice Chair from August 2019-February 2020 during which time she served as interim Deputy Chief Executive); 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 138.

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 Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of the goods or a valid invoice, whichever is later. The total bills paid in the year has increased and the percentage of bills paid within target has deteriorated due to operational delays in the receipting of goods and services. 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 112.

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

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

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

Ian Abbs
Chief Executive

In 2019 we scored above the national average in all six categories of the Patient-Led Assessment of the Care Environment, including for cleanliness, food and privacy.

5 Remuneration report

Chairman's annual statement

As the Chairman of the Remuneration Committee, I am pleased to present our remuneration report for 2019/20.

There were no changes to the Trust's remuneration policy for very senior managers in 2019/20.

Taking into consideration the national pay settlements agreed for Agenda for Change and medical and dental workforces, the committee approved a 2% cost of living increase to executive and senior managerial salaries with effect from 1 April 2019. The scheduled full review of executive and senior management salaries began in 2018/19 in conjunction with Korn Ferry Hay Group consultants and is now completed.

There were changes to the Trust's executive team during 2019/20. Chief Executive Amanda Pritchard became Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement on a secondment basis for up to two years with effect from the 31 July 2019. Ian Abbs was, therefore, appointed as Chief Executive for two years on the same salary as Amanda. Ian has retained the title of Chief Medical Officer, though he has stepped back from this role day to day and Simon Steddon has assumed the role of Medical Director. A new post of Deputy Chief Executive was created to support the Chief Executive in maintaining oversight of the Trust's agenda and Lawrence Tallon has been appointed to this role. Priya Singh was appointed as Executive Vice Chair to provide interim cover for the Deputy Chief Executive pending the recruitment process.

Sir Hugh Taylor
Remuneration Committee Chairman
10 June 2020

Remuneration policy report 2019/20

Senior managers' remuneration policy

Remuneration for the Trust's most senior managers (executive directors who are members of the Board of Directors) is determined by the Board of Directors' Remuneration Committee, which consists of the Chairman and all non-executive directors.

The total remuneration for each of the Trust's executive directors comprises the following elements:

Salary + Pension = Total remuneration

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

	Salary	Pension and benefits
Purpose and link to strategy	To provide a core reward for the role. Salary is set at a level appropriate to secure and retain the high calibre individuals needed to deliver the Trust's strategic priorities, without paying more than is necessary.	NHS Pension Scheme arrangements provide a competitive level of retirement income. Life assurance/death in service benefits may be provided as part of an individual's pension arrangements.
Operation	When determining salary levels, an individual's role, experience and performance, and independently sourced data for relevant comparator groups are considered. Executive director salaries are inclusive of a high cost area supplement. Salary increases typically take effect from 1 April each year.	Executive directors are eligible to receive pension and benefits in line with the policy for other employees. Pension arrangements are in accordance with the NHS Pension Scheme. There is no cash alternative. The NHS Pension Scheme is made up of the 1995/2008 Section and the 2015 Section. New executive directors are entitled to join the 2015 Section, which is a career average revalued earnings scheme. Where an individual is a member of the 1995/2008 Section and is subsequently appointed to the Board, they may remain a member of that Section according to the Scheme rules.
Opportunity	There is no formal maximum limit, however salary increases will ordinarily be in line with increases for the wider NHS workforce (not including incremental progression increases) as recommended by the NHS Pay Review Body. Increases may be higher to reflect a change in the scope of an individual's role, responsibilities or experience.	Existing executive directors are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at **www.nhsbsa.nhs.uk/pensions**. Details of the 2019/20 pension benefits of individual executive directors are available in the single total figure table in the annual report on remuneration. Total pension entitlement for each executive director is available in the total pension entitlement table.

	Salary	Pension and benefits
Opportunity	Where a new executive director has been appointed to the Board on a salary lower than the typical Trust level for such a role, the salary may be reviewed as the executive director becomes established in the role. Salary adjustments may also reflect wider external market conditions. Salary levels for 2019/20 are set out in the single total figure table in the annual report on remuneration.	A new external recruit will be eligible to join the NHS Pension Scheme. The main features of the 2015 Scheme include: • a career average revalued earnings (CARE) scheme with benefits based on a proportion of pensionable earnings each year during the individual's career • a build-up rate of 1/54th of each year's pensionable earnings with no limit on the number of years that can be taken into account. This is a higher build-up rate than the 1995/2008 Scheme • revaluation of active members' benefits in line with inflation, currently the Consumer Price Index (CPI) plus 1.5% per annum • a normal pension age at which benefits can be claimed without reduction for early payment linked to the state pension age. In accordance with NHS Pension Scheme rules, the employer contribution rate is 20.68%.
Performance measures	The overall performance of the individual is a consideration when reviewing salaries.	None.

Salaries for senior managers are established and maintained taking the following elements into consideration: the individual's role, experience and performance, and independently sourced data for relevant comparable organisations. This includes consideration of salary levels at other members of the Shelford Group (which represents 10 of England's leading academic healthcare organisations). Salaries for senior managers are formally reviewed every three years with annual interim reviews.

Senior managers are employed on substantive contracts of employment and are employees of the Trust. Their contracts are open-ended employment contracts which can be terminated by either party with 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 2019/20

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

Remuneration Committee

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

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

Remuneration Committee membership and attendance 2019/20

Name	Actual / Possible
Hugh Taylor (chair)	5 / 5
Paul Cleal (from January 2020)	0 / 1
Felicity Harvey	4 / 5
Girda Niles (until December 2019)	3 / 4
John Pelly	5 / 5
Reza Razavi	4 / 5
Sheila Shribman	5 / 5
Priya Singh	5 / 5
Steve Weiner	5 / 5

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

Attendee	Regular attendee	Attends as required
Ian Abbs, Chief Executive	x	
Julie Screaton, Chief People Officer	x	
Helen Lovelock, 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 2020	March 31 2019
Highest paid director's total remuneration	£239,971	£254,394
Median total remuneration	£41,582	£40,032
Remuneration ratio	5.77	6.35

The calculation is based on full-time equivalent staff working for the Trust on March 31 2020. Where staff are part time, their salaries have been annualised for the purposes of the median ratio calculation. Individual staff remuneration ranged from £22,052 to £240,000 (2018/19, £22,000 to £254,000).

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 2019/20 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	3 months
Jackie Parrott	Apr 2019	Open ended	6 months
Amanda Pritchard (On secondment)	Apr 2012	Open ended	6 months
Julie Screaton	Jun 2017	Open ended	3 months
Martin Shaw	Oct 1998	Open ended	6 months
Eileen Sills	Feb 2005	Open ended	3 months
Simon Steddon	Jul 2019	Open ended	6 months
Lawrence Tallon	Mar 2020	Open ended	3 months

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

Salaries of senior staff

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

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

Salary and benefits of senior managers

The following tables contain details of the salary and benefits of the Trust's senior managers in 2018/19 and 2019/20.

Single total figure 2019/20

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 (until July 2019), Chief Executive and Chief Medical Officer (from August 2019)	235-240	–	235-240
J. Findlay**	Chief Operating Officer	165–170	–	165–170
J. Parrott***	Chief Strategy Officer (from April 2019)	150–155	10-12.5	160-165
A. Pritchard****	Chief Executive (until July 2019)	80–85	–	80–85
J. Screaton**	Chief People Officer	165–170	–	165–170
M. Shaw	Chief Financial Officer	165–170	17.5-20	185-190
E. Sills**	Chief Nurse	100–105	–	100–105
P. Singh	Interim Deputy Chief Executive (from August 2019 to February 2020)	50-55	–	50-55
S. Steddon	Medical Director	140-145	92.5-95	235-240
L. Tallon	Deputy Chief Executive (from March 2020)	10-15	2.5-5	15-20
P. Cleal	Non-executive director (from January 2020)	5–10	–	5–10
F. Harvey	Non-executive director	15-20	–	15-20
G. Niles	Non-executive director (until December 2019)	15–20	–	15–20
J. Pelly	Chairman of the Audit and Risk Committee	15–20	–	15–20
R. Razavi	Non-executive director	15-20	–	15-20
P. Singh	Non-executive director (when not Interim Deputy Chief Executive)	5-10	–	5-10
S. Shribman	Vice-Chair	15-20	–	15-20
H. Taylor***	Chairman	45–50	–	45–50
S. Weiner	Non-executive director	15-20	–	15-20

No senior manager received any taxable benefit, annual or long-term performance bonuses in 2019/20

* I.Abbs was not an NHS Pension Scheme member for the year 2019/20. He is acting up as the Interim Chief Executive until A.Pritchard returns on 31 July 2021.

** J.Findlay, J.Screaton and E.Sills, were not NHS Pension Scheme members for the year 2019/20.

*** J.Parrott opted out of the NHS Pension Scheme for one month, February 2020, and opted back into the scheme in March 2020. The pension-related benefits therefore cover the 11 month period.

**** A.Pritchard's pension net annual increase did not result in a pension related benefits disclosure in 2019/20. Also, Guy's and St Thomas' pays A.Pritchard's salary while she is on secondment with NHS England/Improvement but this is then refunded.

***** H.Taylor is also the Chairman of King's College Hospital NHS Foundation Trust.

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

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 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.

2019/20 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 2020 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2019 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2020 £000
A. Pritchard* Chief Executive	0-2.5	0	65-70	130-135	945	0	1,040
M. Shaw** Chief Financial Officer	0-2.5	5-7.5	80-85	245-250	0**	0**	0**
S. Steddon Medical Director	7.5-10	12.5-15	45-50	110-115	729	81	902
L. Tallon (from March 2020) Deputy Chief Executive	2.5-5	0	10-15	0	77	1	111
J. Parrott*** Chief Strategy Officer	0-2.5	2.5-5	55-60	165-170	1,199	39	1,295

* A.Pritchard pensions disclosure relates to April 2019 to July 2019.

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

*** J.Parrott opted out of the NHS Pension Scheme for one month, February 2020, and opted back in to the scheme in March 2020. The figures reported therefore cover the 11 month period.

I.Abbs, J.Findlay, J.Screaton and E.Sills were not NHS Pension Scheme members for the year 2019/20 and there was no equivalent disclosure for 2018/19 for I. Abbs and J. Screaton.

I.Abbs is Chief Executive during the period of A.Pritchard's secondment to NHS England/Improvement.

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.

Ian Abbs
Chief Executive
10 June 2020

78% of our staff would recommend the Trust as a place to work according to the 2019 NHS Staff Survey.

6 Staff report

Last year, we employed around 18,050 staff, clinical and non-clinical, all of whom contribute to providing high quality patient care in our hospitals and in our community services. 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 non-clinical staff, including in our scientific, technical, Essentia, and administrative teams who provide vital expertise and support. The table below provides a breakdown of our workforce.

Staff numbers

Staff group	Permanently employed	Agency, bank and seconded staff	Total 2019/20
Administration and estates	4,186	369	4,555
Healthcare assistants and other support staff	903	355	1,258
Medical and dental	2,176	188	2,364
Nursing, midwifery and health visiting staff	5,017	599	5,616
Nursing, midwifery and health visiting learners	1,107	337	1,444
Scientific, therapeutic and technical staff	2,611	198	2,809
Social care staff	3	–	3
Total	**16,003**	**2,046**	**18,049**

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 changes across the organisation.

We work hard to ensure that all staff are aware of both internal and external developments that may affect the organisation, such as 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 2019/20, 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 desk and laptops 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.

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 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

TechZone at Guy's provide email and computer access for staff, as well as help with a range of technical issues.

We run a range of sessions to ensure staff have a forum to discuss important issues, and to develop plans to make improvements.

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 from clinical, non-clinical and community teams 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 'Quality Matters' newsletter provides a regular focus on important quality and safety messages for all staff, and our 'Safety Signals' emails share good practice, including learning from serious incidents.

Staff survey

The NHS Staff Survey is the largest annual workforce survey in the world. The survey results are categorised under 11 themes which are scored on a scale of 0-10 where a higher score indicates a better result. This year a new theme of 'team working' was introduced.

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. The 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 (combined acute and community trusts). The response rate to the 2019 survey was 41%, consistent with last year's response although lower than the national average of 46%. We are keen to improve on this.

In 2019 the Trust improved its score in nine out of 11 themes and achieved the best score in our comparator category for quality of appraisals. The Trust achieved above the national average in 8 out of 11 themes and equal to the national average in one theme.

The staff engagement theme combines questions on motivation, ability to contribute to improvements and recommending the organisation as a place to work or receive treatment. We continue to achieve high engagement scores and we improved on our staff engagement score in the 2019 survey, compared to the previous year.

The Trust was below average in two themes – equality, diversity and inclusion and bullying and harassment. These two areas remain a concern and priority for us as we continue to deliver the Trust's equality, diversity and inclusion strategy. Over the past year, we have introduced a range of measures which centred on our Trust value of 'respect others', to drive improvements in these areas:

- we've held 'respect hackathons' to generate new ideas to address disrespectful behaviours. These events brought colleagues from across the Trust together with subject experts, to co-design resources. The sessions explored the support already available to staff, and identified new resources as well as gaps
- we're establishing 'inclusion agents' within each directorate, who can help support all staff and share good practice on inclusion. They will provide guidance on equitable career progression and help to ensure all processes and communications are fair, inclusive and compassionate
- we're expanding our reverse mentoring programme and diverse recruitment panels to help promote and sustain equality in the workplace
- we've delivered a number of development workshops and training to specifically support black, Asian and minority ethnic staff with career progression.

We're proud that 88% of our staff are happy with the standard of care we provide and would recommend the Trust to their friends/relatives. This is compared to the national average of 71% and was the best score in

Staff survey scores

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

	2019		2018		2017	
	Trust score	National average	Trust score	National average	Trust score	National average
Response rate	41%	46%	41%	41%	36%	43%

	2019		2018		2017	
Themes	**Trust score**	**National average**	**Trust score**	**National average**	**Trust score**	**National average**
Equality, diversity and inclusion	8.7	9.2	8.7	9.2	8.9	9.2
Health and wellbeing	6.0	6.0	5.9	5.9	6.1	6.0
Immediate managers	7.0	6.9	6.9	6.8	6.9	6.8
Morale	6.3	6.2	6.2	6.2	New theme in 2018	
Quality of appraisals	6.3	5.5	6.2	5.4	6.2	5.3
Quality of care	7.8	7.5	7.8	7.4	7.9	7.5
Safe environment – bullying and harassment	7.9	8.2	7.8	8.1	8.1	8.1
Safe environment – violence	9.6	9.5	9.5	9.5	9.5	9.5
Safety culture	7.2	6.8	7.1	6.7	7.2	6.7
Staff engagement	7.5	7.1	7.4	7.0	7.5	7.0
Team working	6.9	6.7	New theme in 2019			

London. 78% of our staff told us they would recommend the Trust as a place to work, compared to the average of 64%, and 90% said that the care of patients/service users was our organisation's top priority, compared to the national average of 78%.

The Trust score for the 'health and wellbeing' theme was equal to the national average of 6.0. We have improved by 5% (37% in 2019, 32% in 2018) on staff agreeing with the question 'Does your organisation take positive action on health and wellbeing?'

We are responding to the survey results at Trust-wide and directorate level. In addition to the work highlighted above, we are planning a film that will explore the issues of 'Respect' and piloting a restorative and just learning culture within HR.

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. This year the Trust has developed and is rolling out an e-learning module, 'Speaking up safely'.

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. This is also supported by an

Staff group	Gender		
	Female	Male	Total
Employees	12,858	4,549	17,407
Executive directors	3	5	8
Other senior managers	198	168	366
Total	**13,059**	**4,722**	**17,781**

Number of staff employed on 31 March 2020.

above the national average score in the 'freedom to speak up index', which monitors 'speaking up culture' in the NHS.

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.

Equality, diversity and inclusion

We are proud to serve diverse 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 access, services, and learning and employment opportunities that are inclusive across all strands of equality: age, disability, gender, ethnicity, religion and belief, sexual orientation, gender reassignment, pregnancy and maternity, and marriage and civil partnership – 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 are free from inequality and discrimination. 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 a comprehensive plan to ensure better and fairer outcomes in access to learning and recruitment opportunities, with career progression and development, as well as an ambitious 10-year plan to improve diversity in senior roles, 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 and our Workforce Race Equality Standard data.

We are committed to supporting staff with long-term conditions and/or disabilities, including anyone who acquires a disability 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 are working to achieve the top level in the scheme of 'Disability Confident Leader'. The Trust also supports the use of a 'staff health passport', which aims to facilitate conversations between staff and managers on health matters, including any workplace adjustments that are required as well as 'access to work' provision.

The Trust leads and participates in a number of projects and initiatives to widen access to learning, 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
- equality, diversity and inclusion e-learning as well as unconscious bias training for all staff
- a London-wide reverse mentoring programme, allowing staff to share personal equality and inclusion experiences with senior staff including the Chief Executive and executive directors
- vibrant networks to support staff including: lesbian, gay, bisexual and transgender (LGBT+); black and Asian minority ethnic (BAME); women; 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
- the 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

Employee costs (including executive directors)

	Permanently employed £000	Agency, bank and seconded staff £000	Year ended March 31 2020 Total £000	Year ended March 31 2019 Total £000
Salaries and wages	**735,398**	**58,989**	**794,378**	727,854
Social security costs	**79,311**	**4,295**	**83,606**	75,886
Apprenticeship levy	**3,839**	**–**	**3,839**	3,494
Pension cost: employer's contributions to NHS pensions	**86,922**	**2,361**	**89,283**	81,585
Pension cost: employer contributions paid by NHSE on provider's behalf (6.3%)	**38,990**	**–**	**38,990**	–
Termination benefits	**(55)**	**–**	**(55)**	654
Temporary staff – external bank	**–**	**126**	**126**	6,943
Temporary staff – agency and contract staff	**–**	**29,300**	**29,309**	21,462
Total gross staff costs	**944,405**	**95,071**	**1,039,476**	917,878
Included in above:				
Costs capitalised as part of assets	**(17,006)**	**(1,845)**	**(18,851)**	(19,495)
Less income netted off in staff costs	**(9,311)**	**–**	**(9,311)**	(6,143)
Total staff costs	**918,088**	**93,226**	**1,011,314**	892,240
Analysed into operating expenditure				
Employee expenses – staff and executive directors	**917,607**	**93,226**	**1,010,833**	891,083
Redundancy	**(55)**	**–**	**(55)**	654
Internal audit costs	**536**	**–**	**536**	503
	918,088	**93,226**	**1,011,314**	892,240

- leading the London, Surrey and Kent 'Step into Health' programme which supports people from the armed forces to access employment opportunities in the NHS.

Staff sickness absence

Sickness absence figures are published by NHS Digital, using data drawn for January 2019 to December 2019 from the Electronic Staff Record data warehouse. The latest version, which covers up to December 2019, can be found on the NHS Digital website at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Safe working environment

Guy's and St Thomas' NHS Foundation Trust is committed to the health, safety and wellbeing of its staff.

To achieve this, the Trust has implemented a governance framework supported by policies and procedures which detail the responsibilities of senior leaders, managers and staff for ensuring risks arising from work are eliminated, effectively controlled or mitigated. The health and safety team, through engagement with staff at all levels, has developed a positive health and safety culture which is reflected in the results from our staff survey.

In 2019/20, in addition to ongoing campaigns to reduce the risk of violence and aggression against staff, the Trust has developed protocols to assess the levels of workplace stress and introduced organisational stress risk assessments using the Health and Safety Executive stress management standards. To complement this work, the Trust is training staff across the organisation to become 'mental health first aiders'. These activities are aligned with the Trust's 'Showing we care about you' programme.

This year also saw the introduction of a new strategy to manage musculoskeletal risk. The aim of the strategy is to create and sustain safe working environments by improving the health and safety culture.

The health and safety team continues to engage with clinical colleagues to manage the risk of sharps injuries from medical instruments and has focused on the procurement of safe sharps.

It has also supported the implementation of the new high consequence infectious diseases unit by providing a comprehensive respiratory protection programme for staff and this unit has played a key role in the early stages of the national response to the COVID-19 pandemic.

Occupational health

Our occupational health service focuses on the health and wellbeing of our staff, patients and visitors. We have one of the largest teams in the country and were the first NHS trust to achieve the SEQOHS award for high quality and standards in 2011. We employ a multidisciplinary team of doctors, nurses, safety specialists, researchers and administrative staff who serve around 73,000 staff, including employees of the Trust and other local and national organisations through commercial contracts.

Our public health service offers pre-commencement screening, vaccination and immunisations to ensure our staff and patients are protected from work-related communicable diseases. Advice and tracing of staff contacts in the event of outbreaks, is provided by the public health team. The Trust provides an annual flu vaccination programme led by the directorates and supported by the Chief Nurse and occupational health.

In line with Trust policies and procedures, we provide support and advice to managers on the management of staff sickness absence through our telephone advice line, referral service and by attending local training sessions. We also provide advice to staff and managers dealing with distressing events, ranging from local issues to major incidents which have included the COVID-19 pandemic. We encourage managers with concerns to contact us via our dedicated manager's advice line and promote healthy workplaces, including through workplace adjustments.

Our research projects focus on how best to help people with medical conditions to remain in, or to return to, healthy work. Our small but active team leads on research at the Trust, aiming to help develop evidence-base interventions and ensure that our research has an impact on clinical practice or national policies. We work closely with our research partners including the National Centre for Musculoskeletal Health and Work, the Occupation and Psychiatric Morbidity consortium (OPTIMUM) at King's College London, the Coronel Institute in the Netherlands and other institutions in the UK and abroad. Our work is entirely self-funded.

Our health and wellbeing team provide and support many local and national health and wellbeing initiatives, promoting these through roadshows, promotions and educational events. The programme, '5 ways to a healthier YOU', supports staff to make healthy lifestyle choices by focusing on:

- active body – subsidised gym, swimming pool, zumba classes and support for cyclists
- healthy body – access to physiotherapy, smoking cessation and sleeping advice
- work-life balance – flexible working options, family and childcare support, and support for carers
- healthy eating – tailored dietary support, one-to-one clinics and weight management programmes
- healthy mind – provision of specialist psychological support, and through the Employee Assistance Programme which provides a range of services including counselling.

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 2019 to 31 March 2020.

Table 1: relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
83	78.13

Table 2: percentage of time spent on facility time

Percentage of employee time spent on facility time	Number of employees
0%	50
1%-50%	32
51%-99%	1
100%	0

Table 3: percentage of pay bill spent on facility time	
Total cost of facility time	£148,325.77
Total pay bill	£1,039,476,000
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	24.87%

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.

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

Agency staff

The Trust has continued its focus on reducing the use of agency staff and remaining compliant with NHS Improvement's agency 'cap' which sets maximum pay levels for agency staff. We use robust procedures to monitor and report on agency spend and to reduce the number of breaches of the cap. 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 continue to take steps to minimise agency expenditure, while still working to meet the temporary staffing requirements of the Trust. The Trust has been working closely with other trusts locally and across London to support the effective management of spending on temporary staffing and compliance with pan London maximum bank and agency 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 2-4, and have introduced additional workforce controls to restrict the use of administrative and clerical agency staff in line with the new NHS Improvement rule changes which prohibit the use of administrative and estates agency workers.

Expenditure on consultancy

Expenditure on consultancy in 2019/20 was £2,835,000.

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 2019/20.

On 6 April 2017, public bodies became responsible for collecting tax from those contractors subject to HMRC's IR35 rules; all contractors are subject to a review to determine whether they are affected by the rules. The number of contractors engaged as at 31 March 2020 is shown in the tables overleaf where daily rates exceed £245 per day and the engagement has lasted longer than six months.

High paid off-payroll engagements

All off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months	
Number of existing engagements as of 31 March 2020	17
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between two and three years at the time of reporting	5
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	10

All new off-payroll engagements, or those that reached six months in duration, in 2019/20, 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 2019 and 31 March 2020	3
Of which:	
number assessed as subject to IR35	2
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	1
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 2019/20	
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

Exit packages

Staff exit packages

In 2019/20, a total of 14 exit packages were agreed in the year, 10 of which were compulsory redundancies. The total cost of these exit packages was £557,000. Summary information for 2019/20 and comparative information for 2018/19 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	
	2019/20	2018/19	2019/20	2018/19	2019/20	2018/19
<£10,000	2	4	3	0	5	4
£10,000 – £25,000	1	2	1	0	2	2
£25,001 – £50,000	3	4	0	0	3	4
£50,001 – £100,000	2	1	0	1	2	2
£100,001 – £150,000	1	1	0	0	1	1
£150,001 – £200,000	1	0	0	0	1	0
Total number of exit packages by type	**10**	**12**	**4**	**1**	**14**	**13**
Total resource cost £000	**521**	**377**	**36**	**78**	**557**	**455**

Exit packages: other (non-compulsory) departure payments

Four individuals received a non-compulsory departure payment in 2019/20. Comparative information for 2018/19 is provided in the table below.

	2019/20		2018/19	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	0	0	1	25
Exit payments following Employment Tribunals or court orders	4	36	1	53
Total	**4**	**36**	**2**	**78**

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

2020 is International Year of the Nurse and the Midwife. Throughout the year, we will be celebrating Florence Nightingale's legacy with activities and events to honour our fantastic nurses and midwives.

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

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

Council of Governors

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

It has a number of statutory duties, including appointing the Chairman and non-executive directors, 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 non-clinical constituencies took place in 2019.

The constitution currently requires us to have 31 governors. During 2019/20, five governors received expenses totalling £1,570. 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

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 recommendation to offer Priya Singh a second term of four years as a non-executive director of the Trust, and approved the appointment of a new non-executive director, Paul Cleal.

The Council of Governors reviewed the outcome of the Chairman's appraisal and supported the Chairman serving out his agreed term of office to 31 January 2021.

Members of the Nominations Committee*	
Name	Role
Heather Byron	Patient governor and lead governor (from February 2020)
John Chambers	Staff governor
Annabel Fiddian-Green	Public governor
Hugh Taylor	Chairman
Warren Turner	Stakeholder governor

*The Nominations Committee is serviced by the director of corporate affairs.

Our membership

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

Patients – anyone aged over 18 years who has been a patient within the last five years. 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 26,001 members, of whom 3,699 are patient members, 5,640 are public members and 16,662 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 eight executive board directors including the Chief Executive, Ian Abbs. Its role is to:

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

Council of Governors

Nominated lead governor: Devon Allison (to January 2020) and Heather Byron (from February 2020)

Trust Board Directors attended every Council of Governors meeting.

Patient governors	Elected from	Actual/possible attendance
Devon Allison [lead governor]	July 2016 (until Jan 2020)	3 / 4
Heather Byron [lead governor]	August 2019 (lead governor from February 2020)	2 / 4
Jonathan Farley	until June 2019	1 / 1
John Knight	July 2019	2 / 3
Williams Moses	July 2018 (until May 2019)	0 / 1
Betula Nelson	July 2019	2 / 3
Placida Ojinnaka	July 2018	2 / 4
John Powell	July 2019	2 / 3
Giuseppe Sollazzo	October 2017 (until June 2019)	0 / 1
Mary Stirling	July 2018	3 / 4
Yu Tan	July 2018	3 / 4
Christine Yorke	August 2019	2 / 2

Public governors	Elected from	Actual/possible attendance
Martin Bailey	July 2019	1 / 3
Elaine Burns	July 2018	1 / 4
Marcia Da Costa	July 2018	4 / 4
Annabel Fiddian-Green	July 2018	3 / 4
Paula Lewis-Franklin	July 2019	3 / 3
Margaret McEvoy	July 2018	4 / 4
John Porter	July 2016 (until June 2019)	0 / 1
Samantha Quaye	July 2018	2 / 4
Jenny Stiles	July 2016 (until June 2019)	1 / 1
Peter Yeh	July 2018	3 / 4

Staff governors	Constituency	Elected from	Actual/possible attendance
Tahzeeb Bhagat	Clinical	July 2018	2 / 4
John Chambers	Clinical	July 2018	3 / 4
Tony Hulse	Clinical	July 2018	2 / 4
Laura James	Non-clinical	August 2019	2 / 2
Anita Macro	Community	September 2017	2 / 4
Vicky Rogers	Non-clinical	July 2016 (until June 2019)	1 / 1
Bryn Williams	Non-clinical	July 2016 (until June 2019)	1 / 1
Rachel Williams	Non-clinical	August 2019	1 / 2

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	0 / 4
Jane Fryer	NHS England	October 2015	0 / 4
Alice Macdonald	Southwark Council	July 2018	2 / 4
Matthew Patrick	South London and Maudsley NHS Foundation Trust	November 2013	0 / 4
Lucilla Poston	King's College London	January 2017	2 / 4
Sue Slipman	King's College Hospital	January 2017	0 / 4
Warren Turner	London South Bank University	September 2014	1 / 4

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

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

Tel: 020 7188 7346

Public Board meeting attendance April 2019 – March 2020		
Name	Title	Actual/possible
Ian Abbs [from August 2019]	Chief Executive, Chief Accountable Officer and Chief Medical Officer	4 / 4
Paul Cleal [from January 2020]	Non-executive director	1 / 1
Jon Findlay	Chief Operating Officer	4 / 4
Felicity Harvey	Non-executive director	4 / 4
Girda Niles [until December 2019]	Non-executive director	1 / 3
Jackie Parrott [from April 2019]	Chief Strategy Officer	3 / 3
John Pelly	Non-executive director	4 / 4
Amanda Pritchard [until July 2019]	Chief Executive and Chief Accountable Officer	2 / 2
Reza Razavi	Non-executive director	4 / 4
Julie Screaton	Chief People Officer	4 / 4
Martin Shaw	Chief Financial Officer	3 / 4
Sheila Shribman	Non-executive director	4 / 4
Eileen Sills	Chief Nurse, Director of Patient Experience and Infection Control, and Deputy Chief Executive	3 / 4
Priya Singh	Non-executive director	4 / 4
Simon Steddon [from July 2019]	Medical Director	2 / 2
Hugh Taylor [Chair]	Non-executive director	4 / 4
Steve Weiner	Non-executive director	4 / 4

Committee	Membership April 2019 – March 2020
Audit and Risk	John Pelly (Chair), Priya Singh, Steve Weiner
Cancer Services	Hugh Taylor (Chair), Ian Abbs, Paul Cleal (from January 2020), Jon Findlay, Felicity Harvey, Jackie Parrott, Amanda Pritchard (until July 2019), Reza Razavi, Sheila Shribman, Eileen Sills, Simon Steddon (from August 2019)
Integrated Care	Jon Findlay (Chair), Paul Cleal (from January 2020), Felicity Harvey, Girda Niles (until December 2019), Amanda Pritchard (until July 2019), Julie Screaton, Martin Shaw, Eileen Sills
Quality and Performance	Priya Singh (Chair), all Board members
Remuneration	Hugh Taylor (Chair), all other non-executive directors
Evelina London Board	Sheila Shribman (Chair), Ian Abbs (from August 2019), Amanda Pritchard (to July 2019), Steve Weiner
Strategy and Partnerships	Felicity Harvey (Chair), all Board members
Transformation and Major Programmes	Steve Weiner (Chair), all Board members

not appointed a senior independent director.

The Board relaunched its committees in early 2019 to reflect the needs of the Trust's strategy. The Integrated Care Strategic Business Unit (SBU) was launched on 1 April 2019, building on the success of the Evelina London SBU. It 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.

Since 1 April 2019 the Board's committees have been:

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

Cancer Services – which oversees the strategic development of cancer services across the Trust and local network, and monitors network operational performance.

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

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

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

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

The membership of the Remuneration and Audit and Risk Committees is limited to non-executive directors. The Council of Governors sends 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 managed by the Council of Governors in a general meeting, advised by their Nominations Committee.

In September 2019, 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. They had an opportunity to meet and ask questions of the Board of Directors and governors, and listened to presentations on caring for vulnerable patients, equality, diversity and inclusion initiatives, sustainability, and the 150th anniversary of Evelina London.

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 and Risk Committee

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

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 workplans and received regular reports. It also reviewed and revised its terms of reference.

At its meetings in May 2019 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 was reviewed in 2019/20. The Council of Governors agreed in October 2019 to extend the external audit services contract with Grant Thornton by another two years, until July 2022.

Audit and Risk Committee membership and attendance 2019/20

Name	Actual/possible
John Pelly [Chair]	5 / 5
Priya Singh	2 / 2
Steve Weiner	5 / 5

Remuneration Committee

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

Remuneration Committee membership and attendance 2019/20

Name	Actual/possible
Hugh Taylor [Chair]	5 / 5
Paul Cleal [from January 2020]	0 / 1
Felicity Harvey	4 / 5
Girda Niles [until December 2019]	3 / 4
John Pelly	5 / 5
Reza Razavi	4 / 5
Sheila Shribman	5 / 5
Priya Singh	5 / 5
Steve Weiner	5 / 5

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. Its role is 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 that report regularly to the Trust Management Executive are:

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

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.

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

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.

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

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

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

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 Committee.

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 Trust Board. He is a resident of Southwark.

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

Paul Cleal OBE
Non-executive director

Paul has held leadership and advisory positions in a wide range of both public and private sector organisations, including many years spent as a Partner at PricewaterhouseCoopers. He is currently Vice-Chair of Kingston University.

He has won a number of awards for his diversity work, and previously served as a Board member on the Government's Social Mobility and Child Poverty Commission. He is currently a member of the Premier League's Equality Standard Assessment Panel, helping football clubs progress equality and diversity across all areas of their business.

Paul joined the Board in January 2020.

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 the Medicines, Pharmacy and Industry Group at the Department of Health.

Felicity joined the Board in September 2016.

John Pelly OBE
Non-executive director

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

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

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

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

Professor Reza Razavi
Non-executive director

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

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.

Priya was appointed Executive Vice Chair from August 2019-February 2020 during which time she served as interim Deputy Chief Executive.

Steve Weiner
Non-executive director

Steve lives locally in Southwark. He has spent most of his career in finance with international consumer goods group, Unilever. He retired from his role as Global Controller and part of Unilever's finance leadership team in 2018.

He has extensive experience in making operational and commercial decisions involving large budgets and complex financial constraints and in leading and developing multi-cultural teams.

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

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.

Girda joined the Board as a non-executive director in January 2012 and she completed her second term in December 2019.

Board of Directors – executive directors

Dr Ian Abbs

Chief Executive and Chief Accountable Officer and Chief Medical Officer

Ian became Chief Executive in August 2019. He was appointed Medical Director in January 2011 and Chief Medical Officer in January 2017. He joined the Trust as a consultant renal physician and honorary senior lecturer at King's College London in 1994 and has had a distinguished clinical and academic career, which has included a broad range of senior management positions.

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

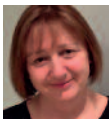
He has many years' experience working at director level in roles that have spanned clinical operations, service modernisation, performance improvement, human resources and workforce planning.

Jackie Parrott

Chief Strategy Officer

Jackie was made Chief Strategy Officer in April 2019. Jackie has over 30 years NHS experience having started her career as a management trainee in south east London. Having managed surgical services and medical specialties, she joined Guy's and Lewisham Trust in 1991 as a general manager for women's services. When Guy's and St Thomas' merged she managed a wide range of specialist services including cancer, cardiothoracic and renal services.

Her career has spanned both operational and strategic management, including a number of policy, planning and partnership roles. In 2010 she became Joint Director of Strategy and then Director of Strategy in 2013.



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.

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.

Dr Simon Steddon

Medical Director and Director of Patient Safety

Simon has been Medical Director since 2017 and became Medical Director, with full Board responsibilities, in July 2019.

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

Simon has a PhD from Queen Mary University of London and an MBA from Westminster Business School. He became clinical director for renal and urological services in 2008 and joint clinical director for abdominal medicine and surgery in 2010. He served as Chief Operating Officer from 2014 to 2016.

Lawrence Tallon

Deputy Chief Executive

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

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

Amanda Pritchard

Chief Executive and Chief Accountable Officer (to July 2019)

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 is currently Chief Operating Officer at NHS England and NHS Improvement on a secondment basis.

Our award-winning apprenticeships are designed to give talented people an opportunity to gain a nationally recognised qualification while completing on-the-job training with our skilled staff.

8 NHS oversight framework

NHS England and NHS Improvement's NHS 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 England and NHS Improvement assigned a score of '1' to Guy's and St Thomas' NHS Foundation Trust in March 2020. 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 NHS 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	2019/20	2018/19
Financial sustainability	Capital service capacity	2	1
	Liquidity	1	1
Financial efficiency	Income and expenditure margin	2	1
Financial controls	Distance from financial plan	1	1
	Agency spend	1	1
Overall scoring		**1**	**1**

In the 2019 national Staff Friends and Family Test 93% of staff said they are 'likely' or 'very likely' to recommend the Trust as a place to be treated.

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 to 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.

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

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

Ian Abbs, Chief Executive and Accounting Officer
10 June 2020

Annual governance statement 2019/20

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 2020 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 assurance on the high-level risks that are deemed the most significant through the year. The constitution of all Board committees has been reviewed, and 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 Medical Director carries responsibility for ensuring this policy is both implemented correctly and sufficiently effective. The Medical Director, in conjunction with the Chief Nurse, also holds responsibility for clinical governance and the appropriate monitoring of clinical standards, 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 quarterly by the Trust Management Executive.

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, peer review, effective performance management, continuing professional development, clinical audit, the application of evidence-based practice and reflective practice. Learning from investigations and root cause analyses feeds into relevant quality improvement initiatives, as well as Schwartz Rounds and our 'Safety Connections' campaign. A safety story is shared with the Trust Risk and Assurance Committee monthly and from there is cascaded throughout the organisation through governance meetings. A Quality Matters newsletter is published monthly for all staff and includes key messages and examples of learning. A library of root cause analysis reports has been established to ensure access to reports and learning is not restricted to the team or department involved in the incident.

As well as learning from internal best practice, near misses and incidents we also carry out gap analysis on new best practice publications or national reports as well as learning from other areas.

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 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 2019/20 we worked to embed our governance arrangements following our 2018/19 governance review. Our arrangements provide the necessary support to deliver our operational priorities, improvement plans and strategic ambitions. This includes a refreshed Board committee structure to ensure optimal assurance. The Trust Management Executive, the most senior executive group below the Board, continues to reinforce the importance of clinical leadership and oversee a number of supporting sub-committees.

The Board Assurance Framework sets out the principal risks to delivery of strategic objectives and the key controls and assurances available to the Board of Directors on management of these significant areas of risk. The Board Assurance Framework incorporates four tiers of assurance encompassing day-to-day management, performance and oversight of controls, internal objective assurance, and external independent assurance. It highlights five areas in 2019/20 where the Board has limited assurance despite significant management attention:

- maintaining operational performance with increasing patient demand that exceeds the Trust's capacity
- investing in digital infrastructure to support operational delivery and meet requirements
- estates improvement to meet growing demand and emerging operating model
- ensuring the Trust consistently delivers high quality care to patients

- the breadth and complexity of the Trust's commercial strategy and ambitions.

Each year the Board completes a formal risk review to identify risks which might threaten the achievement of the Trust's strategy and assigns them to a lead executive director, as well as to the appropriate executive and Board committees for management and assurance.

Controls and assurances include:

- our performance management framework, including performance dashboards and monthly Balanced Scorecard
- 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 the Board Assurance Framework
- reports from the Quality and Performance Committee and the Audit and Risk Committee to the Board
- clinical audit, including national audits, audits arising from national guidance (for example from NICE), confidential enquiries and local audits related to risk or patient safety
- assurances through internal audit, the Care Quality Commission, NHS Improvement, the NHS Resolution (NHSR) and Patient-Led Assessments of the Care Environment (PLACE)
- external regulatory and assessment body inspections and reviews including Royal Colleges, Postgraduate Deanery, Information Commissioner's Office and Health and Safety Executive (HSE) reports
- self-assessment against the compliance framework and CQC registration requirements
- quality 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 Balanced Scorecard, 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. A third SBU will be launched in April 2020 to include cancer services and surgical specialties.

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 Balanced Scorecard collating trends, analysis and action plans for Board review and public scrutiny. A risk-based assessment of the data associated with key indicators helps determine the programme undertaken by the Trust's internal audit department and the quality of our information is also audited externally.

Assurance on compliance with the Health and Social Care Act 2008

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

The CQC carried out a well-led inspection and inspection of adult community, outpatient services and maternity servicers during 2019 which resulted in a' good' overall rating with 'outstanding' for well-led.

Managing risks to data security

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

All staff receive information governance (IG) training as part of corporate induction on joining the Trust, with IG training also mandated for all staff on an annual basis. Data security is included as a core theme within the IG training delivered to staff. Training requirements are supported by comprehensive policies and guidance to ensure access to relevant and up-to-date information.

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

The Trust agreed to a consensual audit by the Information Commissioner's Office (ICO) of its processing of personal (patient and staff) data in January 2020. The audit purpose was to provide the Information Commissioner and the Trust with assurance on the extent to which the Trust complies with data protection legislation, including General Data Protection Regulation (GDPR) and the Data Protection Act 2018. The audit confirmed a reasonable level of assurance in cyber security and business continuity controls, with a high level of assurance in personal data breach management controls.

All standards of the 2019/2020 Data Security and Protection Toolkit (DSPT) were met by 31 March 2020, with the exception that further work was required to meet the DSPT target for 95% of Trust staff to have completed their annual information governance training. An action plan has been agreed with NHS Digital to meet this target before the end of September 2020, with the outcome that the formal status of the Trust's 2019/20 DSPT compliance, as of 31 March 2020, is 'standards not met (plan agreed)'.

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 and repeated in September 2019, focusing on the safe processing and security of personal and sensitive data.

In 2019/20, three incidents were reported to the Information Commissioner's Office (ICO). The first incident related to the loss of an unencrypted data stick containing patient details. The incident was reported to the appropriate authorities. No harm was identified and no further action required by the ICO, due to the actions already taken by the Trust.

The second incident related to an unattended laptop being accessed to send confidential documentation relating to the performance of junior doctors to an unknown recipient and further disseminated through a private WhatsApp group. Following this incident, a full investigation took place. There was no follow-up action from the ICO and they were kept informed throughout the investigation.

The third incident related to the inappropriate disclosure of a patient's record resulting from a formal subject access request (SAR). Investigation revealed that no harm was caused as a result of this incident but a full root cause analysis was completed and learning has been incorporated via changed processes and additional staff training.

Major in-year risks 2019/20

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 2019/20 the key risks with potential impact on achieving our objectives were:

- the breadth and complexity of the Trust's strategic agenda, including an increasing number of strategic partnerships, could destabilise delivery of quality, finance and performance
- patient demand significantly exceeding the Trust's capacity and potentially the ability to meet constitutional standards, impacting on quality, safety 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 can 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 may not achieve its ambition in relation to its commercial opportunities at the desired size and scale without an integrated and comprehensive commercial strategy and robust governance
- recruitment and retention of staff with the right skills and behaviours undermines the Trust's ability to deliver services in line with agreed quality standards and strategic priorities
- 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
- The Trust is unable to sustain financial efficiencies and secure sufficient income and/or capital for services curtailing our ability to deliver high quality care.

Major in-year risks 2020/21

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.

A major cause of risk for 2020/21 is the outbreak of the novel Coronavirus 'COVID-19', which became a global pandemic in March 2020. COVID-19 has posed significant and unique operational and strategic challenges to the Trust, the National Health Service and the country as a whole. The impact of COVID-19 will be felt across all our services and threaten the achievement of the Trust's objectives.

The principal strategic risks for the organisation in 2020/21 therefore remain the same as for 2019/20, but the effectiveness of their controls and assurance will need to be assessed in light of COVID-19. A full review of the Board Assurance Framework and principal strategic risks will therefore be undertaken later in the financial year to assess the overall impact of COVID-19 on the Trust's strategic agenda. The Trust's principal risks may then be updated once the effect of the outbreak is clear. The management of these risks will likely require strategic transformational change in order to treat and mitigate the impact on the Trust.

NHS Improvement well-led framework

In 2019/20 the Trust participated in a thorough self-assessment and external review of its arrangements against the NHS Improvement well-led framework under its 2019 Care Quality Commission inspection. The Care Quality Commission external assessment moved the Trust from 'good' under well-led to 'outstanding'.

Risks to foundation trust governance and corporate governance statement assurance

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

Embedding risk management and incident reporting

The ways in which risk management is embedded in the Trust is covered in the risk and control framework above.

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 feedback when an incident is investigated if the member of staff wishes to receive this.

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

During 2019/20, the Trust has continued to demonstrate a healthy incident reporting culture and remains one of the highest reporters of incidents within our cluster. The Trust has seen a continued rise in incidents reported compared with the previous year and the majority of incidents reported are of no, or low, harm. The Trust's commissioners have praised improvements in processes, structures and outcomes for the management of serious incidents, including the timeliness and quality of reports.

In 2019/20, the Trust reported 10 '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.

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 26,000 members as at the end of March 2020. 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 Board approved a new 'People strategy' in April 2019 that sets out the workforce priorities and plans for the period 2019-2023, aligned with 'Together we care', the Trust's corporate strategy. As part of the annual business planning cycle, an annual workforce planning process is run to triangulate staffing with predicted activity levels and finance plans. Directorate-level plans are aggregated to form an overall Trust plan with strategies and business cases to close potential workforce shortfalls considered through the relevant committees.

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

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

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

Compliance statements

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past 12 months as required by the 'managing conflicts of interest' in the NHS22 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.

The Trust is currently reviewing its sustainability strategy which is due for renewal in 2020. This will then be the Trust's high level sustainable development management plan, as requested by the Sustainable Development Unit and the Trust's strategy commitments will be implemented through a series of management plans. Our sustainability strategy will include commitments in both climate change mitigation and adaption, among other sustainability areas.

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.

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 Balanced Scorecard (previously the IQPR). To this extent, the annual quality report is an extension of our monthly reporting process. The Balanced Scorecard 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 and Risk Committee and the Quality and Performance Committee, and plans to address weaknesses and ensure continuous improvement of the system are in place.

Processes for maintaining and reviewing the system of internal control

The Board

The Board and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and procedures and monitoring of outcomes agreed as indicators of effective controls.

Through its committees, the Board regularly reviews reports on operational performance, including the monthly Balanced Scorecard, 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 monthly Balanced Scorecard 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 and Risk Committee

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

Quality and Performance Committee and Trust Risk and Assurance Committee

The Quality and Performance Committee is a sub-committee of the Board 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.

Internal audit

Internal audit works to a risk-based audit plan, agreed by the Audit and Risk Committee. Its remit covers risk management, governance and internal control processes, both financial and non-financial, across the Trust. The work includes identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards.

A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are issued to and followed-up with the responsible executive directors, and the results of audit work are reported to the Audit and Risk Committee.

Internal audit reports are also made available to the external auditors, who may use these to inform their annual opinion. In addition to the planned programme of work, internal audit provide advice and assistance to senior management on control issues and other matters of concern. The internal audit team also provides an anti-fraud service to the Trust.

Internal audit work also covered includes service delivery and performance, financial management and control, human resources, operational and other reviews. Based on the work undertaken, including a review of the Trust's Board Assurance Framework process, the head of internal audit opinion concluded as follows:

"I have considered all of the work conducted by internal audit staff during 2019/20, including audits undertaken during the year which related to the previous year's plan. I have also considered reactive and proactive work conducted by the Trust's local counter fraud specialists. This includes oversight of all internal audit reports, fraud investigations and personal conduct of specific projects during the year.

Towards the end of the financial year, the Trust implemented its response to the COVID-19 pandemic. As a result of this, various changes were made to Standing Financial Instructions which were approved by the Board in recognition that the Trust may have to enter into arrangements at short notice. A number of transactions were entered into which did not comply with normal procurement arrangements. I am satisfied that these were necessary as a response to urgent requirements and that, where the Trust did deviate from normal practice, this was driven by clinical need and was appropriate in the circumstances prevailing at the time. I am satisfied that board members were sighted on the increased risks that may be involved in these transactions and received information on a regular basis concerning significant transactions.

Although the Internal Audit plan was affected by the COVID-19 pandemic in that a number of audits have been delayed, the internal audit and counter fraud team have provided real-time advice in relation to changes in controls and fraud risks.

I am satisfied that enough coverage was maintained in order to form an opinion.

In my opinion, with the exception of those areas in which limited assurance reports have been issued as reported to the committee during the year, the controls in those areas reviewed are adequate and effective. Where weaknesses have been identified these are being addressed by management and actions have been confirmed through follow up work by internal audit.

I am satisfied that the Board Assurance Framework, as presented to the Audit and Risk Committee in 2019/20 over the course of the year is representative of the key risks faced by the organisation.

I confirm that I have monitored compliance with the Public Sector Internal Audit Standards. In my view, Internal Audit complies with those standards that are applicable to the public sector."

Clinical audit

The Trust's 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.

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. A review of the processes and systems that ensure the completeness, effectiveness and accuracy of the Trust's Board Assurance Framework (BAF) and risk management processes by Internal Audit concluded that there is substantial assurance overall.

Ian Abbs
Chief Executive
10 June 2020

The Trust maintained its overall 'good' CQC rating, with services for adults in the community now rated 'outstanding'.

10 Quality report

Statement on quality from the Chief Executive 2019/20

Due to the impact of the Coronavirus (COVID-19) pandemic on the NHS, all NHS foundation trusts were advised by NHSI/E that inclusion of a quality report in this year's Annual Report and Accounts was optional. However, as part of our commitment to transparency, we have chosen to include as much information as possible.

This report has been shared with Healthwatch Lambeth and Healthwatch Southwark, and with the South East London Clinical Commissioning Group. However, due to the exceptional circumstances, these organisations were not invited to provide a formal response for inclusion in the report published here.

Also, as the report is incomplete, it does not include the independent practitioner's limited assurance report to the Trust's Council of Governors.

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:

- our patients rated the overall experience of care they receive at Guy's and St Thomas' as 8.5 out of 10 in the Care Quality Commission's adult inpatient survey
- we achieved one of the highest engagement scores of all 'combined acute and community trusts' in the 2019 NHS Staff Survey and were the top London trust for staff recommending care at their trust to others. While we are not complacent, and are working hard to address areas where we need to improve, we are proud of these achievements as 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
- we had more research studies open for patients to join in 2018/19 than any other NHS trust in England – 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 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 that we learn and share lessons from our mistakes in order to improve safety for patients, visitors and staff.

Our serious incident assurance panel ensures that all never events and serious incidents are properly investigated and managed.

We publish 'Quality Matters', a regular newsletter which is sent to all staff and which supports the sharing of best practice.

Our 'Learning from excellence' system encourages staff to report examples of good practice and things that work well so that they can be recognised and shared across the Trust.

We encourage all our staff to 'speak up' if they have concerns about patient safety or the quality

of care we provide and have an active and well supported network of 150 'speak up advocates', a confidential email address and external phone line. This year we have also developed a new e-learning module, 'speaking up safely', which is being rolled out to all staff.

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

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 2019 Guy's and St Thomas' was inspected by the Care Quality Commission (CQC). 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.

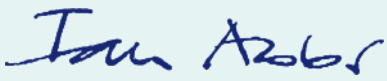
We were therefore extremely pleased to continue to be rated as 'good' overall and 'outstanding' for being a caring organisation and also for being 'well-led'.

Of the three services inspected, our adult community services were rated as 'outstanding', a major improvement on last time and a reflection of the important role we play in delivering care to patients in Lambeth and Southwark. Significant improvements were also recognised in maternity services, which maintained an overall rating of 'good', although our outpatient services were rated as 'requires improvement' despite the inspectors highlighting numerous examples of positive practice.

It is disappointing that our overall rating for being safe remains 'requires improvement'. While the inspection team commented positively on many factors that underpin safe care, including our staffing levels, they did find issues with a number of our processes and procedures and we are determined to tackle these shortcomings.

Looking ahead we also recognise the many challenges we will face as a result of the COVID-19 pandemic. Following the difficult decision in early March to stop or postpone most non-essential activity, we are acutely aware of the additional waiting times challenges we will face as we seek to restart services, and to do so in line with new infection control guidance that we expect to reduce capacity in all settings.

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



Ian Abbs
Chief Executive
10 June 2020

Our quality priorities for 2020/21

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. 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 2020/21.

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, the Trust Management Executive and directorate management teams. The final priorities for 2020/21 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 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 whilst also being efficient and cost effective.

Patient experience – meeting our patients' emotional needs 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 2020/21

Patient safety

Our quality priorities and why we chose them	What success will look like
We will ensure timely recognition of deterioration This priority supports delivery of our quality goal to reduce avoidable harm.	We will: • increase to 95% the number of patients receiving standard NEWS evaluations • improve to 95% the number of observation sets which include all six parameters required for a valid NEWS score.
We will improve mental health care across the Trust including support for staff delivering care This priority supports delivery of our quality goal to make every contact count in supporting the prevention of poor health and builds on the achievements of our 2019/20 quality priority.	We will: • ensure that the Trust's mental health strategy is implemented and embedded in directorates • introduce a simulation-based training programme to reduce the use of restrictive practices • implement a joint programme of work, co-developed with South London and Maudsley NHS Foundation Trust, to improve proactive risk assessment and the integration of mind and body care.
We will improve services for patients with dementia and delirium This priority supports delivery of our quality goal to make every contact count by supporting the prevention of poor health.	We will: • implement a memory service supported by the dementia and delirium team, including follow-up and signposting in the community • establish a network of professionals and services to provide care and support to patients with a dementia diagnosis to achieve optimum outcomes for these patients and their carers • develop an e-learning package for dementia level 2 training to ensure access to training and improve compliance • ensure we remain 'dementia friendly' hospitals, achieving a positive score in our PLACE assessment.
We will ensure our vulnerable patients are kept safe This priority supports delivery of our quality goal to improve the experiences of 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: • develop and implement a bespoke safeguarding adults level 3 training package by October 2020 • work in collaboration with colleagues in South East London Liberty to implement a programme of liberty protection safeguards by July 2020 • develop a clear process to obtain feedback from patients following a safeguarding investigation • have a clear process for verifying and documenting lasting power of attorney • work with clinical teams to raise the awareness of lasting power of attorney.
Through continued partnership working we will identify and act upon the needs of young people at risk of exploitation and violence This priority supports delivery of our quality goal to improve the experiences of 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: • develop and implement a bespoke safeguarding children level 3 training package by August 2020 • provide enhanced training to specific staff groups where a need is identified • develop and implement risk assessment tools specific to this vulnerable group of children • obtain qualitative feedback from young people and service users • review services offered through emergency departments to ensure a consistent London-wide approach.

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like
We will improve our response to deterioration through effective and timely escalation This priority supports delivery of our quality goal to improve the processes and pathways underpinning patient access to our services.	We will: • increase to 50% the number of patients whose escalation for first acute review is preceded by a completed electronic communication support tool (eSBAR form) • increase to 90% the number of patients who are seen by the clinical response team within two hours of a NEWS score of 7 • increase to 90% the number of patients who are admitted to critical care within two hours of a decision to admit • increase to 100% the number of patients who are admitted to critical care within four hours of a decision to admit.

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like
We will improve the learning from deaths processes This priority supports delivery of our quality goal to learn from deaths and our quality goal to be a learning organisation.	We will: • increase to 90% reporting of mortality stage one reviews • increase to 100% the completion of mandatory detailed case note reviews, to identify areas for learning • share areas for learning with clinicians through the local service review meetings and the mortality surveillance group.
We will improve the safe use of insulin for patients This priority supports delivery of our quality goal to improve medicines optimisation ensuring the right patient gets the right medicine at the right time.	We will: • include the target range for blood glucose on e-noting, adjacent to the reported blood glucose • develop, test and implement an insulin transfer checklist for patients newly started on insulin • move variable rate insulin from paper into the MedChart electronic prescribing system for greater visibility and ease of monitoring.
We will continue to be at the forefront of NHS research This priority supports delivery of our quality goal to measure outcomes and participate in research and our quality goal to be a learning organisation.	We will: • continue to recruit participants into a broad range of national NIHR portfolio studies providing opportunities to participate in clinical research to more of our patients • achieve the recruitment target set by the local clinical research network (target to be confirmed).

Patient experience

Our quality priorities and why we chose them	What success will look like
We will increase knowledge and understanding of decision making at end of life for patients and staff, and thereby increasing patient and family engagement This priority supports delivery of our quality goal to improve end of life care and builds on the achievements of our 2019/20 quality priority.	We will: • audit a sample of end of life care patient records to identify areas for improvement • select a survey for bereaved carers to complete to help us improve care in hospital and community settings from April 2020 • develop an introductory film about end of life care for new staff • expand our 'do not attempt cardio-pulmonary resuscitation' (DNACPR) e-learning package for Trust junior doctors • work with local champions to expand use of the 'Let's talk' digital resources for patients.
We will improve patients' and carers' experience of contacting the Trust by telephone This priority supports delivery of our quality goal to improve experience.	We will: • identify and act on key areas for improvement, including those identified by patients • ensure contact numbers on the internal and external websites are up to date • upgrade our customer call centre system to improve call handling.
We will keep patients informed and regularly updated on waiting times in outpatient clinics This priority supports delivery of our quality goal to improve experience.	We will: • ensure patients are kept informed about any delays in outpatient clinics in accordance with best practice.
We will improve communication with patients, families and carers after they leave hospital This priority supports delivery of our quality goal to improve experience.	We will: • ensure that patients, families and carers have details of who to contact if they have a problem after leaving hospital • provide patients, families and carers with information to support self-care after leaving hospital • work with community staff to improve communication and improve support for patients, families and carers.
We will increase use of virtual clinics at Evelina London This priority supports delivery of our quality goal to improve the processes and pathways underpinning patient access to our services.	We will: • retain the positive changes made to outpatient clinics during our response to COVID-19 • establish a system to default to clinic appointments being offered virtually • sustain change and service improvements through a service transformation programme.

Progress against priorities for 2019/20

Patient safety – position at December 2019

Our quality priorities and why we chose them	What success will look like	How did we do?
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.	The Mental Health Board has developed a Trust-wide delivery plan for the implementation of the mental health strategy. In addition, directorate management teams have been asked to develop directorate delivery plans to detail individual directorate approaches. A new mental health improvement lead has been recruited and will start in April 2020. This post will focus on completing the Lily Steiner legacy fund projects which are currently underway. This includes a simulation-based training programme for clinical staff focused on reducing the use of restrictive practices and a joint programme of work, co-developed with South London and Maudsley NHS Foundation Trust, aimed at improving proactive risk assessment and the integration of mind and body care.
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 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.	Screening performance 80%. Time to treat performance over 90%. The e-noting sepsis tools have been refined and were relaunched in December 2019. Tools for paediatric inpatients and Adult ED are in development. Education and training sessions continue across the Trust and an e-learning package has been rolled out which is proving successful in raising awareness and increasing knowledge. Other streams of work relate to care redesign and bringing multiple data streams into a single, usable and effective dashboard.
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' to organisational change (which focuses on strengths rather than weaknesses) to explore: • how this has happened • how to make it happen more.	We continue to receive around 7-10 nominations each month. The process has been refreshed and an acknowledgement is now sent to both the nominator and nominee. From January 2020 a thank you letter and 'Learning from excellence' certificate are sent from the Medical Director.

Clinical effectiveness – position at December 2019

Our quality priorities and why we chose them	What success will look like	How did we do?
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%.	A clinical lead has been identified to lead the working party in review of all LocSSIPS in use. Further stakeholder engagement is needed to take forward required changes and a sub group will be established to support non-theatre areas and identify other systems in use for recording of LocSSIPs. LocSSIPS data is available for community-based specialties from carenotes and for specialties that use e-Noting. Compliance reports are available from both systems and have been presented at surgical safety group meetings, however work is ongoing with IT to automate the reports for review.
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.	The 'right place, right time' programme and the Integrated Care directorate management team are rolling out a series of quality improvement initiatives informed by national best practice and an internal audit targeted at reducing length of stay. We are also trialling a new method of capturing weekly data on patients staying over 21 days with senior clinical engagement to facilitate treatment and discharge of more complex patients. We have also reconvened a programme board with representation from the top three services that have the highest number of patients staying over 21 days. The discharge team are reviewing their discharge practices against King's College Hospital NHS Foundation Trust to ensure the same approach is being made across both trusts. This is starting with the implementation of the best practice discharge protocol across both trusts. The current number of patients staying over 21 days is 162, down from baseline of 184 (a 12% reduction). The current target is 104 patients.
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.	In 2019 – we sent 1.2 million appointment text message confirmations, received 68,000 reschedule requests via DrDoctor (5,000 of these chose their slot online), 12,000 patients booked their own appointment online, and 3,100 patients brought their appointment forward into a cancellation slot. This is a significant increase in use compared to 2018. Overdue un-booked follow up numbers have remained static and not reduced as hoped. In the areas where intense validation support has been provided, the majority of patients require an appointment and there is very little capacity to book. These services are booked onto care redesign in 2020 to redesign their pathways. Training for over 500 administrators completed for referral and waiting list management in October/November 2020.

Progress against priorities for 2019/20

Patient experience – position at December 2019

Our quality priorities and why we chose them	What success will look like	How did we do?
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.	Our bereaved carer survey will be changed in line with the national audit of care at the end of life; we will survey 4-6 months post death rather than our current system (at collection of death certificate). We propose a unified Trust approach to bereavement support and proactive contact with bereaved carers by the clinical team. This will require discussion and planning via the end of life care committee. We have established a link between 'Coordinate my care' and the Local Care Record via e-noting but use within the pilot project has remained low. Federated access is being sought across London and it is likely that this is required to drive increased usage within the hospital setting. Testing has been completed of our digital patient resources developed as part of our 'Let's talk' programme (supporting discussions relating to DNACPR and treatment escalation planning). We will now test implementation with development of local champions within oncology while consulting about the best cross-Trust implementation methodology.
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.	Following its relaunch, the pain council is reviewing its terms of reference and will develop a Trust pain strategy. A number of areas are currently being assessed such as where the majority of our inpatient pain resources are being directed and how inpatient activity impacts on community services. We have conducted a staff focus group and a patient focus group is scheduled for early 2020. We are working with commissioners and King's mental health services (IMPARTS) to see how we can better coordinate care and improve the patient experience. There has been a change from the Abbey to Bolton pain score to standardise non-verbal pain scores across the Trust and patient controlled analgesia (PCA) and epidural observation charts have been updated to incorporate NEWS scoring.
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.	The lead for this work has completed scoping the service and we have established strategic priorities and clear objectives. There is a format for the transition care plan in those services that have significant numbers of young people transitioning to adult services. The patient experience survey and focus groups show improvement in the care of young people. Visits have been completed to other services and this has informed improvements. Young people have told us they do not want dedicated facilities but they do want access to improved WiFi and Netflix. We continue to hold separate clinics for most services, where appropriate, either transitioning or held for young people.

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 2019/20 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 2019/20 represents 100% of the total income received for the provision of NHS services in 2019/20.

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 2019/20, we took part in 52 national clinical audits and four national confidential enquiries. By doing so we participated in 95% of national clinical audits and 100% of national confidential enquiries in which we were eligible to participate.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2019/20 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 2019/20

Audit title	Participation	% of cases submitted
Women and children's health		
Maternal, new-born and infant clinical outcome review programme	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric intensive care (PICANet)	Yes	Not reported
Maternity and perinatal audit (NMPA)	Yes	100%
Paediatric diabetes	Yes	Not reported
Care of children in the ED	Yes	Report not published
Paediatric asthma	Yes	100%
Seizures and epilepsies in children and young people (epilepsy12)	Yes	Report not published

Participation in national clinical audits 2019/20

Audit title	Participation	% of cases submitted
Acute care		
Adult critical care (case mix programme – ICNARC CMP)	Yes	100%
Emergency laparotomy audit (NELA)	Yes	86%
National joint registry (NJR)	Yes	98%
Major trauma: the trauma audit and research network (TARN)	Yes	53%
Bloodstream infections and C.difficile infections	Yes	100%
Mental health (care in the ED)	Yes	Report not published
Seizure management (NASH 3)	No	Staff shortage during data collection period
Perioperative quality improvement programme (PQIP)	Yes	Data collection ongoing
Long-term conditions		
Chronic obstructive pulmonary disease (COPD)	Yes	Not reported
Adult asthma	Yes	Not reported
Pulmonary rehabilitation	Yes	Not reported
Inflammatory bowel disease (IBD)	Yes	100%
UK Parkinson's audit	No	Registered for and completed audit, but failed to submit data by deadline
Diabetes	Yes	100%
Early inflammatory arthritis	Yes	Not reported
Older people		
Fracture liaison service database	Yes	Not reported
Inpatient falls	Yes	100%
National hip fracture database	Yes	100%
Sentinel stroke national audit programme (SSNAP)	Yes	100%
Dementia	Yes	100%
Assessing cognitive impairment in older people; care in emergency departments	Yes	Report not published
Heart		
Cardiac arrest (NCAA)	Yes	100%
Cardiac rehabilitation	Yes	100%
Cardiac rhythm management (CRM)	Yes	Data collection ongoing
Myocardial ischaemia (MINAP)	Yes	152%
Adult cardiac surgery	Yes	100%
Heart failure	Yes	100%
Percutaneous coronary interventions (PCI)	Yes	Data collection ongoing
Congenital heart disease (CHD)	Yes	Data collection ongoing
National vascular registry	Yes	99%

Participation in national clinical audits 2019/20

Audit title	Participation	% of cases submitted
Cancer		
Bowel cancer (NBOCAP)	Yes	50%
Lung cancer (NLCA)	Yes	100%
Oesophago-gastric cancer (NOGCA)	Yes	< 65%
Radical prostatectomy	Yes	100%
Prostate cancer audit	Yes	100%
Breast cancer in older people	Yes	100%
Endocrine and thyroid audit	Yes	Report not published
Blood and transplant		
Serious hazards of transfusion (SHOT)	Yes	100%
Other		
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%
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 continuous surveillance and quality improvement in 11 surgical specialties with more in development. This audit was designed to assess local practice in the absence of surveillance and QI programmes such as are already in place at the Trust.
Smoking cessation	Yes	Report not published

Participation in national confidential enquiries 2019/20

Audit title	Participation	% of cases submitted
Acute bowel obstruction	Yes	100%
Long term ventilation	Yes	100%
In hospital management of out of hospital cardiac arrest (OHCA)	Yes	100%
Dysphagia in people with Parkinson's disease study	Yes	88% (study still open)

National clinical audit

The reports of all national clinical audits published were reviewed during 2019/20 and we intend to take the following actions to improve the quality of the healthcare we provide.

Adult critical care (case mix programme – ICNARC CMP)

Audit results showed that the level of acquired bloodstream infections in one of our four critical care units was higher than the national average. The audit also showed that unplanned readmissions to critical care were higher than the national average for one unit. We have initiated a quality improvement programme where every acquired bacteraemia is reviewed by a medical consultant with a specialist interest in infection control and a mini root cause analysis is undertaken to identify possible improvements. We have also introduced an initiative whereby any readmissions within 48 hours are reviewed by a consultant against a published, validated tool to assess causality and preventability.

ICNARC data has also proved extremely helpful during our response to the COVID-19 pandemic as it has enabled us to benchmark patient outcomes. We have been reassured to observe that our survival data for critically ill patients with coronavirus compares favourably against other units.

National emergency laparotomy audit (NELA)

We were pleased to note in the most recent report that our 30 day mortality remains one of the lowest in the country and that our case ascertainment has risen to 86% (47% in the last report). We need to improve case ascertainment further, risk assess using the objective NELA calculator preoperatively and ensure consultant presence for high risk cases. We are planning a comprehensive package of changes, including changes to the way that laparotomy cases are booked, a new policy, a revised pathway and a NELA specific WHO surgical safety checklist.

National prostate cancer audit (NPCA)

The latest report showed that our rate of readmission following prostate surgery is below the national average and that patients experiencing complications following treatment is also below the national average. We need to improve data quality, however, and a plan is in place to achieve this.

National hip fracture database (NHFD)

The latest audit report shows that our performance has declined in a number of areas. We were aware of this dip in performance, attributable to 85% of another trust's cases being transferred to us. We have established a hip fracture steering group to review NHFD data and ensure that areas for improvement are identified and actioned. Changes have been made to the patient pathway and to junior doctor education and training.

General

Submitting data to the 50+ national audits is a significant burden for the Trust and often takes up a lot of clinical time. One audit, for example, involves 130 separate items of data that have to be extracted from four different electronic systems and then manually uploaded to the national audit portal, for every patient in the audit. We have been working with an external partner to develop innovative software that will automate this process as far as is possible. Following a successful pilot, we are rolling this out to many other national audits and we expect it to result in significant savings in staff time, better quality data being submitted and improvements in our case ascertainment rates.

Local clinical audit

Reports of 119 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.

Children's services

An audit of discharge processes in paediatric and fetal cardiology showed variation in the information provided to parents, issues with follow-up contacts and a lack of coordination with other specialties. Parents reported that the process can feel rushed leading to a lack of confidence when going home. We are introducing a revised discharge checklist and will ensure clearer signoff of medication skills with parents. We are training staff to highlight the importance of discharge planning and communication, and the need to begin discharge planning early.

Clinical imaging and medical physics

A review of awareness of radiation risks and protocols among staff working in the interventional radiology department demonstrated high awareness of local rules and the risks of not wearing personal dosimetry badges. However, few understood the role of shoulder dosimeter badges in monitoring eye dose and the survey highlighted the need for further education in various aspects of radiation safety. In response to this, radiation safety training will be added to audit half days, covering a different topic each time, and an online radiation safety training package is being developed.

Integrated medicine and therapies

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 and documenting that vital signs had returned to normal prior to discharge. An updated discharge leaflet for procedural sedation has been produced, the sedation pro-forma has been updated, and simulation training has been provided for higher trainees in the emergency department.

Medical specialties

Our nutrition and dietetics team conducted an audit of screening for malnutrition risk in the Older Person's Assessment Unit (OPAU). The audit showed that just 30% of patients were screened in line with national guidance. This result has been shared with key stakeholders and we are introducing routine MUST screening – a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese – as well as a dietetic referral pathway for clinicians in the OPAU.

Pharmacy

Pharmacists undertook an audit of the safe management and security of controlled drugs (CD) within wards and departments that showed all areas audited were non-compliant with local and legal guidance for one or more of the audit questions. We are reviewing and updating the CD code of practice for both the CD standard operating procedure and the recording of waste. We will introduce standardised CD practice training for pharmacists and clinicians. Pharmacists will work closely with the clinical areas to support implementation of the improvement plan and we will introduce CD guardians for each directorate to provide ongoing support.

Theatres, anaesthetics and perioperative medicine

An audit of anaesthesia response times in obstetrics showed that improvements needed to be made in our decision-to-delivery times. In response, we will expand the out-of-hours anaesthetic team, introduce a category 1 (the most urgent) caesarean section response protocol to speed up response times and allocate duties to improve the availability of trainees.

Women's services

An audit of length of stay following caesarean section suggested that a number of improvements could be made. Criteria for postoperative blood tests were introduced along with streamlined administrative processes. Re-audit has demonstrated that the mean length of stay for low risk women has been reduced from 2 days 5 hours to 1 day 17 hours. We intend to make further improvements, including to the early establishment of breastfeeding and by incorporating the enhanced recovery pathway into our electronic patient records system.

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 we continue to be at the leading edge of national and international research.

We are part of King's Health Partners – one of eight 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. As of December 2019, 208 non-commercial studies had begun in 2019/20 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. Over 1,500 clinical research studies were active during the year 2019/20, as of December 2019. 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 2019/20 our CQUIN targets were worth £10 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 2019/20.

The Trust's services were assessed by the CQC in 2019 and we were pleased to maintain a 'good' overall rating in the CQC's report published in July 2019. We were delighted that the Trust also maintained its 'outstanding' rating for being caring, and went from being 'good' to 'outstanding' for being well-led. Our ratings for being effective and responsive remained 'good' and we also remain 'requires improvement' for safety.

Our CQC inspection was split across three core services and site visits took place from 2-4 April 2019. Adult community services went from 'requires improvement' in the last inspection to 'outstanding'. We believe this reflects a great deal of hard work by our community staff and demonstrates our commitment to providing the best possible local services to the people of Lambeth and Southwark. Improvements, compassionate care and good practice were

also noted in our maternity services, which raised their safety rating from 'requires improvement' to 'good', while maintaining an overall rating of 'good'.

The Trust's outpatient services, which span multiple directorates and services across the organisation, were also inspected. While areas of outstanding practice were highlighted, such as staff caring for our patients with compassion and promoting a positive culture within the workplace, our outpatient services were rated as 'requires improvement' overall. Our overall rating for being safe also remains as 'requires improvement'. The CQC were clear in their report that the Trust is providing safe care and confirmed we have enough staff, with the right skills and experience to keep people safe and deliver their care. However, the CQC did observe we were non-compliant with some of their key lines of enquiry under the safety domain.

The CQC highlighted one area as a 'must do' which required the Trust to ensure all staff fully comply with the Trust policy for medicines management and administration. They also identified a specific shortfall in one of our skin biopsy outpatient clinics where local anaesthetic prescribing was inconsistent with Trust policy, and the dermatology team took immediate action to address this. Compliance is now being audited regularly.

The remaining recommendations covered five key areas and advised that the Trust should:

- improve the uptake of mandatory training, including safeguarding, to meet its own targets
- enable all staff to have an annual performance review
- improve compliance with the equipment maintenance programme to ensure staff are using appropriate equipment that has been tested and serviced annually
- improve the use of local risk assessments and ensure all staff in a particular area are aware of local risks and mitigations
- continue to address and reduce the referral to treatment times (waiting list), the number of overdue follow-up appointments, and the number of patients failing to attend their appointments.

A CQC action plan has been agreed, and implementation is overseen by a working group and five workstreams which make recommendations to the Trust's Management Executive on Trust-wide actions. Progress is monitored via directorate performance review meetings, and new performance metrics have been created to support this.

Previous reports and full details of our 2019 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 Trust's 'Fit for the future' programme. A steering group, chaired by a deputy medical director, meets fortnightly to review progress across a range of process and quality indicators.

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' (DSPT) is the way we demonstrate our compliance with national data protection standards. All NHS organisations are required to make two interim and one final submission by the end of March 2020, to assure compliance.

Guy's and St Thomas' submitted self-assessment against the 2019/20 DSPT as 'standards not met (plan agreed)'. The Trust showed full compliance in all areas but one, which was achieving the target of 95% of staff having completed their annual information governance training. The Trust achieved 91% and the plan agreed is that we will be compliant with this target of 95% by the end of September 2020, which recognises the pressures due to the COVID-19 pandemic.

Clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit, which is carried out by the Audit Commission, during 2019/20.

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 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 Physician's Structured Judgement Review methodology for any death meeting one of the defined categories below:

- patients with learning disabilities, as part of the National Learning Disability Mortality Review project
- patients with severe mental illness
- patients where concerns about the quality of care have been raised by the patient, their family/carers and/or staff during or after the episode of care
- patients where the death was not expected, for example following certain planned procedures or where the patient 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 'alert' 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 patient has died 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 that the death occurred.

Services and directorates may also undertake additional detailed case record reviews as part of their own mortality review processes, and will share any lessons with the central team. In addition, while the Royal College of Physicians' methodology and the national guidance only relate to the episode of care where a death occurred, we may include previous episodes of care in a review if we believe this will add to the opportunities to improve care.

Paediatric and maternal or neonatal deaths are reviewed using the 'Child death overview panel' and the 'Mothers and babies: reducing risk through audits and confidential enquiries' tools respectively.

Sharing of learning

Learning from reviews of deaths, including those where a detailed case record review has taken place, are 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 2019 to December 2019

	Q1	Q2	Q3	Total
Number of patients who died	241	226	277	744
Number of deaths subjected to case review or investigation	57	49	64	170
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided	3	4	1	8

Themes that have emerged from these reviews include: nutrition and hydration; communication issues with teams, GPs, patients and relatives; management of delirious and challenging patients; adherence to the National Early Warning Score (NEWS) protocol; and anaphylaxis management. Actions to address these issues are presented in the table below.

Thematic learning	Summary of completed actions	Summary of planned actions and/or sharing thematic learning
Nutrition and hydration: use and insertion of nasogastric (NG) tubes and supporting decisions around alternative routes of feeding.	The Trust policy for enteral and parenteral feeding has been updated to make clear the number of NG insertion attempts prior to escalation for senior review.	Learning has been shared with the Trust nutrition team about supporting decisions around appropriateness of use of NG tubes and alternative routes of feeding.
Communication issues with teams, GPs, patients and relatives.	Changes to e-noting electronic discharge letters (EDLs) means that the letters will not be sent until finalised, as this will improve the inclusion of information about a patient's death.	Working with the end of life care committee to improve use of 'Co-ordinate my care' in routine clinical practice. Working with Trust IT team to develop a dashboard to monitor completion of EDLs following a death.
Management of delirious and challenging patients.	None undertaken as only recently identified.	Plan to share with the Trust teams for delirium/dementia to help with training and education.
Adherence to NEWS2 monitoring and associated escalation protocols.	Learning is shared regularly with the acutely ill patients group where utilisation of NEWS2 is also monitored more widely.	Continued collaborative working with the Trust's acutely ill patients group.
Review of the dying patient and cancelling unnecessary medication.	Learning is shared regularly with the Trust medication safety committee and the end of life care committee.	Continued collaborative working with the Trust medication safety and end of life care committees.
Fluid management, especially in patients nearing the end of their life.	The Trust IV fluid management policy has been updated. Targeted education has also been undertaken with clinical teams.	Shared learning through the Trust mortality surveillance group.
Documentation of care.	None undertaken as only recently identified.	Issues with documentation will be escalated through local service/directorate teams, as well as the relevant executive teams.
Anaphylaxis and allergy management.	Trust anaphylaxis kits include all equipment needed to take samples and confirm allergies as quickly as possible.	Plan to improve processes for prompt ordering of tests.

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 which is ahead of the 2020 deadline.

In November 2019, the Trust submitted its autumn/winter 2019/20 self-assessment to NHS England and NHS Improvement. This self-assessment described our continued compliance with the clinical standards, and in particular, the four priority standards. The Trust will undertake its next audit in the spring of 2020.

Speaking up

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 any concerns they may have about patient safety or the way the Trust is run. The initiative is led by the 'freedom to speak up' guardian, supported by a network of 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. This year the Trust has developed a new e-learning module, 'speaking up safely', which is being rolled out to all staff.

The Trust scores higher than the national average in the NHS Staff Survey in relation to staff feeling safe and confident in raising concerns about unsafe clinical practice. We believe this demonstrates a positive speaking up culture but we are not complacent and know we need to do more. We also achieved an above national average score in the NHS 'freedom to speak up index'.

Rota gaps

Junior doctors are allocated to the Trust by Health Education England. 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, on average, filled approximately 95.5% of training grade posts. Any unfilled posts are recruited to with local Trust grade roles. While the Trust does not keep a central record of rota gaps, there are no specialties that have consistent difficulties in recruiting to vacant positions.

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 via the Secondary Uses Service. The SHMI is then calculated by NHS Digital, with results reported quarterly on a rolling year basis.

	Oct 16 – Sep 17	Jan 17 – Dec 17	Apr 17 – Mar 18	Jul 17 – Jun 18	Oct 17 – Sep 18	Apr 18 – Mar 19	Jul 18 – Jun 19
SHMI	73	72	70	70	70	71	73
Banding	3	3	3	3	3	3	3
% Deaths with palliative care coding	50.6%	51.06%	50.94%	52.14%	53.3%	56.18%	56.2%

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 to improve 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 two clinical procedures; hip replacement or knee replacement.

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 these to NHS Digital
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out overleaf.

Primary hip replacement	2014/15	2015/16	2016/17	2017/18	2018/19*
Guy's and St Thomas'	**0.45**	**0.47**	**0.45**	**0.46**	**0.44**
National average	0.44	0.44	0.44	0.47	0.46
Highest	0.52	0.51	0.53	0.56	0.55
Lowest	0.33	0.32	0.30	0.39	0.33

Primary knee replacement	2014/15	2015/16	2016/17	2017/18	2018/19*
Guy's and St Thomas'	**0.29**	**0.31**	**0.30**	**0.29**	**0.29**
National average	0.32	0.32	0.32	0.34	0.34
Highest	0.42	0.40	0.40	0.42	0.41
Lowest	0.20	0.20	0.24	0.22	0.25

*Source: NHS Digital. *2018/19 data provisional.

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 surgery are broadly consistent with the national average. We believe our performance reflects that 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 drives 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 system, combined with local data, 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. This data is then used by the Healthcare Evaluation Data system to calculate readmission rates. Data comparing us to peers, and highest and lowest performers, is not available for the reporting period.

Readmissions	2017/18			2018/19			2019/20		
	Under 16	16 & over	Total	Under 16	16 & over	Total	Under 16	16 & over	Total
Discharges	18,186	78,656	**96,842**	18,752	82,077	**100,829**			
28 day readmissions	813	7,416	**8,229**	992	8,268	**9,260**			
28 day readmission rate	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's Risk and Assurance Committee monitors readmissions on a quarterly 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 as set out in the table below.

Patient experience	2014/15	2015/16	2016/17	2017/18	2018/19
Guy's and St Thomas'	**71.4%**	**77.3%**	**78.3%**	**70.8%**	**72.6%**
National average	68.9%	77.3%	76.7%	68.6%	67.2%
Highest	86.1%	88%	87.3%	85%	85%
Lowest	59.1%	70.6%	66.1%	60.5%	58.9%

Source: NHS Digital

Staff recommendation to friends and family

The Trust has high levels of staff engagement and our results in both the national 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 and NHS Improvement
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

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

Source: NHS staff surveys

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	2016/17		2017/18		2018/19		2019/20	
Guy's and St Thomas'	**A&E**	**Inpatient**	**A&E**	**Inpatient**	**A&E**	**Inpatient**	**A&E**	**Inpatient**
Response rate	15.3%	23.6%	21.9%	20.4%	19.8%	19.8%	18.5%	20.8%
% would recommend	87.3%	97%	83.8%	95.7%	85.6%	95.4%	83.1%	95.2%
% would not recommend	7%	1.3%	7%	1.6%	6.3%	1.6%	7.9%	1.7%

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	2014/15	2015/16	2016/17	2017/18	2018/19
Guy's and St Thomas'	97.1%	97.2%	96.6%	95.4%	96.2%
National average	96%	96%	96%	96%	96%
Best performing trust	100%	100%	99%	99%	99%
Worst performing trust	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.

For 2019/20 there are two significant changes:

- a very challenging new objective of no more than 26 cases
- changes to the definition of a 'trust assigned' case – a reduction in the number of days after admission, from three to two, and the inclusion of any case with a previous admission to our hospitals in the previous four weeks.

The external objective for reportable cases of C.difficile for 2019/20 is no more than 26 cases. Reportable cases are those that are 'toxin positive' (enzyme-linked immunoassay or 'EIA' positive) and are identified beyond two (was three) days of admission to the trust. In addition, trusts must determine and report to commissioners any reportable cases that are deemed to be due to a 'lapse in care'.

At the time of writing the Trust has breached the external C.difficile objective (26) with 29 reportable cases to the end of December 2019, compared with 13 at the end of December 2018. A 'like for like' comparison, using the previous criteria, would be 16 cases, but the reporting changes have increased the number of reported cases to 29. Our overall numbers remain low and our commitment to reducing all infections remains a high priority for clinical teams across the Trust, supported by our infection control and prevention team.

There had been no cases of C.difficile infection due to 'lapses in care' as of December 2019.

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.

Infection control	2015/16	2016/17	2017/18	2018/19
Trust apportioned cases	51	36	27	22
Trust bed-days	324,000	331,097	338,235	343,750
Rate per 100,000 bed-days	15.7	10.9	7.9	6.4
National average	14.9	13.0	13.5	12
Best performing trust	0	0	0	0
Worst performing trust	66	82.7	92.75	80.5

Patient safety incidents

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

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

We believe our performance reflects that:

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

Patient safety incidents	Apr 16 – Sep 16	Oct 16 – Mar 17	Apr 17 – Sep 17	Oct 17 – Mar 18	Apr 18 – Sep 18	Oct 18 – Mar 19	Apr 19 – Sep 19
Guy's and St Thomas'							
Total reported incidents	**9,398**	**9,120**	**10,171**	**9,986**	**10,526**	**11,449**	**10,628**
Rate per 1,000 bed-days	**58.8**	**56.1**	**63.1**	**57.7**	**62.6**	**68.8**	**64.7**
National average (acute non-specialist)	40.2	40.9	42.8	42.5	44.5	46.4	49.8
Highest reporting rate	71.8	68.9	111.7	124	107.4	95.9	103.8
Lowest reporting rate	21.1	23.1	23.5	24.1	13.1	16.9	26.3

Guy's and St Thomas'							
Incidents causing severe harm or death	39	44	40	43	47	42	30
% incidents causing severe harm or death	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.2%
National average (acute non-specialist)	0.4%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%
Highest reporting rate	1.7%	2.1%	2.0%	1.5%	1.3%	1.9%	1.2%
Lowest reporting rate	0%	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 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 NRLS and that data provided to NRLS is reviewed and validated against Trust data to ensure it is consistent.

We continue to use the outcomes of root cause investigations of patient safety incidents to drive quality improvements that support the delivery of high quality and safe care for our patients.

Statement

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 2019/20 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 2019 to March 2020
  - papers relating to quality reported to the Board over the period April 2019 to March 2020
  - feedback from governors dated 25 February 2020
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 August 2019
  - the 2018 national patient survey published June 2019
  - the 2019 national staff survey published February 2020
  - the head of internal audit's annual opinion over the Trust's control environment dated 27 May 2020
  - CQC inspection reports dated July 2019
- 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
10 June 2020

Ian Abbs, Chief Executive
10 June 2020

Excellence in education and training is at the heart of Guy's and St Thomas'. Through our in-house training and collaboration with health and other organisations, we offer a wide range of courses, for clinical and non-clinical staff.

11 Annual accounts

Foreword to the accounts

'These accounts, for the year ended 31 March 2020, have been prepared by the Guy's and St Thomas' NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Ian Abbs
Chief Executive and Accounting Officer
10 June 2020

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

Qualified opinion

Our opinion on the financial statements is modified

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 2020 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity, and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International 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 2019/20 and the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, except for the possible effects of the matter described in the basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2020 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 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

The Trust maintains perpetual inventory systems for a number of stock lines, including pharmacy, but were unable to count all its physical inventories at year end because of the Covid-19 pandemic. Due to the national lockdown arising from the pandemic we did not observe the counting of any of the physical inventories at the end of the year. We were unable to obtain sufficient appropriate audit evidence regarding the totality of inventory quantities held at 31 March 2020, which have a carrying amount in both the Trust and group Statement of Financial Position of £26,286,000, by performing other audit procedures. There may be an impact on the valuation of supplies and services expenditure for the same reason.

Consequently, we were unable to determine whether any adjustment to these amounts were necessary. In addition, were any adjustment to these amounts to be required, the Annual Report would also need to be amended.

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 qualified opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accounting Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

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.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the Trust's financial statements shall be prepared on a going concern basis, we considered the risks associated with the group and Trust's operating activities, including effects arising from macro-economic uncertainties such as Covid-19 and Brexit. We analysed how those risks might affect the Trust's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, we have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Grant Thornton

Overview of our audit approach

Financial statements audit

- Overall materiality: £23,000,000, which represents 1.4% of the group's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:

  Valuation of Land and buildings

  Revenue Recognition and

  The impact of COVID-19 pandemic

The key changes in the scope of our audit from the prior year, is the inclusion of a significant risk relating to the impact of the Covid-19 pandemic.

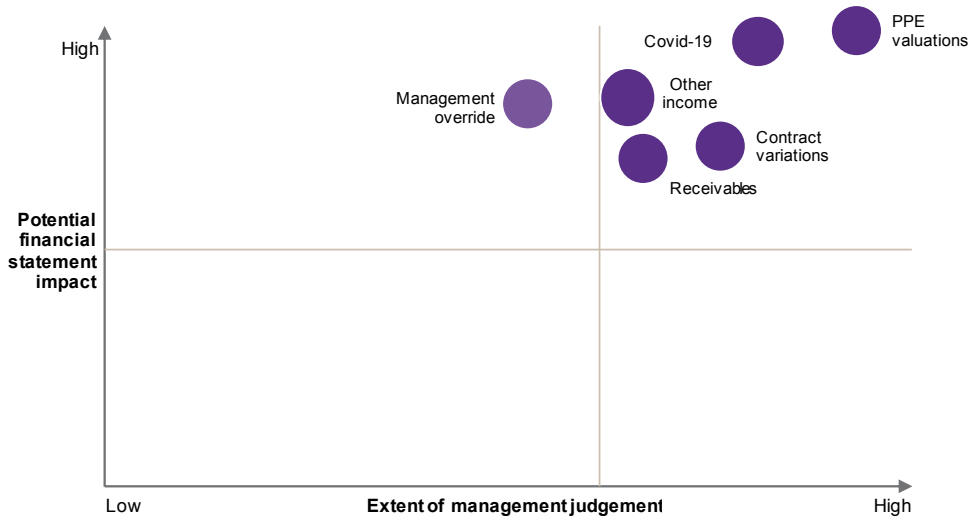
In addition, where inventory falls above the auditor's headline materiality level, as it does at the Trust, then the auditor is required to attend some or all of the audited body's year end stock takes. We had intended to attend stocktakes at the end of March, but the Trust had to cancel the planned stock counts due to concerns about Covid19.We were therefore unable to obtain the assurance we required over inventory quantities and this led to a qualification of our audit opinion. The standards make no mitigation for the reasons stocktake attendance was not executed, and the limitation of scope is therefore a commentary on the work the auditor was not able to undertake to meet the requirements of the auditing standards and not a commentary on the entity's arrangements for the management of its inventories.

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

- We identified one 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. In addition to the matter described in the basis for qualified opinion section, we have determined the matters described below to be the key audit matters to be communicated in our report.

	How the matter was addressed in the audit – Group
Risk 1 Valuation of Land and Buildings The Trust revalues its land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statements date. This valuation represents a significant estimate by management in the financial statements. Management have engaged the services of a valuer to estimate the current value as at 31 March 2020. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions.	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 the valuation experts and the scope of their work. This included considering if the impact of Covid-19 had been considered for impact on valuations. • evaluating the competence, capabilities and objectivity of the valuation expert • writing to the valuer to confirm the basis on which the valuations were carried out

	How the matter was addressed in the audit – Group
The effects of the COVID-19 virus will affect the work carried out by the Trust's valuer in a variety of ways. Inspecting properties could prove difficult and access to evidential data, such as values of comparable assets may be less freely available. RICS Regulated Members have therefore been considering whether a material uncertainty declaration is now appropriate in their reports. Its purpose is to ensure that any client relying upon the valuation report understands that it has been prepared under extraordinary circumstances. In their 2019/20 valuation report the Trust's valuer included a material uncertainty and this was disclosed in note 1.7 to the financial statements. We therefore identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement, and a key audit matter. There are no other significant reporting matters other than the PPE materiality uncertainty issue raised by the Trust's. This is a matter which has been dealt with consistently by Valuers and auditors across the NHS.	• challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding • engaging our own valuer to assess the instructions to the Trust's valuer, the Trust's valuer's report and the assumptions that underpin the valuation • testing, on a sample basis, revaluations made during the year to ensure they have been input correctly into the Trust's asset register The Trust's accounting policy on property, plant and equipment, including land and buildings is shown in note 1.7 to the financial statements and related disclosures are included in note 14. As, disclosed in note 1.7 to the financial statements, the outbreak of Covid-19 has caused uncertainties in markets. As a result, the Trust's valuer has declared a 'material valuation uncertainty' in their valuation report which was carried out with a valuation date of 31 March 2020. The values in the valuation report have been used to inform the measurement of property assets at valuation in the financial statements. The Trust has disclosed the estimation uncertainty related to the year-end valuations of land and buildings in note 1.7 to the financial statements. The Trust's valuer prepared their valuations in accordance with the RICS Valuation – Global Standards using the information that was available to them at the valuation date in deriving their estimates. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation was appropriate, and the assumptions and processes used by management in determining the estimate were reasonable. • the valuation of land and buildings disclosed in the financial statements is reasonable.

Risk 2 Revenue Recognition

Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. In this environment, we considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue.

We rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We determined these to be income from:

- Block contract income element of patient care revenues

We did not deem it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue.

Our audit work included, but was not restricted to:

- evaluating the Trust's accounting policy for recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2019/20
- updating our understanding of the Trust's system for accounting for income from patient care and other operating revenue, and evaluate the design of the associated controls
- For patient care income, agreeing, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners and evaluating the Trust's estimates and the judgments made by management with regard to corroborating evidence in order to arrive at the total income from contract variations recorded in the financial statements.
- For other operating revenue, agreeing, on a sample basis, income and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence
- Agreeing PSF income to supporting evidence.

	How the matter was addressed in the audit – Group
We therefore identified the occurrence and accuracy of these income streams of the Trust and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement and a key audit matter.	The Trust's accounting policy on recognition of income is shown in note 1.3 to the financial statements and related disclosures are included in notes 3 and 4. **Key observations** We obtained sufficient audit assurance to conclude that: • the Trust's accounting policy for recognition of income from patient care activities and other operating revenues complies with the DHSC Group Accounting Manual 2019/20 and has been properly applied; and • income from patient care activities and other operating revenues and the associated receivable balances are not materially misstated
Risk 3 Covid-19 The global outbreak of the Covid-19 virus pandemic has led to unprecedented uncertainty for all organisations, requiring urgent business continuity arrangements to be implemented. We expect current circumstances will have an impact on the production and audit of the financial statements for the year ended 31 March 2020, including and not limited to; Remote working arrangements and redeployment of staff to critical front line duties may impact on the quality and timing of the production of the financial statements, and the evidence we can obtain through physical observation Volatility of financial and property markets will increase the uncertainty of assumptions applied by management to asset valuation and receivable recovery estimates, and the reliability of evidence we can obtain to corroborate management estimates Financial uncertainty will require management to reconsider financial forecasts supporting their going concern assessment and whether material uncertainties have arisen; and Disclosures within the financial statements will require significant revision to reflect the unprecedented situation and its impact on the preparation of the financial statements as at 31 March 2020 in accordance with IAS1.	Our audit work included, but was not restricted to: • Documenting and understanding the implications that the Covid-19 pandemic has on the Trust's ability to prepare the financial statements and updates to financial forecasts • Liaison with other audit suppliers, regulators and government departments to co-ordinate practical cross sector responses to issues as and when they arise We have evaluated: • the adequacy of the disclosures in the financial statements relating to the impact of the Covid-19 pandemic. • whether sufficient audit evidence can be obtained in the absence of physical verification of assets through remote technology • whether sufficient audit evidence can be obtained to corroborate significant management estimates such as asset valuations and recovery of receivable balances • management's assumptions that underpin the revised financial forecasts and the impact on management's going concern assessment and • we have reviewed the Trust's Local and Corporate Risk Register, for risks identified from COVID-19, **Key observations** We obtained sufficient audit assurance to conclude that: • The Trust's disclosures are in line with the DHSC guidance relating to the impact of the COVID-19 pandemic • Financial forecasts and the cashflow analysis of the Trust supports the ability for the Trust to prepare the accounts on a going concern basis • The impact of our non attendance at stocktakes at year end has resulted in a limitation of scope for the existence of inventory and • The inclusion of material uncertainty regarding to the valuation of the Trust's property, plant and equipment has led to a Key Audit Matter as detailed in risk 1 above.

Our application of materiality

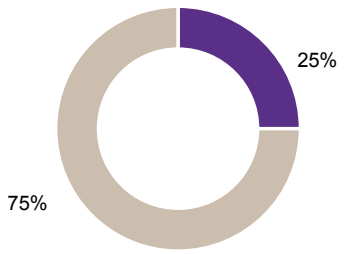
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating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

Materiality was determined as follows:

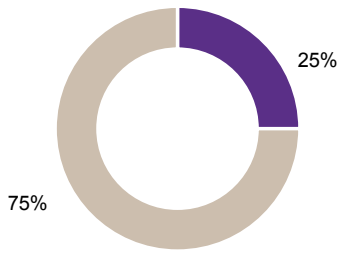
Materiality Measure	Group	Trust
Financial statements as a whole	£ 23,000,000 which is 1.44% of the group's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the group has expended its revenue and other funding. Materiality for the current year is lower than the level we determined for the year ended 31 March 2019 to reflect the firm's response to increased regulatory focus on significant estimates and areas of the accounts such as the valuation of property, plant and equipment.	£ 22,000,000 which is 1.44% 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 lower than the level we determined for the year ended 31 March 2019 to reflect the firm's response to increased regulatory focus on significant estimates and areas of the accounts such as the valuation of property, plant and equipment.
Performance materiality used to drive the extent of our testing	**75%** of financial statement materiality	**75%** of financial statement materiality
Specific materiality	**£**100,000 for the remuneration report. We have determined a lower level of materiality for the annual pay of senior officers as this disclosure if particular interest to the readers of the Annual Report.	**£**100,000 for the remuneration report. We have determined a lower level of materiality for the annual pay of senior officers as this disclosure if particular interest to the readers of the Annual Report.
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 Trust's business, its environment and risk profile and in particular included:

- obtaining supporting evidence, on a sample basis, for property plant and equipment and the Trust's other assets and liabilities
- examination and review of the Trust's disclosures in relation to the COVID-19 pandemic and the impact that this has had on significant financial estimates. This is a change from the scope of the prior year audit work. This work included - evaluating whether sufficient audit evidence can be obtained in the absence of physical verification of assets through remote technology, evaluating whether sufficient audit evidence can

be obtained to corroborate significant management estimates such as asset valuations and recovery of receivable balances; evaluating management's assumptions that underpin the revised financial forecasts and the impact on management's going concern assessment; and discussing with management any potential implications for our audit report if we have been unable to obtain sufficient audit evidence

- gaining an understanding of and evaluating the Trust's internal controls environment including its financial and IT systems and controls during an interim audit visit before the year end;
- obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams;
- obtaining supporting evidence, on a sample basis, for the Trust's operating expenses and finance costs;
- Evaluation by the group audit team of identified components to assess the significance of that component and to determine the planned audit response based on a measure of materiality
- For the purposes of the group audit, undertaking an analytical review for each component of the group to provide assurance for the group as whole.

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.

As described in the basis for qualified opinion section of our report, we were unable to obtain sufficient appropriate audit evidence regarding the Trust and group inventory quantities, which have a carrying amount in the Trust and group Statement of Financial Position of £26,286,000 at 31 March 2020, and related balances. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

In this context, we 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; or
- The Audit Committee in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance.

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 2019/20 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 modified

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 2019/20 and the requirements of the National Health Service Act 2006, and

- except for the possible effects of the matter described in the basis for qualified opinion section of our report, 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 2019/20, 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 2020.

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 forming part of our unqualified conclusion	How the matter was addressed in the audit
Risk 1 Financial Sustainability Our initial risk assessment (at February 2020) identified that the financial position of the Trust remained challenging. The accounts demonstrate a deficit including PSF of £8.4m. In achieving this position the Trust delivered £67.4m of CIP in year, this is short of the ambitious target it had set of £82.4m in its plan, which had been set to reach the internal plan of breaking even excluding PSF. As such the Trust achieved 82% of its cost improvement initiatives with 57% of these savings being recurrent	Our audit work included, but was not restricted to: • A review of a number of Board documents, including detailed finance reports, regulator reports and risk registers • Detailed discussions regarding financial performance with the Finance and Senior Management Team. • A review of the financial planning for 2020/21 prior to the cancellation of business planning across the NHS on March 10th • A review of the first 4 months business plan which supports the trust to breakeven under a block contract scheme with NHSI • Consideration of the future cash flows predicted by the Trust for the 12 months from June 2020 and recognition that the Trust currently hold over £270m cash balances. **Key findings** Based on the work we performed to address the significant risk above, 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 April 2020, 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 2020, 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

London

22nd June 2020

Consolidated statement of comprehensive income for the year ended March 31 2020

	NOTE	March 31 2020 £000	March 31 2019 £000
Operating income from patient care activities	3	**1,425,348**	1,271,868
Other operating income	4	**278,312**	325,256
TOTAL INCOME		**1,703,660**	1,597,124
Operating expenses	6.1	**(1,739,852)**	(1,537,706)
OPERATING (DEFICIT)/SURPLUS		**(36,192)**	59,418
FINANCE COSTS			
Finance income	9	**1,177**	892
Finance expenses	10	**(5,773)**	(5,799)
Public Dividend Capital dividend payable	30	**(22,677)**	(23,448)
Net finance costs		**(27,273)**	(28,355)
Gains/(loss) on disposal of assets	8	**20**	(20)
Share of profit of associates / joint ventures	18.1	**48**	236
Corporation tax (expense)/income	11	**(147)**	170
(DEFICIT)/SURPLUS FOR THE YEAR		**(63,544)**	31,449
Other comprehensive income/(expense)			
Impairments	15	**(70,229)**	(3,333)
Revaluations	17	**45,071**	14,249
TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE YEAR		**(88,702)**	42,365

The notes on pages 112 to 141 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Note to Statement of Comprehensive Income		March 31 2020 £000	March 31 2019 £000
Total comprehensive (expense)/income as above		**(88,702)**	42,365
Less reserve movements in other comprehensive income/(expense)		**25,158**	(10,916)
Total comprehensive (expense)/income before reserve movements		**(63,544)**	31,449
Add back in year impairments and reversals of impairments relating to market valuations included in surplus above (see note 15)		**49,638**	15,188
Adjustment for capital donations and profit on disposal of fixed assets	4	**5,908**	(4,151)
Add back depreciation on donated assets		**12,554**	12,662
CONTROL TOTAL PERFORMANCE INCLUDING PSF		**4,556**	55,148

Statement of financial position as at March 31 2020

		GROUP		TRUST	
	NOTE	**March 31 2020 £000**	March 31 2019 £000	**March 31 2020 £000**	March 31 2019 £000
NON-CURRENT ASSETS					
Property plant and equipment	13	**1,187,225**	1,229,593	**1,187,006**	1,229,443
Intangible assets	14	**54,156**	45,656	**54,156**	45,656
Investments in joint ventures and associates	18.1	**71**	237	**2,050**	2,050
Other investments/financial assets	21	**146**	138	**3,146**	3,086
Trade and other receivables	20.2	**5,733**	2,260	**5,733**	2,260
TOTAL NON-CURRENT ASSETS		**1,247,331**	1,277,884	**1,252,091**	1,282,495
CURRENT ASSETS					
Inventories	19	**26,286**	21,957	**26,286**	21,957
Trade and other receivables	20.1	**171,821**	194,579	**160,481**	194,466
Other investments/financial assets	21	**1,230**	1,230	**1,550**	1,550
Cash and cash equivalents	24	**139,249**	144,057	**137,122**	141,661
TOTAL CURRENT ASSETS		**338,586**	361,823	**325,439**	359,634
CURRENT LIABILITIES					
Trade and other payables	22.1	**(214,392)**	(176,672)	**(203,741)**	(176,745)
Other liabilities	22.2	**(21,241)**	(30,451)	**(20,948)**	(30,100)
Provisions	23.1	**(252)**	(298)	**(252)**	(298)
Borrowings	22.3	**(15,256)**	(12,669)	**(15,256)**	(12,669)
TOTAL CURRENT LIABILITIES		**(251,141)**	(220,090)	**(240,197)**	(219,812)
NON-CURRENT LIABILITIES					
Borrowings	22.3	**(215,301)**	(218,810)	**(215,301)**	(218,810)
Provisions	23.1	**(7,228)**	(3,627)	**(7,210)**	(3,627)
TOTAL NON-CURRENT LIABILITIES		**(222,529)**	(222,437)	**(222,511)**	(222,437)
TOTAL ASSETS EMPLOYED		**1,112,247**	1,197,180	**1,114,822**	1,199,880
TAXPAYERS' EQUITY					
Public Dividend Capital		**374,670**	370,901	**374,670**	370,901
Revaluation reserve		**358,429**	383,587	**358,429**	383,587
Other reserves		**743**	743	**743**	743
Income and expenditure reserve		**378,405**	441,949	**380,980**	444,649
TOTAL TAXPAYERS' EQUITY		**1,112,247**	1,197,180	**1,114,822**	1,199,880

Ian Abbs

Chief Executive and Accounting Officer

10 June 2020

Statement of changes in taxpayers' equity

GROUP 2019/20	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2019	370,901	383,587	743	441,949	**1,197,180**
Deficit for the year	–	–	–	(63,544)	**(63,544)**
Impairments	–	(70,229)	–	–	**(70,229)**
Revaluations – property, plant and equipment	–	45,071	–	–	**45,071**
Public Dividend Capital received	3,769	–	–	–	**3,769**
Taxpayers' equity as at March 31 2020	**374,670**	**358,429**	**743**	**378,405**	**1,112,247**

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**
Transfer to retained earnings on disposal of assets	–	–	–	–	**–**
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**

TRUST 2019/20	Public Dividend Capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at April 1 2019	370,901	383,587	743	444,649	**1,199,880**
Deficit for the year	–	–	–	(63,669)	**(63,669)**
Impairments	–	70,229	–	–	**(70,229)**
Revaluations	–	45,071	–	–	**45,071**
Public Dividend Capital received	3,769	–	–	–	**3,769**
Taxpayers' equity as at March 31 2020	**374,670**	**358,429**	**743**	**380,980**	**1,114,822**

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	–	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**

Consolidated cash flow statement for the year ended March 31 2020

	NOTE	GROUP March 31 2020 £000	GROUP March 31 2019 £000	TRUST March 31 2020 £000	TRUST March 31 2019 £000
Cash flows from operating activities					
Operating (deficit)/surplus from continuing operations		**(36,192)**	59,418	**(36,560)**	59,000
Non-cash income and expense					
Depreciation and amortisation	6.1	**57,367**	57,946	**57,316**	57,928
Impairments and reversals of impairments	15	**50,002**	15,756	**50,002**	15,756
Income recognised in respect of capital donations (cash and non-cash)		**5,929**	(4,151)	**5,929**	(4,151)
Decrease/(increase) in trade and other receivables		**19,261**	(36,403)	**19,558**	(36,869)
(Increase)/decrease in inventories		**(4,329)**	3,118	**(4,329)**	3,118
(Increase)/decrease in other liabilities		**(9,210)**	1,749	**(9,152)**	1,398
Increase/(decrease) in trade and other payables		**32,002**	12,789	**32,298**	12,485
Increase/(decrease) in provisions		**3,567**	(3,003)	**3,567**	(3,003)
Tax refund		**22**	–	**22**	–
Other movements in operating cash flows		**(121)**	169	**(85)**	106
NET CASH GENERATED FROM OPERATING ACTIVITIES		**118,298**	107,388	**118,565**	105,768
Cash flows from investing activities					
Interest received	9	**1,153**	892	**1,274**	1,006
Proceeds from settlements of financial assets		**158**	1,342	**158**	1,662
Purchase of intangible assets		**(17,848)**	(12,166)	**(17,848)**	(12,166)
Purchase of property, plant and equipment		**(81,149)**	(73,860)	**(81,269)**	(73,741)
Proceeds from sale of property, plant and equipment		**260**	15	**260**	15
Receipt of cash donations to purchase capital assets		**(5,929)**	4,151	**(5,929)**	4,151
NET CASH USED IN INVESTING ACTIVITIES		**(103,355)**	(79,626)	**(103,354)**	(79,073)
Cash flows from financing activities					
Public Dividend Capital received		**3,769**	3,573	**3,769**	3,573
Movement in loans from the Department of Health and Social Care		**(4,571)**	7,210	**(4,571)**	7,210
Capital element of service concession payments		**(253)**	–	**(253)**	–
Interest paid on DHSC loans		**(5,664)**	(5,736)	**(5,664)**	(5,736)
Other interest		**–**	(52)	**–**	(52)
Interest element of service concession obligations		**(149)**	–	**(149)**	–
Public Dividend Capital paid		**(12,883)**	(23,483)	**(12,883)**	(23,483)
NET CASH GENERATED FROM FINANCING ACTIVITIES		**(19,571)**	(18,488)	**(19,571)**	(18,488)
Net (decrease)/increase in cash and cash equivalents		**(4,808)**	9,274	**(4,540)**	8,207
Cash and cash equivalents at April 1		**144,057**	134,783	**141,661**	141,661
Cash and cash equivalents at March 31	24	**139,249**	144,057	**137,121**	149,868

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 2019/20 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 clinical services for the foreseeable future, although the nature of what is delivered will continue to be adjusted as the impact of COVID-19 changes. During this period NHS England have changed the process by which the Trust is funded with prospective block funding and a retrospective top-up mechanism to ensure that the Trust breaks even. This is evidenced with the block payments received in April and May to cover the period April, May and June, 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 all of its subsidiary undertakings made up to the year ended 31 March 2020 and incorporate its share of the results of joint ventures and associates using the equity method of accounting. Under IFRS 10, an entity controls an investee when it is exposed to, or has rights to, variable terms from its involvement with the investee and has the ability to affect those returns through its power over the investee. The income, expenses, assets, liabilities, equity and reserves of subsidiaries have been consolidated into the Trust's financial statements and group financial statements have been prepared.

All intragroup balances and transactions, including unrealised profits arising from intragroup transactions, are eliminated 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. 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.

In accordance with the DHSC GAM 2019/20 a separate Statement of Comprehensive Income for the parent (the Trust) has not been presented by the directors.

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statements using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution is received from the associate. e.g., share 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.

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).

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 healthcare services. A performance obligation relating to delivery of a spell of healthcare 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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income. Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

1.3.2 Revenue from research contracts

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

over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

1.3.3 NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department for 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

1.3.4 Other forms of income

Grants and donations

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

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

Apprenticeship service income

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

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 schemes are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. The scheme is not designed to be run in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust 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:

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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

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.

NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS Pension Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme. NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme. The employer's contribution rate in 2019/20 was 3% (2018/19: 2%).

1.6 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item has cost of at least £5,000; or
- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost; or

- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Valuation

All property, plant and equipment is measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets are measured subsequently at 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 2020 the land and building assets were revalued. Enhancements to leasehold properties are valued at historic cost.

Impact of COVID-19 on Gerald Eve's land and buildings valuation

The valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19.

Gerald Eve insert: *"The freehold and long leasehold properties occupied by Guy's & St Thomas' NHS Foundation Trust were valued as at 31 March 2020 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."*

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

Current values in existing use are determined as follows:

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

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

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

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 for service or administration purposes are carried at cost less any impairment loss. 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.

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, 1 – 62 years
- Plant and machinery, 1 – 20 years
- Transport equipment, 2 – 7 years
- IT hardware, 2 – 20 years
- Furniture and fittings, 4 –15 years.

Buildings and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the 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 when it meets the requirements set out in IAS 38 only where all of the following can be demonstrated:

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

Software

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

Measurement

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

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

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value. where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale. Intangible Assets are 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, 3 – 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 Guy's and St Thomas' 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.

Due to the COVID-19 pandemic the Trust was unable to perform its planned year end inventory counts. 78.6% of inventory by value is subject to automated monthly evaluation and accounting. The remaining 21.4% of inventory by value is normally subject to annual stocktakes and had to be evaluated for both quantity and value by comparison to previous years taking into account any known in year changes.

1.13 Cash and cash equivalents

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

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

1.14 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated and grant 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 and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.15 Value Added Tax

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

1.16 Corporation tax

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

The tax expense on the surplus or deficit for the year comprises current and deferred tax due to the Trust's trading commercial subsidiaries, see note 11 to the financial statements. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years.

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

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

1.17 Other reserves

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

1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

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

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

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

1.19 Financial assets and financial liabilities

Recognition

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

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

The Directors do not think there are any changes in the financial architecture of the NHS resulting from COVID-19 that need to be reflected in the Trust's credit risk disclosures.

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 are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from market prices.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets 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.

1.20 Leases

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

1.20A The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The assets and liabilities are recognised at the commencement of the lease. Thereafter the assets are accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.20B The Trust as lessor

Finance leases

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

Operating leases

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

1.21 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020 between the range of 0.51% to 1.99%. In calculating the early retirement and injury benefit provisions, the HM Treasury discount rate of minus 0.50% has been used.

Clinical negligence costs

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

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under

which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excess' payable in respect of particular claims, are charged to operating expenses as and when the liability arises.

Commercial insurance

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

Contingencies

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

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

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

1.22 Third party assets

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

1.23 Losses and special payments

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

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

1.24 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.

Inventory

The Trust's inventory balance of £26.286 million is material to the Trust's accounts. The Trust is satisfied that its inventory balance is presented fairly in all material respects: the Trust maintains perpetual inventory systems for the majority of stock, including pharmacy, and stock is routinely counted in other areas. However, the restrictions on movement in the United Kingdom in March 2020 arising from the COVID-19 pandemic meant that the Trust was unable to perform its planned year end inventory counts, and the auditor has been unable to gain sufficient audit evidence from alternative procedures. The auditor has therefore been unable to complete the procedures required by auditing standards, and is required to issue a qualified opinion. We are aware that a number of trusts in the country are affected by the same issue in 2019/20 and we understand NHS Improvement will disclose the extent to which this has impacted the sector in its consolidated provider accounts when published later in 2020. The auditor's opinion on the financial statements remains unmodified in all other respects.

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.

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).
2) The impact of material uncertainties arising from the COVID-19 pandemic.

1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

1.26 Accounting standards that have been issued but have not yet been adopted

IFRS 16 leases

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

IFRS 16 leases will replace IAS 17 leases, IFRIC 4 'Determining whether an arrangement contains a lease' and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position, the standard also

requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The valuation of peppercorn leases was undertaken by the Trust's valuer, Gerald Eve as at 1 April 2020. Due to the prevailing uncertainty regarding RICS guidance for valuers for 2020/21 and the discount rate that would be applied in April 2021 has meant the Trust is unable to complete the optional disclosure to quantify the likely impact of IFRS 16 implementation in April 2021 due to the materiality of its peppercorn leases calculated values. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition.

No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust is well advanced in the implementation of IFRS 16 and is now evaluating its managed service contracts to identify likely implicit leases within them. The Trust has a significant property lease portfolio. Certain NHS property and community health partnerships properties are occupied without formal agreements in place. An assessment was made about ongoing occupation of the properties and an assumption was made that they would remain occupied for 10 years from 1 April 2020 but this could change when formal agreements are entered into during 2020/21. All current leases are now on a dedicated lease accounting software platform that will enable blanket adjustments concerning revised discount rates, revaluations/impairments, including additions and deletions to the lease portfolio. The software will enable modelling scenarios for projected outcomes based on the current uncertainties to assess impact on the Trust's position as well as to provide accounting information monthly.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

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:

- Fifteen 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;
- Integrated Care 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 Chief Financial Officer and 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.

The Trust is advanced in its plans to reorganise its clinical directorates not already within strategic business units into five further strategic business units.

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 2020 £000	Year ended March 31 2019 £000
NHS England	**698,317**	572,060
Clinical Commissioning Groups (CCGs)	**679,467**	643,000
NHS Foundation Trusts	**1**	7
NHS Trusts	**71**	133
Local authorities	**11,452**	10,345
Department of Health and Social Care	**3**	11,236
NHS other (including Public Health England)	**5,796**	4,903
Non-NHS: private patients	**21,202**	23,453
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	**3,763**	4,163
Injury cost recovery scheme	**1,329**	870
Non-NHS: other	**3,947**	1,698
Total income from patient care activities	**1,425,348**	1,271,868
Of which:		
Related to continuing operations	**1,425,348**	1,271,868
Related to discontinued operations	**–**	–

3.2 Income from patient care (by nature)

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Acute services		
Elective income	**240,105**	220,579
Non-elective income	**165,655**	143,960
Outpatient income	**70,040**	68,452
Follow up outpatient income	**114,436**	98,245
Accident and Emergency income	**33,764**	29,128
High cost drugs income from commissioners (excluding pass-through drugs)	**129,092**	119,129
*Other NHS clinical income	**468,021**	432,396
Community services		
Income from CCGs and NHS England	**120,925**	104,583
Income from other sources (eg local authorities)	**5,915**	11,869
All services		
Private patient income	**21,256**	23,453
AfC pay award central funding	**–**	11,236
Additional pension contribution central funding	**38,990**	–
Other income	**17,149**	8,838
	1,425,348	1,271,868

*For categories that fall outside of Elective and Non-elective inpatients, First and Follow up outpatient, A&E and High cost drugs income categories these are included within Other NHS clinical income

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 2020 £000	Year ended March 31 2019 £000
Commissioner requested services	**1,404,902**	1,248,415
Non-commissioner requested services	**21,256**	23,453
	1,425,348	1,271,868

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 2020 £000	Year ended March 31 2019 £000
Income recognised this year	**3,763**	4,163
Cash payments received in-year	**1,292**	1,451
Amounts added to provision for impairment of receivables	**2,192**	2,674
Amounts written-off in-year	**1,692**	2,991

4 Other operating income (Group)

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Other operating income from contracts with customers:		
Research and development	**53,118**	54,921
Education, training and research	**73,801**	72,807
Non-patient care services to other bodies	**30,824**	33,166
Provider Sustainability Fund (PSF)	**17,357**	47,344
Income in respect of staff recharges	**7,483**	5,259
*Other income	**84,897**	94,202
Other non-contract operating income:		
Education and training – notional income from apprenticeship fund	**556**	399
Charitable and other contributions to expenditure and capital assets	****(1,962)**	9,859
Rental revenue from operating leases – minimum lease payments	**12,042**	7,111
Other non-contract income	**196**	188
	278,312	325,256

*Other income includes: £17m from clinical tests, £14m from external estate recharges & the remaining from catering, staff accommodation rentals, income from commercial activities, clinical excellence awards and other direct credits.

** Capital donations towards the cost of the Trust's capital programme were less than the original expectations set out in the financial plan. As a result of these adverse movements, the capital donation figure for 2019/20 was negative £5.9 million.

5 Additional income disclosures

5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	**20,820**	28,702

5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Within one year	**21,241**	30,451
Total revenue allocated to remaining performance obligations	**21,241**	30,451

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.

5.3 Total benefit obtained from the apprenticeship fund

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Education and training – notional income from apprenticeship fund	**556**	399
Cash income received from the apprenticeship levy scheme where the Trust is an accredited training provider recorded elsewhere in Note 2.1	**61**	45
Total benefit obtained from the apprenticeship levy	**617**	444

6 Operating expenses

6.1 Operating expenses comprise:

	Note	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Purchase of healthcare from NHS and DHSC bodies		**137**	295
Purchase of healthcare from non-NHS and non-DHSC bodies		**32,392**	26,889
Staff and executive directors costs		**1,010,833**	891,083
Non-executive directors		**181**	199
Supplies and services – clinical (excluding drugs costs)		**196,334**	186,250
Supplies and services – general		**9,656**	9,021
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		**152,325**	140,333
Inventories written down (net including drugs)		**447**	725
Consultancy		**2,836**	2,994
Establishment		**24,834**	20,861
Premises – business rates collected by local authorities		**9,863**	8,618
Premises – other		**81,910**	73,659
Transport – other (including patient travel)		**18,312**	17,044
Depreciation		**46,982**	46,971
Amortisation		**10,385**	10,975
Impairments net of reversals		**50,002**	15,756
Credit loss allowance		**4,642**	8,315
Change in provisions discount rate		**25**	(69)
Audit services – statutory audit		***131**	108
Other auditor remuneration (payable to external auditor only)	6.2	**24**	8
Internal audit – staff costs		**536**	503
Clinical negligence – amounts payable to NHS Resolution (premium)		**18,323**	19,156
Legal fees		**1,793**	1,282
Insurance		**1,602**	1,684
Research and development – non-staff		**1,224**	636
Education and training – non-staff		**4,130**	6,309
Education and training – notional expenditure funded from apprenticeship fund		**556**	399
Operating lease expenditure		**16,159**	11,010
Early retirements – non-staff		**(55)**	654
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis		**2,075**	–
Hospitality		**(8)**	65
Other**		**41,266**	35,973
		1,739,852	1,537,706

* Audit services - statutory audit is net of VAT.

** Other operating expenses includes expenditure on commercial activities.

6.2 Other auditor remuneration

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Other auditor remuneration paid to the external auditor		
Audit-related assurance services	**24**	8
	24	8

Payments made to our auditor for non-audit work in 2019/20 were £24k relating to advisory services (2018/19 £8k). The £24k fee above is net of VAT.

6.3 Limitation on auditor's liability

Limitation on auditor's liability for external audit work carried out for the financial years 2019-20 is £2million (2018-19 £2million).

6.4 Operating leases

6.4.1 Operating lease expenditure:

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Minimum lease payments under operating leases recognised as an expense in the year	**16,159**	11,010

6.4.2 Future minimum lease payments:

Future minimum lease payments due:	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Within 1 year	**18,983**	15,839
Between 1 and 5 years inclusive	**66,310**	44,722
After 5 years	**65,785**	44,883
	151,078	105,444

6.4.3 Operating lease income:

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Rental revenue from operating leases – minimum lease receipts	**12,042**	7,111
	12,042	7,111

6.4.4 Future minimum lease receipts:

Future minimum lease receipts due:	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Within 1 year	**8,415**	7,521
Between 1 and 5 years inclusive	**29,762**	25,982
After 5 years	**99,083**	107,524
	137,260	141,027

7 Employee costs and numbers

7.1 Employee costs (including executive directors)

	Year ended March 31 2020 Total £000	Year ended March 31 2019 Total £000
Salaries and wages	**794,378**	727,854
Social security costs	**83,606**	75,886
Apprenticeship levy	**3,839**	3,494
Employer contributions to NHSPA	**89,283**	81,585
Pension cost – employer contributions paid by NHSE on provider's behalf (6.3%)	**38,990**	–
Termination benefits	**(55)**	654
Temporary staff – external bank	**126**	6,943
Temporary staff – agency and contract staff	**29,309**	21,462
Total gross staff costs	**1,039,476**	917,878
Recoveries in respect of seconded staff	**(9,311)**	(6,143)
Total staff costs	**1,030,165**	911,735
Of which:		
Costs capitalised as part of assets	**18,851**	19,495
Analysed into Operating Expenditure (note 6.1)		
Employee expenses – staff & executive directors	**1,010,833**	891,083
Redundancy	**(55)**	654
Internal audit costs	**536**	503
Total employee benefits excluding capitalised costs	**1,011,314**	892,240

7.2 Retirements due to ill-health

During 2019/20 there were 5 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended March 31 2019). The estimated additional pension liabilities of these ill-health retirements is £346k (£360k in 2018/19). 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 2020 £000	Year ended March 31 2019 £000
Loss on disposal of property, plant and equipment	–	(33)
Profit on disposal of property, plant and equipment	20	13
Total (losses) on disposal of assets	20	(20)

9 Finance income

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Interest on bank accounts and other	1,145	800
Interest on other investments / financial assets	32	92
Total finance income	1,177	892

10 Finance expenses

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Loans from the Department of Health and Social Care	(5,636)	(5,744)
Finance costs on service concession arrangements	(149)	–
Unwinding of discounts on provisions	12	(3)
Other finance costs	–	(52)
Total finance expense	(5,773)	(5,799)

11 Tax recognised in Statement of Comprehensive Income

	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Current tax expense		
Current year	**(54)**	(62)
Adjustments in respect of prior years	**(51)**	232
	(105)	170
Deferred tax expense		
Origination and reversal of temporary differences	**(42)**	–
	(42)	–
Total tax (expense)/credit recognised in income statement	**(147)**	170

Tax recognised in other comprehensive income is £nil (2018/19 – £nil)
Tax recognised directly in equity is £nil (2018/19 – £nil)

Reconciliation of effective tax rate	Year ended March 31 2020 £000	Year ended March 31 2019 £000
Operating surplus before taxation – subsidiaries only*	**125**	477
Tax at standard rate of corporation tax in the UK 19% (2018/19 – 19%)	**(96)**	(62)
Adjustments in respect of prior years	**(51)**	232
	(147)	(170)

*Liability for corporation tax only arises from the activity of the commercial subsidiaries whose combine operating surplus before taxation is disclosed. The activities of the Trust do not incur corporation tax, see accounting policy note 1.15 for detailed explanation.

The Finance (No 2) Act 2015, that provides for reductions in the main rate of corporation tax from 20% to 19% effective from 1 April 2017 and to 18% effective from 1 April 2020, was substantively enacted on 26 October 2015. Subsequently, the Finance Act 2016, which provides for a further reduction in the main rate of corporation tax to 17% effective from 1 April 2020, was substantively enacted on 6 September 2016.

12 Surplus attributable to the Trust

The Consolidated Statement of Comprehensive Income shows a deficit of £63,544k (2018/19 Surplus £31,449k) for the Group.

The operating deficit for the Trust was £63,669k (2018/19 operating surplus of £30,976k), 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 2020

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

GROUP AND TRUST	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	IT hardware £000	Furniture and fittings £000	Total £000
Cost or valuation at April 1 2020	243,095	828,846	–	102,035	176,037	164	48,577	3,782	1,402,536
Additions purchased	–	4,930	–	66,642	706	–	2,134	52	74,464
Additions – leased/IFRIC 12 scheme assets (excluding lifestyle)	–	3,476	–	–	454	–	–	–	3,930
Additions – assets purchased from cash donations/grants	–	–	–	2,538	119	–	–	–	2,657
Impairments – charged to operating expenses	(250)	(54,189)	–	(292)	–	–	–	–	(54,731)
Impairments – charged to the revaluation reserve	(41,101)	(29,128)	–	–	–	–	–	–	(70,229)
Reversal of impairments credit to revaluation reserve	–	4,801	–	–	–	–	–	–	4,801
Revaluation	–	24,533	–	–	–	–	–	–	24,533
Reclassifications	–	35,658	6,947	(68,222)	18,717	–	4,674	1,117	(1,109)
Disposal	–	–	–	(240)	(852)	–	–	–	(1,092)
Cost or valuation at March 31 2020	**201,744**	**818,927**	**6,947**	**102,461**	**195,181**	**164**	**55,385**	**4,951**	**1,385,760**
Accumulated depreciation at April 1 2019	–	17,366	–	–	118,540	164	34,458	2,415	172,943
Provided during the year	–	22,924	–	–	16,498	–	7,041	519	46,982
Reclassification	–	–	–	–	–	–	–	–	–
Revaluation	–	(20,538)	–	–	–	–	–	–	(20,538)
Disposals	–	–	–	–	(852)	–	–	–	(852)
At March 31 2019	**–**	**19,752**	**–**	**–**	**134,186**	**164**	**41,499**	**2,934**	**198,535**
Net book value March 31 2020									
Purchased assets	137,084	597,958	6,672	91,969	43,447	–	11,673	1,152	889,955
Financed leased	–	–	–	–	–	–	–	–	–
On-SoFP PFI contracts and other service concession arrangements	–	3,228	–	–	383	–	–	–	3,611
Government granted assets	–	19	–	–	108	–	14	–	142
Donated assets	64,660	197,969	275	10,492	17,056	–	2,199	865	293,517
Total at March 31 2020	**201,744**	**799,175**	**6,947**	**102,461**	**60,995**	**–**	**13,886**	**2,017**	**1,187,225**

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 2020 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."*

13 Property, plant and equipment – March 31 2019

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

Group and Trust	Land	Buildings excluding dwellings	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	£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	–	59,111	719	–	1,704	33	78,414
Additions purchased	–	–	–	3,382	13	–	–	–	3,395
Additions – grants / donations	–	–	–	–	–	–	–	–	–
Impairments – charged to operating expenses	–	(20,625)	–	(29)	–	–	–	–	(20,654)
Impairments – charged to the revaluation reserve	(1,170)	(2,163)	–	–	–	–	–	–	(3,333)
Revaluations	–	4,898	–	–	–	–	–	–	4,898
Reclassifications	2,943	(8,656)		–	–	–	–	–	(5,713)
Transfers to assets held for sale	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
Reversal of impairments credited to operating income	–	–	–	–	–	–	–	–	–
Reclassifications	–	–	–	–	–	–	(12)	–	(12)
Revaluation	–	(19,962)	–	–	–	–	–	–	(19,962)
Disposals	–	–	–	–	(224)	–	–	–	(224)
Other	–	–	–	–	–	–	–	–	–
Reclassifications	–	–	–	–	–	–	–	–	–
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**

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 2019/20 had an impairment charge to income and expenditure in prior years. In 2019/20 the increase in value of these assets resulted in a reversal of the impairments and offset credit to income and expenditure.

e) 2019/20 - Valuation approach

The valuation methodology used this year is same as in previous years; MEA Valuation, but with a different approach by incorporating a revised MEA model in respect of the acute hospital sites to the alternative site approach.

This is as a result of bed capacity and bed utilisation information provided to Gerald Eve by Informatics to inform the alternative site, alternative building approach.

14 Intangible assets

14.1 As at March 31 2020

GROUP AND TRUST	Software licences £000	Information technology £000	Assets under construction £000	Total £000
Cost April 1 2019	6,414	81,774	17,938	106,126
Additions purchased/internally generated	160	1,578	15,986	17,724
Additions – grants/donations of cash	–	84	40	124
Impairments charged to operating expenses	–	–	(72)	(72)
Reclassification	270	7,112	(6,273)	1,109
Disposals	–	–	–	–
Gross cost at March 31 2020	**6,844**	**90,548**	**27,916**	**125,011**
Amortisation April 1 2019	4,099	56,371	–	60,470
Provided during the year	620	9,765	–	10,385
Reclassifications	–	–	–	–
Disposals	–	–	–	–
Amortisation at March 31 2020	**4,719**	**66,136**	**–**	**70,855**
Net book value March 31 2020	**2,125**	**24,412**	**27,619**	**54,156**
Purchased assets	1,926	23,193	26,968	52,087
Government granted assets	103	1,134	651	1,888
Donated assets	37	144	–	181
Total at March 31 2020	**2,066**	**24,471**	**27,619**	**54,156**

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.

14.2 As at March 31 2019

GROUP AND TRUST	Software licences £000	Information technology £000	Assets under construction £000	Total £000
Cost April 1 2019	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**

15 Impairments

	March 31 2020 £000	March 31 2019 £000
Charged to Statement of Comprehensive Income (SOCI):		
Impairments arising from professional valuation including reversals	**(54,439)**	(20,086)
Reversals of impairments arising from professional valuation	**4,801**	4,898
Other impairments of property, plant and equipment	**(72)**	(539)
Other impairments of asset under construction	**(292)**	(29)
Total (impairments) and reversals of property, plant and equipment charged to I&E	**(50,002)**	(15,756)
Net impairment impact on SOCI	**(50,002)**	(15,756)
Charged to revaluation reserve:		
Professional valuation impairments of land value	**(41,101)**	(1,170)
Professional valuation impairments of building value	**(29,128)**	(2,163)
Total impairments charged to other comprehensive Income	**(70,229)**	(3,333)

The majority of the 2019/20 impairment reversal and charge relates to the property valuation.

Land and buildings were valued independently by Gerald Eve as at 31 March 2020 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).

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 2020 £000	March 31 2019 £000
Net impairments charged to operating surplus		
Loss or damage resulting from normal operations	**72**	539
Abandonment of assets in the course of construction	**292**	29
Other (arising from market valuations)	**49,638**	15,188
Total impairments and (reversals) charged to operating surplus	**50,002**	15,756
Total net impairments charged to revaluation reserve	**70,229**	3,333
Total impairments and (reversals)	**120,231**	19,089
Impairments charged to operating expenses:		
Of which Departmental Expenditure Limit (DEL)	**364**	568
Of which Annually Managed Expenditure (AME)	**49,638**	15,188

	March 31 2020 £000	March 31 2020 £000	March 31 2020 £000	March 31 2019 £000	March 31 2019 £000	March 31 2019 £000
	Revaluation reserve	**SOCI**	**Total**	Revaluation reserve	SOCI	Total
From professional valuation of land and buildings:						
Increase in land value	**–**	**–**	**–**	2,943	–	2,943
Increase in building value	**45,071**	**–**	**45,071**	11,308	–	11,308
Impairments in land value	**(41,101)**	**(250)**	**(41,351)**	(1,170)	–	(1,170)
Impairments in building value	**(29,128)**	**(54,189)**	**(83,317)**	(2,163)	(20,086)	(22,249)
Reversal of previous impairments	**–**	**4,801**	**4,801**	–	4,898	4,898
Total movement	**(25,158)**	**(49,638)**	**(74,796)**	10,918	(15,188)	(4,270)
Other valuation movements:						
Other impairments of property, plant and equipment	**–**	**(292)**	**(292)**	–	(29)	(29)
Loss or damage resulting from normal operations	**–**	**(72)**	**(72)**	–	(539)	(539)
	(25,158)	**(50,002)**	**(75,160)**	10,918	(15,756)	(4,838)

16 Investment property

Investment property carrying values

	GROUP AND TRUST	
	March 31 2020	March 31 2019
	£000	£000
Carrying value at April 1	**–**	1,169
Reclassifications to property, plant and equipment	**–**	(1,169)
Carrying value at March 31	**–**	–

17 Revaluation reserve movements

Property, plant and equipment

	GROUP AND TRUST	
	March 31 2020	March 31 2019
	£000	£000
Property, plant and equipment		
Revaluation reserve at April 1	**383,587**	372,671
Impairments	**(70,229)**	(3,333)
Revaluations	**45,071**	14,249
Revaluation reserve at March 31	**358,429**	383,587

18 Subsidiaries and interests in associates and joint ventures

The Guy's and St Thomas' principal subsidiary undertakings, associates and joint ventures as included in the consolidation at March 31 2020 are set out below. The accounting date of the financial statements for the subsidiaries is March 31 2020 and for the joint ventures December 31 2019. 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
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.

18.1 Investments in joint ventures and associates

	GROUP	
	Investments joint ventures and associates March 31 2020 £000	Investments joint ventures and associates March 31 2019 £000
Carrying value at April 1	**237**	71
Share of profit from Joint Venture	**48**	162
Cydar Ltd	**146**	74
Dividends received	**(214)**	(70)
Carrying Value at March 31	**217**	237
Investments in joint ventures and associates	**71**	237
Other investments / financial assets	**146**	138
	217	375

19 Inventories

	GROUP AND TRUST	
	March 31 2020 £000	March 31 2019 £000
Raw materials and consumables	**26,286**	21,957
	26,286	21,957

Please refer to note 1.24 for critical accounting judgements and key sources of estimation uncertainty.

20 Trade and other receivables

20.1 Current

	GROUP AND TRUST	
	March 31 2020	March 31 2019
	£000	£000
Contract receivables: invoiced	**95,510**	113,543
Contract receivables: not yet invoiced	**72,545**	86,317
Capital receivables	**2,303**	12,353
Credit loss allowance	**(34,188)**	(32,138)
Prepayments	**25,065**	6,350
Interest receivable	**24**	–
PDC dividend receivable	**–**	48
VAT and other tax receivable	**4,572**	3,370
Other receivables	**5,990**	4,736
	171,821	194,579

20.2 Non-current

	GROUP AND TRUST	
	March 31 2020	March 31 2019
	£000	£000
Contract receivables	**2,151**	2,260
Clinical pension tax provision reimbursement funding from NHSE	**3,582**	–
	5,733	2,260

20.3 Allowances for credit losses 2019/20 – before IFRS 9 and IFRS 15

	GROUP AND TRUST	
	Contract receivables and contract assets	**All other receivables**
	£000	**£000**
Allowances as at 1 April 2019 brought forward (before IFRS 9 and IFRS 15)		
New allowances arising	**4,642**	8,315
Utilisation of allowances	**(2,592)**	(3,233)
Allowances as at 31 March 2020	**2,050**	5,082

20.4 Allowances for credit losses 2019/20

	March 31 2020	March 31 2019
	£000	£000
Allowances as at 1 April 2019	**32,138**	27,056
Increase in provision	**4,642**	8,315
Amounts utilised	**(2,592)**	(3,233)
Allowances as at 31 March 2020	**34,188**	32,138

21 Other investments/financial assets

Non-current	GROUP March 31 2020 £000	GROUP March 31 2019 £000	TRUST March 31 2020 £000	TRUST March 31 2019 £000
Carrying value at April 1	**138**	1,368	**3,086**	4,898
Additions	**79**	–	**60**	58
Current portion of loans receivable transferred to current financial assets	**–**	(1,230)	**–**	(1,870)
Carrying value at March 31	**217**	138	**3,146**	3,086
Current				
Loans receivable within 12 months transferred from non-current financial assets	**1,230**	1,230	**1,550**	1,870
Loan instalment settled	**–**	–	**–**	(320)
	1,230	1,230	**1,550**	1,550

2019/20 Group other investments/financial assets

Organisation	Current £000	Non-current £000	Interest rate	Maturity date
SpotOn Clinical Diagnostics Ltd	–	**71**	Libor +2%	Dec 2019
Cydar Investments including loan converted to shares	–	**146**		
Other investments	–	–		
	–	**217**		

2019/20 Trust other investments/financial assets

Organisation	Current £000	Non-current £000	Interest rate	Maturity date
Viapath Group	1,230	–	Libor +2%	Apr 2019
Pathology Services Ltd (loan + accumulated interest)	–	2,186	Libor +2%	Mar 2022
Essentia Trading Ltd	320	960	3.50%	Mar 2024
	1,550	**3,146**		

Loans with Pathology Services Ltd and Essentia Trading Limited are removed from the Group Accounts following consolidation adjustments.

22 Current liabilities

22.1 Trade and other payables

	GROUP AND TRUST March 31 2020 £000	GROUP AND TRUST March 31 2019 £000
Trade payables	**71,097**	57,643
Capital payables	**19,654**	23,682
Accruals	**89,015**	71,649
Receipts in advance	**1,142**	1,248
Social security costs	**12,706**	11,456
Other taxes payable	**10,581**	9,704
PDC dividend payable	**9,746**	–
Other payables	**451**	1,290
	214,392	176,672

22.2 Other liabilities

Current	GROUP AND TRUST March 31 2020 £000	GROUP AND TRUST March 31 2019 £000
Deferred income: contract liabilities	**15,288**	20,820
Deferred grants	**11**	3,281
Lease incentives	**5,942**	6,350
	21,241	30,451

22.3 Borrowings

Current	GROUP AND TRUST March 31 2020 £000	March 31 2019 £000
Capital loans from Department of Health and Social Care (DHSC)*	**15,119**	12,699
Obligations under PFI, LIFT or other service concession contracts (excluding lifecycle)	**137**	–
	15,256	12,699

*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.

Non-current	GROUP AND TRUST March 31 2020 £000	March 31 2019 £000
Capital loans from Department of Health and Social Care	**211,761**	218,810
Obligations under PFI, LIFT or other service concession contracts (excluding lifecycle)	**3,540**	–
	215,301	218,810
Total borrowings (current and non-current)	**230,557**	231,479

22.4 Reconciliation of liabilities arising from financing activities

Group	Loans from DHSC £000
Carrying value at 1 April 2019	**231,479**
Cash movements:	
Financing cash flows – payments and receipts of principal	**(4,824)**
Financing cash flows – payments of interest	**(5,813)**
Non-cash movements:	
Additions	**3,930**
Interest charge arising in year	**5,785**
Carrying value at 31 March 2020	**230,557**

22.5 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 2020 £000	Total repaid March 31 2020 £000	Amounts left to draw down March 31 2020 £000	Amounts outstanding March 31 2020 £000	Accrued interest March 31 2020 £000	Total borrowings and interest March 31 2020 £000
Mar 2012	Mar 2037	2.85	80,000	16,776	–	63,224	55	63,279
Jun 2011	Jun 2036	3.27	75,000	18,728	–	56,273	533	56,806
Jun 2011	Jun 2017	1.05	5,000	5,000	–	–	–	–
Sep 2013	Nov 2023	1.95	9,000	4,500	–	4,500	32	4,532
Feb 2016	Feb 2041	1.9	25,000	3,570	–	21,430	47	21,477
Feb 2016	Feb 2041	1.9	14,000	1,747	–	12,253	27	12,280
Feb 2016	Feb 2041	1.9	33,768	2,249	–	31,519	67	31,586
Feb 2016	Feb 2031	1.38	27,232	–	–	27,232	41	27,273
Nov 2017	Nov 2042	1.76	10,000	416	–	9,584	64	9,648
			279,000	**52,986**	**–**	**226,014**	**866**	**226,880**

No security has been pledged against these loans.

All borrowing relates to capital loans that have been secured to support the Trust's ongoing plans to redevelop its 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.

23 Provisions for liabilities

23.1 Overall provisions

	GROUP AND TRUST	
	March 31 2020	March 31 2019
	£000	£000
Current		
*Pensions: injury Benefit	**44**	43
Legal claims	**208**	243
Other	**–**	12
	252	298

	March 31 2020	March 31 2019
	£000	£000
Non-current		
Pensions: injury Benefit	**762**	751
*Clinician pension tax reimbursement	**3,582**	–
Other	**2,884**	2,876
	7,228	3,627

	March 31 2020	March 31 2019
Total provisions	**£000**	£000
Pensions: injury Benefit	**806**	794
Legal claims	**208**	243
*Clinician pension tax reimbursement	**3,582**	–
Other	**2,884**	2,888
	7,480	3,925

23.2 Changes in provisions

	Pensions - injury benefits	**Legal claims**	**Clinician pension tax reimbursement**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
As at April 1 2019*	794	243	–	2,888	**3,925**
Change in Discount Rate	25	–	–	–	**25**
Arising during the year	34	111	3,582	18	**3,745**
Utilised during the year	(35)	–	–	(10)	**(45)**
Reversed unused	–	(146)	–	(12)	**(158)**
Unwinding of discount	(12)	–	–	–	**(12)**
'At March 31 2020	**806**	**208**	**3,582**	**2,884**	**7,480**

23.3 Expected timing of cash flows:

Timing of provisions	**Pensions - injury benefits**	**Legal claims**	**Clinician pension tax reimbursement**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Within one year	44	208	–	–	**252**
Between one and five years	179	–	3,582	1,230	**4,991**
Between one and five years	583	–	–	1,654	**2,237**
	806	**208**	**3,582**	**2,884**	**7,480**

*A new clinician pension tax category has been added to meet the requirements of the Department of Health and Social Care Group Accounting Manual.

Other provisions largely consist of provisions for dilapidations.

£433m is included in the provision of NHS Resolution under legal claims in respect of clinical negligence liabilities of the Foundation Trust (£382m at March 31 2019).

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

24 Analysis in changes of net cash

GROUP	At April 1 2018 £000	Cash changes in period £000	At March 31 2019 £000	Cash changes in period £000	**At March 31 2020 £000**
Cash with the Government Banking Service	133,257	8,158	141,415	4,672	**136,743**
Cash at bank and in hand – commercial bank	1,526	1,116	2,642	136	**2,506**
	134,783	9,274	144,057	4,808	**139,249**

TRUST	At April 1 2018 £000	Cash changes in year £000	At March 31 2019 £000	Cash changes in year £000	**At March 31 2019 £000**
Cash with the Government Banking Service	133,258	8,157	141,415	4,672	**136,743**
Cash at bank and in hand – commercial bank accounts	196	50	246	(132)	**378**
	138,454	8,207	141,661	4,540	**137,121**

25 Contractual capital commitments

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	**11,146**	9,737
Intangible assets	**2,345**	5,355
	13,491	15,092

26 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, or other service concession arrangements), analysed by the period during which the payment is made:

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Not later than 1 year	**2,705**	1,306
After 1 year and not later than 5 years	**8,301**	16,269
Paid thereafter	**1,555**	29,196
Total	**11,931**	46,771

Guy's and St Thomas' NHS Foundation Trust has entered into 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. The 2019 figures included the capital element of Phase 2 of the project, to build the additional orthopaedic theatres. The 2020 figures however excludes this as there was some uncertainty to proceed with the contract as 31 March 2020.

27 Events after the reporting date

There were no events after the reporting date.

28 Contingencies

28.1 Contingent liabilities

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Contingent liabilities for claims against the Group and Trust	**(98)**	(85)
Net contingent liability	**(98)**	(85)

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

29 On-SoFP, LIFT or other service concession arrangements

Guy's and St Thomas' NHS Foundation Trust has entered into 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.

29 Imputed finance lease obligations

The following are obligations in respect of the finance lease element of on-Statement of Financial Position LIFT or other service concession arrangements schemes:

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£000	£000	**£000**	£000
Gross LIFT or other service concession liabilities	**4,622**	–	**4,622**	–
Of which liabilities are due				
- not later than one year;	137	–	137	–
- later than one year and not later than five years	1,119	–	1,119	–
- later than five years	3,366	–	3,366	–
Finance charges allocated to future periods	(945)	–	(945)	–
Net LIFT or other service concession arrangement obligation	**3,677**	–	**3,677**	–
- not later than one year;	137	–	137	–
- later than one year and not later than five years	1,119	–	1,119	–
- later than five years	2,421	–	2,421	–

29.1 Total on-SoFP, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£000	£000	**£000**	£000
Total future payments committed in respect of the LIFT or other service concession arrangements	**17,348**	–	**17,348**	–
Of which liabilities are due				
- not later than one year;	2,487	–	2,487	–
- later than one year and not later than five years	9,695	–	9,695	–
- later than five years	5,166	–	5,166	–

29.2 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£000	£000	**£000**	£000
Unitary payment payable to service concession operator	**2,487**	–	–	–
Consisting of				
- Interest charge	149	–	149	–
- Repayment of finance lease liability	263	–	263	–
- Service element and other charges to operating expenditure	2,075	–	2,075	–
Total amount paid to service concession operator	**2,487**	–	**2,487**	–

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 2020 was £22,677k (2018/19 £23,448k), based on average relevant net assets less average GBS cash balances totalling £647,924k.

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' NHS Foundation Trust has had a number of material transactions with the Department and with other entities for which the department is regarded as the parent Department as listed below:

- NHS Foundation Trusts
- NHS Trusts
- Department of Health
- Public Health England
- Health Education England
- 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	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
Non-NHS Related party transactions				
Guy's and St Thomas' Charity	**2,291**	989	**28**	26
King's College London	**12,061**	8,979	**7,084**	6,110
Viapath*	**4,222**	3,377	**3,154**	2,130
SSAFA GSTT Care LLP	**47**	1,097	**–**	–

	Receipts from related party		Payments to related party	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
Non-NHS Related party transactions				
Guy's and St Thomas' Charity	**6,266**	10,724	**87**	98
King's College London	**23,137**	21,894	**23,610**	22,388

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

	31 March 2020	31 March 2019
Trust debtor with wholly owned subsidiaries		
Essentia Trading Ltd	**1,958**	2,257
GSTT Enterprises Ltd	**–**	75
Essentia Trading Ltd	**99**	2,128
Pathology Services Ltd	**2,187**	–
Trust creditor with wholly owned subsidiaries		
Essentia Trading Ltd	**660**	1,107
Trust income from wholly owned subsidiaries		
Essentia Trading Ltd	**583**	912
GSTT Enterprises Ltd	**–**	104
Pathology Services Ltd	**92**	59
	60	–
Trust expenditure with wholly owned subsidiaries		
Essentia Trading Ltd	**3,789**	4,660

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.

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 South Bank Universities.

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 Guy's and St Thomas' 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' NHS Foundation Trust.

32 Financial assets and liabilities

32.1 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**	Held at amortised cost
	March 31 2020 £000	March 31 2019 £000
Carrying values of financial assets as at 31 March 2020 under IFRS 9		
Trade and other receivables (excluding non-financial assets) - with NHS and DHSC bodies	**96,295**	123,647
Trade and other receivables (excluding non-financial assets) - with other bodies	**48,040**	63,590
Other investments / financial assets	**1,447**	1,439
Cash and cash equivalents	**139,249**	144,057
Total at 31 March 2020	**285,031**	332,733

Group and Trust	**Loans and receivables**	Loans and receivables
	March 31 2020 £000	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	**96,295**	102,088
Trade and other receivables (excluding non-financial assets) - with other bodies	**48,040**	46,929
Other investments / financial assets	**1,447**	2,709
Cash and cash equivalents	**139,249**	134,783
Total at 31 March 2018	**285,031**	286,509

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32.2 Carrying value and fair value of financial liabilities

Group and Trust	**Held at amortised cost**	Held at amortised cost
	March 31 2020 £000	March 31 2019 £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Loans from DHSC	**226,880**	231,479
Obligations under LIFT and other service concession contracts	**3,677**	3,677
Trade and other payables (excluding non-financial liabilities) - with NHS and DHSC bodies	**27,150**	17,154
Trade and other payables (excluding non-financial liabilities) - with other bodies	**152,733**	137,110
IAS 37 provisions which are financial liabilities	**7,480**	3,925
Total at 31 March 2019	**417,920**	389,668

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 2020 £000	March 31 2019 £000
In one year or less	**195,390**	167,232
In more than one year but not more than two years	**15,373**	12,777
In more than two years but not more than five years	**49,989**	39,742
In more than five years	**157,167**	169,917
	417,920	389,668

32.4 Loan disclosure

	Current	**Non current**	**Total**	**Weighted average interest rate %**
	£000	**£000**	**£000**	
March 31 2020				
Fixed interest rate instruments	**15,119**	**211,761**	**226,880**	**2.48%**
March 31 2019				
Fixed interest rate instruments	12,669	218,810	231,479	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 NHS Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust 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 2019/20.

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 2020 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 £197k cash and cash equivalents at March 31 2020 (£227k at March 31 2019) 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. £2,844k is held as client monies on behalf of tenants as a result of assurities (£2,798k at March 31 2019).

34 Losses and special payments

Group and Trust

Losses	**Year ended March 31 2020 Cases**	**Year ended March 31 2020 £000**	Year ended March 31 2019 Cases	Year ended March 31 2019 £000
Cash losses	**27**	**93**	3	250
Stores losses and theft	**85**	**403**	124	753
Bad debts and claims abandoned	**877**	**3,272**	1,108	3,222
Total losses	**989**	**3,768**	1,235	4,226

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	**34**	**16**	27	15
Total special payments	**34**	**16**	27	15
Total losses and special payments	**936**	**3,784**	1,262	4,241
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.

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 (2018/19: nil). There were no disposals of artefacts during either year.

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

The Trust incurred £nil (£2k 2018/19) in charges relating to the late payment of Commercial Debts.

37 Adoption of new accounting standards during 2019/20

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

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.

The implementation of IFRS 16 for the public sector has been delayed until April 2021. Due to the material uncertainty referred to in Note 1.26 it is not possible to estimate its future impact.

contacts

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Email: chiefexecutive2@gstt.nhs.uk

Patient Advice and Liaison Service (PALS)
If you require information, support or advice about our services, contact:
PALS
Tel: 020 7188 8801 (St Thomas')
or 020 7188 8803 (Guy's)
Email: pals@gstt.nhs.uk

Membership
If you are interested in becoming a member of our NHS Foundation Trust, contact:
Tel: 0800 731 0319
Email: members@gstt.nhs.uk

Recruitment
If you are interested in applying for a job at Guy's and St Thomas', contact:
The Recruitment Centre
Tel: 020 7188 0044
www.guysandstthomas.nhs.uk/careers

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