St George's Healthcare NHS
NHS Trust

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Annual report and accounts 2003 – 2004

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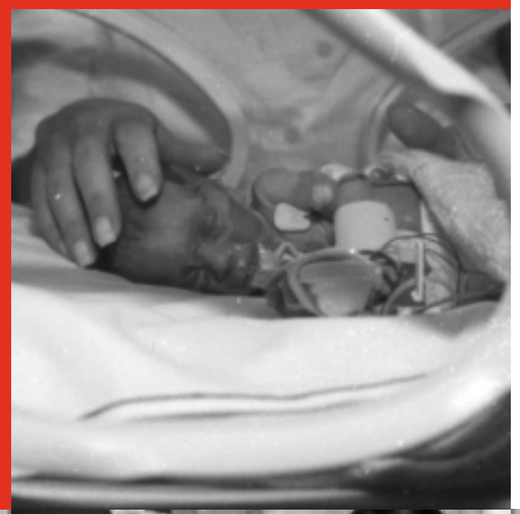


Front cover: Midwives Millie Kessaye (left) and Oumie Singateh (right).

Main photo (top right): A premature baby is cared for in an incubator in the hospital's neonatal intensive care unit

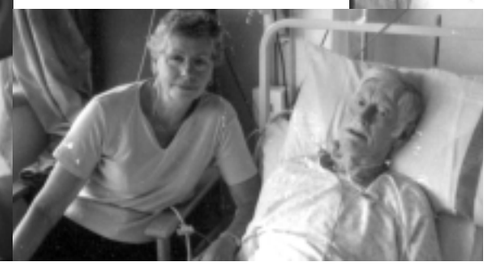
Above (left to right): An A&E resuscitation team discuss the treatment of an elderly patient rushed in by paramedics. An elderly patient has her bloods taken by a student nurse. A young boy has his injured finger examined by a doctor in A&E. A heart patient is visited by his wife. A surgeon and his assistant.

Welcome to the 2003/04 annual report for St George's Healthcare NHS Trust.

St George's is one of the country's leading teaching hospitals with an international reputation for patient care, education and research.

A local hospital based in Tooting, London but also a national centre of excellence, we provide care for thousands of families in South West London and offer an advanced range of pioneering treatments and therapies to patients from across the UK.

This annual report charts the progress we made between April 2003 and March 2004 in improving patient care and the challenges we faced in that time.



Foreword

2003/04 was a year of challenges and change for St George's, but it was also a year of quiet success.

The quality of our care improved. We opened a state-of-the-art medical facility for neurosciences and cardiothoracic medicine. And we continued to drive down waiting times for operations, emergency treatment, diagnostic scans and appointments.

We also welcomed a new Chairman and Chief Executive to the Trust. Here, Chairman Naaz Coker and Chief Executive Peter Homa describe how St George's went from strength to strength in 2003/04:

"2003/04 was a busy year for St George's, one that presented us with many challenges.

Those challenges however have had a remarkable effect. If anything, they have made us stronger.

Our performance this year earned us a rating of two stars – the third year in a row that we have been awarded this rating. However, as many of the targets against which we are assessed are now more demanding than ever, the rating we received demonstrates the considerable progress we have made improving the care we give our patients.

Changing times

We improved many aspects of that care this year. Read this report and we hope you see the evidence of those changes for yourself – evidence which shows the creativity and commitment of our staff, and their many achievements. The commitment of our staff is remarkable, and their professionalism inspiring. They continue to be our greatest single asset.

There is not the space within this foreword to thank our staff for everything they have done this year. But there are two achievements that deserve to be mentioned.

Waiting times fall

We know that the time it takes for some patients to have an operation or an appointment is still far too long. Waiting times however are falling and we are committed to reducing them even further. Two years ago, a patient might have waited over a year for an operation. Now, the maximum waiting time for surgery is nine months. In March, two out of three inpatients were waiting less than 61 days.

Hospital environment improves

The second achievement has to be the improved fabric of the hospital. Slowly but surely, the hospital is being transformed into a warm, welcoming and attractive public place for patients and staff.

The opening of the Atkinson Morley Wing – a dedicated centre for our specialist teams in neurosciences and cardiothoracic medicine – was the most visible sign of this refurbishment.

Creating our future

But 2003/04 is in the past. What matters is where we go from here.

Our first priority is to build on our renewed sense of confidence and pride and create a strategy for the future.

This strategy must involve everyone in its development: not just people at the top of the organisation, but staff throughout the Trust and beyond, to the patients who we care for and the diverse community that we serve. We want everyone to understand the direction we are to travel and the essential role they will play in our quest for excellence.

More importantly, we want to develop a new culture at St George's – a culture of ambition and innovation.

An organisation is only ever as good as the people who work for it. And our staff are good. They are innovative. They are ambitious. But above all, they are passionate about improving patient care.

"There is no doubt we have the ability and the ambition to secure a place for St George's as one of the UK's top hospitals"

Investing in the hospital environment

Second, we must continue to invest in the fabric of the hospital. Building on the work of last year, we will spend £16m in 2004/05 upgrading the patient environment and increasing the capacity of our services. This work will include a new endoscopy unit and national training centre for endoscopy, and refurbishment of the intermediate care facilities, the therapy area and day hospital at the Bolingbroke Hospital.

Financial performance

Our financial position was one of the most challenging aspects of last year.

However, a programme of financial recovery is already underway and we will work tirelessly to ensure that the Trust's finances are built on a strong foundation. When the programme is complete, we will have the stability we need to plan more effectively for the future.

We will strengthen our position by reducing costs, by becoming more efficient in the way we provide services, and by securing additional income wherever possible.

Serving our community

A hospital has a special place in the community it serves. Perhaps more so in our case because of the sheer scale of our work and the vast number of people we employ.

There are some people who fear we have forgotten our roots; that what interests us more is the national services we offer such as neurosciences, cancer treatment or cardiothoracic medicine.

In our heart however we are a local hospital. The community is the lifeblood of this Trust and we are proud to be a part of it.

The year ahead

2003/04 has come and gone, and next year promises to be just as busy and demanding. Hundreds of thousands of patients will walk through our doors expecting the care they receive to be even better than the last time they visited us.

But with our sights set firmly on a future that is founded on the proud achievements of the past, there is no doubt we have the ability and the ambition to secure a place for St George's as one of the UK's top hospitals."

A local hospital and proud of it: St George's is a vital part of the community that it serves

Opposite page:
Chief Executive Peter Homa (left) and Chairman Naaz Coker (right)

Naaz Coker Chairman

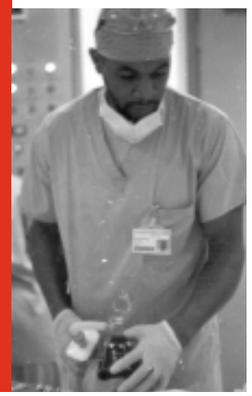
Peter Homa Chief Executive

Facts and figures

- Over **1,000** beds
- **27** operating theatres
- A **two-star** trust
- Over **5,000** staff
- An annual budget of more than **£300m**
- **Half a million** patients treated every year

This year,

- We treated **52,000** inpatients and **22,000** day case patients.
- **100,000** patients had a first outpatient appointment while **274,000** patients had a follow-up consultation
- **86,000** patients were seen and treated in A&E
- **8,500** pints of blood were transfused
- **207,000** x-rays, CT, MRI and ultrasound scans were taken
- **4,000** babies were delivered
- And **27,000** women were screened for breast cancer



Left: Operating theatre practitioner Richard Maynard gets a patient ready for surgery.
Main photo (below): A nurse with a toddler in her care
Below (left to right): An A&E member of staff writes up her notes. Staff nurse Sally Toden monitors the condition of a patient brought in to the A&E resuscitation area. Midwife Oumie Singateh checks the health of a baby who has just been born.

Our services

To 600,000 Londoners we are a local hospital that offers them care and support through some of the most difficult times of their lives.

To patients from across the capital and beyond, we are a cutting-edge trust that offers specialist care for cancer as well as treatment for injuries and illnesses that affect the brain, the heart and the chest.

The Trust has over 1,000 beds across three sites in South West London: the Wolfson Neuro-rehabilitation Centre in Wimbledon, the Bolingbroke Hospital in Wandsworth and St George's Hospital – our main site – in Tooting.

From each of these sites, we provide general, acute and specialist services to patients from the South East of England. We are also part of the South West London Cancer Network, performing 75% of all complex cancer surgery in the region.

The care we offer patients is commissioned on their behalf by primary care trusts (PCTs) – local NHS organisations that plan and deliver health services for the communities in their area.

Over 100 PCTs in England commission more than £200m of services from us every year. Patients travel from as far afield as Norwich and the Channel Islands, Ashford in Kent, and Poole in Dorset to be cared for at St George's.

With an annual budget in excess of £300 million, the scale of our work is immense.

In 2003/04 we treated over 52,000 inpatients while a further 22,000 patients had operations performed as day case procedures. Over 100,000 patients had a first outpatient appointment last year and 274,000 patients had follow-up appointments. Plus, around 86,000 people came to us for emergency treatment in our A&E department.

As a teaching hospital, we enjoy a close partnership with the Faculty of Health and Social Care Services – a joint venture between Kingston University and St George's Hospital Medical School. Students benefit from the wealth of clinical experience that the hospital has to offer as they train to become the doctors and nurses, midwives and physiotherapists, and scientists and radiographers of the future; while we, in turn, draw on the innovative research and teaching culture that thrives at both the School and the University.

"The care I received was exemplary. The quality of nursing was of a high standard often in very difficult circumstances." Moira, patient

Clinical excellence

We treat over half a million patients every year, every one of whom expects the care they receive to be of a high standard.

There is nothing we prize more highly at St George's than the quality of our care. Our reputation as a modern, groundbreaking trust depends on it and our mission is always to make that care better, safer and faster.

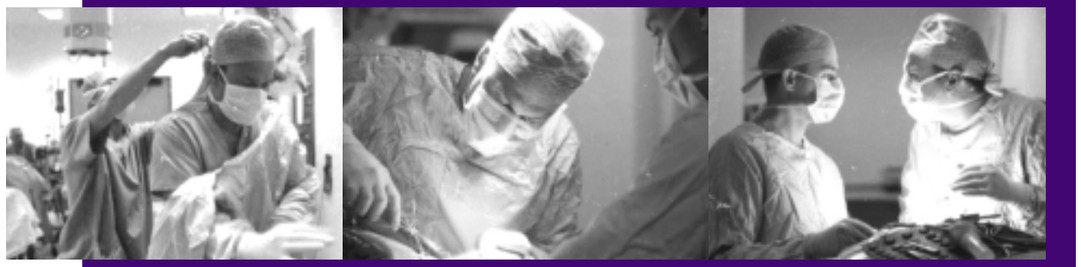
Advancing patient care

St George's is a hospital at the forefront of medical innovation and discovery.

The partnership that exists between the Trust and St George's Hospital Medical School allows us not only to advance our knowledge of the human body and the diseases that affect it, but use that knowledge to benefit the patients in our care.

We were awarded nearly £7m by the Department of Health this year to support research into cancer, women's health, HIV and AIDS, medical genetics and many other fields of medicine.

Nearly 400 projects, including a portfolio of commercial and non-commercial clinical trials, were hosted by the hospital. Projects were funded by a wide range of organisations including the Department of Health, leading health charities such as the Institute for Cancer Research, Cancer Research UK and the British Heart Foundation, and several high-profile pharmaceutical firms. They included a study into the ageing brain and cognitive decline, a trial of mechanical heart valves, and the testing of HIV-inoculated goat serum in the treatment of secondary progressive multiple sclerosis.



Francis

Francis Johnston is a neurosurgeon at St George's Hospital.

Every year, he performs 500 highly complex and invasive procedures on patients with injuries and conditions affecting the brain and the nervous system.

He became a consultant ten years ago and specialises in repairing aneurysms and damage to the spinal cord.

8.53

The first operation of the morning is already underway.

An atmosphere of intense concentration fills the operating room. A clock on the wall records the time that has elapsed since the operation began, and numerous machines – all rigged up to monitor the patient's vital signs – beep regularly in the background.

The silence is broken for a split second as Francis shares a joke with one of his colleagues. 'I'm only allowed to do the easy ones,' he laughs.

Main photo (above): Neurosurgeon Francis Johnston changes into his scrubs
Opposite page (left to right): Preparing for the operation. The operation begins. A brief pause to review the progress of the procedure with registrar, Tom Manning.

Clinical genetics

Our clinical genetics team is a perfect example of how we are using scientific discovery to advance the treatment of our patients.

Ever since scientists and researchers started to unravel the mysteries of the human genome, clinical genetics has emerged as a leading medical specialty capable of predicting people's long-term health problems.

The regional genetics service at St George's was founded in 1986 and is one of only a handful of hospitals in the country to offer an outpatients clinic to families concerned about passing on genetic disorders and diseases. The clinic sees around 3,000 patients every year.

Laboratories at the Trust run more than 15,000 complex tests every year on chromosomes and specific genes, some of which can reveal if a patient is susceptible to a disease even if the symptoms have yet to appear.

"The calibre of your staff was magnificent. I doubt my father would have received better care."

Thomas, relative of patient

Breakthrough for dialysis patients

Moving away from the laboratory into the operating theatre, surgeons at St George's have pioneered a breakthrough procedure that will allow patients with end stage kidney failure to continue receiving dialysis.

A metre-long plastic artery used by renal surgeons bypasses blood vessels blocked during dialysis.

In dialysis, blood is pumped from the body into a machine, where it is cleaned and then pumped back. The treatment is the only option for patients who cannot undergo transplants, either because of complications or because no donor organs are available.

Some patients are connected to the dialysis machine by a venous catheter inserted into their chest, which can lead to infections and blood clots. Although a medical procedure called an angioplasty can unblock the vein affected, the operation is only a temporary solution and clots often return in less than a year.

In the past, dialysis patients with damaged blood vessels were left no other option but to face a decline in their condition.

The new procedure, which should allow patients to live for another five or six years, is expected to be copied by surgeons around the world.

Protecting patients

Everyone makes mistakes and hospitals are no exception.

The safety of our patients however is paramount.

At St George's we believe in fostering a culture of openness and honesty so that lessons can be learned and the safety of our patients improved.

With this in mind, in 2001 we launched an innovative patient safety training programme. Three years later, more than 2,000 staff have taken the one-day course.

Drawing on techniques used by high-risk industries such as aviation and shipping, the course teaches staff how to predict and manage situations that are susceptible to risk. The programme is open to everyone who comes into contact with patients as part of their work.

Central venous access

Complications caused by the placing of central venous catheters have led to the creation of a clinical team responsible for performing the procedure on all of our patients.

Central venous catheters deliver blood, drugs and antibiotics directly into the veins of patients who are seriously ill.

Placing them, however, can be dangerous and can often lead to infections and complications.

Now a new service has been set up to place catheters in patients as they rest in bed rather than in the operating theatre. The central team, which is led by a group of highly-trained nurses, has reduced the number of infections and complications caused by the procedure, and has taught hundreds of junior doctors and nurses how to perform it safely.

Patients have even been trained to administer medication through the catheters themselves, allowing them to be discharged home far sooner than would previously have been possible.

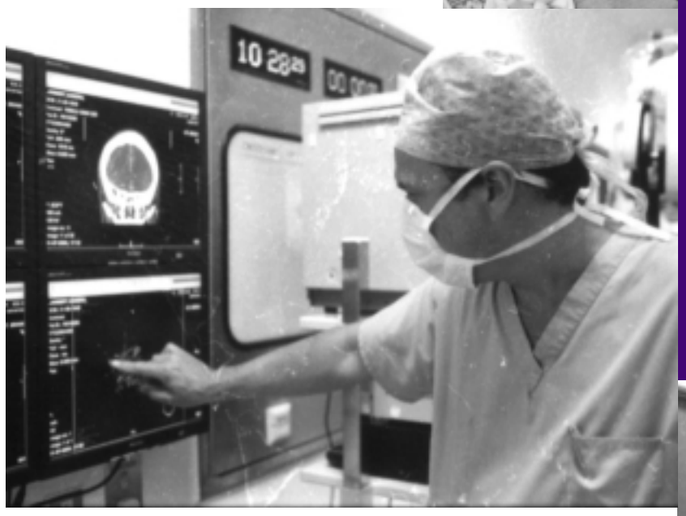
Infection control

Protecting patients from the spread of infections is a concern for most hospitals but especially trusts like St George's that treat a large number of vulnerably ill patients who need invasive treatment and therapy.

Figures released in July 2004 show cases of Methicillin Resistant Staphylococcus Aureus (MRSA) at St George's fell from 115 to 93 between 2001/02 and 2003/04.

There were fewer reports of MRSA in 2002/03 but overall the figures indicate a gradual reduction in cases over the last four years.

Despite this reduction, we know we cannot afford to be complacent. The issue of infection control is one we take very seriously and we are committed to reducing all infections acquired by patients – and not just MRSA – further still.



Right: Relaxing between operations
Main photo (below): Checking the scans of his next patient
Below right: Monitoring Tom's progress

The patient lies face-down on the operating table asleep, his head held firmly in place to stop it moving around during the procedure.

The patient has a trapped nerve in his neck. The nerve is swollen and is rubbing against two plates of bone. Without treatment, the injury might lead to a loss of movement in the elbow or a weakening of the grip.

With the help of his registrar, Tom Manning, Francis carefully cuts open the patient's neck and drills out a piece of bone. With part of the bone removed, the pressure on the nerve should ease off.

Less than half an hour later, the operation is over. 'Everything went well,' says Francis. 'We should have got rid of the pain for him.'

10.20

After a quick break, Francis heads over to intensive care to check on his patient, who is already coming round from the anaesthetic. Francis asks him to squeeze his hand to make sure his grip hasn't been affected by the procedure.

Confident that everything went well, Francis returns to the operating theatre for his next operation.

10.28

While Francis has been away, his next patient has already been prepared for surgery.

The patient is covered head to toe in surgical cloths except for a small part of her face over her left temple. The woman has suffered an aneurysm in her brain and the operation, which is set to last two and a half hours, will attempt to seal the rupture.

Much of Francis' time as a consultant is spent training junior surgeons, especially in procedures to repair aneurysms. Francis will supervise this particular operation, which his registrar Tom will perform, and remain on standby to take over if needed.

Carefully, Tom makes incisions in the patient's skin behind the hairline. He then begins the painstaking process of removing sections of skin and skull to give him access to the part of the brain damaged by the aneurysm.

13.00

With both operations completed, Francis spends his afternoon in clinic.

On a typical day he will see between eight and ten patients, each one affected by a variety of neurological conditions and problems. It seems as though this aspect of his work – meeting patients, piecing together their medical history, and working out a diagnosis – is the bit that he enjoys the most.

'It's a lot like being a detective,' he admits.

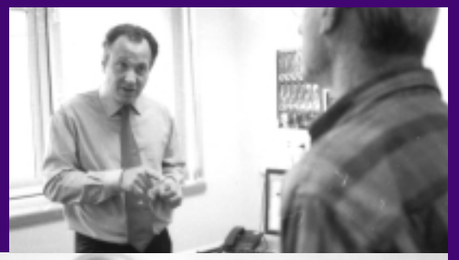
His first patient has Scheuermann's disease, a condition where the spine grows out of shape. Another is a bricklayer whose work has led him to develop multiple nerve compressions.

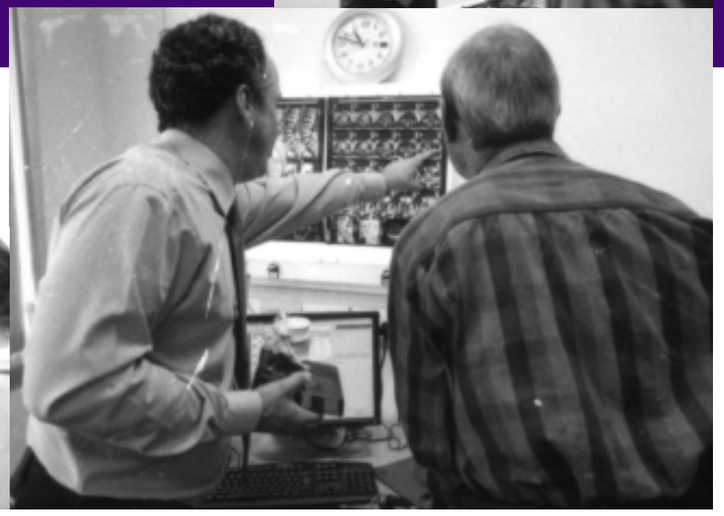
With each patient he takes the time to carefully explain the condition that they have and the treatment that is available.

16.34

His day is finally over. With all his patients seen, all that is left for Francis to do is review his case load for tomorrow.

Top of his list is an operation to remove a tumour the 'size of a man's fist' from the brain of a patient. It's a procedure he's clearly looking forward to.





Left to right:
Francis in clinic

A key priority for the Trust has been to integrate infection control practice into the everyday care of patients.

Our Medical Director has overall responsibility for infection control. But at ward level, over 100 'link nurses' encourage good practice in the clinical areas in which they work.

We have also made it easier for staff to wash their hands and prevent the spread of infection through contact with patients.

Alcohol gel for example is now distributed throughout the Trust. The gel, which staff find quicker and easier to use than soap, has been placed at all clinical hand washing basins, by the end of nearly every bed, and given out to staff in the form of a personal dispenser which they can carry around with them at all times. We were also one of six pilot sites in the country to test a national campaign developed by the National Patient Safety Agency (NPSA) to boost hand hygiene in hospitals.

Finally, St George's is set to be one of the first hospitals in the country to track thousands of instruments used in operations to prevent the spread of communicable diseases.

The Trust began the exhaustive process this year of giving each of its 20,000 surgical instruments a unique marker that will help it to monitor the use of instruments from patient to patient.

By linking instruments to individual operations, patients will be given stronger protection against the transmission of blood-borne diseases – such as HIV and variant-CJD.

Improving patient outcomes

Victims of heart attacks received faster access to life-saving treatment at St George's this year, according to a report published by the Royal College of Physicians.

The figures show that in 2003/04 thrombolytic drugs were given to 92% of heart attack victims within 30 minutes of arrival at A&E and 76% in 20 minutes.

A patient suffering a heart attack will stand a much better chance of survival if they receive the clot-busting drugs within an hour of calling for medical help.

The figures show a considerable improvement in our response times. In 2002, only 57% of patients were receiving the drug within half an hour.

Staff in A&E have improved the speed with which the medication is given by making two important changes to the way they treat patients: the thrombolytic drug used has been changed from a slow drip infusion to a one-off injection that takes ten seconds to administer; and a dedicated area has been set up to take electrocardiography (ECG) readings of patients with chest pains within five minutes of their arrival at the department.

Monitoring mortality

On a much larger scale, our ability to improve standards of care was enhanced this year by the launch of a brand new surveillance system for monitoring mortality.

The system tracks mortality across 30 clinical areas and compares the latest figures with data collected over the last five years. If the number of deaths rises or falls unexpectedly, an alert is generated which prompts a newly-appointed clinical audit team to investigate the reason for the change.

Taking into account factors such as age, sex and the type of operation, mortality rates at St George's have fallen by 6.9% in the last five years. There are now one in 15 fewer deaths than there were between 1999 and 2003 – a trend confirmed by Dr Foster, an independent organisation that analyses the state of health services in the UK, in their annual Good Hospital Guide. According to Dr Foster, the mortality index for St George's between 2001/02 and 2002/03 dropped from 88 to 87.1 (any score below 90 is deemed to be low).

Clinical governance

Our monitoring of mortality is one of several methods we use to maintain and improve the quality of our care – part of a process known as clinical governance.

The Healthcare Commission (formerly the Commission for Health Improvement) visited St George's in early 2003 to conduct a review of our governance procedures. It found several areas of good practice but also made a number of recommendations for improving patient care.

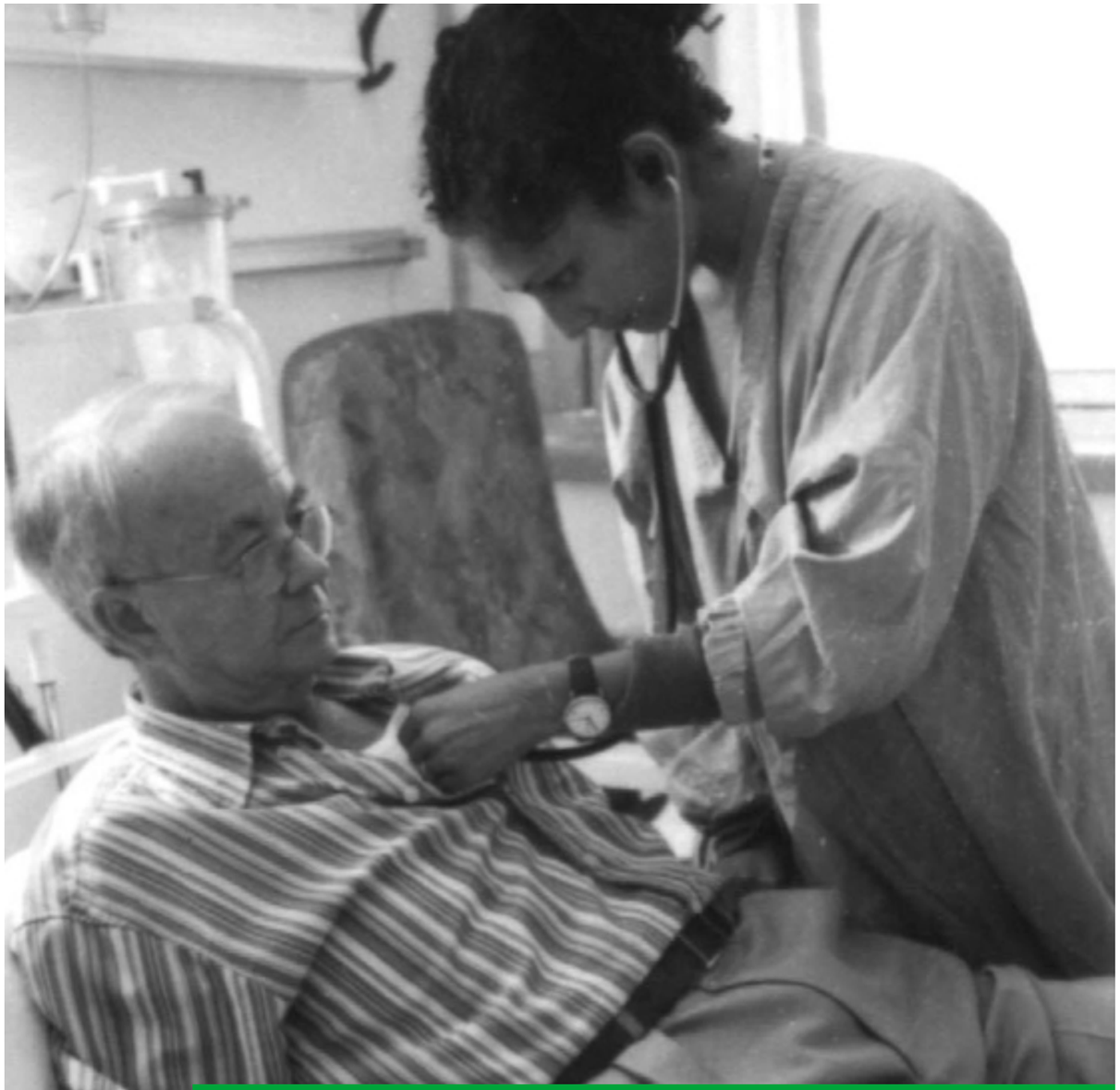
Since then a programme of work has sought to implement the changes requested by the Commission.

"I would never have believed my health problem could have been dealt with so thoroughly in just the space of six months." Patient

Aspects of that programme include a new clinical governance strategy, the appointment of a clinical audit team to investigate changes in care and the more frequent use of integrated care pathways in the treatment of patients.

The clinical audit team ran over 90 audits this year, examining several areas of care including the referral criteria for anaemia and colonoscopy, infections in the trauma and orthopaedics department, the link between medication and falls among the elderly, and delays in cardiac patients being discharged from hospital.

Integrated Care Pathways (ICPs) set standards of care for operations and the treatment of diseases. Linked to the best research evidence available at any one time, the pathways ensure care is of the same high quality from patient to patient and that elements of care are not missed out. Eight new pathways were developed in 2003/04 including treatments for community-acquired pneumonia, urinary tract infections and acute coronary syndromes.



Brian

Brian is 66 years old. He lives in Guildford.

Four months ago, he was diagnosed with a heart condition called angina.

He has come to St George's for a major operation on his heart called a coronary artery bypass graft.

Day 1 – 13.51

Brian and his wife Veronica arrive at the hospital. His operation is eighteen hours away.

They make their way up to Benjamin Weir ward, a specialist ward for cardiothoracic patients, where they are given a warm welcome by staff nurse Jane Wall. She shows them around the ward and to his room.

14.25

Over the next hour, a steady flow of doctors, nurses and anaesthetists file in to Brian's room. They explain what will happen in his operation and check to make sure he is fit for surgery – even though he has already passed a pre-operation assessment three weeks ago.

If the operation goes to plan, Brian should be able to leave hospital by the weekend – a prospect he is clearly looking forward to:

'The sooner I get home the better,' he says.

On the surface, Brian seems relatively healthy. He hasn't touched a cigarette in 30 years and he swims regularly – or at least he did until he started having problems.

Modern care

With every year that goes by, the vision of a modern NHS – where waiting times are low, and patients have equal access to treatment regardless of where they live – starts to become a reality.

Waiting times for operations, appointments and diagnostic scans at St George's continued to fall in 2003/04 as services became faster and more convenient for patients.

More operations were performed. New services were built around the needs of patients. We discovered new ways of working to bring old services up-to-date. And the power of new technology was used to help doctors and nurses deliver better patient care.

Waiting times fall

Our goal this year was to reduce the maximum waiting time for an operation to nine months and the maximum waiting time for a first outpatient appointment to 17 weeks.

At the end of March, no one was waiting more than nine months for surgery with two out of three patients waiting less than 61 days.

And even though 54 patients waited more than 21 weeks for a first outpatient appointment in the early part of the year, by the end of March no one was waiting more than 17 weeks.

The fall in waiting times was partly due to an increase in the number of operations performed. Figures show a 3.6% rise in the number of procedures carried out in 2003/04 compared to the previous year – an extra 139 operations per month.

Similar progress was made in radiography where, with new investment in staff and equipment,

- The wait for an MRI scan fell from four months to ten weeks
- The wait for a CT scan fell from seven weeks to four weeks
- and the wait for an ultrasound fell from ten weeks to a fortnight.

Main photo: Heart patient Brian Brigden is assessed for surgery by anaesthetics registrar Aasifa Darugar
Left to right: Brian and his wife Veronica arrive at St George's for his operation. Teaching sister Sheridan Buchanan talks to Brian about what will happen in the operation tomorrow.

'I didn't have any problems until after Christmas,' he explains. 'I got out of breath doing simple exercises, like taking the bin bags out.'

Since then, he has been seen quite quickly. He saw a consultant in February, had an angiogram in April, and now – three months later – is at St George's for his operation.

'It's been very quick,' he says.

Day 2 – 07.57

Brian has been awake for the last hour.

There is a knock at the door and Jane, the staff nurse, peers in.

'Right: are we all ready?,' she asks.

Brian climbs on to the operating trolley and is taken the short distance from the ward to the suite of operating theatres, and into a small room adjacent to the theatre where he will 'prepped' for surgery.

Brian's operation will be different to most in that he has agreed to take part in a surgical trial.

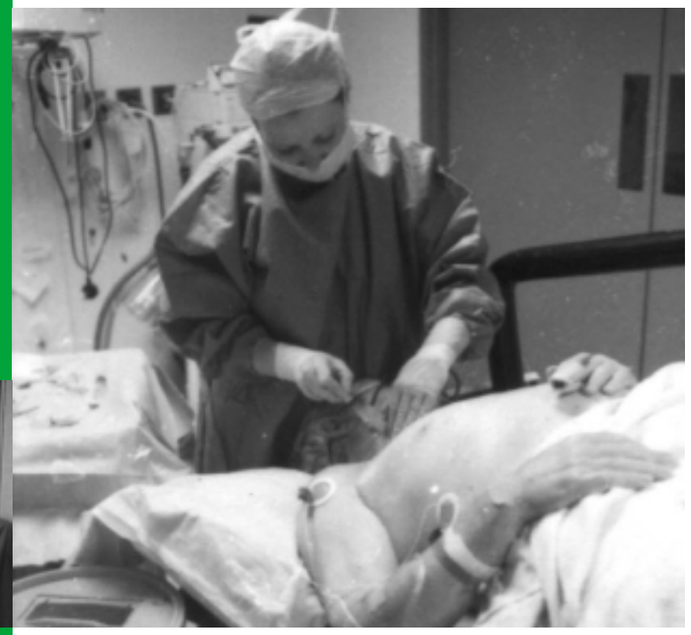
In normal open heart surgery, the heart is stopped and put on a bypass machine.

Brian however has been randomly selected to have his operation 'off bypass'.

The surgical team are attempting to discover if patients who have operations without the aid of a bypass machine have fewer complications following surgery.

Brian retired over a year ago after a life-long career in the pharmaceutical industry. And it was his work, he believes, that made him volunteer for the trial.

'If it's going to help someone else later on or be a revolutionary type of surgery, then I'm all for it,' he says.



Above: Brian is taken through into the anaesthetics room
Main photo (right): Anaesthetist Yvonne Looney prepares Brian for surgery

Choose and book

Services became more convenient this year as more and more patients were able to choose when they came in to hospital.

In March, 89% of operations and day case procedures were booked as were 73% of outpatient consultations.

Under this system, patients are able to book a date for their operation or appointment at a time that is convenient for them.

Patients are set to be given even greater choice in 2005 with the launch of a national system called 'choose and book'.

Patients needing heart surgery can already choose to have their operation at St George's if they have to wait more than six months at another hospital.

But by Christmas of 2005, patients from across the country will be able to choose from between four or five hospitals they are referred to by a GP and be able to book the outpatient appointment using a national electronic and telephone booking service.

Faster emergency care

Nowhere has progress been more apparent than in A&E where over 86,000 patients were treated this year.

In December 2002, five out of ten patients were looked after in four hours.

In the final three months of this financial year, nine out of ten patients were treated in that time despite a huge rise in the number of patients seen. A&E staff treated 6,500 more patients this year compared to 2002/03. On one day alone in March, over 300 patients came to us for help – the highest number of attendances ever recorded in a single day.

The speed with which treatment is now given in A&E follows a comprehensive review of the way care is organised in the department.

A single check-in procedure when a patient first arrives in casualty has cut down on paperwork.

A fourth consultant and a new nurse consultant have been appointed.

Three new roles were created, including an x-ray co-ordinator, a porter to take patients to the Medical Assessment Unit (MAU), and a physiotherapist. (The x-ray co-ordinator in particular has saved up to a third of the A&E radiographer's time).

"My 7-month old son was seen within minutes of arrival at A&E and was given the most dedicated and professional care I have witnessed in the NHS."

Father of patient

Two clinical decision units successfully reduced the number of patients admitted from A&E to a hospital bed. The units – one for adults and one for children – were set up for patients who need more detailed tests carried out and their condition monitored before a decision can be made about their treatment.

A separate unit inside A&E was created to make sure patients with minor injuries were treated and sent home within four hours.

Finally, a six-bedded surgical assessment unit was tested to see if patients with surgical or urological problems could be fast-tracked through to diagnosis and early treatment before being admitted for an operation or discharged home.

New technology

We took a giant leap this year harnessing the power of new technology to deliver better patient care.

In January, our radiography service went 'filmless.' Virtually all examinations – over 207,000 x-rays, CT, MRI and ultrasound scans every year – can now be viewed via a digital imaging system called PACS (Picture Archiving and Communication System).

The new software, which is integrated with the scanning technology used to perform the examinations, allows doctors and radiographers to view diagnostic pictures on a computer seconds after they have been taken.

As storing the virtual examinations on a computer takes up less physical space than films, clinicians now have access to an ever-expanding library of scans for their patients. Before, because of the sheer space needed to store all the records, films were destroyed after four years.

PACS is also proving to be safer for the environment. Reusable plates have replaced the old x-ray films, which had to be produced using toxic chemicals. And as exposures are more reliable with the new system, fewer x-rays have to be taken which means that patients are less exposed to radiation.

Digital hearing aids

Patients with hearing problems were able to take advantage of the latest technology this year as part of our involvement with the Modernising Hearing Aid Service (MHAS).

As a third wave site for the programme, St George's now gives digital hearing aids to all new patients suitable to have this type of aid.

The digital aids contain a tiny computer that processes sound more precisely than the old analogue aids, which rely on tiny microphones to amplify sound. The computer allows the aid to be finely programmed to suit the individual wearer's hearing ability.

Redesigning services

St George's became a trailblazer site for speeding up treatment in urology and plastic surgery in May 2003 when it was awarded nearly £200,000 by the NHS Modernisation Agency.

Two projects, funded under the banner of the Agency's Action On programme, will reduce

treatment delays for patients with urological problems or injuries and burns that need reconstructive surgery.

The plastic surgery project, which is due to finish in February 2005, will focus on three areas. Two GPs will be trained and supported by St George's to perform minor surgery in the community. Patients needing emergency hand surgery will have their operations done as day case procedures, meaning that more operations will be performed more quickly and without the need for an overnight stay in hospital. And a senior orthopaedics nurse will become the region's Trauma Co-ordinator, liaising with clinical teams across the area to fast-track patients through to St George's for surgery on severe soft tissue injuries to the lower leg.

A new urology outpatients clinic at Queen Mary's Hospital, Roehampton will offer patients access to diagnostic tests and the results of those tests on the same day as their first appointment.

In the past, patients have had to wait anything up to 180 days for a second appointment while tests are carried out.

The one-stop clinic will wipe out the delay and the anxiety of patients waiting several weeks before they are given a diagnosis.

"Your hospital stands out for its cleanliness, modern facilities and helpful staff." Thomas, patient

Outpatient hysteroscopy clinic

In the past, women needing a hysteroscopy – a procedure used to detect cancer of the womb and remove benign lumps or tissue – would either be admitted as an inpatient or a day case patient.

A third of women had to spend up to three days in hospital while the procedure itself might last only 15 minutes.

A new outpatient hysteroscopy clinic launched in February now allows women to return home after just one hour.

The hysteroscopy is now performed with a local anaesthetic and has reduced the length of time women have to wait for the procedure from five or more months to one month following referral by a GP for suspected cancer.

The clinic expects to see 350 women every year.

Regenerating St George's

We spent nearly £10m making our hospitals cleaner and more comfortable for patients, visitors and staff this year, while at the same time increasing the capacity of our services.

The most visible sign of this regeneration was the opening late last year of the Atkinson Morley Wing. A £50m private finance development on the St George's Hospital site, the state-of-the-art facility provides modern accommodation for neurosciences and cardiothoracic services. Four storeys contain over 200 beds, eight operating theatres, five cardiac catheterisation laboratories and an extensive range of diagnostic equipment.

With the completion of the Wing, the remaining mixed sex Nightingale-style wards at St George's Hospital were finally replaced, with single sex accommodation provided at ward level through segregated bays.

The opening of the Wing however was only one of many projects that modernised the fabric of the hospital environment.

Close to 150 paintings for example were placed around the hospital, giving mundane hospital corridors and waiting areas a distinctive character all of their own.

An £800,000 project to refurbish the hospital's maternity unit included the transformation of the delivery suite from a haphazard collection of cramped and depressing spaces into a range of modern, yet warm, birthing rooms. Co-ordinated colours, softer lighting and wood-like flooring have made each room seem more like a home rather than an institution.

And finally, the newly refurbished Ear, Nose and Throat (ENT) outpatient clinic, with its 13 fully-equipped consulting rooms, opened in July, making the department the most modern of its kind in the country.

Praise from PEAT

A team of inspectors from the Patient Environment Action Team welcomed the improvements being made to the hospital's buildings when they visited the Trust at the end of the year. 'Cleanliness across the whole site has improved,' wrote the inspectors in their report, 'and is enhanced by the improved tidiness and refurbishment taking place.'

They also praised staff for being 'open and friendly' and added that there was 'definitely a better spirit around the site from last year.'

The team inspected a number of locations around the hospital, including the outpatients department and A&E, and examined everything from the state of the wards to waste handling, car parking and hospital food.

08.57

Brian is taken into the operating theatre.

Over the course of the next four hours, the surgeon – Mr Chandrasekaran (or Chandra as he is known) – and an eight-strong team will take arteries from Brian's left arm and his chest, and graft them onto his heart.

Everything is ready. All that's left is to give Brian the anaesthetic. Just before he goes under, he whispers a few words to the anaesthetist:

'It all runs like clockwork, doesn't it.'

And with that, he falls asleep.

09.27

Chandra and his team now get to work. It is a long, complicated and delicate procedure. Chandra starts by opening up Brian's chest to gain access to his heart. At the same time, his registrar, Dr Boden, cuts open Brian's left arm to remove an artery for one of the five grafts that will be created.

13.30

Four hours later the operation is over. It has been a success.

Brian is taken from theatre to the recovery area where his condition will be monitored by a team of nurses for the next few hours.

For Chandra, it's a chance to reflect on its success.

'Mr Brigden should make a full recovery,' he says.

'If he hadn't have had the operation he would have been at risk of having a heart attack.'

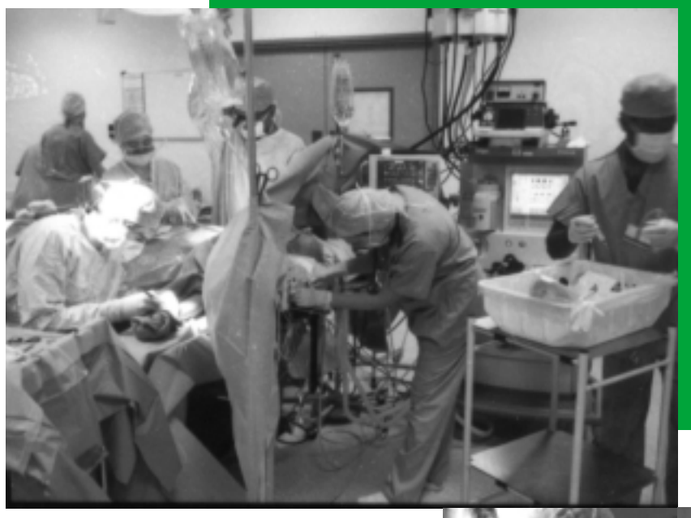
Postscript

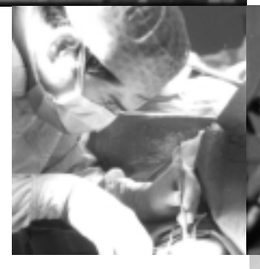
Brian made a full recovery from his operation and woke up later that same day.

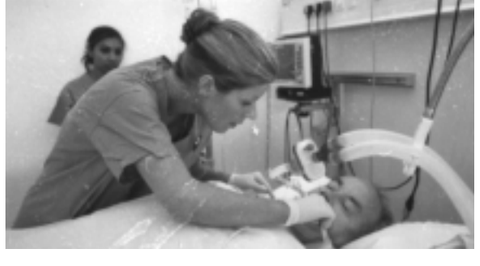
Over the next few days, he was moved back to Benjamin Weir ward, taken off the monitoring equipment, and began work with a hospital physiotherapist to build up his strength before returning home.

He has now been referred for a programme of cardiac rehabilitation at his local hospital.

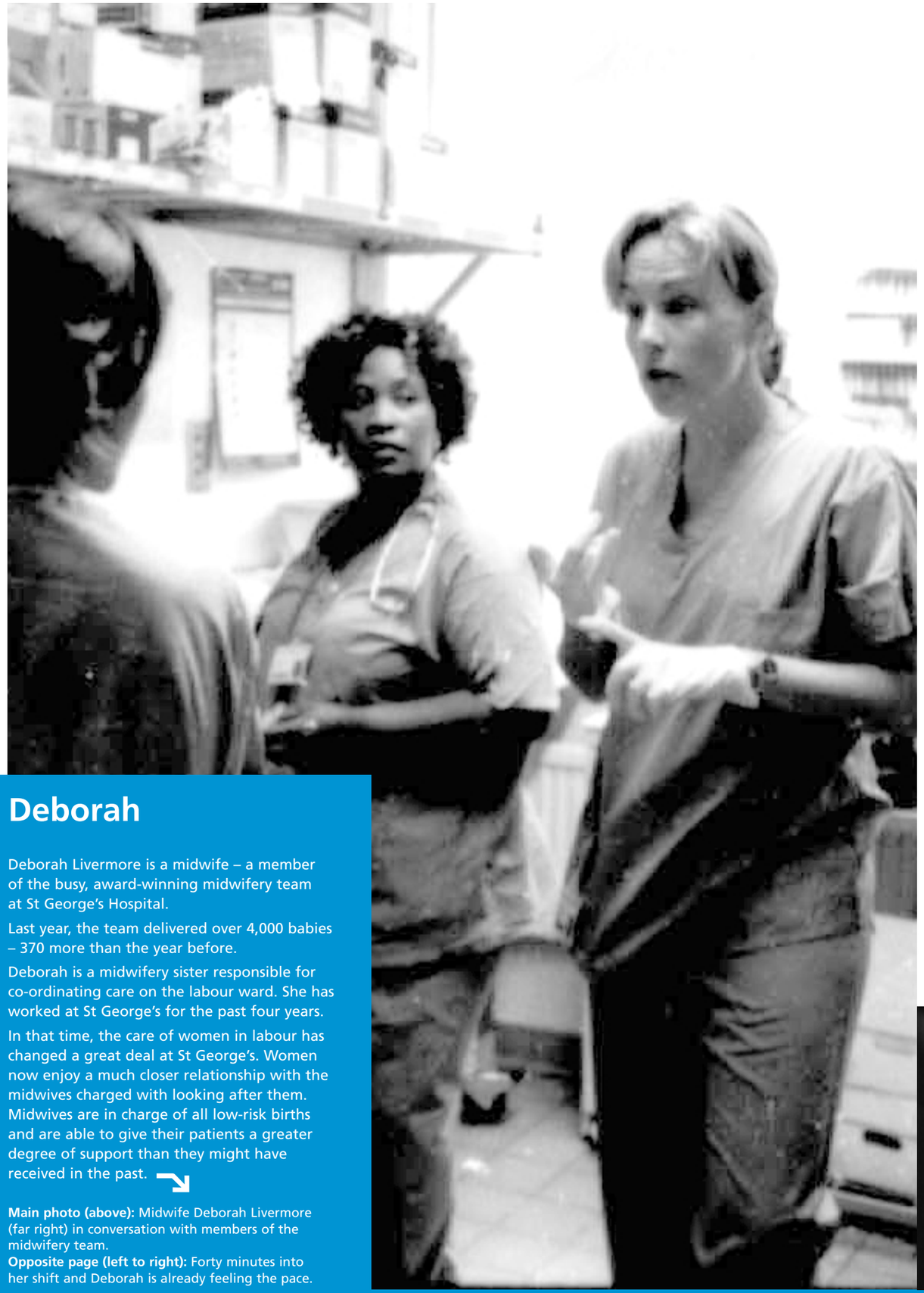
He is looking forward to going swimming again.







Main photo (above): The operation starts.
Right: Registrar Dr Boden removes an artery from Brian's arm
Far right: Anaesthetist Yvonne Looney checks Brian's vital signs while clinical research fellow Gunaratnam Niranjani looks on.
Below right: Recovery nurse Denise Crossan checks on Brian's progress after the operation.



Deborah

Deborah Livermore is a midwife – a member of the busy, award-winning midwifery team at St George's Hospital.

Last year, the team delivered over 4,000 babies – 370 more than the year before.

Deborah is a midwifery sister responsible for co-ordinating care on the labour ward. She has worked at St George's for the past four years.

In that time, the care of women in labour has changed a great deal at St George's. Women now enjoy a much closer relationship with the midwives charged with looking after them. Midwives are in charge of all low-risk births and are able to give their patients a greater degree of support than they might have received in the past.

Main photo (above): Midwife Deborah Livermore (far right) in conversation with members of the midwifery team.
Opposite page (left to right): Forty minutes into her shift and Deborah is already feeling the pace.

Community values

A hospital has a special place in the community that it serves.

First and foremost we are a local hospital. Thousands of families from across the London boroughs of Wandsworth, Sutton and Merton rely on St George's to care for them when they are sick or in pain.

But with over 5,000 staff, we are also one of the largest employers in the region and a major contributor to the local economy.

Proud of our diversity

We are proud of our place in the community, and are keen to embrace the many cultures and traditions that make it so diverse.

That diversity is reflected in our staff, over 40% of whom are black or of another minority ethnic background.

We value that diversity and see it as a strength. By mirroring the diversity that is all around us, our staff are better placed to understand and provide for the cultural and spiritual needs of all our patients, whatever their ethnicity.

But diversity isn't just about colour.

As a hospital and employer, we believe everyone should be valued equally, regardless of their age or disability, their faith or colour of their skin, their sex or sexuality, or the country in which they were born.

Information and Involvement

The views of patients, members of the public, our staff, and everyone who has a stake in the running of the hospital are important to us.

By engaging the people we treat in a dialogue about the services that we run, we can make sure our care is centred on their needs not ours. In other words, we can become a truly public service.

Our values

- We will contribute responsibly to the community that we serve
- We will listen to the views and opinions of our patients and the public, and involve them in the running of our services
- We will embrace the rich cultural diversity of the community that surrounds us
- We will treat all our employees and patients fairly and equally, regardless of their gender, ability, race, faith or colour

Listening to patients

There are a variety of ways in which patients can make their views known and their voices heard.

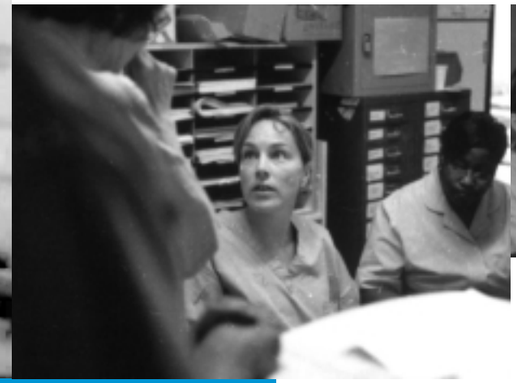
The Patient Advice and Liaison Service (PALS) was created three years ago to give advice and information to patients about the hospital, and provide on-the-spot help with their problems.

PALS received a record number of enquiries this year – over 1,200 contacts (up 40% from the previous year). Of these, nearly 60% were answered within one week.

In December, we welcomed the launch of the new patient forum – an independent group of people drawn from the local community who will help to shape services at St George's.

Patient forums have replaced Community Health Councils and there is one for every NHS Trust and Primary Care Trust in England.

Although the relationship between St George's and the forum is still in its infancy, we look forward to working more closely with the forum and its members in the future.



Under Section 11 of the Health and Social Care Act of 2001, we now have a legal responsibility to involve and consult patients and the public whenever we plan or make changes to our care.

Over the last two years there have been more than 100 projects that have involved patients in the development of services, either though focus groups, interviews, or participation in Trust committees.

The views of our patients are also sought through regular, large-scale surveys.

The Department of Health requires every NHS Trust to obtain feedback from patients about their experiences of care. The information is used to identify priorities for improving the quality of services and to monitor progress against targets contained in the NHS Plan.

"I was treated with the utmost courtesy and care. I have nothing but praise for every member of staff." Robert, patient

A survey of inpatients, carried out for St George's by an independent research company in January 2004, showed that 40% of those asked rated the quality of care at St George's as 'excellent' – up from 29% two years ago.

Overall, nearly 90% of inpatients thought the care they received was 'good', 'very good', or 'excellent', while the number of people who said they would recommend the hospital to friends and family rose from 54% in 2001 to 62%.

What patients thought of our services this year:

- **89.4%** of patients thought the care they received was 'good, 'very good' or 'excellent'.
- **62.5%** of patients would recommend St George's to their friends and family.
- **48.4%** of patients thought the room or ward they stayed in was 'very clean' – up from 37.6% in 2002.
- **84.4%** of patients said they were given enough privacy when they were examined or treated.
- **36.5%** of patients had to share a room or bay with patients of the opposite sex – down from 52.7% in 2002.
- **90.2%** of patients rated the courtesy of nursing staff as 'good', 'very good', or 'excellent'.
- **80.1%** of patients 'always' had confidence and trust in the doctors treating them.

Source: St George's Inpatient Survey 2004

Over 500 patients were surveyed this year and while the results show a number of areas in which St George's is doing well, such as improved cleanliness, it also highlighted several aspects of care that we need to improve, such as the privacy of our patients when their condition or treatment is discussed.

Complaints and improvements

From time to time, we know our services fail to meet the high standards expected by patients.

Although we are always sorry when standards slip, complaints allow us to gain a deeper understanding of what patients experience when they come to hospital.

We received nearly 800 complaints in 2003/04, 50 more complaints than the previous year.

We also received 252 letters that thanked staff for the care that had been received. On top of that, there were over 5,700 cards, notes, donations and gifts given to wards and clinics by grateful patients.

The four most common complaints of 2003/04 – and indeed, of 2002/03 – were:

- The quality of clinical care
- Delays and cancellations in outpatient appointments
- Communications and information given to patients
- And the attitude of staff

In response to the complaints received this year, we made a number of changes to our services:

- The patient transport service now calls patients wherever possible to let them know if there will be a delay in picking them up
- A&E has purchased a safe to store the valuable possessions of patients
- And the new digital imaging system for viewing x-rays, CT and MRI scans can now be accessed in the consulting room where paediatric neurologists hold their clinics. Parents can now view their children's scans during an appointment.

When you make a complaint, you should expect to receive the following:

- A letter acknowledging receipt of the complaint sent to you within two working days
- And a full written response to your complaint from the chief executive within 20 working days

We had to achieve 85% compliance against each aspect of the complaints process this year. In other words, at least 85% of full written responses for example had to be sent within 20 working days.

Main photo (above): Deborah takes a phone call from a woman concerned about the health of her unborn baby.

Top right: Discussing a case with registrar Asmita Patwardhan.
Above: Examining a woman due for a caesarean section.

We failed to achieve these targets, issuing 79% of acknowledgement letters within two working days and 49% of full written responses within 20 working days.

However, a range of measures set to be introduced next year will improve our performance in this area.

If, after receiving a full written response, you are still unhappy with the way your complaint has been handled, you can request an Independent Review of your case.

We received 16 such requests this year. Of these, five complaints were referred back to the tTrust for resolution, eight were rejected, and three complainants chose not to pursue the request. Two reviews were requested in the previous financial year and were completed in this one.

08.11

Deborah is now forty minutes in to her shift. She has already stabilised the condition of a woman who gave birth two hours ago and taken an anxious phone call from a desperate woman, 24 weeks pregnant. The woman lost her first baby and is naturally concerned about the health of her second.

Deborah advises the woman to come in.

09.26

The woman who phoned earlier arrives with her worried partner in tow.

Deborah takes her to one of the birthing rooms to check on her condition. Accompanying her is Claire, a first year student nurse from Kingston University who is observing Deborah today.

Thankfully, both mother and baby are fine. But just to be on the safe side, Deborah discusses the case with registrar Asmita Patwardhan.

Half an hour later the woman leaves, looking visibly reassured.

11.41

A woman is rushed down from the hospital's day assessment unit. She was due to have a caesarean section two days from now but her waters have broken. This will be the woman's third child born at St George's. The procedure will have to be brought forward to this afternoon.

13.13

Ginny and Mark, a young couple from Tooting, arrive at the delivery suite. This will be their first baby.

They have both been up since five a.m. 'We'll make Ginny as comfortable as possible,' says Deborah, 'and let nature carry on.'

Over the course of the next few hours, Deborah will keep a close eye on Ginny and her baby, checking its heart rate and watching out for signs of distress.

18.15

Deborah has been in theatre for the last hour with the woman who came in earlier needing a caesarean section. The procedure went smoothly, and mother and baby are brought back to the delivery suite to rest.

Deborah checks back with Ginny and Mark. Ginny's contractions have become more frequent. Nevertheless, she seems happy and relaxed (although that may have something to do with the epidural which Deborah has just topped up).

'I don't know how women used to do this without an epidural,' says Ginny.

Mark sits by Ginny's bedside, the look on his face reveals he is far more nervous than she is.

'We're almost there,' says Deborah.

19.47

Over an hour and a half later, Ginny starts what will be one of her final contractions. Mark is there, clutching her hand and encouraging her to push.

Minutes later, the baby is born – a beautiful baby boy weighing a healthy 7lb and 10 ounces. Deborah passes the baby straight to Ginny. The look on her face is enough to bring a smile to Deborah's.

A hushed stillness descends on the room as Ginny and Mark gaze into their eyes of their newborn son.

From the corridor, Deborah hears a hubbub of noise and laughter. The night shift has arrived.

20.11

It is now more than 13 hours since Deborah arrived at work. All that's left for her to do is the 'handover' – a chance to sit down (at long last) and pass the cases in her care over to a midwife on the next shift.

She finally leaves a few minutes after half past eight, completely exhausted and in need of a good night's rest.

Top left: Soon-to-be mum Ginny begins one of her final contractions.
Main photo (top right) and above: Minutes later, Ginny and Mark see their newborn son for the first time.

You can also ask the Health Service Ombudsman to investigate your complaint if you feel it has not been dealt with appropriately or if an Independent Review has been refused.

The Ombudsman returned the report of one complaint referred in the previous year.

Patient information

Giving patients clear, well-written information about conditions and treatments is an invaluable way of helping them understand the disease they are living with or the operation they are to have.

There are now more than 120 information leaflets in circulation at St George's, co-ordinated by a newly-appointed full-time patient information officer. Titles cover a wide range of health topics such as home births, healthy eating for diabetes, tissue donation, post mortem examinations, coronary procedures, travel and deep vein thrombosis (DVT) and MRSA. More than 50 publications are in development at any one time.

"The advice and counselling I received was informative and reassuring throughout, not only to myself but to the rest of my family." John, patient

An employer of choice

We aim to be an employer of choice – a place where people want to work.

We believe all of our employees should have a healthy balance between their life at work and their life outside of work. And we are equally as committed to helping everyone develop new skills and reach their full potential.

Consulting staff

We value the opinions of our staff and believe in fostering a culture of openness and transparency, so that they feel able to share their experience of working at St George's to help us become a better employer.

An open forum is held every month where staff can meet the Chief Executive, Peter Homa, and discuss issues of concern.

There is also a Partnership Forum, on which all trade unions with membership with the Trust are represented, and a Partnership Executive, which provides a regular means of ensuring staff-side representatives are involved in the running of the hospital.

Added to which, a survey of staff opinion is held every year. The latest poll, published in March 2004, revealed that the Trust has taken positive steps since the last survey to address staff concerns about training, appraisals about their work and security in the workplace.

The study also found that staff believe the Trust has an open culture for reporting incidents and mistakes.

Staff numbers rise

The number of staff rose this year by 2.4%: from 5,133 in April 2003 to 5,255 in March 2004.

These new staff included:

- 51 consultants, registrars and doctors
- 15 nurses
- 5 radiographers
- 4 midwives
- and 2 physiotherapists

Independent analysis of our employment figures show the effect the extra staff are having on patient care. The number of doctors to beds is proven to have a strong effect on mortality, while the ratio of nurses to beds is an influence on patient satisfaction.

Figures published by Dr Foster show that there were 59 doctors and 152 nurses per 100 beds in the Trust in 2001/02. This increased to 67.9 doctors and 169.2 nurses per 100 beds in 2002/03.

Violence against staff

It is a sad reality that in the world we live in today, doctors, nurses and other hospital staff are often the victims of violence.

In 2003/04, there were 47 assaults on staff by patients and 50 cases where they were abused verbally.

Staff should be free to care for patients without living in fear of attack and we have absolute zero tolerance for such behaviour.

Where appropriate, we will take action and encourage staff to seek prosecution against those responsible.

The final score

Each summer, the Healthcare Commission (formerly known as the Commission for Health Improvement) awards every NHS organisation in the country a star rating based on their performance for the financial year that has passed.

St George's held its ground in this year's performance ratings and kept its two stars for the third year running.

The award, which was announced by the Healthcare Commission on 21 July, shows that we are performing well overall but have not yet reached consistently high standards to merit the top award of three stars.

We achieved seven of the nine key targets and narrowly missed the target to treat 90% of A&E patients in four hours by less than one per cent.

We also failed to achieve the outpatient waiting time target after 54 patients breached the maximum waiting time of 21 weeks for a first outpatient appointment earlier in the year. This was caused in part by computer problems which have since been fixed.

We were placed in the top band of performance for two further categories, which focused on clinical care and patients' access to services, but did less well in areas such as responding to complaints and the number of cancelled operations.

Key targets

The Trust achieved seven of the nine key targets:

- 12 hour waits for emergency admission via A&E post decision to admit
- All cancers: 2 week wait
- Financial management
- Hospital cleanliness
- Improving Working Lives
- Outpatient and elective (inpatient and day case) booking
- Patients waiting longer than the standard for elective admission

We underachieved on the two remaining key targets:

- Outpatients waiting longer than the standard
- Total time in A&E: 4 hours or less

Focus areas

As well as being assessed against nine key targets, trusts are judged on their performance in a further three categories: clinical focus, patient focus, and capacity and capability focus.

Each aspect of performance in these areas is given a score on a scale of one (poor) to five (good).

St George's was in the top band of performance for the clinical and patient focus areas, but was placed in the lowest band of performance for capacity and capability.

Above: A nurse listens to the heartbeat of a baby in neonatal intensive care.
Right: A child in A&E has a plaster set on her arm.
Far right: Paramedics bring in a patient to A&E suffering from severe chest pains

Clinical focus

Thrombolysis – 30 minute door to needle time	★★★★★
Child protection	★★★★★
Clinical governance composite indicator	★★★★★
Composite of participation in audits	★★★★★
Indicator on stroke care	★★★★★
"Winning ways" – processes and procedures	★★★★★
Clinical negligence	★★★
Deaths following a heart bypass operation	★★★
Deaths following selected non-elective surgical procedures	★★★
Emergency readmission following discharge (adults)	★★★
Emergency readmission following discharge for a fractured hip	★★★
Infection control	★★★

Patient focus

Patients waiting longer than standard for revascularisation	★★★★★
Breast cancer: 1 month diagnosis to treatment	★★★★★
Day case patient booking	★★★★★
A&E emergency admission waits (4 hours)	★★★★
Delayed transfers of care	★★★★
Adult inpatient and young patient surveys: access and waiting	★★★
Adult inpatient and young patient surveys: better information, more choice	★★★
Adult inpatient and young patient surveys: building closer relationships	★★★
Adult inpatient and young patient surveys: clean, comfortable, friendly place to be	★★★
Adult, inpatient and young patient surveys: safe, high-quality, co-ordinated care	★★★
Better Hospital Food	★★★
Breast cancer: 2 month GP urgent referral to treatment	★★★
Six month inpatient waits	★★★
Thirteen week outpatients	★★★
Cancelled operations	★
Patient complaints	★

Capacity and capability focus

Hospital Episode Statistics (HES) and Workforce datasets: data quality on ethnic group	★★★
Staff opinion survey: health, safety and incidents	★★★
Staff opinion survey: human resource management	★★★
Staff opinion survey: staff attitudes	★★★
Information governance	★★
Consultant appraisal	★
Junior doctors' hours	★

For more information about star ratings, please visit
http://ratings2004.healthcarecommission.org.uk/

Creating our future

We want to make St George's a hospital that everyone can be proud of, and the test we now face is to build on the progress that has already been made.

There are a number of ventures planned for next year and beyond that will make the care we give our patients even better, safer and faster.

Our ambition is to transform St George's into one of the best hospitals in the country, and enhance its reputation as a centre of outstanding patient care, high-quality teaching and innovative research.

1 We will continue to improve clinical care for our patients by making treatment more convenient.

A special project has already been launched to improve the convenience of care for inpatients by looking at services through their eyes. The project, which will look at the 'elective patient journey', will examine what happens when patients come in for an operation, pinpoint the delays that occur, and make the journey of care faster.

Linked to this programme are two schemes that hope to reduce the amount of time a patient has to spend in hospital both before and after an operation.

Starting this year, a new ward management system will help doctors agree the date that a patient will return home as soon as they arrive in hospital for an operation.

Reducing the length of stay in this way will allow patients to leave hospital far sooner than they might have done in the past. And if they spend less time in hospital, they are less likely to acquire an infection.

A pre-operation health assessment already used in day surgery will shorten the time spent in hospital before an operation. The assessment, which will be extended to inpatient surgery, will make sure patients are ready for an operation before they come in. This, in turn, should lead to fewer cancellations of procedures (there were 3,820 operations cancelled by the trust this year for medical and non-medical reasons) and make better use of time in our theatres.

2 We will continue to improve access to services by reducing waiting times for emergency treatment, surgery, appointments and diagnostic tests.

By December 2005, we will reduce the maximum waiting time for an operation from nine to six months, and the maximum waiting time for an outpatient appointment from 17 to 13 weeks.

Each of these targets is well within our reach. At the end of March, only 540 patients were waiting more than six months for an operation, and only 195 patients were waiting more than 13 weeks for an appointment.

In emergency care, we will seek to ensure that, from January 2005, 98% of A&E patients are cared for in four hours or less.

Waiting times for diagnostic examinations, such as MRI and CT scans, will also be reduced.

"The surgical treatment I received was outstanding and the nursing care was exceptionally good."

Patient

3 We will continue to create the financial stability we need to develop our services, by reducing costs, by becoming more efficient in the way we provide services, and by securing additional income wherever possible.

4 We will continue to improve the hospital environment.

A comprehensive strategy for our estates and buildings is being developed which will not only create the physical space and capacity we need to deliver first class care for our patients, but also consider new ways for our buildings to support different models of care.

We will also spend more than £16m in 2004/05 on a number of capital projects.

A new £4.6m endoscopy unit – one of three national training centres for endoscopy – will open in the autumn and reduce waiting times for the diagnostic and therapeutic procedure used to detect gastro-intestinal cancers. GPs, nurses and allied health professionals will be among those to benefit from training at the centre, leading to a much wider proficiency in the procedure among health professionals.

Over £1.6m will be spent next year to improve pharmacy services.

A new operating theatre called St James 7 is set to open in August 2004 and will allow us to increase the number of operations we perform.

The intermediate care facilities, the therapy area and the day hospital at the Bolingbroke Hospital in Wandsworth will be refurbished.

Over £1m will be spent upgrading the renal unit at St George's Hospital with a view to developing it into a tertiary treatment centre.

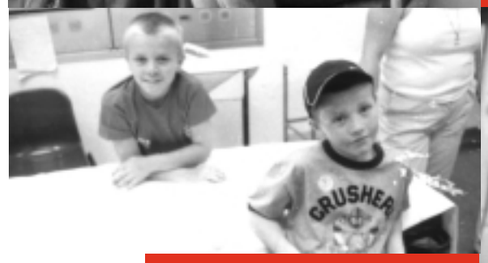
A new maxillofacial laboratory will transform St George's into the regional centre for maxillofacial treatment.

And a new patient information centre will open later in the year.

5 We will continue to deliver care as close to a patient's home as possible.

We will work closely with local GPs and primary care trusts to deliver specialist care in the community wherever possible and clinically appropriate, particularly for the management of chronic diseases such as chronic obstructive pulmonary disease (COPD) and diabetes.

By 2006, we will aim to move 10% of outpatient care from hospital to primary care through the use of General Practitioners with a Special Interest.



Top: A husband comforts his wife as she waits to see one of the hospital's midwives.
Above: Local youngsters in A&E
Main photo (right): A mother peers down at her baby daughter as she keeps her warm.

Top left: A&E nurses Rachel Colley and Sally Toden review the treatment of a patient.
Below left: Clinical research fellow Gunaratnam Niranjani stands over a surgical patient awaiting an operation.
Main photo (right): A dialysis patient with a nurse

Below (left to right): An elderly patient has her bloods taken in A&E. An A&E doctor checks the abdomen of a young girl brought in with stomach pains. Student doctors receive advice from a consultant. Operating theatre practitioner Richard Maynard adjusts a drip.

6 We will continue to lay the foundations of patient choice.

The NHS is changing to give patients a greater say in when, where and how they are treated. By December 2005, patients across the country will be able to choose from between four or five providers which hospital or consultant they are referred to by their GP for a first outpatient appointment. Patients will be able to book their appointment electronically immediately with their GP or practice staff, call a telephone booking service or book it via the internet.

We will continue to develop the infrastructure, the technology and the skills of our staff to support the introduction of Choice.

7 We will continue to improve the health of our local community and increase access to healthcare in South West London by working closely with GPs, our partners in primary care, neighbouring hospitals, London Ambulance, the Strategic Health Authority, local government, voluntary agencies and charities.

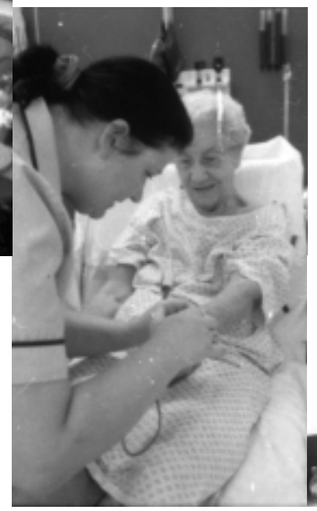
8 We will continue to develop our workforce so that there are the right numbers of staff in the right place at the right time to meet the needs of our patients.

As services develop and expand, our workforce will continue to grow. New roles and new ways of working will be phased in to ensure care is made better, safer and faster for our patients. The boundaries that exist between jobs will be pushed back to enable staff to become multi-skilled in patient care.

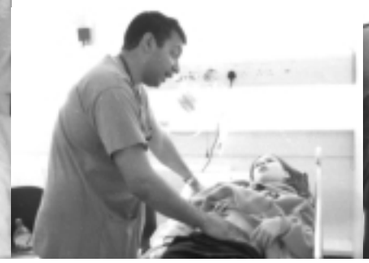
Finally, we will build on the Trust's culture of leadership and change so that staff have the freedom and confidence to innovate and improve the care they give their patients.

9 We will continue to work closely with local education providers, such as the St George's Medical School, Kingston University, local schools, colleges of further education and the South West London Workforce Development Confederation to plan and provide educational opportunities for all of our employees to reach their full potential.

10 We will continue to work with staff and their representatives to prepare for the introduction of the new national consultant contract, the working time directive for junior doctors and Agenda for Change – an NHS-wide programme aimed at improving pay and conditions for staff.



"Congratulations on the running of this huge hospital, with such caring and dedicated staff, from the most humble employee to the top consultant." Patient



Our board

St George's Healthcare NHS Trust is managed by a Trust board which consists of the Chairman, the Chief Executive, full-time executive directors and part-time non-executive directors.

The role of the board is to

- set the overall strategic direction of the Trust
- ensure that the Trust provides high quality, effective and patient-centred care
- provide effective financial control
- ensure high standards of corporate governance
- and help promote links between St George's and the local community

Public meetings of the Trust Board are held regularly and provide the opportunity for staff, patients and the public to attend and to ask questions about the running of the hospital.

Naaz Coker Chair
Member of the Remuneration Committee

Naaz was appointed Chair of the Trust in November 2003 following the retirement of the former Chairman, Catherine McLoughlin, in October.

Naaz's career spans 30 years in the public and voluntary sectors. She spent 20 years in the NHS where her roles ranged from Pharmaceutical and Clinical Director to General Manager in acute NHS trusts.

She then spent ten years with the King's Fund, a large charitable foundation working in the field of health and social care, where she was the Director of the Race and Diversity Programme and fellow in Leadership Development.

Naaz has been Chair of the British Refugee Council since 1998 and has written widely on racism and ethnic health inequalities in the NHS.

Diane Mark Vice-Chairman
Member of the Audit Committee. Member of the Remuneration Committee

Diane Mark was appointed as non-executive director in May 2000. Her professional background is in banking.

Diane holds a variety of public and voluntary appointments, including a Lay Observer with the Preliminary Investigations Committee of the Royal College of Veterinary Surgeons, a Justice of the Peace on the Wimbledon Bench, a Treasurer of a local residents association, as well as working at the Citizens Advice Bureau.

She has recently been appointed a Trustee of St George's Charitable Foundation.

Professor Sean Hilton Non-executive director

Professor Sean Hilton joined the Trust Board as a non-executive director representing the Medical School and the University of London. He has been a general practitioner in Kingston upon Thames for 25 years, and since 1993 has been Professor of General Practice and Primary Care at the Medical School.

His main academic activities have been in undergraduate education and in research in primary care. From 1997-2002 he was Dean of Undergraduate Medicine in the School.

His interests include development of the NHS at the primary/secondary care interface, disease prevention and medical professionalism.

Valerie Vaughan-Dick Non-executive director
Member of the Audit Committee. Member of the Remuneration Committee

Valerie took up her position on the board in May 2002. Valerie lives locally and has a long standing connection with healthcare services and voluntary bodies. She is a Chartered Public Accountant and has held senior positions in a number of public and voluntary sector organisations.

David Knowles Non-executive director
Member of the Audit Committee. Member of the Remuneration Committee

David Knowles was appointed a non-executive director in January 2000. He has experience in a wide range of managerial roles in health services, in the NHS and in Canada and was, for 18 years, District Administrator, District General Manager and Chief Executive of Central London Health Districts. In 1992 he retired from the NHS and joined the King's Fund where he is now Director of Leadership Development.

Ashley Elsdon Non-executive director
Member of the Remuneration Committee

Ashley Elsdon is currently Product Development Manager (Housing and Protection) for Legal and General. Alongside his professional career, Ashley is actively involved in several voluntary projects. He is Chair of Governors of Priory Special School and has been a volunteer for the charity Nightwatch. He has been involved in the health service since becoming a member of Croydon Community Health Council in 1996. He has been a member of the Board since November 1998.

Dr Peter Homa CBE Chief Executive

Peter was appointed Chief Executive in November 2003 and succeeded the Trust's former Chief Executive Ian Hamilton.

After completing the NHS National Management Training Scheme in London in 1981, Peter gained extensive healthcare management experience working in various hospitals in England and Canada.

In 1989, he joined the Leicester Royal Infirmary and became Unit General Manager and subsequently Chief Executive. In 1998, Peter was selected to create and lead the NHS Executive's National Patients' Access Team to help reduce the number of patients waiting for NHS treatment.

In August 1999, he was appointed as the inaugural director for the Commission for Health Improvement and received a CBE for services to health care in the 2000 Queen's birthday honours list. Peter is an Honorary Professor of Health Policy at the London School of Economics and is Past President of the Institute of Health Service Management.

Marie Grant Director of Operations

Marie was appointed to the Trust in September 2000 as Director of Nursing having previously been Executive Director of Nursing and clinical development at the Whittington Hospital for five years. She has presented at many national and regional conferences.

Marie has held a number of senior management positions throughout her career in the NHS including the first non-medical clinical directorship in the UK.

She was appointed Director of Operations within the Trust in March 2002.

Professor Paul Jones Medical Director

Paul is Professor of Respiratory Medicine at St George's Hospital Medical School. He became Medical Director in November 1998.

He was appointed Clinical Senior Lecturer in the Medical School and Consultant Physician at St Helier Hospital in 1985. At St Helier Hospital he became the Clinical Director for Medicine and Care of the Elderly when it became a first wave trust. He transferred his clinical work to St George's in 1995 and became Service Delivery Unit (SDU) Leader for Chest Medicine, then SDU Leader for General Medicine. He heads a world-leading research team in the field of health status measurement for chronic lung disease.

Sue Cooper Acting Director of Nursing

Sue was appointed Acting Director of Nursing in April 2003, having previously been the Deputy Director of Nursing and Head of Nursing for Surgery and Clinical Support Services.

She has held a number of senior positions in clinical neurosciences, management and research. Sue has a passion for nursing and a special interest in developing and empowering the roles of ward sister and charge nurse to improve the patient's experience of care.

She also has an interest in the role of art and design in healthcare to improve the hospital environment for staff and patients.

Kevin Harbottle Acting Director of Finance

Kevin was appointed Acting Director of Finance in August 2002, having been the Trust's Deputy Finance Director for the previous six years.

He joined the NHS in 1983 and qualified as an accountant in 1988, later becoming a fellow of the Chartered Institute of Management Accountants. Since qualifying he has held a number of senior financial posts within the local health economy. He is also secretary to the Association of UK University Hospitals Finance Directors' Group.

Janet Hunter Director of Modernisation

Janet was appointed Director of Modernisation in May 2002, having previously been a Director at Oxfordshire Health Authority. She joined the NHS in 1990 and has held several senior positions leading service and organisational change.

Prior to this, she worked in the voluntary sector and was a Community Health Council (CHC) Chair.

She holds a Masters level qualification in public administration.

Colin Watts Director of Human Resources

Colin was appointed Director of Human Resources when the Trust was first established. His previous career in the NHS included a number of senior HR posts, and a long association with St George's.

He was originally from the engineering industry, where he obtained his MSc in management, and then worked as a training officer before joining the NHS.

Until recently he was a governor of South Thames College, having also spent a period as Chair.

He is currently a member of the Service Delivery and Organisation (SDO) research and development board, which is part of the Department of Health.

He is also a governor of Kingston University and an external member of the Standards Committee of the London Borough of Wandsworth.

Board members' attendance at meetings in 2003/04

Non-executive Directors	
Catherine McLoughlin	Attended 6 of 6 meetings
Naaz Coker	Attended 6 of 6 meetings
Ashley Elsdon	Attended 7 of 12 meetings
Sean Hilton	Attended 3 of 5 meetings
David Knowles	Attended 8 of 12 meetings
Diane Mark	Attended 10 of 12 meetings
Valerie Vaughan-Dick	Attended 10 of 12 meetings

Executive Directors	
Ian Hamilton	Attended 3 out of 4 meetings
Peter Homa	Attended 8 of 8 meetings
Sue Cooper	Attended 11 of 12 meetings
Marie Grant	Attended 9 of 12 meetings
Kevin Harbottle	Attended 12 of 12 meetings
Paul Jones	Attended 11 of 12 meetings
Janet Hunter	Attended 10 of 12 meetings
Colin Watts	Attended 11 of 12 meetings

Financial summary 2003 – 2004

In 2003/04 St George's Healthcare reported a deficit of £11,766,000 (excluding financial support £1,116,000) on income and expenditure and a 3.8% rate of capital cost absorption which is within the materiality range 3.0% to 4.0% required by the NHS Executive.

The Trust met both its Capital Resource Limit and its External Financing Limit.

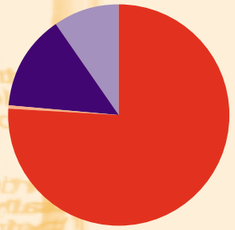
The following statements represent a summary of financial information about the Trust.

Signed on behalf of the Board on 21 July 2004

Peter Homa, Chief Executive

Colin Gentile, Director of Finance

Income by Source
for the year ended 31 March 2004

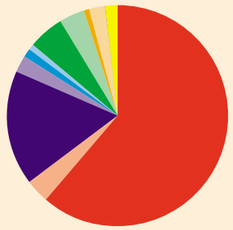


	£000
NHS Patient Care	241,034
Patient Care (Other)	1,516
Education, Training & Research	44,295
Other	30,652

Top five suppliers:

- Dräger Medical
- Medtronic
- Boston Scientific
- Johnson and Johnson
- Guidant

Expenditure by type
for the year ended 31 March 2004



	£000
Pay	194,913
Services from other NHS Trusts & Bodies	11,060
Clinical Supplies & Services	53,408
General Supplies & Services	7,870
Establishment	3,969
Transport	2,635
Site	16,694
Depreciation	11,843
Clinical Negligence	2,479
Other Finance Costs & Other	7,335
Auditors Remuneration	156
Public Dividend Capital Dividend Payable	5,785

The full annual accounts are available on request from the Director of Finance, Bronte House, St George's Hospital, Blackshaw Road, London SW17 0QT. Telephone: 020 8725 1346

Statement of directors' responsibility in respect of Internal Control

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

Accountability for Risk Management is set out in the Trust's Risk Management Strategy, as detailed below.

The overall responsibility for Risk Management in the Trust lies with the Chief Executive, as Accountable Officer, who also chairs the Trust's Risk Management Committee.

At Executive Director level, during 2003/04, the Medical Director undertook Executive responsibility for managing clinical risk, the Finance Director for managing financial risk and the Director of Operations for managing non-clinical Risk.

The Corporate Governance Manager was the Trust's Corporate Risk Manager, supporting the development of all elements of the Trust's Risk Management Strategy to ensure that the Trust fulfilled its statutory requirements, as specified by the Department of Health and the South West London Strategic Health Authority.

Work with partner organisations has been undertaken through a number of initiatives, such as; a Strategic Direction Conference, to which all local stakeholders were invited, a Strategy and Oversight Committee, participation in the local Overview and Scrutiny Committee, compilation of the Local Development Plan and Service Level Agreement negotiations with local PCTs.

2. 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 organisation's policies, aims and objectives,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The designated system of internal control has not been in place at St. George's Healthcare for the whole year ended 31 March 2004, but was in place by 31 March 2004 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Under the oversight of the Chief Executive and Executive Directors leadership is given to the risk management process by the assignment of corporate roles and responsibilities to managers, within a designated Corporate Governance Directorate, and a robust Governance Committee structure.

A range of Risk Management training and educational opportunities are available for all Trust staff. This is provided by the Corporate Governance Departments, including Clinical and Non Clinical Risk Management, Clinical Effectiveness and Audit, Complaints and Improvements, Patient Advice & Liaison Services, Health & Safety & Fire and Legal Services. There are also awareness- raising training sessions for staff bi-monthly on Adverse Incident reporting and the Risk Management Strategy and Policy and a bi-monthly risk newsletter for all staff.

The Trust seeks to learn from good practice through the use of the in-house Trust magazine 'In Touch', patient forums and involvement groups, patient surveys, compliments and suggestions received, the Trust Risk Newsletter, involvement with the NPSA and the NLRS and benchmarking practices with similar organisations.

4. The risk and control framework

Key elements of the Risk Management Strategy include a risk evaluation matrix based on the 5x5 risk matrix of the AS/NZ Risk Management Standard used by the Department of Health to enable the systematic identification, management and economic control of risks to which the Trust is exposed; a definition of acceptable risk, a strategic Principal Risk Register and Assurance Framework, and a performance scorecard.

Risk Management is embedded into the activity of the organisation through the use of performance management tools, including the use of the results of external Assurance Assessments such as CNST, RPST and CHI, self-assessment of the DOH 22 Controls Assurance Standards and associated action plans. The Trust's performance scorecard includes elements of governance and risk management.

Service Delivery Units also include risk management within their regular Governance meetings and record action taken on their clinical governance logs. Involvement in risk management activities is included within the Trust's objective setting and Individual Performance Review of staff.

The Assurance Framework is a detailed document that includes the Principal risks of the organisation. The following paragraphs describe each element of the framework and clearly demonstrate how this provides evidence to support the Statement on Internal Control (SIC)

- The Trust Board identify strategic objectives in March each year; these are balanced over the areas of core Trust business. Principal objectives for 2003/04 were also identified and these reflected areas identified in the Trust's Principal Risk Register 2002/03 and the findings and recommendations from External Assurances such as CHI and the Risk Pooling Scheme for Trusts (RPST). These are then incorporated into the Trust Corporate Service Plan.
- In addition each Clinical Directorate and other non Clinical Department identify objectives linked to the Strategic and Principal objectives.
- The Risk Management Department co-ordinate the development of a Controls Assurance Action Plan overseen by the Trust Risk Management Committee.
- Risk workshops and meetings are held across all departments of the Trust, from the Trust Board, Executive Team (top down) to individual directorates and departments (bottom up). This facilitates and identifies principal risks to achieving the Trust's Strategic, Principal and Directorate level objectives. The Risk Management and Internal Audit Departments facilitate these activities. Individual risks are then risk rated and scored and action plans devised to mitigate them.

The Trust's Risk Management Committee, Chief Executive, Executive Team and Trust Board closely monitor this process.

Key stakeholders are involved in the management of risks via patient and public involvement activities, Public Board meetings, at which two members of the Patient and Public Forum are participant observers and attendance by the Chief Executive or nominated deputy at the local Overview and Scrutiny Committee. The Trust also recently held a Clinical Strategy day, to which key stakeholders were invited and participated. There is a robust Communication Strategy and Department which liases with the local media and publicises involvement activities. There are also a number of active patient user groups both within the Trust and locally who are involved in service planning and design.

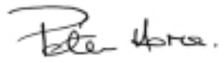
5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by external Audit reports, Internal Audit reports, clinical Audit reports, Controls Assurance Assessments reports from external assurors such as CHI, CNST, RPST, Royal Colleges and other external accreditation bodies.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control through the following internal mechanisms: the Risk Management Department, Executive Team, Risk Management Committee, Audit Committee, Internal Audit, Clinical Governance Committee, the Trust Board and the results of the 03/04 Controls Assurance Standards Assessments.

Action plans to address weaknesses in controls and assurances and to ensure the continuous improvement of the system of internal control is in place.

In addition to the processes outlined previously, further development work is on-going to build on our embedded Assurance Framework. This includes a critical analysis of the action plans to ensure timely and appropriate actions have been and continue to be taken to achieve our objectives. Work to further develop risk management performance indicators within the Trust Performance Scorecard and strengthen links to the Trust Service Plan is also well advanced. Additional action such as restructuring, departmental reviews of risk management processes, further development of risk management education and training techniques such as root cause analysis, linking to the National Patient Safety Agency National Learning and Reporting system is also on-going.



Peter Homa, Chief Executive
21 July 204

Independent Auditors' Report to St George's Healthcare NHS Trust on the Summary Financial Statements

I have examined the summary financial statements set out on pages 37 to 43.

This report is made solely to St. George's Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 54 of the Statement of Responsibilities of Auditors and of Audited Bodies, prepared by the Audit Commission.

Respective responsibilities of directors and auditors

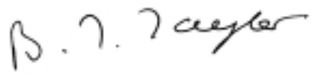
The directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statements with the statutory financial statements. I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion

I conducted my work in accordance with Bulletin 1999/6 'The auditor's statement on the summary financial statements' issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In my opinion the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2004 on which I have issued an unqualified opinion.



Bernadette Taylor
20 August 2004

Audit Commission Fourth Floor Millbank Tower
Millbank London SW1P 4HQ

Related Party Transactions

St George's Healthcare NHS Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as the ultimate controlling party. During the year St George's Healthcare NHS Trust received monies amounting to £11,995,974 from the Department of Health. This relates to grants for training, teaching and research. As at 31 March 2004 the Trust accounts included a debtor balance of £nil and a £440,992 creditor balance with the Department of Health.

The Trust also received £113,693,209 from its main commissioners Wandsworth Primary Care Trust; £49,569,873 from Sutton & Merton PCT and £17,346,653 from Croydon PCT. This related to contract income for patient services. As at 31 March 2004 the Trust accounts included debtor balances with Wandsworth Primary Care Trust £3,522,836; Sutton & Merton Primary Care Trust £1,893,785 and Croydon Primary Care Trust £nil. The Trust accounts included creditor balances with Wandsworth Primary Care Trust £608,909; Sutton & Merton Primary Care Trust £nil and Croydon Primary Care Trust £65,293.

In addition, the Trust received £34,578,108 from the South West London Workforce Development Confederation.

As at 31 March 2004 the Trust accounts included a debtor balance of £750,876 and a creditor balance of £nil.

Catherine McLoughlin CBE, who was the Chair of the Trust Board until October 2003, was also a member of the Board of St George's Charitable Foundation during the financial year.

The Acting Finance Director, Kevin Harbottle has been the Acting Treasurer of the Charitable Foundation since December 2002. During 2003/04 the Charitable Foundation raised charges to the Trust totalling £96,398, and the Trust incurred capital and revenue expenditure to be funded by the Charitable Foundation amounting to £951,606. As at 31 March 2004 the Trust accounts included a debtor balance of £5,640,473 and a creditor balance of £58,852 with the Charitable Foundation.

Another member of the Trust Board, Professor Robert Boyd, was the Principal of St George's Hospital Medical School, which is part of the University of London until his resignation in September 2003. During 2003/04 the Trust raised charges of £1,881,878 for costs incurred on behalf of the Medical School, and the Medical School raised charges of £3,822,334 for costs incurred on behalf of the Trust. These transactions related mainly to clinical staff and overhead costs. As at 31 March 2004 the Trust accounts included a debtor balance of £4,610,355 and a creditor balance of £6,340,159 in respect of the Medical School.

Derek Dundas, Associate Medical Director is a trustee of the George Cordiner Radiological Fund. During the year the Trust made payments to the fund amounting to £nil. As at 31 March 2004 the Trust accounts included a debtor balance of £31,276.

Financial summary 2003 – 2004

Income and expenditure for the year ended 31 March 2004

	2003/04 £000	2002/03 £000	2001/02 £000	2000/01 £000	1999/00 £000 Restated
Income from Activities	244,682	215,344	192,062	169,244	152,504
Other Income	72,815	71,848	59,426	55,376	53,906
Total Expenditure	(318,147)	(282,912)	(250,875)	(224,620)	(212,692)
Surplus/(deficit) for Financial Year	(650)	4,280	613	0	(6,282)

Expenditure by type for the year ended 31 March 2004

	2003/04 £000	**2003/04 %**
Pay	194,913	61.26%
Services from other NHS Trusts & Bodies	11,060	3.48%
Clinical Supplies & Services	53,408	16.79%
General Supplies & Services	7,870	2.47%
Establishment	3,969	1.25%
Transport	2,635	0.83%
Site	16,694	5.25%
Depreciation	11,843	3.72%
Clinical Negligence	2,479	0.78%
Other Finance Costs & Other	7,335	2.30%
Auditors Remuneration*	156	0.05%
Public Dividend Capital Dividend Payable	5,785	1.82%
Total Expenditure	**318,147**	**100.00%**

*Auditors' remuneration relates entirely to services carried out in relation to the statutory audit.

Income by Source for the year ended 31 March 2004

	£000	**%**
NHS Patient Care	**241,034**	75.92%
Patient Care (Other)	**1,516**	0.48%
Education, Training & Research	**44,295**	13.95%
Other	**30,652**	9.65%
Total Income	**317,497**	100.00%

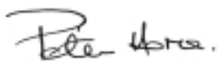
Income and expenditure account for the year ended 31 March 2004

	2003/04 £000	2002/02 £000
Income from activities:		
Continuing operations	**244,682**	215,344
Other operating income		
Continuing operations	**72,359**	71,139
Operating expenses:		
Continuing operations	**(312,181)**	(274,534)
Operating surplus (deficit)		
Continuing operations	**4,860**	11,949
Cost of fundamental reorganisation/restructuring	**0**	0
Profit (loss) on disposal of fixed assets	**(123)**	355
Surplus (deficit) before interest	**4,737**	12,304
Interest receivable	**456**	354
Interest payable	**0**	0
Other finance costs – unwinding of discount	**(58)**	(116)
Other finance costs – change in discount rate on provisions	**0**	0
Surplus (deficit) for the financial year	**5,135**	12,542
Public Dividend Capital dividends payable	**(5,785)**	(8,262)
Retained surplus (deficit) for the year	**(650)**	4,280

Financial summary 2003 – 2004

Balance sheet as at 31 March 2004

	31 March 2004 £000	31 March 2003 £000
Fixed assets		
Intangible assets	**814**	973
Tangible assets	**192,560**	178,293
Investments	**0**	0
	193,374	179,266
Current assets		
Stocks and work in progress	**4,273**	3,437
Debtors	**32,566**	25,906
Investments	**0**	0
Cash at bank and in hand	**68**	63
	36,907	29,406
Creditors: Amounts falling due within one year	**(45,369)**	(36,889)
Net current assets (liabilities)	**(8,462)**	(7,483)
Total assets less current liabilities	**184,912**	171,783
Creditors: Amounts falling due after more than one year	**0**	0
Provisions for liabilities and charges	**(3,908)**	(1,999)
Total assets employed	**181,004**	169,784
Financed by:		
Taxpayers' equity		
Public dividend capital	**104,771**	107,134
Revaluation reserve	**50,123**	40,106
Donated Asset reserve	**14,368**	12,813
Government grant reserve	**816**	847
Other reserves	**1,150**	1,150
Income and expenditure reserve	**9,776**	7,734
Total taxpayers equity	**181,004**	169,784



Peter Homa, Chief Executive
21 July 204

Cash flow statement for the year ended 31 March 2004

	2003/04 £000	2002/02 £000
Operating activities		
Net cash inflow (outflow) from operating activities	**18,679**	17,393
Returns on investments and servicing of finance:		
Interest received	**426**	321
Interest paid	**0**	0
Interest element of finance leases	**0**	0
Net cash inflow/(outflow) from returns on investments and servicing of finance	**426**	321
Capital expenditure		
Payments to acquire tangible fixed assets	**(14,409)**	(11,175)
Receipts from sale of tangible fixed assets	**3,663**	946
(Payments to acquire)/receipts from sale of intangible assets	**(206)**	(302)
(Payments to acquire)/receipts from sale of fixed asset investments	**0**	0
Net cash inflow (outflow) from capital expenditure	**(10,952)**	(10,531)
Dividends paid	**(5,785)**	(8,262)
Net cash inflow/(outflow) before management of liquid resources and financing	**2,368**	(1,079)
Management of liquid resources		
Purchase of current asset investments	**0**	0
Sale of current asset investments	**0**	0
Net cash inflow (outflow) from management of liquid resources	**0**	0
Net cash inflow (outflow) before financing	**2,368**	(1,079)
Financing		
Public dividend capital received	**0**	1,085
Public dividend capital repaid (not previously accrued)	**(2,363)**	0
Public dividend capital repaid (accrued in prior period)	**0**	0
Loans received	**0**	0
Loans repaid	**0**	0
Other capital receipts	**0**	0
Capital element of finance lease rental payments	**0**	0
Cash transferred from/to other NHS bodies	**0**	0
Net cash inflow (outflow) from financing	**(2,363)**	1,085
Increase (decrease) in cash	**5**	6

Financial summary 2003 – 2004

Statement of total recognised gains and losses for the year ended 31 March 2004

	2003/04 £000	2002/03 £000
Surplus (deficit) for the financial year before dividend payments	**5,135**	12,542
Fixed asset impairment losses	**0**	0
Unrealised surplus (deficit) on fixed asset revaluations/indexation	**13,578**	22,718
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**1,956**	2,592
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets	**(1,301)**	(1,118)
Additions/(reductions) in "other reserves"	**0**	1,150
Total recognised gains and losses for the financial year	**19,368**	37,884
Prior period adjustment		
– Pre-95 early retirement	**0**	(1,866)
– Other	**0**	0
Total gains and losses recognised in the financial year	**19,368**	36,018

Public Sector Payment Policy

Better Payment Practice Code – measure of compliance	2003/04 Number	2003/04 £000
Total bills paid in the year	**105,272**	**127,727**
Total bills paid within target	**79,566**	**97,384**
Percentage of bills paid within target	**75.58%**	**76.24%**

The Better Payment Practice Code requires the Trust to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

The Late Payment of Commercial Debts (Interest) Act 1998	2003/04 £000	2002/03 £000
Amounts included within Interest Payable (Note 9) arising from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0

Management costs

	2003/04 £000	2002/02 £000
Management costs	**10,528**	9,275
Income	**317,041**	286,483

The Trust's pay awards to managers in 2003/04 did not exceed 3.6%.

Salary and Pension entitlements of senior managers

	Age	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Golden hello/compen-sation for loss of office £000	Real increase in pension at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2004 (bands of £5000) £000	Benefits in kind (Rounded to the nearest £100) £
Mrs Naz Coker, Chairman (from November 2003)	55	5-10	0-5	0	0-2.5	0-5	0
Miss Catherine McLoughlin, CBE Chairperson (until October 2003)	60	10-15	0-5	0	0-2.5	0-5	0
Mr Ian Hamilton, Chief Executive (to February 2004)	52	120-125	0-5	0	(10) - (7.5)	50-55	0
Mr Peter Homa, Chief Executive (from December 2003)	47	50-55	0-5	0	0-2.5	0-5	0
Non-executive Directors							
Mr Ashley Elsdon, Non-executive Director	35	5-10	0-5	0	0-2.5	0-5	0
Professor S Hilton, Non-executive Director (from December 2003)	54	5-10	0-5	0	0-2.5	0-5	0
Mrs Diane Mark, Non-executive Director	52	5-10	0-5	0	0-2.5	0-5	0
Mr David Knowles, Non-executive Director	62	5-10	0-5	0	0-2.5	0-5	0
Mrs Valerie Vaughan-Dick, Non-executive Director	43	5-10	0-5	0	0-2.5	0-5	0
Executive Directors							
Mrs Marie Grant, Deputy Chief Executive and Director of Operations	*	90-95	0-5	0	0-2.5	30-35	0
Mr Kevin Harbottle, Acting Director of Finance	42	75-80	0-5		0-2.5	15-20	0
Professor Paul Jones, Medical Director	57	30-35	0-5	0	0-2.5	0-5	0
Other Directors							
Mrs Sue Cooper, Director of Nursing	*	65-70	0-5	0	2.5-5	10-15	0
Mrs Janet Hunter, Director of Modernisation	47	75-80	0-5	0	0-2.5	10-15	0
Mr Colin Watts, Director of Human Resources	57	75-80	0-5	0	0-2.5	25-30	0
Mr Colin Rickard, Acting Director of Capital Projects	*	*	*	*	*	*	*

* Consent to disclosure withheld

Remuneration is determined by the Remuneration and Benefits Committee of the Board. The Trust uses data from the NHS and other public sector organisations to determine salaries. Salaries are basic with no bonus.

Peter Homa, Chief Executive, was appointed on 1 December 2003 through national competition and interview panel, with representatives of the South West London Strategic Health Authority, Trust Board and external advisers. The appointment is substantive and is subject to ongoing review by the Trust chair.

All members of the management board have similarly been recruited and are subject to ongoing review by the Chief Executive.

Notes

Acknowledgements

The communications unit would like to thank the following people, without whose support and time this report would have been considerably harder to publish:

Brian and Veronica Brigden, Mr Chandrasekaran, Francis Johnston, Deborah Livermore, Ginny and Mark Bailey, Sam Tanner, Jeremy and Sarah at Hildebrand, Pat Lawrence, Alistair Douglas, Neil Redfern, Hilary Walker, Angela Helleur, Rowena Lamb, Martin Emery, Avey Dosanjh, Aodhan Breathnach, Ruth Law, Derek Reid, Aasifa Darugar, Yvonne Looney, Barbara Kleban and everyone in TSSU, Andrew Prescott, Richard Maynard, Steve Milan, Kate Hutt, Jan Poloniecki, Cathy Stirling, Tom Manning, Andrew Stewart, Geoff Cattini, Belinda Andrews, Sharon Welby, Trudi Kemp, Mark Evenden, Sam Prigmore, Krys Gebhardt, Gunaratnam Niranjani, Rachel Stanfield and Paul Bulmer

Kimberley O'Hara, Sheridan Buchanan, Jane Wall and all the staff on Benjamin Weir ward

Louise Backhouse, Anne-Marie Tiernan and all the staff on Caroline ward

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Dave Wilcox, Nikki Shopland, Rachel Colley, Sally Toden and all the staff in A&E

And finally all the many patients and staff who were photographed and interviewed for this report.

Back cover (left to right):
Heart patient Brian Brigden talks to teaching sister Sheridan Buchanan about his forthcoming operation. A new arrival in the delivery suite. Neurosurgeon Francis Johnston (on right) pauses mid-operation to discuss the progress of procedure with his registrar, Tom Manning.