St George's Healthcare NHS
NHS Trust

St George's + Quality healthcare

Annual report & accounts 2004/05

St George's Healthcare NHS Trust is one of London's leading teaching hospitals with an international reputation for the quality of its patient care, education and research.

A local hospital but also a national centre of excellence for the care of patients with injuries and diseases affecting the brain, the heart and the chest, St George's offers an advanced range of pioneering treatments and therapies to more than half a million people every year.

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Front cover:
(Left to right) Renal surgeons Eric Chemla and Rene Chang.

Gillian + Recovery

GILLIAN Reynolds from Raynes Park in London is on cloud nine.

The 44-year-old medical secretary was only a baby when she was first diagnosed with epilepsy. But three years ago, her seizures became worse. Much worse. They became so severe and so wildly unpredictable that she never knew when or where an attack would happen or how long one might last.

The seizures were quite simply destroying her life.

But in December of this year, Gillian had a groundbreaking operation as part of our new epilepsy surgery programme to remove a tiny piece of her brain that was responsible for triggering her fits.

She has been free of seizures ever since.

This report, which covers the period April 2004 to March 2005, explains how we helped Gillian and hundreds of other patients like her to overcome an injury or illness this year, many of which were life-threatening conditions.

What follows is an account of the improvements that were made to patient care in the last twelve months and the challenges this hospital faced in that time.

Transformed: Thanks to our new epilepsy surgery programme, Gillian Reynolds has been free of seizures since December 2004.

The hospital had a prosperous and productive year, according to its Chairman and Chief Executive. Staff gave outstanding care to their patients. And in many cases that care was better than ever before.

St George's + Progress

WELCOME to the 2004/05 annual report for St George's Healthcare NHS Trust. We are pleased to report that the past twelve months were a period of unparalleled success for patient care.

The staff of our three hospitals once again gave exceptional care to patients and looked after them with the same diligence, expertise, ingenuity and compassion which the community has come to rely on so very much in recent years.

We achieved virtually all the Government's access targets for patients, particularly the ones for emergency care, outpatient appointments, rapid cancer referrals and heart surgery, and continued to reduce waiting times for all forms of treatment and diagnosis.

And our status as a leading centre for teaching and research was reinforced by hundreds of projects and studies that advanced our knowledge of the human body and the diseases that affect it.

This report is an account of the progress we made in 2004/05 and the pages that follow are filled with examples and stories of how our patient care went from strength to strength during the year.

The progress that we made in providing safe patient care was rewarded with a reduction in the annual premium we pay to a national clinical insurance scheme called CNST.

Our hard-hitting infection control programme led to fewer infections of the drug-resistant organism MRSA this year, giving patients the reassurance that staff across the hospital are taking every precaution possible to shield them from infections.

Our stroke unit, led by Professor Hugh Markus, was hailed as one of the best in the country by the Royal College of Physicians.

Our A&E team achieved a key Government target to see and treat 98 per cent of patients within four hours.

We opened a state-of-the-art endoscopy unit for the rapid diagnosis and treatment of bowel cancer.

We received a top accolade for the quality of our clinical care. CHKS, a company that provides a service which allows hospitals to assess their clinical performance against others, not only judged St George's to be one of the best hospitals in the country but also singled out the Trust for having the most improved clinical care based on a range of indicators which included mortality, complications, infections, length of stay and emergency readmissions.

Finally, a new post-operative treatment protocol developed by Professor David Bennett and colleagues from the General Intensive Care Unit led to fewer complications and infections in patients after surgery.

Anyone familiar with the events of the past twelve months will know that the year was dominated by the pressing issue of our finances. We ended the year with a deficit of £21.6m even though £10.4m was saved by a range of actions which included reducing our establishment of staff by 100 vacant posts.

"Staff once again gave exceptional care to patients"

The hospital has lived with a financial problem for many years and the time has come for it to be resolved once and for all. It is abundantly clear that our financial position is impeding the speed and scope of our plans for modernisation.

Work has already begun on shaping a strategy to reform both our services and our finances and change is absolutely essential if we are to get this hospital back on financial track.

In doing so, we know it is incumbent upon us to maintain the high standard of care that patients expect from this hospital.

The financial turnaround of this hospital will take time, hard work and patience. It may be two to three years before the Trust is back on an even keel. But when that happens, we will have a firm and rock-solid financial foundation upon which we can plan more effectively for the future and drive through even more improvements to patient care.

We will then be in a much stronger position to achieve our vision of becoming one of the best acute teaching trusts in the country.

Looking forward: The Trust's Chief Executive Peter Homa and Chairman Naaz Coker.

Peter Homa Chief Executive

Naaz Coker Chairman

IT'S HALF past four in the afternoon and for the fourth time this week Anneli Lloyd is preparing herself for another three-hour session of dialysis. But unlike most patients who receive dialysis for end stage kidney failure, Anneli is nowhere near hospital. The 33-year-old is actually thirty miles away in a village on the outskirts of Guildford in the comfort of her living room.

Anneli developed a problem with her kidneys when she was 22, the result of a genetic condition she shares with her younger sister. She has to be dialysed for several hours every other day to remove waste products and excess water from her blood. Most patients have to ferry themselves to hospital for treatment but Anneli was given training by renal nurses this year to manage her dialysis by herself at home.

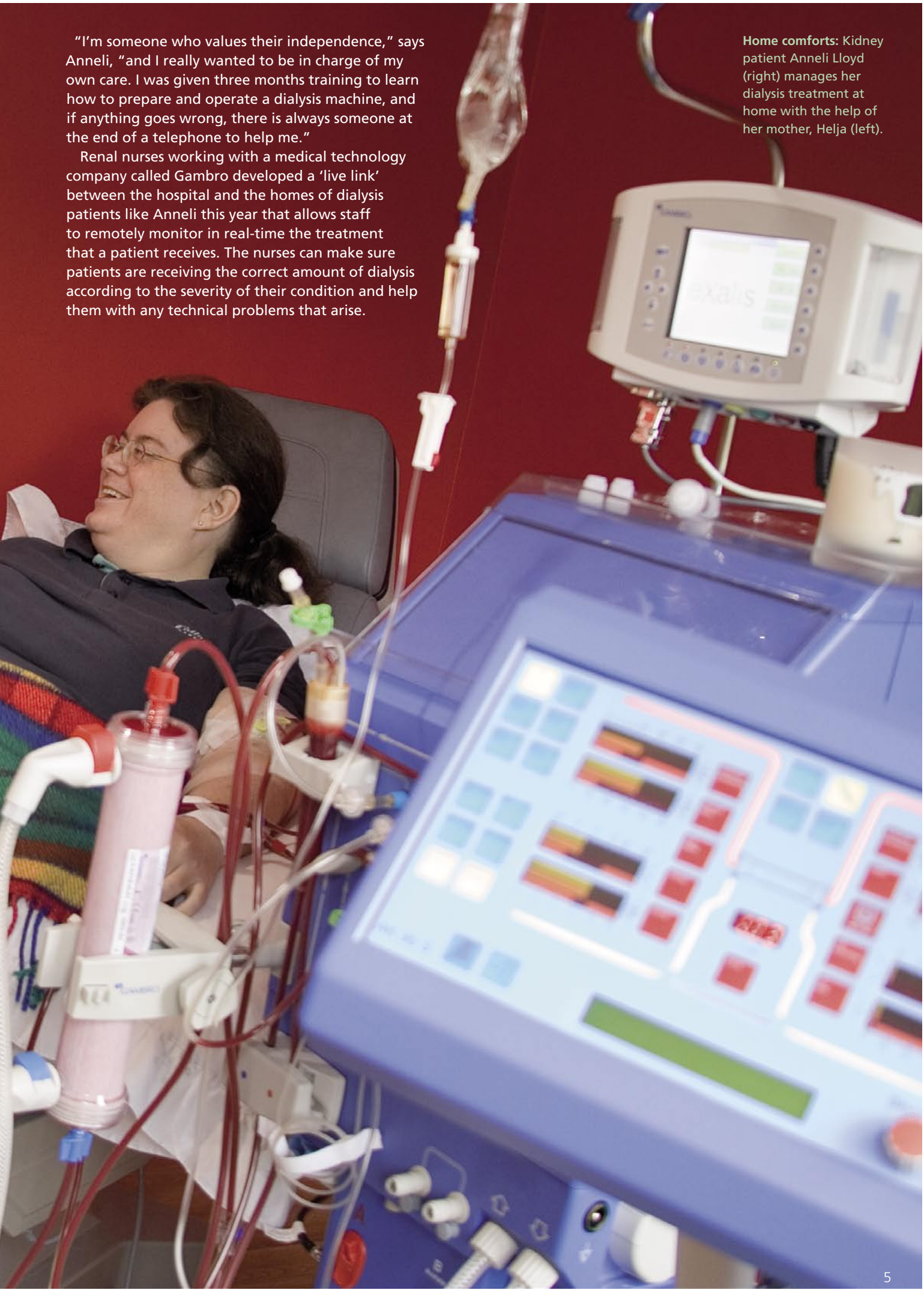
Joining the home haemodialysis programme has given Anneli some much-needed control over her condition, something she has craved for many years. It means she is spared the expense, the discomfort and the distress of travelling back and forth to hospital several times a week for treatment.

Anneli + Technology

Investment in new technology is helping patients like Anneli take control of their care and their lives.

"I'm someone who values their independence," says Anneli, "and I really wanted to be in charge of my own care. I was given three months training to learn how to prepare and operate a dialysis machine, and if anything goes wrong, there is always someone at the end of a telephone to help me."

Renal nurses working with a medical technology company called Gambro developed a 'live link' between the hospital and the homes of dialysis patients like Anneli this year that allows staff to remotely monitor in real-time the treatment that a patient receives. The nurses can make sure patients are receiving the correct amount of dialysis according to the severity of their condition and help them with any technical problems that arise.



Home comforts: Kidney patient Anneli Lloyd (right) manages her dialysis treatment at home with the help of her mother, Helja (left).

The average length of stay was reduced from 30 to 18 days

The new treatment has reduced infections and complications in patients after surgery.

IT'S BEEN a fruitful year for Professor Ephraim David Bennett whose first name funnily enough means exactly that.

Bennett, a veteran of intensive care with more than 30 years experience of this important field of medicine, this year found a way to reduce the number of infections and complications developed by patients after surgery.

Infections and complications are recognised risks of any operation and patients have to be observed very closely by intensive care teams in the hours that follow surgery to ensure their health doesn't deteriorate.

But the risk of morbidity can be reduced if more oxygen is dispatched around the body via the bloodstream, as David explains.

"Several studies have shown that the risk of death and disease increases after surgery if not enough oxygen reaches organs and tissues," says David.

"But by stimulating the heart to make it pump more often, we can increase the amount of oxygen that is delivered to vital parts of the body."

The study he carried out with colleagues from the hospital's General Intensive Care Unit – one of five such units in the Trust – found that infections and complications were halved in a group of sixty surgical patients that were given extra intravenous fluid and a drug called Dopexamine in the eight hours immediately after surgery.

And because fewer patients became sick, the average length of stay on the unit fell too – from a month to 18 days.

"I have nothing but praise for the way in which I have been treated at St George's."

Joan MacIntyre, patient

David + Research

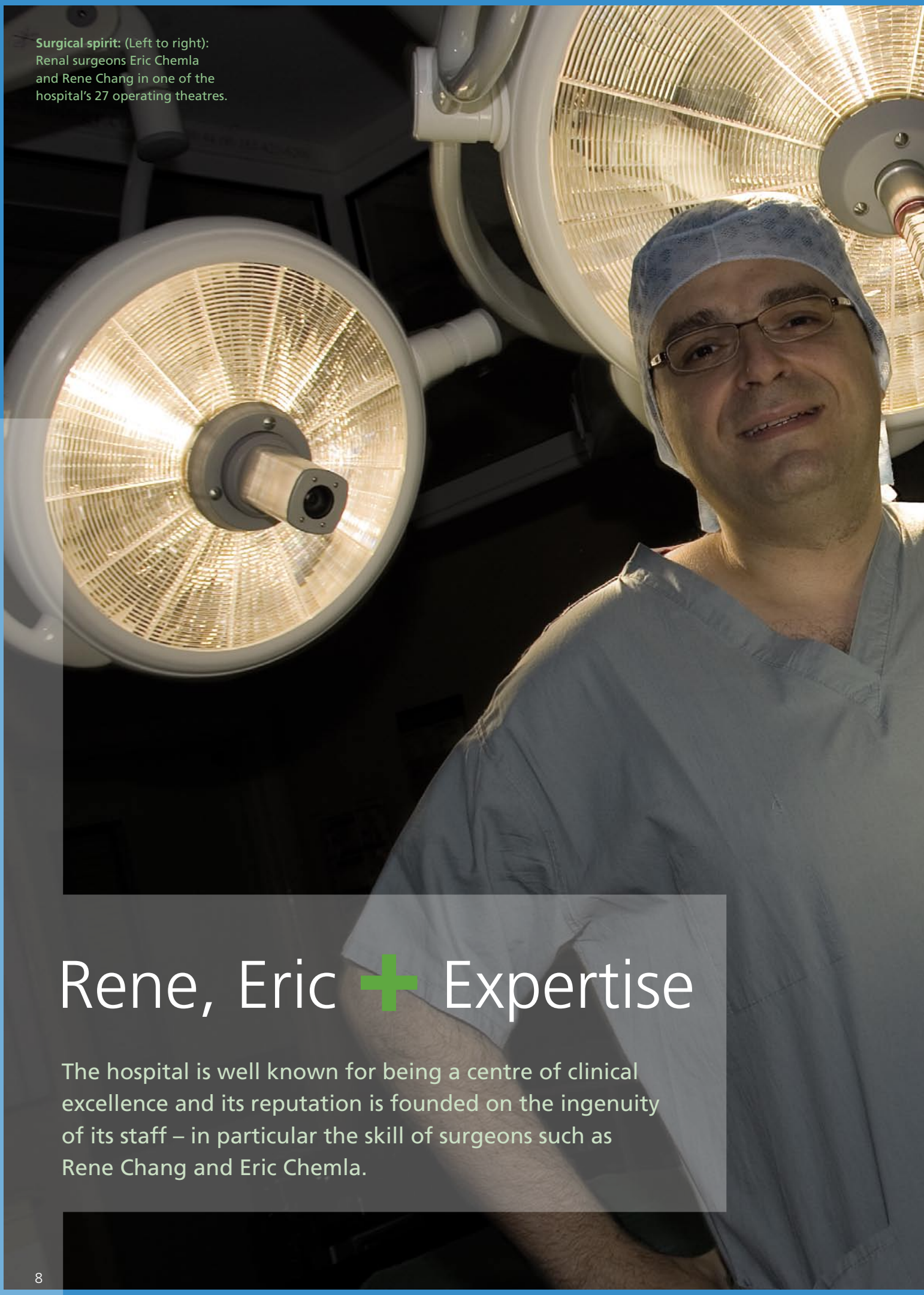
St George's is at the forefront of medical innovation and discovery, and cutting-edge research carried out by our intensive care team this year has improved the recovery of patients after surgery.

The study has been so successful that the post-operative treatment is now prescribed for all surgical patients on the unit.

St George's is a hospital at the forefront of medical innovation and discovery, and this year we spent more than £7m on nearly 400 studies and projects which advanced our knowledge of the human body and created new technology to improve the treatment and diagnosis of our patients.

Projects included the development of software for analysing digitally-captured retinal images of diabetic patients and the creation of an automated program for the more accurate measurement of chromosomal abnormalities in a foetus during ultrasound scans, which won a major prize at this year's London NHS Innovation Awards.

Pioneer: Professor David Bennett



Surgical spirit: (Left to right): Renal surgeons Eric Chemla and Rene Chang in one of the hospital's 27 operating theatres.

Rene, Eric + Expertise

The hospital is well known for being a centre of clinical excellence and its reputation is founded on the ingenuity of its staff – in particular the skill of surgeons such as Rene Chang and Eric Chemla.

THE SUNLIT walls of Rene Chang's office are stark and bare except for a patch of space directly behind his desk which is filled with a large leaf of parchment paper. The mounted parchment, a gift from a Chinese pastor who was once a patient, contains a brief albeit touching inscription that never fails to inspire. 'Skilled hands return spring,' the characters read and to Rene, the hospital's Director of Kidney Transplantation, the words are a constant reminder of the ability that he and his fellow surgeons have to give hope and a new lease of life to patients who suffer from end stage renal failure.

In the eleven years Rene has led the transplant unit, his team has successfully transplanted nearly 800 kidneys. In that time, the unit has grown both in productivity and quality, and its national reputation has flourished not surprisingly as a result. His team had the best one year success rate for a kidney transplant out of all units in the country in 2002 and 2003.

"The unit has become one of the best centres for renal transplantation in the country," says Rene, who is originally from Malaysia. "Next year, we hope to perform our first keyhole extraction of a kidney from a living donor which, because it is less invasive than a normal operation, should reduce the length of time a donor has to spend recovering in hospital."

"The unit has become one of the best centres for renal transplantation in the country"

Sadly, most patients are not as fortunate as Mr Chang's Chinese pastor. A national shortage of kidney donors means the majority of sufferers are forced to live out their days waiting patiently on dialysis for an organ to become available. Many never receive a new kidney, such is the demand. But as much as there is a shortage of organs, so too is there a shortage of surgeons capable of creating suitable access points in the body's bloodstream for dialysis.

The 'gold standard' of access is an Arteriovenous Fistula (or AVF). But it takes a surgeon to create it. And in the absence of a surgical solution, the alternative is dialysis by central venous catheter – a device inserted into the bloodstream that unfortunately leaves patients prone to infections, blood clots and ultimately failure of dialysis.

When French surgeon Eric Chemla, who has a special interest in AVF surgery, joined the renal unit three years ago, only half of the hospital's patients were dialysed by AVF. Now that figure is closer to 90 per cent. He explains how the unit has developed in that time: "When I first came to St George's," says Eric, "we only had two surgeons on the renal access programme – myself and another consultant. Now we have four, which means we are able to perform a greater number of AVF procedures which in turn means that more patients are being dialysed properly."

Patients come from all over the country to have the procedure at the hospital and every week surgeons operate on as many as 20 patients. "We are rapidly building ourselves a reputation as a tertiary referral centre for this work," he adds, "and as a place that will treat the very complex cases that no other centre will touch."

"Staff were very particular in their hygiene procedure which we were pleased to see"

Patient

Aodhan + Hygiene

Protecting patients from infections is a top priority for our doctors and nurses, and this year saw the hospital increase the intensity of its anti-microbial campaign.

FOR SOMEONE who has watched over a 50 per cent reduction in bloodstream infections of MRSA since 2001, you would have thought Dr Aodhan Breathnach would be, well, pleased.

But ask the chief medical microbiologist to explain the lengths to which the hospital has gone in recent years to shield patients from infections and he seems reluctant to call the campaign a success.

"The number of infections could rise at any time if there is any let up in our anti-microbial programme," warns Aodhan, "and there is a great deal of work still to do before we reduce the number of infections to an absolute minimum.

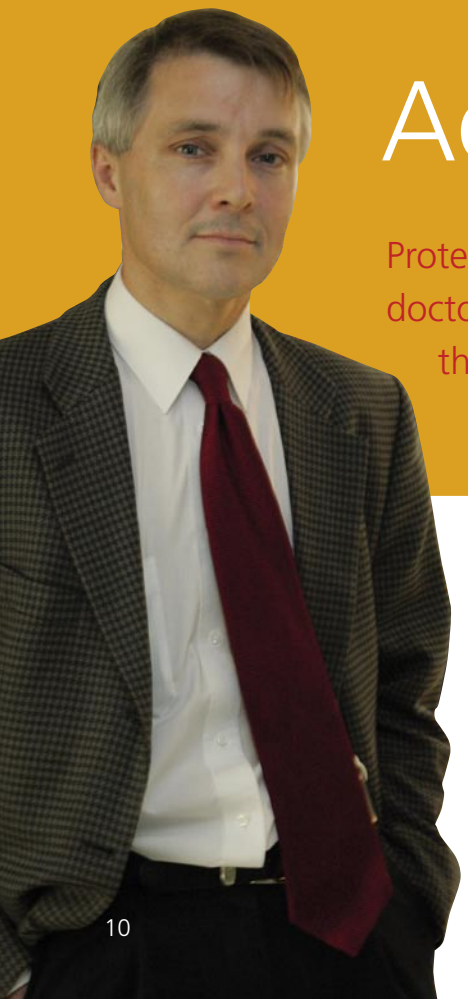
"Sixty-three infections of MRSA during 2004/05 may not seem significant when set against the backdrop of 56,000 inpatient admissions over the course of the year, but staff, patients and visitors need to guard against complacency."

The hospital has introduced an array of measures in recent years to protect patients from infections. A trust-wide campaign has encouraged doctors and nurses to clean their hands with an alcohol disinfectant gel before and after coming into contact with patients. Long-standing protocols require patients with infections to be 'barrier-nursed' with gloves and aprons to prevent infections being spread to others. Patients are screened for MRSA on admission from other hospitals and nursing homes, and when they enter high-risk areas such as intensive care, cardiac and orthopaedic wards. A team of specialist nurses has even been appointed to supervise the safe placing of intravenous lines, which are a known source of infections.

Moreover, patients have been encouraged to quiz doctors and nurses about the cleanliness of their hands if they want the reassurance that precautions are being taken to protect them from infections.

"Many infections are actually caused by patient's own organisms", Aodhan continues, "and hospital-acquired infections are an intrinsic and unavoidable risk of the life-saving surgery and other treatments we offer our patients. This risk can never in fact be eliminated entirely, but it can be reduced by the simple measures we are trying to focus on here in St George's – good hand hygiene, controlled use of antibiotics, better care of intravenous lines and better ward cleanliness."

Ensuring wards are kept spotlessly clean is an essential ingredient of the hospital's 'clean and



Wary: The hospital's chief medical microbiologist Dr Aodhan Breathnach.

MRSA infections by year:

- 2001/02 115
- 2002/03 75
- 2003/04 93
- 2004/05 63

Now wash your hands: The hospital has taken steps to boost standards of hand hygiene among visitors and staff to stop infections spreading to patients.

"The ward was always kept extremely clean."

Mary Joyce, patient

screen' strategy, says Aodhan, which is why the hospital's 30 modern matrons were given greater powers this year to regulate hygiene standards in clinical areas. Regular ward inspections are now carried out with little or no warning, and the senior nurses have the executive authority to fail audits on the spot if they believe standards of hygiene are not up to scratch.

MRSA first emerged in the 1960s when the bacteria Staphylococcus Aureus – the 'SA' in MRSA – grew resistant to the effects of an antibiotic called methicillin. Other bacteria such as tuberculosis have developed similar resistance to medication down the years through the widespread use of antibiotics in both medicine and agriculture.

So what does this mean for the future of infection control? Will all infections become harder and harder to beat in the future? Can antibiotic-resistant bacteria such as MRSA ever be eradicated from hospitals? Unfortunately not, says Dr Chris Streather, one of the hospital's three new medical directors with board-level responsibility for infection control.

"Making sure our wards are clean and free of germs may help in the day to day fight against MRSA and other infections," says Chris, "but ultimately we need a long-term strategy to slow down the development of bacteria to safeguard the efficacy of the antibiotics we have left."

The solution, as he sees it, is to regulate the supply of the medication so that it is only prescribed when absolutely necessary and only then for a fixed amount of time.

"The use of antibiotics needs to be regulated and prescribed appropriately by both hospitals and GPs," he adds.

The "regulation" he has in mind is an antibiotic surveillance programme. Although the programme launched by new antibiotics pharmacist Chikondi Savieli this year is still in its infancy, during 2005/06 the scheme will grow into a comprehensive review of antibiotic usage throughout the hospital. This work will include scrutinising the prescribing patterns of individual doctors.

"Antibiotics are often prescribed without a stop date in mind," warns Chikondi, "which can lead to any number of problems. If they are taken for longer than is necessary, the antibiotics can kill off the good bacteria inside the body. This can lead to patients becoming unwell in hospital. The body can also become resistant to the antibiotic that has been prescribed which means the medication will be less effective at treating a bacterial infection the next time round."

Experts from the hospital are teaming up with their colleagues in primary care to prevent the onset of disease and promote healthier ways of living.

Nicola, Grace + Health

Nicola Arnold came to our new genetics clinic to find out if she and her seven-week-old daughter, Grace, were at risk from cancer.

Wandsworth has a very young population – half of which is between the ages of 20 and 44.

LITTLE Grace Arnold is the apple of her mother's eye and like all new parents Nicola wants her baby daughter to grow up healthy and strong. But Grace, who is only seven weeks old, may have been born with a gene that could make her more susceptible to cancer when she is older.

Nicola's father and grandmother both had the disease and there is a strong possibility that she may have inherited the cancer-causing DNA from her relatives.

"My grandmother fought off several bouts of cancer," says Nicola, "and my father died from the disease only a few years ago.

"So there is a good chance it will affect me too."

A few weeks before Grace was born, Nicola went to our new cancer genetics clinic, which tours GP practices and hospitals in the area, to find out if she was in any danger.

An analysis of her family's medical history found that she was and Nicola has since been referred to the hospital for further genetic testing.

The thought of knowing what health problems will trouble you in later life may fill you with dread, but Nicola is happy knowing what she does. In her eyes at least, forewarned is definitely forearmed.

One in 20 people with cancer develop the disease because of a gene mutation

"There's no guarantee I will get cancer but at least my GP and I can keep an eye on things and start taking precautions," she says.

Doctors believe that one in 20 people with cancer develop the disease as the result of a gene mutation running through their family, and the field of clinical genetics, whereby DNA is analysed for genes that render people susceptible to a disease, is seen by many as a way of preventing – or at the very least delaying – health problems. The mobile clinic that began this year is one of the many ways in which the hospital is helping local primary care trusts combat cancer and the other major threats to public health.

Serving the local community

Although the Trust's three hospitals are based primarily in Wandsworth, which like all metropolitan areas is one of great contrasts and diversity, St George's serves a population of 1.3m from across South West London. The region's primary care trusts commission the Trust to provide all the normal services you would expect from a local NHS hospital such as maternity, geriatric, paediatric and emergency care.

The communities vary in size, wealth and diversity and as such are affected by health problems in many different ways, as Dr Trudi Kemp, a consultant in public health, explains:

"Every community is different," says Trudi. "Wandsworth for example has a very young population, half of which is between the ages of 20 and 44. Young people tend to use hospital emergency services rather than register with a GP.

"Similarly, we know that certain conditions are more common in some ethnic groups than others.

"Twenty per cent of the local population are non-white. Coronary heart disease is more prevalent in white people than black people but it is higher in the South Asian community, in which diabetes is also more of a problem.

"Conditions such as hypertension, renal failure and sickle cell anaemia are also more likely to affect the black community than any other group.

"We have to take all these factors into account when planning or changing our services."

Although Trudi believes the NHS can cope with what seems to be a rising tide of chronic disease, there are plenty of people who fear that services will collapse under the weight of such overwhelming demand.

Trawl through the reams and reams of public health data collected in recent years and you soon see why.

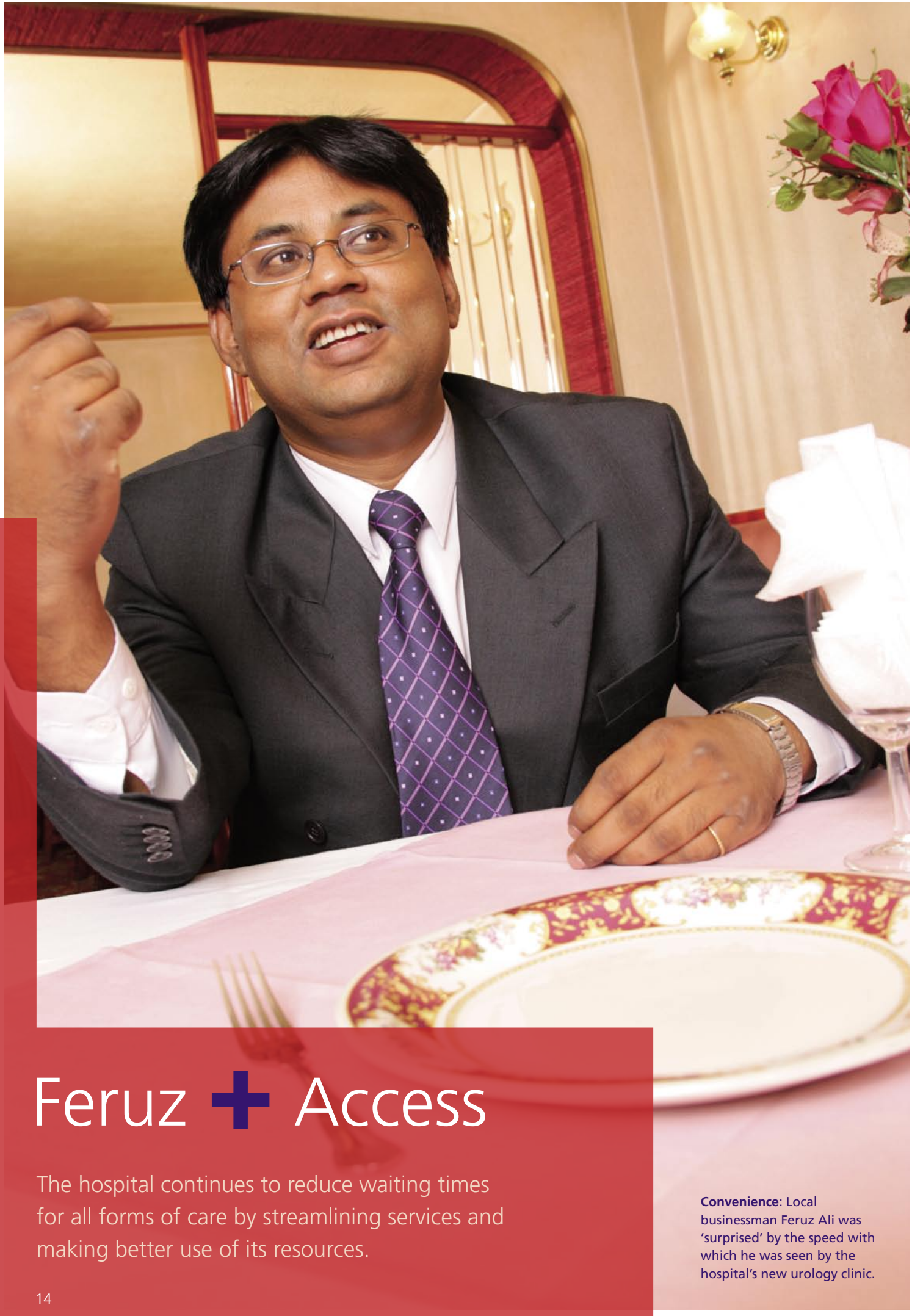
Local doctors for example predict that one in ten people in Wandsworth will have diabetes by 2010. Obesity has risen in prevalence by almost 400 per cent in the last 25 years. Plus there's been a surge recently of sexually transmitted infections such as chlamydia and gonorrhoea.

Wandsworth is not the only community affected by chronic disease problems. Diabetes, obesity and lung disease threaten every area to some extent. So how should the NHS respond? And how can hospitals help?

Although public health matters are principally the concern of primary care, says Trudi, co-operation is vital and hospitals must work alongside primary care organisations and other agencies to promote healthy lifestyles.

"We need to encourage children and young people to take regular exercise and eat more healthily," she continues. "In a similar way, we need to encourage young adults to avoid the risks which we know will lead to problems in later life such as smoking, drinking and drug use.

"The best way of doing this is for the various arms of the NHS to work together. That way, the expertise that exists in both the hospital and the community can be shared for the good of patients."



Feruz + Access

The hospital continues to reduce waiting times for all forms of care by streamlining services and making better use of its resources.

Convenience: Local businessman Feruz Ali was 'surprised' by the speed with which he was seen by the hospital's new urology clinic.

RESTAURANT owner and father-of-five Feruz Ali is not a man who likes to be kept waiting. So when doctors found trace amounts of blood in his urine earlier this year, 39-year-old Feruz feared the worst: not that he might be ill but that the endless trips to hospital would interfere with his very busy life.

"I care about my health," says Feruz, who emigrated to England from Bangladesh in 1976. "But I have a family to take care of, a business to run and I don't have the time to keep running back and forth to hospital for appointments and tests."

But when he left his one and only appointment at a new urology clinic at Queen Mary's Hospital in Roehampton armed with a diagnosis from his doctor after only two hours, Feruz was "pleasantly surprised."

"I was taken from one room to another," he remembers, "and there was no hanging around at all. I had an appointment, an ultrasound scan, an endoscopy and several other tests all in the space of a couple of hours. The doctor then gave me my results, which thankfully showed there was nothing wrong, and I was on my way."

A year ago, patients may have waited up to 18 months for a diagnosis, even if all they were waiting for was a very simple 'all clear'. Appointments, tests and scans would be organised for different days, often many weeks apart.

But the new urology clinic at Queen Mary's Hospital, which was opened last autumn by St George's Hospital and Wandsworth PCT with funding from the NHS Modernisation Agency, rolls every aspect of outpatient care into a one-off visit for patients, making treatment for busy people like Feruz far more convenient.

According to hospital strategist Karen Larcombe, the 'one-stop shop' solution offered by the Roehampton clinic and another clinic set up this year that offers immediate diagnosis for people who have suffered a Transient Ischaemic Attack (otherwise known as a 'mini-stroke') is a concept that has gone down extremely well with patients.

"The model of care provided by the one-stop shop clinics is something we are very interested in applying to other outpatient services," says Karen.

"And patients seem to welcome the idea. When we tested some of the ideas we have for our five-year clinical strategy on members of the public in January, more than 80 per cent of people said they favoured the one-stop shop approach."

Although one-stop shop clinics are years away from becoming the norm for outpatient care, the trust continues to work flat out to make services more convenient and accessible for patients by reducing waiting times for all forms of treatment.

In January, the hospital received word that it was the first trust in the country to reduce waiting times for heart surgery to below six months. For surgery overall, only four out of 21,000 patients had to wait longer than the target time of nine months for an operation while only five out of 108,000 patients waited more than 17 weeks for a first outpatient appointment.

Marie Grant is the Trust's Director of Operations and the woman responsible for the day-to-day running of the hospital.

"Waiting times have fallen this year," says Marie, "but we know that some patients still wait far too long for treatment.

"However, we expect to reduce waiting times even further over the next few years. By December, the Government expects us to have a maximum waiting time of six months for an operation and 13 weeks for an outpatient appointment.

"We are well on the way to achieving those targets."

Only four out of 21,000 patients had to wait more than nine months for an operation

Hive of activity

There was a flurry of activity across the hospital in 2004/05.

Surgeons performed a thousand more day case procedures than the previous year. Consultants held nearly 13,000 more outpatient appointments. GPs referred 7,000 extra patients to hospital than the year before and ordered 20 per cent more diagnostic tests.

Nowhere was this surge of activity more apparent than in our Accident and Emergency Department where medical teams treated 96,000 patients in 365 days – 10,000 more patients than in 2003/04.

Two years ago, if you walked into A&E with a minor injury, chances are that you would have waited more than four hours to receive treatment. Back then, figures show the department was struggling to treat 50 per cent of patients within the Government's target time of four hours. But after an intensive programme of streamlining the

way care is provided in the department, which includes categorising patients according to the severity of their medical problem on arrival and allowing experienced nurse practitioners to treat minor injuries on their own without a doctor present, only two per cent of patients waited more than four hours for treatment between October and the end of March. In most cases, they were patients who needed more specialist clinical attention.

It was a performance that won the team a commendation from the Department of Health in the form of a capital grant worth £100k, which paid for the refurbishment and expansion of the Clinical Decision Unit (CDU), an area of A&E where patients can stay for up to 12 hours for further monitoring and tests without being fully admitted to hospital.

Although some people suspected that meeting the Government target would reduce the amount of time doctors and nurses could spend with patients, Nicky Shopland, one of two matrons stationed in A&E, says the newfound efficiency had a remarkable effect on clinical outcomes.

"When the four-hour target was first introduced," says Nicky, "we were a little concerned about whether what was expected of us was possible and what this would do to the standard of care.

"We didn't want to rush patients through treatment without diagnosing their problems properly.

"But the way we make clinical decisions about patients has actually improved in recent years. We now see fewer return patients than we did two years ago – a sign that we are getting diagnoses and treatments right the first time round we see someone."

Two independent reports published this year support Nicky's claim that outcomes have improved.

Figures from the Myocardial Infarction National Audit Project (MINAP) show 93 per cent of heart attack victims were given clot-busting drugs within 30 minutes of arriving at the hospital in 2004/05 compared to 57 per cent in 2002.

And a survey of several hundred emergency patients found 85 per cent thought the care ranged from 'good' to 'excellent', while the number of patients who had to wait more than 15 minutes for pain relief fell from 41 per cent in 2003 to 10 per cent in 2004.

Making better use of our beds

'Efficiency' and 'productivity' may strike some people as odd terms to use when talking about the health service; as concepts that are more relevant to industry than a hospital. But if waiting times are to fall, says Marie Grant, then valuable resources such as beds and operating theatres must be used more wisely than they have been in the past.

"The hospital has over a thousand beds," says Marie, "and we have to make the best use we can of them.

"Similarly, we need to reduce the number of cancelled operations – of which there were a thousand this year – and drive home the message that patients really need to attend their outpatient appointments.

57,000 patients failed to attend outpatient appointments this year

"More than 57,000 patients failed to attend their outpatient appointments this year, all of which resulted in lost capacity for the hospital.

"We are currently reviewing our outpatient systems and have set ourselves a target of reducing missed appointments by 5 per cent.

"But we have taken steps this year to improve the way we manage our beds."

The steps she refers to included several schemes to trim the amount of time patients have to stay in hospital – where and only where clinically appropriate.

The cardiology unit for example introduced pre-operation health checks for patients due to have a procedure called a Percutaneous Coronary Intervention (PCI).

Instead of asking patients to come in the night before surgery for assessment, teams carry out the checks a fortnight before in an outpatient clinic. The result was a saving of 160 bed days for the unit over the course of three months which in turn released capacity for more patients to be seen. More than 90 per cent of patients now stay one night in hospital rather than two.

Nurses from a second clinical unit approached the problem of bed management by streamlining the very end of the so-called 'patient journey'. In doing so, they helped colleagues from the Accident and

The year in numbers:

- 4,300 babies delivered
- 28,000 women screened for breast cancer
- 49,000 operations
- 87,300 GP referrals
- 96,300 patients treated in A&E
- 181,600 x-rays, ultrasound, MRI and CT scans
- 393,000 outpatient appointments

"Everyone was extremely kind and helpful and I am very grateful for the efficiency of care I received."

Patient

The hospital's A&E team saw thousands more patients this year but still managed to reduce waiting times for emergency treatment.

Emergency department meet the Government's all-important four-hour target for treatment.

One of the things that used to prevent patients receiving a prompt admission to an inpatient bed from A&E was the speed with which patients were discharged from acute medical wards.

Admission is only possible if a bed is free and for Noreen Ducat, matron of the hospital's five acute medical wards, the never-ending demand for beds coupled with a rather slow discharge procedure was a constant source of irritation for her and her fellow nurses.

"Patients were not being discharged quickly enough once they were identified as clinically ready to leave hospital," explains Noreen.

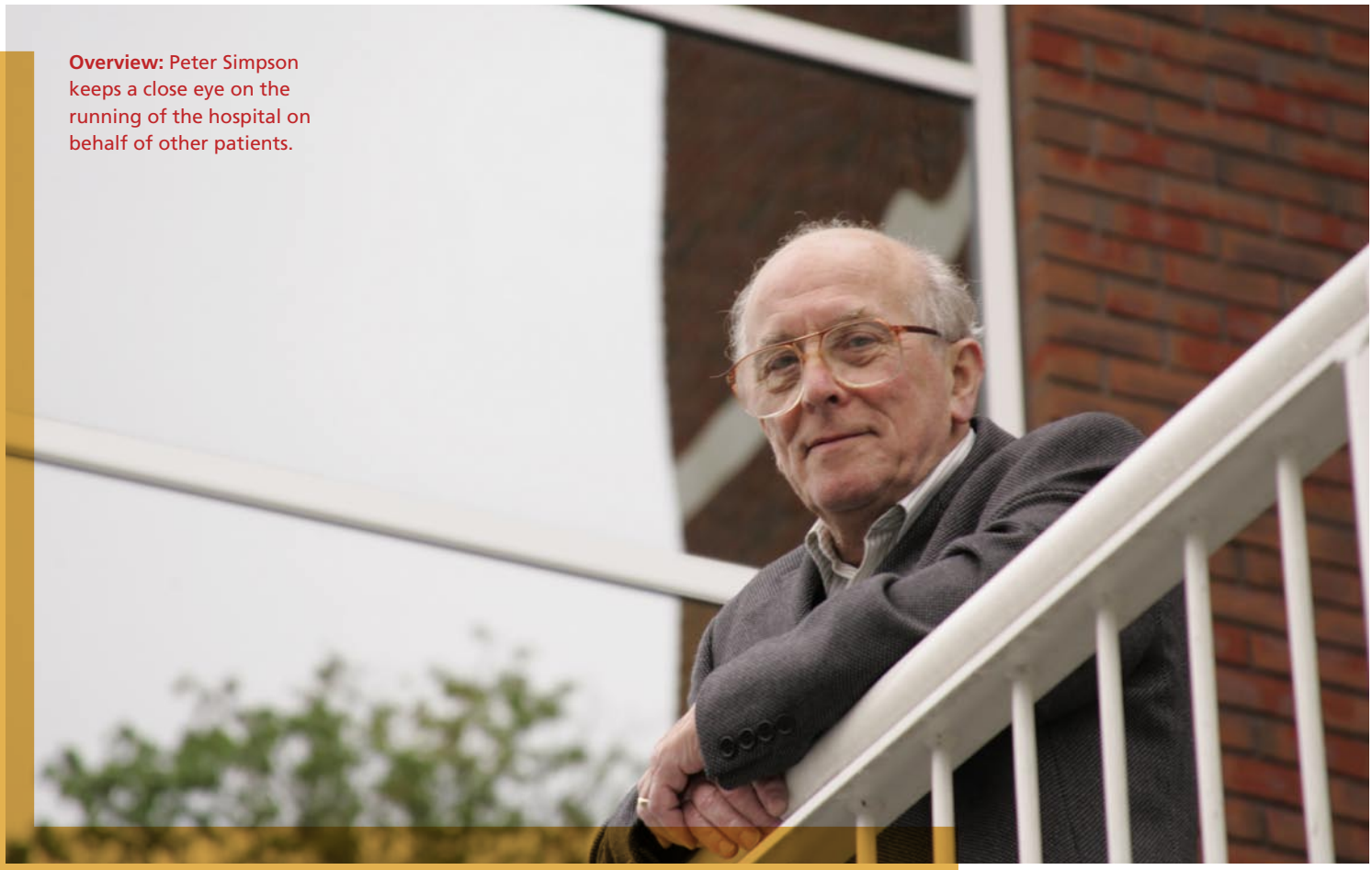
"Some patients would be told that they were ready to leave hospital in the morning but wouldn't go home until later in the day."

So to make the much-needed beds available for emergency admissions, acute medical wards moved to a nurse-led – but doctor-approved – discharge protocol in September. Doctors now decide the medical criteria which patients have to meet before they can be discharged. Once they do, nurses have the power to send them home.

Acute medical patients are now discharged by nurses 24 hours a day, seven days a week. As a result of the new protocol plus daily meetings to co-ordinate activity across the five medical wards and a re-launch of the unit's discharge lounge, the average length of stay for a patient on the unit fell from nearly ten days in January 2004 to six days in January 2005. This in turn has led to fewer medical "outliers" – a term used to describe patients admitted to a surgical ward because no medical beds are available. Figures for the same two months show the number of outliers fell from 720 to just 156.

"The hospital has over 1,000 beds and we have to make the best use we can of them"

Marie Grant, Director of Operations



Overview: Peter Simpson keeps a close eye on the running of the hospital on behalf of other patients.

Peter + Openness

As a public body, a hospital must be open and honest about the way it spends money and runs its services. And one man believes St George's is more open than ever before.

PETER Simpson is one of those people who is never out of hospital but he would be the first to admit there is nothing wrong with his health.

For Peter, a retired Customs and Excise Officer at Heathrow Airport, is a member of the hospital's patient forum. Like the health committee of the local borough council, the forum holds the hospital to account by keeping a close watch on its services.

As often as two days a week, the outspoken 73-year-old can be seen inspecting wards, speaking to patients or entrenched in meetings, making sure that the views of patients are always heard. "The hospital can't know if it's serving patients properly unless it knows what their views are," believes Peter, whose wife Margaret is a renal patient at the hospital.

"The relationship between the forum and the hospital is cordial and constructive," he adds, "and in the time I've been a member of the forum I've always been impressed by the way the hospital tries to seek the views of patients and involve them as much as possible."

Several mechanisms are in place to make members of the public and staff aware of what is happening around the hospital and allow them to comment on its services.

Patients and staff are surveyed every year about their experiences of the hospital at the request of the Department of Health. The business of the Trust is discussed in public every two months at board meetings, while staff forums are held every month for employees of the hospital to question senior managers about the running of the Trust. A communications office created in March 2004 publicises information about the hospital to staff and the community through the local media and in-house publications. A complaints office investigates and responds to criticisms of care – of which there were 660 in 2004/05 – while another team called the Patient Advice and Liaison Service offers fast, on-the-spot solutions for patients' enquiries and concerns.

January will be remembered not only as the month in which the Freedom of Information of Act finally came into force but also the month in which the hospital really opened itself up to public scrutiny.

"I've always been impressed by the way the hospital tries to seek the views of patients."

Peter Simpson, member of the Patient forum

As the new year began, St George's became one of the first hospitals to release mortality figures for heart surgery on its website. Along with complications, infections and readmissions, mortality is seen as an important guide to whether the care provided by a hospital is any good.

The information published included 'raw data' for the number of deaths following three types of heart surgery over a period of three years. Also featured were mortality figures for the hospital's five heart surgeons 'risk-adjusted' to take account of the complexity of the operation, the age of the patient and any pre-existing conditions.

The data came from an innovative surveillance programme that tracks mortality across 30 clinical areas to detect adverse changes in care and improve patient safety. It's proved so successful that the creators of the programme – statistician Dr Jan Poloniecki and the hospital's former medical director Professor Paul Jones – won a top accolade in the 2004 Health Service Journal Awards for their work in developing the system.

Although the publication of the figures was welcomed by a number of patient groups, the move was criticised by certain quarters of the medical community. Sir Bruce Keogh of the Royal Society of Cardiothoracic Surgeons said in an interview with the Daily Telegraph that St George's had "jumped the gun". Consultant cardiac surgeon Robin Kanagasabay explains why the hospital took the rather contentious decision to make the information available to the public:

"As surgeons we know that openness is the future in the NHS," says Robin, "and the public have a real desire to know how hospitals and individual surgeons are performing.

"However, there is a very real concern that publishing raw mortality data could lead to surgeons taking on only the easiest and least severe of cases.

"Nevertheless, we have had a careful debate about the issues and we think we have struck the right balance between presenting information in a way which is understandable but which does not oversimplify."

The hospital plans to publish mortality figures for all forms of surgery later next year.

To view the hospital's mortality figures for heart surgery, visit www.stgeorges.nhs.uk

Hospital receives fewer complaints

The hospital received fewer complaints about its services this year. The number received fell from nearly 800 in 2003/04 to 660 in 2004/05 while the number of compliments rose from 5,700 to 9,100.

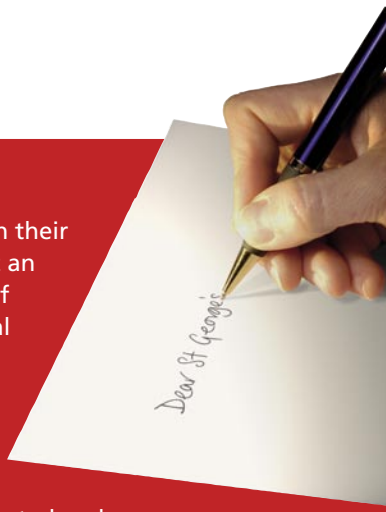
The four main areas of complaint this year were clinical treatment, communication, waiting times, and the attitude of staff.

In response to these complaints, we made a number of changes to our services. These included teaching sessions for staff to promote cultural and religious diets to patients and additional MRI scanning sessions in neuroradiology to reduce waiting times.

When making a complaint, patients should expect to receive a letter acknowledging receipt of the complaint within two working days and a full written response from the Chief Executive of the hospital within twenty.

By year end, 97 per cent of complaints were acknowledged within two working days while 65 per cent of full written responses were issued within the target time of twenty days.

Patients who are dissatisfied with the way the hospital has dealt with their complaint can request an independent review of their case. The hospital received three such requests during the year. Of these, one was referred back for resolution by the Trust, another was rejected and we are awaiting the outcome of the third.



Patients may also ask the Health Service Ombudsman to consider their complaint, if they believe it has not been dealt with appropriately by the hospital or if an independent review has been refused. The Health Service Ombudsman returned the report of one complaint referred in the previous year. The actions and improvements associated with this review have been undertaken. This year we received five Ombudsman requests. Of these, two were satisfied. We are awaiting the Ombudsman's verdict on the remaining three.

Ben + Opportunity

As one of the largest employers in South West London, we aim to foster an environment in which staff can reach their full potential.

"IF I could write my perfect job, this would definitely be it," says Ben Hall, a 27-year-old F grade nurse who began a six-month training programme in December to become a medical care practitioner.

"As a nurse you have to follow very strict protocols of care. But as a medical care practitioner, you have the opportunity to be more involved in problem-solving and that's the part that really appeals to me."

Diagnosing patients has traditionally been the work of doctors but the role of medical care practitioner – as piloted by Ben and three other nurses this year – could change the way we tell them apart from their clinical counterparts.

The new profession mirrors the role of the physician's assistant in the US, a medical post that was originally created in the 1960s for navy corpsmen returning from the Vietnam War.

Onwards and upwards: Nurse and trainee medical care practitioner Ben Hall will soon carry out tasks traditionally performed by doctors.

"Everyone I encountered carried out their job with efficiency, while managing to be friendly, supportive and informative.'

Patient

When Ben and his classmates complete their training in May 2005, they will be seconded to medical teams throughout the hospital where they will work closely with consultants and junior doctors for the duration of the 18-month trial for the NHS Modernisation Agency.

The practitioners will have the power to review patients for diagnosis and discharge and will be a key link between the medical team and their nursing colleagues on the wards.

The role of medical care practitioner may end up as a direct-entry profession in years to come but at present it's a prime example of how nurses are taking on more and more responsibility for patient care. Nurses have been given the authority to discharge patients, prescribe medication and carry out minor surgery – tasks that were previously performed by doctors – and there is now an elite group of highly-trained nurses within the hospital who are equipped with advanced knowledge and skills.

These advanced clinical roles offer nurses an alternative career pathway other than the one that normally ends in management. They also mean that patients are able to receive treatment more quickly, especially in Accident and Emergency where Emergency Nurse Practitioners operate a 'see and treat' scheme for patients with minor injuries. The skills and experience they have allows doctors the flexibility to focus on more complex cases.

Improving pay and conditions

It stands to reason that if roles are adapting to meet the changing needs of patients, then salaries must change too to reflect the additional skills and expertise needed by staff.

This year saw a raft of employment initiatives implemented throughout the NHS to ensure people are rewarded fairly and squarely for the work they do.

The consultant contract, which nearly 80 per cent of our consultants are now signed up to, gave doctors more recognition for their work through a higher basic salary as well as defining their objectives and commitments to the NHS more fully.

The European Working Time Directive, which limits the number of hours that can be worked by a junior doctor to 58 hours a week of work with a requirement for 11 hours of rest between duties, came into force on 1 August 2004. We made sure all the rotas drawn up for junior doctors complied with the regulations by the time they came into effect. This was achieved by increasing the numbers of Medical Support Assistants, recruiting additional doctors and the introduction of a Compensatory Rest policy.

The third and final scheme, Agenda for Change, began to harmonise salaries and conditions for all other NHS staff such as nurses, physiotherapists and radiographers.

A teaching hospital through and through

St George's Hospital is awash with opportunities for life-long learning and career development, especially for nurses.

We actively encourage our 2,500 nurses to broaden their skills and expertise and a strong, well-directed education programme exists to teach and train nurses throughout their career.

The programme includes a week-long induction course for all new recruits, a Staff Nurse Competency Development Package to steer D grade nurses towards becoming E grades, courses for healthcare assistants, and the Royal College of Nursing's Clinical Leadership Programme to train F and G grade nurses how to be effective leaders and drivers of change.

By providing excellent development opportunities, we aim to foster an environment in which staff feel valued and able to reach their full potential. The return on that investment is higher standards of care for our patients.

One of the hospital's most important strategic links is with the Faculty of Health and Social Care Sciences – a joint venture between Kingston University and St George's University of London (formerly St George's Hospital Medical School).

Student doctors and nurses benefit from the wealth of clinical experience that exists within the hospital as they take their first steps towards becoming the health professionals of the future; while the Trust, in turn, draws on the innovative research and teaching culture that thrives at both institutions.

Equality of opportunity

More than 5,500 staff work for St George's Hospital, which is one of the largest employers in an area of London filled with an eclectic mix of cultures and traditions.

It's a mix that is reflected in our staff, around 40 per cent of whom are black or of another ethnic background. As a result our staff are ideally suited to understand and provide for the cultural and spiritual needs of all our patients, whatever their ethnicity.

We firmly believe that everyone should be valued equally, regardless of their age or ability, their faith or colour of their skin, their sex or sexuality, or the country in which they were born.

Our constant aim is to provide equality of opportunity for everyone who works or is applying to work at the hospital.

St George's is modernising its estate to make the environment for patients more comfortable and attractive.

Libby, Roger + Regeneration

CANCER of the bowel claims the lives of 20,000 people every year but the deadly disease can be treated if caught early with the aid of an investigative procedure called an endoscopy.

In November, St George's Hospital opened a state-of-the-art £4.6m unit for endoscopy funded by Wandsworth PCT, the Department of Health and the health charity Beating Bowel Cancer. Doctors believe the centre, which is described by the team that designed it as 'the most advanced of its kind in the country', will lead to the early detection of cancers affecting the stomach, the bowel and the lungs by reducing the amount of time someone has to wait for an endoscopy down to a fortnight.

In five years' time, the centre is expected to perform more than 11,000 procedures every year.

The unit was the brainchild of the hospital's Director of Endoscopy, Roger Leicester, and Lead nurse Libby Thomson.

"The needs of patients really have been put at the heart of the new unit's design," says Roger. "The unit is light, bright, airy and spacious and we have put a lot of thought into making the layout of the unit as comfortable as possible for patients."

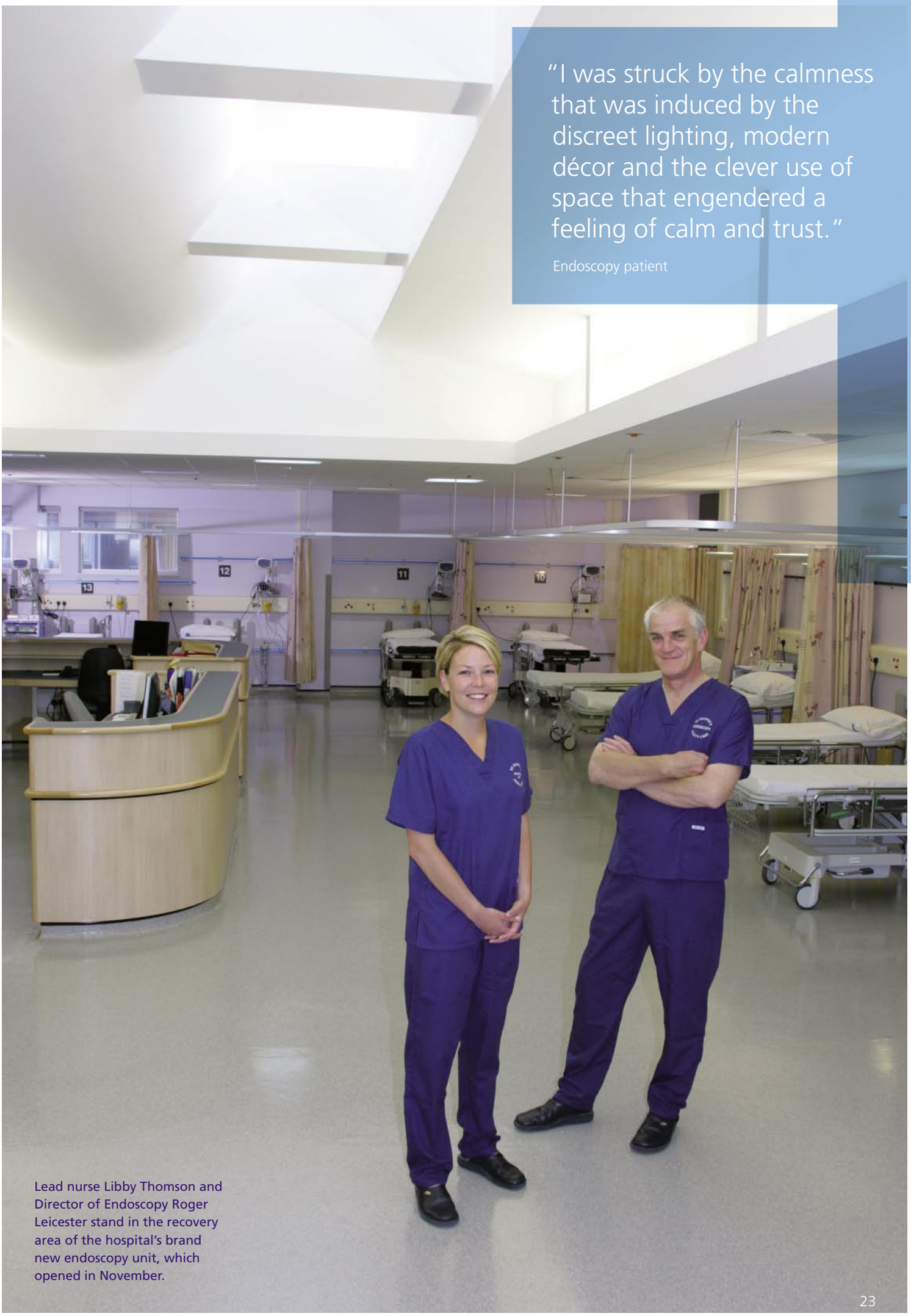
As well as performing procedures on patients, the new unit has been designated a national training centre for endoscopy.

Up to 300 doctors and nurses will be trained how to perform an endoscopy on site every year, while thousands more will be taught around the world with the aid of broadcast technology installed in each of the unit's four endoscopy rooms.

The endoscopy unit was one of several projects that regenerated the hospital's estate in 2004/05 to modernise the 'patient environment'. Other capital schemes included the refurbishment of the hospital's hydrotherapy pool which is used to help patients regain the use of their limbs after a major accident and the expansion of the fracture clinic to provide two more consulting rooms and four extra examination cubicles.

Projects scheduled for 2005/06 include a new unit for sterilising surgical instruments, a new centre that will offer free accommodation to parents of children in hospital for long-term treatment, and a new facial prosthetics laboratory.

In five years time, the new endoscopy unit will perform 11,000 procedures every year



"I was struck by the calmness that was induced by the discreet lighting, modern décor and the clever use of space that engendered a feeling of calm and trust."

Endoscopy patient

Lead nurse Libby Thomson and Director of Endoscopy Roger Leicester stand in the recovery area of the hospital's brand new endoscopy unit, which opened in November.

We continually monitor standards of care to ensure patients are given the best possible treatment.

St George's + Standards

EVERY summer, the Healthcare Commission awards all NHS organisations in the country a star rating based on their clinical, financial and operational performance for the previous financial year. St George's Healthcare NHS Trust was awarded one star in the 2004/05 ratings.

The award, which was announced by the Commission in mid-July, shows that the hospital achieved six of the eight key targets, including the waiting time targets for emergency care, outpatient appointments and rapid referrals for suspected cancer patients as well as hospital cleanliness. However, the Trust was penalised for failing to meet the nine-month waiting time target for surgery and the target for financial management.

We were placed in the top band of performance for two further categories, which focused on clinical care and patients' access to services, but performed less well in the third and final category which covers areas such as staff attitudes and information governance.

2004/05 is the final year of star ratings. Next year, the health watchdog will conduct annual 'health checks' on Trusts which promise to give a more comprehensive and meaningful picture of NHS performance and clinical care.

Key targets

The Trust successfully achieved six of the eight key targets:

- **12 hour waits for emergency readmission via A&E post decision to admit**
- **All cancers: two week wait**
- **Hospital cleanliness**
- **Outpatient and elective (Inpatient and day case booking)**
- **Outpatients waiting longer than the standard (17 weeks)**
- **Total time in A&E: four hours or less**

We failed to achieve the target for financial management after we ended the year with a deficit of £21.6m and we narrowly missed the final target for inpatient access after four out of 21,000 patients waited more than nine months for surgery.

Focus areas

As well as being assessed against eight primary targets, our performance was measured against a further 32 secondary standards grouped into three categories – clinical care, patient access and finally, capacity and capability.

Our performance against each of these targets was given a score on a scale of one to five: one being poor and five being good.

"I have nothing but praise for the way in which I have been treated at St George's."

Joan MacIntyre, patient

Clinical focus

The Trust was placed in the top band of performance in this focus area.

Child protection	★★★★★
Clinical risk management	★★★★
Composite of participation in audits	★★★★★
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	★★★
Indicator on stroke care	★★★★★
MRSA	★★★
Thrombolysis – composite of 60 min. call to needle time and 30 min. door to needle time	★★★★★

Patient focus

The Trust was placed in the top band of performance in this focus area.

A&E emergency admission waits (four hours)	★★★★★
Better hospital food	★★★
Breast cancer: one month diagnosis to treatment	★★★★★
Breast cancer: two month GP urgent referral to treatment	★★★★★
Cancelled operations	★
Delayed transfers of care	★★★
Outpatient and A&E patient surveys: access and waiting	★★★
Outpatient and A&E patient surveys: better information, more choice	★★★
Outpatient and A&E patient surveys: building closer relationships	★★★
Outpatient and A&E patient surveys: clean, comfortable, friendly place to be	★★★
Outpatient and A&E patient surveys: safe, high quality, coordinated care	★★★
Patient complaints	★★
Patients waiting longer than the standard for revascularisation (six months)	★★★★★
Six month inpatient waits	★★★★
Thirteen week outpatient waits	★★★★
Waiting times for rapid access chest pain clinic	★★★★★

Capacity and capability focus

The Trust was placed in the middle band of performance in this focus area

Data quality on ethnic group	★★★★
Information governance	★★★
Staff opinion survey: health, safety and incidents	★★★
Staff opinion survey: human resource management	★★★
Staff opinion survey: staff attitudes	★★★
Workforce indicator	★★★★

For more information about the star ratings system, please visit http://ratings2005.healthcarecommission.org.uk.

St George's + Direction

St George's Healthcare NHS Trust is managed by a Trust board which consists of a Chairman, a Chief Executive, nine full-time executive directors and five part-time non-executive directors. The role of the board is to oversee the strategic direction of the hospital, ensure that the Trust delivers high-quality, patient-centred care and provide effective financial control.

The board meets in public every two months to discuss the running of the hospital. Staff, patients and members of the public are welcome to attend these meetings to question the hospital's senior managers and raise issues or concerns.

Naaz Coker,
Chairman

Diane Mark,
Vice Chairman

Professor Sean Hilton,
Non-Executive Director

Valerie Vaughan-Dick,
Non-Executive Director

Mike Rappolt,
Non-Executive Director

Valerie Moore,
Non-Executive Director

Dr Peter Homa,
Chief Executive

Marie Grant,
Director of Operations

Dr Chris Streather,
Medical Director

Dr Patricia Hamilton,
Medical Director

Mr Mike Bailey,
Medical Director

Dr Geraldine Walters,
Director of Nursing and
Patient Involvement

Colin Gentle,
Director of Finance

Colin Watts,
Director of Human
Resources

Karen Castille,
Director of Service
Improvement and
Strategy

Neal Deans,
Director of Estates

Non-Executive Directors

Name	Register of Interests
Naaz Coker, *Chairman*	Chair, Refugee Council Home Office Race Equality Advisory Panel Ismaili Muslim Council for European Union Non Executive Director, Community Channel Trustee, Media Trust
Diane Mark, *Vice Chairman*	Trustee, St George's Charitable Foundation Trustee, Ronald McDonald House, Tooting
Professor Sean Hilton	Governor, Anglo-European Chiropractic College Trustee, General Practice Airways Group
Valerie Vaughan-Dick	Director of Resources, Central Police Training and Development Authority Director, V&A UK Limited
Mike Rappolt	Non Executive Director, PC Medics plc Chairman, Wimbledon Civic Theatre Trust Governor, Contemporary Dance Trust Shareholder, PA Consulting Group (less than 1% of company) Deputy Chairman, Raynes Park High School Various Shareholdings (all under 1% of company)
Valerie Moore	Lay Magistrate, Department of Constitutional Affairs Inner London Youth Panel, Department of Constitutional Affairs Partner, Moore Adamson Craig Partnership LLP

Executive Directors

Name	Register of Interests
Dr Peter Homa, *Chief Executive*	Honorary Professor of Health Policy, London School of Economics Honorary Senior Lecturer, Faculty of Medicine, University of Leicester
Marie Grant, *Director of Operations*	None
Dr Chris Streather, *Medical Director*	Occasional contributor to MPs briefings, New Healthcare Network
Dr Patricia Hamilton, *Medical Director*	Vice President for Training Assessment, Royal College of Paediatrics and Child Health
Mr Mike Bailey, *Medical Director*	None
Dr Geraldine Walters, *Director of Nursing and Patient Involvement*	Visiting Professor, Buckinghamshire Chilterns University College
Colin Gentile, *Director of Finance*	None
Colin Watts, *Director of Human Resources*	Governor, Kingston University External Member, Standards Committee, London Borough of Wandsworth
Karen Castille, *Director of Service Improvement and Strategy*	NHS Supporter, New Health Network
Neal Deans, *Director of Estates*	None

St George's + Finances

Financial summary 2004-2005

In 2004/05 St George's Healthcare NHS Trust reported a deficit of £21,656,000 on income and expenditure and a 3.2% rate of capital cost absorption which is within the materiality range of 3.0% to 4.0% required by the NHS Executive. The Trust met both its Capital Resource Limit and External Financing Limit. The following statements represent a summary of financial information about the Trust.

Signed on behalf of the Board on 14 July 2005

Peter Homa Chief Executive

Colin Gentile Director of Finance

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

A copy of the Statement of Internal Control can be found in the full accounts.

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

I have examined the summary financial statements set out on pages 29 to 36.

This report is made solely to the Board of 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 2005 on which I have issued an unqualified opinion.

Susan Exton District Auditor
16 August 2005

Audit Commission 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ

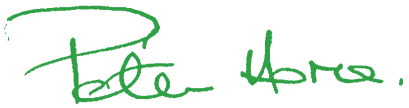
Income and expenditure account for the year ended 31 March 2005

	NOTE	2004/05 £000	2003/04 £000
Income from activities	3	260,935	244,682
Other operating income	4	72,597	72,359
Operating expenses	5-7	(349,182)	(312,181)
OPERATING SURPLUS (DEFICIT)		(15,650)	4,860
Cost of fundamental reorganisation/restructuring		0	0
Profit (loss) on disposal of fixed assets	8	(460)	(123)
SURPLUS (DEFICIT) BEFORE INTEREST		(16,110)	4,737
Interest receivable		422	456
Interest payable	9	(2)	0
Other finance costs – unwinding of discount		(58)	(58)
Other finance costs – change in discount rate on provisions		0	0
SURPLUS (DEFICIT) FOR THE FINANCIAL YEAR		(15,748)	5,135
Public Dividend Capital dividends payable		(5,908)	(5,785)
RETAINED SURPLUS (DEFICIT) FOR THE YEAR		**(21,656)**	**(650)**

All income and expenditure is derived from continuing operations.

Balance sheet as at 31 March 2005

	NOTE	31 March 2005 £000	31 March 2004 £000
FIXED ASSETS			
Intangible assets	10	627	814
Tangible assets	11	250,225	192,560
Investments	14.1	0	0
		250,852	193,374
CURRENT ASSETS			
Stocks and work in progress	12	4,331	4,273
Debtors	13	37,226	32,566
Investments	14.2	0	0
Cash at bank and in hand	18.3	68	68
		41,625	36,907
CREDITORS: Amounts falling due within one year	15	(61,558)	(45,369)
NET CURRENT ASSETS (LIABILITIES)		(19,933)	(8,462)
TOTAL ASSETS LESS CURRENT LIABILITIES		230,919	184,912
CREDITORS: Amounts falling due after more than one year	15	0	0
PROVISIONS FOR LIABILITIES AND CHARGES	16	(5,338)	(3,908)
TOTAL ASSETS EMPLOYED		**225,581**	**181,004**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	22	116,688	104,771
Revaluation reserve	17	103,729	50,123
Donated asset reserve	17	15,789	14,368
Government grant reserve	17	854	816
Other reserves	17	1,150	1,150
Income and expenditure reserve	17	(12,629)	9,776
TOTAL TAXPAYERS EQUITY		**225,581**	**181,004**



Peter Homa, Chief Executive
14 July 2005

Cash flow statement for the year ended 31 March 2005

	NOTE	31 March 2005 £000	31 March 2004 £000
OPERATING ACTIVITIES			
Net cash inflow/(outflow) from operating activities	18.1	4,126	18,679
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		371	426
Interest paid		(2)	0
Interest element of finance leases		0	0
Net cash inflow/(outflow) from returns on investments and servicing of finance		**369**	**426**
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		(10,265)	(14,409)
Receipts from sale of tangible fixed assets		0	3,663
(Payments) to acquire intangible assets		(239)	(206)
Receipts from sale of intangible assets		0	0
(Payments to acquire)/receipts from sale of fixed asset investments		0	0
Net cash inflow/(outflow) from capital expenditure		**(10,504)**	**(10,952)**
DIVIDENDS PAID		(5,908)	(5,785)
Net cash inflow/(outflow) before management of liquid resources and financing		**(11,917)**	**2,368**
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		**(11,917)**	**2,368**
FINANCING			
Public dividend capital received		22,917	0
Public dividend capital repaid (not previously accrued)		(11,000)	(2,363)
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 (to)/from other NHS bodies*		0	0
Net cash inflow/(outflow) from financing		**11,917**	**(2,363)**
Increase/(decrease) in cash		**0**	**5**

Financial summary 2004-2005

Statement of total recognised gains and losses for the year ended 31 March 2005

	2004/05 £000	2003/04 £000
Surplus (deficit) for the financial year before dividend payments	(15,748)	5,135
Fixed asset impairment losses	0	0
Unrealised surplus/(deficit) on fixed asset revaluations/indexation	54,758	13,578
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	1,188	1,956
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets	(1,630)	(1,301)
Additions/(reductions) in "other reserves"	0	0
Total recognised gains and losses for the financial year	38,568	19,368
Prior period adjustment	0	0
Total gains and losses recognised in the financial year	**38,568**	**19,368**

Income from activities

		2004/05 £000	2003/04 £000
Strategic Health Authorities		625	1
NHS Trusts		9	880
Primary Care Trusts		256,032	240,153
Foundation Trusts		196	0
Local Authorities		28	0
Department of Health		745	0
NHS Other		167	0
Non NHS:	– Private Patients	2,027	1,516
	– Overseas patients (non-reciprocal)	382	0
	– Road Traffic Act	679	1,614
	– Other	45	518
		260,935	**244,682**

Road Traffic Act income is subject to a provision for doubtful debts to reflect expected rates of collection.

Other operating income

	2004/05 £000	2003/04 £000
Patient transport services	0	0
Education, training and research	49,602	44,295
Charitable and other contributions to expenditure	525	463
Transfers from donated asset reserve	1,581	1,255
Transfers from government grant reserve	49	46
Non-patient care services to other bodies	3,079	2,529
Other income	17,761	23,771
	72,597	**72,359**

Included in 'Other Income' is £4,451,872 relating to the Central Office for Research Ethics Committee (2003/04: £3,208,000).

5. Operating expenses

5.1 Operating expenses comprise:	2004/05 £000	2003/04 £000
Services from other NHS Trusts	2,591	2,292
Services from other NHS bodies	8,898	8,768
Services from Foundation Trusts	329	0
Purchase of healthcare from non NHS bodies	330	0
Directors' costs	1,212	883
Staff costs	224,049	194,030
Supplies and services – clinical	57,808	53,408
Supplies and services – general	8,964	7,870
Establishment	3,929	3,969
Transport	2,772	2,635
Premises	20,452	16,694
Bad debts	160	620
Depreciation and amortisation	11,375	11,584
Fixed asset impairments and reversals	0	259
Audit fees	118	55
Other auditor's remuneration	114	101
Clinical negligence	5,000	2,479
Other	1,081	6,534
	349,182	**312,181**

Salary and pension entitlements of senior managers

a) Remuneration	2004-05		2003-04	
	Salary *(bands of £5000)*	Other remuneration *(bands of £5000)*	Salary *(bands of £5000)*	Other remuneration *(bands of £5000)*
	£000	£000	£000	£000
Name and Title				
Mr Peter Homa, *Chief Executive*	155-160	0-5	50-55	0-5
Mr Colin Gentile, *Director of Finance (from June 2004)*	95-100	0-5		
Mr Kevin Harbottle, *Acting Director of Finance (to May 2004)*	70-75	0-5	75-80	0-5
Mrs Marie Grant, *Deputy Chief Executive*	110-115	0-5	90-95	0-5
Dr Geraldine Walters, *Director of Nursing (from May 2004)*	85-90	0-5		
Ms Sue Cooper, *Director of Nursing (to May 2004)*	60-65	0-5		
Dr Christopher Streather, *Medical Director*	140-145	0-5		
Mr Mike Bailey, *Medical Director*	100-105	0-5		
Dr Patricia Hamilton, *Medical Director*	205-210	0-5		
Mr Colin Watts, *Director of Human Resourses*	85-90	0-5	75-80	0-5
Mrs Janet Hunter, *Director of Modernisation (to August 2004)*	25-30	0-5	75-80	0-5
Mrs Karen Castille-Wardle, *Director of Service Improvement and Strategy (from January 2005)*	20-25	0-5		
Mr Neal Deans, *Director of Facilities (from January 2005*)	15-20	0-5		
Non-Executive Directors				
Mrs Naaz Coker*, *Chairman*	20-25	0-5	5-10	0-5
Professor Sean Hilton*, *Non-Executive Director*	5-10	0-5	5-10	0-5
Ms Diane Mark†*, *Non-Executive Director*	5-10	0-5	5-10	0-5
Ms Valerie Moore*, *Non-Executive Director (from August 2004)*	0-5	0-5		
Ms Valerie Vaughan-Dick†*, *Non-Executive Director*	5-10	0-5	5-10	0-5
Mr David Knowles, *Non-Executive Director (to July 2004)*	0-5	0-5	5-10	0-5
Mr Michael Rappolt †*, *Non-Executive Director (from August 2004)*	0-5	0-5		

In both 2004-05 and 2003-04, there were no benefits in kind.

† Audit committee

*Remuneration and benefits committee

Salary and pension entitlements of senior managers

b) Pension benefits

Name and Title	Real increase in in pension & related lump sum at age 60 *(bands of £2500)* £000	Total accrued pension & related lump sum at age 60 at 31/03/05 *(bands of £5000)* £000	Cash equivalent transfer value at 31/03/05 £000	Cash equivalent transfer value at 31/03/04 £000	Real increase in cash equivalent transfer value £000
Mr Peter Homa, *Chief Executive*	125-127.5	185-190	646	200	441
Mr Colin Gentile, *Director of Finance (from June 2004)*	17.5-20	115-120	395	304	82
Mr Kevin Harbottle, *Acting Director of Finance (to May 2004)*	0-2.5	75-80	241	239	5
Mrs Marie Grant, *Deputy Chief Executive*	30-32.5	175-180	722	57	135
Dr Geraldine Walters, *Director of Nursing (from May 2004)*	10-12.5	90-95	333	292	34
Ms Sue Cooper, *Director of Nursing (to May 2004)*	0-2.5	60-65	262	266	0
Dr Christopher Streather, *Medical Director*	17.5-20	80-85	258	193	60
Dr Patricia Hamilton, *Medical Director*	12.5-15	185-190	780	690	70
Mr Colin Watts, *Director of Human Resourses*	10-12.5	135-140	623	539	69
Mrs Janet Hunter, *Director of Modernisation (to August 2004)*	5-7.5	50-55	192	164	23
Mrs Karen Castille-Wardle, *Director of Service Improvement and Strategy (from January 2005)*	12.5-15	105-110	369	314	47

There was no employers contribution to stakeholder pension.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

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 basis with no bonus.

The Trust's Chief Executive, Peter Homa, 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 advisors. 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.

Management costs

	2004/05 £000	2003/04 £000
Management costs	13,846	10,528
Income	333,532	316,716

The Trust's pay awards to managers in 2004/05 did not exceed 3.225%

Better payment practice code

Better Payment Practice Code – measure of compliance

	Number	£000
Total bills paid in the year	102,583	138,542
Total bills paid within target	81,680	114,772
Percentage of bills paid within target	80%	83%

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

	2004/05 £000	2003/04 £000
Amounts included within Interest Payable (Note 9) arising from claims made under this legislation	2	0
Compensation paid to cover debt recovery costs under this legislation	0	0

Our values

- We will treat all people with respect and dignity
- We will deliver care in partnership with others
- We will continually strive for clinical excellence
- We will ensure probity and transparency in spending public money
- We will be an exemplary employer
- We are committed to excellence in education, training and research
- We will be open and honest with each other and with those outside the organisation.

"Thank you St George's. You have provided our baby daughter with the best possible start."

Fiona and Jeremy Williams

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