St George's University Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2014/15

Excellence in specialist and community healthcare

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

St George's University Hospital NHS Foundation Trust

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Chairman's foreword

Christopher Smallwood, chairman

We are very pleased to end 2014/15 as a foundation trust after being authorised by Monitor on 2nd February 2015. This is a considerable achievement.

We have changed our name to St George's University Hospitals NHS Foundation Trust to reflect our relationship with St George's, University of London.

Becoming a foundation trust involved two years of close inspection, first by NHS London, then by the Trust Development Authority, by the CQC and finally by Monitor. The governance of the trust was carefully examined and the quality and safety of the care we provide was subject to detailed scrutiny. All of this means we are officially recognised as a strong organisation with good quality services.

As a foundation trust we will be formally accountable to our 21,000 members. Our council of governors will play an increasingly important role in the future of St George's to hold the trust leadership to account. They will also ensure we continue to provide care to the highest of standards and ensure that we have a high level of public engagement in our work.

Our council of governors is made up of 15 elected public governors, five staff governors and eight appointed governors from partner organisations, all of whom have the same statutory responsibilities. Our governors represent the interests of members and the wider public focussing on key priority areas including finance, patient experience, membership engagement and strategic planning. They will also help to ensure we continue to provide care to the highest standards and ensure that we have a high level of public engagement in our work.

Our plans for the future of St George's are exciting. We will increase our collaboration with St George's, University of London; we will expand our centres of international excellence including neurosciences and cardiac sciences; we will continue to integrate and grow our community and acute services, and not least build on what we are told every week in '24 Hours in A&E' that we are "among the most advanced emergency and trauma services in the world".

As everyone is aware, financial pressures are intensifying across the NHS. The majority of trusts are now in deficit, particularly those like St George's which provide a high proportion of emergency care.

For the first time in many years, St George's is reporting a deficit following a decline in our financial position towards the end of 2014/15.

We are working with our regulator – Monitor – to understand this deterioration and to identify ways of improving our financial position.

Further savings must be found and new, more economical ways of delivering care will need to be explored.

We are committed to this work and also to maintaining the quality of our services, of which I remain proud.

Chief executive's statement

Miles Scott, chief executive

I would like to thank our staff, volunteers, members and partners for making 2014/15 such a memorable year.

While one of the significant achievements of the year was becoming a foundation trust, like many other trusts, our finances and performance have been and remain challenging.

We unfortunately ended the year with a £16m deficit instead of a planned £5m surplus which has since led to the organisation being reviewed by Monitor.

We begin 2015/16 with a stretching savings target of six per cent of our operating expenditure. Our progress against this will impact on our year-end figure for 2016/17. We are working with Monitor and are implementing cost improvement programmes in order to improve our financial situation.

As a board, we are fully committed to providing the highest quality of patient care. We made changes to the executive team from August 2014, with a view to better deliver sustained service improvements in quality, safety and efficiency.

Despite our financial position at year end, it has been an exciting year at St George's in many ways.

Following on from the launch of the helipad, we celebrated the opening of several new facilities including the haematology and oncology outpatients clinic, the First Touch garden and more services in the community at the Nelson Health Centre.

We have continued to receive support and positive feedback from those who enjoy watching our emergency team on Channel 4's '24 Hours in A&E'.

News that we were successful in our bid to be part of the '100,000 genomes' project was a great boost. This three-year programme focuses on cancer and rare diseases and has the potential to transform the future of healthcare.

Our achievement of becoming an NHS foundation trust was the result of a long period of improvement from a workforce whose energy, commitment and compassion is outstanding.

It also demonstrates that we consistently live up to our values; Excellent, Kind, Responsible and Respectful. This becomes even more important now as our accountability to our communities increases through our council of governors.

Becoming a foundation trust means we can refocus our efforts on our strategy and the development of our services, to better meet the diverse and changing needs of our patients in the future and keep them at the heart of everything that we do. It also means being able to make our own decisions about how we invest in our sites and services.

I am immensely proud of the trust and our staff who provide the best care they can 24 hours a day, 365 days a year.

We must continue with the same excellent work going into 2015/16 to build on our successes.

What we do

Introduction

Everything St George's does is focused on our patient need. From local services to nationally leading specialties, our vision is for patients to experience the highest possible quality of care.

With over 8,500 dedicated staff caring for patients around the clock, we are the largest healthcare provider, major teaching hospital and tertiary centre for south west London, Surrey and beyond.

Our main site, St George's Hospital, is one of the country's principal teaching hospitals and shares its site with St George's, University of London which trains the next generation of healthcare, science and medical students and also carries out advanced medical research.

St George's also shares the site with St George's, University of London and Kingston University's Faculty of Health and Social Care Sciences, which is responsible for training a wide range of healthcare professionals from across the region.

As well as acute hospital care, we provide a full range of specialist care following integration with Community Services Wandsworth in 2010.

The trust serves a population of 1.3 million across south west London. A large number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

We also provide care for patients from a larger catchment area in south east England for specialities such as complex pelvic trauma. Other services treat patients from all over the country, such as family HIV care and bone marrow transplantation for non-cancer diseases. The trust also has a nationwide state of-the-art endoscopy training centre.

A number of our services are part of established clinical networks, which bring together doctors, nurses and other clinicians from a range of healthcare providers working to improve the quality of services for patients. These include the London Cancer Alliance, the South London Cardiac and Stroke Network and the South West London and Surrey Trauma Network of which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

This report tells the story of how St George's has performed during the year that we became a foundation trust and includes our reporting as both a foundation trust and a NHS trust. It also looks ahead to next year's priorities for providing quality, patient-centred care at a time when St George's, like many other trusts, is experiencing significant financial pressures.

Life as a foundation trust

The 2014/15 year was characterised by two main events; becoming a foundation trust and the challenging end – financially and operationally – to the year.

As a foundation trust we are regulated by Monitor, rather than the Department of Health. This different regulatory framework means we are freer from most central government control. Although this brings increased responsibility, the additional freedom enables us to grow and modernise our services to best meet local needs. This is better for all our patients as it means we can bring new treatments and services to them more quickly. We can work more closely with our partner organisations, meaning we can grow and develop more rapidly in response to an ever changing environment. Foundation trusts can decide how to invest their financial surpluses.

Our 21,000 strong membership represents the communities we serve as a trust. Developing this membership will increase the trust's accountability to patients, staff and the public, which will result in real benefits for all of our stakeholders.

Our council of governors was established in 2014 as a shadow council, before becoming fully functional upon authorisation. Their first official meeting was held on 10th February 2015.

Our successful foundation trust application is recognition of the high quality services and safe care we provide in our hospitals and in the community and shows that we can live up to our values; **Excellent, Kind, Responsible and Respectful**.

Facts and figures

St George's is a vibrant, multi-faceted organisation. The following is not an exhaustive list, but gives a flavour of the trust, its size, activity, quality and services during 2014/15 as both an NHS trust and a foundation trust.

Overall, in 2014/15, the trust saw **669,570** outpatients, delivered **5,039** babies, undertook **46,731** elective inpatient and day case procedures and admitted **51,021** non-elective patients.

Our emergency department saw **142,892** patients including early pregnancy unit attendances, while Queen Mary's Hospital minor incident unit saw **16,729** patients.

The trust has a designated large hyper acute stroke unit, providing an extremely high quality service, and received **1,711** stroke patients during 2014/15.

The trust is a major centre for tertiary services including cardiovascular, neurosciences, renal, cancer and specialised children's services for south west London and Surrey.

It is also one of four major trauma centres in London and we received **1376** major trauma calls in 2014/15, **192** of whom came to us via our new helipad.

We officially opened the helipad in April 2014 which strengthened our role as a major trauma centre.

We were delighted to welcome Channel 4's '24 hours in A&E' TV crew onto our site from May 2014 for just under two months. They filmed 30 episodes in total. The first episode aired on 30th October 2014 and was viewed by 2.5 million people.

Our services

As the largest healthcare provider in south west London, St George's has an important role to play in the local economy.

We provide healthcare services at:

Hospitals

St George's Hospital, Tooting

Queen Mary's Hospital, Roehampton

Therapy centres

St John's Therapy Centre

Health centres

Balham Health Centre

Bridge Lane Health Centre

Brocklebank Health Centre

Doddington Health Centre

Eileen Lecky Clinic

Joan Bicknell Centre

Nelson Health Centre

Stormont Health Centre

Tooting Health Centre

Tudor Lodge Health Centre

Westmoor Community Clinic

Other settings

HMP Wandsworth

We also provide services in GP surgeries, schools, nurseries, community centres and in patients' homes.

Clinical services are split into four divisions:

- **Surgery, theatres, neurosciences and cancer**
- **Medicine and cardiovascular**
- **Children's & women's, diagnostics, therapeutics and critical care**
- **Community services**

The trust's tertiary and specialist services treat the most complex injuries and illnesses. Many specialist services are provided as part of clinical networks for which the trust acts as the clinical hub, for example, the trust is the inpatient centre for paediatric, ear, nose and throat, plastics and maxillo-facial surgery for south west London.

The trust became one of the four major trauma centres in London in 2010 and in the same year was designated a hyper acute stroke unit. The trust's stroke service consistently receives excellent reports as part of the Sentinel audit, which shows the service to be in the top quartile nationally.

The trust was the first in London to provide primary angioplasty services 24 hours a day, treating heart attack victims with rapid stenting of the arteries around the heart and is one of eight heart attack centres in London.

The vast majority of the trust's acute services are delivered at St George's Hospital. The trust believes this is a key strength of the organisation, bringing together the full range of acute clinical services and clinical expertise on a single site.

The diagram on the next page shows the divisional structure and the services each division delivers for the differing cohorts of patients who access St George's services.

Find out more about our services and the clinicians and healthcare professionals that provide them on the services section of our website **www.stgeorges.nhs.uk/services**

Key

Flagship tertiary services	Key specialist services	Local hospital services	Support services	Community services

Division	Directorates	Clinical services within each directorate						
Surgery, theatres, neurosciences and cancer	Surgery & trauma	T&O	ENT	Maxillofacial	Plastics	Urology	General surgery	Dentistry
		Audiology						
	Theatres & anaesthetics	Theatres & decontamination	Anaesthetics & acute pain					
	Neurosciences	Neurosurgery & neuro-radiology	Neurology	Neuro-rehab	Pain clinic			
	Cancer	Cancer						
Medicine & cardiovascular	A&E & acute medicine	A&E	Acute medicine					
	Specialist medicine	Lymphoedema	Clinical infection unit	Rheumatology	Diabetes / endocrinology	Chest medicine	Endoscopy & gastroenterology	Dermatology
	Renal, haematology & oncology	Renal transplantation	Renal	Medical oncology	Clinical haematology	Palliative care		
	Cardiovascular	Cardiology	Cardiac surgery	Vascular surgery	Blood pressure unit			
Children's & women's, diagnostics, therapeutics and critical care	Children's	Paediatric surgery	Newborn services & NICU	PICU	Paediatric medicine			
	Women's	Gynaecology	Obstetrics					
	Therapeutics	Adult critical care	Therapies	Pharmacy				
	Diagnostics	Clinical genetics	Breast screening	Pathology	Radiology	Laboratory haematology		
	Outpatients	Outpatients						
Community services	Children & family	School & special school nursing	Children's continuing care	Health visiting	Child safeguarding team	Children's therapies & immunisation	Homeless, refugees and asylum seeker team	
	Older people & neuro-rehab	Community nursing & community ward	Intermediate care	Specialist nursing	Older people and neuro therapies	Day hospitals	Elderly rehab	Community learning disabilities
	Adult & diagnostic	Outpatient services	Minor injuries unit	Diagnostics	Integrated sexual health services	Specialist rehab services	Adult therapy services – physiotherapy, podiatry, dietetics	
	Offender healthcare	Primary care	Substance misuse	Inpatient care	Primary care mental health			

Working in the community

As well as acute hospital services, we provide a wide variety of specialist care and a full range of community services to patients following integration with Community Services Wandsworth in 2010.

Nelson Health Centre, Merton

The new Nelson Health Centre delivers a range of outpatient and diagnostic services. It offers an alternative to hospital based care and treatment for local patients. Services at the Nelson:

- **deliver a high quality, holistic service to assess, diagnose and treat patients, delivering 'one stop' care where possible**
- **provide improved convenience and reduced waiting times for patients**
- **simplify the patient pathway to minimise the number of visits, improving patient experience and increasing efficiency**
- **provide a feedback system for GPs in Merton, enabling them to manage their patients within their practice as far as is clinically appropriate.**

Ophthalmology services are delivered by Moorfields Eye Hospital NHS Foundation Trust. We are working with Merton Clinical Commissioning Group to develop additional services and to improve referral and ordering. The site will also host clinical networking and education sessions for staff.

Family Nurse Partnership, Wandsworth

The trust has become the successful provider for delivering the Family Nurse Partnership (FNP) programme in Wandsworth. This evidence based programme provides intense support to teenage parents from early pregnancy until their baby turns two years old.

Saturday Fully Integrated Sexual Health Clinic

In January, the trust opened the first fully integrated sexual health service on a Saturday morning in south west London. The clinic offers screening, testing and treatment for all sexually transmitted infections; post-exposure prophylaxis for HIV; emergency hormonal contraception; pregnancy testing; and cervical cytology screening. The Saturday service is running as a one year pilot and will be fully evaluated after six months.

Amputee rehab

The amputee rehabilitation team at Queen Mary's Hospital led the International Society for Prosthetic and Orthotics National Conference 2014 at the Royal College of Surgeons.

The theme focused on the management of the multiple limb amputee and the complex rehabilitation processes required for the successful management of these patients. The trust has had particular experience of these patients, offering intensive multi-disciplinary rehabilitation in its unique inpatient rehabilitation facility on Gywnne Holford ward. This expertise was shared with a full conference of over 150 delegates.

Lead Dr Sooriakumaran with his team at the conference

Project Search

Project Search is a work based training programme for adults with learning disabilities aged between 18 and 25, with the objective of them finding paid work. They spend 35 weeks with the trust in different parts of the St George's Hospital learning about some of our vital support services. They are also supported with literacy, completing application forms and handling job interviews.

Children and families clinical team leaders win CPHVA award

In May 2014, St George's clinical team leaders won the Community Practitioner Team of the Year Award from the Community Practitioners and Health Visitors Association. This is thanks to their approach to supporting teams, developing practice and providing high quality care for the families of Wandsworth.

Three community staff in top 150 nationally

Ruth Godden (community team leader), Hannah Bracey (specialist health visitor) and Zoe Sargent (head of children and families nursing) became three of 150 outstanding health visitors who were identified to join the prestigious Institute of Health Visiting's Fellowship programme nationally.

This programme recognises the professional achievement of these exceptional health visitors, creating a new country-wide group of expert and confident health visitor leaders who make a difference to the health outcomes of children and their families.

South London Membership Council (SLMC) Recognition Award

In October 2014, the falls and bone health service was awarded for its outstanding 'bone boost' service delivered by integrated falls and bone health service with Nordic walking delivered by ex-patient walk leaders.

Research Grant

The trust and Kingston University were collaboratively awarded a £300k research grant to look at physical activity in care homes. The study commenced in January 2015.

Annual community open day

Our annual community open day at St George's hospital attracted over 1000 visitors in November 2014.

Visitors had the chance to look around the simulation suite, view hospital artwork, get involved with fitness activities and learn about the hospital's history.

Over 60 stalls were set up ranging from advice about alcohol, heart disease and tuberculosis to finding out about nursing as a career. This was a joint event with St George's, University of London.

Research

Our research and development portfolio is constantly increasing, enabling us to develop new and improved clinical treatments for our patients, and sustaining St George's reputation as an established centre for clinical innovation.

Research was cited as a key component of the trust's ten year strategy 2012-2022, with the specific aim to 'drive research and innovation through our clinical services'. To support this, a research strategy was developed, comprising six key objectives:

1. **develop a culture that places research at its core**
2. **maximise the benefits of our partnership with St George's, University of London**
3. **partner with an Academic Health Science Centre (AHSC) at the heart of a vibrant South London Academic Health Science Network (AHSN)**
4. **increase the success of funding from research networks and grant-giving bodies**
5. **become a preferred partner with industry for pharmaceutical research and medical innovation**
6. **establish a robust infrastructure to support research.**

These objectives continue to be central to our strategic goals and the ongoing focus on research has widened the scope of opportunity for both trust-led and collaborative work.

Clinical trials

The trust's enthusiasm in steering complex and wide-ranging research trials has firmly positioned St George's as a site of clinical advancement.

This year alone, the trust has independently conducted over 170 research projects, recruiting over 8,000 NHS patients and allowing both

them and us to stand at the forefront of medical innovation. Our Clinical Research Facility has engaged in projects spanning the testing of new drugs to trialling surgical instruments and researching the genetic identifiers of disease.

Such growth in research has helped us to develop strategic links with external organisations, and enabled us to increase the proportion of studies meeting performance targets.

Working in partnership

The trust's relationship with St George's, University of London plays a vital role in the delivery of a vibrant research, education and academic agenda, and informs both the care we provide and the development of our workforce.

In 2014 we moved closer to establishing our first clinical academic group (CAG). Clinicians from the trust and academics from the university are working in partnership on a range of cardiology research programmes.

Our joint involvement in the successful development of a variety of new vaccines, potential treatments for vascular dementia and improved diagnostic tools for a range of infectious pathogens, highlights the importance of this relationship to the advancement of both academic knowledge and clinical practice.

St George's reputation, drive towards research and bond with the university has afforded us a status worthy of supporting a range of exciting externally-led studies, and has earned us collaborative opportunities with Genomics England for the 100,000 Genomes Project (focussing on the influence of genes on rare, cancerous and infectious disease), as well as various foetal health trials alongside Great Ormond Street and Premaitha Health.

Working with our partners

We understand and believe in working with our partners. These are partners that we have worked with since being an NHS trust through to being a foundation trust, unless specified below. Here are some of our key partnerships that help make our trust a success.

St George's, University of London

Building on centuries of joint endeavour, the university and hospital offer higher quality education, training, research and clinical care. The partnership has been striving to and will continue to improve using the resources and expertise available on site.

This year has led to a number of innovations after implementing the Joint Implementation Board, including the planned launch of the cardiology clinical academic group.

We also have joint director posts with St George's, University of London, including our medical director, director of human resources and director of estates and facilities.

St George's Hospital Charity

The work of St George's Hospital Charity enhances the physical environment of the trust for patients, staff and visitors. The charity funds research and state-of-the-art equipment. Through fundraising the charity is able to fund projects which touch the lives of the thousands of people cared for at the hospital and in the community each year.

The charity has donated to and supported these projects:

- **a magic carpet for the play team – a specialist piece of equipment that aids with sensory play**
- **a sofa for the lilac suite in the maternity unit where women and their families are given support following a stillbirth**
- **Dermatascopes to provide our melanoma specialists with modern equipment to increase their ability to spot melanomas, take digitally transferable photos and add them to patient records**
- **Accuvein machines to help doctors and nurses find a child's vein with maximum accuracy and minimal anxiety**
- **funding an early-onset dementia patient and relative support group across south west London for 12 months to help hundreds of local people access peer-to-peer support.**

South London NHS Genomics Network Alliance

The south London based Genomics Network Alliance was successful in becoming a pioneering Genomic Medicine Centre, part of the ground-breaking 100,000 Genomes Project. The three-year programme, which began in February 2015, has the potential to transform the future of healthcare.

The Genomics Network Alliance serves a population of more than seven million people and is a partnership between the following London hospital trusts and universities and two of the country's biggest patient organisations:

- **four NHS trusts: Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust**
- **two universities: King's College London and St George's, University of London**
- **two patient organisations: Macmillan Cancer Support and Genetic Alliance UK**
- **two Academic Health Science Networks: covering South London (The Health Innovation Network) and Kent, Surrey and Sussex**
- **one Academic Health Science Centre: King's Health Partners.**

South West London Pathology (SWLP)

Croydon Health Services NHS Trust, Kingston Hospital NHS Foundation trust and St George's University Hospitals NHS Foundation Trust formed a partnership to deliver a single, integrated, high quality, NHS led pathology service to hospitals and GPs across south west London.

The partnership brings together the best of each trust's current pathology services and provides them in a co-ordinated and streamlined way. This entity is called 'South West London Pathology'.

The partnership officially started on 1st April 2014. St George's University Hospitals NHS Foundation Trust is the host organisation for all its services.

NHS South West London

NHS South West London brings together five clinical commissioning groups: Croydon, Kingston, Richmond, Sutton & Merton and Wandsworth. NHS South West London works with St George's University Hospitals NHS Foundation Trust on designing services to meet the specific needs of our patients.

South London healthcare networks

The trust is at the heart of several healthcare networks operating across south London. We work alongside our colleagues from the NHS, private and voluntary sectors to deliver expert care to patients and their families from diagnosis to rehabilitation.

These networks include trauma, cancer, cardiac and stroke. The sharing of expertise and ability to streamline care pathways across these networks has led to consistently high quality care and improved outcomes for patients.

Kingston Hospital NHS Foundation Trust

Our working relationship with Kingston Hospital NHS Foundation Trust has continues with a number of consultants who have commitments to both trusts.

The work covers a range of specialties and this ensures a smooth flow of patients between organisations. Both organisations participate in wider south west London clinical networks and have recently collaborated on the development of stroke and trauma services for the sector.

Wandsworth Council

St George's, Wandsworth CCG, Wandsworth Council, local GPs and pharmacists work together on the Planning All Care Together (PACT) programme.

PACT puts service users, patients and carers at the heart of service delivery and uses the strengths of NHS and council services as well as the voluntary sector to design and deliver innovative approaches to care, which better meets the needs of people with long term conditions in Wandsworth.

Telehealth and telecare already support patients with long-term health conditions, help increase independence and support them staying at home for as long as possible.

Healthwatch

Healthwatch England is a national organisation that makes sure the overall views and experiences of people with health and social services are heard of and taken seriously.

Healthwatch Wandsworth and Healthwatch Merton give local people in the area the chance to voice their views on health and social care services. It works for the local community by helping to shape and improve the services the local communities use and by engaging with local people.

Ronald McDonald House

Ronald McDonald House Charities keeps families together so children in hospital can get the love and comfort they need. The charity provides 'home away from home' accommodation for families with children in hospital; somewhere free to stay for as long as they need to.

The mission of Ronald McDonald House Charities is to ensure there are sufficient funds and expertise to develop and sustain free accommodation at specialist children's hospitals in the UK.

The House at St George's Hospital is one of 14 across the UK. Many families travel miles from home so that their child can receive expert medical care and many have to remain in hospital for months at a time.

First Touch

First Touch is a charity which funds medical equipment, specialist nurse training and a welfare scheme for families whose babies are being cared for on the neonatal unit at St George's Hospital.

The charity recruited 'ambassadors' in Tooting, Balham, Wandsworth, Wimbledon, Raynes Park and Colliers Wood to raise its profile. Actress Martine McCutcheon and her fiancé Jack McManus are the charity's patrons. The trust partnered with First Touch for their Chelsea Flower Show garden in 2014 which was then brought to St George's Hospital as a feature for patients and visitors to enjoy.

Health Innovation Network

The Health Innovation Network (HIN) is a membership organisation which is driving lasting improvements in patient and population health outcomes by spreading the adoption of innovation into practice across the health system and capitalising on teaching and research strengths.

As the Academic Health Science Network for South London the prioritised health challenges for local communities include diabetes, dementia, musculoskeletal health issues, cancer and alcohol.

London Cancer Alliance

We play and active role in the London Cancer Alliance. The London Cancer Alliance works collaboratively with 15 NHS provider organisations, including St George's University Hospitals NHS Foundation Trust, plus two academic health science networks – Health Innovation Network South London and Imperial College Health Partners.

It was established in 2011 as the integrated cancer system across west and south London and it serves a population of over five million.

Their vision is to provide equitable, world-class cancer care, health outcomes and patient experience, delivered through comprehensive and seamless pathways, based upon national and international standards, research and evidence.

Their mission is to work collaboratively across the integrated system to deliver safe and effective care, improve cancer clinical outcomes and enhance patients' and carers' experience and quality of life.

Full Circle Fund

The Full Circle Fund is dedicated to enhancing the quality of life of patients through pioneering supportive therapies. Based in haematology, oncology and paediatric wards, the fund's services benefit adults, babies and children with life-threatening conditions.

A range of therapies offered by the fund aims to achieve improved quality of life, a reduction of anxiety, improvements in sleeping, feelings of wellbeing and control and a reduction in the perception of pain.

It works in three key areas:

- **therapy – quality of life support and training programmes for patients**
- **research – scientific research and evaluation for better understanding of supportive therapies and survivorship**
- **education – informing and educating healthcare professionals and the general public about the role and benefits of supportive therapy.**

Living our values

Our mission is to provide excellent clinical care, education and research to improve the health of the populations we serve. Our vision is to become an excellent integrated provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research.

We are committed to keeping patients at the heart of everything that we do and our values are designed to inspire our staff to achieve this.

The following values set out the standards we have set ourselves.

Excellent

- look after our patients as we would like to be looked after ourselves
- set ourselves high standards and be open to new ideas
- be professional in our approach and in our appearance
- promote and share best practice

Kind

- anticipate and respond to patients' and carers' concerns and worries
- support each other under pressure and consider the impact of our actions on others
- help people find their way if they look unsure or lost
- smile, listen and be friendly

Responsible

- have patient safety as our prime consideration
- be responsible for ensuring good patient experience
- use resources wisely
- challenge poor behaviour in others
- learn from experience including our mistakes

Respectful

- keep patients, families and carers involved and informed
- protect patients' dignity and confidentiality
- wear our name badges, introduce ourselves and address people in a professional manner
- respect colleagues' roles in patient care and experience
- value and understand the diversity of those around us

Responding to your concerns

The trust cared for over one million patients in 2014/2015. We accept that among this number of patients, the experience for some will not meet their expectations.

The trust adheres to the Parliamentary and Health Service Ombudsman's Principles for Remedy, which provide guidance on the way in which public bodies respond to complaints and concerns raised by patients and their representatives.

We are absolutely prepared to change and improve in response to feedback from patients, visitors and other stakeholders. The lessons learned and trends identified from information collected via our complaints process play an important part in improving the quality of care we provide.

In addition, our Patient Advice and Liaison Service (PALS) helps to address any problems or concerns that patients may have regarding the trust's services. PALS staff listen to the views and comments of patients ensuring that feedback is passed on. They also advise staff regarding access to interpreters, signers and other services patients may need to improve their experience. PALS staff also provide customer care training to colleagues and often assist staff when they are in need of support.

The table below lists the written complaints received between 1st April 2014 and 31st March 2015.

Complaints are tracked on a financial year by year basis, so these complaints collectively consist of being an NHS trust and a foundation trust.

	TOTAL NUMBER OF WRITTEN COMPLAINTS RECEIVED
Admissions, discharge and transfer arrangements	50
Aids and appliances, equipment, premises (including access)	1
Appointments, delay/cancellation (outpatient)	176
Appointments, delay/cancellation (inpatient)	26
Length of time waiting for a response, or to be seen: NHS Direct	0
Length of time waiting for a response, or to be seen: Walk in centres	0
Attitude of staff	95
All aspects of clinical treatment	420
Communication/information to patients (written and oral)	167
Consent to treatment	2
Complaints handling	0
Patients privacy and dignity	10
Patients property and expenses	13
CCG commissioning (including waiting lists)	0
Independent sector services commissioned by CCGs	0
Independent sector services commissioned by trusts	0
Personal records (including medical and/or complaints)	37
Failure to follow agreed procedures	4
Patient's status, discrimination (eg. racial, gender, age)	2
Mortuary and post mortem arrangements	0
Transport (ambulances and other)	25
Policy and commercial decisions of trusts	2
Code of openness – complaints	0
Hotel services (including food)	10
Other	12
TOTAL	**1052**

The table below highlights some actions that we have taken in response to feedback.

CONCERN	ACTION
Trauma and orthopaedics (delays in clinic)	Restructuring of fracture clinic to reduce delays. We now have a consultant who is not booked to see patients but sits in a central control room so that they can offer advice and support to the registrars who see a high volume of patients. They can advise in complex clinical cases and as they do not have their own list of patients, are easily accessible to all registrars. This has reduced delays in fracture clinic and improved patient care.
Cardiothoracics (pain management)	An increase in complaints related to pain management particularly where bank/agency staff have been looking after patients was noted. The sister and matron have developed a leaflet for these staff explaining unique pain patients experience post thoracic surgery and a quick reference guide. The thoracic clinical nurse specialist (CNS) is also producing short booklets on common thoracic surgery and post-operative complications to help temporary staff to manage these patients. A second CNS for thoracics is being appointed which will help allow the majority of patients to be pre assessed. This will allow greater discussion about post-operative care so the patient will be aware what to expect and understand how to use the patient controlled analgesia alongside oral analgesia.
Transport (delays)	A training schedule was set up in December 2014 and all trust staff now have access to training on the transport systems and processes on a monthly basis. The training covers issues such as ensuring the correct transport booking is submitted and escalation procedures are reinforced to ensure delays to patient journeys are minimised.
Offender Healthcare (various)	In response to complaints a number of actions have been taken, some general and some more specific including: • every quarter, a group of randomly selected prisoners are sent invitations to meet with the head of offender healthcare to provide feedback on healthcare services • a healthcare professional regularly attends to prisoner wing forum to obtain feedback • each November prisoners are invited to complete a prisoner survey and the results are compared to the previous year • standardised guidance is being produced for a clinicians to promote best practice and provide training for all clinicians in ear care • a patient information leaflet will be made available to patients presenting with ear wax impactation. This is being produced by the clinical lead nurse for the offender healthcare service and will be completed by the end of October 2015.

Emergency planning

The NHS Commissioning Board Emergency Preparedness Framework 2013 states that emergency preparedness continues to be a key priority for the NHS. The requirements are set out in NHS Commissioning Board Planning framework (everyone counts: planning for patients). It also requires all NHS organisations to have emergency preparedness plans in place and to practice those plans.

In addition, because we are an acute trust, we have a duty under the Civil Contingency Act 2004 to show that we can deal with a range of incidents that may have an impact on health or patient care whilst still delivering services to patients.

The trust has a major incident steering group and a business continuity steering group which meet quarterly to discuss continuous improvement options, exercising the plans and training for staff with responsibilities within the plans.

As the major trauma centre for south west London and Surrey, St George's chairs the emergency preparedness element of the South West London and Surrey Trauma Network (SWLSTN). This allows for the sharing of good practice and the innovation of ideas and innovation across the trauma units within the region. This group is now an established part of the SWLSTN and meets regularly across the year.

In November 2014, St George's underwent its annual emergency preparedness, resilience and response (EPRR) assurance process. A team of EPRR practitioners from NHS England (London) visited the site and measured us against a number of core standards. The standards were given a red, amber or green status. Of the 37 supporting standards there were only three amber ratings with the rest being assessed as green. The trust achieved a 'substantial' rating only narrowly missing out on gaining 'full' status. This was a significant achievement for St George's, but leaves no room for complacency. Recommendations from the assurance process will be instigated to further strengthen our emergency preparedness.

2014/2015 saw a number of events that had the potential to have a significant impact on the trust. Key events include:

- **RideLondon in August 2014**
- **trust response to Ebola**
- **health worker strike action in October and November of 2014**
- **health worker strike action in January 2015.**

To ensure the trust met its emergency preparedness requirements for the above events, multi-disciplinary operational planning groups assessed how these events would affect the trust and put a series of measures in place to ensure that the trust continued to make patients its priority.

Strategic report

Our clinical and operational performance

The trust has continued to work hard in 2014/15 to drive performance improvement across the organisation in all service areas.

We are proud, though not complacent, of our progress and achievements. As a large and complex teaching trust encompassing a tertiary centre, a major trauma unit, a busy A&E and a wide ranging portfolio of services, there are greater risks to the routine delivery of day to day operational and financial targets than in many other trusts.

Over the past years, St George's has either met or exceeded many of the targets set for the trust across a range of key performance indicators (KPIs), both operational and clinical. This provides both patients and commissioners continued assurance that St George's is a safe place to receive high quality clinical care.

Early in 2014/15 the trust made significant improvement against the 62 day cancer treatment target from 2013/14, meeting the target for Q1 and Q2 of 2014/15. We faced some challenges in delivering performance in Q3 and have implemented a number of actions to bring performance back to target. The trust continues to work collaboratively with external partners and peer trusts to share lessons learnt and improve operational practices.

The trust was pleased with its infection control performance and mixed sex accommodation breach performance in 2014/15, all of which showed an improvement on the 2013/14 position. However, with the demand rising and the complexity of activity increasing, the trust does not underestimate the challenge of meeting ever more demanding key targets over the coming years alongside delivering strong financial performance.

The trust met all 18 week Referral to Treatment (RTT) targets in Q1. The trust was not required to meet targets for the remainder of the year as breach of RTT targets was authorised as part of a national RTT resilience programme. The trust, like many others, actively focused on reducing the number of long waiters on our lists.

2014/15 was a challenging year with performance being affected against a number of targets which included: A&E four hour standard and the 62 day cancer treatment target. Significant winter pressures and an increase in the complexity and acuity of patients coming into A&E combined with a rise in unplanned admissions resulted in the trust not meeting the four hour wait target. Over the past year the trust has significantly increased A&E staffing, both medical and nursing and is working internally and with external partners to ensure that actions are taken to achieve sustainable performance delivery and to improve the flow of patients through the organisation and their care pathway.

In the final quarter of 2014/15 and into 2015/16 the trust struggled with delivery of the four hour emergency standard, 18 week referral to treatment waiting time, and to a lesser extent, the 31 and 62 day cancer targets. As result of this we are undertaking a joint trust and Clinical Commissioning Group (CCG) investigation in to our emergency services and referral to treatment times.

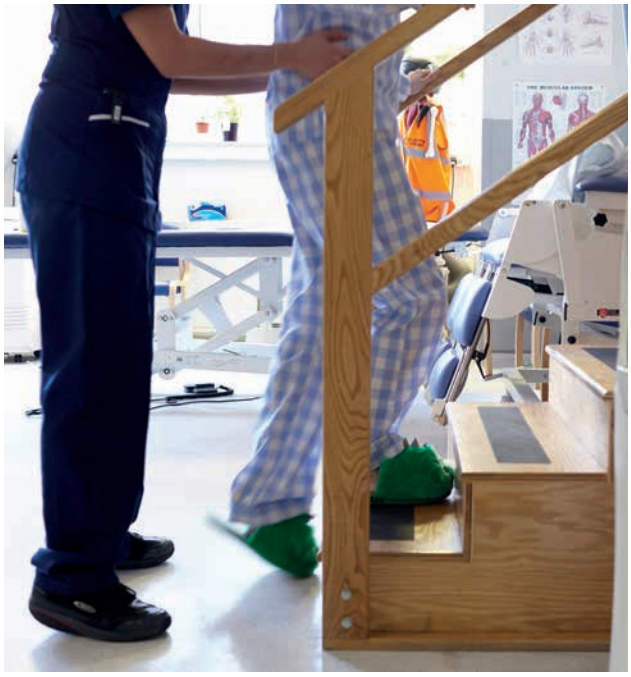
This work started at the beginning of 2015/16 and the key themes to emerge so far are:

- **opportunities to strengthen our primary care arrangements for minimising impact on urgent care**
- **recognised need for a 'transformative' model of care that responds to the growing age profile of patients**
- **protecting and expanding ambulatory care services, including through development of a surgical assessment unit**
- **potential CCG interest in seeing the development of ambulatory care services out of hospital, such as at the Nelson Health Centre**
- **strong commissioner support for an acute medical unit, better hospital flow and discharge**
- **aspiration to see a set of flow based key performance indicators that can be monitored by commissioners.**

At this stage the likely performance impact of the issues being discussed in the joint investigation are not known. In moving further towards prospective performance modelling and assurance, the trust and its commissioners face a number of challenges including:

- **predicting any changes in the age profile (and therefore length of stay) of patients attending the emergency department and/or being admitted**
- **modelling the likely impact on performance of any short or long term recommendations arising from the joint investigation**
- **funding the additional activity that will be needed to further reduce waiting times and keep them low sustainably.**

A group of trust and commissioner executive directors is being convened to consider how best to model these impacts and the outcomes from the review in to our future plans.



Indicator	Target	2014/15 Performance
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	>=95%	92.31%
62-day wait for first treatment from urgent GP referral for suspected cancer	>=85%	85.60%
62-day wait for first treatment from NHS Cancer Screening Service referral	>=90%	91%
31-day wait for second or subsequent treatment – surgery	>=94%	99%
31-day wait for second or subsequent treatment – anti-cancer drug treatments	>=98%	100%
All cancers: 31 day wait from diagnosis to first treatment	>=96%	98%
Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected)	>=93%	96%
Cancer: two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected)	>=93%	96%
C.difficile – meeting the C.difficile objective	40 threshold	ACHIEVED – 38 cases against annual threshold of 40
MRSA bacteraemias (blood stream infections)	(0 with do minimis of 6)	6
Mixed sex accommodation breaches	0	16
Emergency readmissions within 30 days following an elective or emergency spell at the trust	5%	3.20%
Data completeness: community services, comprising:		
Referral to treatment information	50%	55%
Referral information	50%	88%
Treatment activity information	50%	69%

Trust performance against national targets (actual performance shown in bold, target or threshold shown in brackets)

Financial review 2014/15

Overview

St George's Healthcare NHS Trust was a granted licence to operate as a foundation trust on 1st February 2015. As a result, two sets of accounts have to be submitted; one for each legal entity: as an NHS trust for ten months (01/04/14 – 31/01/15) and as an NHS foundation trust for two months (01/02/15 – 31/03/15). Both sets of accounts are attached but the commentary below covers all 12 months to enable the reader to compare results to previous years.

Financial Performance 2014/15

The squeeze on public spending continues to create financial pressures on the health service. These are partly due to the underlying costs which inevitably increase as it serves an ageing population with growing expectations led by advances in technology and medicine. To enable the trust to meet this challenge we need to improve our efficiency year on year and the trust remains committed to maintaining quality of care while delivering these efficiencies.

The trust planned to make a surplus of £5m for the 2014/15, but actually incurred a revenue deficit of £16.8m. This compares with a surplus of £4.7m in 2013/14. The total savings challenge the trust faced in 2014/15 was £45.2m. Delivery was at £37.6m, a undershoot of £7.6m.

The breakdown of financial performance between the two accounting periods and the combined position for 12 months operation is shown in the table.

The trust faced a number of difficulties in 2014/15. These fall into four categories: system wide issues across the NHS, capacity issues at the trust, operational issues at the trust and changes in external funding decisions.

One major operational change was the introduction of South West London Pathology (SWLP) from April 2014 which is a partnership hosted by the trust with Kingston and Croydon hospitals to provide pathology services. The impact on the trust income and expenditure was to increase income by £22m offset by an additional £22m of costs.

	10 mths to 31st Jan 2015	2 mths to 31st March 2015	**2014/15 total**	2013/14 total
Statement of comprehensive income	£000	£000	**£000**	£000
Operating income from patient care activities	507,341	105,315	**612,656**	594,644
Other operating income	84,272	14,131	**98,403**	70,073
Total operating income from continuing operations	591,613	119,446	**711,059**	664,717
Operating expenses of continuing operations	(592,421)	(124,474)	**(716,895)**	(649,212)
Operating surplus / (deficit)	(808)	(5,028)	**(5,836)**	15,505
Finance costs				
Finance income	66	92	**158**	94
Finance expense – financial liabilities	(2,693)	(580)	**(3,273)**	(3,253)
Finance expense – unwinding of discount on provisions	(15)	(3)	**(18)**	(26)
PDC dividends payable	(6,414)	(1,282)	**(7,696)**	(7,624)
Net finance costs	(9,056)	(1,773)	**(10,829)**	(10,809)
Surplus/(deficit) for the year	(9,864)	(6,801)	**(16,665)**	4,696
Transfer to retained earnings on disposal of assets	(91)		**(91)**	0
Retained surplus/-deficit for the period	**(9,955)**	**(6,801)**	**(16,756)**	4,696
Other recognised gains and losses	0	(60)	**(60)**	0
Total comprehensive income / (expense) for period	-9,955	-6,861	**-16,816**	4,696

Income

Healthcare income from CCGs and NHS England increased by 4.2 per cent over 2014/15. The trust received £5.6m relating to achieving 18 weeks referral to treatment targets and £3.7m to help improve clinical services during winter. The trust saw increases in its elective and outpatients income but these were achieved at a premium costs in staffing and the use of private hospital facilities. Taking out the impact of SWLP the trust's other income was consistent with 2014/15.

Expenditure

Expenditure increased more than income over the year and therefore the trust incurred the deficit of £19.8m over the 12 month period.

Pay costs increased excluding the impact of SWLP by 6.4%.

Nursing costs rose by £9m due to the increase in workforce to ensure safe staffing levels. There was also an impact due to additional capacity on wards and in theatres. Across all pay groups the trust experienced difficulties in recruitment and the cost of agency and bank staff was £16m more than 2013/14.

Non-pay costs increased by 12.3% and the main cost drivers were the use of private facilities for activity in cardiac and general surgery increased by £1.2m over 13/14. Clinical consumables and drugs increased by £9.0m of which the trust received re-imbursement of approximately £5.6m from commissioners.

In addition, the trust invested £1.4m extra in IT projects to accelerate its modernisation plans.

Capital expenditure

The breakdown of capital expenditure between the two accounting periods and the combined position for 12 months' operation is shown in the table below.

	2014/15			
£m	10 months to 31st Jan 2015	2 months to 31st March 2015	Total 2014/15	2013/14
Capital expenditure	30.7	7.7	38.4	30.7

The totals include the capital value of finance leases taken out in year for medical equipment. The trust had planned capital expenditure for the 12 months of £57m and spent £38.4m. The underspend relates mainly to slippage on the energy project, bed capacity projects and replacement of major medical equipment. This expenditure will now be incurred in 2015/16.

Cash and liquidity

The trust had a year-end cash balance of £24.2m which is equivalent to approximately 11 days of operating expenses – ahead of the 10 days operating expenses minimum set by the trust and regarded as best practice. However the cash balance includes approximately £12.5m in respect of the unspent balance of a loan taken out to finance the replacement and renewal of energy plant – see capital structure section below. The trust's treasury management policy permits the investment of temporary cash surpluses with the National Loans Fund to earn interest income which is then re-invested in services.

Capital structure

The trust has drawn down against three loans in year. A loan of £13.3m was secured from the London Energy Efficiency Fund to finance a major capital project to replace and renew energy plant on the St George's Hospital site which will reduce energy costs and carbon emissions. The trust had spent approximately £0.8m on this project by 31st March 2015 and so the closing cash balance includes £12.5m which is committed to this project. The trust also borrowed £9.1m in capital loans from the Department of Health to finance bed capacity projects, a new hybrid theatre and a new surgical assessment unit. A further £5.6m of these capital loans will be drawn down in 2015/16 as these projects are completed. Finally, the trust secured a working capital loan of £15m on being licensed as a foundation trust to help manage its cash flow. All these loans are included within *borrowings* on the statement of financial position with the repayments due split between current and non-current depending on whether they are repayable within one year and after one year respectively.

Continuity of service rating

The continuity of service rating (COSR) rating is the new four-point risk rating (where a larger number indicates a better rating) used by Monitor to assess the financial viability of foundation trusts. It consists of two metrics: debt service cover and liquidity. Debt service demonstrates that a trust is able to meet all debt obligations from the surplus produced in year. The liquidity metric aims to ensure that the trust can meet all of its cash obligations. Unlike the old rating system this does not take into account the

working capital facility which the trust has in place with the Independent Trust Finance Facility, and is purely based on the trust's own internal resources. The aim of the systems is to provide assurance that the trust is 'a going concern' and able to continue to provide healthcare services. The trust's continuity of services risk rating (COSR) for the financial year was 3, in accordance with the planned value.

Pension scheme

The pension scheme operated by the trust is the NHS Pension Scheme managed by the NHS Pensions Agency. Employer and employee contributions to the scheme are collected and paid over to the NHSPA on a monthly basis. Therefore the cost of membership of the scheme is included in operating expenses. Pensions information for senior managers is disclosed in accordance with the requirements of the Greenbury report in the enclosed remuneration report. Further information on the accounting and valuation policy of the NHS Pension Scheme is given in note 1.5 in the Accounts.

Ensuring financial sustainability

The look and shape of the trust will change significantly within the next five years in order to better manage the changing needs of our patients.

We will be consulting with our staff and members to engage them in changes which will mean more patients receiving care away from the acute environment and patients experiencing better facilities and environment within the hospital.

We have begun the ground work for these important decisions, whilst recognising they take place in an increasingly cash constrained environment.

The trust faces an increased level of financial challenge in 2015/16 as a result of continued tariff pressures. The trust is looking to identify savings of £43m. To support the delivery of these challenging targets the trust has invested significantly in a service improvement programme with the support of NHS London. This has been an area of real focus for the trust in 2013/14 and the methods and approach are beginning to bring real benefits which will help us meet our productivity challenge in 2015/16 and beyond whilst improving the quality of care we offer and the patient experience we deliver.

The trust's long term financial value is dependent primarily on its ability to deliver high quality clinical activities efficiently and to earn sufficient surpluses to finance the capital investment necessary to sustain its facilities and equipment infrastructure to a reasonable standard. The principal risks to long term value therefore are the changes in patient flows and configuration of services that may take place locally and nationally. The trust must ensure its clinical strategy anticipates these changes so that its financial viability is assured.

As a major trauma centre, we have been particularly affected by the operational pressures that have been seen nationally.

During the winter we were faced with unprecedented demand from very ill patients and fixed capacity in terms of beds and operating theatres. This resulted in the cancellation of planned operations and longer waiting times for some patients. Financially, it led to reduced income from planned activity combined with increased costs for staff and supplies.

Monitor granted us foundation trust status in February 2015 on the basis we would break even in 2014/15 and make a small surplus in 2015/16. The regulator is now concerned that we have recorded a £16.8 million loss for 2014/15 and that the current status of business planning for 15/16 indicates a revenue deficit of £46.2m.

Monitor has opened an investigation into the sudden deterioration in finances to examine how and why the situation happened, to identify possible solutions and to provide a sustainable way forward for the future.

It will include a rapid assessment of corporate governance, financial management, control and reporting arrangements in order to determine the extent to which each of these factors may have contributed to the deterioration.

Monitor's investigation will also include a review of the trust's performance, in particular the failure to achieve the four hour waiting time standard in A&E and the attainment of sustainable compliance with referral to treatment standards within expected timescales.

Once the investigation is complete, Monitor will determine what action is required. The process that Monitor will adopt in assessing their concerns can be seen in the letter from monitor on our website – www.stgeorges.nhs.uk

Directors are required under the National Health Service Act 2006 to prepare financial statements for each financial year. The Secretary of State, with the approval of the Treasury, directs that these financial statements give a true and fair view of the state of affairs of the NHS foundation trust and of the income and expenditure of the NHS foundation trust for that period. In preparing those financial statements, the directors are required to: apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury; make judgements and estimates which are reasonable and prudent; and state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.

The directors are required under the Monitor Code of Governance to consider whether or not it is appropriate to adopt the going concern basis in preparing the trust's financial statements (annual accounts). As part of its normal business practice, the trust prepares annual financial plans.

The trust's objectives for financial risk management are to minimise exposure to price risk, credit risk and liquidity risk. Price risk is managed by the application of contractual agreements with suppliers where applicable to achieve certainty over pricing levels. Credit and liquidity risk is managed by the use of credit management checks regarding customer viability and where risk is identified compensating controls e.g. payment in advance are implemented where practicable. The trust's principal cash flow risk relates to the significant lead time that may be incurred in receiving payment for debt receivable from other NHS organisations.

The trust incurred a deficit of £6.8 million during the two month period ended 31 March 2015 and a combined deficit of £16.8 million for the whole of 2014/15. At year end the board was seeking interim cash funding support from Monitor for 2015/16 of £52.2 million.

The directors have reviewed the proposed 2015/16 financial plan in detail throughout its development from October 2014 to date. The plan is for a deficit of £46m having taken account of the realistic underlying financial position going into 2015/16, the risks and cost pressures faced in 2015/16 and the level of cost reduction the trust can deliver. The trust has an existing working capital facility of £25m but this will not be sufficient to meet the cash requirements of the deficit revenue position, and the capital plan which has been reduced to the minimum possible requirement. The trust therefore requires additional cash support of £52.2m to maintain normal operating and quality standards. The board has a reasonable expectation that this will be agreed with DH with the support of the regulator.

The trust engaged in discussions with Monitor regarding the level and timing of interim cash support funding at year end, however these discussions had not concluded at the time the financial statements were approved. As directed by the NHS Foundation Trust Annual Reporting Manual 2014/15, the executive directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the trust will continue to be provided in the foreseeable future.

Although these factors represent material uncertainties that may cast significant doubt about the trust's ability to continue as a going concern, the directors, having made appropriate enquiries, still have reasonable expectations that the trust will have adequate resources to continue in operational existence for the foreseeable future.

On this basis, the trust has adopted the going concern basis for preparing the accounts and has not included the adjustments that would result if it was unable to continue as a going concern.

We remain committed to a patient centred, open and transparent culture, and all of our planning for the future will be discussed openly either in our trust board meetings held in public or through a range of member engagement events, supported by social media. Since the earliest indication that we would not achieve our predicted end of year surplus we have regularly communicated and engaged with staff and stakeholders on our financial position. The chief executive has briefed staff via all staff emails and the trust wide 'team brief' system since December 2014. More recently we held all staff briefing events and issued information through our weekly staff e-newsletter, eG.

In addition, a statement from the chief executive to key stakeholders was sent to appraise them of our financial position and also of the monitor investigation.

Planning for 2015/16

As the new financial and regulatory year begins, it is very clear to the board that the trust will face a number of challenges in 2015/16 relating to finance, capacity, workforce and quality.

The main impact of the last year's deficit is that we had to take out a £15m loan to support our position and for the next financial year we will have to reduce our planned capital expenditure by £12.3m from an initial budget of £69m including external funding from loans and leases to £56.7m. This will reduce planned spending and investment in IT, medical equipment and building and maintenance. The projects and investments will still be made, just over a longer timescale than if the finances been in a better position. Essential and important business as usual investments required to maintain standards, clinical and quality and access will still proceed.

Although many factors that affect our financial position are beyond our control, we are taking responsibility for the situation and have devoted much effort to tackling our challenges.

We are putting in to place a range of measures to safeguard the trust's long term financial position including a thorough financial review of every service and we are looking at alternative approaches to service delivery. We have stepped up our monitoring of costs and activity, established additional measures to limit non-essential spending, cut temporary staff costs and reviewed our capital expenditure. Our measures to protect quality will continue by scrutinising every savings proposal to ensure that there is no adverse impact on quality. The introduction of weekly quality indicators, such as safe staffing levels, act as early warning signals to identify any negative impact on quality as soon as possible.

We aim to deliver on an already challenging cost improvement programme of £43m and will require an additional £52.2m cash support to ensure we retain quality standards, have sufficient beds, theatre and critical care capacity to meet demands from patient activity.

Moving forward we have set ourselves key performance and quality objectives for 2015/16. These can be on page 109 of the quality report.

Progress towards our ten year plan

Although the trust is experiencing short term operational and financial concerns we retain a focus on our long term future.

Our ten year strategy was developed in November 2012 meet the needs of our patients and service users and to set out the direction of travel over the forthcoming years. It took into account that we hoped to achieve foundation trust status in the very near future.

The strategy was underpinned by two key guiding principles, values and quality. St George's has a set of values which describe the behaviours that all trust staff are expected to demonstrate in all aspects of their work, including delivery of excellent patient care.

Patients are at the heart of everything we do, and the overriding concern is to ensure that we provide them with the highest quality services.

The trust uses the national definition of quality, which is divided into the following three domains:

- **Patient safety – quality care is care which is delivered so as to reduce or eliminate all avoidable harm and risk to the individual's safety**
- **Patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from care as possible**
- **Patient outcomes (clinical effectiveness) – quality care is care which is delivered according to best evidence as to what is clinically effective in improving an individual's health outcomes.**

St George's mission and vision

As part of the development of the new trust strategy, we reviewed and updated our mission statement and vision. These key statements are:

MISSION The trust's purpose	**MISSION** To provide excellent clinical care, education and research to improve the health of the populations we serve
VISION What the trust wants to be	**VISION** An excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research

St George's strategy

The trust's strategy is outlined below:

The following outlines in more detail what each of these statements mean and some of our achievements in 2014/15 to help deliver towards them. Included in the tables are some of the actions we want to take in 2015/16.

Renowned integrated services enabling people to live at home

To deliver this element of the trust's strategy and vision we will redesign care pathways to keep more people out of hospital.

Evidence shows that home and community based services are safe and effective at keeping people out of hospital. We know that people prefer not to have to go to hospital. Innovations in both technology and the skills of staff mean that St George's can do more of this than ever before.

The actions we will take to deliver this vision include:

- develop health promotion and self-care services that allow patients to better manage their own condition
- work more closely with all providers of community based services
- improve the experience and outcomes for older people, children and those with long term conditions through integrating services.

What we have done in 2014/15 to deliver the vision?

- begun to implement the major restructure of community services, in line with Wandsworth CCG's "Commissioning Adult Health Services" (CAHS) model of care, including new outcome frameworks and universal care plans
- worked with both Wandsworth and Merton CCGs to develop and implement "Better Care Fund" plans, designed to better integrate hospital, community and social care.

What do we intend to do in 2015/16 to deliver the vision?

- complete the implementation of the CAHS model, including the redesign of services for frail older people designed to keep them of hospital and speed their discharge if they are in hospital.
- bid to provide community services to the population of Merton, in response to Merton CCGs tender process, allowing the trust to offer better integrated services to the population of its two main local CCGs.

To provide the highest quality local hospital care in the most effective and efficient

To deliver this element of the trust's strategy and vision we will need to redesign and reconfigure our local hospital services to provide higher quality care.

We will continue to redesign local hospital services to ensure that patients have a better experience with high quality and efficient pathways into, during and back out of hospital. We agree that the current configuration of hospital services in south west London is not clinically or financially sustainable, and will work closely with partners and stakeholders to determine the best solutions.

The actions the trust will take to deliver this vision include:

- enhance services and facilities for maternity services and the care of children
- provide more ambulatory care in a community setting or home
- redesign models of care for people with urgent and emergency health needs, including admissions avoidance from A&E
- play an active role in delivering service reconfiguration in south west London, now as part of the SW London Collaborative Commissioning strategy, or through alternative routes if necessary.

What we have done in 2014/15 to deliver the vision?

- completed the building works at Queen Mary's Hospital, Roehampton, for the new neuro-rehabilitation ward, further enhancing QMH as a centre of rehabilitation excellence, as well as freeing up capacity at St George's Hospital for more acute work
- approved the business case for a surgical assessment unit to better manage surgical patients coming through A&E, offering them a better service and reducing the number of admissions to hospital.

What do we intend to do in 2015/16 to deliver the vision?

- deliver additional bed capacity, both on site and off site, to help meet the demand for services and help ensure the trust meets its key waiting time targets
- continue to work closely with the SW London Collaborative Commissioning Programme and take a leadership role in the acute provider and out of hospital projects.

A comprehensive regional hospital with outstanding outcomes

To deliver this element of the trust's strategy and vision we will need to consolidate and expand our key specialist services.

Central to our role as the regional hospital is the delivery of tertiary and specialist services. We have identified the services that make the most significant contribution to the mission and vision of the trust, and are seeking to develop their excellence further.

The actions the trust will take to deliver this vision include:

- develop our key specialist children's services, through the development of the Lanesborough wing as the Children's & Women's Hospital
- expand cardiovascular and neurosciences services and the catchment populations they serve
- further develop our role as a major trauma centre
- plan for the future of renal services in south west London, working with Epsom & St Helier hospital and commissioners
- promote our reputation as a leading centre for cancer services, as part of the London Cancer Alliance.

What we have done in 2014/15 to deliver the vision?

- completed the business case for a new hybrid theatre, to support specialist vascular surgery, with work starting on site in April 2015
- opened a new cancer ward, to improve the patient experience and to ensure that capacity on site for this specialist work better matches demand

What do we intend to do in 2015/16 to deliver the vision?

- complete the business case for relocation of the renal service and begin work on the new renal department
- expand cardiology and neurosurgery services, with additional capacity and the appointment of further consultant posts to ensure that patients of south west London can access the specialist care they require.

Thriving research, innovation and education driving improvements in clinical care

To deliver this element of the trust's strategy and vision we will need to provide excellent and innovative education to improve patient safety, experience and outcomes and drive research and innovation through our clinical services.

As a leading UK teaching hospital we aspire to improve patient safety, patient experience and outcomes through excellence in our provision of education and training for the staff, students and trainees.

Healthcare organisations with vibrant programmes of research provide higher quality clinical care and recruit, motivate and retain the best staff. We need to strengthen our focus on this agenda in the future.

The actions the trust will take to deliver this vision include:

- ensure development of a competent, caring and capable workforce
- develop a culture that places research at the core and incentivises the development of research
- maximise the benefits of the partnership with St George's, University of London
- develop the strategic alliance with King's Health Partners Academic Health Science Centre at the heart of a vibrant South London Academic Health Science Network.

What we have done in 2014/15 to deliver the vision?

- increased the number and range of multi-professional training events within the simulation centre
- opened the dental simulation suite, offering world class teaching facilities for dental trainees.

What do we intend to do in 2015/16 to deliver the vision?

- continue to increase the number of patients recruited into National Institute for Health Research (NIHR) studies excluding the impacts of large one off studies
- increase collaborations between St George's, University of London institutes and trust clinical directorates through the development of further clinical academic groups in cardiology and neurosciences (CAGs).

Transformed productivity, environment and systems

St George's systems, processes and quality of the environment sometimes hinder us in the provision of consistently outstanding care. The trust must address this.

We will have a rolling improvement programme that delivers against its goals; the information, communications and technology (ICT) strategy, the estates strategy, implemented South West London Pathology service and a well-regarded private patients service.

The actions the trust will take to deliver this vision include:

- enhance clinical, operational and financial performance through a robust improvement programme
- maximise the potential of ICT to support the delivery of high quality healthcare
- improve buildings and the environment, including the development of critical care capacity and new facilities for renal services
- make systems and processes more customer focussed.

What we have done in 2014/15 to deliver the vision?

- deployed 350 'Workstations on Wheels' to wards, delivered complex IT requirements of the new South West London Pathology project and deployed e-prescribing and drug administration deployed to the paediatric intensive care and paediatric inpatient wards, renal, cardiac and neurology services
- through the capital programme delivered 45 additional beds to enable the trust to deliver its complex portfolio of services, as well as made significant progress on the development of a range of other projects that will enhance and improve inpatient capacity.

What do we intend to do in 2015/16 to deliver the vision?

- complete the deployment of electronic prescribing, drug administration and clinical documentation to inpatients, theatres and the emergency department on the St George's Hospital site
- provide transparency on outcomes by publishing consultant level activity data, clinical quality measures and survival rates from all nationally agreed audits.

A workforce proud to provide excellent care, teaching and research

To deliver this element of the trust's strategy and vision we will need to develop a highly skilled, motivated and engaged workforce championing our values.

The workforce is vital to the delivery of the highest quality clinical services, education and research, and will need to evolve to meet future needs. We need to value our staff and ensure they champion our values. Evidence tells us that happy staff result in happy patients.

The actions the trust will take to deliver this vision include:

- maximise the wellbeing staff and their levels of contribution and engagement
- improve the efficiency and productivity of the workforce
- improve patient safety, experience and outcomes through the provision of excellent and innovative education
- strengthen the sense of belonging to the trust by all community and acute staff.

What we have done in 2014/15 to deliver the vision?

- improved student feedback on clinical placements, with the National Student Survey score significantly better
- 1,175 nursing staff have attended multi-professional simulation based training events alongside medical staff in the past year and the nursing participation rate has increased overall to 50%.

What do we intend to do in 2015/16 to deliver the vision?

- continue to increase the number of patients recruited into National Institute of Health Research studies excluding the impacts of large one off studies
- increase collaborations between the institutes at St George's, University of London and trust clinical directorates through the development of clinical academic groups in cardiology and neurosciences.

St George's business model

St George's is at the heart of a dynamic, fluid and fast changing healthcare environment in south west London. The six CCGs that make up the south west London cluster are Wandsworth, Kingston, Merton, Richmond, Croydon and Sutton. All are co-terminus with their local authorities. The trust understands the people that it provides services to, its plans to develop and enhance those services and its position in the local health economy. These insights and judgements inform the organisation's business model.

The core local population of the trust is 561,790 people who live in the London boroughs of Wandsworth, Merton and parts of Lambeth.

For the specialist and tertiary services the trust provides, the catchment population increases up to 3.4 million, encompassing the five south London boroughs, Surrey and beyond, and for some services the trust offers supra-regional and national services.

St George's is confident that it can provide high quality and safe care to all its patients and service users. The table below outlines the populations served by the trust and the services those populations primarily access.

Populations and services of St George's

Specialist level	Catchment population		Services provided include
	Area	Population	
Community	Wandsworth	310,000	• Children and family services • Adult, specialist and diagnostic services • Older people and neuro-rehabilitation services • Offender healthcare at HMP Wandsworth
Secondary	44 wards across Wandsworth, Merton and Lambeth	560,000	• Accident and emergency • Acute medical services • Full range of surgical services • Maternity and paediatrics • Diagnostics and therapies • Outpatients and diagnostic services at the Nelson Health Centre
Tertiary	South west London, Surrey and beyond	3.4 M	• Cardiac surgery and cardiology • Paediatric surgery • Neurosurgery and neurology • Renal services including transplant • Trauma
National specialist centre	Primarily south east, south central and eastern England.	25M+	• Family HIV care • Lymphoedema • Penile cancer

Based on growth estimates from the 2011 Census, the population of south west London and Surrey will increase by 330,000 over the next 10 years.

We have made the following judgements:

- the population is growing across all age groups and so demand for all of the services currently provided will continue to grow
- the trust will experience an increasing demand for maternity and paediatric care, particularly from Wandsworth
- the total number of older patients will also increase, bringing an increase in the demand for long term condition management
- with the increase in the number of people over 65, the demand for St George's tertiary services – cardiovascular, stroke, neurosciences, will grow
- the ethnic make-up of the population will be a driver for demand for certain services over the coming years.

In response to these factors and clinical demands the trust:

- has developed a comprehensive strategy that seeks to address the needs of the various population groups that access St George's services
- is funding developments for children's and women's health that will enable it to meet the growing demand for these services
- is a major trauma centre with a refurbished and re-developed A&E, providing facilities that a young and fluid population are likely to need improved management of long term conditions
- is expanding its cardiac, stroke, long term conditions and neurosciences services to meet future population demand
- has identified the integration of services, with more support in the community and better management of long term conditions in the community, as key to managing the overall demand on the trust.

The health economy

St George's has made the following key judgements and assessments about the health economy:

- the need to do more with less – NHS funding is severely challenged but quality and service must be maintained
- the local population will grow, as will the number of people with long term conditions, and the numbers of elderly, all of which will place new pressures on the trust
- the new focus on quality – government and patient expectations regarding the quality of the service the NHS provides is increasing. This focus on outcomes, transparency, and patient measurement of service quality will all impact on the trust
- leadership and partnership – the changing healthcare environment offers opportunities for St George's to play a leadership role in developing the vision for care in south west London. The trust will need to work in partnership to deliver its own trust strategy and to support and provide leadership to the South West London Collaborative Commissioning programme
- St George's is a fixed point in the health economy – regardless of the outcome of sector wide reviews, the role of St George's as the regional tertiary centre will remain.

St George's understands the markets it operates in, the other providers in those markets and those services that it wishes to grow and develop over time. St George's:

- has a clear understanding of who its partners are in the delivery of care and, more importantly, who its competitors are and for what services
- has a clear understanding of the market in services it wishes to grow – cardiovascular, neurosciences and paediatrics
- is developing proposals to expand capacity on site
- has determined that the new Children's and Women's Hospital development will consolidate its dominant position in paediatrics in south west London and will grow activity over time
- for stroke, major trauma and renal transplantation, has a solid market position and is delivering on active plans, for example the helipad for major trauma, to expand capacity on site.

We will use this strategy, along with the supporting strategies, to frame our annual plans. These annual plans will incrementally move us towards the delivery of our vision and will be the method by which we are able to determine organisational, team and individual priorities, develop implementation plans and track progress.

We also recognise that we cannot deliver this strategy in isolation and will work in partnership with others in its effective implementation.

The trust strategy will need to be revisited on an annual basis to check that it still represents the right direction of travel for the trust and to reassess the priorities for implementation.

The principal risks and uncertainties facing the foundation trust are listed and explained in the annual governance statement as a foundation trust on page 224.

Care Quality Commission

In line with the requirements of the Health and Social Care Act 2008 (the Act), the trust continues to be registered with the Care Quality Commission (CQC), the regulator of health and social care in England, without condition, to provide the following services:

- **treatment of disease, disorder or injury**
- **surgical procedures**
- **diagnostic and screening procedures**
- **maternity and midwifery services**
- **termination of pregnancies**
- **family planning clinics**
- **assessment or medical treatment for persons detained under the 1983 (Mental Health) Act.**

In order to maintain registration as a healthcare provider, the trust must demonstrate that it meets the 16 essential outcomes of quality and safety set out in the Act under the following headings:

- **involvement and information**
- **personalised care, treatment and support**
- **safeguarding and safety**
- **quality of management**
- **suitability of management.**

During 2014/15, the trust conducted quarterly self-assessments of performance at divisional levels against outcomes to confirm compliance across all areas of quality and safety. These were reported to the quality and risk committee and trust board. In addition, a rolling programme of quality inspections provided additional assurance on levels of compliance.

In February 2014, the trust was subject to a Chief Inspector of Hospitals Inspection by the CQC, against the five domains of quality:

Are services caring?
Are services safe?
Are services effective?
Are services responsive?
Are services well led?

The inspection took place at St Georges' Hospital, Queen Mary's Hospital, St John's Therapy Centre and several Health Centres. The CQC inspected the eight core services:

- **children and young people's services**
- **critical care**
- **end of life care**
- **outpatients departments**
- **surgery**
- **medical**
- **maternity and gynaecology**
- **urgent and emergency care**

The trust received an overall rating of 'good' with adult critical care and some areas of maternity considered to be 'outstanding'. There were two areas of non-compliance identified and the trust was required to develop an action plan to address these:

- **implementation of the Mental Capacity Act at Queen Mary's Hospital**
- **availability of medical records in the outpatient department at St George's Hospital.**

The action plan is reviewed by commissioners, the CQC and Monitor on a quarterly basis and it is anticipated the plan will be closed at the next meeting on 17th June 2015.

There has been significant progress:

Implementation of MCA at QMH

All actions are now completed. 100% of staff have been trained. The effectiveness of this training and ongoing practice around MCA has been audited twice through a bespoke case note audit, undertaken by a multidisciplinary team.

Each audit has identified recommended actions to further improve practice and these are being implemented. The adult safeguarding board monitors this work on an ongoing basis.

Availability of medical records in the outpatient department

All actions are now completed and improvements in notes availability is monitored through the monthly divisional management board. Whilst the actions put in place resulted in an improving performance, ongoing monitoring has shown a decrease in availability due to the relocation of medical records as part of increasing trust bed capacity. The risk of decreased availability has been captured on the divisional and corporate risk register and further focussed work is underway, supported by the service improvement team. Monitoring of performance continues as part of business as usual.

The internal self-assessments of compliance are supported by information provided via the CQC's Intelligent Monitoring Report (IMR) which is published quarterly. This report contains a range of triangulated data and benchmarked performance indicators.

The trust compliance framework will be revised to reflect the requirements of the new regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our success in becoming a foundation trust is partially down to our CQC results. We are one of few trusts nationally to have achieved 'good' rating which proves that we are recognised for the high quality services and safe care we provide in our hospitals and in the community

Since the new inspection regime has come into place, St George's is one of two trusts in London to achieve the overall score 'good'.

Below are some of the achievements and successes at St George's over the past year. To put them into context, they are grouped under the five questions used by the CQC:

Are we safe?

Benefits of electronic Prescribing Medicines Administration (ePMA)

Since the introduction of ePMA in June 2014, the system has been delivering benefits to patients and staff. Numerous audits have demonstrated:

- **improvements in prescribing standards**
- **better dosing of high risk medications such as vancomycin**
- **releasing time to care from drug rounds**
- **reduction in medicines risk associated with prescribing**
- **improved quality of reporting.**

The antimicrobial stewardship team, Balpreet Dhanda (lead pharmacist) and Dr Matthew Laundy (clinical lead) provide their views.

"ePMA has enabled the trust to adopt antimicrobial prescribing as part of the trust's strategy in reinforcing antimicrobial stewardship. Prescribers are required to prescribe antimicrobials with a documented indication, and review or stop date, in line with trust and national policy. Reporting functions help identify patients on antimicrobials automatically, who may benefit from a review with the clinical team to optimise management of infections. Auditing is also key in monitoring antibiotic consumption and monitoring adherence. ePMA has already helped in automating this process, in the future we will build on this foundation to deliver antibiotic consumption data at ward, team and trust level to ensure good antimicrobial stewardship."

By positively identifying the patient and drug, ePMA has stopped the wrong patient's profile being opened 377 times and the wrong medication being given 2357 times.

The wards that have gone live with ePMA are benefiting from improved antimicrobial stewardship, more readily available information on missed doses, venous thromboembolism and ultimately a safer working environment for patients and staff.

Are we caring?

St George's doctor receives award from Prime Minister

Dr Na'eem Ahmed was named a 'Point of Light' by Prime Minister David Cameron in January 2015.

Dr Ahmed set up the Selfless charity, an online volunteering website to promote 'skillanthropy', encouraging young people to use their skills to give something back to society, both in the UK and overseas.

Over 1,000 volunteers have now registered with the 'Selfless' website registering their skills, the languages they speak and their location. The site, which has a special focus on healthcare volunteering, then matches individuals with volunteering opportunities that will suit them.

Na'eem first got a taste for volunteering after securing a place at medical school. He established a network of student health ambassadors to carry out health education projects across London. The health ambassadors are still going strong and are now funded by the Mayor of London's Team London.

Na'eem then went on to create a successful international volunteering project he called 'Elective Aid' which provides medical students with the opportunity to deliver medical aid to rural Bangladeshi inhabitants. The project has enabled over 10,000 Bangladeshi villagers to receive free medical attention.

Dr Ahmed is the 189th winner of the 'Points of Light' award, which recognises outstanding individual volunteers and was developed in partnership with the hugely successful Points of Light programme in the USA.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/st-georges-doctor-receives-award-from-prime-minister/

Pioneering new buddy scheme to improve experience of care for cancer patients

The trust is delighted to be taking part in a pioneering 'buddy scheme' to help other NHS trusts in England to improve cancer patients' experience of care.

St George's was identified by the recent Cancer Patient Experience Survey (CPES) as being one of the most highly rated by patients. This puts us in a position to mentor another trust, showing them what we do so to help them improve their patients' experience of care.

The buddy scheme is being run by NHS Improving Quality. The aim is to spread and accelerate innovative practice via peer to peer support and learning. It is hoped this will lead to a reduction in national variation in cancer patients' experiences of care.

We are now beginning to work with our buddy trust, with support from NHS Improving Quality, to develop improvement plans specific to their individual needs.

At the end of the scheme, NHS Improving Quality will carry out an evaluation to measure the impact of the improvement plans, and a report will be published by the end of 2015.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/st-georges-is-taking-part-in-pioneering-new-buddy-scheme-to-improve-experience-of-care-for-cancer-patients/

New specialist youth service for victims of gang-related violence

St George's major trauma centre (MTC) hosts specialist youth workers dealing directly with young victims of gang crime. The youth workers will be placed in every MTC in London to support victims and reduce youth violence in London under the major expansion of a ground-breaking project.

The Mayor of London, Boris Johnson, has made victim services for young people a priority.

Working through the Mayor's Office for Policing And Crime (MOPAC), the £600,000 initiative will enable Redthread, a youth charity, to put specialist youth workers into all four MTCs in the capital.

The funding means that for the first time, all of London's MTCs will have specialists working directly with victims of gang violence being treated at the hospital.

Many services exist for young people convicted of a gang related crime but few offer support to young gang members who are also victims of violence, many of whom suffer long term mental health trauma as a result of their experiences.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/st-georges-to-create-a-new-specialist-youth-service-for-victims-of-gang-related-violence/

Are we effective?

St George's is one of the most improved trusts for cancer patient experience

The trust has been listed as one of the most improved trusts for cancer patient experience.

This is according to a league table released by Macmillan Cancer Support. The Macmillan league table is based upon the national cancer patient experience survey 2014 which was published last week and asked over 110,000 cancer patients across the country for their views on their care.

The survey asked patients questions about whether their diagnosis and treatment options were explained clearly to them; whether they felt supported in their care; and whether they felt they were treated with respect. It does not attempt to measure medical care.

The results showed that cancer patients are becoming increasingly positive about their care with 89% rating it as either excellent or very good.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/st-georges-is-one-of-the-most-improved-trusts-for-cancer-patient-experience/

Are we responsive?

Opening of the helipad

The Mayor of London, Boris Johnson officially opened our helipad in May 2014.

Planning for the £5m helipad began in 2010 shortly after St George's Hospital was designated as the major trauma centre for the South West London and Surrey Trauma Network.

It is the first London helipad south of the Thames and will routinely receive patients from the Kent, Surrey and Sussex Air Ambulance as well as the London's Air Ambulance and possibly further afield if required.

The Helicopter Emergency Landing Pad (HELP) appeal donated £1m to the helipad construction, which took 11 months to complete.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/13440-2/

South London NHS Genomics Medicine Centre announced

The South London based Genomics Network Alliance, including St George's University Hospitals NHS Foundation Trust and St George's, University of London as founding members, was announced as a successful bidder in the race to become a pioneering Genomic Medicine Centre, part of the ground-breaking 100,000 Genomes Project.

The NHS England announcement is the result of a rigorous national selection process. It follows the Prime Minister's pledge earlier this year to establish the UK as a world leader in genetic research and to transform patient care by unlocking the power of DNA. The national programme will focus on cancer and rare diseases and will enable pioneering research to decode 100,000 human genomes, a scale not seen anywhere else in the world.

The three-year programme, which began in February 2015, has the potential to transform the future of healthcare.

The Genomics Network Alliance serves a population of more than seven million people and is a partnership between leading hospital trusts, two universities and two of the country's biggest patient organisations.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/south-london-nhs-genomics-medicine-centre-announced/

Providing Offender Healthcare

The Offender Healthcare Service has been set up to improve the health of offenders whilst working in an environment designed to limit their liberty.

HMP Wandsworth is one of the largest prisons in Western Europe with a capacity for 1665 prisoners and up to 600 new prisoners entering its doors each month.

The service believes depriving someone of healthcare or deliberately providing second rate healthcare is not an acceptable form of punishment for any humane society.

The impact on public health when prisoners are released from prison without their healthcare needs having been addressed is another aspect considered.

These pose a risk to communities through the transmission of diseases and the burden of mental health problems.

In spring 2015, a consortium led by the trust, comprising South London and Maudsley NHS Foundation Trust and existing dental and optician providers, won a five year contract to run the prison's healthcare services.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/providing-offender-healthcare-healthier-inside-and-out/

Are we well led?

St George's staff awarded cancer team of the year award

A specialist cancer team, based at St George's Hospital, has been recognised with a national award for its pioneering approach and care for men facing penile cancer.

Penile cancer is a rare form of cancer and is only seen in 1 in 100,000 people. Judges were impressed by the team's new surgical techniques and its work with charities to improve patient's experiences.

The dedicated department received the award from the QIC (Quality in Care programme) awards. The annual honours recognise good practice and teamwork between the NHS, patient groups and the industry in therapy areas such as cancer treatment.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/st-georges-staff-awarded-cancer-team-of-the-year-award/

St George's to become the UK's first Centre of Excellence for non-invasive prenatal screening

St George's will be teaming up with Premaitha Health to create the UK's first Centre of Excellence for non-invasive prenatal screening.

Premaitha will provide a non-invasive prenatal test (NIPT) at St George's Hospital, making us the first NHS facility to offer an in-house NIPT screening for pregnant women in the UK.

NIPT is an advanced screening for pregnant women, using a small blood sample rather than an invasive procedure such as an amniocentesis. The test estimates the risk of a fetus having Down's Syndrome or other serious genetic diseases.

NIPT has a higher detection rate and lower false positive rate than the current combined test offered to pregnant women in the UK. The greatly reduced false positive rate of this new screening method also means that fewer pregnant women will undergo unnecessary invasive follow-up procedures such as amniocentesis and chorionic villus sampling which are stressful and carry a small risk of miscarriage.

Working in partnership, St George's and Premaitha intend to establish a UK Centre of Excellence for Prenatal Screening. St George's will offer this test to pregnant women through the NHS and also privately. This will provide accurate and reliable results in a matter of days, allowing pregnant women and their families to receive the information they need to make informed decisions in a much faster timeframe, reducing anxiety as much as possible.

Read the full story: https://www.stgeorges.nhs.uk/newsitem/uks-first-centre-of-excellence-for-non-invasive-prenatal-screening/

Information management and technology

Information management and technology play an ever increasing and essential role in supporting the delivery of safe high quality care to our patients. 2014/15 saw further enhancements and new features introduced.

Integrated clinical information programme

The trust introduced more clinical content to the acute clinical information systems as part of its integrated clinical information programme (iCLIP).

The new clinical content to our main acute clinical information system now encompasses electronic prescribing and medicines administration (ePMA) and clinical documentation. It is now live across half of the hospital inpatient beds including cardiac services, renal services, neurosciences and paediatrics.

St George's was the first hospital in the UK to implement an electronic 'end-of-bed' charting solution in a critical care setting that integrates with the hospital's electronic medical record. We are also the first trust in the country to use a barcode scanning as part of patient and drug identification.

OpenRiO

OpenRio is the trust's strategic clinical record system for the community which provides electronic patient records in the community setting.

Last year, St George's became the first trust to migrate community information system RiO from the national contract to locally managed arrangements. This has enabled us to upgrade RiO and we now have over 1,000 users in the community.

We are now working with the supplier to introduce the ability for our community teams to update and view information in the patient's own home.

Electronic document management

Electronic document management (EDM) allows paper health records to be stored electronically so that they are available to be viewed at any location where care is being delivered. This will improve patient experience and quality of care by ensuring that relevant information is always available whilst significantly reducing the trust's reliance on paper medical records.

EDM is now deployed across maxillo-facial outpatient areas following a successful deployment across paediatrics. New referrals to the trust are now stored immediately in the EDM system instead of a paper folder for urology, chest medicine and rheumatology. Completion of the deployment will enable us to move closer towards our goal of being a 'paper-light' organisation.

The clinical portal

The vision is that a single portal will bring all these clinical systems (iCLIP, RiO, EDM) and other specialist clinical solutions to the end user via a single interface. The first phase is now live supporting South West London Pathology where microbiology and cellular pathology results are now available.

Information and communications development planned for 2015/16

Upgrading our acute clinical information system

Upgrading to the latest 2015 version will improve the user experience through a more contemporary look and feel. It will also resolve some existing issues in the current deployment and allow us to deploy new functionality.

Integrated whiteboards

We will be installing interactive electronic whiteboards in all wards which use state-of-art technology to display real time patient information including discharge information. So, at a glance you can see the expected date of discharge, the discharge details and if the patient is ready for discharge. The information will support staff in planning and delivering care to our patients.

Integrated vital signs monitors (iVSM)

Integrated vital signs monitors will send patient observations (temperature, blood pressure etc) directly to the patient's electronic medical record: eliminating the need to transcribe results into the record and thereby releasing time to care. Additionally, the monitor will calculate the national Early Warning Score (nEWS) which identifies deteriorating patients at the bedside to support rapid and appropriate escalation of care if required. The nEWS was introduced in 2012 to standardise the assessment of acute illness severity in the NHS and St George's was an early implementer of this system.

Benefits of the iVSM include:

- they are a visual reminder about nEWS at the bedside
- they eliminate transcribing of results – saving time and transcription errors
- the results are immediately available to clinicians across trust
- they eliminate the need to access limited number of computers, or move the computer on wheels around with the monitor
- they may improve the recording of complete sets of observations and correctly scoring the nEWS
- less time spent recording observations means more time can be spent on direct patient care.

National staff survey

The 2014 national NHS staff survey took place in all NHS organisations in autumn 2014. We had an overall response rate of 39%, compared to a national average of 43%. The trust's response rate for 2014 was slightly reduced from 2013 (41%) but the national response rate also reduced. The range of questions remains consistent from year to year, making it possible to benchmark against previous years as well as performance alongside other trusts.

Our overall engagement score remains above average and encompasses the recommendations by staff of the trust as a place to work or to receive treatment. Although there has been very little significant movement in the trust's scores compared to 2013, all of the movement that has occurred has been positive.

In 2014, the trust surveyed all staff to gain a more accurate view and around 40% of staff responded.

The trust's top five areas of performance were reported as:

- staff agreeing that they would feel secure raising concerns about unsafe clinical practice
- low levels of violence against staff
- well-structured appraisal
- staff agreeing that their role makes a difference to patients
- staff recommending the trust as a place to work or receive treatment.

Two areas we performed below the national average in 2014 include:

- The trust provides equal opportunities for career progression or promotion
- Staff experiencing harassment, bullying and abuse from other staff.

Unfortunately, staff experiencing harassment has remained steady with 31% of staff saying that they have experienced harassment, bullying or abuse from staff in the past 12 months. One of the greatest concerns is that 38% of black and minority members of staff report discrimination as compared to 14% of white members of staff.

Our future priorities and targets as a result of the staff survey

The overall objective of our *workforce* and *organisational development strategy* is to develop a highly skilled, motivated and engaged workforce.

	2013/14		2014/15		IMPROVEMENT/ DETERIORATION
RESPONSE RATE	**St George's University Hospitals NHS Foundation Trust**	**National Average**	**St George's University Hospitals NHS Foundation Trust**	**National Average**	
	41%	49%	39%	43%	Increase/decrease

TOP 4 RANKING SCORES	**Trust**	**National Average**	**Trust**	**National Average**	
% of staff agreeing that they would feel secure raising concerns about unsafe clinical practice	N/A	N/A	76%	67%	N/A
% of staff experiencing physical violence from patients, relatives, or the public in last 12 months	14%	15%	12%	14%	2% decrease
% of staff having well-structured appraisals in last 12 months	40%	38%	41%	38%	1% increase
% of staff agreeing that their role makes a difference to patients	92%	91%	92%	91%	No change

BOTTOM 4 RANKING SCORES	**Trust**	**National Average**	**Trust**	**National Average**	
% of staff believing the trust provides equal opportunities for career progression or promotion	78%	88%	76%	87%	2% decrease
% of staff experiencing discrimination at work in last 12 months	19%	10%	19%	11%	No change
% of staff experiencing harassment, bullying, or abuse from staff in last 12 months	31%	24%	31%	23%	No change
% of staff working extra hours	73%	70%	75%	71%	2% decrease

One of our priorities is to continue the work we have done to tackle harassment, bullying or abuse from staff in the past 12 months. The trust has a comprehensive programme to prevent bullying and to identify bullying and to tackle it where it occurs. Through investigations, we are aware that members of staff have encountered bullying behaviour and we are taking formal action where such actions are known to have occurred.

The strategy to tackle bullying includes coaching and training for managers dealing with difficult staffing issues. In addition, the development of a new service providing listening for members of staff and an opportunity to raise concerns has been established. The bullying and harassment support line run by the staff support service is still in operation.

As part of our plans to address the health and wellbeing of staff we will implement a wellbeing strategy in order to reduce sickness absence and to enhance a sense of personal responsibility and engagement amongst staff. This includes a review of the associated policies and self-help health sessions for staff during the formal part of any sickness process.

To ensure all line managers are fully trained to tackle workforce and employee relations issues we will review line management training to include focus on holding difficult conversations. All training and development will include a values based self-awareness element.

We will commission work to understand the relationship between a selected number of culture change initiatives and their intended impact.

St George's has a number of key activities designed to improve understanding of what matters to staff. These activities include Listening into Action, team brief and patient safety forums. More information can be found on page 44 in the 'supporting good people management' section.

Trust employee information

Valuing and developing our staff

The overall objective of our *workforce* and *organisational development strategy* is to develop a highly skilled, motivated and engaged workforce.

Over the last year we have taken forward our objective to embed the values, ensuring that staff are recognised for their achievements and contribution based on the values.

We have a well-established values awards system that recognises the work done by individuals and teams who exemplify our values. These awards celebrate the improvements in the services we provide to patients and each other.

In 2014 we introduced a new incremental progression scheme, initially for senior staff to establish the link between contribution and salary reward. This scheme will be extended to the majority of staff over the next 12 months following a staff engagement exercise and will be linked to a revised appraisal scheme.

We recognise that as well as listening to our patients, it is also important that we listen to our staff and involve them when we try to identify where improvements could and should be made. We launched the Listening into Action programme in 2013 with the aim of achieving a fundamental shift in the way we work and lead by putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the trust as a whole.

Listening into Action has been adopted in a growing number of departments and will continue to be used as a sustainable way of continuously improving our services.

Essentially, Listening into Action is about:

- **engaging all the right people around delivering better outcomes for our patients, our staff and our trust**
- **aligning ideas, effort and expertise behind the patient experience, safety and quality of care**
- **overcoming widespread challenges around staff engagement and morale**
- **developing confidence and capability of our leaders to 'lead through engagement' collaborating across the usual boundaries**
- **engendering a sense of pride.**

During conversations with our staff as part of Listening into Action the idea of providing a service for staff, based on PALS, was aired. A staff advisory service called LIAiSE (Listening into Action is Staff Engagement) was established as a

pilot. The LIAiSE adviser provides a listening and signposting service, identifying where support is available. This has proved to be a success in busy departments such as the emergency department and been instrumental in making changes in the workplace that improves the working lives of our staff.

Staff engagement

Our workforce is vital to the delivery of the highest quality clinical services, education and research, and will need to evolve to meet future needs. We need to value our staff and ensure they champion our values.

Patients have told us that happy staff result in happy patients. Our workforce is the most important asset we have, so we understand the importance of engaging with our staff and we are constantly monitoring how well we keep them engaged and informed. In order for us to serve our patients and the public effectively, we have a number of different channels available to keep staff up to date, generate discussions and provide feedback on different issues that affect us all.

Listening into Action

Listening into Action launched at St George's in 2013 and is growing in momentum as more teams adopt and spread the approach in their areas.

Each service taking part holds a 'Big Conversation' where staff are given the opportunity to talk about what gets in the way of delivering the best possible care for patients.

We have held over 10 Big Conversations. As a result of these conversations we have achieved a number of 'quick wins' based on staff ideas and have introduced a number of longer term projects to address some of the issues.

Each year with 10 teams look at a particular issue or improvement that they have identified for themselves. For example, in 2014 the sterile service department looked at the way they work together and they have seen a marked improvement in communication, attitude and efficiency.

We have also held a number of themed conversations, to seek views from staff on a range of issues, including discharge planning, volunteer experiences, end of life care and nurse induction.

Living our Values awards

The values awards give staff, patients and the public an opportunity to nominate a member of staff or team that they feel demonstrates our values. Winners are awarded with a certificate and badge in a team presentation with the chief executive and they become eligible or entry into our annual awards ceremony.

Team brief system

The Listening into Action Big Conversations and staff Friends and Family Test told us that staff felt they need to understand more about their own areas of work and other areas of the trust if they are to perform effectively. Taking into account this response and to provide a communications channel to ensure that feedback from staff makes it right up to the most senior management at the trust, we introduced a staff newsletter and the team brief system.

The team brief is made up of a core brief provided by the chief executive and a local brief produced by each division or directorate. Every other month the chief executive begins the process by presenting the core brief at each divisional management board meeting and separately to divisional directors.

Those senior managers then brief their teams and include a local brief relevant to their specific clinical division or directorate. Every manager is responsible for a face-to-face team brief meeting with their staff once every other month. The team brief was introduced not just to communicate information downwards but to truly engage and involve staff in staff in key issues that affect the trust. Every member of staff has the opportunity to discuss and question the points being raised with line managers, who feed this information back up to the board.

Patient safety forums

These are presented by senior members of staff, often using an example of a serious incident at the trust. Staff are encouraged to ask questions as to how we can make patients safer at the trust.

By George! staff newsletter

By George is a bi-monthly publication written for staff, by staff. It contains trust news and information about different teams, as well as positive patient experiences. Hard copies are made available so trust staff who cannot easily access our intranet have access to their newsletter.

Gazette magazine

Our stakeholder magazine includes features and news stories from across all our services. Members of staff are encouraged to send ideas to the communications team. Copies of the magazine are available to our patients, visitors, stakeholders and local authorities. The last edition of Gazette is 2014/15 was available online only as a cost-saving measure.
You can see it here https://www.stgeorges.nhs.uk/about/publications/the-gazette/

All staff emails

Our all-staff email, 'eG', is issued every Thursday. Work has been undertaken to make it more appealing, such as limiting word length and including photos.

Supporting good people management

Our annual staff survey results and information from our exit questionnaires help inform our plans for strengthening line management skills which play a crucial role in motivating and developing our staff. Managers have access to a range of management development courses along with tailored support from the workforce directorate in order to embed good practice.

Staff have accessed nationally provided in-house leadership development programmes, ranging from those intended for emerging leaders through to a leadership toolkit available for all staff online.

We have a range of courses provided on site to develop staff.

Managers and leaders:

- Appraise your staff
- Band 6 leadership programme
- Band 7 ward managers programme
- Currently commissioning 15 credit module from Kingston University for aspiring band 7s effective people management
- Conflict resolution
- ILM Level 2 in team leading
- ILM Level 3 in first-line management
- Leading and motivating your team
- Mentoring
- Performance conversations
- Responding to complaints
- Resolving conflict.

Junior doctors:

- Teaching skills
- Assessment and supervision in education and training
- Developing authority (foundation only)
- Authority and impact workshop
- Leadership and management (core training programme).

Faculty development:

- Advanced clinical communications
- Recognising postgraduate supervisors – accreditation workshop
- Professional boundaries
- Authority and impact workshop
- Trainee in difficulty.

All staff:

- Acting assertively
- AMSPAR medical terminology
- Authority and impact in the workplace
- Being your best
- Business administration QCF L2 and 3
- Effective administrator
- Effective customer service
- Excel with Excel
- Influencing for impact

- **Leadership and Influencing skills for support staff**
- **Manage your time with Outlook**
- **Medical terminology**
- **Resilient thinking for peak performance**
- **Sage & Thyme**
- **Team development**
- **Working with Word**
- **Writing persuasive letters and emails**
- **Writing effective emails and reports.**

For healthcare assistants (HCAs) we have a four day development programme, qualification credit framework and help with literacy and numeracy. We support staff on salary supported courses such as the foundation degree which leads to a gradual increase in banding from two – four and we also support healthcare assistants to complete nurse training. We developed a trust wide HCA development pathway and also made a film to raise the profile of support workers across the trust and as an aid to recruitment.

We have introduced the care certificate which focuses on the induction of support workers and the assessment of their competence. The education team worked closely with corporate nursing and therapies leads to develop a robust induction and assessment of support workers which leads to the completion of the care certificate.

The trust has also been involved in responding to service needs by developing innovative bespoke courses in partnership with King's College, London.

The trust also offers a bespoke facilitation service to teams in order to increase their effectiveness and cohesiveness. Coaching is available to managers/leaders on a one-to-one basis.

During 2014, over 700 staff members took advantage of the development opportunities available to them. This included over 200 managers who attended appraisal skills, which has resulted in an increase in the number of staff reporting that they have received a well-structured appraisal.

The trust has developed the role of the physicians associate (PA) and has established a PA board with representation from PAs to ensure good educational development and raising the profile of this innovative role.

The trust has also trained nurses and midwives in: IV drug administration, venepuncture and cannulation and medicines management.

To assist all staff to access and record all development and to monitor mandatory and statutory training compliance, the trust is launching a new, web-based learning management system.

The trust has commenced a pilot group of apprentices in outpatients and plans to build on this work in the year to come. Staff on the foundation degree in healthcare practice will now achieve a higher apprenticeship award.

Now in its 15th year of operation, St George's advanced patient simulator (GAPS) centre trains more than 1,800 doctors, nurses, medical and nursing students and other health professionals per year. It is widely recognised as one of the most innovative inter-professional healthcare simulation facilities in the country and has been successful in bidding for educational contracts both regionally and nationally. However, its core business is the training of St George's healthcare staff in caring for acutely ill patients. Staff learn in multi-professional teams and learn by engaging in conversations about practice provoked by experiences gained in a realistic environment.

Simulation-based training takes place in the GAPS Centre, on the wards, in the delivery suite, the emergency department, operating theatres, critical care units and in the community. For the first time GAPS has delivered simulation-based training in local dental practices improving the capacity for dental practice staff to respond to life-threatening medical emergencies. This has followed on from a successful programme in local primary medical care practices in 2014.

GAPS is a major provider of skills training and is consistently highly rated by external participants for Acute Trauma Life Support, the European Trauma Course, Basic and Advanced Surgical Skills and Care of the Critically Ill Surgical Patient courses. In addition, specific specialty area courses are aimed at St George's staff and these include obstetric skills and drills, tracheostomy care, advanced airway skills for anaesthetists, trans-thoracic and trans-oesophageal echocardiography skills. Trainee surgeons are able to use advanced computerised laparoscopic trainers and cardiac surgical teams train using the *Orpheus* cardiac bypass simulator.

Most full-immersion, high-fidelity simulation-based training courses are inter-professional. These include the foundation programme, core medical trainee and final year medical school simulation days. *Acclimatisation* for healthcare staff new to the NHS is a particularly innovative new programme. It has now had 21 participants and will continue to facilitate the transition of non-UK trained staff into safe and effective NHS practice.

The St George's simulation *Train the Trainer* course is always oversubscribed. GAPS has now trained more than 300 healthcare staff in the techniques of simulation-based training. The great strength of the centre is the teaching faculty base of more than 300 experienced clinical educators.

Despite its considerable educational output, the GAPS team is relatively small. Seven permanent centre staff include clinical course facilitators, technical staff, administrators and an educationalist. GAPS hosts between two and four simulation fellows, advanced specialist medical trainees who take time out from their training programmes to develop expertise in simulation-based training. GAPS staff are regular presenters at international meetings and author papers in peer-reviewed journals.

Workforce of the future

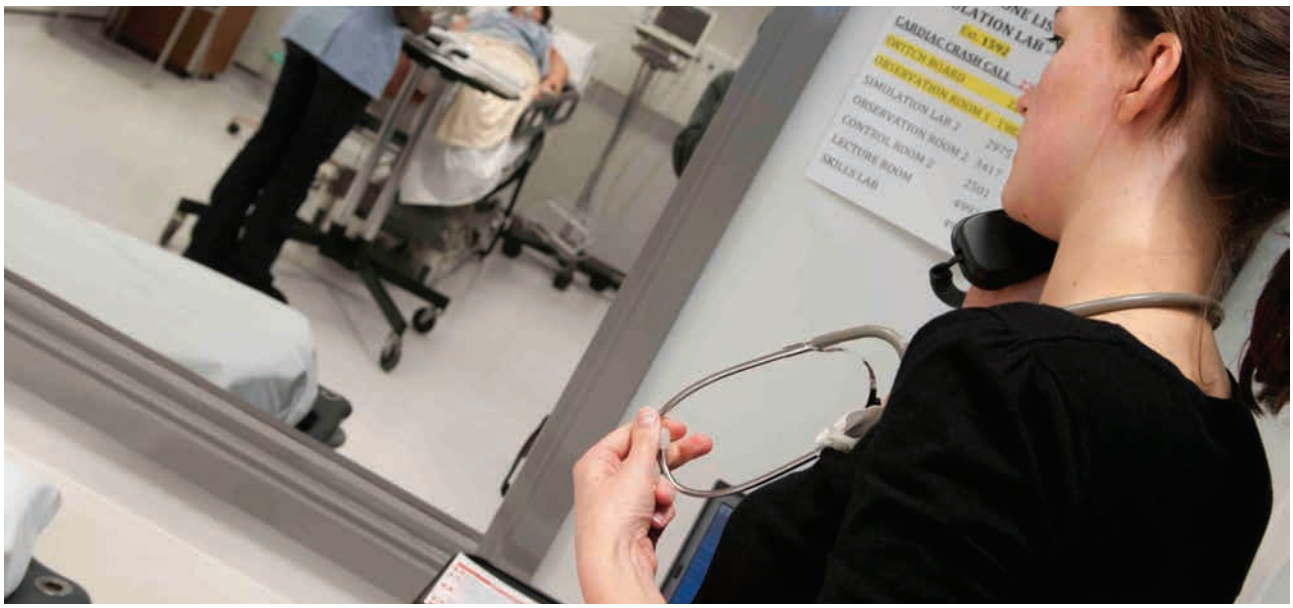
Student Nurses
St George's has 330 student nurses and has developed a guaranteed employment route for them in partnership with our nursing directorate and King's College, London and Kingston University. This model of guaranteed employment is one of the recommendations of the Shape of Caring Review by Lord Willis (2015) with the proviso that there will be a robust period of preceptorship.

Doctors in Training
St George's is one of five lead providers across South London; it is commissioned to run training programmes by one of the three London local education and training boards (LETBs). These boards have been set up by Health Education England and are responsible for making sure that the NHS is successfully training the future workforce for our population. Lead providers have been tasked with leading educational development and innovation and managing their local training communities. St George's is responsible for a total of 13 specialty training programmes (for pan London, south London and south west London) – core medicine, core surgery, core dental, cardiothoracic surgery, clinical radiology, clinical genetics, geriatrics, gastroenterology, geni to urinary medicine, general surgery, higher anaesthetics, trauma and orthopaedics and vascular surgery.

St George's is an active member of the Confederation of South London Lead Providers (COSL), a forum which encourages the lead providers to work collaboratively and share best practice to enhance the quality of medical and dental education delivered across south London. COSL aims to ensure that excellence in healthcare education is delivered across south London, to provide the best training.

Retention

Retaining staff is just as important as recruiting. The trust has worked closely with nursing colleagues on various initiatives around retention. One of the areas identified to aid retention was to support newly qualified nurses/midwives through the preceptorship programme. This was designed and delivered by the education team after feedback from students and newly qualified nurses and in conjunction with the Preceptorship Framework (DoH, 2010).



The programme consists of the following:

- six months preceptorship support
- named preceptor
- preceptorship handbook
- regular progress meetings
- four study days
- preceptee workshops.

Sickness absence

Attendance at work is reported monthly to the trust board and at divisional management boards to ensure that staff are supported to return to work and to ensure we have as many staff available for work as possible.

SICKNESS ABSENCE FULL YEAR 2014/15

STAFF GROUP	%
Add Prof Scientific and Technical	3.51%
Additional Clinical Services	5.31%
Administrative and Clerical	4.08%
Allied Health Professionals	2.33%
Estates and Ancillary	6.06%
Healthcare Scientists	1.50%
Medical and Dental	0.67%
Nursing and Midwifery Registered	4.30%
Grand Total	**3.54%**

Occupational health and staff support

The occupational health service supports the wellbeing of staff so that they can work safely and effectively. In 2014, a wellbeing strategy was introduced to promote healthier lifestyle choices for staff and empowering staff to manage their own health and wellbeing needs and providing the skills to champion the wellness needs of those around them.

The trust provides a staff support service to which staff can confidentially self-refer at times of particular difficulty or stress in their lives whether at work or at home.

The trust is committed to protecting the health, safety and welfare of its employees and this policy sets out the steps the trust will take to identify stress in the workplace and effectively manage stress where it occurs.

Our *stress management policy* outlines the responsibilities of managers and employees in tacking stress and along with the accompanying procedure and management guidelines will support managers in identifying and managing the causes and effect of stress in the workforce, and help to minimise the impact of work-related levels of stress within the organisation.

Regulatory ratings and disclosures

The trust is regulated by Monitor, to whom it submits its annual plan. Details contained within the trust's annual plan and the in-year submissions made will be the basis from which Monitor will assess and assign a risk rating for the trust.

The role of ratings is to provide a judgement of performance and to indicate when there is a cause for concern for the trust.

In accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) the trust confirms that the income it receives from the provision of goods and services for the purposes of the health service in England is greater than the income it receives for any other purposes.

The trust has a number of income generating activities and the surplus these activities generate is used by the trust to fund the provision of goods and services for the purposes of the health service in England.

The trust has performed positively against the regulatory targets in 2014/15 although the financial performance has deteriorated. The financial position is discussed in more detail in the finance review section.

The trust has faced significant challenges in 2014/15 and has not met the A&E four hour target. This was discussed regularly with commissioners and the trust is proactively engaging with Monitor about actions being taken to improve performance against this target.

The trust achieved foundation trust status in Q4 2014/15. Prior to this the trust was regulated under the Trust Development Authority accountability framework and also undertook self-assessment against the Monitor Risk Assessment Framework. An overview of the assessment is as follows:

2014/15	Annual Plan	Q1	Q2	Q3	Q4
Continuity of service rating		3	3	3	under review
Governance rating		Green	Green	Amber /Red	Amber /Red

Due to the investigation being undertaken by Monitor, our rating for Q4 has been replaced as 'under review'. Monitor is investigating financial sustainability concerns at the trust, triggered by the deterioration in the trust's financial position. For more information regarding the Monitor investigation, please see page 25.

After making enquiries, the directors have a reasonable expectation that the trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The accounts have been prepared under a direction issue by Monitor under the National Health Service Act 2006.

Promote equal opportunities

The trust serves the diverse local population of south west London and beyond. This population is ethnically diverse – nearly 50% of the population is from non-white British backgrounds and speaks over 300 languages. Among our staff, we are proud to reflect this with nearly 50% of our staff from different ethnic communities.

The changes in our local population are rapid and it is vitally important that all patients and staff who come into contact with us in different settings feel included, respected and valued.

By treating everyone in a fair and inclusive manner, we send a strong signal about the values of the NHS and Britain at large.

In 2014/15 we undertook our second assessment using the NHS Equality Delivery System and used the results to set our corporate equality priorities for 2015-2019. We did this in consultation with our staff and other stakeholders and the findings were approved by the board.

The results of this assessment and our equality reports can be seen at https://www.stgeorges.nhs.uk/about/living-our-values/equality-and-human-rights/

Our workforce by gender

A breakdown of the workforce by gender is set out in the table below.

	WTE		%	
STAFF GROUP	FEMALE	MALE	FEMALE	MALE
Directors	2	7	22.2%	77.8%
Senior managers (AFC 8c +)	62.8	33.5	65.2%	34.8%
All staff	5778.1	2064.2	73.7%	26.3%

From April 2015, in line with the rest of the NHS, we will adopt a new Workforce Race Equality Standard (WRES). The WRES has been developed to support NHS organisations in ensuring that staff from black and ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. NHS organisations will be required to demonstrate progress against a number of indicators of workforce equality in the workforce, especially at leadership levels. It is important that our staff

and leaders reflect the communities in which they work, bringing diverse experiences to the table and acting as positive role models for others to follow.

Over the past two years, we have made significant improvements in maternity services through a model of staff dialogues and inclusive leadership. The *'Maternity Futures'* project has been recognised across midwifery services in London and nationally.

In December 2014, the trust issued its *Policy on the Employment of Disabled People* with input from union representatives which includes information including:

- **giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities**
- **continuing the employment of, and for arranging appropriate training for, employees who become disabled**
- **training, career development and promotion of disabled employees.**

The policy sets out the trust's commitment to employing people with disabilities and making appropriate arrangements for disabled applicants to be shortlisted if they meet the minimum requirement for the post. This is a well-established process; applicants are able to indicate they have a disability at the outset of the process and successful applicants can discuss any required adjustments to the role with the recruiting manager with support from the occupational health department if necessary.

The policy also covers the steps that we take to retain staff in employment should they become disabled, which includes identifying any training and career development requirements. We monitor the responses of disabled staff through the staff survey. In future, the particular needs of disabled staff will form part of the 'St George's as One' initiative which focuses how we ensure all staff are able to contribute equally at the trust and have their contribution valued.

We continue to develop and invest in initiatives to improve the experiences of all our staff, recognising that they are most valuable asset. As the trust develops and grows, employees' attitudes, knowledge and skills need to be enhanced and supported. This ensures that we have staff at all levels of the organisation to deliver the best healthcare we can in the hospital and in the community. To support this strategy, we continually revise our programme for organisational development and invest in appropriate initiatives.

An example of this is our commitment to the role of physician associates who support doctors in the diagnosis and management of patients, ensuring doctors can work more effectively. Within maternity services, we have recently trained 41 midwives at different levels of seniority in enhancing their skills and the support given to women in achieving Optimum Birth in line with best evidence and government policy. New developments include introducing the programme for the new Care Certificate for healthcare assistants and those in other supportive roles.

As part of our duties under the Equality Act 2010, the trust collects a range of employment data to monitor diversity and inequalities. The results are published in annual workforce monitoring reports on the trust's website – https://www.stgeorges.nhs.uk/

Information about the diversity of our patient activity is now included in these reports. Equality impact assessments are undertaken to provide assurance that corporate policies and major service developments and functions take account of diversity and are not discriminatory.

Through patient involvement and engagement activities, the trust makes effort to ensure we work in partnership with patients, carers and staff. Our Friends and Family Test now includes information on key demographics to monitor whether our feedback represents the community we serve.

The trust is committed to building in human rights values and principles in all of its work and contact with patients, the public and our workforce. A good way to understand human rights is to see them as a vehicle for making principles such as dignity, equality, respect, fairness and autonomy central to our experiences. The equality and human rights committee provides leadership and assurance for the trust in this subject area. The committee continues to improve the governance of this area within the trust and develop its learning through the organisation.

Sustainability report

The trust remains committed to sustainability by minimising the environmental impact of our services and the goods we purchase. We remain on target to cut our carbon emissions by 10 per cent by 2015, by 34 per cent by 2020 and by 80 per cent by 2050.

These are challenging targets and will require the trust to undertake a step-change in the way it works, reducing waste through the organisation, using less when it is safe to do so, making the best use of new technologies and most importantly engaging our leadership and the whole workforce in this necessary change exercise. The financial savings made through these changes will be re-invested in our organisation and our people to improve our services.

During 2014, we ran sessions with staff to ask them what that would like us to do to make the trust more sustainable. Over the period 2015-2020 we will re-engage with staff, embed sustainability through the organisation and demonstrate the financial and other benefits that arise from these activities.

We are working with community partners such as Transition Town Tooting and our suppliers to realise these ambitions. During 2014/2015, we also took into account the revised guidance produced by the NHS Sustainable Development Unit and Public Health England. The new voluntary framework takes a holistic, integrated approach to health and wellbeing, along with a focus on carbon hotspots and use of goods and services. It encourages sustainability in people and places, while building resilience and forward planning to make better use of limited resources.

The trust has started work on adopting this new framework as part of its internal learning, recognising the challenges in the country and the NHS at large to make best use of all our resources. We will report on this in our next annual report.

We support the NHS in its pledge, made at the United Nations in 2014 to be the first sustainable healthcare organisation in the world. For this financial year the trust has procured all its imported electricity from renewable sources which do not produce carbon emissions.

In August 2014, we signed an agreement for an energy performance contract with British Gas to significantly reduce our energy consumption and carbon emissions by replacing our ageing energy infrastructure which is over 40 years old. This is currently in the design phase and construction is due to start in July 2015 and will take approximately a year to complete. The project will improve reliability of energy supply, provide an enhanced healthcare environment and will cost approximately £12m with the funding coming from a specially designed European Union loan scheme. British Gas will guarantee energy savings of approximately £19m to the trust over 15 years. Additionally as part of the contract, British Gas will implement a series of energy improvement measures from LED lighting to the installation of our first solar panels that will generate enough energy for 150 homes once installed.

Area	Non – financial metric 2013-14	Non – financial metric 2014-15			Financial 2013-15	Financial 2014-15*
Water	360,603	338,205	M3	Water	£297,278	£483,377
Imported electricity	18,902,959	17,768,425	kWh	Energy (gas and electricity)	£4,339,220	£4,306,386
Gas	74,640,321	71,597,845	kWh			
Co2 emissions from building energy use	13,737	13,177	Tonnes CO2			
Waste				**Total waste cost**	**£527,636**	**£577,832**
High temperature disposal	184 tonnes	191 tonnes				
Alternative treatment	1099 tonnes	1049 tonnes				
Landfill (offensive waste)	57 tonnes	110 tonnes				
Re-cycling: as % of total domestic waste	33%	25%				

*Figures for 2014/15 are estimated based upon check meters and historical data

Counter fraud

The trust is committed to providing a zero tolerance culture to fraud, bribery and corruption while maintaining an absolute standard of honesty and integrity in dealing with our assets. We are committed to the elimination of fraud and illegal acts within the trust and ensure rigorous investigation and disciplinary sanctions or other actions as appropriate. We adopt best practice procedures to tackle fraud, as recommended by our regulators NHS Protect.

Over 2014/15, we have delivered counter fraud awareness sessions targeting all levels of staff. This work is ongoing. We have anti-fraud and anti-bribery policies and publicise successful disciplinary, civil and criminal investigations in the trust newsletter, eG. In the 2014/15 financial year counter fraud received 109 contacts and opened 13 new cases. Eight cases were referred for disciplinary consideration and five cases for criminal prosecution.

Counter fraud is accountable to the director of finance, performance and informatics and the audit committee. All concerns are investigated by our counter fraud team or NHS Protect as appropriate.

Protocols are in place with the human resources department, procurement department and internal audit to ensure the counter fraud culture is embedded within the trust. An excellent working relationship has also been established with the Home Office and with the local Safer Neighbourhood Team.

The strategic report was approved by the board of directors on 28 May 2015 and signed on its behalf by:

Miles Scott
Chief executive
Date: 28 May 2015

Directors' report

Our board

The board of director's primary role is to set the trust's strategic direction and objectives, ensure delivery of these within planned resources and oversee the trust's performance.

The board is comprises of a chairman, six non-executive directors – including a university representative – and eight executive directors (four voting and four non-voting). One of the six non-executive directors became a voting member of the board following authorisation as a foundation trust.

The chairman and the non-executive directors come from different professional backgrounds with a wide range of skills and experience that reflect the needs of the trust. Although members of the board, non-executive directors are not part of St George's executive management team and are effectively independent experts in their field employed to challenge the trust and provide expert leadership and guidance. They hold the executive directors to account for the day-to-day running of the trust.

The board of directors is made up of:

- chairman
- five independent non-executive directors
- one university representative non-executive director (Peter Kopelman)
- four voting executive directors (chief executive, chief nurse, medical director and director of finance)
- five non-voting directors, who attend board meetings in advisory capacity.

The board has a scheme of delegation in place and a schedule of powers and decisions reserved to the board to ensure that decisions are taken at the appropriate level.

The chairman and non-executive directors' responsibilities include:

- contributing to the development of strategic plans to enable the trust to fulfil its leadership responsibilities for healthcare of the local community
- ensuring that the board sets challenging objectives for improving its performance across the range of its functions
- monitoring the performance of the executive team in meeting the agreed goals and improvement targets
- ensuring that financial controls and systems of risk management are robust and that the board is kept fully informed through timely and relevant information
- accountability to NHS England for the delivery of the trust's objectives and ensuring that the board acts in the best interests of its local community
- taking part in the appointment of executive and other senior staff
- ensuring that the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business.

Non-executive directors, including the chairman, were appointed by the Trust Development Authority when we were an NHS trust. Now that we are a foundation trust, the appointment of the chairman and non-executive directors is approved by the council of governors and was carried out in February 2015. All board appointments are made using fair and transparent selection processes with specialist human resources input. When appointing to the board, due consideration is given to the range of skills and experience required for the running of the trust.

Each year every member of the board has a formal appraisal to review their strengths, aspirations and learning and development needs. Each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

Declarations of interest

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is the responsibility of all staff to ensure that they are not placed in a position which risks or appears to risk conflict between their private interest and NHS duties.

The primary responsibility applies to all NHS staff, including the executive team and non-executive directors. Members of the board are asked to declare any interests they have before the start of each board meeting. Interests of board members have been declared within the directors' report on the following pages.

Register of interests

All staff who are either responsible for and/or involved in the requisitioning and/or purchasing of goods and services, should declare any interests they are aware of.

Executive directors 2014/15

Miles Scott

Chief Executive

Declared interests:

- Member of Higher Education Funding Council for England Healthcare Advisory Board
- Chair of National Institute for Health and Care Excellence Safe Staffing Advisory Committee
- Chair of NIHR CLAHRC South London Board
- Chair of South London Clinical Research Network Partnership Board
- Vice Chair of Health Innovation Network
- Member of Health Education South London Board

About:

Miles was chief executive of Bradford Teaching Hospitals NHS Foundation Trust from August 2005 to November 2011. Before joining Bradford Teaching Hospitals, Miles was chief executive of Harrogate and District NHS Foundation Trust for four years. He started his NHS career on the General Management Training Scheme in 1988 after graduating from Cambridge University with a degree in History. His career in the NHS has encompassed acute, community and mental health services, the King's Fund and Trent Regional Office.

Steve Bolam

Chief Financial Officer; Deputy CEO

Declared interests:

None

About:

Steve was appointed in September 2012. He joined the trust from Southampton, Hampshire, Isle of Wight and Portsmouth PCTs. Steve has significant board-level experience, having previously held director-level roles at Hampshire PCT, Basingstoke and North Hampshire NHS Foundation Trust and Nuffield Orthopaedic Centre NHS Trust, Oxford.

Jennie Hall

Chief Nurse and Director of Infection Prevention and Control

Jennie started on 1st June 2014

Declared interests:

- Clinical Director, South London Patient Safety Collaborative at Health Innovation Network
- Honorary Clinical Fellow of Kingston University Health and Social Sciences

About:

Jennie joined St George's in June 2014 following her post as Programme Director (London) in the Trust Development Authority. She has worked in the NHS for 30 years and has provided strategic leadership at director/chief nurse level to the nursing and midwifery profession. Jennie has a successful track record in implementing initiatives to reduce mortality, enhance patient safety and patient experience through setting goals and targets to achieve sustainable change. Jennie has broad experience in operational management including mergers. In 2012/13 she led the transaction programme for the dissolution of South London Healthcare NHS Trust which included the design and implementation of a quality and safety handover process for all corporate and clinical services.

Simon Mackenzie

Medical Director
(joint post with St George's, University of London)

Simon started on 5th January 2015

Declared interests:

None

About:

Simon has extensive experience in critical and intensive care, both as a practising consultant and as a clinical leader. He has driven quality and safety improvement programmes, as well as having sat on national bodies, including two years as president of the Scottish Intensive Care Society.

His previous role was medical director at University Hospitals Division NHS Lothian. NHS Lothian, which provides services from more than ten hospitals and other community settings, also has close ties with the University of Edinburgh. As a teacher, Simon prioritises work on clinical leadership, improvement and information and data.

Peter Jenkinson

Director of Corporate Affairs

Declared interests:

None

About:

Peter joined St George's as trust secretary in June 2009 and has responsibility for corporate governance including the corporate office, communications, risk management and membership functions. Prior to taking up this post he was at Winchester and Eastleigh Healthcare NHS Trust for seven years, holding a variety of roles including company secretary, head of corporate services and head of governance. Prior to joining the NHS in 2002, Peter gained experience working in various departments of central government and in the IT industry.

Wendy Brewer

Joint Director of Human Resources
(joint post with St George's, University of London)

Declared interests:

- Member of Executive Team, St George's, University of London

About:

Wendy joined St George's University Hospitals NHS Foundation Trust and St George's, University of London in February 2012. She has over nine years' experience working in human resources roles within the NHS; having previously worked at Lewisham Healthcare NHS Trust, Bromley PCT and King's College Hospital NHS Foundation Trust. Wendy has also worked in the mental health and charity sectors.

Eric Munro

Joint Director of Estates and Facilities

(joint post with St George's, University of London)

Eric started on 30th June 2014

Former interim Director of Estates and Facilities David Hastings left in July 2014.

Declared interests:

- Member of Executive team, St George's, University of London

About:

Eric joined the trust and university from West London Mental Health NHS Trust, where he was responsible for the large-scale redevelopment of the Broadmoor Hospital and St Bernard's Hospital. Eric has significant experience in the higher education environment as well as in the NHS.

Martin Wilson

Director of Delivery and Improvement

Martin started on 4th August 2014

Former interim Director of Delivery and Improvement Bernie Bluhm left in June 2014.

Declared interests:

None

About:

Martin started his career as a nurse before moving into general management via the NHS Management Training Scheme. He has undertaken a number of senior roles in the acute sector and in strategic health authorities, including as regional director for flu resilience during the swine flu pandemic and as director of operations, QIPP and transformation at NHS North East. Since 2011 he has worked for McKinsey and Company supporting hospitals, including large London foundation trusts, to improve their quality and sustainability. Martin has been a member of the NHS Top Leaders programme and continues to practice clinically as a nurse.

Rob Elek

Director of Strategy

Rob started on 1st February 2015

(Suzanne Marsello and Karen Larcombe covered this role as joint acting directors of strategy from October 2014 to January 2015).

Declared interests:

- Director of consultancy company

About:

Prior to joining St George's Rob worked at Moorfields Eye Hospital NHS Foundation Trust as the director of strategy and business development. He led the expansion of its satellite network from 13 to 23 sites. Rob also directed annual planning and business development, managed corporate functions and a new hospital project. His key achievements include strengthening relationships with commercial and third sector organisations and developing new partnership models for the delivery of NHS patient care. Rob also acted as the interim chief operating officer during autumn 2013. He recently supported the production of Monitor's new strategy development toolkit and has held senior NHS roles in strategy, major capital projects, business and commercial development. His career outside the NHS includes management consultancy and recruitment.

Ros Given-Wilson

Former Medical Director

Ros left her position as part-time Medical Director in December 2014

She is now a consultant radiologist for the trust with a speciality in breast and paediatric imaging.

Declared interests:

- Medical adviser, Gibraltar Health Authority
- Chair of Local Governing Body Dunottar School

About:

Rosalind Given-Wilson set up the South West London Breast Screening Service in 1991 and was director of screening, then director of diagnostics, then medical director from 2007 until 2015.

She has research interests in the optimisation of breast imaging and decision making having published over 120 papers and abstracts. She is involved with national quality assurance of breast screening for the Department of Health's advisory committee on breast cancer screening. She runs St George's national breast screening training centre, providing post graduate training and has held the Royal College of Radiologists Breast imaging Professorship which involved lecturing nationally and internationally on breast imaging.

Dr Trudi Kemp

Former Director of Strategic Development

Trudi left the trust in September 2014

Declared interests:

None

About:

Trudi was appointed in April 2009, after working as a public health consultant at St Geroge's since 2002. She was responsible for the trust's strategy development and implementation and business plans. She was an honorary senior lecturer at St George's, University of London and a trainer for registrars and specialists in public health and was involved in undergraduate and postgraduate student teaching. Qualified in medicine in 1986, she also holds Master's degrees in Medical Law and Ethics and in Public Health, and is a Fellow of the Faculty of Public Health.

Professor Alison Robertson

Former Chief Nurse and Director of Operations

Alison left the trust in June 2014

Declared interests:

None

About:

Alison joined St George's in February 2010, following her post as chief nurse at Brighton and Sussex University Hospitals NHS Trust. She has worked in the NHS for over 25 years and has provided strategic leadership to the nursing and midwifery profession in several NHS trusts, including Queen Victoria Hospital NHS Trust and Surrey & Sussex Healthcare NHS Trust. Alison has a successful record in reducing hospital acquired infections and in implementing initiatives to improve the patient experience. She has also led several successful initiatives to enhance patient safety and quality of care, setting goals and targets to achieve positive change. Alison has broad experience working in the community and is a qualified health visitor. In July 2010, she became Honorary Senior Fellow within Kingston University and St George's, University of London, Faculty of Health and Social Sciences. She has also written publications on several topics, including care for children and cystic fibrosis.

Non-executive directors 2014/15

All non-executive directors are independent other than Peter Kopelman as he a representative of St George's, University of London.

Christopher Smallwood

Chairman

Declared interests:

None

Membership of Committees:

- Nominations of Remunerations
- Finance and Performance
- Commercial Board
- FT Programme Board

About:

Christopher has extensive NHS experience having previously been chair of Kingston Hospital NHS Foundation Trust and prior to that, chair of NHS Hounslow. He is a policy adviser to The Prince's Charities and until 2005, was economic adviser to Barclays plc, following several years as a partner at the city consultancy Makinson Cowell. Christopher has also worked at TSB Group as strategic development director and chief economist. He was economics editor of The Sunday Times and chief economist and head of financial strategy and planning for BP. He has been an economic adviser to HM Treasury and a special adviser at the Cabinet Office. He was also, until recently, a member of the Competition Commission.

Professor Peter Kopelman

Representative of St George's, University of London

Declared interests:

- Governor, Kingston University
- Director, INTO – SGUL LLP
- Deputy Chair & Trustee, London Higher Chair, Faculty Board, Royal Pharmaceutical Society
- South London Health Innovation Network
- South London Collaboration for Leadership in Applied Health Research and Care
- UK Higher Education Advisory Committee

Membership of Committees:

- Workforce Quality and Risk Nominations and Remunerations

About:

Peter graduated from St George's in 1974 and undertook most of his junior doctor training at St George's Hospital. He was Vice Principal, Queen Mary, University of London, and Deputy Warden of the Medical and Dental School (2001-06) and Dean of the Faculty of Health, University of East Anglia (2006-08).

He has been closely involved in undergraduate and postgraduate medical education and chairs the Clinical Examining Board of the Federation of Royal Colleges of Physicians (UK) and the National Institute for Health Research Academic Careers Panel. He is a member of the UK Healthcare Education Advisory Committee. Professor Kopelman has a long-standing interest in diabetes care, nutrition and obesity, with a major research interest in obesity. He is a member of the UK Department of Health and Food Standards Agency Scientific Advisory Committee on Nutrition, the Department of Health Expert Panel on Obesity, and is Science Advisor to the Office of Science and Innovations Foresight Obesity Project. Additionally, he is a member of the national and international committees on nutrition and academic affairs.

Mike Rappolt

Non-executive director

Declared interests:

- Member of the Parkside Residents' Association Committee
- Various shareholdings (all under 1% of company)
- Trustee of St George's Hospital Charity

Membership of Committees:

- Audit
- Nominations and Remunerations
- Finance and Performance

About:

Mike has 40 years' of international management experience including 29 years as a management and IT consultant with PA Consulting Group, where he was a main board director for 12 years, chaired the audit committee, and from which he retired in 2001. He was a governor of Contemporary Dance Trust for 13 years setting up and chairing the audit committee and was also a non-executive director of a small quoted IT services company for five years.

He was chairman of the Wimbledon Civic Theatre Trust and a committee member of his local residents' association. Mike joined the board of St George's University Hospitals NHS Foundation Trust as a non-executive director in 2004 and he chairs the trust's audit committee.

Mike is also the deputy chairman and the senior independent director for the trust.

Stella Pantelides

Non-executive director

Declared interests:

- Consulting – various financial and professional services sector firms

Membership of Committees:

- Workforce
- Nominations and Remunerations
- Finance and Performance

About:

Stella has extensive commercial and human resources experience gained through senior leadership roles in a wide range of organisational settings. She combines the running of a successful consulting company on workforce and organisational strategy with a number of public appointments, including the Judicial Appointments Commission and non-executive director on the Service Personnel Board at the Ministry of Defence.

Dr Judith Hulf

Non-executive director

Declared interests:

- Responsible Officer and Senior Medical Advisor, General Medical Council

Membership of Committees:

- Audit
- Quality and Risk
- Nominations and Remunerations

About:

Judith is the responsible officer and senior medical adviser to the General Medical Council. Prior to this she was a consultant general and cardiothoracic anaesthetist at University College London Hospital until 2009 and President of the Royal College of Anaesthetists 2006-2009. Judith has chaired many important taskforces including the Swine Flu (H1N1) Critical Care Clinical Group for the Department of Health and the Extra Corporeal Membrane Oxygenation (ECMO) sub-group. She was awarded a CBE in June 2009.

Sarah Wilton

Non-executive director

Declared interests:

- Non-Executive Director of Capita Managing Agency and of Hampden Members' Agency.
- Director/trustee and Vice Chair of Paul's Cancer Support Centre
- Magistrate at South West London Magistrates' Court

Membership of Committees:

- Audit
- Quality and Risk
- Nominations and Remunerations
- Finance, Performance and information
- FT Programme Board

About:

Sarah is a qualified chartered accountant with PricewaterhouseCoopers. She has held several senior executive positions at Lloyd's of London, delivering major change programmes including restructuring, outsourcing, efficiency and effectiveness reviews.

Before joining St George's, Sarah was a non-executive director at NHS Wandsworth where she was chair of the resources committee and a member of the audit committee and children's trust. Sarah also oversaw the integration of Community Services Wandsworth with St George's as co-chair of the joint NHS Wandsworth and St George's University Hospitals NHS Foundation Trust integration programme board.

Sarah has held non-executive director appointments at two Lloyd's agencies, Capita Managing Agency since 2004 and Hampden Agencies Limited since 2008, chairing the audit and risk committees. She is a Magistrate at Wimbledon Magistrates Court and a Trustee of the Paul D'Auria Cancer Support Centre.

Kate Leach

Associate Executive Director – appointed voting member of the board in February 2015 post foundation trust authorisation

Non-executive director

Declared interests:

- Director of Kate Leach Consulting

Membership of Committees:

- Workforce
- Commercial

About:

Kate has over 18 years' commercial experience within the pharmaceutical industry, the majority of which spent with GlaxoSmithKline. She has won many GSK and external marketing awards. As a commercial leader, Kate has held director-level positions leading a number of GSK's therapy business units including urology, HIV, vaccines and respiratory. She has a wealth of experience in commercial excellence, strategic planning, market access, branding and capability development. In addition, Kate has a proven track record launching new brands into multiple therapeutic markets.

Council of governors and membership

Our council of governors

In June 2014 members of the trust were invited to both nominate themselves and vote for the governor they would like to represent them on the council of governors. This included nominations and voting for both staff and public governors to join a group of appointed governors from partner organisations.

The trust received an overwhelming response to our call for nominations to stand as a governor with 75 members of the public standing for our 15 public governor positions.

In July 2014, we announced the newly elected governors who formed the inaugural council of governors. As a shadow council they undertook an induction programme which included joining internal inspections, receiving presentations from executive directors and clinical staff and joining the trust at major events.

The council of governors became a full council when the trust was authorised as a foundation trust on 1st February 2015.

Role of the governors

The council of governors is responsible for the appointment of the chairman and the non-executive directors, agreeing their terms and conditions, as well as the appointment of the external auditor. Each financial year, the council of governors is consulted by the board on the trust's forward plans and receives the annual accounts, auditors' report, annual report and quality report. Governors respond as appropriate when consulted by the directors on specific issues. Governors are unpaid, however they are entitled to receive reimbursement of expenses.

Lead governor

The council of governors select one of their elected members to be the lead governor of the council of governors. The lead governor co-ordinates communication between Monitor and the other governors. They act as the main point of contact for the chairman and the senior independent director. The lead governor at the date of this report is Kathryn Harrison.

Composition of the council

The council comprises of:

- 15 elected public governors
- 5 elected staff governors
- 8 partner appointed governors

Membership and terms of office of the council during 2014/15 are outlined below.

CONSTITUENCY NAME	GOVERNOR NAME	POLITICAL AND FINANCIAL INTEREST	TERM OF OFFICE	
			3 YEARS	2 YEARS
Public: Wandsworth	Stuart Goodden	None	3	
Public: Wandsworth	Yvonne Langley	None	3	
Public: Wandsworth	Doulla Manolas	None		2
Public: Wandsworth	Felicity Merz	None		2
Public: Wandsworth	Derek McKee	None		2
Public: Wandsworth	Stephen Miles	None	3	
Public: Merton	Sue Baker	None	3	
Public: Merton	Anneke De Boer	None		2
Public: Merton	Sheila Eden	None		2
Public: Merton	Hilary Harland	None	3	
Public: South west Lambeth	Gail Adams	Labour Party	3	
Public: Regional	Mia Bayles	Conservative Party	3	
Public: Regional	Edward Crocker	None		2
Public: Regional	Kathryn Harrison	None		2
Public: Regional	Jan Poloniecki	None	3	
Staff: Medical & Dental	J P van Besouw	None	3	
Staff: Community Services Division	Noyola McNicolls-Washington	None		2
Staff: Non-Clinical Staff	Jenni Doman	None		2
Staff: Nursing & Midwifery	David Flood	None	3	
Staff: Allied Health Prof.& Other	Hilary Rattue	None	3	
Appointed: Healthwatch Merton	Barbara Price	None	3	
Appointed: Merton Council	Cllr Phillip Jones	None	3	
Appointed: Healthwatch Wandsworth	Mike Grahn	None	3	
Appointed: St George's, University of London	Dr Frances Gibson	None	3	
Appointed: Kingston University	Dr Val Collington	None	3	
Appointed: Wandsworth Clinical Commission Group	Dr Patrick Bower	None	3	
Appointed: Merton Clinical Commissioning Group	Dr Andrew Murray	None	3	
Appointed: Wandsworth Council	Cllr Sarah McDermott	None	3	

Meetings of the council

The council held one full meeting in 2014/15. This was the authorisation meeting of the council of governors on 10th February 2015. At this meeting the council received the Monitor FT Licence, approved the new trust name, approved the appointment of Mike Rappolt as the senior independent director, approved the appointments of chairman and chief executive.

A training and development plan has been developed for the council of governors, which includes both external and internal training and engagement.

Establishing a membership committee

Governors attend board meetings and members' health talks where they can meet and talk with trust members. The trust is in the process of establishing a membership engagement committee as a sub-committee of the council of governors. This will include a programme of activities for governors both in the community and at the trust to reach out to and meet with members.

Members who wish to communicate with governors and/or directors can do so by contacting the membership office via membership@stgeorges.nhs.uk.

Register of governors' interests

A register of governors' interests is maintained. A copy of the latest version submitted to the council of governors is available on the trust's website or it may be inspected during normal office hours at the corporate director's office.

Communicating and engaging with our members

The trust recognises the importance of communicating effectively with members, ensuring that they are properly informed and able to participate as they choose. Communication with members must also be a two way process and mechanisms are in place to ensure that members, governors and the trust are able to engage in a quality dialogue.

We commenced membership recruitment in April 2010. By the end of 2012 we had a membership base of over 5,000 public members. By the time of our governor elections in June 2014 the trust had established a public membership base of over 12,000 members.

We regularly communicate with members to keep them up to date with the latest news and events. To ensure that we reach our members who do not have access to the internet or email we publish a printed publication called the Gazette. We maintain a dedicated membership and governor page on the website and communicate and engage with our members through social media.

During 2014/15 we introduced events for members called 'Medicine for Members' as a way for the members to learn about key public health issues, such as alcohol & drug awareness, mental health and depression, obesity and keeping your heart healthy.

Some of members also attend the other major events during the year such as the community open day and the Annual General Meeting.

Membership by constituency

Staff	8,176
Public	
Wandsworth	4,099
Merton	3,051
Rest of England	4,632
Lambeth	616
Out of trust area	13
Total	12,411
As graphic	20,587

MEMBERSHIP RETURN				
This is the 2014/15 annual membership report and forms part of our membership plan for 2015/16 **NOTE:** Socio-economic data is completed using profiling techniques (eg: post codes) or other recognised methods	ACTUAL MEMBERS 31-MAR-15	ELIGIBLE MEMBERSHIP 31-MAR-15	ACTUAL 2014-15	ESTIMATED 2015-16
MEMBERSHIP SIZE AND MOVEMENTS				
PUBLIC CONSTITUENCY				
At year start (April 1)			12,215	12,376
New members			374	374
Members leaving			213	213
At year end (31 March)			12,376	12,537
STAFF CONSTITUENCY				
At year start (April 1)			7,546	8,181
New members			1,786	1,786
Members leaving			1,151	1,151
At year end (31 March)			8,181	8,816
ANALYSIS OF MEMBERSHIP				
PUBLIC CONSTITUENCY				
Age (years):		14		
0-16		798		
17-21		11,153		
22+		11,965		
Unknown				
Total		12,376		
ETHNICITY				
White		6,959		
Mixed		583		
Asian or Asian British		2,256		
Black or Black British		1,774		
Other		246		
Unknown		147		
Total		12,376		
SOCIO-ECONOMIC GROUPINGS*:				
AB		3,786		
C1		3,856		
C2		1,860		
DE		2,820		
Unknown		54		
Total		12,376		
GENDER:				
Male		4,914		
Female		7,307		
Unknown		55		
Total		12,376		
STAFF CONSTITUENCY				
Members		8,181		

Membership strategy

The trust's membership strategy sets out the framework that the trust will use to continue to build, manage and engage with its membership.

The objectives of this strategy are to:

- outline the definition of membership and its roles and responsibilities
- define the membership community
- identify the size of membership required and outline the strategic approaches for recruitment to, and building of, the membership
- outline proposals for the effective management of the active membership
- outline proposals for engagement and communication activities to ensure that members' views can be taken into account in the trust's decision making process
- identify the resources necessary for building and managing the membership
- identify how the membership strategy can contribute to the trust's community engagement and partnership working
- outline the mechanisms that will be used to evaluate the effectiveness of the strategy.

Managing an active membership

The trust recognises that members have a valuable role to play in the future direction of the organisation and is committed to creating and maintaining effective engagement with its members. Members who are well informed and who feel that they are listened to are more likely to remain in long term membership and equally can be effective advocates for the trust.

Member engagement

The trust recognises that members' interests and capacity to engage with the trust will vary widely. It is the trust's strategy to ensure that members have the opportunity to participate and are enabled to do so in the way they feel is most appropriate to them.

Engagement objectives

To ensure members are fully engaged the trust will work to:

- increase the number of informed and active members
- develop electoral processes which encourage active members to participate in the election of governors
- train and support elected governors, so that they can fulfil their roles effectively and participate in policy development and decision making processes
- develop a partnership culture between members, governors and trust management to facilitate effective working relationships.

Communication and engagement activities

The communication dialogue with members will be achieved through:

- the trust's Gazette magazine for all staff, stakeholders and public members
- monthly e-bulletins for public members
- a programme of regular member events called Medicine for Members
- other events including the trust's Annual General Meeting/Annual Members Meeting and the Community Open Day
- dedicated member and governor page within the trust website
- use of social media including Twitter and Facebook
- governor constituency meetings with members.

Code of Governance

The board of directors (the board) of the trust attaches great importance to ensuring that the trust operates to high ethical and compliance standards. In addition it seeks to observe the principles of good corporate governance set out in the Monitor NHS Foundation trust Code of Governance.

The board is responsible for the management of the trust and for ensuring proper standards of corporate governance are maintained. The board accounts for the performance of the trust and consults on its future strategy with its members through the council of governors.

The council's role is to influence the strategic direction of the trust so that it takes account of the needs and views of the members, local community and key stakeholders, to hold the board to account on the performance of the trust, to help develop a representative, diverse and well-involved membership, and to help make a noticeable improvement to the patient experience. It also has to carry out other statutory and formal duties, including the appointment of the chairman and non-executive directors of the trust and the appointment of the external auditor.

Governance structure

A change to the trust's constitution was approved by the board of directors and the council of governors in February 2015 to reflect the name change of the trust. The council was in place prior to becoming a foundation trust in shadow form. The trust is open and transparent with the community through the public council of governor meetings, the various health events held during the year and the large amount of information available on our website.

The trust board sub-committees include:

Audit committee (more information can be found on page 68.)

Workforce committee

Nominations and remuneration committee

Quality and risk committee

Finance and performance committee

Commercial board

To see the full trust corporate governance structure – please see appendix one of the annual governance statement.

Directors

The directors who held office during 2014/15 can be seen along with their declared interests, skills, expertise and experience from page 54. The trust has a separate chairman and chief executive. The chairman is independent.

Chairman

The trust's chairman is Christopher Smallwood. He is a non-executive director and chair of the council of governors. He was appointed in August 2011. The chairman and non-executive directors meet, without executive directors present, every two months. The chairman conducts annual appraisals of non-executive directors and will, as part of that process, identify any personal development needs.

Deputy chair and senior independent director

The trust's deputy chairman and senior independent director is Mike Rappolt. His appointment was ratified by the council of governors in February 2015. The senior independent director leads the annual appraisal process for the chairman and will report the outcome of that appraisal to the council of governors.

Chief executive

The trust's chief executive is Miles Scott. He was appointed in September 2011.

The board

The board of directors is made up of:

- chairman
- five independent non-executive directors
- one university representative non-executive
- four executive directors
- five non-voting directors, who attend board meetings in advisory capacity.

No executive director currently holds a non-executive role in another foundation trust or comparable organisation.

The board meets regularly and has a formal schedule of matters specifically reserved for its decision. This includes high level matters relating to strategy, business plans and budgets, regulations and control, annual report and accounts, audit and monitoring how the strategy is implemented at operational level. The board delegates other matters to the executive directors and senior management.

Regular contact, including with the non-executive directors, is maintained between formal meetings. Board meetings follow a formal agenda, which includes a review of quality and patient care, strategy, clinical governance, operational performance and performance against quality indicators set by the Care Quality Commission Monitor and by management, such as infection control targets, patient access to the trust and emergency department waiting times.

The directors have timely access to all relevant management, financial and regulatory information. On being appointed to the board, directors are fully briefed on their responsibilities. Ongoing development and training requirements for individual directors are assessed annually through the appraisal process, with the chairman leading on collective board development, which is addressed at board workshops.

The board of directors has standing orders, which set out the procedure for meetings and for recording decisions. The board's standing orders allow any director to have their comments recorded in the minutes. The board of directors confirm the code of conduct on an annual basis, which includes the Nolan Principles of public life. The trust has arranged NHS Litigation Authority indemnity cover for directors.

Each board sub-committee evaluates its effectiveness on an annual basis and will raise any concerns about resources via that process. Each board sub-committee also reports to the board after each of its meetings so can raise concerns with the board through those reports.

The board agrees its financial, quality and operating objectives in public on an annual basis, following input from the council of governors. The board will then monitor progress against those objectives on a quarterly basis.

The trust has a stakeholder map including relevant third party bodies and other key stakeholders. Executive directors are appointed as 'owners' of each respective relationship, to ensure effective communication and engagement with each respective stakeholder.

Attendance at board and sub board committee meetings 2014/15

The following table sets out the number of directors meetings held during the year and the number of board committee meetings attended by each director:

DIRECTOR	TRUST BOARD	AUDIT COMMITTEE	QUALITY & RISK COMMITTEE	NOMINATIONS & REMUNERATIONS COMMITTEE	FINANCE & PERFORMANCE	WORKFORCE COMMITTEE
Miles Scott	13/13	1/5			11/12	
Christopher Smallwood	12/13			3/3	11/12	
Steve Bolam	13/13	4/5			11/12	
Jennie Hall (started June 14)	12/12	3/5	10/11		9/10	3/4
Simon Mackenzie (started Jan 15)	4/4		1/3		1/3	1/2
Eric Munro (started June 2014)	12/13	3/5	4/11		7/9	
Peter Jenkinson	13/13	5/5	10/11		10/12	3/6
Wendy Brewer	12/13				10/12	6/6
Rob Elek (started Feb 15)	2/2				1/2	
Martin Wilson (started Aug 14)	10/10	1/5	6/8		8/8	
Non-Executive Director						
Mike Rappolt	12/13	5/5	4/11	1/3	9/12	
Sarah Wilton	12/13	5/5	11/11	3/3	10/12	
Peter Kopelman	13/13		8/11	3/3		2/6
Stella Pantelides	13/13		3/11	2/3	2/12	6/6
Kate Leach	9/13			2/2		3/5
Judith Hulf	9/13	2/5	9/11	2/3		

Governors are encouraged to attend board development sessions and are given the opportunity to ask questions or comment at the meeting.

There have been several governor induction sessions where board members and governors can meet to discuss various issues. A programme of sessions has been drafted for 2015/16 to include joint board/council workshops in areas such as finance, workforce, equality and quality.

The commercial board

The commercial board is a sub-committee of the trust board and is responsible for overseeing both the development and implementation of a trust-wide commercial strategy. The remit of the commercial board includes strategic growth in NHS income as well as non NHS income. The commercial board also has a role in providing assurance that commercial activity is being developed appropriately. Membership comprises non-executive, corporate and divisional representatives.

Audit committee

The audit committee is a committee of the board of directors. The committee has four main roles:

1. to review and independently scrutinise the trust's systems of clinical governance, internal control and risk management. This ensures that by proper process and challenge, integrated governance principles are embedded and practiced across all St George's activities as well as supporting the achievement of the trust's objectives.
2. to review key internal and external financial, clinical, fraud and corruption and other policies, reports and assurances functions, in order to provide independent assurance on these functions to the board.
3. to review the integrity of financial statements prepared on the trust's behalf.
4. to undertake all other statutory duties of an NHS audit committee.

The membership of the committee is made up of three non-executive directors, one of whom has financial experience.

The nominations committee

The aims of the nominations committee are to:

- develop the remuneration framework and terms of service for senior managers who are not on the NHS Agenda for Change payscales
- oversee all appointments to the trust board
- ensure that plans are in place for orderly succession of appointments to executive director posts.

The committee's membership is made up of the chairman and all of the non-executive directors.

There have been five new executive director appointments to the board during 2014/15.

An external search company was used in three of the four appointments (not the chief nurse).

Appointment, re-election and the nominations committee

The directors are responsible for assessing the size, structure and skill requirements of the board, and for considering any changes necessary or new appointments. For executive director appointments, the board of directors' nomination and remuneration committee, which comprises of the chairman and the non-executive directors assisted by the director of human resources and also involving the chief executive, will produce a job description, decide if external recruitment consultants are required to assist in the process and if so instruct the selected agency, shortlist and interview candidates.

For non-executive appointments, the council of governors' nominations and remuneration committee, comprising of 10 members of the council of governors, the chairman, with the company secretary in attendance, will recommend a process to the council for approval.

The council of governors approved appointments and the length of term for non-executive directors on 10th February 2015

- Christopher Smallwood – 1st February 2016
- Mike Rappolt – 1st February 2016
- Sarah Wilton – 31st December 2017
- Stella Pantelides – 1st January 2017
- Judith Hulf – 1st January 2017
- Peter Kopelman – 30th September 2018
- Kate Leach – 1st February 2018.

The council of governors have a statutory power to appoint or remove non-executive directors.

Non-executive directors are appointed for a three-year term in office. A non-executive director can be re-appointed for a second three-year term in office on an uncontested basis, subject to the recommendation of the nominations and remuneration committee and the approval of the council of governors. In most cases, a non-executive director will not serve longer than nine years.

Mike Rappolt has served over nine years because the board recognised the importance of continuity as it prepared for foundation trust status. Mike is the chair of the audit committee. The trust obtained special dispensation from the Trust Development Authority to extend Mike's term of office past the normal limit. Once we became authorised as a foundation trust, the current non-executive directors were appointed until the end of their terms or 12 months, whichever is longer (in accordance with the constitution). The council of governors will consider the appointment of non-executive directors on an individual basis when their term of office comes near to an end.

Removal of the chairman or another non-executive director requires the approval of three quarters of the members of the council of governors. The chairman, other non-executive directors, and the chief executive (except in the case of the appointment of a new chief executive) are responsible for deciding the appointment of executive directors. The chairman and the other non-executive directors are responsible for the appointment and removal of the chief executive, whose appointment requires the approval of the council of governors.

Led by the chairman, the council will periodically assess their collective performance and communicate to members and the public how they have discharged their responsibilities. This has not been done but it will be part of the annual cycle of business for the council.

Council of governors

The council of governors' nominations and remuneration committee is made up of 10 governors, with chief executive and company secretary only attending to support and advise.

The council of governors has met once in the reporting period (2014/15). After each meeting of the council, the chairman will feed back any views of governors to the board at the next meeting of the board of directors.

Directors' responsibilities statement and going concern

The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the trust's performance, business model and strategy (Code of Governance C.1.1).

Each director has stated that as far as they are aware, there is no relevant audit information of which the trust's auditors are unaware and they have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

The trust has controls in place to mitigate the risk of bribery including register of gifts and hospitality and a standards of business conduct policy, which requires all budget holders to complete declarations of interest on an annual basis.

The directors are required under the National Health Service Act 2006 to prepare financial statements for each financial year. The Secretary of State, with the approval of the Treasury, directs that these financial statements give a true and fair view of the state of affairs of the trust and of the income and expenditure of the trust for that period. In preparing those financial statements, the directors are required to: apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury; make judgements and estimates which are reasonable and prudent; and state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the financial statements. The directors are required under the Monitor Code of Governance to consider whether or not it is appropriate to adopt the going concern basis in preparing the trust's financial statements (annual accounts). As part of its normal business practice, the trust prepares annual financial plans.

The Trust incurred a deficit of £6.8 million during the two month period ended 31 March 2015 and a combined deficit of £16.8 million for the whole of the 2014/15 financial year.

At year end the directors were seeking interim cash funding support from Monitor for 2015/16 of £52.2 million.

The board has reviewed the proposed 2015/16 plan in detail throughout its development from October 2014 to date. The plan is for a deficit of £46m having taken due account of the realistic underlying financial position going into 2015/16, the risks and cost pressures faced in 2015/16 and the level of cost reduction the organisation can be stretched to deliver. The trust has an existing working capital facility of £25m but this will not be sufficient to meet the cash requirements of the deficit revenue position and the capital plan which has been reduced to the minimum possible requirement. The trust therefore requires additional cash support of £52.2m to maintain normal operating and quality existing standards. The board has a reasonable expectation that this will be agreed with the Department of Health with the support of the regulator.

The trust was engaged in discussions with Monitor regarding the level and timing of interim cash support funding at year end however these discussions had not concluded at the time the financial statements were approved. Although these factors represent material uncertainties that may cast significant doubt about the trust's ability to continue as a going concern, the directors, having made appropriate enquiries, still have reasonable expectations that the trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the NHS Foundation Trust Annual Reporting Manual 2014/15, the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the trust will continue to be provided in the foreseeable future.

Therefore the trust has adopted the going concern basis for preparing the accounts and the accounts do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Trust auditors

The council of governors is required to appoint the external auditor of a foundation trust. At its meeting in February 2015 the governors appointed Grant Thornton as the external auditor until 2017.

Grant Thornton were initially appointed as our external auditors in November 2012 following a competitive tender process. Prior to this, our external audit service was provided by the Audit Commission. The audit committee reviews the work and findings of the external auditor and considers the implications and management's responses to their work. The Grant Thornton contract expires in 2017 so the council of governors were required to re-instate their contract after becoming a foundation trust. The council of governors agreed in February 2015 once authorised as a foundation trust to remain with Grant Thornton until 2017.

The trust and board of directors have also been through external evaluation in the form of the foundation trust authorisation by the Monitor assessment team.

The trust's internal audit service is provided by the London Audit Consortium, a specialist NHS audit consortium. The strategic internal audit plans are approved annually by the audit committee.

The audit committee reviews reports from internal audit, including:

- the internal audit risk based strategic and operational plans
- regular progress reports
- individual internal audit reports
- the internal audit annual report, and head of internal audit opinion.

The head of internal audit attends the audit committee. The range of areas audited during the year are included in the annual governance statement.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of St George's, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in St George's Healthcare NHS Trust for the period April 2014 to January 2015 inclusive and as a foundation trust – St George's University Hospitals NHS Foundation Trust from February 2015 to March 2015 and up to the date of approval of the annual report and accounts.

We have included information referring to the following disclosures in the strategic report:

- any important events since the end of the financial year affecting the NHS foundation trust
- an indication of likely future developments at the NHS foundation trust
- an indication of any significant activities in the field of research and development
- policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities
- policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period
- policies applied during the financial year for the training, career development and promotion of disabled employees
- actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees
- actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance
- actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust
- in relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the NHS foundation trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity.

We have included information relating to the arrangements in place to govern service quality, quality governance and quality in the annual governance statement which starts on page 86. The section includes:

- how the foundation trust has had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework and a summary of action plans to improve the governance of quality.
- material inconsistencies (if any) between:
  - the annual governance statement;
  - annual and quarterly board statements required by the Risk Assessment Framework, the corporate governance statement submitted with the annual plan, the quality report and annual report
  - reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the trust.

Statement of compliance with the NHS Foundation Trust Code of Governance

The board of directors considers that it was compliant with the provisions of the revised NHS Foundation Trust Code of Governance. The council of governors retains the power to hold the board of directors to account for its performance in achieving the trust's objectives.

St George's University Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Statement of the chief executive's responsibilities

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust.

The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed St George's University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the accounts direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of St George's University Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the accounts direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- prepare the financial statements an ongoing concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed

Miles Scott
Chief Executive
St George's University Hospitals NHS Foundation Trust

28/5/2015

Annual Governance Statement 2014/15 – as an NHS trust

April 2014 to January 2015

Scope of responsibility

The trust board is accountable for governance in St George's Healthcare NHS Trust. As accountable officer and chief executive of this board, I have responsibility for maintaining a sound system of governance including internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the trust is administered prudently and economically and that resources are applied effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

Accountability for risk management is set out in the trust's risk management policy. The executive team is collectively responsible for maintaining the systems of internal control and directors are accountable to me for ensuring effective governance arrangements in their individual areas of responsibilities. These areas of responsibility are detailed in the trust's *scheme of delegation*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of St George's Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in St George's Healthcare NHS Trust for the period April 2014 to January 2015 inclusive.

Note: This governance statement covers the period April 2014 to January 2014 inclusive, as the trust was authorised as a foundation trust on 1st February 2015. A separate governance statement has been provided for the period February to March 2015.

Capacity to handle risk

The trust has an integrated governance approach to ensure decision making is informed by a full range of corporate, financial, clinical and information governance, and ensures compliance with the five main principles of the corporate governance code: leadership, effectiveness, accountability, remuneration and relations with stakeholders. This governance framework spans from 'board to ward' and is outlined in appendix one.

There is an established and robust governance framework, supported and maintained by a framework of committees. The trust board (the 'board') has overall responsibility for the effectiveness of the governance framework and as such requires that each of its sub-committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness. The board itself has standing orders, reservation and delegation of powers and standing financial instructions in place which is reviewed annually.

As the accountable officer, I support the chairman in ensuring the effective performance of the board

and its sub-committees. I achieve this in a number of ways.

- monitoring of attendance
- maintaining an overview of the quality of the presented information, including agenda items and supporting evidence
- requesting the attendance of representatives from across the trust as and when required
- ensuring that there is an annual declaration of interests by the members
- ensuring that each of the board sub-committees reviews its own performance and reports this to the board.

Senior leadership in corporate governance is provided by the director of corporate affairs through the trust's compliance unit. Governance is embedded across the corporate directorates and clinical divisions, led by directors or divisional chairs, thus ensuring clear responsibility and accountability across the trust.

Each division has an established and active governance structure which reports into a divisional management board and divisional governance committee; these in turn report directly into the trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks.

The governance framework is designed to manage governance and performance in an integrated way.

Quality governance in St George's Healthcare NHS Trust

As an NHS trust, patients are at the heart of everything that we do and hence our mission is *"To provide excellent clinical care, education and research to improve the health of the populations we serve".*

To achieve this, our vision of being an excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research is underpinned by our values:

Central to achieving this mission is a robust quality governance framework which is maintained to drive a quality focused agenda and promote transparency and accountability. Quality governance is dependent on a combination of structures and processes at and below board level to lead on trust-wide quality performance.

These strive to:

- ensure that required standards are achieved
- investigate and take action on sub-standard performance
- plan and drive continuous improvement
- identify, share and ensure delivery of best-practice
- identify and manage risks to quality.

The trust uses the national definition of quality, which is divided into the following three domains:

- patient safety – quality care is care which is delivered so as to reduce or eliminate all avoidable harm and risk to the individual's safety
- patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from care as possible
- patient outcomes (clinical effectiveness) – quality care is care which is delivered according to best evidence as to what is clinically effective in improving an individual's health outcomes.

Roles and responsibilities for quality

Board members

Responsibilities for quality are shared across the director of corporate affairs, the chief nurse and the medical director:

- **the chief nurse is responsible for patient safety and patient experience**
- **the medical director is responsible for patient outcomes**
- **the director of corporate affairs is responsible for ensuring that there is a robust governance system in place to support the delivery of quality across these three domains.**

Domains of quality	**PATIENT SAFETY** (chief nurse)	**PATIENT EXPERIENCE** (chief nurse)	**PATIENT OUTCOMES** (medical director)
Supported by	**Quality governance** (director of corporate affairs)		

Chief nurse

The chief nurse has board level responsibility for professional nursing and midwifery issues and provides strong leadership to the nursing profession. She also has the role of director of infection prevention and control for the trust, and is the trust board lead for adult and children's safeguarding.

The principal responsibilities of the chief nurse include the following:

- **accountability for the delivery of safe high quality patient care as the overriding priority of the trust, including the specific responsibility to ensure that patients, staff and other persons are protected against risks of acquiring healthcare-associated infections, through the provision of appropriate care, in suitable facilities, consistent with good clinical practice**
- **developing and implementing systems to ensure, and continually improve, quality of nursing and midwifery care**
- **developing and implementing systems and processes to ensure cost efficacy and value for money in relation to the nursing/midwifery service**
- **ensuring there are appropriate systems (including information systems) in place to monitor quality and safety and identify areas for improvement**
- **as lead for improving patient experience, lead the trust with respect to complaints, taking overall responsibility for the management of complaints and performance in relation to complaints and PALS.**

Medical director

The medical director, supported by associate medical directors has a pivotal role, in partnership with clinical directors and Care Group Leads, in extending the influence and understanding of medical staff in the development of the trust. His/her role and responsibilities include:

- **responsibility for the formulation of safe and efficient medical staffing policy and practice supported by the associate medical director for human resources**
- **overseeing the formulation and implementation of medical research and education policies, practise and strategies supported by associate medical directors for education and training and research**
- **being the trust's Caldicott Guardian and is therefore responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing**
- **responsible officer for the trust.**

Director of corporate affairs

The director of corporate affairs is responsible for the establishment and continuous development of governance arrangements and processes, many of which are related to the achievement or monitoring of quality related performance. Through the implementation and management of a quality focused governance framework, the trust ensures that the delivery of safe high quality patient care remains the overriding priority.

Board sub-committees

The trust's governance framework sets out the trust's system of integrated governance and the mechanism by which it leads, directs and controls its functions in order to achieve its organisational objectives. The governance framework forms part of the overarching governance manual – a set of documents which set out the trust's committee and divisional management structures and the roles and responsibilities. The trust committee structure is included along with a detailed chart of feeder committees to the quality and risk committee, the formal board sub-committee with overall responsibility of quality governance.

The primary function of the trust board is to promote a quality-focused culture across the trust. This is achieved through the implementation of

an effective reporting process that engages the board in understanding and improving the quality of care offered by the trust, and ensures that quality remains at the forefront of the board's agenda.

Quality and risk committee

The quality and risk committee (QRC), a sub-committee of the trust board, has been established *'to steer and monitor the strategic and operational implementation of an integrated approach to quality and risk, assurance and compliance, and to ensure that high quality, safe and effective treatments and services are being provided to patients, and that risk to patients, visitors and staff is minimised'*.

The committee will also oversee and monitor the implementation of systems to underpin quality (including clinical governance and patient safety). It shall:

- **receive assurance that the standards of patient care are continuously improved and that standards set by external agencies, including the Care Quality Commission, are met**
- **review, monitor and develop the trust's systems and processes for complaints and incidents management to ensure performance targets are achieved and organisational learning takes place**
- **ensure lessons are learnt and services improved in response to never events and serious incidents.**

The main source of assurance for the QRC comes from key components of the trust's quality governance framework – the three governance committees: patient safety committee, patient experience committee and organisational risk committee. They can be considered as the fulcrum of the flow of information between the divisions and the board.

Patient experience committee and patient safety committee

The patient safety and patient experience committees are executive committees established to reduce avoidable harm and to improve the patient experience. Both of these committees are chaired by the chief nurse with membership that reflects the purpose of each committee as described in their respective terms of reference.

The divisions are represented by the divisional directors of nursing and governance, or an appropriate senior clinician to ensure that the flow of governance is strong between the divisions and corporate structure of board and sub-committees.

Organisational risk committee

An integral part of ORC's business is the strategic governance of the divisional and corporate directorate risk registers. Risk registers are essential in good quality governance as they will house the divisional and corporate directorate challenges to delivering the strategic aims of the organisation. They describe how each such challenge is being managed and the plans to further mitigate the risks.

Board initiatives

In order to promote a quality-focused culture across the trust and to ensure that the board has the leadership, skills and knowledge to effect delivery of the quality agenda, several board level initiatives have been undertaken, including:-

- **introduction of patients' stories, including incidents and complaints, at board meetings**
- **divisional presentations presented at board meetings, focusing on quality aspects of different services and specialities**
- **introduction of quality inspections.**

The board revises the trust's strategic aims and objectives on an annual basis. This enables the board to review the trust's strategic aims and affiliated actions, ensuring that they are still relevant and focused on the delivery of safe, high quality services.

The divisional management structure

The trust is structured into four clinical divisions, supported by corporate directorates. The divisions are responsible for operating a system of governance that ensures:

- **evidence-based clinical practice is in place and audited**
- **accountability for service and financial performance**
- **good practice is systematically disseminated**
- **effective management of risk**
- **when adverse incidents and complaints occur they are investigated within the agreed timescales and lessons learnt disseminated and embedded**
- **poor clinical practice is identified and dealt with to prevent harm to patients**
- **leadership skills are developed within the clinical team and the organisation**
- **professional development programmes reflect the principles of clinical governance and support the delivery of the trust's objectives**

- high quality data are collected to monitor clinical care and performance
- compliance with the Care Quality Commission standards for quality and safety, and other external standards and regulatory requirements.

Each division is led by a divisional chair. The divisional chair, working together with the divisional management team, is responsible for the delivery of quality patient care; and ensuring that there is effective cross-divisional working to improve patient care pathways and working between specialties. The divisional chair is also accountable for clinical quality, performance, governance, finance, and service developments within his/her division.

The divisional chair is supported by a divisional director of operations (a full-time manager) and a divisional director of nursing and governance. Other members of the supporting management team include clinical directors, who are responsible for the delivery of clinical services for specific care groups, general managers, heads of nursing, a management accountant and a human resources manager.

Professional leadership is provided to medical staff within the divisions by the medical director and associate medical directors, through the divisional chairs, where these are doctors. Professional leadership is provided to nurses and midwives by the chief nurse, through the divisional directors of nursing and governance, the director of midwifery or chief therapist.

Divisional management/governance boards

Each division has a divisional management board (DMB) established to review and monitor the implementation of the division's strategies and business plans.

Each division also has a divisional governance board (DGB) established to support the DMB in ensuring an integrated approach to quality, risk and patient safety. The DGB is chaired by the divisional chair and is responsible for:

- setting and monitoring implementation of the division's quality improvement strategy
- monitoring of all aspects of clinical governance and clinical/non clinical risk within the division and ensuring that lessons are learnt from adverse incidents or complaints and corrective action plans are put in place
- providing leadership, focus and consensus on key aspects of quality, risk and patient safety, based upon expertise within the division
- providing assurance to the board that high quality, safe, effective treatments and services are provided to patients and that risk to staff and visitors is minimised
- reviewing external sources of assurance and ensuring that compliance with regulations maintained
- ensuring evidence provided for continued compliance with CQC standards.

As well as regular reporting to and contribution from each division to patient safety committee (PSC), patient experience committee (PEC) and organisational risk committee (ORC), the divisions present six-monthly reports regarding quality related performance to the PSC and PEC and two monthly reports regarding risk as part of the risk register reviews to the ORC. These reports are presented by the divisional directors of nursing and governance and provide for the escalation of significant risks and issues up the committee structure, to the trust board, as appropriate.

Each division also reports to the quality and risk committee at least once per year on the delivery of their respective quality improvement strategy.

In accordance with the trust's performance management framework, divisions are held to account by the executive directors on a quarterly basis across a range of performance domains, one of which is quality.

Quality reporting and monitoring

A central function of the trust board is to promote a quality-focused culture across the trust. This is achieved through the implementation of an effective reporting process that engages the board in understanding and improving the quality of care offered by the trust, and ensures that quality remains at the forefront of the board's agenda.

The quality account

The directors are required under the Health Act 2009 and the National Health Service (quality accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Introduced in 2010, the trust produces an annual quality account. This is a quality focused report, approved by the trust board and published on trust website. The accounts look at the three domains of quality: patient safety, clinical effectiveness and patient experience. The primary aim is to support the NHS in improving the quality of healthcare services by improving the organisation's accountability to the public.

The quality performance report

The purpose of the report is to update the board on key developments in quality. Like the quality account, the report looks at the three domains of quality and focuses on the trust's performance in these areas by looking at several indicators and performance measures i.e.-

- **patient safety: including infection control, serious incident reporting, pressure ulcers, workforce and recruitment**
- **patient experience: including same sex accommodation, access to interpreter services, patient surveys, PALS and complaints**
- **clinical effectiveness: including NICE compliance, clinical outcomes including national audits, local audits and mortality monitoring.**

The quality performance report is now combined with **the trust performance report**:

The trust performance report is presented to the finance and performance committee on a monthly basis and to board every two months. This report contains a summary of operational performance across all domains of performance, including quality metrics such as infection rates. Any quality issues identified by the finance and performance committee are referred to the quality and risk committee for further consideration. The quality metrics within the trust performance scorecard are also reviewed monthly by the quality and risk committee.

The quality improvement strategy

The trust's quality improvement strategy was originally approved by the board in November 2010 and is reviewed and updated annually by the quality and risk committee. The strategy outlines the trust's vision for quality improvement over the next five years, detailing key priority areas and planned action to promote continuous improvement in the safety and quality of services provided by the trust.

Serious incidents

All serious incidents are reported to the board as part of a weekly synopsis report. At each of its meetings, the board will review selected incidents in more detail. In addition, the QRC will also review selected serious incidents and never events in detail, as well as receiving assurance that lessons from all serious incidents are being learnt within divisions, via the patient safety committee. The serious incident reporting to board also includes any safeguarding serious case reviews.

External assessment of the trust's quality governance framework

As part of the application for foundation trust status, the trust completed a self-assessment of the robustness of this quality governance framework against Monitor's Quality Governance Framework.

The trust has completed an action plan to address any recommendations made by Monitor, including the development of a revised risk management strategy and policy to ensure that risks are identified and managed.

Care Quality Commission compliance

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

The Care Quality Commission undertook a Chief Inspector of Hospitals inspection in February 2014 which resulted in an overall rating of 'good'. The trust received two compliance actions:

- **There was a poor general understanding and implementation of the principles of the Mental Capacity Act 2005. (Queen Mary's Hospital)**
- **Medical records must be made available to staff working in the outpatients clinics. (St George's Hospital)**

Action plans have been implemented in response to these compliance actions and monitored internally through the quality and risk committee and externally through the clinical quality review meetings with commissioners.

Risk management

The trust is committed to providing high quality care, in an environment which is safe for patients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness. Robust risk management and internal control are an essential part of good governance and is integral to the delivery of this commitment. The governance committee structure shown in appendix one provides an effective and robust system of risk management across the trust.

The key aim of the trust's risk management approach is to ensure that all risks to the trust's achievement of strategic objectives (whether clinical, non-clinical, information, research or financial) are identified, analysed, evaluated, treated, monitored and managed appropriately.

The system of risk management is described in the trust's risk management policy which is

accessible to all staff via the trust intranet. It is based on an iterative process of:

- **identifying and prioritising the risks to the achievement of the organisation's policies, aims and objectives**
- **evaluating the likelihood of those risks being realised and the impact should they be realised**
- **managing the risks efficiently, effectively and economically.**

This is achieved through a sound organisational framework, underpinned by a robust policy framework, which promotes early identification of risk, the co-ordination of risk management activity, the provision of a safe environment for staff and patients, and the effective use of financial resources. It ensures that staff are aware of their roles and responsibilities and outlines the structures and processes through which risk is assessed, controlled and managed.

Risks are identified through feedback from many sources such as proactive risk assessments, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, stakeholder/partnership feedback and internal/external assurance assessments.

Key stakeholders are involved in the management of risks via patient and public involvement groups and activities, patient and staff surveys, board meetings, Healthwatch and the local adult care and Health Overview and Scrutiny Committees.

Risks are evaluated using a recognised risk assessment tool which assesses the impact and likelihood of the risk occurring using a 5 x 5 matrix scoring system. This risk score feeds into the decision-making process about whether a risk is considered acceptable. Higher level unaccepted risks require control measures/contingency plans to reduce them to an acceptable level. Each risk has an identified owner who is responsible for reassessing and monitoring the effectiveness of the controls in place to manage and mitigate the risk; this is recorded and reported back regularly to the appropriate committees.

Risk management is embedded within the organisation through the corporate, divisional, directorate and care group structures and the reporting and feedback mechanisms are in place (as shown in appendix two).

The compliance unit, which includes the corporate risk and assurance department, supports staff in disseminating good practice across the organisation. Involvement in risk management activities is also included within the trust's objective setting and individual performance review of staff and the organisation's business planning process. The corporate risk and assurance department works closely with the head of patient safety to ensure a joined up approach to improving patient safety.

The trust's board assurance framework, which is aligned to the trust's strategic corporate objectives, is a high level document based on structured and on-going assessment of the principal risks to the trust achieving its corporate objectives. It describes the controls and assurance mechanisms in place to manage the identified risks.

The executive management team and the quality and risk committee (QRC) regularly review the board assurance framework, with the most significant risks being reported at the trust board (a meeting in public). Divisional and directorate risk registers are reviewed regularly by the organisational risk committee with high level risks being reported to the QRC.

In addition, the trust uses its assurance map to record the outcome of any external accreditation visit or statutory inspection, and assurance that actions are being taken to address any issues identified is provided to the board.

Risk management training is a mandatory requirement for trust staff at induction. Further education is available for trust staff, relevant to their authority and duties; this includes modules within the clinical leadership programme and senior staff induction programme. Expert guidance and facilitation from the corporate risk and assurance department supports this function.

External assurance as to the robustness of this system has been provided through the trust's preparation for foundation trust status, including the completion of the Quality Governance Assurance Framework and assessment by Monitor. As a result of this assessment, further improvements have been made to the risk management framework to strengthen 'ward to board' risk management. A revised risk management strategy was approved by the board in November 2014 which will lead to continued improvement.

Principal risks identified in 2014/15

The following risks were identified by the board as being the principal risks during 2014/15, and the associated controls overseen by the executive management team and the quality and risk committee. The most significant risks on the board assurance framework are reviewed by the board at

each meeting, following recommendation from the executive management team and the quality and risk committee. These risks will therefore change during the year, however risks that have remained consistently in the list of most significant risks during the year are:

REF	DESCRIPTION	RATING (at January 2015)
3.2-05	The trust does not deliver its cost reduction programme objectives	25
01-12	Bed capacity may not be sufficient for the trust to meet demands from activity, negatively affecting quality, throughout the year.	20
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting quality, throughout the year.	20
01-14	Staffing to support capacity may not be sufficient for the trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.	20
01-15	Critical care capacity may not be sufficient for the trust to meet demands from activity, negatively affecting quality, throughout the year.	20
01-07	Risk to patient safety and experience as a result of potential trust failure to meet 95% emergency access standard	20
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	20
3.6-05	Cashflow risks – operational finance: forecast cash balances will be depleted	20
2.1-05	The tariffs applicable to trust clinical services are adversely changed as a result of national and local tariff changes	20

Information governance

The board is aware of the importance of maintaining high standards of information governance, including protecting the confidentiality of patients' information. The trust has appointed the director of finance, performance and informatics as the senior information risk officer and the medical director as Caldicott Guardian. The trust also has an information governance manager and a range of policies, procedures and training to ensure that staff are aware of information governance requirements.

The information governance committee oversees the completion of the information governance toolkit on an annual basis, as well as reviewing any information governance incidents. The toolkit rating for the reporting period was satisfactory.

The trust has had one information commissioner reportable data security breach in this reporting period. The information commissioner was informed on 11th March 2015; this incident is still under investigation.

Data quality

The trust has an information team, reporting to the director of finance, performance and informatics, who oversee the quality of data. The trust has a data quality strategy, to ensure continual improvement in the quality and integrity of data, which is monitored by the data quality group and the finance and performance committee on a quarterly basis.

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

Performance is monitored monthly by the finance and performance committee and the board, via the monthly quality and performance report, the finance report and the workforce report. Performance is reported through a number of key performance indicators (KPIs) as per Trust Development Authority and Monitor regulatory frameworks. At the end of this reporting period (January 2015) the trust was performing positively against these frameworks, with a quality score of 4 against TDA accountability framework which signifies that no intervention is required and shows a quality governance score against Monitor's risk assessment framework of two which is 'amber-green'.

During 2014/15 the trust demonstrated strong performance against the key performance indicators. Key achievements this year include:

- **Achievement of 'de minimis' thresholds for MRSA and C.difficile infections**
- **Mortality and Summary Hospital Morality Indicator performance remains strong for the trust. The latest SHMI data indicates that the trust is one of 15 trusts where the indicator is 'lower than expected' and we remain one of 11 trusts were mortality rates are lower than expected for two consecutive years.**

Areas of underperformance were:

- **A&E four hour standard: The trust did not achieve the A&E four hour waiting time standard. The**

trust has implemented action plans to address A&E performance, supported by commissioners and ECIST (Emergency Care Intensive Support Team), which is monitored monthly by the finance and performance committee and the board

- Referral to treatment (RTT) waiting times: RTT indicators have been excluded from the overall rating as breach of target was authorised as part of the national RTT resilience programme which was extended to quarter 4 of 2014/15. The board however have reviewed action plans to address specific areas of non-compliance.

The trusts' Continuation of Services (CoSR)

The position remained at three until Q4 where it was changed to under review. The board was concerned regarding financial performance. At the end of this reporting period, the trust was showing a year to date deficit of £6.5m which was £11.5m adverse to the year to date target of £5m surplus. This is an adverse movement in month of £7.2m. The month 10 results showed a worsening of the position as a result of under delivery of income targets and excess costs of extreme operational pressures during January. The trust had also had final confirmation of losses around project diamond (additional payments to recognise specialist cancer treatment) and from the education contract.

Compliance with NHS pensions scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. Accounting policies for pensions and other retirement benefits are set out in note 1.3 on page 228 to the accounts and that details of senior employees' remuneration can be found on page 192 of the remuneration report.

Equality and diversity

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. Accounting policies for pensions and other retirement benefits are set out in note 1.3 on page 228 to the accounts and that details of senior employees' remuneration can be found on page 220 of the remuneration report.

Climate Change Act and adaptation reporting requirements

The trust has undertaken risk assessments and carbon reduction delivery plans are in place, in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality account attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I am confident as to the effectiveness of the system described above and that conclusion is informed in a number of ways:

The head of internal audit has provided me with reasonable assurance that the internal controls are operating effectively within the fundamental financial systems, as a whole. That opinion is that overall reasonable assurance could be provided both that controls are generally sound and operating effectively and that the internal controls are operating effectively within the fundamental financial systems.

The internal audit plan for the year included reports across the main operational areas of the trust as follows:

- safety/patient focus reviews: safeguarding of children; nursing, midwifery and care establishments; and capacity planning

- **governance reviews: board assurance framework and risk reporting; Care Quality Commission registration; whistleblowing; information governance and security; service improvement programme**
- **financial systems reviews: fundamental financial systems audits; central stores, London Community Resource Network research funding**
- **clinical and cost effectiveness: data quality reviews in respect of referral to treatment time reporting, cancer waiting time reporting, overall data quality governance and the performance information database; medical locums; SWL Pathology IT portal project; E-rostering project**
- **care, environment and amenities reviews: estates maintenance follow up reviews (2); fire safety follow-up reviews (3); cleaning; postage; and estates statutory compliance.**

A range of assurances from significant assurance to limited assurance have been given. The limited assurance reports can be seen in Appendix 3.

The head of internal audit has stated that in all cases, management has taken a positive approach and developed action plans to address the issues raised and considers that the Trust will build upon the improvements already achieved during the year.

In addition to the head of internal audit opinion, the audit committee chairman provides a written report following each committee meeting to the next meeting of the trust board, which includes significant conclusions arising from the committee's work, concerns and recommendations. A summary of the full range of internal audits undertaken in the year and the associated level of assurance are included in appendix three.

Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The board assurance framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation achieving its principal objectives have been regularly reviewed.

The trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively. The board has completed a review of its effectiveness and that of its sub-committees through completion of the governance assurance framework assessment and the annual effectiveness reviews.

My review is also informed by a variety of other sources of information. These include:

- **the views and comments of stakeholders**
- **patient and staff surveys**
- **internal and external audit reports**
- **clinical benchmarking and audit reports**
- **mortality monitoring**
- **reports from external assessments, including the CQC Chief Inspector of Hospitals inspection in February 2014**
- **Deanery and Royal College assessments**
- **accreditation inspections of clinical services**
- **patient environmental action team self-assessments and PLACE assessments.**

The trust has produced a quality account for 2014/15 and the governance system described above has been used to validate its content and the data on which it is based.

Through review of these assurances, the board has considered any issues that fall within the definition of 'significant issue' according to the requirements of this Governance Statement.

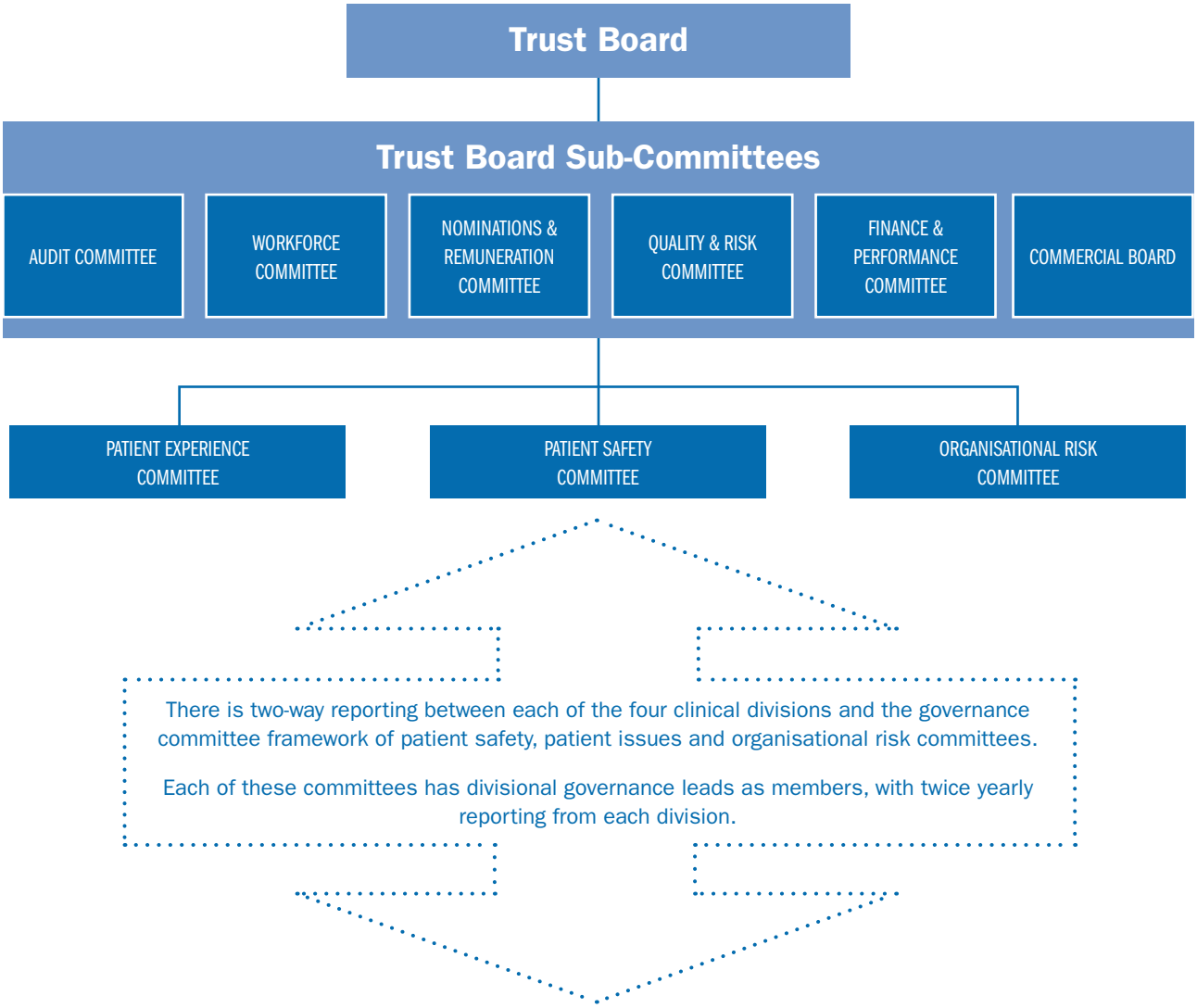
The board has been particularly concerned with the limited assurance provided by internal audit in respect of the trust's compliance with fire safety, and the limited progress to date in implementing the agreed action plan when reviewed by internal audit. I am overseeing the implementation of that comprehensive action plan to address the audit recommendations and other aspects of non-compliance. Progress had been made in addressing the gaps in compliance, but some areas of non-compliance remain.

The existing risk on the board assurance framework relating to compliance with fire safety regulations, and the potential impact that this non-compliance might have on patients, has been reviewed in the light of this limited assurance and will be one of the trust's most significant risks until the action plan has been successfully completed. Therefore, the board will have greater visibility of the risk and will monitor the implementation of controls to manage the risk. Progress in implementing this action plan has been monitored and will also continue to be monitored by the audit committee.

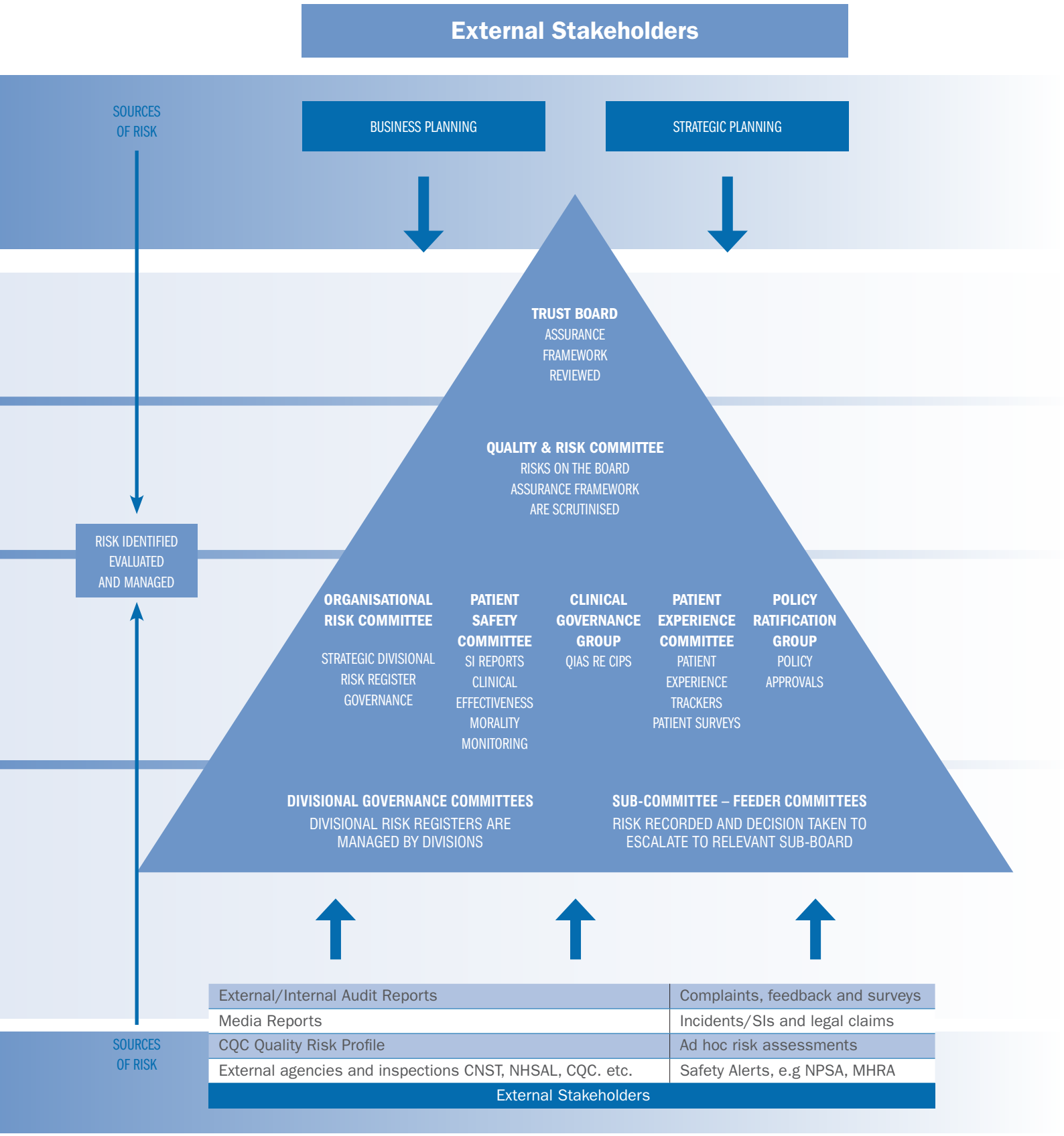
Miles Scott
Chief Executive
St George's Healthcare NHS Trust
28/5/2015

Annual governance statement appendix 1

Governance framework



Annual governance statement appendix 2



Appendix 3 – internal audit reports issued in 2014/15

Summary of 2014/15 internal audit projects

Topic	Assurance Level
Patient safety and service quality	
Safeguarding of children	Reasonable
Nurse, midwifery and care establishments	Reasonable
Capacity planning	n/a
Clinical & cost effectiveness	
Medical locums	Reasonable
E-rostering project review	n/a
Governance	
Assurance framework and risk register	Reasonable
St Georges, University of London partnership arrangements (draft report)	Reasonable
CQC registration	Reasonable
Whistleblowing	Limited
Trust transformation programme	n/a
Fundamental financial systems	
Financial ledger	Significant
Financial reporting and budgetary control	Reasonable
Accounts payable	Significant
Cash and investments	Reasonable
Capital asset register/capital charges	Significant
Income and debtors	Significant
Arrangements with commissioners	Reasonable
Joint research funding – LCRN office	Limited
Central stores	Limited
Human resources and payroll	
Payroll	Significant
Estates and facilities	
Estates maintenance follow-up (two reviews)	Limited
Fire safety follow-up (three reviews)	2 Limited, 1 n/a
Cleaning	Reasonable
Postage	Reasonable
Estates statutory compliance	Reasonable
IT/Information	
Information governance and security/data accreditation	Reasonable
IT portal project – two reviews	Reasonable
Data quality – RTT reporting	Reasonable
Data quality – overall governance arrangements	Limited
Data quality – performance database	Limited
Cancer data quality follow-up	Reasonable

Annual Governance Statement 2014/15 – as a foundation trust

February 2015 – April 2015

Scope of responsibility

The trust board is accountable for governance in St George's University Hospitals NHS Foundation Trust. As accountable officer and chief executive of this trust, I have responsibility for maintaining a sound system of governance including internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

Accountability for risk management is set out in the trust's risk management policy. The executive team is collectively responsible for maintaining the systems of internal control and directors are accountable to me for ensuring effective governance arrangements in their individual areas of responsibilities. These areas of responsibility are detailed in the trust's *Scheme of Delegation*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of St George's University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in St George's University Hospitals NHS Foundation Trust for the period February 2015 to March 2015 and up to the date of approval of the annual report and accounts.

Note: This governance statement covers the period February 2015 to March 2015, as the trust was authorised as a foundation trust on 1st February 2015. This statement covers the two month period, noting some changes to the governance structure (the removal of the foundation trust programme board as a sub-committee of the board), the addition of one non-executive director (previously an associate non-executive but appointed as a full non-executive director by the council of governors) and the change in name for the trust. A separate governance statement has been provided for the period April 2014 to January 2015.

Capacity to handle risk

The trust has an integrated governance approach to ensure decision-making is informed by a full range of corporate, financial, clinical and information governance, and ensures compliance with the five main principles of the corporate governance code: leadership, effectiveness, accountability, remuneration and relations with stakeholders. This governance framework spans from 'board to ward' and is outlined in appendix one.

There is an established and robust governance framework, supported and maintained by a framework of committees. The trust board (the 'board') has overall responsibility for the effectiveness of the governance framework and as such requires that each of its sub-committees

has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness. The board itself has standing orders, reservation and delegation of powers and standing financial instructions in place which are reviewed annually.

As the accountable officer, I support the chairman in ensuring the effective performance of the board and its sub-committees. I achieve this in a number of ways.

- **monitoring of attendance**
- **maintaining an overview of the quality of the presented information, including agenda items and supporting evidence**
- **requesting the attendance of representatives from across the trust as and when required**
- **ensuring that there is an annual declaration of interests by the members**
- **ensuring that each of the board sub-committees reviews its own performance and reports this to the board.**

Senior leadership in corporate governance is provided by the director of corporate affairs through the trust's compliance unit. Governance is embedded across the corporate directorates and clinical divisions, led by directors or divisional chairs, thus ensuring clear responsibility and accountability across the trust.

Each division has an established and active governance structure which reports into a divisional management board and divisional governance committee; these in turn report directly into the trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks.

The governance framework is designed to manage governance and performance in an integrated way.

Quality governance

As an NHS trust, patients are at the heart of everything that we do and hence our mission is *"To provide excellent clinical care, education and research to improve the health of the populations we serve".*

To achieve this, our vision of being an excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research is underpinned by the values of:

excellent
kind
responsible
respectful

Central to achieving this mission is a robust quality governance framework which is maintained to drive a quality focused agenda and promote transparency and accountability. Quality governance is dependent on a combination of structures and processes at and below board level to lead on trust-wide quality performance.

These strive to:

- **ensure that required standards are achieved**
- **investigate and take action on sub-standard performance**
- **plan and drive continuous improvement**
- **identify, share and ensure delivery of best practice**
- **identify and manage risks to quality.**

The trust uses the national definition of quality, which is divided into the following three domains:

- **patient safety – quality care is care which is delivered so as to reduce or eliminate all avoidable harm and risk to the individual's safety**
- **patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from care as possible**
- **patient outcomes (clinical effectiveness) – quality care is care which is delivered according to best evidence as to what is clinically effective in improving an individual's health outcomes.**

Roles and responsibilities for quality

Board members

Responsibilities for quality are shared across the director of corporate affairs, the chief nurse and the medical director:

- **the chief nurse is responsible for patient safety and patient experience;**
- **the medical director is responsible for patient outcomes;**
- **the director of corporate affairs is responsible for ensuring that there is a robust governance system in place to support the delivery of quality across these three domains.**

Domains of quality	**PATIENT SAFETY** (chief nurse)	**PATIENT EXPERIENCE** (chief nurse)	**PATIENT OUTCOMES** (medical director)
Supported by	**quality governance** (director of corporate affairs)		

Chief nurse

The chief nurse has board level responsibility for professional nursing and midwifery issues and provides strong leadership to the nursing profession. She also has the role of director of infection prevention and control for the trust, and is the trust board lead for adult and children's safeguarding.

The principal responsibilities of the chief nurse include the following:

- **accountability for the delivery of safe high quality patient care as the overriding priority of the trust, including the specific responsibility to ensure that patients, staff and other persons are protected against risks of acquiring healthcare-associated infections, through the provision of appropriate care, in suitable facilities, consistent with good clinical practice**
- **developing and implementing systems to ensure, and continually improve, quality of nursing and midwifery care**
- **developing and implementing systems and processes to ensure cost efficacy and value for money in relation to the nursing/midwifery service**
- **ensuring there are appropriate systems (including information systems) in place to monitor quality and safety and identify areas for improvement**
- **as lead for improving patient experience, lead the trust with respect to complaints, taking overall responsibility for the management of complaints and performance in relation to complaints and PALS.**

Medical director

The medical director, supported by associate medical directors has a pivotal role, in partnership with clinical directors and care group leads, in extending the influence and understanding of medical staff in the development of the trust. His/her role and responsibilities include:

- **responsibility for the formulation of safe and efficient medical staffing policy and practice supported by the associate medical director for human resources**
- **overseeing the formulation and implementation of medical research and education policies, practise and strategies supported by associate medical directors for education and training and research**
- **being the trust's Caldicott Guardian and is therefore responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing**
- **responsible officer for the trust.**

Director of corporate affairs

The director of corporate affairs is responsible for the establishment and continuous development of governance arrangements and processes, many of which are related to the achievement or monitoring of quality related performance. Through the implementation and management of a quality focused governance framework, the trust ensures that the delivery of safe high quality patient care remains the overriding priority.

Board sub-committees

The trust's governance framework sets out the trust's system of integrated governance and the mechanism by which it leads, directs and controls its functions in order to achieve its organisational objectives. The governance framework forms part of the overarching governance manual – a set of documents which set out the trust's committee and divisional management structures and the roles and responsibilities. The trust committee structure is included along with a detailed chart of feeder committees to the quality and risk

committee, the formal board sub-committee with overall responsibility of quality governance.

The primary function of the trust board is to promote a quality-focused culture across the trust. This is achieved through the implementation of an effective reporting process that engages the board in understanding and improving the quality of care offered by the trust, and ensures that quality remains at the forefront of the board's agenda.

Quality and risk committee

The quality and risk committee (QRC), a sub – committee of the trust board, has been established *'to steer and monitor the strategic and operational implementation of an integrated approach to quality and risk, assurance and compliance, and to ensure that high quality, safe and effective treatments and services are being provided to patients, and that risk to patients, visitors and staff is minimised'.*

In respect of its role in quality:

The committee will also oversee and monitor the implementation of systems to underpin quality (including clinical governance and patient safety). It shall:

- **receive assurance that the standards of patient care are continuously improved and that standards set by external agencies, including the Care Quality Commission, are met**
- **review, monitor and develop the trust's systems and processes for complaints and incidents management to ensure performance targets are achieved and organisational learning takes place**
- **ensure lessons are learnt and services improved in response to never events and serious incidents.**

The main source of assurance for the QRC comes from key components of the trust's quality governance framework – the three governance committees: patient safety committee, patient experience committee and organisational risk committee. They can be considered as the fulcrum of the flow of information between the divisions and the board.

Patient experience committee and patient safety committee

The patient safety and patient experience committees are executive committees established to reduce avoidable harm and to improve the patient experience. Both of these committees are chaired by the chief nurse with membership that reflects the purpose of each committee as described in their respective terms of reference.

The divisions are represented by the divisional directors of nursing and governance, or an appropriate senior clinician to ensure that the flow of governance is strong between the divisions and corporate structure of board and sub-committees.

Organisational risk committee

An integral part of ORC's business is the strategic governance of the divisional and corporate directorate risk registers. Risk registers are essential in good quality governance as they will house the divisional and corporate directorate challenges to delivering the strategic aims of the organisation. They describe how each such challenge is being managed and the plans to further mitigate the risks.

Board initiatives

In order to promote a quality-focused culture across the trust and to ensure that the board has the leadership, skills and knowledge to effect delivery of the quality agenda, several board level initiatives have been undertaken, including:

- **introduction of patients' stories, including incidents and complaints, at board meetings**
- **divisional presentations presented at public board meetings, focusing on quality aspects of different services and specialities**
- **introduction of quality inspections.**

The board revises the trust's strategic aims and objectives on an annual basis. This enables the board to review the trust's strategic aims and affiliated actions, ensuring that they are still relevant and focused on the delivery of safe, high quality services.

The divisional management structure

The trust is structured into four clinical divisions, supported by corporate directorates. The divisions are responsible for operating a system of governance that ensures:

- **evidence-based clinical practice is in place and audited**
- **accountability for service and financial performance**
- **good practice is systematically disseminated**
- **effective management of risk**
- **when adverse incidents and complaints occur they are investigated within the agreed timescales and lessons learnt disseminated and embedded**
- **poor clinical practice is identified and dealt with to prevent harm to patients**
- **leadership skills are developed within the clinical team and the organisation**

- **professional development programmes reflect the principles of clinical governance and support the delivery of the trust's objectives**
- **high quality data are collected to monitor clinical care and performance**
- **compliance with the Care Quality Commission standards for quality and safety, and other external standards and regulatory requirements.**

Each division is led by a divisional chair. The divisional chair, working together with the divisional management team, is responsible for the delivery of quality patient care; and ensuring that there is effective cross-divisional working to improve patient care pathways and working between specialties. The divisional chair is also accountable for clinical quality, performance, governance, finance, and service developments within his/her division.

The divisional chair is supported by a divisional director of operations (a full-time manager) and a divisional director of nursing and governance. Other members of the supporting management team include clinical directors, who are responsible for the delivery of clinical services for specific care groups, general managers, heads of nursing, a management accountant and a human resources manager.

Professional leadership is provided to medical staff within the divisions by the medical director and associate medical directors, through the divisional chairs, where these are doctors. Professional leadership is provided to nurses and midwives by the chief nurse and director of operations, through the divisional directors of nursing and governance, the director of midwifery or chief of therapy.

Divisional management/governance boards

Each division has a divisional management board (DMB) established to review and monitor the implementation of the division's strategies and business plans.

Each division also has a divisional governance board (DGB) established to support the DMB in ensuring an integrated approach to quality, risk and patient safety. The DGB is chaired by the divisional chair and is responsible for:

- **setting and monitoring implementation of the division's quality improvement strategy**
- **monitoring of all aspects of clinical governance and clinical/non clinical risk within the division and ensuring that lessons are learnt from adverse incidents or complaints and corrective action plans are put in place**
- **providing leadership, focus and consensus on key aspects of quality, risk and patient safety, based upon expertise within the division**
- **providing assurance to the board that high quality, safe, effective treatments and services are provided to patients and that risk to staff and visitors is minimised**
- **reviewing external sources of assurance and ensuring that compliance with regulations maintained**
- **ensuring evidence provided for continued compliance with CQC standards.**

As well as regular reporting to and contribution from each division to patient safety committee (PSC), patient experience committee (PEC) and organisational risk committee (ORC), the divisions present six-monthly reports regarding quality related performance to the PSC and PEC and two monthly reports regarding risk as part of the risk register reviews to the ORC. These reports are presented by the divisional directors of nursing and governance and provide for the escalation of significant risks and issues up the committee structure, to the trust board, as appropriate.

Each division also reports to the quality and risk committee at least once per year on the delivery of their respective quality improvement strategy.

In accordance with the trust's performance management framework, divisions are held to account by the executive directors on a quarterly basis across a range of performance domains, one of which is quality.

Quality reporting and monitoring

A central function of the trust board is to promote a quality-focused culture across the trust. This is achieved through the implementation of an effective reporting process that engages the board in understanding and improving the quality of care offered by the trust, and ensures that quality remains at the forefront of the board's agenda.

The quality account

The directors are required under the Health Act 2009 and the National Health Service (quality accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Introduced in 2010, the trust produces an annual quality account. This is a quality focused report, approved by the trust board and published on trust website. The accounts look at the three domains of quality: patient safety, clinical effectiveness and patient experience. The primary aim is to support

the NHS in improving the quality of healthcare services by improving the organisation's accountability to the public.

The quality performance report

The purpose of the report is to update the board on key developments in quality. Like the quality account, the report looks at the three domains of quality and focuses on the trust's performance in these areas by looking at several indicators and performance measures i.e.

- **patient safety: including infection control, serious incident reporting, pressure ulcers, workforce and recruitment**
- **patient experience: including same sex accommodation, access to interpreter services, patient surveys, PALS and complaints**
- **clinical effectiveness: including NICE compliance, clinical outcomes including national audits, local audits and mortality monitoring.**

The quality performance report is now combined with **the trust performance report:**

The trust performance report is presented to the finance and performance committee on a monthly basis and to board every two months. This report – which can be accessed via our website – contains a summary of operational performance across all domains of performance, including quality metrics such as infection rates. Any quality issues identified by the finance and performance committee are referred to the quality and risk committee for further consideration. The quality metrics within the trust performance scorecard are also reviewed monthly by the quality and risk committee.

The quality improvement strategy

The trust's quality improvement strategy was originally approved by the board in November 2010 and is refreshed annually. The strategy outlines the trust's vision for quality improvement over the next five years, detailing key priority areas and planned action to promote continuous improvement in the safety and quality of services provided by the trust. This strategy is reviewed and updated annually by the quality and risk committee.

Serious incidents

All serious incidents are reported to the board as part of a weekly synopsis report. At each of its meetings, the board will then review in more detail selected incidents. In addition quality and risk committee will also review selected serious incidents and never events in detail, as well as receiving assurance that lessons from all serious incidents are being learnt within divisions, via the patient safety committee. The serious incident reporting to board also includes any safeguarding serious case reviews.

External assessment of the trust's quality governance framework

As part of the trust's application for foundation trust status, the trust completed a self-assessment of the robustness of this quality governance framework against Monitor's Quality Governance Framework.

The trust has completed an action plan to address any recommendations made by Monitor, including the development of a revised risk management strategy and policy to ensure that risks are identified and managed 'board to ward'.

Care Quality Commission compliance

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

The Care Quality Commission undertook a Chief Inspector of Hospitals inspection in February 2014 which resulted in an overall rating of 'good'. The trust received two compliance actions:

- **there was a poor general understanding and implementation of the principles of the Mental Capacity Act 2005. (Queen Mary's Hospital)**
- **medical records must be made available to staff working in the outpatients clinics (St George's Hospital).**

Action plans have been implemented in response to these compliance actions and monitored internally through the quality and risk committee and externally through the clinical quality review meetings with commissioners.

Risk Management

The trust is committed to providing high quality care, in an environment which is safe for patients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness. Robust risk management and internal control are an essential part of good governance and is integral to the delivery of this commitment. The governance committee structure shown in appendix one provides an effective and robust system of risk management across the trust.

The key aim of the trust's risk management approach is to ensure that all risks to the trust's

achievement of strategic objectives (whether clinical, non-clinical, information, research or financial) are identified, analysed, evaluated, treated, monitored and managed appropriately.

The system of risk management is described in the trust's risk management policy which is accessible to all staff via the trust intranet. It is based on an iterative process of:

- **identifying and prioritising the risks to the achievement of the organisation's policies, aims and objectives**
- **evaluating the likelihood of those risks being realised and the impact should they be realised**
- **managing the risks efficiently, effectively and economically.**

This is achieved through a sound organisational framework, underpinned by a robust policy framework, which promotes early identification of risk, the co-ordination of risk management activity, the provision of a safe environment for staff and patients, and the effective use of financial resources. It ensures that staff are aware of their roles and responsibilities and outlines the structures and processes through which risk is assessed, controlled and managed.

Risks are identified through feedback from many sources such as proactive risk assessments, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, stakeholder/partnership feedback and internal/external assurance assessments.

Key stakeholders are involved in the management of risks via patient and public involvement groups and activities, patient and staff surveys, public board meetings, the local Healthwatch groups and the local adult care and health overview and scrutiny committees.

Risks are evaluated using a recognised risk assessment tool which assesses the impact and likelihood of the risk occurring using a 5 x 5 matrix scoring system. This risk score feeds into the decision-making process about whether a risk is considered acceptable. Higher level unaccepted risks require control measures/contingency plans to reduce them to an acceptable level. Each risk has an identified owner who is responsible for reassessing and monitoring the effectiveness of the controls in place to manage and mitigate the risk; this is recorded and reported back regularly to the appropriate committees.

Risk management is embedded within the organisation through the corporate, divisional, directorate and care group structures and the reporting and feedback mechanisms are in place (as shown in appendix two).

The compliance unit, which includes the corporate risk and assurance department, supports staff in disseminating good practice across the organisation. Involvement in risk management activities is also included within the trust's objective setting and individual performance review of staff and the organisation's business planning process. The corporate risk and assurance department works closely with the head of patient safety to ensure a joined up approach to improving patient safety.

The trust's board assurance framework, which is aligned to the trust's strategic corporate objectives, is a high-level document based on structured and ongoing assessment of the principal risks to the trust achieving its corporate objectives. It describes the controls and assurance mechanisms in place to manage the identified risks.

The executive management team and the quality and risk committee (QRC) regularly review the board assurance framework, with the most significant risks being reported to each public trust board meeting. Divisional and directorate risk registers are reviewed regularly by the organisational risk committee with high-level risks being reported to the QRC.

In addition, the trust uses its assurance map to record the outcome of any external accreditation visit or statutory inspection, and assurance that actions are being taken to address any issues identified through these inspections is provided to the board.

Risk management training is a mandatory requirement for trust staff at induction. Further education is available for trust staff, relevant to their authority and duties; this includes modules within the clinical leadership programme and senior staff induction programme. Expert guidance and facilitation from the corporate risk and assurance department supports this function.

External assurance as to the robustness of this system has been provided through the trust's preparation for foundation trust status, including the completion of the quality governance assurance framework and assessment by Monitor. As a result of this assessment, further improvements have been made to the risk management framework to strengthen 'ward to board' risk management. A revised risk management strategy was approved by the board in November which will lead to continued improvement.

Principal risks identified in 2014/15

The following risks were identified by the board as being the principal risks during 2014/15, and the associated controls overseen by the executive management team and the quality and risk committee. The most significant risks on the board assurance framework are reviewed by the board at each meeting, following recommendation from the executive management team and the quality and risk committee. These risks will therefore change during the year, however risks that have remained consistently in the list of most significant risks during the year are:

REF	DESCRIPTION	RATING (at March 2015)
3.2-05	The trust does not deliver its cost reduction programme objectives	25
01-12	Bed capacity may not be sufficient for the trust to meet demands from activity, negatively affecting quality, throughout the year.	20
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting quality, throughout the year.	20
01-14	Staffing to support capacity may not be sufficient for the trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.	20
01-15	Critical care capacity may not be sufficient for the trust to meet demands from activity, negatively affecting quality, throughout the year.	20
01-07	Risk to patient safety and experience as a result of potential trust failure to meet 95% emergency access standard	20
3.7-06	Failure to meet the minimum requirements of the Monitor risk assessment framework	20
3.6-05	Cashflow risks – operational finance: forecast cash balances will be depleted	20
2.1-05	The tariffs applicable to trust clinical services are adversely changed as a result of national and local tariff changes	20

Information governance

The board is aware of the importance of maintaining high standards of information governance, including protecting the confidentiality of patients' information. The trust has appointed the director of finance, performance and informatics as the senior information risk officer and the medical director as Caldicott Guardian. The trust also has an information governance manager and a range of policies, procedures and training to ensure that staff are aware of information governance requirements.

The information governance committee oversees the completion of the information governance toolkit on an annual basis, as well as reviewing any information governance incidents. The IG toolkit rating for the reporting period was satisfactory.

The trust has had one information commissioner reportable data security breaches in this reporting period, relating to correspondence sent to a patient's GP without the patient's consent. The information commissioner was informed on 11th March 2015; this incident is still under investigation.

Data quality

The trust has an information team, reporting to the director of finance, performance and informatics, who oversee the quality of data. The trust has a data quality strategy, to ensure continual improvement in the quality and integrity of data, which is monitored by the data quality group and the finance and performance committee on a quarterly basis.

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

Performance is monitored monthly by the finance and performance committee and the board, via the monthly quality and performance report, the finance report and the workforce report. Performance is reported through a number of key performance indicators (KPIs) as per Trust Development Authority (TDA) and Monitor regulatory frameworks. At the end of this reporting period March 2015 the trust was performing positively against most metrics within these frameworks, but showing deterioration in the TDA accountability framework rating and Monitor risk assessment framework quality governance score of 'amber-red', due to a failure to meet two cancer targets in January, the 31 day standard at 95.1 per cent against a target of 96 per cent and the 62 day standard with performance at 80.9 per cent against a target of 83 per cent.

During 2014/15 the trust has demonstrated strong performance against most of the key performance indicators. Key achievements this year include:

- **achievement of 'de minimis' thresholds for MRSA and C.difficile infections**
- **mortality and SHMI performance remains strong**
- **The latest SHMI data indicates that the trust is one of 15 trusts where the indicator is 'lower than expected' and we remain one of 11 trusts were mortality rates are lower than expected for two consecutive years.**

Areas of underperformance were:

- **A&E four hour standard:**

  The trust did not achieve the A&E four hour waiting time standard. The trust has implemented action plans to address A&E performance, supported by commissioners and ECIST (Emergency Care Intensive Support Team), which is monitored monthly by the finance and performance committee and the board

- **Referral to treatment (RTT) waiting times**

  RTT indicators have been excluded from the overall rating as breach of target was authorised as part of the national RTT resilience programme which was extended to quarter 4 of 2014/15. The board however have reviewed action plans to address specific areas of non-compliance

- **Continuation of Services (CoSR)**

  The position remained at three until Q4 where it was changed to under review. The board was concerned regarding financial performance – as at month 11, the trust is showing a deficit year to date of £9.5m which was £14.75m adverse to the year to date target of £5.25m surplus. This was an adverse movement in month of £3.2m. The month 11 results showed a worsening of the position as a result of under delivery of SLA inpatient income targets and excess costs of continuing operational pressures during February.

Compliance with NHS pensions scheme regulations

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality and diversity

Control measures are in place to ensure that all the trust's obligations under the equality, diversity and human rights legislation are complied with. The trust has completed a self-assessment against the Equality Delivery System (EDS) standards and has agreed annual objectives to ensure continual improvement in this area.

Climate Change Act and adaptation reporting requirements

The trust has undertaken risk assessments and carbon reduction delivery plans are in place, in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the trust's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality account attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I am confident as to the effectiveness of the system described above and that conclusion is informed in a number of ways:

The head of internal audit has provided me with significant assurance that the internal controls are operating effectively within the fundamental financial systems, as a whole. That opinion is that overall reasonable assurance could be provided both controls are generally sound and operating effectively and that the internal controls are operating effectively within the fundamental financial systems.

The internal audit plan for the year included reports across the main operational areas of the trust as follows:

- **safety/patient focus reviews:** safeguarding of children; nursing, midwifery and care establishments; and capacity planning
- **governance reviews:** board assurance framework and risk reporting; Care Quality Commission registration; whistleblowing; information governance and security; service improvement programme
- **financial systems reviews:** fundamental financial systems audits; central stores, London Community Resource Network (LCRN) research funding
- **clinical and cost effectiveness:** data quality reviews in respect of Referral to Treatment Time reporting, cancer waiting time reporting, overall data quality governance and the performance information database; medical locums; SWL Pathology IT portal project; E-rostering project
- **care, environment and amenities reviews:** estates maintenance follow up reviews (2); fire safety follow-up reviews (3); cleaning; postage; and estates statutory compliance.

A range of assurances from significant assurance to limited assurance have been given. The limited assurance reports can be seen in appendix three. The head of internal audit has stated that in all cases, management has taken a positive approach and developed action plans to address the issues raised and considers that the trust will build upon the improvements already achieved during the year.

In addition to the head of internal audit opinion, the audit committee chairman provides a written report following each committee meeting to the next meeting of the trust board, which includes significant conclusions arising from the committee's work, concerns and recommendations. A summary of the full range of internal audits undertaken in the year and the associated level of assurance are included in appendix three.

Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The board assurance framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation achieving its principal objectives have been regularly reviewed.

The trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively. The board has completed a review of its effectiveness and that of its sub-committees through completion of the board governance assurance framework assessment and the annual effectiveness reviews.

My review is also informed by a variety of other sources of information. These include:

- **the views and comments of stakeholders**
- **patient and staff surveys**
- **internal and external audit reports**
- **clinical benchmarking and audit reports**
- **mortality monitoring**
- **reports from external assessments, including the CQC Chief Inspector of Hospitals inspection in February 2014**
- **Deanery and Royal College assessments**
- **accreditation inspections of clinical services**
- **patient environmental action team self-assessments and PLACE assessments.**

The trust has produced a Quality Account for 2014/15 and the governance system described above has been used to validate its content and the data on which it is based.

Through review of these assurances, the board has considered any issues that fall within the definition of 'significant issue' according to the requirements of this governance statement.

The board has previously been particularly concerned with the limited assurance provided by internal audit in respect of the trust's compliance with fire safety, and the limited progress to date in implementing the agreed action plan when reviewed by internal audit. I am overseeing the implementation of that comprehensive action plan to address the audit recommendations and other aspects of non-compliance. Progress had been made in addressing the gaps in compliance, but some areas of non-compliance remain.

The existing risk on the board assurance framework relating to compliance with fire safety regulations, and the potential impact that this non-compliance might have on patients, has been reviewed in the light of this limited assurance and will be one of the trust's most significant risks until the action plan has been successfully completed. Therefore the board will have greater visibility of the risk and will monitor the implementation of controls to manage the risk. Progress in implementing this action plan has been monitored and will also continue to be monitored by the audit committee.

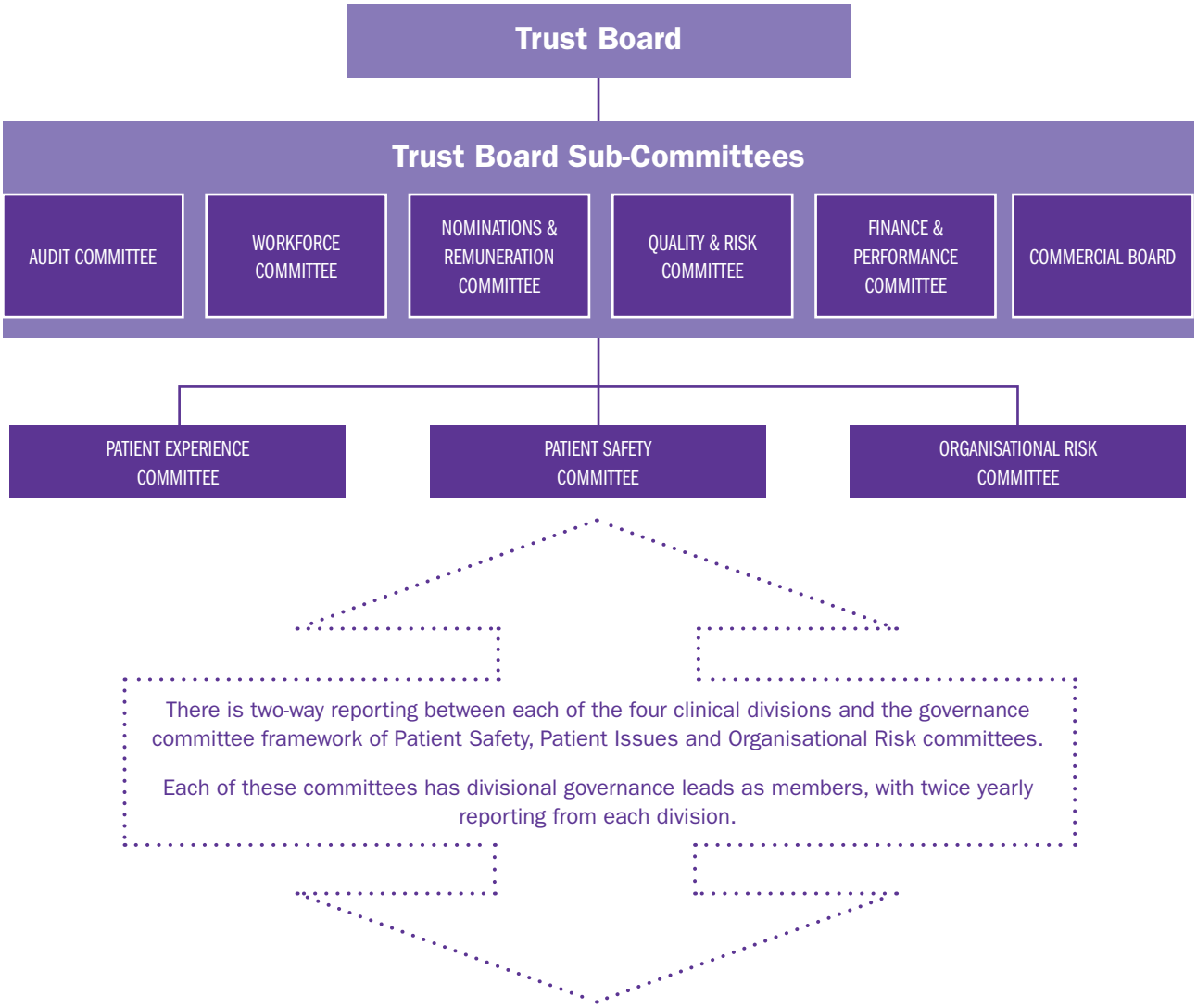
The board have also been particularly concerned with the significant deterioration in the financial performance in the last quarter of the year, moving from a projected breakeven position at month 9 to an outturn deficit of £16.8m. Due to the severity and rapidity of deterioration in the financial position post authorisation, Monitor has launched a formal investigation into the trust's compliance with its licence. This investigation will include a rapid assessment of corporate governance, financial management, control and reporting arrangements, in order to determine the extent to which each of these factors may have contributed to the trust's inability to plan for and forecast a realistic position for year-end and to the significant deterioration in financial position during the year. Monitor's investigation will also include a review of the trust's performance, in particular concerns being the failure to achieve the four-hour waiting time standard in A&E and the attainment of sustainable compliance with referral to treatment standards within expected timescales.

Miles Scott
Chief Executive
St George's University Hospitals NHS Foundation Trust

28/5/2015

Annual governance statement appendix 1

Governance framework



St George's University Hospitals NHS Foundation Trust has four clinical divisions:

WOMEN & CHILDREN, THERAPIES AND CRITICAL CARE	MEDICINE AND CARDIOTHORACIC SERVICES	SURGERY, THEATRES NEUROSCIENCES AND CANCER	COMMUNITY SERVICES

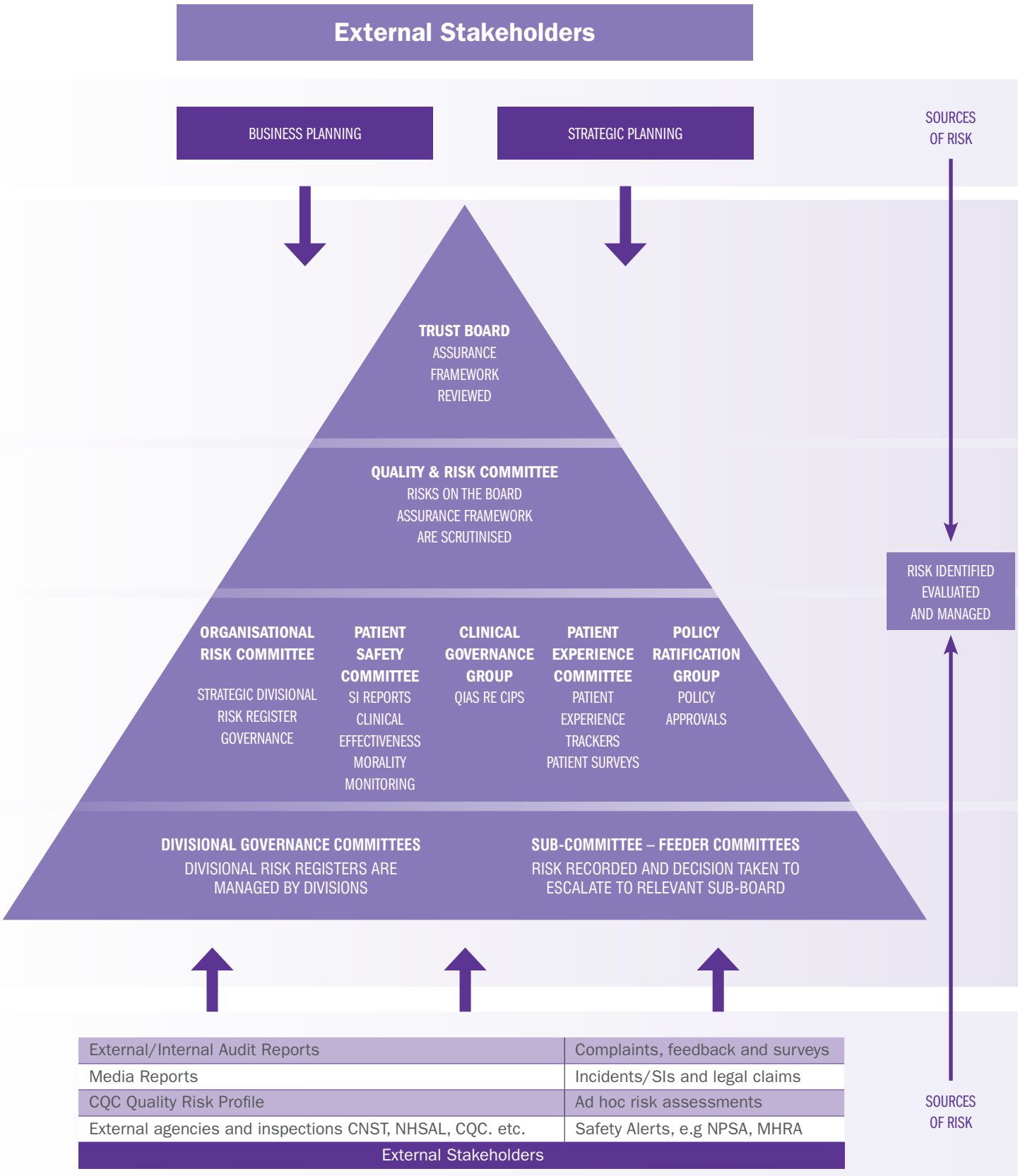
Divisional Governance Structure:

Each of the clinical divisions has an established governance framework, at the top of which each division has a divisional management board and divisional governance committee.

These committees manage all aspects of governance within each division and seek and receive assurance from across their respective care groups.

Each of the divisional directors of nursing and governance are substantive members of the committees of patient safety, patient issues and organisational risk.

Annual governance statement appendix 2



Appendix 3 – Internal Audit Reports issued in 2014/15

Summary of 2014/15 internal audit projects

Topic	Assurance Level
Patient safety and service quality	
Safeguarding of children	Reasonable
Nurse, midwifery and care establishments	Reasonable
Capacity planning	n/a
Clinical and cost effectiveness	
Medical locums	Reasonable
E-rostering project review	n/a
Governance	
Assurance framework and risk register	Reasonable
St George's, University of London partnership arrangements (draft report)	Reasonable
CQC registration	Reasonable
Whistleblowing	Limited
Trust transformation programme	n/a
Fundamental financial systems	
Financial ledger	Significant
Financial reporting and budgetary control	Reasonable
Accounts payable	Significant
Cash and investments	Reasonable
Capital asset register/capital charges	Significant
Income and debtors	Significant
Arrangements with commissioners	Reasonable
Joint research funding – LCRN office	Limited
Central stores	Limited
Human resources and payroll	
Payroll	Significant
Estates and facilities	
Estates maintenance follow-up (two reviews)	Limited
Fire safety follow-up (three reviews)	2 Limited, 1 n/a
Cleaning	Reasonable
Postage	Reasonable
Estates statutory compliance	Reasonable
IT/Information	
Information governance and security/data accreditation	Reasonable
IT portal project – two reviews	Reasonable
Data quality – RTT reporting	Reasonable
Data quality – overall governance arrangements	Limited
Data quality – performance database	Limited
Cancer data quality follow-up	Reasonable

Statement of the chief executive's responsibilities as the accountable officer of the trust

The chief executive of the NHS Trust Development Authority has designated that the chief executive should be the accountable officer to the trust. The relevant responsibilities of accountable officers are set out in the accountable officers memorandum issued by the chief executive of the NHS Trust Development Authority. These include ensuring that:

- **there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance**
- **value for money is achieved from the resources available to the trust**
- **the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them**
- **effective and sound financial management systems are in place**
- **annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.**

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Signed

Miles Scott
Chief Executive

Date: 28/5/2015

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- **apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury**
- **make judgements and estimates which are reasonable and prudent**
- **state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.**

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the board

Miles Scott
Chief Executive

Date: 28/5/2015

Steve Bolam
Chief Financial Officer; Deputy CEO

Date: 28/5/2015

Remuneration report

Annual statement on remuneration

The trust has two committees, one dealing with executive pay and appointments and the other with non-executive directors.

The **board of directors' nominations and remuneration** membership includes the chairman and all non-executive directors. The director of corporate affairs acts as secretary to the committee, the director of workforce provides advice to the committee as required and the chief executive attends when appropriate.

The **council of governors' nominations and remuneration committee** membership includes public, staff and appointed governors, and is supported by the director of corporate affairs.

Remuneration policy 2014/15

The policy agreed by the relevant committees for this year is as set out below:

Executive directors

The remuneration policy for executive directors is set by the board of directors' nominations and remuneration committee.

Prior to becoming a foundation trust, remuneration for executive directors has been set on spot rates based on publicly available benchmark data and market data available through search companies. Remuneration has been reviewed annually against the available data and in the context of any national pay awards.

In 2014/15 the trust appointed five new executive directors:

- **Joint director of estates and facilities**
- **Chief nurse**
- **Director of delivery and improvement**
- **Medical director**
- **Director of strategy**

For each new appointment the committee agreed remuneration levels against available benchmarked information.

Following authorisation as a foundation trust, the committee will be considering a recommendation to commission support from the Hay Group in setting a strategy for the remuneration of executive directors.

All other members of staff are paid either on Agenda for Change or medical terms and conditions. Senior managers' salaries, benefits and pension entitlements are published in the trust's annual report.

Chairman and non-executive directors

As an NHS trust, the remuneration for non-executive directors and chairman is set at £6,500 and £25,000 respectively, by the Appointments Commission and then Trust Development Authority.

As a foundation trust it is for the council of governors to set the remuneration and allowances, and other terms and conditions of office, of the chairman and non-executive directors. The council of governors agreed the initial remuneration for chairman and non-executive directors at its meeting in April 2015, taking into consideration the recommendations of the council of governors' nominations and remuneration committee.

The council of governors agreed that the remuneration should be set established using the following guiding principles:

- **Competitive: remuneration should be competitive with comparable trusts on a comparative workload basis, so that council should be able to attract at least as good a chairman and non-executive directors as other comparable trusts**
- **Value for money: the total cost of the chairman and non-executive directors should be demonstrably good value for taxpayers' money in comparison with other comparable trusts**
- **Aligned with role: remuneration should be appropriate to the role of chairman and non-executive directors.**

The council agreed that remuneration should be comparable to the market rate for the benchmark peer group (large acute foundation trusts in London) in the NHS providers remuneration survey and publicly available benchmarking data. The council agreed that given financial circumstances the remuneration for the chairman should be incremental but that for the other non-executives it should be set at a comparable level immediately.

For the chairman, the council of governors agreed to commit to achieving the mean point within the peer group range but to do so in a phased approach – to set the initial remuneration to £45,000 with effect from 1st February 2015, with a further review in autumn 2015 with a view to moving to the mean point within the peer group range from February 2016, as part of the appointment/reappointment process – as with the non-executives this to be linked to an explicit expectation of time commitment, say ten days per month.

For non-executive directors, the council agreed to set their remuneration at a spot rate, £12,000, with effect from 1st February 2015.

The council of governors considered the option of applying specific uplifts to salary for certain additional non-executive responsibilities, but noted that all non-executive directors had additional responsibilities over and above their basic role, including chairing board sub-committees, and therefore agreed that initially there should be a single rate for all non-executive directors. This could be reviewed again in future.

The council agreed that these arrangements should be subject to an annual review, informed by appraisal information and current benchmark information.

Attendance at the council of governors' nomination and remuneration committee during the year is set out below:

Governors nomination and remuneration Committee 2014/15

Governor	Constituency	March 2015
Ed Crocker	Public Governor	✓
Kathryn Harrison	Public Governor	✓
Mia Bayles	Public Governor	✓
Fran Gibson	Appointed governor	✓
Hilary Harland	Public Governor	✓
Philip Jones	Appointed Governor	✓
Hilary Rattue	Staff Governor	✓
Anneke de Boer	Public Governor	Apologies
J-P Van Besouw	Staff Governor	Apologies
Sue Baker	Public Governor	Apologies
Christopher Smallwood	Chairman	Apologies

Severance and payments

There have been no terminations of contract for executive or non-executive directors during 2014/15.

Remuneration relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

Financial year	2014/15	2013/14
Remuneration of highest paid director, £	226,221	226,249
Median employee remuneration, £	33,352	33,839
Highest paid director's remuneration as ratio of median	6.78	6.69
Employees paid more than highest paid director	2	3

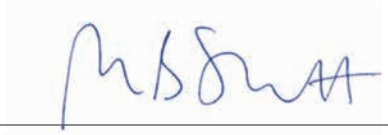
The 2013/14 median salary was re-calculated on the same basis as was used for 2014/15 so is different to last year's published figures.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions or the cash equivalent transfer value of pensions.

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

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 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 result of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures 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 benefit accrued to the member as a result of 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 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 an arrangement which the individual has transferred to the NHS pension scheme) and uses common market valuation factors for the start and end of the period.

Signed: 

Date: 28.V.15

Chief Executive

Signed: 

Date: 28/5/15

Chief Financial Officer; Deputy CEO

For more information on salary and pension entitlements of senior managers, please see pages 171-174t and 220-223ft.

Quality report

Statement on quality by Miles Scott, chief executive

There is no single way to define quality, especially for such a large organisation with such a wide spectrum of services and with more than one million patient contacts every year.

However, what is clear is that both patients and the organisations that scrutinise us think we are a strong organisation and provide high quality services.

More than 90 per cent of our patients receiving care across a range of settings have told the Department of Health that they would recommend St George's as a place to receive treatment and be cared for through the Friends and Family Test.

In the latest edition of the National Staff Survey our staff are again ranked as being amongst the most highly motivated in the country and in the highest band for staff who feel proud of their trust and would recommend that their friends and family receive care there.

The Care Quality Commission declared that St George's was meeting every one of the essential domains of care following their unannounced inspection in February 2014. The CQC found the overall standard of care we provide at all of our sites to be 'good' and awarded the trust an overall 'good' rating, with some aspects of care rated as 'outstanding', confirming St George's place as one of the country's leading teaching hospitals.

This level of recognition from the CQC provides assurance that we offer high standards of clinical services to our local community and beyond and that we remain true to our values to provide excellence across clinical care, education and research, which ultimately means better care for all our patients.

Our Quality Account 2014/15 is full of examples of high performance and commendable practice. We are one of the few trusts in the country to have reported lower than expected mortality rates every year since publication started. Our mean level of performance for 'Harm Free Care' was 94.47% for the period of this report (April 2014 to March 2015) and was slightly above the national average (93.79%) although we did not achieve our internal target of 95%. Beneath this high level figure there have been reductions in the level of harm caused by pressure ulcers and falls. Whilst the number of patients acquiring C.difficile this year rose slightly, we were below our national trajectory for this type of infection and St George's now has one of the lowest rates of C.difficile in London. Last year we also further increased the number of clinical audits we took part in.

We achieve these high levels because the culture at St George's is to always look at how we can improve. There is a deep rooted desire running throughout the organisation to always find ways to make things better for our patients. Sometimes those improvements are huge developments that are easily noticeable for everybody, like our new helipad which has been in operation for a year and is helping the most seriously injured and ill people from across the south east of England receive the expert life-saving care they need. But sometimes they are the less obvious but equally important changes, like improving our discharge planning processes in the flow programme so that patients are less likely to have to return to hospital for further treatment after going home.

Since the last Quality Account, as well as the new helipad, we have opened new facilities for patients with the commissioning of Gordon-Smith ward for oncology patients, additional facilities within Amyand and Allingham wards, provided services for the community at the Nelson Health Centre and welcomed the First Touch Garden at the main entrance of the St George's Hospital.

During 2014/15 we continued to build on our partnership with King's Health Partners as joint leaders of the new South London Collaboration for Applied Health Research and Care (CLAHRC). The CLAHRC pools the clinical and research expertise of both the NHS and universities in south London, and will make sure that patients benefit from innovative new treatments and techniques that could revolutionise future healthcare. We have also been active participants in the Health Innovation Network (South London). Continued investment in research and our services at St George's and Queen Mary's Hospitals and in the community is key to our plans for the future of the trust. News that we were successful in our bid to be part of the '100,000 genomes' project was a great boost. This three-year programme

focuses on cancer and rare diseases and has the potential to transform the future of healthcare.

We became a foundation trust in February 2015. This achievement was the result of a long period of improvement from a workforce whose energy, commitment and compassion is outstanding. It also demonstrates that we consistently live up to our values; Excellent, Kind, Responsible and Respectful. This becomes even more important now as our accountability to our communities increases through our council of governors.

Becoming a foundation trust means we can refocus our efforts on our strategy and the development of our services, to better meet the diverse and changing needs of our patients in the future and keep them at the heart of everything that we do. It also means being able to make our own decisions about how we invest in our sites and services.

Yours sincerely

Miles Scott Chief Executive

Dashboard: our priorities from last year

Key

- Achieved our aims and/or targets
- Part achieved our aims and/or targets
- Did not achieve our aims and/or targets

123 Page where more information can be found within the Quality Account available from St George's Website

PRIORITY	STATUS	PAGE
Reduce grade three and four pressure ulcers		110
London Quality Standards		112
Increase number of patients taking part in research projects		118
Participation in clinical audits		120
Use of CQUIN payment framework		122
Data quality		123
Maintain information governance toolkit band		124
Reducing medication errors		126
Reducing patient falls		127
Implement the national safety thermometer		128
Implement the early warning score indicator at HMP Wandsworth		129
Maintain lower than expected mortality rates		130
Assessing risk of VTE in admitted patients		131
Root cause analysis of VTE cases		131
Reducing rate of C.difficile infections		132
Patient safety incident reporting		133
Increase number of community learning disability referrals seen within four weeks of referral		134
Respond to 85 per cent complaints within 25 days		135
Increase the return rate for Friends and Family Test		137
Increase the number of patients who would recommend us to friends and family		137
Increase sexual health support in Wandsworth secondary schools		140
Improve participation rates for patient reported outcome measures		141
Reduce hospital readmissions		145
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers		147
Never events		148
Reducing rate of MRSA infections		148

Priorities for improvement in 2015/2016

In 2013/14 we agreed a new quality improvement strategy which centres on the three essential domains of patient safety, experience and outcomes.

For 2015/16 we have refreshed this strategy and agreed six new commitments against each domain which illustrate how we will achieve improvements. These priorities have been determined through a review of activity during 2014/15 and through engagement with key stakeholders. In addition, we have committed to build and strengthen existing work programmes recognising that a 12 month period may not be sufficient to fully embed sustainable changes.

The priorities indicated below are reflected in the quality improvement strategy annual plan for 2015/16 and each element has agreed outcomes with a nominated person accountable lead for delivery against the priorities.

Improving patient safety

- we will create reliable processes to reduce avoidable harm. Examples of outcome measures: audit of practice against the WHO safer surgery checklist, ward level data eg heatmap/safety thermometer to support management action at the front line
- we will establish strong multidisciplinary teams who communicate clearly across boundaries through development forums for clinical governance leads
- we will give timely and relevant feedback to teams to enable staff to be knowledgeable about patient safety
- we will promote a culture of zero tolerance through challenging unsafe practice
- we will promote an open and transparent culture where we listen and act on staff concerns through the Safety Forum initiative, and ongoing development/ monitoring in relation to the Duty of Candour
- we will encourage the involvement of patients in patient safety initiatives through the roll out of the patient safety booklet/films.

Improving patient experience

- we will listen to and involve people who use our services through further improvement work in relation to the complaints function and monitoring of key metrics
- we will use feedback as a vehicle for continuous improvement adopting best practice where possible through triangulation
- we will ensure that our patients are cared for in a clean, safe and comfortable environment through use of the clinical audit programme and ensuring that findings are acted upon
- we will ensure that our most vulnerable patients and service users are listened to and protected from harm through introduction of the dementia and delirium team and monitoring of the clinical care for individual patients.

Improving patient outcomes

- we will evaluate clinical audit results and act on findings to ensure audit contributes to improvements for patients
- we will support staff to improve outcomes by provision of training and expert support
- we will communicate outcomes, promoting shared learning and prioritisation of improvement projects
- we will evidence that we are clinically effective and implementing evidence based best practice
- we will fully participate in national clinical audits and use results to improve local practice
- we will aspire to achieve best practice across all clinical areas so that patients have the best possible outcome.

Our four clinical divisions have each taken these commitments and translated them into quality improvement plans specific to their patients and services. The implementation of these plans will be overseen by our Quality and Risk Committee, which is responsible for monitoring quality at the trust.

We will be reporting on our performance against our quality improvement strategy at our (held in public) board meetings throughout 2015/16. Our performance will also be reported on our website: **www.stgeorges.nhs.uk**

Looking forward, there are a number of additional quality priorities that the organisation will need to implement during 2015, such as the outcome of the NHS England review of maternity services, which is expected to recommend choice for maternity care; plus the expected revised national cancer strategy.

The table below indicates progress that has been made against the priorities since the publication of the 2013/14 Quality Account:

IMPROVEMENT PRIORITY FOR 2014/15	PROGRESS AS OF MARCH 2015
Conduct twice yearly nursing and midwifery reviews as recommended in the National Quality Board report 'how to ensure the right people, with the right skills, are in the right place at the right time.'	• Establishment review completed in May, recommendations agreed by the board with all bar one implemented during 2014/15 • Further acuity/dependency review undertaken in autumn of 2014 • Safe staffing framework in place and amended to include 'Red flag' indicators • Monthly reporting to board in place regarding safe staffing • Nursing/midwifery workforce programme in place since August 2014 to support the forward planning for recruitment and retention of staff and the commissioning of additional operational capacity during the year.
To ensure that we implement the recommendations of the Clwyd/Hart review of the complaints system in hospitals to further strengthen our response to patient complaints, learn from their feedback and use as a means to implement improvements.	• Work undertaken to strengthen the complaints function including performance management for response time and to ensure evidence of learning from complaints • Participation in national patient surveys for inpatient, maternity and paediatric settings. Final results awaited for some surveys and work to focus on response to findings • National cancer patient survey results received indicating that St George's was one of the 10 most improved trusts. Responses to findings now agreed and being implemented • Annual community patient survey (Sept 2014) outcomes reviewed with action plans at DGB • Strengthening of use of Family Friendly Test (FFT) now in place across inpatient, emergency department (ED), midwifery settings. A trial of the medication safety thermometer also completed. Focus on triangulation of commentary with complaints/compliments data. FFT feedback and data being displayed, actions taken. Emergency Department have marked uptake in responses using SMS service.
To ensure that we meet the 'Duty of Candour' requirements and make sure we continue to endorse and develop a culture of openness and transparency.	• Report produced to identify current practice and challenges. Monthly reports being collated to indicate compliance with Duty of Candour • Master classes held to raise awareness with senior clinicians and support good practice with patients.
To ensure we focus on improving the experience of patients visiting our outpatient departments.	• Roll out of E-triage began February 2015 • Capacity and demand analysis completed across specialities • Refurbishment of estate to commence April 2015 including improved signage and new furniture installed in clinic rooms • Patient experience training delivered to call centre and clinic administrative staff March 2015, training opportunities advertised to staff • Successful recruitment of permanent staff, ongoing staff forums. Roll out of FFT in April 2015.
To continue to focus on reducing avoidable grade 3 and 4 pressure ulcers, implementing the Sepsis Care Bundle to improve care of patients with severe sepsis and improving our discharge process.	• Patients admitted with sepsis from the ED are regularly audited to identify MISSED (Mortality In Severe Sepsis in the ED) this is reported at the sepsis group • The trend for grade 3 and 4 pressure ulcers is showing a downward trajectory.
To maintain our commitment to improving end of life care.	• Programme board established with agreed scope to take forward trust-wide actions to implement NICE standards and five priorities (which replaced the Liverpool Care Pathway) • Audit of palliative care activity completed during the year with presentation to key committees • Development of new care plan for patients.
To establish the dementia and delirium team to meet the national CQUIN requirements, embed the 'butterfly' scheme and improve the care of this vulnerable group of patients.	• Full nursing team recruited and have to date met all CQUIN targets for 2014/15 • Dementia and delirium guidelines updated • Dementia training roll out.

Developing the Quality Account

All NHS trusts report the same information which allows us to benchmark our performance against other trusts. This is important for not only letting us know how we are doing, but means that trusts with similar services can learn from each other.

The Department of Health (DH) and Monitor produce guidance on what should be reported in the Quality Account for NHS trusts and NHS foundation trusts.

As St George's achieved foundation trust status mid-year 2014/2015 we must comply with both Monitor's reporting requirements and those set by DH. This year's Quality Account relates to the quality of our services across the entire year, including the time when they were provided by St George's Healthcare NHS Trust. Monitor requires us to produce an annual Quality Report which includes all of the reporting requirements of the Quality Account plus some additional requirements they have set.

Every NHS trust in the country has to report against the mandatory indicators listed below:

- Mortality rates
- Patient reported outcome measures (PROMS)
- Emergency readmissions
- Responsiveness to patients' needs
- Friends and family test for staff
- Venous thromboembolism rates (VTE)
- C.difficile rates
- Patient safety incidents

To meet both DH and Monitor's quality reporting requirements we have consolidated all the quality information into one document – the Quality Report, but for reporting purposes to DH we will call the Quality Report the 'Quality Account'.

Monitor requires the trust to report on nine voluntary indicators that reflect how we are improving patient experience, patient outcomes and patient experience. We have reported on ten this year in a bid to better reflect the services we provide and the patients we care for.

We have worked with local stakeholders to identify which indicators to include in this year's Quality Account to make sure that the areas that matter most to the people who use and provide our services are covered. These stakeholders included our staff, our council of governors, patients, local Clinical Commissioning Groups (CCGs), Wandsworth Healthwatch and Wandsworth Council.

The voluntary indicators we have chosen to include fit into the three essential domains of our quality improvement strategy – improving patient safety, improving patient experience and improving patient outcomes. In this year's Quality Account, we continue with the same indicators as last year to ensure continuity, comparability and a clear narrative for readers to follow and have selected additional indicators; 'end of life care' under 'improving patient experience' and 'clinical records' under 'improving patient outcomes'. We will measure our performance against these in next year's Quality Account (2015/16).

Improving patient safety voluntary indicators:

- Medication errors
- Patient falls
- Patient safety thermometer
- Offender healthcare

Improving patient experience voluntary indicators:

- Community learning disability referrals
- Complaints
- End of life care **(new for 2015/16)**

Improving patient outcomes voluntary indicators:

- Sexual health in secondary schools
- Clinical outcome measures in community services
- Clinical records **(new for 2015/16)**

The draft Quality Account has been shared with stakeholders both for assurance and to increase understanding of the value of the report and how we record the data for each indicator. This Quality Account has been reviewed by:

- St George's Quality and Risk Committee
- St George's Audit Committee
- St George's Executive Management Team
- St George's Board
- St George's Patient Reference Group
- Wandsworth Healthwatch
- Merton Healthwatch
- Lambeth Healthwatch
- Wandsworth CCG
- Wandsworth Council Adult Care and Health Overview and Scrutiny Committee

Sharing a draft version of the report with our stakeholders has given them the opportunity to provide feedback on our performance in a formal statement. These statements are published in Annex 1.

To put our performance into context we have compared our performance for all of the indicators in this report against our own performance over the last two years, and where possible and relevant, against the national average performance as published on the Health & Social Care Information Centre **www.hscic.gov.uk**

Testing

It is a requirement that our auditors test certain indicators to provide assurances that there is a robust audit trail.

- **One indicator is mandatory. This is referral to treatment times (RTT)**
- **One indicator needs to be selected by the Trust. For 2014/15 we have chosen 'emergency readmissions within 28 days of discharge'.**
- **One local indicator needs to be selected by the trust's council of governors. For 2014/15 they have chosen 'clinical outcome measures in community services'. Within the process for this area, sufficient data was not available for audit.**

London Quality Standards

Why is this important?

Many patients are admitted to hospital as emergencies and the treatment they receive in the first hours and days in hospital is very important. The London Quality Standards (LQS) were developed in 2011 after a review found variable, and often inadequate, involvement of consultants in the assessment and management of acutely ill patients in London. It was estimated that improved care would save 500 lives each year across the city. The standards specify the optimal way to manage patients in the crucial early period after admission. There are different standards appropriate for different groups of patients.

As part of the south west London five year strategic plan, St George's agreed to progress towards meeting the full range of the LQS by the end of 2016/17. In November 2014 we participated in a Peer Review Audit with the other acute providers in south west London. This covered the full range of LQS except for maternity. http://www.swlccgs.nhs.uk/2015/03/south-west-london-urgent-emergency-care-peer-review-visit-report/

The audit methodology meant that to be scored green the trust had to fully meet the standard. Where the standard was not met, or was met in part it was scored red. Where there was insufficient evidence for the peer assessors to make a decision it was scored amber. As the standards and methodology have changed it is not possible to undertake a direct comparison with previous internal assessments.

How are we doing?

In total St George's met 123 of the 177 standards in full. Most others were met in part. The main challenges we need to overcome are of two types. The first is that sometimes we are delivering what is required but not as quickly as we would like to. The second is where we are delivering the standard most of the time but not every hour of every day.

	RED: NOT FULLY MET	AMBER: INSUFFICIENT EVIDENCE	GREEN: MET
Adult acute medicine (22 standards)	7	1	14
Adult emergency general surgery (26 standards)	7	7	12
Emergency department (14 standards)	3	0	11
Critical care (26 standards)	4	0	22
Fractured neck of femur pathway (13 standards)	2	0	11
Paediatric acute medicine (22 standards)	6	1	13
Paediatric surgery (23 standards)	5	1	17
Urgent care centre (31 standards)	8	0	23

What are our aims?

Our aim is to continue to work towards meeting the standards by 2016/17. One of the challenges is the availability of key staff. We are working with the other acute trusts in south west London (Croydon, Epsom and St Helier, Kingston) to identify areas where working together is beneficial.

Learning from other organisations

At St George's we are committed to learning from other organisations to see how we can apply best practice from high performing services elsewhere for the benefit of our patients.

As well as learning from best practice we have a duty to learn from other organisations where serious mistakes have been made and serious failing uncovered. It is vital that we understand what went wrong at these organisations so that we can make sure that we are doing all that we can to minimise the risk of the same things happening at St George's.

We have strong governance and audit processes that help us react quickly and decisively to emerging reports, guidance, inquiries and recommendations.

As well as reviewing the integrity of our financial accounts, our audit committee (which is made up of non-executive directors) reviews and independently scrutinise the trust's systems of clinical governance, internal control and risk management. This ensures through proper processes and challenges that integrated governance principles are embedded and practised across all St George's activities and that they support the achievement of the trust's objectives.

The audit committee ensures that the work of its own internal auditors, clinical auditors and external auditors is aligned. The audit committee reviews the work and findings of the external auditors and considers the implications and the trusts responses, and makes sure that the responsibility and accountability for developing and implementing and necessary actions sits at board and senior clinical level.

Below is a brief summary of how we have continued to react to some high profile inquiries and reports. As part of our commitment to transparency and to increase patient confidence in our services we publish our reaction to high profile inquiries and reports on our website and discuss them in board meetings which are open to all members of the public. These papers and details of our board meetings are available at **www.stgeorges.nhs.uk/about/board/board-meetings/**

Mid Staffordshire NHS Foundation Trust public review

The inquiry was chaired by Sir Robert Francis QC whose report made 290 recommendations to the Secretary of State for Health.

The board held strategy sessions during 2013/14 and following the agreement to the seven commitments below has monitored progress against individual elements of those commitments during 2014/15.

The trust board committed to:

- **ensure that quality is maintained as the board's top priority**
- **to strengthen clinical leadership including medical and nursing**
- **to embed and live the trust's values**
- **to ensure that there is a clear approach to the identification of a single lead consultant in multidisciplinary care**
- **to ensure the constant improvement in the quality of care**
- **to devolve the boards commitment to quality at every level though the organisation**
- **to meet the trust's responsibilities under the duty of candour.**

The trust has also during 2014/15 continued to review progress against a number of key reports considered in the previous year:

- **The Keogh mortality review**
- **Berwick review into patient safety, 'A promise to learn, a commitment to act: improving the safety of patients in England'**
- **The Clywd-Hart Report – 'Putting patients back into the picture'**
- **The Cavendish review of healthcare assistants and support workers in the NHS and social care.**

Monitoring has been undertaken through the patient safety, patient experience, quality and risk and workforce committees with oversight by the board.

The trust has received the Kate Lampard QC report which was a 'lessons learned' report drawing on the findings from all of the published investigations into Jimmy Savile and the subsequent allegations into wrongdoing at NHS organisations. The trust is currently considering this report, the recommendations and implications for the trust will be considered in Q1 of 2015/16.

Review of services

St George's is the largest healthcare provider in south west London, and one of the largest in the country. St George's serves a population of 1.3 million people across south west London. A large number of services, like cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

Most of the services are provided at St George's Hospital in Tooting, but we also provide many services from Queen Mary's Hospital in Roehampton, health centres across Wandsworth, Wandsworth Prison and from GP surgeries, schools, nurseries and in patients' own homes.

We also provide care for patients from a larger catchment area in south east England for specialist services like complex pelvic trauma. Other services treat patients from all over the country like family HIV care, bone marrow transplantation for non-cancer diseases and penile cancer.

A number of our services are members of established clinical networks which bring together doctors, nurses and other clinicians from a range of healthcare providers working to improve clinical outcomes and patient experience. These networks include the South London Cardiac and Stroke Network and the South West London and Surrey Trauma Network, for which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

During 2014/15 we provided and/or sub-contracted 54 NHS services. We have reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of NHS services by St George's University Hospitals NHS Foundation Trust for 2014/15.

The services we provide can be categorised as:

- **National specialist centre**
  We provide specialist care to patients from across the country for complex pelvic trauma, family HIV care, lymphoedema and penile cancer.
- **Tertiary care**
  We provide tertiary care like cancer services, neurosciences and renal services for the six boroughs of south west London and the counties of Surrey, Sussex and Hampshire.
  We also provide specialist children's cancer services in partnership with The Royal Marsden NHS Foundation Trust.
- **Local acute services**
  We provide a range of local acute services like A&E, maternity and general surgery to the people of Wandsworth, Merton, and Lambeth.
- **Community services**
  We provide a full range of community services to the people of Wandsworth, making sure people can manage their health better by accessing the services they need closer to where they live and work and in their own homes.

Our clinical divisions

Our services are split into four clinical divisions, which all have their own clinically led divisional management boards. Each board has a divisional chair who is an experienced clinician, providing expert clinical leadership to the staff of each service so that the needs of the patients who use them are best met. Every division has a divisional director of nursing and governance who is responsible for nursing, patient experience and making sure that there are strong governance structures within their division for improving the quality of their services and safeguarding high standards of care. Each division also has a divisional director of operations who is responsible for managing the operational, business and logistical aspects of providing healthcare services. The divisional boards are made up of the clinical directors and heads of nursing who are responsible for the specialist services within their division.

Surgery, theatre, neurosciences and cancer division

Surgery and trauma clinical directorate

- **Trauma and orthopaedics**
- **Ear, nose and throat**
- **Maxillofacial**

- Plastic surgery
- Urology
- General surgery
- Dentistry
- Audiology

Theatres and anaesthetics clinical directorate
- Theatres and decontamination
- Anaesthetics and acute pain
- Resuscitation

Neurosciences clinical directorate
- Neurosurgery and neuroradiology
- Neurology
- Neurophysiology
- Neurorehabilitation
- Pain clinic

Cancer clinical directorate
- Cancer

Medicine and cardiovascular division

Emergency and acute medicine
- Emergency department
- Acute medicine and senior health

Specialist medicine
- Lymphoedema
- Infection department
- Rheumatology
- Diabetes and endocrinology
- Chest medicine
- Endoscopy and gastroenterology
- Dermatology

Renal, haematology and oncology clinical directorate
- Renal transplantation
- Renal
- Medical oncology
- Clinical haematology
- Palliative care

Cardiovascular clinical directorate
- Cardiology
- Cardiac surgery
- Vascular surgery
- Blood pressure unit
- Thoracic surgery

Community services

Community Adult and Children's directorate

Community Adult Health services
- Community nursing and community wards
- Intermediate care services
- Older people and neuro-therapies
- Day hospitals
- Specialist nursing
- Community learning disabilities
- Elderly rehabilitation in patient wards

Children and family services
- School and special school nursing
- Children's continuing care
- Health visiting
- Child safeguarding team
- Children's therapies and immunisation
- Homeless, refugees and asylum seeker team

Adult and diagnostic services
- Outpatient services
- Minor Injuries Unit
- Diagnostics
- Specialist rehabilitation
- Adult therapies – physiotherapy, dietetics and podiatry
- Integrated sexual health

Offender healthcare
- Primary care
- Substance misuse
- Inpatient care

Where our services are based?

Hospitals

We provide healthcare services at:
St George's Hospital, Queen Mary's Hospital

Therapy centres

- St John's Therapy Centre

Health centres

- Balham Health Centre
- Bridge Lane Health Centre
- Brocklebank Health Centre
- Doddington Health Centre
- Eileen Lecky Clinic
- Joan Bicknell Centre
- Stormont Health Centre
- Tooting Health Clinic
- Tudor Lodge Health Centre
- Westmoor Community Clinic
- Nelson Health Centre

Prisons

- HMP Wandsworth

Community

We also provide services in GP surgeries, schools, nurseries, community centres and in patients' own homes.

Find out more about our services and the clinicians and healthcare professionals who provide them on the services section of our website **www.stgeorges.nhs.uk/services**

Staff friends and family test (FFT)

Staff who would recommend the trust as a place to receive treatment to friends or family

Why is this important?

One of the trust's strategic aims is to be an exemplary employer. To achieve this we must commit time, resources and effort into supporting our staff and making St George's both a great place to receive healthcare and a great place to work. Our staff are core to our success and are well-placed to judge the quality of care we provide to our patients.

How did we do?

In the National NHS Staff Survey staff are asked to state whether *If a friend or relative needed treatment I would be happy with the standard of care provided by my organisation.*

In the 2014 National NHS staff survey, 73 per cent of our staff said that they agreed with this statement. This is higher than the national average (median) for acute trusts of 65 per cent and higher than last year when 68 per cent of staff said that they agreed with this statement.

Staff recommendation of the trust as a place to work or receive treatment

As well as giving an individual score for each question, a score is calculated for a number of key indicators based on the answers to the questions grouped under each indicator. One of these key indicators is staff recommendation of the trust as a place to work or receive care.

On a scale of 1-5, with 5 being the most positive, St George's scored 3.78 compared to 3.67 nationally for acute trusts. Last year our score was 3.73.

This key indicator gives us a top ranking score, for which we compare favourably with other acute trusts in England. This also means that we have maintained our status as one of the top 20 per cent of trusts in the country for staff who would recommend the trust as a place to work or receive treatment.

YEAR	STAFF WHO WOULD RECOMMEND ST GEORGE'S AS A PLACE TO WORK OR RECEIVE TREATMENT (1 BEING POOR, 5 BEING EXCELLENT)
2014/15	3.78
2013/14	3.73
2012/13	3.68
National average for acute trusts (2014/15)	3.67

Friends and family staff survey

A new requirement in 2014 was to conduct the friends and family test with our own workforce.

In quarters one, two and four we gave staff the opportunity to complete the survey, which comprises two questions:

How likely are you to recommend this organisation to friends or family if they needed care or treatment?

How likely are you to recommend this organisation to friends or family as a place to work?

Our scores, by quarter, are listed here:

	WOULD RECOMMEND FOR TREATMENT	WOULD RECOMMEND AS A PLACE TO WORK
Q1	81%	58.5%
Q2	80%	57%
Q4	81%	59%

Our aims

Our workforce is vital to the delivery of the highest quality clinical services, education and research, and will need to evolve to meet future needs. We need to value our staff and ensure they champion the trust's values. Patients have commented that happy staff result in happy patients.

We aim to further improve our score in the staff recommendation of the trust as a place to work or receive care indicator in the National NHS staff survey and maintain our status as one of the top 20 per cent of trusts in the country. We aim to further improve our scores in the Friends and Family staff survey in 2015.

Our 2015/16 workforce strategy action plan sets out a programme of work that will support the trust to respond to the issues raise in the staff survey. These include:

Confidence to raise concerns

The trust is in the top 20 per cent for staff agreeing that they would feel secure about raising concerns about unsafe clinical practice. This is a new question and in the context of the recent national 'Speak up review' likely to be seen as a key indicator. However, this contrasts with ratings in the worse than average category for members of staff witnessing and reporting potentially harmful errors or incidents.

Tackling poor behaviour and bullying

Trust performance has remained steady with 31 per cent of staff saying that they have experienced harassment, bullying or abuse from staff in the past 12 months. The strategy to tackle bullying includes coaching and training for managers dealing with difficult staffing issues, tracking and following up the range of concerns that were raised in the CQC inspection in 2014 and elsewhere, a poster campaign, the development of a service providing listening for members of staff and an opportunity to raise concerns, the bullying and harassment support line, which is run by the staff support service.

Discrimination

The trust position has remained the same with regard to members of staff reporting discrimination. Of greatest concern is that 38 per cent of black and minority members of staff report discrimination as compared to 14 per cent of white members of staff. It is of further concern that 34 per cent of black and minority members of staff report experiencing harassment, bullying or abuse from members of staff in the last 12 months as compared to 29 per cent of white members of staff. St George's is establishing a 'St George's as One' inclusion programme in 2015.

Our workforce strategy explains how we aim to maximise the wellbeing of our staff and their levels of contribution and engagement. You can read the workforce strategy at www.stgeorges.nhs.uk/about/our-strategy/strategies

Listening into Action

We recognise that as well as listening to our patients, it is also important that we listen to our staff and involve them when we try to identify where improvements could and should be made. That's why we are fully on board with the national Listening into Action staff engagement programme.

Listening into Action launched at St George's in March 2013. It is our way of working with and engaging staff at St George's. It's about achieving a fundamental shift in the way we work and lead, putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the trust as a whole. In the process, Listening into Action is adopted and spread as a way of sustaining continuous improvement.

Essentially, Listening into Action is about:

- **engaging all the right people around delivering better outcomes for our patients, our staff and our trust**
- **aligning ideas, effort and expertise behind the patient experience, safety and quality of care**
- **overcoming widespread challenges around staff engagement and morale**
- **developing confidence and capability of our leaders to 'lead through engagement' collaborating across the usual boundaries, and**
- **engendering a sense of collective ownership and pride.**

Listening into Action complements other important projects taking place at the trust, and the change methodologies, systems and experience staff develop and gain through this programme is in many cases used to help achieve changes which are identified by Listening into Action.

We have held Big Conversations in 2013 and 2014. Staff from all departments, levels and roles came together and talked openly about what matters to them, and what changes should be prioritised. We use the feedback from these events to inform our future actions and to support and enable our teams to do the very best for our patients and their families, in a way that makes us proud of our work.

Research

Why is it important?

At St George's, we are committed to innovating and improving the healthcare we offer and a key way we do this is by participating in research. Our clinical staff keep abreast of the latest treatment developments and through clinical trials, patients are offered new drugs and devices and better clinical care evolves. The key reason for our participation in clinical research is to develop new and improved clinical treatments for our patients and to realise better ways to manage illness, thereby ultimately improving the health of our local community.

St George's is a collaborating site with Genomics England for the '100,000 Genomes Project'. Initially the focus will be on rare disease, cancer and infectious disease. The project will allow researchers to work together to build and share new knowledge about the influence of genes on health and disease that may be translated into new diagnostic and treatment options for patients.

St George's, in its partnership with St George's, University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams are collaborating with scientists to investigate the causes of range of diseases, to develop better ways of diagnosis and tailored treatments. St George's has been heavily involved in the development of new vaccines, on potential new treatments for vascular dementia and on better diagnostic for a range of infectious pathogens. This highlights the importance of the relationship with the university to improve both academic knowledge and clinical practice.

We also want to thank the local community for participating in research. Patients who participate in research may derive an individual benefit from, for example, new treatment opportunities. However, support has been much wider with sometimes less clear individual benefits. In this last year, nearly 1,600 healthy teenage volunteers in our local schools have given throat swabs and information about themselves to help us understand meningococcal infection, one of the leading causes of meningitis. Our GP healthcare partners have also offered great support, discussing trial opportunities with and giving information to patients.

Our strong relationship with the pharmaceutical industry enables our clinical staff to keep abreast of the latest developments and our patients to have access to the newest treatments within clinical trials. This includes access to new drug treatment in a range of cancers, hepatitis B and C, epilepsy, cardiovascular disease, Parkinson's disease, Meniere's disease, multiple sclerosis, Crohn's disease, ulcerative colitis and stroke.

In 2014, the trust invested funds to allow clinicians (doctors, nurses and other health professionals) to have time away from clinical duties to develop their research ideas into research protocols. With clinical duties covered by colleagues, these individuals are able to focus for a short period of time (generally six months) to develop new ideas and treatments for patients at St George's. To be successful, these proposals will be externally reviewed and we hope will be funded by research-grant awarding bodies.

Our outcomes

I. Participation:

One of the key ways of offering new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR), which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. These studies are adopted onto the NIHR portfolio. In the calendar year 2014, there were 194 NIHR adopted trials open and recruiting in St

George's, with 9,021 patients taking part. This was an increase from the 2013 where 3,994 patients took part in 182 research trials.

This is an astonishing increase but is down to several unusual trials that are looking at new diagnostic techniques and require many samples to check the outcomes. We would hope to continue to improve, but may not be able to meet this level next year.

The number of patients receiving relevant health services provided or sub-contracted by St George's in 2014/15 that were recruited during that period to participate in research approved by the National Institute of Health Research (NIHR) is 10, 574.

II. Approvals:

In 2014, the research office approved 187 new studies to be performed at St George's, an increase from 164 in 2013. These range from clinical trials of medicinal products (new drugs) and medical devices, through to service and patient satisfaction studies. Around 60% of these are adopted on the NIHR portfolio, up from 30% in 2013. Non-adopted studies include 'Proof of Concept' studies, in which our researchers and clinicians are gathering evidence that may develop into larger adopted trials, student studies and trials sponsored by commercial companies.

The approval time targets changed in April 2014. Previously, studies were expected to be approved within 30 days, but since April, we are now expected to approve within 15 days. Before April, 88% were approved within 30 days, but there has been a drop since April in the 15 day target, to 62%. Overall, we have approved 69% in the given timeline.

This is a focus for improvement in 2015.

III. Trials starting recruitment

In our most complex trials, we endeavour to get the study approved and the first patients recruited within 70 days of submission to the research office. This is a new national metric and we have seen a steady improvement in 2014 from 40.3% in Dec 2013 to 76.1% of trials up to September 2014, and we are hoping to achieve 80% when the NIHR publishes the figure for all trial approved in 2014.

We intend to continue improving this measure through 2015.

IV. Ensuring compliance with 'Good Clinical Practice[1]' guidelines for research

All trials require one institution or company to have the legal responsibility to ensure that the trial is run safely and gathers good quality information in order to answer the research question e.g. *does a new drug lead to better outcomes compared to the standard treatment?* When we are the responsible institution (sponsor) all our trials are closely monitored by a team from the research office. When we host studies that are sponsored by other organisations or companies, we also undertake our own system of review (audit), in order to ensure best practice and optimal safety for our patients. In 2014, we aimed to audit 10% of all active trials (19 trials), and we actually reviewed 21 studies to ensure that our staff are meeting all of the regulatory and compliance requirements, and patient safety is maintained.

Our aims in 2015

I. Increase participation

We intend to maintain and improve upon our patient participation rates in NIHR adopted trials at 2013 levels, understanding that 2014 was an unusual year. We hope to recruit 5,000 patients or more in 2015.

We intend to ensure that patients are made aware of the research opportunities at the trust. In order to do this we will participate in the International Clinical Trials Day on 20th May.

We will also be running research focused articles in the St George's gazette, which is available to patients and the local community.

II. Approvals

In 2015, we intend that at least 80% of our trials are approved by the Joint Research and Enterprise Office (JREO) within 15 days.

We have already noticed an increase in the number of proposed studies, and we intend to meet the challenge of approving more studies in a shorter time.

III. Trials starting recruitment

We intend to continue increasing the number of trials that get up and running quickly so that the trials can be successful. We hope to achieve 80% or relevant trials recruiting their first patient within 70 days.

IV. Ensuring quality

We will continue to review 10 per cent of all active research studies each year to provide assurance of the safety and quality of studies undertaken here.

We will continue to provide our clinicians with the opportunity to take time to develop their ideas to write successful grant applications. We will allow clinicians time to recruit patients to trials in their daily roles and support them with research staff.

[1]https://www.gov.uk/good-clinical-practice-for-clinical-trials

Participation in clinical audits

During 2014/15, 37 national clinical audits and five national confidential enquiries covered NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period St George's participated in 97.3 per cent of national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits which we were eligible to participate in.

The national clinical audits and national confidential enquiries that St George's was eligible to participate in during 2014/15 are listed in Appendix A alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports from the 28 national clinical audits were reviewed by trust board in 2014/15. A summary of the actions agreed in response to these audits is given in Appendix B.

The reports of 19 local clinical audits were reviewed by St George's in 2014/15. A summary of the actions agreed is given in Appendix C.

Use of CQUIN payment framework

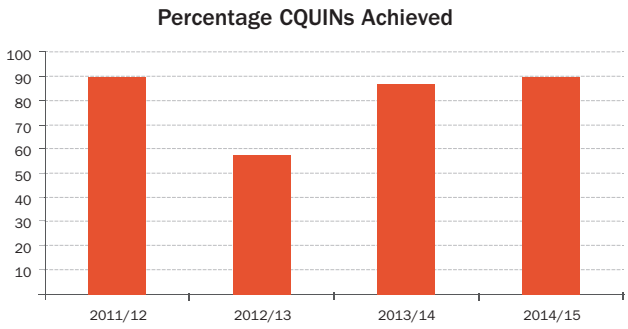
A proportion of our income in 2014/15 was conditional on meeting quality improvement and innovation goals. These are objectives agreed between the trust and its commissioners and clinical commissioning groups, through the Commissioning for Quality and Innovation (CQUIN).

They key aim of CQUINs is to support a shift towards a vision where quality is the organising principle. The framework therefore helps ensure that quality is always part of discussions between commissioners and healthcare providers everywhere.

We achieved 90 per cent overall performance against the 33 CQUINs we agreed with our commissioners for quarters one to three in 2014/15 and envisage to do so for Q4. Last year we achieved 87 per cent of our CQUINs.

Following commissioner review and approval the forecasted financial achievement will be in excess of £10.5m.

Further details of the agreed goals for 2014/15 can be found in a dashboard in appendix D.



Statement from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It regulates care provided by the NHS, local authorities, private companies and voluntary organisations that provide regulated activities under the Health and Social Care Act 2008.

The CQC registers, and therefore licenses, all NHS trusts. It monitors trusts to make sure they continue to meet very high standards of quality and safety. If services drop below the CQC's essential standards it can require action to be taken, impose fines, issue public warnings, or launch investigations. In extreme cases it has the power to close services down.

St George's University Hospitals NHS Foundation Trust is registered with the CQC and is licensed to provide services from each of its locations. The trust has no conditions placed on it and the CQC has not taken any enforcement action against the trust in 2014/15.

In May 2013, Professor Mike Richards was appointed as Chief Inspector of Hospitals and under his leadership, a new style CQC inspection and a new framework of standards has been developed which focus upon five domains:

- Are services **safe?** *Are people protected from abuse and avoidable harm?*
- Are services **effective?** *Does people's care and treatment achieve good outcomes and promote a good quality of life, and is it evidence based where possible?*
- Are services **caring?** *Do staff involve and treat people with compassion, kindness, dignity and respect?*
- Are services **responsive**? *Are services organised so that they meet people's needs?*
- Are services **well led**? *Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?*

The CQC rating system has four categories – **outstanding**, **good**, **requires** i**mprovement** or **inadequate**. NHS trusts are given an overall rating and a range of services within the trust are also given one of these four ratings.

How did we do?

In February 2014 the trust was subject to a full inspection using the new CQC inspection methodology against the five domains. The CQC inspected the treatment and care provided at St George's Hospital, Queen Mary's Hospital, St John's Therapy Centre and selected community services provided from other health centres in Wandsworth.

The CQC found the overall standard of care to be **good** across all sites and has awarded the trust an overall **good** rating, with some aspects of care rated as **outstanding**. St George's and Queen Mary's Hospitals both received **good** overall ratings.

The CQC rated 62 specific standards. Out of these, **four were rated outstanding**, **50 were rated good** and **eight were in the 'requires improvement' category**. None of our services were judged inadequate. The full breakdown of how our hospitals performed against each of the five CQC essential domains is available over the coming pages.

CQC statement on St George's Hospital

SERVICE	CQC ESSENTIAL DOMAIN – SAFE	CQC ESSENTIAL DOMAIN – EFFECTIVE	CQC ESSENTIAL DOMAIN – CARING	CQC ESSENTIAL DOMAIN – RESPONSIVE	CQC ESSENTIAL DOMAIN – WELL LED	OVERALL
A&E	Good	Not assessed	Good	Good	Good	Good
Medical care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
ITU/CCU	Outstanding	Good	Good	Good	Outstanding	Outstanding
Maternity	Good	Good	Outstanding	Good	Good	Good
Children & Young People	Good	Good	Good	Good	Good	Good
End of Life Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not assessed	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

CQC statement on Queen Mary's Hospital

SERVICE	CQC ESSENTIAL DOMAIN – SAFE	CQC ESSENTIAL DOMAIN – EFFECTIVE	CQC ESSENTIAL DOMAIN – CARING	CQC ESSENTIAL DOMAIN – RESPONSIVE	CQC ESSENTIAL DOMAIN – WELL LED	OVERALL
A&E (Minor Injuries Unit)	Requires Improvement	Not able to rate	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not able to rate	Good	Requires Improvement	Good	Good
Community Inpatient Services	Good	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time
Overall	Requires Improvement	Good	Good	Good	Good	Good

The audit of our community services at Queen Mary's Hospital, St John's Therapy Centre and other health centres was a pilot to help the CQC develop the methodology for auditing community services in the future. The CQC is not yet rating community services so no rating was given for the community inpatient service at Queen Mary's or for the services based at St John's and our other health centres.

The CQC reported its findings back to us at a quality summit that included representatives from:

- St George's University Hospitals NHS Foundation Trust
- The CQC
- The Trust Development Authority (TDA)
- NHS England
- Wandsworth Council
- Healthwatch Wandsworth
- Wandsworth CCG
- Merton CCG

In its report on the trust, the CQC highlighted numerous examples of commendable practice, including:

- outstanding maternity care underpinned by information provided to women and partners and robust midwifery staffing levels with excellent access to specialist midwives
- exceptional end of life care demonstrated within the maternity department
- outstanding leadership of intensive care and high dependency units with open and effective team working and a priority given to dissemination of information, research and training
- excellent multidisciplinary working within and across community and acute teams
- the functioning of the hyper acute stroke unit, short term reablement and rehabilitation service
- the well led, integrated working and calm environment within A&E

- **multi-professional team working in neuro theatres**
- **systems developed by the trust to promote the safety of children, young people and families**
- **an evident culture of positive learning from medicine administration errors**
- **development and use of DVDs to engage staff with ongoing practice improvements.**

As well as highlighting some aspects of care which required improvement the CQC also asked that we take action to ensure staff awareness and implementation of the Mental Capacity Act at Queen Mary's Hospital. The CQC noted that most staff had attended or completed training on safeguarding adults and that there was appropriate specialist input through the trust's safeguarding lead and two specialist learning disability nurses. However, varying levels of understanding of the Mental Capacity Act were identified.

Since the February inspection the trust has taken action to address the two issues identified by the CQC. A formal action plan was developed and approved by the trust board before being shared with the CQC. The plan set out how the trust would ensure improvements in the availability of medical records in outpatient clinics, it also set out the measures we would take to ensure that trust staff at Queen Mary's Hospital (QMH) have a good level of understanding of the Mental Capacity Act in order to deliver safe, responsive and effective care.

There has been an improvement project in the corporate outpatient department and better availability of medical records was just one of the improvements made. This improvement is monitored on an ongoing basis.

The trust designed and delivered a tailored training programme to all staff at QMH around the implementation of the Mental Capacity Act and all staff have now attended and have evaluated the training and a case note audit showed practice had improved.

Progress on the action plan has been presented to the trust's commissioners and the CQC on a quarterly basis and both commissioners and the CQC have indicated that they are assured good progress has been made to improve quality of care where needed.

Data quality

The collection of data is vital to the decision making process of any organisation, particularly NHS trusts like St George's. It forms the basis for meaningful planning and helps to alert us to any unexpected trends that could affect the quality of our services.

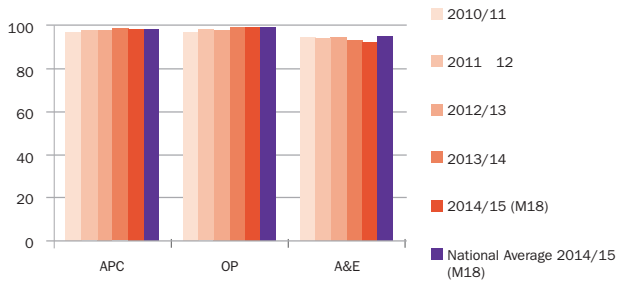
Most data is gathered as part of the everyday activity of frontline and support staff who work throughout the trust in a huge variety of settings. It is important that we accurately capture and record the care we provide and the information in this report aims to demonstrate how well we are doing this. We have been working closely with our IT suppliers this year to increase the robustness of our data capture and processing.

St George's submitted records during 2014 for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

HES is the national statistical data warehouse of the care provided by English NHS hospitals and for NHS hospital patients treated elsewhere. The body provides a data source for a wide range of healthcare analyses of the NHS, government and many other organisations and individuals.

The percentage of records in the published data which included the patient's valid NHS number was:

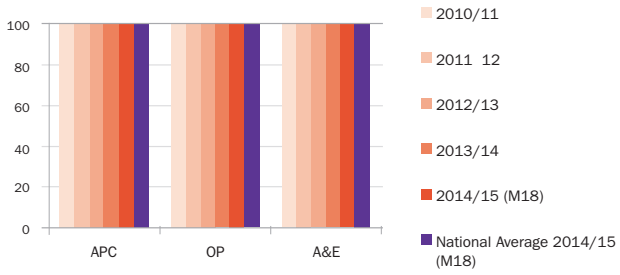
VALID NHS NO	APC	OP	A&E
2014/15 (M8)	98.6	99.4	92.7
2013/14	98.7	99.4	93.4
2012/13	98.3	99	95.1
2011/12	97.7	98.6	94.5
2010/11	97.3	98.6	94.4
National Average 2014/15 (M8)	99.1	99.3	95.1



Our NHS Number completeness remains good, but is still fractionally behind the national average for admitted care and A&E. We have a data quality improvement strategy which we have developed with our commissioners that details planned improvements in the way our Patient Administration System (PAS), Cerner, accesses the national Patient Demographic Service (PDS) that should see these numbers improve next year.

The percentage of records in the published data which included the patient's valid general medical practice was:

RECORDS WITH VALID GP NUMBER	ADMITTED CARE (PER CENT)	OUTPATIENT CARE (PER CENT)	A&E (PER CENT)
2014/15 (M8)	100	100	100
2013/14	100	100	99.9
2012/13	100	100	100
2011/12	100	100	100
2010/11	100	100	100
National Average 2014/15 (M8)	99.9	99.9	99.2



Note: The data quality figures shown above are correct as at month 8 (April 2014 to November 2014 data). This is the most recent data available.

We continue to achieve exemplary scores in registered GP practice recording, where we perform better than the national average across admitted, outpatient and A&E services.

Information governance

Information governance is the term used to describe the standards and processes for ensuring that organisations comply with the laws, regulations and best practices in handling and dealing with information. Information governance ensures necessary safeguards for, and appropriate use of, patient, staff and business information.

The key objective of information governance is to maintain high standards of information handling by ensuring that information used by the organisation is:

- **Held securely and confidentially**
- **Obtained fairly and efficiently**
- **Recorded accurately and reliably**
- **Used effectively and ethically**
- **Shared appropriately and lawfully.**

We have an ongoing information governance programme, dealing with all aspects of confidentiality, integrity and the security of information.

Annual information governance training is mandatory for all staff, which ensures that everyone is aware of their responsibility for managing information in the correct way. An internal audit conducted in 2014/15 gave the trust 'reasonable' assurance that the trust is managing information appropriately and that staff are aware of their responsibilities.

Our patient administration system increased both the security and accuracy of information at the trust. All staff accessing the system use a secure and strictly authenticated smartcard which defines what they are permitted to access in the system. Virtual desktops are now in use across two thirds of the trust, increasing the security and availability of our systems.

The trust has introduced a new electronic system for managing referrals improving both the accuracy and allocation of appointments. The trust has begun the implementation of an electronic document scanning project, moving away from a dependence on paper records.

How did we do?

Each year we submit scores and provide evidence to the Department of Health (DH) by using the NHS Information Governance Toolkit. The toolkit is an online system which allows NHS organisations and partners to assess themselves against DH information governance policies and standards. It also allows members of the public to view each organisation's score and compare them.

The trust's information governance assessment report overall score for 2014/2015 was 77 per cent and was graded green, or 'satisfactory' according to the criteria set nationally. This is the highest grading possible, and can only be awarded by achieving an attainment Level 2 on every requirement in the NHS Information Governance Toolkit.

The information quality and records management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

You can explore the information governance scores for St George's, and other organisations, at **https://www.igt.hscic.gov.uk**. St George's is listed as an acute trust and our organisation code is RJ7.

YEAR	INFORMATION GOVERNANCE ASSESSMENT SCORE (PER CENT)	GRADE
2014/15	77	Green
2013/14	79	Green
2012/13	79	Green
2011/12	77	Green

Clinical coding error rate

Why is this important?

Clinical coding is the translation of medical terminology written down by a healthcare professional. It describes the patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, using a coded format which is nationally and internationally recognised.

The system uses healthcare resource group (HRG) codes, which identify procedures or diagnoses that have been judged to consume a similar level of resource. For example, there are a number of different knee-related procedures that all require similar levels of resource, so they may all be assigned to one HRG code.

Therefore, for every consultant episode (a period of care under one consultant) and hospital spell (a period of care from admission to discharge), each patient is assigned an HRG code.

HRG codes consist of five characters: two letters followed by two numbers and a final letter. The first two letters correspond to body areas or body systems, identifying the area of clinical care that the HRG falls within. The final letter identifies the level of complexity associated with the HRG.

Healthcare providers are paid based on the HRG coding system. This is known as Payment by Results (PbR). The aim of PbR is to provide a transparent, rules-based system for paying hospitals for the work they do. It is very important that we code patient care accurately, so that we are paid appropriately for the complexity of the care we provide.

How did we do?

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

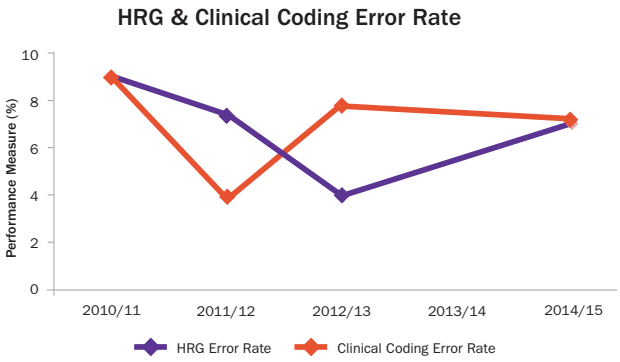
We were last subjected to the PbR clinical coding audit in 2012/13, when we were in the best performing 25 per cent of trusts in the country.

AUDIT COMMISSION (ALL SERVICES)	ERROR RATE (%)	ERROR RATE (%) INCLUDING ALL ERRORS
Primary diagnoses incorrect	6.5	6.5
Secondary diagnoses incorrect	8.6	9.9
Primary procedures incorrect	1.3	1.3
Secondary procedures incorrect	8.3	14.1

SUBCHAPTER	ADMITTED PATIENT SPELLS	% OF EPISODES CHANGING HRG
AA	100	14
LA	100	0
Total	200	7
Secondary procedures incorrect	8.3	14.1

HRG ERROR RATE	PERFORMANCE MEASURE (%)
St George's 2014/15	7
St George's 2013/14	#N/A
St George's 2012/13	4
St George's 2011/12	7.4
St George's 2010/11	9

CLINICAL CODING ERROR RATE	PERFORMANCE MEASURE (%)	INC ERRORS
St George's 2014/15	7.2	8.7
St George's 2013/14	#N/A	
St George's 2012/13	7.8	
St George's 2011/12	3.9	
St George's 2010/11	9	



Note: The results should not be extrapolated further than the actual sample audited. HRG subchapters AA (Nervous System Procedures and Disorders) and LA (Renal Procedures and Disorders) were reviewed within the sample.

Improving patient safety

Reducing medication errors

Over the years we have worked hard to develop and maintain our strong reporting culture. Following their audit of the trust in February 2014, the CQC reported that there is an evident culture of positive learning from medicine administration errors at St George's.

This year the National Reporting and Learning System have reported that St George's medication error reporting is higher than the national benchmark for reporting medication incidents. Last year we reported 1,574, reflecting a good safety culture at the trust. Of these incidents, 92 per cent resulted in no harm, 5 per cent in low harm and 3 per cent in moderate harm. There were no medication errors that resulted in severe harm to patients. The most common types of error are omissions and delays to administer medication and administering the wrong dose of medication.

No harm – 93 per cent

Low harm – 5 per cent

Moderate harm – 2 per cent

Severe harm – 0 per cent

Medication incident reporting is up over a third over the previous year, but the degree of harm is unchanged.

We have an intensive medication safety teaching programme for clinical staff and our pharmacy team manage a comprehensive audit programme, including auditing prescribing accuracy, medicines reconciliation, antibiotic point prevalence, medicine handling and medication safety. The pharmacy medication safety team also co-ordinate medication safety monitoring visits to clinical areas to monitor medication safety issues.

During 2014/15 medication safety visits have been extended to community services and non-ward areas including radiology and endoscopy.

Reducing patient falls in the community and whilst under the care of the hospital

Why is this important?

People aged over 75 suffering falls is one of the main causes of emergency admissions to hospitals. Incidents of falls within healthcare environments equally contribute to the length of stay of complex patients, as well as presenting a risk to both patients and the organisation.

Unfortunately, we will never be able to completely eliminate the risk of our patients falling. We know that even in the community one in three people over the age of 65 will fall, rising to one in two for over 80 year olds. However we also know that falling is not an inevitable part of ageing and that reversible risk factors can be addressed to reduce the risk of falling and fracturing.

The inpatient hospital population has some of the similar characteristics as the community dwelling population, and in addition there are the additional risks around acute illness and sudden change in environment which presents further challenges for those impaired by cognition/vision etc. Following the acute phase of management the patient begins their rehabilitation. An inherent part of patient rehabilitation is risk taking, which must balance the management of risk with the need to facilitate progress and enable goal attainment. We try to make sure that a multifactorial falls and bone health risk assessment is completed and that a care plan to reduce the individual's risk factors is implemented, providing a quality patient experience within a safe environment.

How did we do?

Hospital inpatient services:

We have developed an electronic multifactorial falls risk assessment in line with the NICE falls guidelines and in line with the Wandsworth community based falls and bone health risk profile –to enable an exchange of meaningful assessment information for comparison of patient status and facilitate a smooth exchange of discharge information. We have developed and implemented a bed rails risk assessment tool which must be completed for all adult inpatients on admission to hospital. We have developed patient information leaflets on falls prevention and the use of bed rails. We have been running monthly patient simulation study days to promote best clinical practice for falls and other harms.

In some clinical areas we have trialled bed and chair sensors which can be used as an adjunct to falls prevention in some patients. We are looking at exploring other technology which may help in falls prevention.

There has been no significant reduction in the number of inpatient falls across the trust this year.

Community based services:

The integrated falls and bone health service (IFS&BH) is predominantly a prevention focused service that dovetails with other reactive community services. A major part of this team's work has been around ensuring that a falls and bone health risk profile is completed irrespective of the service that the patient accesses so that the prevention of falls and fractures is seen as a core role for all staff. The risk profile has been modified to fit with the existing services. It is a standard part of the service provision for the following teams:

- **IFS&BH**
- **CAHS (community adult health services)**
- **Community neuro team**
- **Brysson Whyte Rehabilitation Unit**
- **Day Hospital at St John's Therapy Centre**
- **Community nursing, community matrons and specialist nursing.**

The IFS&BH service provides community based multifactorial assessments with actions plans agreed with the patient to address the reversible risk factors identified. Part of the service provision is the running of 25 community based exercise groups a week – six of these with transport to ensure a fair and accessible service to all. The joined up approach across community services and with the acute service along with the expansion of the IFS&BH team and service provision has ensured that there is greater capacity to provide specialist intervention for the populations at risk of fall and fractures.

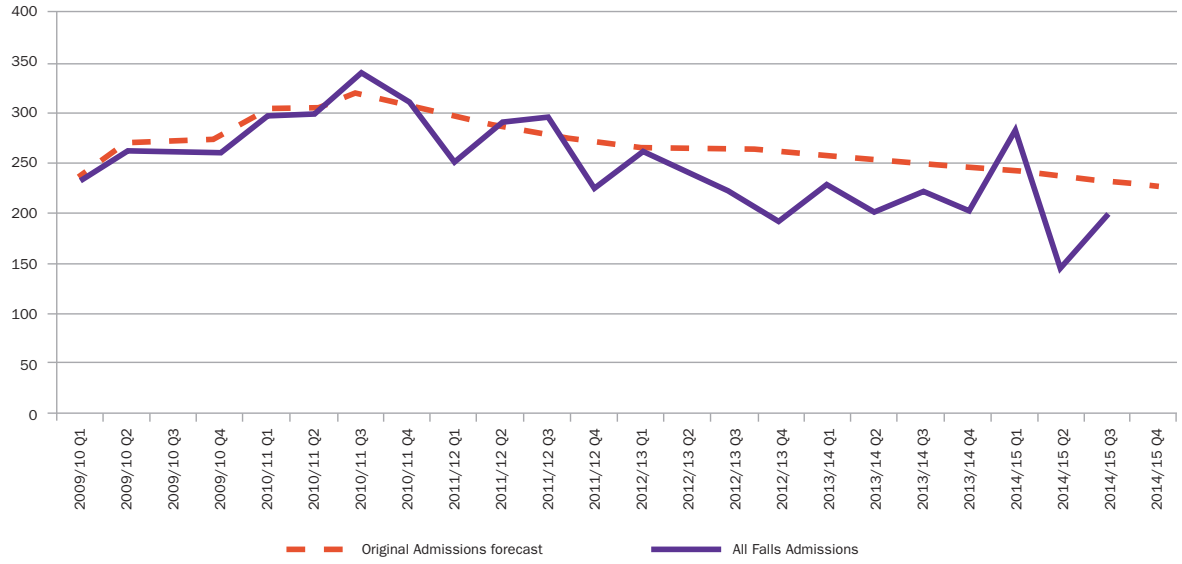
2012 saw the launch of the Bone Boost programme to provide a care pathway for people with osteoporosis or osteopenia to reduce the incidence of fragility fracture in Wandsworth. In 2014 the service was awarded the SLMC (South London Membership Council) Recognition Award for outstanding contribution to the community. Watch a video about the Bone Boost service and the impact it has had on the patients who have been referred to it at **www.stgeorges.nhs.uk/services/senior-health/bone-boost**

Building on the success of joint working with the acute based osteoporosis service further development work has continued to enable an acute based service and a community service to morph into a truly integrated service – improving the seamless care that these patients receive. There are further plans this year to build on this work for the most frail populations of patients with osteoporosis to ensure that services are delivered in a timely fashion in the right place for this group.

Our aims

We aim to reduce the current rate of reported falls during an inpatient episode and continue to reduce the admissions for falls patients in Wandsworth in 2015/16. We will continue to identify the trends and themes and implement targeted action plans through structured evaluation and benchmark ourselves against other organisations when possible.

NHS Wandsworth Non-elective Emergency Admissions
(Patients 65 and over with a fall coded (W00 - W19) in ICD 1 to 5. Source data SUS



Patient safety thermometer

Making sure that patients do not suffer avoidable harm is a key focus for the trust and one of the priority areas in our "Sign up to Safety" plans. This year we have consolidated our use of the national safety thermometer across community and inpatient services.

The safety thermometer is a quick and simple point-of-care tool for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care.

Developed by the NHS for the NHS, the safety thermometer collects data on high risk areas including falls, pressure ulcers, urinary catheter related infections and blood clots. The safety thermometer allows us to merge patient safety data across all the teams and wards in the trust, with the built-in analysis charting functions allowing us see the results straight away so we always have a clear picture of what is happening in any service at any time.

We now have regular and reliable data for all of the high risk areas listed above across all inpatient and community services. All data recorded on the safety thermometer is submitted to the Health & Social Care Information Centre with monthly national reports developed and published at **www.hscic.gov.uk/thermometer** Teams can then be given feedback on the percentage of their patients who are "harm free" which gives them a powerful tool for improvement.

The monthly data shows that 94.4% of our patients were free of the harms being measured in this way. This compares with a national benchmark of 93.8 per cent.

A new patient safety thermometer for medication safety has been piloted on some of our wards and we are considering use of further pilots in paediatric and maternity services.

Implementing the early warning score indicator at HMP Wandsworth

Why is this important?

We provide all healthcare and substance misuse services to the 1,665 offenders at HMP Wandsworth, the largest prison in the UK. The Jones Unit is a six bedded inpatient facility in the prison. The unit is a step down from a hospital ward and is used for offenders whose condition needs closer monitoring than can be provided on an outpatient basis whilst they stay in their cell. Prisoners requiring isolation are also located on the Jones unit. The unit reduces the need for unwell offenders to be transferred to St George's Hospital, freeing up beds in the hospital for other patients.

The early warning score indicator is a simple tool in a patient's observation notes used by medical and nursing staff to determine the severity of illness. A number of observations are regularly recorded on the chart which allows any deterioration to be quickly identified. The observations recorded are:

- Heart rate
- Respiratory rate
- Blood pressure
- Level of consciousness
- Oxygen saturations
- Temperature.

The early warning score indicator has been used at St George's and Queen Mary's Hospital for a number of years and our aim for 2013/14 was to introduce the early warning score indicator to offender healthcare services.

How did we do?

The early waning score indicator has been successfully implemented at HMP Wandsworth with all patient observation charts on The Jones Unit including the indicator. All offender healthcare service staff have been trained on use of the early warning scare indicator meaning that any deterioration is identified quickly.

Our aims

The national Early Warning Score (nEWS) has been implemented on the Jones Unit. Further work is required in 2015/16 to maintain consistent approach in the use and recording of nEWS. Currently, nEWS is recorded in paper format. In 2015/16 exploratory work will be undertaken to devise an electronic template so that the nEWS is integral to clinical information system and to patients' medical record.

Mortality

Why is this important?

The summary hospital level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates. It shows whether the number of deaths linked to an organisation is more or less than would be expected, when considered in light of average national mortality figures, given the characteristics of the patients treated there. It also shows whether that difference is statistically significant.

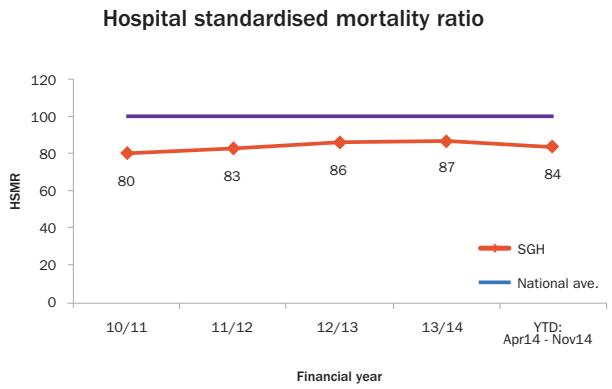
Our outcomes

Our SHMI continues to be amongst the lowest in country, with our mortality categorised as lower than expected for two consecutive years. The table below summarises the quarterly publications for this period.

PUBLICATION DATE	REPORTING PERIOD	RATIO	BANDING
April 2014	October 2012 – September 2013	0.78	Lower than expected
July 2014	January 2013 to December 2013	0.80	Lower than expected
October 2014	April 2013 to March 2014	0.81	Lower than expected
January 2015	July 2013 – June 2014	0.84	Lower than expected

Source: Health and Social Care Information Centre

At St George's we continue to use the hospital Standardised Mortality Ratio (HSMR) in addition to the SHMI to monitor mortality. The chart below shows our performance over the last few years. With the HSMR, if our mortality matched the expected rate our score would be 100. The HSMR indicates that St George's mortality is consistently significantly better than expected.



Source: Dr Foster Intelligence

These data are reviewed by the trust's mortality monitoring committee which meets on a monthly basis. The group, which is chaired by the associate medical director for governance and has members from across the Trust also considers mortality data at diagnosis and procedure level and reviews all deaths in hospital following an elective admission. By examining this range of data we are able to scrutinise our outcomes and the care we provide to patients. Where there are lessons to be learnt these are identified and acted upon and where best practice is observed this is acknowledged and shared.

Palliative care coding

As it includes all deaths the SHMI makes no adjustment for palliative care. The Health and Social Care Information Centre publishes contextual indicators to support interpretation of the SHMI, one of which is 'the percentage of deaths with palliative care coding'. This presents crude percentage rates of deaths that are coded with palliative care either in diagnosis or treatment fields. The data displayed below shows the percentage of deaths with palliative care coding for the trust compared to the national average.

PUBLICATION DATE	REPORTING PERIOD	ST GEORGE'S	NATIONAL
April 2014	October 2012 – September 2013	21.0%	20.9%
July 2014	January 2013 to December 2013	23.6%	22.0%
October 2014	April 2013 to March 2014	26.2%	23.6%
January 2015	July 2013 – June 2014	27.6%	24.6%

Source: Health and Social Care Information Centre

Our aims

As previously our aim for the coming year is to maintain our strong performance and consistently achieve a mortality ratio which is lower than expected. We will achieve this by continuing and expanding our scrutiny of deaths and taking action as necessary.

Assessing risk of VTE in admitted patients

Why is this important?

Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein, which can cause substantial long term health problems.

Risk assessments for VTE ensure that we intervene with preventative measures at the earliest possible time according to the needs of each patient. It also helps us to identify any instances of deep vein thrombosis or pulmonary embolus occurring within 90 days of admission so that we can investigate and learn how to avoid these in the future.

The focus on this condition has helped to improve practice and ensure that our patients are treated safely.

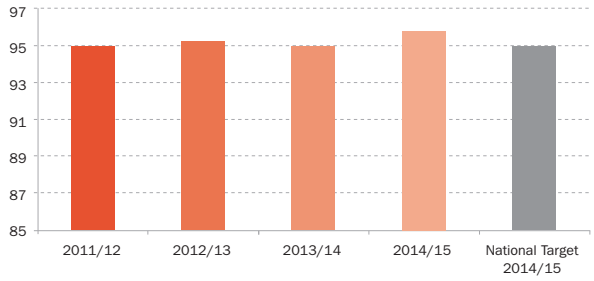
How did we do?

All trusts across the country need to report the number of documented VTE risk assessments being conducted on admission as a proportion of the total number of hospital admissions.

We also have to report the proportion of those cases where there is a documented risk assessment that appropriate thromboprophylaxis has been prescribed.

110,817 patients were admitted at St George's and Queen Mary's Hospitals between April and February 2014/15. 106,218 of these were documented on their discharge summary as being given VTE risk assessments, which is 95.8 per cent. The national target for VTE risk assessments is 95 per cent. In 2013/14 we documented risk assessments for 95 per cent of 116,256 patients.

Percentage Patients Risk Assessed for VTE



Root cause analysis of VTE cases at St George's and Queen Mary's Hospitals

Following on from the CQUIN last year root cause analysis continues to be carried out in cases identified as hospital acquired thrombosis. We have identified 98 cases which have had their index admission at St George's. In those who had previously been admitted to another hospital, we have notified those hospitals of the case. All 98 cases at St George's, have been notified to the admitting consultant and to the care group and divisional leads.

Root cause analysis has been completed in 78 (79.6 per cent) of these cases. This exceeds the national target of 75 per cent. Results show that risk assessment was carried out in 95.8 per cent of patients and appropriate prophylaxis given in 65.9 per cent of cases. Reasons for inadequate prophylaxis included failing to record the reasons for prophylaxis doses not being given, not escalating the dose for patients who weighed more than 100kg, and failure to reassess patients who were at high risk of bleeding on admission. These findings have been presented at the specialties' governance and care group meetings and actions to improve practice have been implemented

In 2015/16 year the VTE prevention programme will continue to be included as a key performance indicator for the trust.

Our aims

VTE prevention and treatment is a top clinical priority for St George's. We are amongst the highest performing trusts in the country for VTE prevention, but we are working hard to make further improvements.

To help us further improve the number of patients risk assessed and the number of patients given appropriate thromboprophylaxis we will continue our programme of training, education and feedback across the trust. Basic VTE training has been added to the trust's mandatory training programme that all staff have to complete every year.

To ensure that all new staff are aware of the importance of VTE risk assessments, we have made VTE awareness part of the staff induction programme that all staff have to complete before starting work with us, and have developed specialist VTE training programmes for junior doctors. Our clinical divisions now have named VTE leads, and we have recruited junior doctor and physician associate VTE champions, new roles to further raise awareness of the important of VTE prevention amongst medical staff.

We have also invested extra resources into extra consultant time to be dedicated to VTE risk assessments and teaching, and have a specialist VTE nurse supporting assessments, teaching, auditing and awareness across the trust.

Our performance against both of these indicators will be continue to reported on a monthly basis at divisional governance meetings, with divisional VTE leads helping to maintain awareness of the importance of VTE assessments across all of our wards.

To further increase the profile of VTE prevention we have implemented the national Safety Thermometer which looks each month at high risk areas including VTE, falls, pressure ulcers, urinary catheter related infections and blood clots, and have introduced a harm free care study day for nursing and midwifery staff which has VTE prevention as one of the modules.

Infection control

Why is this important?

The prevention and control of healthcare acquired infections at St George's is a top priority. Our aim is to make our facilities as clean and safe for patients as possible. Alongside the cleanliness of our wards, we also continue to focus on our programme of comprehensive training for staff, stringent hand hygiene and careful use of antibiotics.

We use an array of measures to stop the spread of infection to patients. Our infection control team, made up of doctors and nurses, works around the clock, monitoring infections and providing ward staff with advice on how to prevent, treat and contain the spread of infection to patients.

What is C.difficile?

Clostridium difficile (C.difficile) is a bacteria that can cause mild to severe diarrhoea and inflammation of the bowel. C.difficile infection can be prevented by a range of measures, including good hand hygiene, careful use of antibiotics and thorough environmental cleaning. By monitoring the prevalence of infections acquired in hospital, we can introduce better measures to reduce the risk of infection for all of our patients.

C.difficile is present naturally in the gut of around three per cent of adults and 66 per cent of children. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C.difficile bacteria can multiply and cause symptoms such as diarrhoea and fever.

As C.difficile infections are often caused by antibiotics, most cases usually happen in a healthcare environment, such as a hospital or care home. Both appropriate and inappropriate antibiotic use can cause C.difficile infection and there is always a balance of risk in treating patients with antibiotics. A strong antimicrobial stewardship program is important to ensure appropriate antibiotic usage only. Transmission can occur from patient to patient however with good modern infection control practices this is not common, although in the past it was far more common. Older people are most at risk from infection, with the majority of cases (80 per cent) occurring in people over 65.

Most people with a C.difficile infection make a full recovery. However, in rare case the infection can be protracted and occasionally fatal.

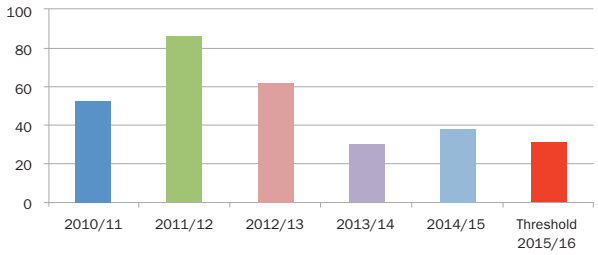
Our C.difficile outcomes

37 patients acquired C.difficile whilst under our care during 2014/15. This is an increase on the previous year although we achieved our nationally agreed threshold of 40. It was agreed with the local commissioning support unit that of the 30 cases reviewed 23 cases were unavoidable

(77 per cent) and seven cases there was some element of lapse of care (23 per cent).

YEAR	NUMBER OF PATIENTS – ACQUIRED *C.DIFFICILE*
2014/15	37
2013/14	30
2012/13	62
2011/12	86
2010/11	52
Threshold 2015/16	31

Number of patients - acquired C.difficile



Our aim

Our 2015/16 target is to prevent all avoidable C.difficile infections and acquire no more than our nationally agreed threshold 31 cases of C.difficile

Rate of patient safety incidents and percentage resulting in severe harm or death

Why is this important?

Modern healthcare is increasingly complex and occasionally things go wrong, even with the best practices and procedures in place.

An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. The rate of reported patient safety incidents (unintended or unexpected incidents which could have led, or did lead, to harm for one or more patients receiving NHS healthcare) is expected to increase as a reflection of a positive patient safety culture.

This view is supported by the National Patient Safety Agency who state “organisations that report more incidents usually have a better and more effective safety culture. You can’t learn and improve if you don’t know what the problems are”.

Patient safety incidents

There were 10,187 reported patient safety incidents in 2014/15 compared to 9,739 the previous year. This shows that we continue to actively report as many incidents as we can, demonstrating that at St George’s we are committed to developing good systems that enable us to learn from things that go wrong and prevent them from happening again.

Of the 10,187 patient safety incidents there were 31 high and extreme severity incidents during the year. This is 0.3 per cent of all reported patient safety incidents.

YEAR	NUMBER OF PATIENT SAFETY INCIDENTS
2014/15	10,187
2013/14	9,739
2012/13	9,084
2011/12	9,663

The number of never events declared over this period was five. None of these incidents resulted in harm to the patient.

DIVISION	SERVICE	NEVER EVENT
Surgery	Dentistry	Retained Foreign Object (Throat Swab)
Women’s	Obstetrics	Retained Swab
Women’s	Obstetrics	Retained Swab
Women’s	Obstetrics	Retained Swab
Community services	Dermatology	Wrong site surgery

Over the last year we have introduced some important changes to help us reduce any risk to our patients. We have:

- **Carried out a patient safety week which has focussed on staff concerns**
- **Carried out regular staff open forums so that staff are aware of safety messages**
- **Taken part in the national Sign up to Safety Campaign and identified our priorities for improvement.**

Improving patient experience

Community learning disability referrals

Why is this important?

The Wandsworth Community Learning Disability Health Team (CLDHT) is a multi-professional team providing community based healthcare for adults with learning disabilities. The service facilitates access to generic NHS services.

The service is provided in the setting most appropriate to the service users' needs. This can be in their own home, place of work or education, in the community, in an NHS facility, or at the CLDHT team base.

Our CLDHT provides a person-centred, multi-disciplinary community service to people who need a specialist learning disability service, so there may be just one or several CLDHT professionals involved with a service user at any one time. Most service users have a network around them which can include family members and a range of health and social care providers. Working collaboratively with colleagues in the CLDHT and the service user's network is essential for the delivery of a quality service that meets their needs.

It is important that people referred to the service are assessed for eligibility within a four week period. This is so we can make sure that people with learning disabilities are in receipt of appropriate care to support their complex health needs as soon as possible.

Confirming eligibility for CLDHT services is a time intensive process that can be delayed by, for instance, accessing healthcare records. Once a referral is received the service user will follow the eligibility pathway, and as soon as it is established the individual has a learning disability they will be accepted by the CLDHT.

If the referral is for somebody who is already known to the CLDHT they will be accepted straight away. If the person is unknown to the CLDHT there is a three stage process to determine eligibility. The referral can be accepted at any point where there is sufficient evidence of a learning disability:

- **review of documentation such as past assessments, IQ tests, reports, Statements of Educational Needs**
- **initial screening test**
- **IQ test (e.g. Wechsler adult intelligence scale) and social functioning assessment (e.g. Vineland or adaptive behaviour assessment system)**

To receive the CLDHT service, clients must have a learning disability which is:

- **impaired intelligence (a significantly reduced ability to understand new or complex information and learn new skills with an IQ of less than 70)**
- **impaired social functioning (a reduced ability to cope independently)**
- **both of which started before adulthood with a lasting effect on development.**

If at any point in the eligibility process, it becomes clear the person does not have a learning disability, they will be signposted to the most appropriate service. If the individual is assessed as having a learning disability but it is felt they are not in need of specialist services for their specific problem, they will be signposted to the most appropriate mainstream service.

How did we do?

2013/14 was the first year we formally reported on the rate of patients going through the eligibility pathway within 28 days of referral. Because of this we had a target that increased every quarter, with our target starting at making sure 80 per cent of service users referred between April and June 2013 were assessed within 28 days, increasing to 95 per cent for those referred between January and March 2014.

For the first quarter of 2014/15 we achieved our target by making sure that 80 per cent of referred service users were assessed. 100 per cent of patients referred between July 2013 and March 2014 were assessed within 28 days.

For 2014/15, 100% of patients referred to the service were seen on the eligibility pathway within 28 days of receipt of the referral.

Complaints

Why is this important?

Last year we had more than one million appointments and inpatient stays at our hospitals and in the community. With this number of patients and appointments, we know that there will unfortunately be times when we do not meet the expectations of our patients.

We encourage our patients and their friends, family and carers to let us know when this happens so we can make the changes that are needed to improve.

As well as dealing directly with our staff, patients and their friends, family and carers can also discuss any concerns they have with our Patient Advice and Liaison Service who will work with them and the service to resolve any issues. Complaints and compliments can also be formally submitted to our complaints and improvements department. We aim to investigate and provide a full response to all formal complaints within 25 working days of the complaint being received.

The lessons learned and trends identified from information collected from our complaints process play a key role in improving the quality of our services and the way we engage with our patients and visitors.

Our outcomes

In 2014/2015 we received 1052 formal complaints, a slight reduction compared to 1,083 complaints in 2013/14.

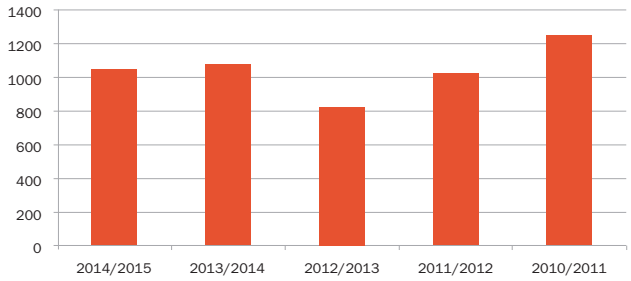
It is very difficult to benchmark complaints against other trusts as there is no uniform way for trusts to record complaints, meaning there is a lot of inconsistency across the NHS.

We view all types of patient feedback as positive and we are constantly looking at how we can encourage patients, carers and families to give their views.

Number of complaints

YEAR	NUMBER OF COMPLAINTS
2014/2015	1052
2013/2014	1083
2012/2013	825
2011/2012	1031
2010/2011	1253

Number of complaints



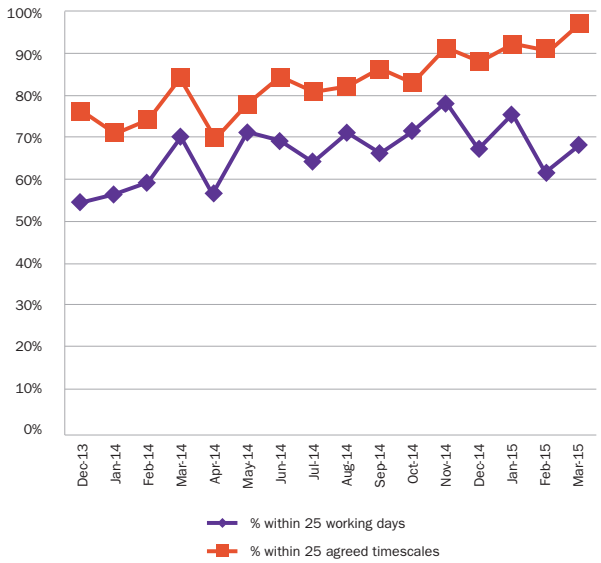
Complaints response rate

We fully responded to 68 per cent of complaints within 25 working days. Our target is that 85 per cent of complaints are fully responded to within 25 working days.

We fully responded to 84 per cent of complaints within 25 working days or an agreed timescale. Our target is that 100 per cent of complaints are fully responded to within 25 working days or an agreed timescale.

The chart below tracks performance throughout the year. Whilst performance regarding responding to complaints within agreed timescales improved throughout the year to almost 100 per cent in March, hitting the 25 working day target is proving to be a challenge in some areas. A focussed piece of work is underway to ascertain the reasons for each late response so that actions can be taken regarding any themes or areas of particular concern that are identified.

Complaint response times by month



Patient advice and Liaison Service (PALS)

Our Patient Advice and Liaison Service (PALS) received 7662 contacts in 2014/15, of which 3,567 were concerns rather than information requests. In 2013/14 PALS received 6,943 contacts, of which 2,674 were concerns.

Our PALS is a patient friendly, easy to access advice, help and information service for patients and their family, friends and carers. The PALS team listen to any concerns people have and help to find ways of resolving them. The team also take note of every contact and feedback to our clinical services so that we can make improvements for our patients. You can find out more about PALS on our website at **www.stgeorges.nhs.uk/patients-and-visitors**

Our aims

We are clear that we must improve our response rate to complaints, making sure that we significantly increase the number of complaints responded to within 25 days.

As well as making sure we acknowledge and respond fully to all complaints in a timely fashion, we will also work to make sure we continue to adhere to use complaints to make improvements. Some improvements made in response to complaints received in 2014/2015 are in the table below.

Improving patient experience

1. **we will listen to and involve people who use our services**
2. **we will use feedback as a vehicle for continuous improvement adopting best practice where possible**
3. **we will ensure that our patients are cared for in a clean, safe and comfortable environment**
4. **we will ensure that our most vulnerable patients and service users are listened to and protected from harm**
5. **we will protect patients' dignity**
6. **we will focus on the fundamentals of care that matters to patients.**

How to make a complaint

If you would like to make a complaint or compliment about any aspect of our service you can email **complaints.compliments@stgeorges.nhs.uk** or write to use at:

Complaints and Improvements Department
St George's Hospital
Blackshaw Road
London, SW17 0QT

CONCERN	ACTION
Trauma and orthopaedics (delays in clinic)	Restructuring of fracture clinic to reduce delays. We now have a consultant who is not booked to see patients, but sits in a central control room so that they can offer advice and support to the registrars who see a high volume of patients. They can advise in complex clinical cases and as they do not have their own list of patients, are easily accessible to all registrars. This has reduced delays in fracture clinic and improved patient care.
Cardiothoracics (pain management)	An increase in complaints related to pain management particularly where bank/agency staff have been looking after patients was noted. The sister and matron have developed a quick reference guide and a leaflet for staff explaining the unique pain patients experience post thoracic surgery. The thoracic clinical nurse specialist is also producing short booklets on common thoracic surgery and post-operative complications to help temporary staff in managing these patients. A second CNS for thoracics is being appointed which will help allow the majority of patients to be pre assessed. This will allow greater discussion about post-operative care so the patient will be aware what to expect and understand how to use the patient controlled analgesia alongside oral analgesia.
Transport (delays)	A training schedule was set up in December 2014 and all trust staff now have access to training on the transport systems and processes on a monthly basis. The training covers issues such as ensuring the correct transport booking is submitted and escalation procedures are reinforced to ensure delays to patient journeys are minimised.
Offender healthcare (various	In response to complaints a number of actions have been taken, some general and some more specific including: · every quarter, a group of randomly selected prisoners are sent invitations to meet with the head of offender healthcare to provide feedback on healthcare services. · a healthcare professional regularly attends to prisoner wing forum to obtain feedback. · each November prisoners are invited to complete a prisoner survey and the results are compared to the previous year. · standardised guidance is being produced for a clinician to promote best practice and provide training for all clinicians in ear care. · a patient information leaflet will be made available to patients presenting with ear wax impactation. This is being produced by the clinical lead nurse for the offender healthcare service and will be completed by the end of October.

Contacting PALS

You can visit the PALS office between 9am and 5pm, no appointment is needed. You can find PALS on the ground floor of Grosvenor Wing at St George's Hospital.

Alternatively, you can contact PALS by phone on **020 8725 2453**. If you call outside of normal office hours a member of the PALS team will return your call the next working day. You can also email PALS at **pals@stgeorges.nhs.uk**

Responding to patients' needs

Why is this important?

Patient experience is a key measure of the quality of care. At St George's, we continually strive to be more responsive to the needs of our service users, including needs for privacy, information and involvement in decisions. In 2014, St George's received the results of the national cancer patient experience survey.

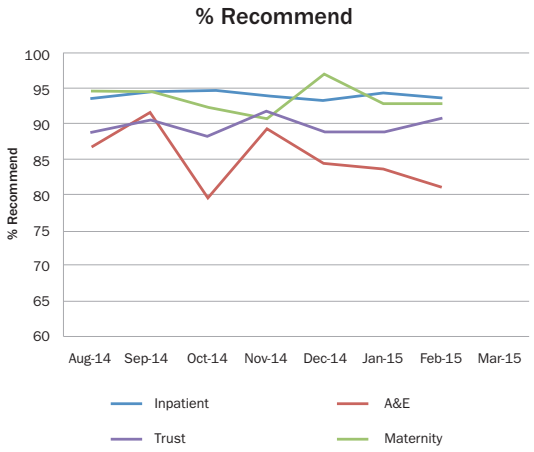
The results indicated that St George's was one of the ten most improved trusts within the NHS which was encouraging and a testament to the team who had delivered the improvement. However, the survey also indicated that the trust still had work to do in a number of areas. One of these was in relation to patients' perception about the quality of communication between staff and patients, particularly when patients were admitted to the trust. In addition, the survey indicated that there is an opportunity to improve the knowledge for staff working with patients who have cancer in order to improve the quality of service provision.

Building on work already undertaken, St George's is committed to the delivery of the highest standards of care for patients. The national cancer patient experience survey indicated that we need to focus on the areas outlined above and therefore the trust has made this area a priority for improvement during 2015/16.

In 2013 a new measure was introduced – the friends and family test (FFT).

Friends and family test

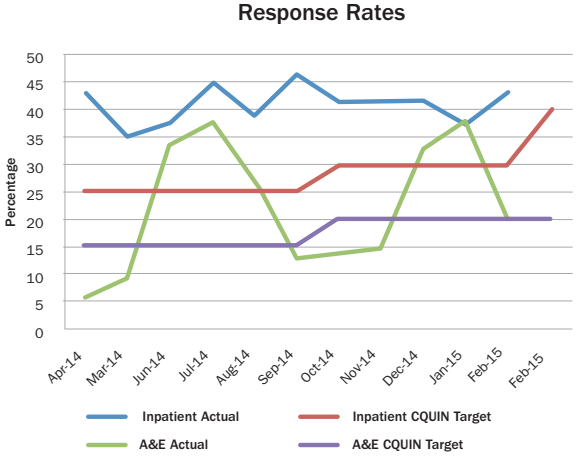
The friends and family test is a national initiative and asks patients on discharge about how likely they are to recommend our hospital wards, accident and emergency department and maternity services to a friend or relative based on their treatment. There are six options; Extremely likely, Likely, Neither likely nor unlikely, Unlikely, Extremely unlikely or Don't know.

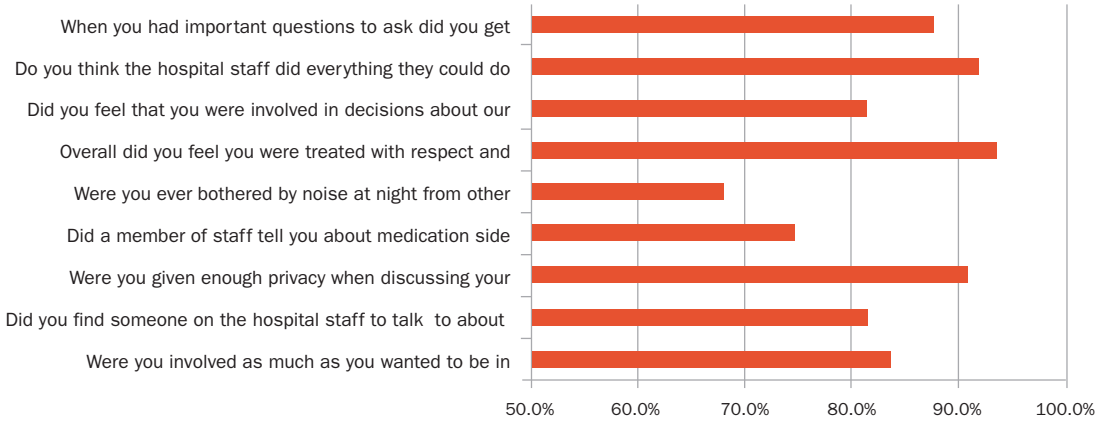


The scoring is based on the percentage of people that said they were "Extremely likely" or "Likely" to recommend our service if a friend or family member needed similar care or treatment.

The FFT has now been in place for two years, having been rolled out in A&E and inpatient adult areas for April 2013, maternity in October 2013 followed by outpatient and community services in September 2014.

The maternity survey is different from A&E and adult wards as there are four occasions or 'touch points' when women are asked to rate the service (antenatal, birth, postnatal ward and postnatal community) whereas A&E and inpatient adult areas is only once on discharge.





For 2014/15, there was a minimum target for the number of surveys completed. A&E was required to achieve a response rate of 15 per cent (rising to 20 per cent) and inpatient wards were required to achieve a response rate of 25 per cent (rising to 30 and then 40 per cent by March 2015).

In addition we also have a number of other survey questions that we ask patients (anonymously) about their experience based on the national annual inpatient survey. A bespoke system allows for almost real-time feedback to enable staff to share good practice and implement any actions that may be required. We will continue to undertake national surveys but hope this process allows for more rapid feedback and action. The data above is a summary for the year outlining the additional questions with the percentage relating to positive answers.

Staff use word clouds to display comments from patients in their clinical areas. Our word clouds give greater prominence to the words that appear most often in our survey results.

National inpatient survey

The national inpatient survey is conducted every year by the CQC to find out how patients aged 16 or over who spent at least one night in hospital felt about their experience. As in 2013, the 2014 survey was split into 10 sections with trusts given a score between 0 and 10 for each section. As well as the scored for each section, trusts were ranked as being “better” than most other trusts in the country (green), “about the same” as most other trusts in the country (amber) or “worse” than most other trusts in the country.

We were ranked as being “about the same” as most other trusts in the country in all 10 sections. This was also the case with the 2013 survey.

A word cloud from a patient survey.

SURVEY SECTION	SCORE
A&E department	8.6
Waiting list and planned admissions	8.6
Waiting to get to a bed on a ward	7.2
The hospital and ward	7.9
Doctors	8.5
Nurses	8.2
Care and treatment	7.7
Operations and procedures	8.4
Leaving hospital	7.2
Overall views of care and services	5.4
Overall experience	8.0

A workshop was held on 20 March 2015 where the detailed report provided by our survey contractor was analysed. Areas for improvement were identified and these were:

- **cleanliness of toilets**
- **need for additional equipment or home adaptations to be discussed with patients**
- **confidence and trust in nurses**
- **assistance at mealtimes**
- **noise at night from patients and staff**
- **communication about bathrooms and toilets (separate male and female).**

A further workshop will be held to develop an action plan.

End of life care

Why is this important?

In February 2014 end of life care was reviewed as part of our CQC inspection. The services offered by the specialist palliative care team, the bereavement team and mortuary teams were considered to be excellent.

Patients had treatment plans explained, and relatives were included in the care planning process. There were good interactions between staff and patients and families had experienced good end of life care.

However the CQC indicated that there was a lack of strategic direction for end of life care from the top of the organisation. As a result, the trust implemented during 2014/15 a programme of work to address the CQC concerns.

Under the leadership of the chief nurse a programme board has been established from operational and palliative care leads to deliver an agreed programme of work to ensure that there is a stronger strategic framework in place and the trust is meeting the priorities from the Department of Health “One Chance to get it right” document.

What we will do?

In 2014/15 we received £15,000 of CQUIN money to train facilitators on Sage and Thyme Foundation Level Communication skills. The Sage and Thyme Model can be taught to any member of staff (e.g. healthcare assistants, doctors, administration staff) in contact with distressed people (not just patients) in any setting (e.g. hospital, nursing home, social care). As part of the end of life care approach for 2015/16 we will be focussing on the development, and roll out of this training across the trust for staff working in both acute and community settings.

Our aims

Our aim will be to deliver the training programme to an agreed number of staff during the year. The actual number will be agreed by the end of Q1 2014/15. The end of life programme board will monitor progress against this target.

Improving patient outcomes

Sexual health in secondary schools

Why is this important?

Supporting young people to grow up with a good knowledge about their sexual health and how to both protect themselves and keep safe is really important. Historically, Wandsworth has had a high teenage pregnancy rate which has halved in the last 10 years due to improved services and education.

Schools are responsible for providing sex and relationships education. St George's provides school nursing services in Wandsworth.

To improve access to sexual health advice, support and signposting our school nursing service provides a drop in service in secondary schools in Wandsworth. Our target is for 50 per cent of secondary schools in Wandsworth to have sexual health support on the school grounds.

How did we do?

All 11 secondary schools in Wandsworth have a school nurse who spends up to three days a week in the school supporting pupils.

These schools also have a weekly drop-in session when pupils can see a school nurse confidentially (there is always the need however to inform pupils that if a safeguarding concern is raised this will need to be shared).

All of our school nurses have received training in sexual health and the administration of emergency contraception, with a patient group direction (PGD) and competency framework for the administration of emergency contraception developed and implemented.

Sexual health information is freely available in all secondary schools. Information is also given to pupils about The Point sexual health clinics in Wandsworth, with pupils actively encouraged to attend if they are likely to be sexually active.

Our aims

We have three main aims for young people in Wandsworth:

- **to have quick and easy access to sexual health information in a confidential and appropriate way giving them the option to make informed choices about their sexual health**
- **to be protected from harm**
- **to have easy access to emergency contraception where a holistic assessment will be carried out by a school nurse. This then gives the opportunity to make sure the young person is safe and address any other health concerns.**

Update March 2015

This continues to be a school nursing service priority. The school nurses offer sexual health advice during drop-in sessions. Only two secondary schools have agreed to the administration of emergency contraception in school at present.

Clinical outcome measures in community services

Interventions can extend over a long period and care can focus on many different issues, not just illness but promoting health and wellbeing. These factors can make it hard to measure clinical outcomes in community services. The NHS continues to work with professional bodies like the Royal College of Nursing and Chartered Society of Physiotherapy to develop the best way to measure clinical outcomes.

During 2014/15, while some progress was made, we do not yet have measurable outcome data. During 2015/16 we'll focus on the development of our data collection processes and define key outcome measures.

Patient reported outcomes measures (PROMS)

Why is this important?

Patient reported outcome measures (PROMs) assess the quality of care from the patient's perspective. Covering four procedures they calculate health gains after surgical treatment using short, self-completed, pre – and post-operative questionnaires.

Our outcomes

The table below shows the percentage of patients who reported an increase in their health following surgery, using three scoring methods, which are explained briefly below. The range is between 0 and 100 and higher scores are better. This makes no adjustment for the type of patients treated.

For all four procedures EQ-5D™ and EQ-VAS indices measure a general view of health, and for three there is also a measure specific to the condition treated.

- **EQ-5DTM is a combination of five key criteria concerning general health**
- **EQ VAS assessed the current state of the patient's general health marked on a visual analogue scale**
- **Condition specific measures include a series of questions specific to the patient's condition.**

		APR11 – MAR12 (FINAL)		APR12 – MAR13 (FINAL)		APR13 – MAR14 (PROVISIONAL)		APR14 – SEP14 (PROVISIONAL)	
		SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.
Hip replacement (primary)	EQ-5D™	87.8	87.3	100	89.7	*	89.3	*	90.6
	EQ-VAS	57.9	63.6	72.2	65.5	*	65.1	*	66.7
	Specific	93.2	95.7	95.0	97.1	83.3	97.2	*	97.5
Hip replacement (revision)	EQ-5D™	-	-	68.4	72.3	62.5	70.0	*	70.1
	EQ-VAS	-	-	47.1	53.7	62.5	52.1	*	49.3
	Specific	-	-	78.9	84.6	66.7	83.2	*	88.0
Knee Replacement (primary)	EQ-5D™	63.0	78.4	68.8	80.6	*	81.4	No data	82.2
	EQ-VAS	30.0	53.8	53.3	54.9	*	55.1		56.5
	Specific	76.5	91.6	86.7	93.2	*	93.8		94.2
Knee Replacement (revision)	EQ-5D™	-	-	*	67.5	*	81.4	No data	*
	EQ-VAS	-	-	*	49.0	*	55.1		*
	Specific	-	-	*	82.1	*	93.8		*
Groin hernia	EQ-5D™	48.0	49.9	36.4	50.2	45.5	50.6	*	50.2
	EQ-VAS	40.2	38.9	32.7	37.7	18.9	37.3	26.7	38.2
	Specific								
Varicose vein	EQ-5D™	58.2	53.2	48.6	52.7	50.9	51.8	0	53.4
	EQ-VAS	50.0	42.0	26.7	40.9	30.8	40.1	50.0	40.9
	Specific	81.5	83.1	79.4	83.3	74.5	83.6	85.7	84.9

Source: Health and Social Care Information Centre

Data notes: Total questionnaire count for survey and procedure type is less than 30.

The latest available data is for April 2014 to September 2014 and does not allow us to make comparison to the national picture as the number of completed pre and post-operative questionnaires is too low.

Adjusted health gain

Adjusted average health gains have been calculated using statistical models which account for the fact that each provider organisation treats patients with a different casemix. This allows for fair comparisons between providers and England as a whole.

Data reported in the table below shows that for the majority of measures there are insufficient records for this analysis to be reported for St George's patients. This is true for all measures for the partial year 2014/15.

Provisional data for 2013/14 shows that for varicose vein surgery we are an outlier for two of the three measures, meaning that our patient reported outcomes are worse than the national average. For groin hernia there is only one measure available, and this shows our patient reported outcomes to be worse than the national average. The number of records is too low for analysis of hip and knee replacement outcomes. It should be noted that at St George's we perform only a small number of complex cases of knee and hip replacements, with the majority of routine cases being referred to the South West London Elective Orthopaedic Centre for treatment.

		APR11 – MAR12 (FINAL)	APR12 – MAR13 (FINAL)	APR13 – MAR14 (PROVISIONAL)	2014/15 YTD (PROVISIONAL)
Hip replacement (primary)	EQ-5D	*	*	*	*
	EQ-VAS	*	*	*	*
	Specific	Not outlier	*	*	*
Hip replacement (revision)	EQ-5D	-	*	*	*
	EQ-VAS	-	*	*	*
	Specific	-	*	*	*
Knee Replacement (primary)	EQ-5D	*	*	*	No procedures
	EQ-VAS	*	*	*	No procedures
	Specific	*	*	*	No procedures
Knee Replacement (revision)	EQ-5D	-	*	*	No procedures
	EQ-VAS	-	*	*	No procedures
	Specific	-	*	*	No procedures
Groin hernia	EQ-5D	Not outlier	Not outlier	*	*
	EQ-VAS	Not outlier	Negative 95% outlier	Negative 95% outlier	*
	Specific	Not applicable			
Varicose vein	EQ-5D	Not outlier	Not outlier	Not outlier	*
	EQ-VAS	Not outlier	Negative 95% outlier	Negative 95% outlier	*
	Specific	Not outlier	Negative 99.8% outlier	Negative 95% outlier	*

Source: Health and Social Care Information Centre

*Data notes: *insufficient records*
– split between primary and revision procedures was not made in 2011/12

Participation

St George's is responsible for providing patients with the opportunity to complete pre-operative questionnaires. Post-operative questionnaires are sent by contractors working for the Department of Health directly to patients that have completed the initial survey. Our aim is to provide the choice of completing the questionnaire to all appropriate patients, however it is voluntary and not all patients will choose to take part.
Our participation rate for the most recent period considered here (April 2014 to September 2014) is 41.1 per cent, which is below the national average of 76.7 per cent.

Our participation rate for the most recent period considered here (April 2014 to September 2014) is 41.1 per cent, which is below the national average of 76.7 per cent. Local monitoring is in place and following observation of a decline in submissions at the start of the year a number of actions were taken which resulted in a significant increase. We therefore expect that our end of year position will be much improved, which will in turn contribute to increasing the availability of trust level data about our patient reported outcomes. This work will continue to be overseen by the Patient Experience Committee.

	APR11 – MAR12 (FINAL)		APR12 – MAR13 (FINAL)		APR13-MAR14 (PROVISIONAL)		APR14 – SEP14 (PROVISIONAL)	
	SGH	England	SGH	England	SGH	England	SGH	England
All procedures	64.5%	74.6%	66.8%	75.5%	77.4%	77.3%	41.1%	76.7%
Hip replacement	88.2%	82.3%	87.0%	83.2%	137.1%	87.1%	70.0%	86.1%
Knee replacement	101.7%	89.3%	127.9%	90.4%	137.5%	95.1%	140.0%	96.6%
Groin hernia	52.4%	60.6%	72.1%	61.7%	69.8%	60.8%	40.9%	58.3%
Varicose vein	68.9%	48.9%	34.3%	44.3%	71.7%	40.7%	31.1%	42.4%

Source: Health and Social Care Information Centre

Note: Participation rates of over 100% are possible for a number of reasons: an operation is cancelled following completion of the pre-operative questionnaire; surgery is carried out by a different provider; coding issues.

Clinical records – driving quality improvement through technology

Why is this important?

By March 2016, NHS England says that the Care Quality Commission (CQC) will measure digital maturity within healthcare settings as part of their inspection regime. In addition, by 2020, being 'paperless' will be a prerequisite for holding an operating licence to provide publicly funded healthcare.

These significant measures will mean that successfully deploying electronic clinical documentation is an even bigger priority for health care professionals and health care providers. By implementing an electronic clinical documentation system the trust will enable transformational programmes that focus on modernisation, increased patient safety and greater productivity.

National initiatives: –

- **Five Year Forward View – systems that 'talk to each other' to enable different parts of the health service to work together and harness the shared benefits that come from interoperable systems**
- **patients being able to access their online records and write in them**
- **'NHS Paperless'.**

Local drivers:-

- **risk management, patient and staff safety**
- **real time reporting**
- **transparency and accountability**
- **aligned with CQUINs and KPIs.**

How did we do it?

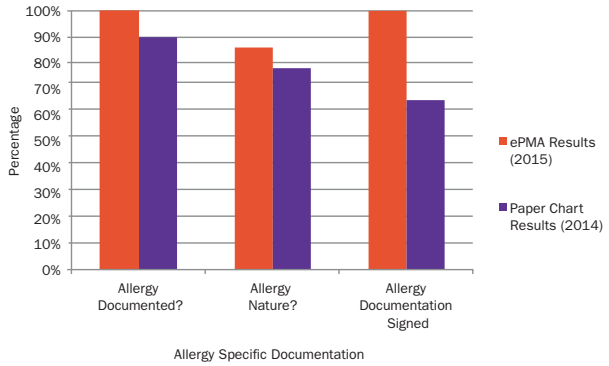
We have deployed electronic clinical documentation and electronic prescribing and medicines management (ePMA) to 44 per cent of the hospital. This has been supported by clinician engagement in designing and implementing the system. A comprehensive training programme was devised to support the rollout.

Electronic Prescribing and Medicines Administration (ePMA)

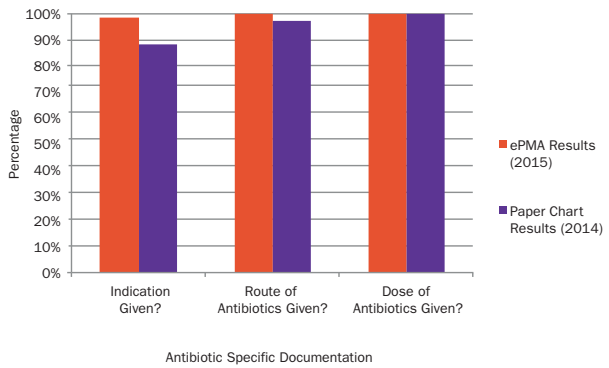
The deployment of ePMA has delivered patient safety benefits to the organisation. This has resulted in improved adherence with organisational policies including the following:

	PRE-IMPLEMENTATION	POST-IMPLEMENTATION
Eliminating incomplete prescriptions	38.2% Complete	100% Complete
Eliminating inappropriate use of dose units e.g. mcg	98.5% Appropriate use	100% Appropriate use
Reduction in inappropriate drug form and route combinations	96.6% Appropriate use	99.97% Appropriate use

All patients with medications prescribed now have allergies documented and signed, with an improvement in the documentation of the nature of the allergy.



National standards for antibiotic prescribing are now being adhered to with 100% compliance.



Clinical documentation

The clinical functionality has created a driver to ensure real time bed state is a reality in wards that are live with clinical documentation. Discharge summaries should now reach GPs within 24 hours of discharge. Discharge summary reports are cascaded on a daily basis to relevant clinical leads.

Venous thromboembolism (VTE) risk assessment compliance in areas that are live is now transparent as it is possible to report directly from the electronic record. This has meant it has been possible to target areas where compliance has not been at the agreed level. Other risk assessments such as pressure ulcer prevention assessment and falls are now audited with greater ease.

	SPECIALITY	BED STATE % ON 10/03/15
Average	Cardiac	100%
Average	Neuro	100%
Average	Paeds	98%
Average	Renal	100%

Our aim

In 2015/16 we aim to further deploy electronic clinical documentation and ePMA to inpatient bed areas.

The clinical systems programme board will continue to drive the deployment by monitoring:

- the deployment plan
- pre and post deployment support including the use of 'champion users' and training
- risk associated with the transition from paper to electronic processes
- issue logs to identify any themes or trends that might impact patient care and safety
- future developments ie care pathways
- implementation of interactive white boards and vital signs monitoring equipment
- data captured and data quality
- training for pre-registration students and temporary staffing.

Reducing hospital readmissions

Why is this important?

Monitoring emergency readmission rates can help us to prevent or reduce unplanned readmissions to hospital. An emergency readmission is recorded when a patient has an unplanned readmission to hospital within 30 days of a previous discharge.

This Quality Account refers to emergency readmissions within 30 days rather than Health and Social Care Information Centre compendium indicator's 28 days. This is because trusts report on their emergency readmissions within 30 days at frequent intervals as part of their quality reporting and as per Monitor compliance and NHS Trust Development Authority accountability frameworks.

Reducing hospital readmissions is a substantial and hugely challenging task given the financial and regulatory constraints, but the potential benefits are enormous to patients. We are committed to reducing readmissions for all patients, whether they have received emergency or elective (planned) treatment, by making sure that all discharges are properly planned and that patients are not discharged until it is safe to do so, and that the appropriate community and social services are in place to support them in their own home when they are ready to leave hospital. For patients admitted for elective care, an important part of this process is the pre-operative assessment, which reduces the risk of complications during and following their stay in hospital.

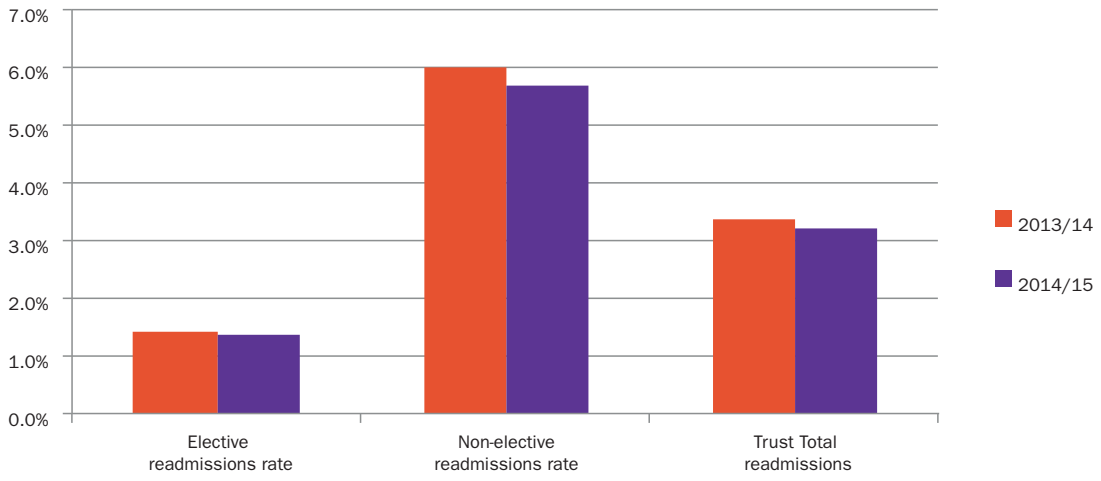
Reducing the number of emergency and elective readmissions would ease the pressure on our emergency department, which is one of the busiest in the country. This would in turn create extra capacity in the hospital for elective patients and mean that less elective procedures are cancelled because of surges in emergency activity. Reducing elective readmissions would also mean that waiting times for elective procedures could be reduced.

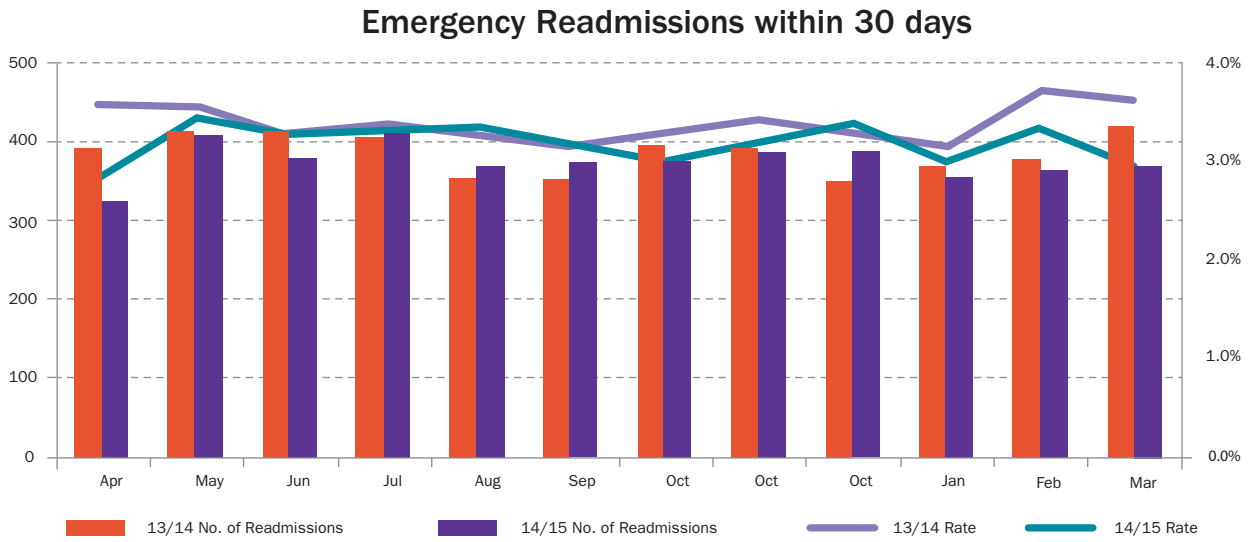
The risk is heightened in the winter when pressure on our services increases significantly. We have plans to help us to manage the surge in attendance and admissions in the winter, including opening a winter ward that is closed during warmer months when there is less emergency activity.

We also have a complex modelling system that helps us to predict how busy our emergency department will be at any given time by analysing activity levels over previous weeks and years. This helps us to make sure that we have the appropriate staffing levels in our emergency department. This of course means that waiting times are shorter, but more importantly that our patients receive the care and attention their condition needs.

How did we do?

Reducing emergency readmissions has always been one of our priorities. In 2014/15, 3.2 per cent of patients were readmitted to hospital within 30 days. In real terms this means that 4,500 patients were readmitted to hospital within 30 days of being discharged from their previous emergency or elective admission. 3.38 per cent of patients were readmitted within 30 days of discharge in 2013/14.





EMERGENCY READMISSIONS WITHIN 30 DAYS	2013/14	2014/15
Trust readmissions rate	3.38%	3.20%
Elective readmissions rate	1.40%	1.35%
Non-elective readmissions rate	5.98%	5.69%

Our increased readmission rates highlight the complexity of the challenges we face. As St George's Hospital is a major trauma centre, hyper-acute stroke unit and heart attack centre, we treat the most seriously ill patients and most complex cases from across south west London and Surrey. This means that the risk of patients needing to be readmitted after leaving hospital is higher for St George's than or other acute trusts in that area. We regularly receive patients via the helipad from Sussex, Kent, Hampshire and further afield.

EMERGENCY READMISSIONS WITHIN 30 DAYS	PATIENTS AGED 0-15	PATIENTS AGED 16+	OVERALL TRUST
Trust readmissions rate	1.30%	3.50%	3.20%
Elective readmissions rate	0.90%	1.40%	1.35%
Non-elective readmissions rate	1.50%	6.80%	5.69%

Our community virtual wards provide a highly responsive multi-disciplinary approach to the management of patients with long term conditions who are registered with a Wandsworth GP in their own homes. By providing care to patients in their own homes we can help to avoid emergency attendances and readmissions for some patients by addressing complications before they escalate into serious issues.

Our four community virtual wards in Wandsworth are helping us to treat patients with chronic long term conditions who are more likely to need acute services more effectively in the community, reducing the number of patients who need to be readmitted following discharge.

Our aims

Reducing hospital readmissions is a substantial task given the financial, regulatory, and systemic constraints. Reducing emergency readmission remains one of our key priorities and a continued area of focus for between St George's and our partners in primary care and local councils. Our key focus is on readmissions for patients aged 16 and above as an readmission rates for paediatrics are just five percent.

During 2015/16 we will continue our efforts to reduce readmissions by making sure that all discharges are properly planned, appropriate community services are in place, and patients are not discharged until it is safe to do so.

Performance

INDICATOR	TARGET	2014/15 PERFORMANCE	2015/16 TARGETS
Mortality	Lower than expected mortality rate	**ACHIEVED** – St George's was identified by the Health and Social Care Information Centre (HSCIC) as one of 15 trusts that have had a lower than expected mortality rate in the latest period published (July 2013 to June 2014). The trust has maintained this position for two consecutive years.	Maintain lower than expected mortality rate
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	>= 90%	**PARTIALLY ACHIEVED** – 85.6% The trust met the target for Q1. However the Trust did not meet the target for Q2-4 2014/15, as breach of RTT targets was authorised as part of the national RTT backlog reduction programme.	To achieve sustainable compliance with 18 week waiting times target for admitted and non – admitted patients. To improve specialty level compliance in line with aggregate achievement.
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	>= 95%	**ACHIEVED** – 96.3%	
Maximum time of 18 weeks from point of referral to treatment in aggregate – patient on an incomplete pathway	>= 92%	**PARTIALLY ACHIEVED** – 91.4% The trust met the target for Q1. However the trust did not meet the target for Q2-4 2014/15, as breach of RTT targets was authorised as part of the national RTT backlog reduction programme.	
A&E: maximum waiting time of four hours form arrival to admission/transfer/discharge	>= 95%	**NOT ACHIEVED** – 92.31% The target was not met due to failure to meet 95% target in Q1, 3 and 4.	Improve performance above 95%
Patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust	Compliance	**COMPLIANT – 62.7%** – (percentage of patients admitted to stroke unit who had actually had a stroke)	Maintain compliance
62-day wait for first treatment from urgent GP referral for suspected cancer	>= 85%	**PARTIALLY ACHIEVED** – 85.6% Performance is greater than target for year cumulative Apr – Feb 2014/15. However the target was not met in Q3.	Improve performance against 62 day wait from urgent referral for suspected cancer target, with performance above 85%
62-day wait for first treatment from NHS Cancer Screening Service referral	>= 90%	**ACHIEVED** – 91.2%	Maintain and continue to improve performance
31-day wait for second or subsequent treatment – Surgery	>= 94%	**ACHIEVED** – 98.6%	Maintain and continue to improve performance
31-day wait for second or subsequent treatment – anti-cancer drug treatments	>= 98%	**ACHIEVED** – 100%	Maintain and continue to improve performance
All cancers: 31-day wait from diagnosis to first treatment	>= 96%	**ACHIEVED** – 97.7%	Maintain and continue to improve performance
Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected)	>= 93%	**ACHIEVED** – 96.4%	Maintain and continue to improve performance

Clostridium C.difficile – meeting the C.difficile objective (M)	40	**ACHIEVED** – 38 cases against annual threshold of 40.	No more than 31 cases of C.Diff during 2015/16
MRSA	0	**NOT ACHIEVED** – 6 cases of MRSA	To meet our target of zero avoidable cases
Mixed Sex Accommodation Breaches	0	**NOT ACHIEVED** – The trust had 16 breaches of mixed sex compliance in 2014/15	Improve mixed sex accommodation compliance to prevent future breaches
Never Events	0	**NOT ACHIEVED** – The Trust had 5 Never Events in 2014/15	No never events in 2015/16
Certification against compliance with requirements regarding access to health care for people with a learning disability (Q)	Compliance	**COMPLIANT**	Maintain compliance
Data completeness: community services, comprising:			
referral to treatment information	50%	**ACHIEVED** – 55%	Maintain and continue to improve performance
referral information	50%	**ACHIEVED** – 88%	Maintain and continue to improve performance
treatment activity information	50%	**ACHIEVED** – 70%	Maintain and continue to improve performance
Note: 1. RTT performance reported is YTD average for April to February 2014/15. 2. Cancer performance reported is aggregate YTD for April to February 2014/15.			

Annex 1: Statements from commissioners, Healthwatch and Overview and Scrutiny Committees

Wandsworth CCG (on behalf of local CCGs)

Wandsworth Clinical Commissioning Group (WCCG) works closely with St George's University Hospitals NHS Foundation Trust to ensure that it provides high quality care for patients.

There are robust arrangements in place with the trust to agree, monitor and review the quality of its services. During 2014/2015 WCCG requested a board to board with St George's University Hospitals NHS Foundation Trust which gave commissioners the opportunity to share concerns and agree an open approach with a clear quality focus, there is an expectation that this transparency continues.

The Clinical Quality Review Group meets monthly and brings together GPs, senior clinicians and managers from both St George's University Hospitals NHS Foundation Trust, Wandsworth CCG, associate commissioners and NHSE. We have received assurance throughout the year from the trust in relation to key quality issues, both where quality and safety has improved and where it occasionally fell below expectations with remedial plans put in place and learning shared wherever possible.

WCCG recognises that St George's University Hospitals NHS Foundation Trust faces an extremely challenging year in 2015/2016, WCCG plans to actively engage with the trust on strategies to mitigate the effects of financial difficulties. It is our expectation is that quality will be prioritised despite the challenging context, we will therefore be implementing processes for enhanced quality surveillance.

WCCG are disappointed that there will not be CQUINS for the next financial year as we have considered them to be a powerful vehicle for improvement. We will continue to work with the trust to identify alternative ways to continue to progress these quality priorities.

The CQC report from the February 2014 (published in April 2014) found the overall standard of care to be good across all sites within the Trust. However there were eight areas which needed improvement and the trust's progress with the subsequent the action plan has been monitored by the Clinical Quality Review Group.

Wandsworth CCG commissioners have reviewed the trust's Quality Account for 2014/15 and the summary of performance against national standards, with expectations for the year ahead. The Quality Account does cover many examples of good quality within the trust and St George's University Hospitals NHS FT is open in identifying some of its own weaknesses.

The CCG note that the ED (emergency department) 4-hour target has been challenging during 2014/15 and has not been consistently achieved over the year. The CCG will continue to work with St George's University Hospitals NHS Foundation Trust to address the challenge for the year ahead to improve the flow of patients through the hospitals to support the 4-hour target. Another challenging area has been the achievement of the 18 week referral to treatment target and cancer target of maximum weight of 62 days from urgent GP referral to first treatment (excluding rare cancers).

WCCG would like to see an accelerated improvement in respect of the issue of bullying and harassment reported in the staff survey.

The trust has been open and honest in its reporting of serious incidents to commissioners during 2014/2015 and has taken positive steps to learn for incidents and implement planned actions. There have been five 'never events' reported throughout the year which has increased, the CCG notes the work that the trust are undertaking in obstetrics and surgery to address the root causes of these incidents.

WCCG welcomes the continued focus on patient safety and patient experience and has endorsed the proposed quality indicators. We would like to see the Clwyd Hart recommendations fully implemented including asking complainants to feedback on the complaints process.

WCCG regularly gathers feedback from GPs and this has been used to identify primary care clinician's views and issues related to the care provision at St George's University NHS FT. The trust has worked collaboratively in addressing the issues highlighted by GPs and this demonstrates the value that the trust places in this feedback. The Quality Account could have reflected the good work that has been undertaken as a result of this feedback.

The CCGs fully endorse the proposals set out in the Quality Account. WCCG can confirm to the best of our knowledge that the account contains accurate information in relation to the quality of services provided by St George's University Hospitals NHS Foundation Trust. We welcome the specific priorities for 2014/15 which the trust has highlighted in the quality report; all are appropriate areas to target for continued improvement and link with clinical commissioning priorities.

Wandsworth Council (OSC)

Statement from Wandsworth Adult Care and Health Overview and Scrutiny Committee.

Whilst this statement is submitted on behalf of the Wandsworth Adult Care and Health Overview and Scrutiny Committee, the very tight timescale allowed for its submission means that it has not been possible to agree it at a Committee meeting. The comments made reflect the established view of the Committee and its work over the past year, and have been prepared in consultation with its leading members.

In previous years, statements from the Overview and Scrutiny Committee on the Quality Account have repeatedly highlighted the contrast between the clinical excellence of many of the services provided by St George's and the much less satisfactory measures of patient experience. The current Quality Account again highlights the significantly lower than average mortality rates associated with treatment at St George's. However, on this occasion there are also encouraging signs of improvements in patient experience, with improved results in surveys of the experience of users of cancer and maternity services. There is still a long way to go, with surveys of patient experience still rating the Trust at no better than the national average, but the direction of change is clearly positive.

The most evident challenge for the Trust over the past year has been in managing the demand for its services. Performance targets have been missed in relation to the length of time patients spend in the accident and emergency department, the 62-day wait from GP referral to treatment for cancer, the 18 week target for referral to treatment, and the proportion of cancelled operations not re-booked within 28 days. We are aware that the challenges the trust faces in the management of demand are exacerbated by its role as a provider of tertiary services, including its role as a major trauma centre. Whilst the Overview and Scrutiny Committee is strongly supportive of these specialist functions, from which Wandsworth residents benefit, it is important that they are managed in a way that does not disadvantage local patients who rely on the Trust for secondary care.

The Trust's ability to manage high levels of demand is also linked to the strength of its partnership arrangements with Wandsworth CCG and other local CCGs, and with the Council. Conversely, the ability of Wandsworth Council and Wandsworth CCG to achieve the targets set out in the Better Care Fund plan is dependent upon actions to be taken by the Trust. It is therefore important that the Trust continues to prioritise local partnership arrangements and to fully implement its commitments made under those arrangements.

There remain some issues that have been a long-standing concern for the Overview and Scrutiny Committee which remain problematic. For example, the proportion of complaints responded to within the target timescale has consistently been too low over several years. Whilst the Trust's acknowledgement that improvements are needed is welcome, it is important that action on this is prioritised and that a clear timetable for improvement is set.

It is also a concern that, for the second year running, that the Trust has reported five 'never' events. It appears that four of the five events related to retained swabs. Whilst these may not have resulted in harm to patients, it is important that they are learnt from and action is taken so that they do not recur.

The Overview and Scrutiny Committee is broadly supportive of the priorities for 2015/16 set out in the Quality Account, and welcomes the introduction of an additional priority around end of life care. However, a number of the targets in relation to the local priorities – for example, offender healthcare and sexual health in schools – are entirely process-orientated. It would be preferable to have an increased focus on outcomes. The Overview and Scrutiny Committee would also be supportive of a local priority on 'parity of esteem', seeking to ensure that people with a mental disorder are not disadvantaged in their use of acute care services.

Finally, the Overview and Scrutiny Committee acknowledges that the Trust is currently facing a very difficult financial position. It is important that the Trust should find ways of dealing with this that do not place at risk the safety or quality of services offered to patients.

Richard Wiles, Chair 18/05/2015

Healthwatch Wandsworth

For the purposes of HWW, the most important areas are patient safety, patient experience and outcomes and performance indicators.

In the National NHS Staff Survey, staff are asked whether *"If a friend or relative needed treatment I would be happy with the standard of care provided by my organisation".*

In the 2014 survey, 73 per cent of St George's staff said that they agreed with the statement. This is higher than the national average (median) for acute trusts of 65 per cent, and higher than last year when 68 per cent of staff said that they agreed with this statement.

As well as giving an individual score for each question, a score is calculated for a number of key indicators based on the answers to the questions grouped under each indicator. One of these key indicators is staff recommendation of the trust as a place to work or receive care. On a scale of 1-5, with 5 being the most positive, St George's scored 3.78 compared to 3.67 nationally for acute trusts. Last year its score was 3.73. This gives a very positive view of the hospital's standard, although over time, we would like to see this increase even further.

As a commitment to improving quality, the trust says: "We aim to further improve our score in the staff recommendation of the trust as a place to work or receive care indicator in the National NHS staff survey and maintain our status as one of the top 20 per cent of trusts in the country. We aim to further improve our scores in the Friends and Family staff survey in 2015." We hope that this can be achieved.

There is also quite a worrying figure, in that 31% of staff say that they have experienced harassment, bullying or abuse from staff in the past 12 months. The trust says it has a strategy to tackle bullying including coaching and training for managers dealing with difficult staffing issues, tracking and following up the range of concerns that were raised in the CQC inspection in 2014.

It is also worth noting that income generated by the NHS services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of NHS services by St George's University Hospitals NHS Foundation Trust for 2014/15, so at present, there are no competing demands for private care at the Trust.

Patient safety

The Trust has a good record on patient safety and in 2014, and in its inspection of the Trust in February 2014, CQC reported that there is an evident culture of positive learning from medicine administration errors at St George's, which is a very positive finding in HWW's view.

This year the National Reporting and Learning System has reported that St George's medication error reporting is higher than the national benchmark for reporting medication incidents, which indicates openness by clinicians, another positive sign. Last year it reported 1,574 errors, reflecting a good safety culture at the trust. Of these incidents, 92 per cent resulted in no harm, 5 per cent in low harm and 3 per cent in moderate harm. There were no medication errors that resulted in severe harm to patients.

We welcome the hospital's commitment to reducing the number of inpatient falls – SGH says it aims to reduce the current rate of reported falls during an inpatient episode and continue to reduce the admissions for falls patients in Wandsworth in 2015/16. It has also committed to identifying the trends and themes and implement targeted action plans through structured evaluation, which is again very positive.

The trust also has a good venous thromboembolism (VTE) assessment in place, which HWW welcomes. The national target for VTE risk assessments is 95 per cent, and in 2013/14, the trust achieved risk assessments for 95 per cent of 116,256 patients.

The Trust has a very robust infection control programme in place and is not above the national average on cases. Its target in 2015/16 target is to prevent all avoidable *C.difficile* infections and acquire no more than our nationally agreed threshold 31 cases of *C.difficile*.

In terms of patient safety incidents, there were 10,248 (provisional data) reported patient safety incidents in 2014/15 compared to 9,772 the previous year. Only a very tiny percentage of these led to patient harm, and as the Trust says, it shows that there is a culture of openness in the

organisation, and reporting incidents can help to improve standards in the long term.

The hospital's record on medical research is impressive, in its role as a teaching hospital, and the number of local people taking part in clinical trials has increased substantially in recent years, which is very encouraging and allows local people to help to improve health services for all. This is a great example of collaboration between the Trust and its local population.

Patient experience

The number of complaints received by the Trust has remained broadly the same for the last few years – in 2014-2015 it received 1052 formal complaints, a slight reduction compared with 1,083 complaints in 2013-14. Given that the number of patient interactions/consultations at the hospital is probably several million a year, this is a very good record and shows the high standard of services overall.

The National Patient Survey, carried out by CQC in which the Trust participates, appears to give a slightly mixed picture: inpatient and maternity services perform well but satisfaction with A&E services appears to be falling, based on figures for 2013-14. This is an area which needs special attention and we are aware that the Trust is currently trying to address the issues of capacity and demand.

The results of this year's inpatient survey are not yet available and have not been included in the QA. We hope that they continue to show a good general level of 3 satisfaction.

The Friends and Family Test, which was introduced in 2013, is a useful indicator of patient satisfaction, but it does not have any statutory penalties attached to poor performance, and so HWW believes this is a limited tool.

The programme of Quality Inspections conducted by St George's has been supported by HWW – both from a policy perspective and by providing volunteers to act as patient representatives on inspections. HWW has advocated for improvements in the programme, some of which have been implemented. It is therefore of concern to HWW that the QI programme has been stopped due to unfilled staff vacancies. It is hoped that the programme will be restarted as soon as possible because of its benefits to St George's staff and the potential for keeping standards of care as high as possible.

Patient outcomes

The Trust has a generally good standard of patient outcomes, according to figures obtained as part of their CQC inspection. However, two areas that need some improvement are the outcomes of varicose vein surgery and groin hernias, in which the Trust falls below the national average. We would like to see some progress in these areas in time for next year's QA.

The Trust appears to be doing some very good work in reducing hospital readmissions. In 2014/15, only 3.2 per cent of patients were readmitted to hospital within 30 days. In real terms this means that 4,500 patients were readmitted to hospital within 30 days of being discharged from their previous emergency or elective admission. This is very impressive achievement and we hope that this level can be maintained or improved on in the longer term.

Performance indicators

The Trust has performed well on most of its performance indicators, including mortality rates and cancer treatment waiting times. On mortality rates, the Trust deserves recognition for being one of only 15 Trusts in the country identified by CQC as having lower than expected mortality rates.

Cancer waiting times are within the 18-week limit specified in the NHS Constitution. However, A&E waiting times continue to be the problem area, and HWW realises there is no easy answer to these difficulties. As one of the busiest A&E departments in the country, the Trust faces major challenges, particularly after a winter in which A&E admissions nationally have increased. The Trust is trying to address these problems and we hope to have further meetings with Trust representatives to discuss how these can be resolved.

Ambra Caruso, Healthwatch Wandsworth Manager
18/05/2015

Healthwatch Merton

Healthwatch Merton would formally like to recognise the achievement of St George's acquiring Foundation Trust status over the last year, which recognises the high quality services and safe care provided at St George's hospital and in the community.

Healthwatch Merton is pleased to see that St George's Hospital has performed well across most of its performance indicators. Healthwatch Merton is also happy that the trust has been tackling the issue of hospital readmissions over the past year and have seen a reduction in this. We ask that St George's continues to tackle and improve on reducing the number of readmissions in the coming year.

We were pleased to read in the Care Quality Commission report that 'there is a positive culture of learning from medicine administration errors', this only further supports the trust's good record on patient safety over the past year and its commitment to continued improvement and self-learning.

On the subject of learning, Healthwatch Merton recognises the trust's good work as a teaching hospital and the excellent medical research that it does. We note that the research work has seen an increase in the number of local people taking part in helping to improve medical provision and services for the better.

Notes of caution

A&E waiting times continue to be problematic and though we are aware that the trust is continually trying to find solutions, we ask that you ensure you work with the many local Healthwatches surrounding the trust to aid you in doing this.

In addition to this A&E satisfaction rates seem to be dropping and highlight that this department needs a particular focus. Healthwatch Merton has identified A&E as a workstream for 2015/16 and would like to work with the trust in the coming year on this.

A happy and motivated staff team works and interacts better with its patients, families and others when managed in a supportive, learning and open environment. It is therefore concerning that a third of staff have reported experiencing bullying, harassment and abuse from other staff in the past year. We acknowledge the trust has a strategy to tackle this and hope to see the number of staff experiencing this dramatically reduced in the coming year, which can only be better for the people St George's Hospital serves.

Healthwatch Merton Manager.
18/05/2015

Healthwatch Lambeth

Healthwatch Lambeth is pleased to provide this response to St George's Hospital Quality Accounts for 2014/15.

Healthwatch Wandsworth work more closely with St George's Trust than we do and provide volunteers to act as patient representatives on inspections. Healthwatch Lambeth endorses their more detailed analysis of the evidence presented under patient safety, patient experience and outcomes and performance indicators in the accounts.

The Quality Account shows many good standards of patient safety, experience and outcomes including evidence obtained during the recent CQC inspection. However, we are concerned to read that 31% of staff say that they have experienced harrassment, bullying or abuse from staff in the past 12 months and hope that future accounts are able to show real progress as a result of the strategy to tackle bullying. All people caring for people, especially people who are ill, need to be treated with dignity and respect so they can deliver outstanding experience and outcomes.

Our work in Lambeth during 2014/15 has highlighted to us the importance of gathering feedback from families and carers as well as patients. Carers' views of hospital discharge/ going home from hospital provide a valuable insight to how these multi-agency processes can be improved. We would like to see greater reference to family and carer feedback in all Quality Accounts in the future.

Catherine Pearson, Healthwatch Lambeth Manager
18/05/2015

Statement from the governors of St George's University Hospitals NHS Foundation Trust

My governor colleagues and I feel the report is well written with clear presentation, and we are broadly supportive of the trust's priorities for improvement in the coming year. We are pleased to see that progress has been made on the action plan that was implemented following the CQC report. However, there are some areas of concern that are repeatedly reported at board meetings where governors are assured that action has been taken, so it's disappointing to see some of these appearing in the Quality Account.

- **Meeting London Quality Standards: Adult acute medicine and adult emergency surgery still require improvement with standards far from being fully met, more so in surgery than in medicine. This poor performance was also picked up by the CQC in their inspection. These acute pathways make up a large percentage of inpatient work at St George's. It's important that the trust focuses on its everyday clinical work as well as its specialist areas.**
- **Complaints: The stated standard response rate to patient complaints has been on the board agenda regularly but there appears to be little improvement in this area.**
- **Research: Research is incredibly important with its link to improving patient care and treatments. However, the needs of the research team should not override the needs of the patient.**
- **Never events: The report outlines three never events in obstetrics concerning retained swabs during the last year. It seems that very little learning has taken place from RCA in these instances. At a recent board it was reported that senior clinicians were continuing to review the situation so it is disappointing that it has not improved and the error keeps occurring.**
- **We welcome the steps being taken to improve the staff ratings around bullying, harassment and discrimination and hope this is reflected in the next staff survey results.**

Kathryn Harrison, Lead Governor
21/05/2015

Independent auditor's limited assurance report to the Council of Governors and Board of Directors of St George's University Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Directors and Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- Emergency re-admissions within 28 days of discharge from hospital

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

Respective responsibilities of the directors and auditor

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' issued by Monitor.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2014/15', and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2014/15'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual', and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2014 to 28 May 2015
- papers relating to quality reported to the board over the period 1 April 2014 to 28 May 2015
- feedback from Commissioners, dated 21/05/2015
- feedback from Governors, dated 21/05/2015
- feedback from local Healthwatch organisations, dated 18/05/2015
- feedback from Overview and Scrutiny Committee, dated 18/05/2015
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2014
- the national patient survey, dated 21/05/2015
- the national staff survey, dated 24/02/2015
- Care Quality Commission Intelligent Monitoring Report, dated December 2014

- **the head of internal audit's annual opinion over the trust's control environment, dated 26 May 2015**

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body and the Board of Directors of the Trust as a body, to assist the Board of Directors and Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Board of Directors and Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body, the Council of Governors as a body and St George's University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- **evaluating the design and implementation of the key processes and controls for managing and reporting the indicators**
- **making enquiries of management**
- **analytical procedures**
- **limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation**
- **comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the quality report and**
- **reading the documents.**

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by St George's University Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- **the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual';**
- **the Quality Report is not consistent in all material respects with the sources specified above; and**
- **the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual'.**

Grant Thornton UK LLP
Grant Thornton House
Melton Street
Euston Square
LONDON
NW1 2EP
28 May 2015

Annex 2: Statement of directors' responsibilities for the quality report

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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- **the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance**
- **the content of the Quality Report is not inconsistent with internal and external sources of information including:**
  - **board minutes and papers for the period April 2014 to April 2015 papers relating to quality reported to the board over the period April 2014 to April 2105**
  - **feedback from commissioners dated 25/05/2015**
  - **feedback from governors dated 21/05/2015**
  - **feedback from local Healthwatch organisations dated 18/05/2015**
  - **feedback from Overview and Scrutiny Committee dated 18/05/2015**
  - **the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 01/04/2014**
  - **the latest national patient survey dated 08/05/2015**
  - **the latest national staff survey dated 24/02/2015**
  - **the head of internal audit's annual opinion over the trust's control environment dated 26/05/2015**
  - **CQC Intelligent Monitoring Report December 2014**
- **the quality report presents a balanced picture of the trust's performance over the period covered**
- **the performance information reported in the Quality Report is reliable and accurate**
- **there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice**
- **the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and**
- **the quality report has been prepared in accordance with Monitor's annual reporting guidelines (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.**

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

By order of the board

Chairman: 

Chief Executive: 

Appendices

Appendix A: Participation in national clinical audits and national confidential enquiries

The national clinical audits and national confidential enquires that St George's University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

	RELEVANT	PARTICIPATING	SUBMISSION RATE (%) / COMMENT
ACUTE			
National confidential enquiry into patient outcome and death	✓	✓	Sepsis: Currently 80%, data submission deadline 30th April 2015
			Gastrointestinal haemorrhage: 100%
			Lower limb amputation: 71%
			Tracheostomy care: 92%
Adult community acquired pneumonia	✓	✓	Ongoing: deadline for data entry is 31st May 2015
ICNARC case mix programme	✓	✓	Ongoing
National emergency laparotomy audit	✓	✓	2014 data – 19.4%. 2015 – ongoing
National joint registry	✓	✓	Ongoing
Pleural procedure	✓	✓	50%
Severe trauma (Trauma Audit & Research Network – TARN)	✓	✓	Ongoing
BLOOD & TRANSPLANT			
National comparative audit of blood transfusion	✓	✓	Audit of patient information and consent: 100%
			Audit of transfusion in children and adults with sickle cell disease: 100%
CANCER			
Bowel cancer	✓	✓	Ongoing
Head and neck oncology (DAHNO)	✓	✓	Ongoing (national data entry system not currently available)
Lung cancer (NLCA)	✓	✓	Ongoing, data entry for 2014 is open until 29th May 2015.
Oesophago-gastric cancer (NAOGC)	✓	✓	Ongoing
Prostate cancer	✓	✓	*Ongoing*
HEART			
Acute coronary syndrome or Acute myocardial infarction (MINAP)	✓	✓	Ongoing, data entry deadline 31st May 2015
Congenital heart disease	✓	✓	Ongoing
Cardiac rhythm management	✓	✓	Ongoing, data entry deadline 30th June 2015
Coronary angioplasty (PCI)	✓	✓	100%
National adult cardiac surgery audit	✓	✓	Ongoing, data entry deadline 30th June 2015
National cardiac arrest audit	✓	✓	Ongoing
National heart failure audit	✓	✓	Ongoing, data entry deadline 1st June 2015
National vascular registry	✓	✓	Carotid intervention: Ongoing
			AAA: Ongoing
			Peripheral arterial disease: Ongoing

LONG TERM CONDITIONS			
Diabetes (Adult)	✓	✓	*Core diabetes audit – Began collecting data in January 2015. Data collection is ongoing* Diabetes care in pregnancy: 100% Diabetes foot care – deadline 31st July 2015. We have not participated to date but intend to begin submissions in 2015/16
Diabetes (Paediatric) (NPDA)	✓	✓	100%
Inflammatory bowel disease (IBD)	✓	✓	Ongoing, data collection September 14 to February 16
National chronic obstructive pulmonary disease (COPD) audit programme	✓	✓	Organisational: 100% Secondary: 64.8% Pulmonary rehab: Ongoing, deadline for data entry is 10th July 2015
Renal replacement therapy (Renal registry)	✓	✓	Ongoing
Rheumatoid and early inflammatory arthritis	✓	✓	*Ongoing, data entry for 2014 is open until 30th April 2015.*
MENTAL HEALTH			
Mental health care in the emergency department	✓	✓	96%
OLDER PEOPLE			
Falls and Fragility Fractures Audit Programme National Hip Fracture database	✓	✓	Ongoing
Older people (care in emergency departments)	✓	✓	100%
Sentinel stroke national audit programme (SSNAP)	✓	✓	Ongoing
OTHER			
Elective surgery (National PROMS Programme)	✓	✓	Ongoing
National audit of intermediate care	✓	✓	Organisational: 100% Patient surveys: Number per organisation not reported
Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) standards for ulnar neuropathy at elbow (UNE) testing	✓	✗	We did not participate due to extended clinics and insufficient staff to complete the audit
WOMEN'S & CHILDREN'S HEALTH			
Epilepsy 12 audit (Childhood epilepsy)	✓	✓	100%
Fitting child (care in emergency departments)	✓	✓	100%
Maternal, newborn and infant clinical outcome review programme (MBRRACE-UK)	✓	✓	Ongoing
Neonatal intensive and special care	✓	✓	Ongoing
Paediatric intensive care (PICANet)	✓	✓	Ongoing

Appendix B: National clinical audit actions undertaken

The reports of 10 national clinical audits were reviewed by the provider in 2014/15 and St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

NATIONAL CLINICAL AUDIT	ACTION*
National diabetes inpatient audit	Overall 82% reported that they were satisfied or very satisfied with the overall care of their diabetes whilst in hospital. The main areas for improvement appear to be in the timing and suitability of meals and staff knowledge of diabetes. Action is underway to tackle these problems and funding from an external source is being used to finance a part time Band 6 nurse to conduct a project looking at the development of an inpatient diabetes team.
National head and neck cancer audit 2013 – ninth annual report (2014)	Action plan: • Explore the re-instatement of the RMH CNS)cancer nurse specialist) in the head and neck clinic to support those patients going for primary RT/Chemo-RT • All grades of medical staff when they start should be informed of the ideal pathway and who to involve • CNS, (and dietetic and SALT), contact numbers are displayed in all clinic rooms in ENT and Maxillofacialto remind doctors to refer patients and provide ease of referral • CNS to see patients when they are told the cancer diagnosis from FNA even if primary tumour has not been identified at that time • Letter with CNS information to be given to patients who come to the clinic for diagnosis but not able to see the CNS.
National cardiac arrest audit 2013/14	Action plan: • Closely monitor the numbers of emergency calls and determine what proportion are cardiac arrests and which are peri arrest (patient medical emergencies) • Identify any unusual trends in activity and report this back to individual care groups to investigate • Analyse cardiac arrest data monthly to look at the number of calls and survival, comparing these to previous months • Resuscitation training for all qualified nurses includes recognition and management of the deteriorating patient in an attempt to prevent cardiac arrest • Recently standardised all the defibrillators at St George's Hospital to a single model from four separate models • Ensure that emergency resuscitation equipment is readily available or accessible in all areas of the trust.
Sentinel stroke national audit programme (SSNAP)	Action Plan: The plan is multifaceted and requires engagement and support from other services within the trust, commissioners, ambulance services and local trusts. Some of the key actions include • Identified metrics to present to board as part of ongoing performance monitoring to raise awareness and suggest quarterly reporting in line with audit publication • Monthly data review by the clinical team at stroke care group • Monthly senior management meeting on stroke performance • Dedicated clinical time to validate data • A new clinical proforma • Consultant doubling-up on the HASU (hyper acute stroke unit) • Seven day therapy is now up and running. Planned improvements for the coming year include improved MRI access, increased TIA clinic activity and embedding extra consultant cover on the SU.
UK irritable bowel disease audit	At the time of this audit we did not have a paediatric IBD specialist nurse in post. This role was recruited to in February 2014 and now all paediatric inpatients are reviewed by an IBD nurse specialist.

College of emergency medicine sepsis audit 2013	Medical and nursing teaching sessions held to address: • Improving completeness of documentation of initial observations • Prescribing oxygen • Completion of audit form in notes • Prescription of fluids. Regular project meetings to ensure progress and delivery of the above actions.
British thoracic society (BTS) paediatric bronchiectasis report 2013/14	Since the appointment of the paediatric respiratory consultant the trust has contributed 1.5 WTE paediatric physiotherapists to the team to increase time available for respiratory physiotherapy and offer some cover for regional work. We now have a nominal lead for paediatric respiratory physiotherapy. From December 2014 we started a monthly bronchiectasis clinic as part of the respiratory clinic. For these clinics we are expecting the physiotherapist to be available to see children alongside the physician. It is anticipated that the development of a regular clinic will ensure a consistent approach to the performance of routine investigations.
National hip fracture database (NHFD) report 2014	Business cases have been prepared in order to increase consultant numbers. This will support improved discharge planning, facilitating quicker admission to the orthopaedic ward. Another business case has been developed to accommodate additional trauma capacity, thereby reducing delays between admission and surgery. It is expected that an additional ortho-geriatrician will be in post from March 2015. This role will impact on a number of standards, including senior review within 72 hours of admission and medication assessment. Three additional physician assistant posts have also been introduced which through a shared workload will enable improvement in a number of standards such as bone health assessment and conducting the abbreviated mental test. Recruitment of a dedicated trauma co-ordinator who will be responsible for co-ordinating the collation and completion of the trust's NHFD data will ensure robust data entry and an accurate reflection of our service.
Epilepsy 12 round 2	Action plan: • Audit results have been presented to all specialties and disciplines involved in the care of paediatric epilepsy patients for discussion, recommendations and action planning. • Changes to the waiting area have been made. • Explore the context and issues around staff not working well together. • Amend the epilepsy proforma to include a 'water safety' tick box.
Clinical audit of COPD exacerbations to acute units	Recommendations for access to specialist care has been partially addressed as, subject to provision of appropriate junior support the respiratory team will move to seven day working.

*Based on information available at the time of publication

Appendix C: Local clinical audit actions undertaken

The reports of five local clinical audits were reviewed by the provider in 2014/15 and St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

LOCAL CLINICAL AUDIT	**ACTION***
National early warning score (nEWS) audit	Actions are ongoing with continued education for registered nurses on Harm Free Care days (which are being expanded and strengthened further), nurse induction and other EWS training events. General ICU provides a three hour training session for healthcare assistants bi-monthly and EWS assessment is included as a part of the Band 5 assessment centre. It should be noted that electronic documentation has commenced in some areas and this will support accurate calculation of the warning score. Six-monthly re-audit was included in the annual programme for 2014/15.
Venous access device care audit	There was an improvement in four of the six standards compared to the 2013 audit. Poorly performing areas have been provided with their results and asked to submit action plans addressing local issues to the Venous access service and Infection control team. Ward staff will be supported through increased education provided by both of these teams, particularly in areas where attendance at FRED training has been low. All wards have also been asked to consider the use of tubi-grip instead of bandages. Re-audit will assess the impact of these changes. It is planned that the frequency of audit will increase to six-monthly and that performance across all areas of the trust will be measured.
Protected mealtimes audit	All ward areas have to ensure that they challenge and escalate non-clinically urgent interruptions, as appropriate. In addition wards that did not display information for staff, patients and visitors regarding protected mealtimes are required to display the corporate poster. Sisters and matrons, in liaison with dietitians have been asked to review nutritional screening practice and standards. Six-monthly re-audit included in the annual programme.
WHO surgical checklist audit Q3 2014/15	Action Plan: • Present findings at theatre care group and divisional governance board meetings. • MD to discuss with clinical directors and care group leads and request action plans for those specialties which are non-compliant. • Theatre matrons and team leaders to ensure there is discussion at local team meetings and an action plan for areas of non-compliance. • Theatre staff to report as adverse incident if checks are not completed.
Audit of type I education course (beta cell education resources for training in insulin and eating: BERTIE) at Queen Mary's Hospital	To explore other methods/times of presenting the BERTIE course or of providing education in smaller more manageable chunks by liaising with staff at other trusts to obtain details of the courses they offer and the rate of uptake they experience. If there is anything they are doing differently that increases attendance rate then we will consider a changed timeframe for BERTIE (e.g. evenings/Saturdays). To provide GPs with a new referral template and to re-audit to assess if this is used.

Appendix D: Further details of the agreed CQUIN goals for 2014/15

Quarter 4 and final year end CQUIN (Commissioning for Quality and Innovation) performance and achievement is currently being reviewed and finalised with commissioners. The Trust forecasts CQUIN performance delivery of 90 per cent for 2014/15.

CQUIN goals and indicators	Achievement	Comments
National CQUINs		
Friends & family test – Implementation of FFT to outpatients and daycase services – Increased response rates – Improved performance on the Staff Friends and Family Test	**Fully met**	
NHS safety thermometer – Reduction in the prevalence of pressure ulcers acquired by patients in the trust, measuring reduction in grades 2&3 for pressure ulcers using national safety thermometer as the measure. – Audit 3 nursing homes and development improvement plans	**Partially met**	Audit undertaken and action plan developed. Training package also developed and delivered to nursing homes staff. Reduction target of no more than 40 grade 3+ pressure ulcers not met.
Dementia – Find, assess, investigate and refer – Clinical leadership – Supporting carers of people with dementia	**Fully Met**	
Local CQUINs		
End of life – Establish an ongoing education and training programme around keyareas of end of life care – Extension of use of CMC or equivalent and audit use of LCP	**Fully met**	
Smoking cessation – Smokers are supported by being given advice and sign posted to relevant SSS if interested in quitting.	**Fully Met**	
NIA/PAU consultant cover – To ensure the paediatric assessment unit has consultant cover for 7days a week, between 9am and 9pm	**Fully Met**	
Maternity services – Increase midwifery workforce ratio – Supernumerary midwife cover on Delivery Suite – Deliver 144 hours consultant cover	**Fully met**	
GP communication – Continue to improve on the quality and speed of communication of discharge letters to GPs. Expand the services involved and work on developments to improve communication to patients.	**Partially met**	OP and A&E discharge summaries targets met. IP discharge summaries target of 85% electronic delivery to GPs within 48hrs not met.
Care of the elderly – To improve patient care on discharge and help signpost patients to the correct care without the need for readmission.	**Fully Met**	
Heart failure – The aim of this indicator is to improve quality of care, and reduce mortality and morbidity	**Fully Met**	
COPD – (chronic obstructive pulmonary disease) To improve the COPD pathway.	**Fully Met**	
TB – Improve contacts with positive TB patients, improve communication with GPs, ensure positive plural TB patients have a home visit in two weeks and complex TB patient are better cared for	**Fully Met**	
Medicines management – Implementation of the New Oral Anticoagulants (NOACs) guidance. Improved reporting of medication-related safety incidents.	**Fully Met**	

End of Life Care – Improve training and awareness of how to deal with EOLC. Patients placed on CMC	**Fully Met**	
Community CQUINs		
Outcomes framework – Development of an outcomes framework for the services provided within the new community adult health service model	**Fully Met**	
Learning Disabilities – Review of the service to support future redesign	**Fully Met**	
Children's services – Review of the service to support future redesign	**Fully Met**	
Information sharing – Developing multi disciplinary teams and a platform for primary care to access community data	**Fully Met**	
COTE – MDT Team – Developing MDTs to ensure staff are sharing information and providing advice and support from people with different skills.	**Fully Met**	
NHS England CQUINs		
Dashboards – Ensure providers embed and routinely use the required clinical dashboards developed during 2013/14 for specialised services.	**Fully Met**	
Perinatal pathology – To implement a nationally predictable reporting time of 42 calendar days for 70% if perinatal autopsies and also adhere to the current specification a total of 90% of all perinatal autopsies issued within 56 days	**Not Met**	Database and reporting matrix set-up and implemented. Reporting time targets not met.
Cardiac surgery – Patients referred as semi urgent to have coronary artery bypass grafting as an inpatient (with or without transfer) within 7 days of angiogram. 20% reduction in patients not being treated within 7 days following baseline received.	**Fully Met**	
Specialised orthopaedics – Complex cases of orthopaedic surgery (mainly revisions) are discussed in a network MDT and in line with agreed network protocols, to improve outcomes and reduce infections and revisions.	**Fully Met**	
Tertiary level fetal medicine Opinion within 3 days	**Fully Met**	
Retinopathy in prematurity – Increase in screening of babies with a birth weight of <1501g or a gestation of <32+0 weeks who undergo 1st Retinopathy of Prematurity (ROP) screening whilst still an in-patient and screening 'on time'	**Fully Met**	
Neuro rehab – Patient flow improvement through clinical utilisation review. Implementation of a real time web-based waiting list management system	**Fully Met**	
Severe and complex obesity – Review clinical pathway and tariff	**Fully Met**	
Breast screening – Increase in uptake	**Fully Met**	
Early years – CHIS to CHIS interface and smoking cessation	**Fully Met**	
Offender healthcare – Hepatitis B immunisation – uptake	**Partially Met**	Implementation plan was developed and delivered. However, uptake targets were not met in Q3 and Q4.
Offender healthcare – TB screening	**Fully Met**	
Offender healthcare – Staffing – The indicator measures the level of staffing in post across Offender healthcare services and aims to reduce instances where offenders cannot access healthcare due to staffing shortages.	**Partially Met**	All targets were delivered. However, final staffing establishment agreement was delayed and exceeded original deadline of Q2.
Offender healthcare – Access to mental health	**Fully Met**	

Summary financial report

As an NHS Trust

1st April 2014 – 31st January 2015

Foreword to the accounts

These accounts for the year ended 31 January 2015 have been prepared by the St George's Healthcare NHS Trust under section 98(2) of the National Health Service Act 2006 (as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Independent auditor's report to the directors of St George's University Hospitals NHS Foundation Trust

We have audited the financial statements of St George's Healthcare NHS Trust for the period ended 31 January 2015 under the Audit Commission Act 1998.

The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- **the table of salaries and allowances of senior managers [and related narrative notes] on page 171T**
- **the table of pension benefits of senior managers [and related narrative notes] on page 172T**
- **the table of pay multiples [and related narrative notes] on page 172T.**

This report is made solely to the Board of Directors of St George's University Hospitals NHS Foundation Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust's directors and the trust as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that

is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- **give a true and fair view of the financial position of St George's Healthcare NHS Trust as at 31 January 2015 and of its expenditure and income for the period then ended; and**
- **have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.**

Opinion on other matters

In our opinion:

- **the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and**
- **the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.**

Matters on which we report by exception

We report to you if:

- **in our opinion the governance statement does not reflect compliance with the NHS Trust Development Authority's Guidance**
- **we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or**

we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Certificate

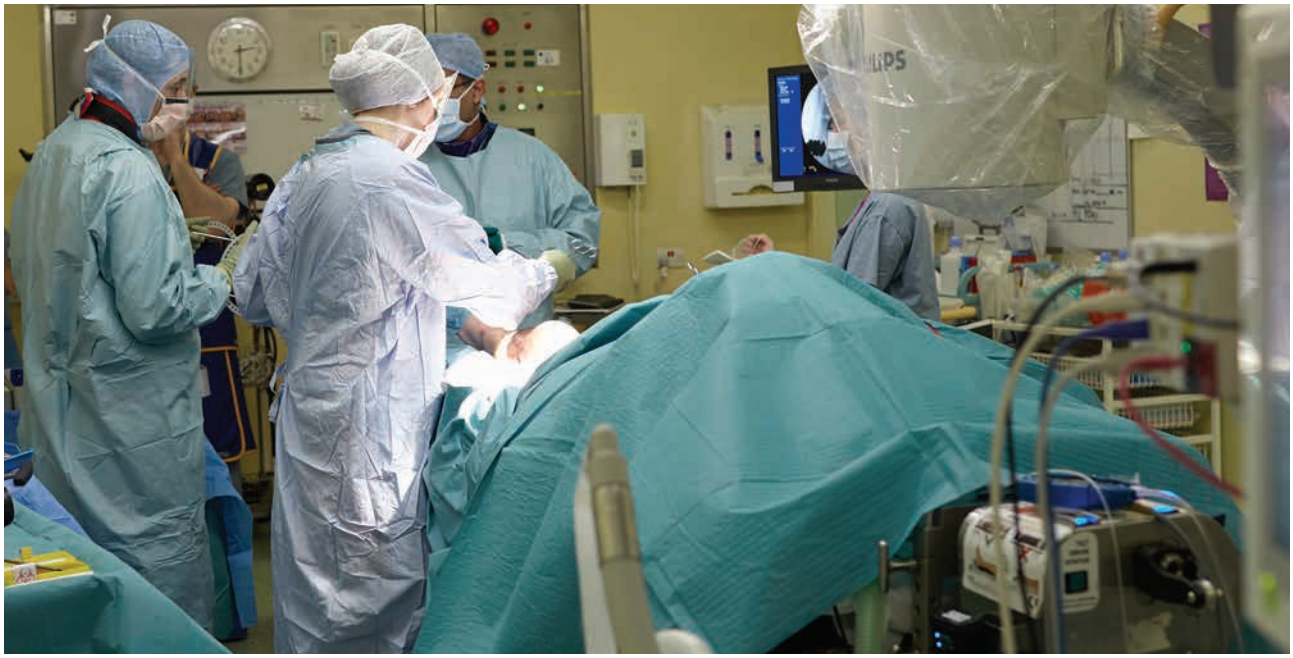
We certify that we have completed the audit of the accounts of St George's Healthcare NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Paul Dossett

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

Grant Thornton House
Melton Street
Euston Square
LONDON
NW1 2EP

28 May 2015



Salary and pension entitlements of senior managers

A) Remuneration

	For 10 months period ended 31 January 2015 2014-15						2013-14					
	10 months Salary (bands of £5,000) £000	**Expense payments (taxable) total to nearest £00**	**Performance pay and bonuses (bands of £5,000) £000**	**Long term performance pay and bonuses (bands of £5000) £000**	**All pension-related benefits (bands of £2,500) £000**	**TOTAL (bands of £5,000) £000**	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Name and Title												
Executive Directors												
Mr Miles Scott Chief executive	185-190		0			185-190	210-215	39				215-220
Mr Steven Bolam Chief Financial Officer; Deputy CEO	140-145		0			140-145	160-165					160-165
Mrs Alison Robertson Chief nurse & director of operations (left June 2014)	30-35		0			30-35	140-145					140-145
Dr Rosalind Given-Wilson Medical director	70-75		0			70-75	135-140		45-50			185-190
Ms Wendy Brewer Director of human resources	60-65		0			60-65	70-75					70-75
Dr Trudi Kemp Director of strategic development (left Sept 2014)	50-55		0			50-55	90-95		5-10			100-105
Mr Neal Deans Director of estates & facilities (left March 2014)	20-25		0			20-25	80-85					80-85
Mr Peter Jenkinson Director of corporate affairs	95-100		0			95-100	110-115					110-115
Ms Jennie Hall Chief nurse and director of infection prevention and control (from June 2014)	90-95		0			90-95	0					0
Dr Simon Mackenzie Medical director (from Jan 15)	10-15		0			10-15	0					0
Mr Eric Munro Director of estates & facilities (from Jun 2014)	45-50		0			45-50	0					0
Mr Martin Wilson Director of delivery and improvement (from August 2014)	60-65		0			60-65	0					0
Mr Rob Elek Director of strategy (from Feb 2015)	0		0			0	0					0

Salary and pension entitlements of senior managers

A) Remuneration

	For 10 months period ended 31 January 2015 2014-15						2013-14					
	10 months Salary (bands of £,5000) £000	**Expense payments (taxable) total to nearest £00**	**Performance pay and bonuses (bands of £5,000) £000**	**Long term performance pay and bonuses (bands of £5000) £000**	**All pension-related benefits (bands of £2,500) £000**	**TOTAL (bands of £5,000) £000**	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Name and Title												
Non-Executive Directors												
Mr Christopher Smallwood Trust chair	15-20		0			15-20	20-25					20-25
Mr Michael Rappolt Non-executive director	5-10		0			5-10	5-10					5-10
Dr Judith Hulf Non-executive director	5-10		0			5-10	5-10					5-10
Professor Peter Kopelman Non-executive director	5-10		0			5-10	5-10					5-10
Ms Kate Leach Non-executive director	5-10		0			5-10	5-10					5-10
Ms Stella Pantelides Non-executive director	5-10		0			5-10	5-10					5-10
Ms Sarah Wilton Non-executive director	5-10		0			5-10	5-10					5-10
Mr Paul Murphy Non-executive director (left June 2013)	5-10		0			1-5	5-10					5-10

Salary and pension entitlements of senior managers
B) Pension benefits

Name and Title	Real increase in pension at age 60	Real increase in pension and related lump sum at age 60 (bands of £2,500) £000	Lump sum at aged 60 related to accrued pension at 31 January 2015 (bands of £5,000) £000	Total accrued pension at age 60 at 31 January 2015 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 January 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase in Cash Equivalent Transfer Value 31 January 2015 £000	Employers Contribution to Stakeholder Pension To nearest £100
Mr Miles Scott Chief executive	**0 to 2.5**	7.5-10	210 to 215	70 to 75	1201	1136	65	
Mr Steve Bolam Chief Financial Officer; Deputy CEO	**2.5 to 5**	7.5-10	115 to 120	35 to 40	596	546	50	
Mrs Alison Robertson Chief nurse and director of operations	**0 to 2.5**	1 to 2.5	175 to 180	55 to 60	1023	1021	2	
Dr Rosalind Given-Wilson, Medical director	**0.00**	0.00	100 to 105	15 to 20	616	1792	0	
Wendy Brewer Director of human resources	**0 to 2.5**	5 to 7.5	115 to 120	35 to 40	786	731	55	
Dr Trudi Kemp Director of strategic development	**7.5 to 10**	30 to 32.5	115 to 120	35 to 40	279	555	0	
Mr Neal Deans Director of estates & facilities	**0 to 2.5**	0.00	0.00	0	0	0	0	
Mr Peter Jenkinson Director of corporate affairs	**0 to 2.5**	5 to 7.5	60 to 65	20 to 25	338	307	31	
Ms Jennie Hall Chief nurse and director of infection prevention and control	**2.5 to 5**	17.5 to 20	185 to 190	60 to 65	1066	974	93	
Dr Simon Mackenzie Medical director	**0 to 2.5**	0.00	0.00	0	0	0	0	
Mr Eric Munro Director of estates & facilities	**2.5 to 5**	1 to 2.5	0.00	5 to 10	55	38	18	
Mr Martin Wilson Director of delivery and improvement	**2.5 to 5**	12.5 to 15	50 to 55	15 to 20	202	179	23	
Mr Rob Elek Director of strategy	**0 to 2.5**	2.5 to 5	60 to 65	20 to 25	57	0.329	56	

Statement of comprehensive income for year ended 31 January 2015

	NOTE	10 months ended 2014-15 £000s	2013-14 £000s
Gross employee benefits	10.1	**(368,801)**	(408,611)
Other operating costs	8	**(223,620)**	(240,601)
Revenue from patient care activities	5	**507,341**	594,644
Other operating revenue	6	**84,272**	70,073
Operating surplus/(deficit)		**(808)**	15,505
Investment revenue	12	**66**	94
Other gains and (losses)	13	**(91)**	0
Finance costs	14	**(2,708)**	(3,279)
Surplus/(deficit) for the financial year		**(3,541)**	12,320
Public dividend capital dividends payable		**(6,414)**	(7,624)
Retained surplus/(deficit) for the year		**(9,955)**	4,696

Other comprehensive income

Net gain/(loss) on revaluation of property, plant & equipment		**12,853**	0
Total comprehensive income for the year		**2,898**	4,696

Financial performance for the year

Retained surplus/(deficit) for the year		**(9,955)**	4,696
IFRIC 12 adjustment (including IFRIC 12 impairments)		**1,014**	1,269
Adjustments in respect of donated gov't grant asset reserve elimination *[if required]*		**1,627**	67
Adjusted retained surplus/(deficit)		**(7,314)**	6,032

The notes on pages 1 to 46 form part of this account.

Statement of financial position as at 31 January 2015

Non-current assets

	NOTE	Balance £000s	31 January 2015 £000s	C/fwd £000s	31 March 2014 £000s
Property, plant and equipment	15	309,250	(309,250)	0	286,859
Intangible assets	16	17,047	(17,047)	0	13,466
Total non-current assets		326,422	**(326,422)**	0	300,325

Current assets

Inventories	21	7,842	(7,842)	0	7,149
Trade and other receivables	22.1	68,439	(68,439)	0	67,856
Other current assets	25	11	(11)	0	11
Cash and cash equivalents	26	19,681	(19,681)	0	22,256
Sub-total current assets		95,973	(95,973)	0	97,272
Total current assets		95,973	(95,973)	0	97,272
Total assets		422,395	(422,395)	0	397,597

Current liabilities

Trade and other payables	28	(89,169)	89,169	0	(87,571)
Provisions	35	(751)	751	0	(759)
Borrowings	30	(4,193)	4,193	0	(3,082)
Total current liabilities		(94,113)	94,113	0	(91,412)
Net current assets/(liabilities)		1,860	(1,860)	0	5,860
Total assets less current liablilities		328,282	(328,282)	0	306,185

Non-current liabilities

Provisions	35	(1,158)	1,158	0	(1,264)
Borrowings	30	(67,619)	67,619	0	(49,151)
Total non-current liabilities		(68,777)	68,777	0	(50,415)
Total assets employed:		259,505	(259,505)	0	255,770

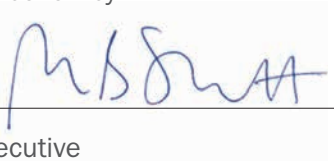
Financed by:

Public dividend capital	133,312	(133,312)	0	132,475
Retained earnings	23,178	(23,178)	0	31,531
Revaluation reserve	101,740	(101,740)	0	90,614
Other reserves	1,150	(1,150)	0	1,150
Total taxpayers' equity:	259,505	(259,505)	0	255,770

St George's Healthcare NHS Trust was licensed as a Foundation Trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

The notes on pages 1 to 46 form part of these accounts.

The financial statements on pages (i) to (iv) and the notes on pages 1 to 46 were approved by the Board on and signed on its behalf by

Signed:  Date: 28.V.15

Miles Scott Chief Executive

Statement of changes in taxpayers' equity for the year ending 31 January 2015

Changes in taxpayers' equity for 2014-15

	Public dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves
Balance at 1 April 2014	**132,475**	**31,531**	**90,614**	**1,150**	**255,770**
Retained surplus/(deficit) for the 10 months ended 31st January 2015		(9,955)			**(9,955)**
Net gain / (loss) on revaluation of property, plant, equipment			12,728		**12,853**
Transfers between revaluation reserve & retained earnings in respect of assets transferred under absorption		1,602	(1,602)		**0**
New temporary and permanent PDC received – cash	837		0		**837**
Transferred to NHS Foundation Trust	(133,312)	(23,178)	(101,740)	(1,150)	**(259,380)**
Net recognised revenue/(expense) for the year	**(132,475)**	**(31,531)**	**(90,614)**	**(1,150)**	**(255,770)**
Balance at 31 January 2015	**0**	**0**	**0**	**0**	**0**

Changes in taxpayers' equity for the year ended 31 March 2014

	Public dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves
Balance at 1 April 2013	**131,475**	**21,750**	**92,775**	**1,150**	**247,150**
Retained surplus/(deficit) for the year		4,696			4,696
Transfers between reserves		2,161	(2,161)	0	0
Transfers under modified absorption accounting – PCTs & SHAs		2,941			**2,941**
New temporary and permanent PDC received – cash	1,000				1,000
Other movements	0	1,466	(1,483)	0	(17)
Net recognised revenue/(expense) for the year	**1,000**	**11,264**	**(3,644)**	**0**	**8,620**
Transfers between reserves in respect of modified absorption – PCTs & SHAs		(1,483)	1,483	0	**0**
Balance at 31 March 2014	**132,475**	**31,531**	**90,614**	**1,150**	**255,770**

St George's Healthcare NHS Trust was licensed as a Foundation Trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

Statement of cash flows for the 10 months ended 31 January 2015

Cash flows from operating activities

	10 months ended 31st Jan 2014-15 £000s	2013-14 £000s
Operating surplus/ (deficit)	**(808)**	15,505
Depreciation and amortisation	**17,465**	18,994
Government granted assets received credited to revenue but non-cash	**(145)**	(71)
Interest paid	**(2,680)**	(3,253)
Dividend (paid)/refunded	**(3,812)**	(7,718)
(Increase)/decrease in inventories	**(693)**	42
(Increase)/decrease in trade and other receivables	**(570)**	(21,849)
(Increase)/decrease in other current assets	**0**	16
Increase/(decrease) in trade and other payables	**(771)**	26,241
Provisions utilised	**(466)**	(472)
Increase/ (decrease) in movement in non-cash provisions	**338**	443
Net cash inflow/ (outflow) from operating activities	**7,858**	27,878

Cash flows from investing activities

Interest Received	**66**	94
(Payments) for property, plant and equipment	**(22,942)**	(19,544)
(Payments) for intangible assets	**0**	(8,028)
Net cash inflow/ (outflow) from investing activities	**(26,456)**	(27,478)
Net cash inform / (outflow) before financing	**(18,598)**	400

Cash flows from financing activities

Gross temporary and permanent PDC received	**837**	1,000
Loans received from DH – new capital investment loans	**6,153**	0
Other loans received	**12,000**	0
Other loans repaid	**(194)**	(388)
Cash transferred to NHS foundation trusts or on dissolution	**(19,682)**	0
Capital element of payments in respect of finance leases and On-SoFP PFI and LIFT	**(2,772)**	(2,883)
Net cash inflow/ (outflow) from financing activities	**(3,658)**	(2,271)
NET increase/ (decrease) in cash and cash equivalents	**(22,256)**	(1,871)
Cash and cash equivalents (and bank overdraft) as at 1st April 2014	**22,256**	24,127
Cash and cash equivalents (and bank overdraft) as at 31st January 2015	**0**	22,256

St George's Healthcare NHS Trust was licensed as a Foundation Trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

Notes to the accounts

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health.

The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected.

The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.0 Going concern

These financial statements have been prepared on the basis that the Trust is a going concern.

As directed by the NHS Trust Manual For Accounts, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. Therefore financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

There has been no transfer of assets during 2014/15.

1.4 Charitable funds

"St George's Hospital Charity, although a related party, does not fall under common control with the trust. We have therefore retained the previous policy of not consolidating the Charity accounts.

IAS27 requires consolidation if the trust has the power to govern the Charity's financial and operating policies to its benefit."

1.5 Pooled budgets

The trust was not part of any Pooled budget during 2014/14.

1.6 Critical accounting judgements and key sources of estimation uncertainty

The trust's financial statements have been prepared on a going concern basis, i.e. in the expectation that the trust will continue to operate for the foreseeable future. This is reasonable for a non-profit public sector organisation unless it risks being dissolved with no transfer of its activities to another public sector body.

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Independent valuers were appointed to carry out revaluation of land and buildings. This revaluation was based on MEA (modern equivalent assets) basis.

The trust has made a critical judgement regarding the treatment of assets that are finance leases. These Finance leases relate to equipment assets used by the trust and a Private Finance Initiative (PFI). See paragraphs 1.16 Leases and 1.17 PFI Transactions.

1.6.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

Plant, Property and Equipment – Para 1.10 and Note 15

Intangible Assets – Para 1.11 and Note 16

Provision for Impairment of Receivables – Note 22.3

Provisions – Para 1.20 and Note 35

Revenue figures have been adjusted for the

Impairment of Receivables. The trust has made an appropriate Provision for Impairment of debts past their due date according to their age.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Goods are sold on an incidental basis. Income is recognised at the point the sale transaction occurs.

1.8 Employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the trust commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment 9 & 34

Recognition

Property, plant and equipment is capitalised if:

- **It is held for use in delivering services or for administrative purposes;**
- **It is probable that future economic benefits will flow to, or service potential will be supplied to the trust**
- **It is expected to be used for more than one financial year;**
- **The cost of the item can be measured reliably; and**
- **The item has cost of at least £5,000; or**
- **Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or**
- **Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.**

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Please note that full Land and Building valuation was carried out by an independent valuer as at 31st January 2015.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- **Land and non-specialised buildings – market value for existing use**
- **Specialised buildings – depreciated replacement cost**

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- **The technical feasibility of completing the intangible asset so that it will be available for use**
- **The intention to complete the intangible asset and use it**
- **The ability to sell or use the intangible asset**
- **How the intangible asset will generate probable future economic benefits or service potential**
- **The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it**
- **The ability to measure reliably the expenditure attributable to the intangible asset during its development**

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), and indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets.

The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

Asset lives

Software – 3 to 5 years
IT – 3 to 8 years
Buildings – 3 to 100 years
Plant & Machinery – 1 to 25 years
Furniture & Fittings – 5 to 25 years

At each reporting period end, the NHS trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget.

Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income.

They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The values of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that are to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained

as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

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

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS trust as lessor

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

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

1.17 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are

capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's Statement of Financial Position.

Other assets contributed by the NHS trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

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

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

1.20 Provisions

Provisions are recognised when the trust has a present legal or constructive obligation as a result of a past event, it is probable that the trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2 per cent in real terms (1.8 per cent for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust'. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.22 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or those do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the

difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets;* and

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Value Added Tax

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

1.28 Foreign currencies

The trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions.

At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend [NHS trust only]

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5 per cent) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.31 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments.

They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS bodies not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

For 2013/14 and 2014/15, in accordance with the direct accounting policy from the Secretary of State, the trust does not consolidate the NHS charitable funds for which it is the corporate Trustee.

From 1st April 2014 the trust has entered in a Joint Operation (as per IFRS 11) with Kingston NHS Foundation Trust and Croydon NHS Trust.

1.33 Joint operations

From 1 April 2015, the trust has participated in South West London Pathology, an arrangement with Kingston NHS Foundation Trust and Croydon University Hospitals NHS Trust to provide Pathology for all three organisations. The proper treatment of this was reviewed using a flowchart based on IFRS11.

The operation is under joint control: its board is made up of the three chief executives and finance directors of each trust, none of whom have overall authority. Ownership is divided based on expected usage:

Croydon University Hospitals NHS Trust	25.80%
KIngston NHS Foundation Trust	27.50%
St George's University Hospital NHS Foundation Trust	46.70%

SWL Pathology is not a separate vehicle to the three Trusts, making this a Joint Operation as defined by IFRS11.

Potential treatment	Reason not applicable under IFRS 11
Associate	Trust executives sit on the SWL pathology board, giving control over its direction.
Outside group scope	Trust executives sit on the SWL pathology board, giving control over its direction.
Subsidiary	The trust shares control with two other organisations
Joint venture	SWL pathology is not a separate vehicle, for example supplies are ordered via its constitute trusts.

1.34 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year [detail if not the case]:

IFRS 9 Financial Instruments – subject to consultation – subject to consultation

IFRS 13 Fair Value Measurement – subject to consultation

IFRS 15 Revenue from Contracts with Customers

2. Pooled budget

St George's Healthcare NHS Trust does not have any pooled budget arrangements.

3. Operating segments

This note is not applicable for St George's Healthcare NHS Trust as the organisation does not consider itself to have more than one operating segment that accounts for at least 10% of total revenue.

Income from CCGs accounts for 61% of the trust Revenue with a further 37% from NHS England. No customer external to the NHS accounts for more that 10% of the trust's revenue hence there are no other segments.

4. Income generation activities

The trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.

None of these are income generation activities whose full cost exceeded £1m or were otherwise material.

5. Revenue from patient care activities

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
NHS Trusts	**639**	1,132
NHS England	**203,121**	220,249
Clinical commissioning groups	**291,945**	358,384
Foundation trusts	**211**	3,841
Department of Health	**0**	265
NHS Other (including Public Health England and Prop Co)	**2,964**	607
Non-NHS:		
Local authorities	**13**	535
Private patients	**3,322**	3,736
Overseas patients (non-reciprocal)	**1,013**	1,274
Injury costs recovery	**3,634**	4,064
Other	**479**	557
Total revenue from patient care activities	**507,341**	594,644

6. Other operating revenue

Injury Cost Recovery income is subject to a provision for impairment of receivables of approx. 15% to reflect expected rates of collection

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**0**	5,711
Patient transport services	**165**	0
Education, training and research	**44,977**	48,263
Charitable and other contributions to revenue expenditure – NHS	0	0
Charitable and other contributions to revenue expenditure – non – NHS	**684**	930
Receipt of donations for capital acquisitions – charity	**57**	1,299
Non-patient care services to other bodies	**24,040**	7,215
Income generation	**4,521**	2,829
Rental revenue from operating leases	**164**	199
Other revenue	**9,664**	3,627
Total other operating revenue	**84,272**	70,073
Total operating revenue	**591,613**	664,717

7. Overseas visitors disclosure

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
Income recognised during 2014-15 (invoiced amounts and accruals)	**1,013**	1,274
Cash payments received in-year (re receivables at 31 March 2014)	203	258
Cash payments received in-year (in respect of invoices issued 2014-15)	116	20
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	539	680
Amounts written off in-year (irrespective of year of recognition)	173	808

8. Operating expenses

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
Services from other NHS trusts	**712**	893
Services from CCGs/NHS England	**0**	146
Services from NHS foundation trusts	**5,460**	4,784
Total services from NHS bodies	**6,172**	5,823
Purchase of healthcare from non-NHS bodies	**5,503**	5,131
Trust chair and non-executive directors	**61**	58
Supplies and services – clinical	**117,865**	127,628
Supplies and services – general	**12,775**	15,135
Consultancy services	**4,858**	3,052
Establishment	**6,557**	6,765
Transport	**4,752**	4,649
Service charges – On-SOFP PFIs and other service concession arrangements	**5,834**	6,726
Service charges – On-SOFP LIFT contracts	**0**	
Total charges – Off-SOFP PFIs and other service concession arrangements	**0**	
Total charges – Off-SOFP LIFT contracts	**0**	
Business rates paid to local authorities	**1,808**	2,084
Premises	**27,675**	29,969
Insurance	**63**	73
Legal fees	**579**	640
Impairments and reversals of receivables	**0**	386
Inventories write down	**0**	0
Depreciation	**15,109**	18,004
Amortisation	**2,356**	990
Audit fees	**95**	169
Other auditor's remuneration [detail]	**0**	0
Clinical negligence	**7,745**	9,372
Research and development (excluding staff costs)	**581**	1,199
Education and Training	**1,096**	1,343
Change in discount rate	**0**	0
Other	**2,116**	1,405
Total operating expenses (excluding employee benefits)	**223,620**	240,601

Employee benefits

Employee benefits excluding Board members	**368,022**	407,711
Board members	**779**	900
Total employee benefits	**368,801**	408,611
Total operating expenses	**592,421**	649,212

9 Operating leases

The trust has two main categories of asset held under operating leases:

1. Plant & machinery, mainly office equipment and pool cars;

2. Buildings owned by NHS Property Services Ltd and Community Health Partnership that are used by the Community Services division.

9.1 St George's Healthcare NHS trust as lessee

	Land £000s	Buildings £000s	Other £000s	10 months ended 31st January 2014-15 £000s Total £000s	2013-14 £000s
Payments recognised as an expense					
Minimum lease payments				**13,276**	14,689
Total				**13,276**	14,689
Payable:					
No later than one year	0	14,444	8	**14,452**	14,316
Between one and five years	0	9,667	20	**9,687**	3,811
After five years	0	0	0	**0**	0
Total	**0**	**24,111**	**28**	**24,139**	18,127
Total future sublease payments expected to be received:				0	0

9.2 St George's Healthcare NHS trust as lessor

The trust receives rental revenue from retail outlets on its premises

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
Recognised as revenue		
Rental revenue	164	199
Total	**164**	199
Receivable:		
No later than one year	197	197
Between one and five years	570	734
After five years	0	0
Total	**767**	931

10 Employee benefits and staff numbers

10.1 Employee benefits

	10 months ended 31st January 2014-15 Total £000s	Permanently employed £000s	Other £000s
Employee benefits – gross expenditure			
Salaries and wages	**314,602**	266,159	48,443
Social security costs	**23,477**	23,477	0
Employer contributions to NHS BSA – pensions division	**31,975**	31,975	0
Other pension costs	**20**	20	0
Total employee benefits	**370,074**	**321,631**	**48,443**
Employee costs capitalised	1,273	1,090	183
Gross employee benefits excluding capitalised costs	**368,801**	**320,541**	**48,260**

	10 months ended 31st January Total £000s	Permanently employed £000s	Other £000s
Employee benefits – gross expenditure 2013-14			
Salaries and wages	**346,514**	301,863	44,651
Social security costs	**26,825**	26,825	0
Employer contributions to NHS BSA – pensions division	**36,290**	36,290	0
Other pension costs	**135**	135	0
Total – including capitalised costs	**409,764**	365,113	44,651
Employee costs capitalised	**1,153**	1,104	49
Gross employee benefits excluding capitalised costs	**408,611**	364,009	44,602

10.2 Staff numbers

	10 months ended 31st January 2014-15 Total Number	Permanently employed Number	Other Number	2013-14 Total Number
Average staff numbers				
Medical and dental	**1,145**	1,102	43	1,083
Administration and estates	**2,115**	1,618	497	1,843
Healthcare assistants and other support staff	**576**	576	0	570
Nursing, midwifery and health visiting staff	**3,279**	2,514	765	3,128
Scientific, therapeutic and technical staff	**1,961**	1,787	174	1,723
Total	**9,076**	**7,597**	**1,479**	8,347
Of the above – staff engaged on capital projects	**25**	21	4	20

The transfer of pathology staff as part of the South West London Pathology arrangement increased staffing numbers by approximately 250 whole time equivalent.

10.3 Staff sickness absence and ill health retirements

	10 months ended 31st January 2014-15 Number	2013-14 Number
Total days lost	58,540	59,030
Total staff years	7,629	7,329
Average working days Lost	7.67	8.05
Number of persons retired early on ill health grounds	**12**	5
	£000s	£000s
Total additional pensions liabilities accrued in the year	**679**	609

10.4 Exit packages agreed in 2014-15

	2014-15			2013-14		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies Number**	**Number of other departures agreed Number**	**Total number of exit packages by cost band Number**	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages by cost band Number
£10,000-£25,000	0	0	0	1	0	1
£25,001-£50,000	0	0	0	3	0	3
Total number of exit packages by type (total cost)	**0**	**0**	**0**	4	0	4
Total resource cost (£s)	**0**	**0**	**0**	116,812	0	116,812

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the trust has agreed early retirements, the additional costs are met by the trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions' scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period. In 2014/15, there were no exit packages.

10.5 Exit packages – other departures analysis

There were no other exit packages in 2013/14 or 2014/15.

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14 per cent of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5 per cent.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14 per cent of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5 per cent up to 8.5 per cent of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a final salary scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties

effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better payment practice code

11.1 Measure of compliance

	10 months ended 31st January 2014-15 Number	10 months ended 31st January 2014-15 £000s	2013-14 Number	2013-14 £000s
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**146,851**	**234,597**	136,028	229,392
Total non-NHS trade invoices paid within target	**85,813**	**129,877**	110,250	176,006
Percentage of NHS trade invoices paid within target	**58.44%**	**55.36%**	81.05%	76.73%
NHS Payables				
Total NHS trade invoices paid in the year	**3,526**	**47,055**	4,717	57,846
Total NHS trade invoices paid within target	**1,040**	**22,937**	2,946	44,580
Percentage of NHS trade invoices paid within target	**29.50%**	**48.75%**	62.45%	77.07%

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

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
Amounts included in finance costs from claims made under this legislation	**1**	5
Total	**1**	5

12 Investment revenue

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
Rental revenue		
Subtotal	**0**	0
Interest revenue		
Bank interest	**66**	94
Subtotal	**66**	94
Total investment revenue	**66**	94

13 Other gains and losses

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
The loss in 2014/15 relates to the disposal of medical equipment.	**(91)**	0
	(91)	0

14 Finance costs

Interest

	10 months ended 31st January 2014-15 £000s	2013-14 £000s
Interest on loans and overdrafts	**39**	0
Interest on obligations under finance leases	**128**	165
Interest on obligations under PFI contracts:		
– Main finance cost	**2,526**	3,084
Interest on obligations under LIFT contracts:		
Interest on late payment of commercial debt	**0**	4
Total interest expense	**2,693**	3,253
Other finance costs	**0**	0
Provisions – unwinding of discount	**15**	26
Total	**2,708**	3,279

15.1 Property, plant and equipment 2014/15

Cost or valuation:

	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2014	**72,476**	**183,442**	**0**	**19,455**	**94,535**	**144**	**22,807**	**12,930**	**405,789**
Additions of assets under construction				**22,979**					**22,979**
Additions purchased	0	0	0		2,848	0	123	35	**3,006**
Additions – non cash donations (i.e. physical assets)	0	0	0	0	0	0	0	0	**0**
Additions – purchases from cash donations & government grants	0	0	0	0	50	0	0	0	**50**
Additions leased	0	0	0		4,393	0	0	0	**4,393**
Reclassifications	0	7,286	0	(17,617)	60	0	4,345	362	**(5,564)**
Reclassifications as held for sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	(169)	0	0	(1,278)	0	0	0	**(1,447)**
Upward revaluation/ positive indexation	(8,544)	21,272	0	0	0	0	0	0	**12,728**
Impairments/negative indexation	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Transfers to NHS foundation trust	(63,932)	(211,831)	0	(24,817)	(100,608)	(144)	(27,275)	(13,327)	**(441,934)**
Transfers (to)/from Other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0	**0**
At 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Depreciation

At 1 April 2014	**0**	**20,996**	**0**	**0**	**72,811**	**144**	**16,601**	**8,378**	**118,930**
Disposals other than for sale	0	(78)	0		(1,278)	0	0	0	**(1,356)**
Charged during the year	0	8,355	0		4,590	0	1,544	620	**15,109**
Transfers to NHS foundation trust	0	(29,273)	0	0	(76,123)	(144)	(18,145)	(8,998)	**(132,683)**
At 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Asset financing

	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Owned – purchased	0	0	0	0	0	0	0	0	0
Owned – donated	0	0	0	0	0	0	0	0	0
Owned – government granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation reserve balance for property, plant & equipment

	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2014	57,924	21,297	0	0	9,356	23	435	1,579	**90,614**
Movements (specify)	(8,544)	21,272	0	0	(1,601)	0	0	0	**11,127**
At 31 January 2015	**49,380**	**42,569**	**0**	**0**	**7,755**	**23**	**435**	**1,579**	**101,741**

Additions to assets under construction

	Assets under construction & payments on account £000's
Land	0
Buildings excluding dwellings	22,979
Dwellings	0
Plant & machinery	0
Balance as at YTD	**22,979**

St George's Healthcare NHS Trust was licensed as a foundation trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

15.2 Property, plant and equipment prior year 2013/14

Cost or valuation

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and poa £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
At 1 April 2013	71,461	177,757	0	12,304	87,773	144	22,685	12,583	**384,707**
Transfers under modified absorption accounting – PCTs & SHAs	1,015	1,926	0	0	0	0	0	0	**2,941**
Additions purchased	0	3,094	0		4,453	0	121	319	**7,987**
Additions government granted	0	127	0	0	272	0	1	14	**414**
Additions leased	0	0	0	0	1,165	0	0	0	**1,165**
Reclassifications	0	538	0	(3,791)	1,937	0	0	14	**(1,302)**
Reclassifications as held for sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,065)	0	0	0	**(1,065)**
At 31 March 2014	**72,476**	**183,442**	**0**	**19,455**	**94,535**	**144**	**22,807**	**12,930**	**405,789**

Depreciation

At 1 April 2013	0	10,959	0	0	68,316	144	14,976	7,596	**101,991**
Disposals other than for sale	0	0	0	0	(1,065)	0	0	0	**(1,065)**
Charged during the year	0	10,037	0	0	5,560	0	1,625	782	**18,004**
At 31 March 2014	**0**	**20,996**	**0**	**0**	**72,811**	**144**	**16,601**	**8,378**	**118,930**
Net book value at 31 March 2014	**72,476**	**162,446**	**0**	**19,455**	**21,724**	**0**	**6,206**	**4,552**	**286,859**

Asset financing

Owned – purchased	71,461	102,152	0	18,571	15,294	0	5,780	2,537	**215,795**
Owned – donated	1,015	10,345	0	884	1,050	0	46	381	**13,721**
Owned – government granted	0	1,920	0	0	874	0	0	56	**2,850**
Held on finance lease	0	0	0	0	4,506	0	380	602	**5,488**
On-SOFP PFI contracts	0	48,029	0	0	0	0	0	976	**49,005**
Total at 31 March 2014	**72,476**	**162,446**	**0**	**19,455**	**21,724**	**0**	**6,206**	**4,552**	**286,859**

15.3 Property, plant and equipment

The trust has recognised capital donations receivable towards the cost of the construction of a helipad and various items of medical equipment. These donations are receivable from the County Air Ambulance Trust, St George's Hospital Charity and First Touch Charity.

The trust's valuation of land and buildings were reviewed in March 2013 by the Valuation Office on the Modern Equivalent Asset (MEA) basis applicable to an NHS trust. The valuation was effective from 31 March 2013.

An extensive valuation was carried out in March 2015 with an effective date of 31st January 2015.

Buildings are subject to composite depreciation rates according to their elemental breakdown e.g. substructure 80 years, internal walls 25 years etc. Medical equipment is in general depreciated over 5, 10 or 15 years.

Buildings (excluding dwellings) asset lives from 3 to 100 years

Dwellings asset lives from 15 to 80 years

Plant & machinery asset lives from 1 to 25 years

Transport equipment asset lives from 5 to 7 years

Information technology asset lives from 3 to 15 years

Furniture & fittings asset lives from 5 to 25 years

There is no compensation from third parties for assets impaired, lost or given up, that is included in the trust's surplus.

16.1 Intangible non-current assets

	IT – in-house & 3rd party software £000's	Computer Licenses £000's	Licenses and Trademarks £000's	Patents £000's	Development Expenditure – Internally Generated £000's	Total £000's
At 1 April 2014	**18,949**	**792**	**0**	**0**	**0**	**19,741**
Additions purchased	0	365	0	0	0	**365**
Additions – purchases from cash donations and government grants	0	8	0	0	0	**8**
Reclassifications	5,564	0	0	0	0	**5,564**
Transfer to NHS foundation trust	(24,513)	(1,165)	0	0	0	**(25,678)**
At 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation At 1 April 2014	**5,796**	**479**	**0**	**0**	**0**	**6,275**
Charged during the year	2,263	93	0	0	0	**2,356**
Transfer to NHS foundation trust	(8,059)	(572)	0	0	0	**(8,631)**
At 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**
Asset financing: net book value at 31 January 2015 comprises:						
Total at 31 January 2015	0	0	0	0	0	**0**

St George's Healthcare NHS Trust was licensed as a foundation trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

16.2 Intangible non-current assets prior year

	IT – in-house & 3rd party software £000's	Computer Licenses £000's	Licenses and Trademarks £000's	Patents £000's	Development Expenditure – Internally Generated £000's	Total £000's
Cost or valuation:						
At 1 April 2013	10,852	715	0	0	0	11,567
Additions – purchased	6,795	77	0	0	0	6,872
Additions – internally generated	0	0	0	0	0	0
Additions – donated	0	0	0	0	0	0
Reclassifications	1,302	0	0	0	0	1,302
At 31 March 2014	**18,949**	**792**	**0**	**0**	**0**	**19,741**
Amortisation At 1 April 2013	4,902	383	0	0	0	5,285
Charged during the year	894	96	0	0	0	990
At 31 March 2014	**5,796**	**479**	**0**	**0**	**0**	**6,275**
Net book value at 31 March 2014	**13,153**	**313**	**0**	**0**	**0**	**13,466**

16.3 Intangible non-current assets

For computer software internally generated intangible assets are valued at cost unless assessed as having a fair value which differs to cost.

Software purchased is amortised on a straight line basis over the life of the asset.

Software assets relating to the Trust iCLIP patients data systems are amortised over ten years.

All other software assets are amortised between five and ten years.

17 Analysis of impairments and reversals recognised in 2014-15

There were no impairments or reversals recognised in 2014/15.

18 Investment property

The trust has no investment property.

19 Commitments

19.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:	31 January 2015 £000s	31 March 2014 £000s
Property, plant and equipment	**17,792**	2,279
Total	**17,792**	2,279

19.2 Other financial commitments

The trust has not entered into any non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

20 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
At 31 January 2015	0	0	0	0
Prior period:				
Balances with other central government bodies	25,974	0	6,678	0
Balances with local authorities	557	0	0	0
Balances with NHS bodies outside the departmental group	22	0	230	0
Balances with NHS trusts and foundation trusts	6,876	0	4,161	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	34,427	0	76,502	0
At 31 March 2014	**67,856**	**0**	**87,571**	**0**

St George's Healthcare NHS Trust was licensed as a foundation trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

21 Inventories

	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2014	**1,781**	**5,252**	**0**	**52**	**0**	**64**	**7,149**	0
Additions recognised as an expense in the period	41,240	12,194	0	0	0	0	**53,434**	0
Inventories recognised as an expense in the period	(40,825)	(11,896)	0	0	0	0	**(52,721)**	0
Transfers (to) foundation trusts	(2,176)	(5,550)	0	(52)	0	(64)	**(7,842)**	0
Balance at 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

22.1 Trade and other receivables

	Current		Non-current	
	31 January 2015 £000s	31 March 2014 £000s	**31 January 2015 £000s**	31 March 2014 £000s
NHS receivables – revenue	**0**	31,252	**0**	0
NHS prepayments and accrued income	**0**	1,620	**0**	0
Non-NHS receivables – revenue	**0**	26,428	**0**	0
Non-NHS prepayments and accrued income	**0**	8,186	**0**	0
Provision for the impairment of receivables	**0**	(5,177)	**0**	0
VAT	**0**	5,546	**0**	0
Other receivables	**0**	1	**0**	0
Total	**0**	67,856	**0**	0

Total current and non-current	**0**	67,856

Included in NHS receivables are prepaid pension contributions:	**0**

The great majority of trade is with clinical commissioning groups. As clinical commissioning groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Receivable past their due date but not impaired

	31 January 2015 £000s	31 March 2014 £000s
By up to three months	**5,090**	1,384
By three to six months	**1,999**	2,132
By more than six months	**10,398**	4,234
Total	**17,487**	7,750

No further commentary has been included

22.3 Provision for impairment of receivables

	2014-15 £000s	2013-14 £000s
Balance at 1 April 2014	**(5,177)**	(5,664)
Amount written off during the year	**186**	873
(Increase)/decrease in receivables impaired	**0**	(386)
Transfer to NHS foundation trust	**4,991**	
Balance at 31 January 2015	**0**	(5,177)

The trust provides for the impairment of receivables on the basis of historical collection rates information and management assessment on the recoverability of non NHS debts.

St George's Healthcare NHS Trust was licensed as a foundation trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

23 NHS LIFT investments

The trust does not have any LIFT investments.

24.1 Other financial assets – current

The trust has no other current financial assets

24.2 Other financial assets – non current

The trust has no other non-current financial assets

25 Other current assets

	31 January 2015 £000s	31 March 2014 £000s
Other assets	**0**	11
Total	**0**	11

26 Cash and cash equivalents

	31 January 2015 £000s	31 March 2014 £000s
Opening balance	**22,256**	24,127
Net change in year	**(22,256)**	(1,871)
Closing balance	**0**	22,256
Made up of		
Cash with government banking service	**0**	22,045
Commercial banks	**0**	211
Cash and cash equivalents as in statement of financial position	**0**	22,256
Cash and cash equivalents as in statement of cash flows	**0**	22,256

St George's Healthcare NHS Trust was licensed as a foundation trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

27 Non-current assets held for sale

The trust has no non current assets held for sale.

28 Trade and other payables

	Current		Non-current	
	31 January 2015 £000s	31 March 2014 £000s	**31 January 2015 £000s**	31 March 2014 £000s
NHS payables – revenue	0	6,171	0	0
NHS accruals and deferred income	0	439	0	0
Non-NHS payables – revenue	0	49,656	0	0
Non-NHS payables – capital	0	3,280	0	0
Non-NHS accruals and deferred income	0	6,126	0	0
Social security costs	0	4,412		
Tax	0	4,537		
Payments received on account	0	5,031	0	0
Other	0	7,919	0	0
Total	0	87,571	0	0

Total payables (current and non-current)	**0**	**87,571**
Included above:		
Outstanding pension contributions at the year end	**0**	5,336

29 Other liabilities

The trust has no other liabilities.

30 Borrowings

	Current		Non-current	
	31 January 2015 £000s	31 March 2014 £000s	**31 January 2015 £000s**	31 March 2014 £000s
Loans from other entities	**0**	388	**0**	194
PFI liabilities				
Main liability	**0**	810	**0**	46,454
Finance lease liabilities	**0**	1,884	**0**	2,503
Other (describe)	**0**	0	**0**	0
Total	**0**	**3,082**	**0**	**49,151**
Total other liabilities (current and non-current)	**0**	**52,233**		

St George's Healthcare NHS Trust was licensed as a foundation trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

31 Other financial liabilities

The trust does not have any other financial liabilities.

32 Deferred revenue

	Current	
	31 January 2015 £000s	31 March 2014 £000s
Opening balance at 1 April 2014	**1,888**	2,037
Deferred revenue addition	**0**	1,888
Transfer of deferred revenue	**(1,888)**	(2,037)
Current deferred Income at 31 January 2015	**0**	1,888
Total deferred income (current and non-current)	**0**	1,888

33 Finance lease obligations as lessee

The trust has a number of finance leases for high value capital medical equipment and the Picture Archiving Communications System (PACS) which is provided under a managed equipment service. In addition for trust accounts for £1.5m capital investment in catering facilities undertaken by Mitie PLC in 2009/10 as a finance lease.

The trust has no building or land finance leases.

Amounts payable under finance leases (Other)

	Minimum lease payments		Present value of minimum lease payments	
	31 January 2015 £000s	31 March 2014 £000s	**31 January 2015 £000s**	31 March 2014 £000s
Within one year	**0**	2,010	**0**	1,884
Between one and five years	**0**	2,532	**0**	2,378
After five years	**0**	138	**0**	125
Less future finance charges	0	(293)		
Minimum lease payments / present value of minimum lease payments	**0**	4,387	**0**	4,387
Included in:				
Current borrowings			**0**	1,884
Non-current borrowings			**0**	2,503
Total			**0**	4,387

34 Finance lease receivables as lessor

The trust does not have any finance leases where it is the lessor.

St George's Healthcare NHS Trust was licensed as a foundation trust by Monitor with effect from 1st February 2015 and therefore all the assets and liabilities of the trust transferred to the successor organisation, St George's University Hospitals NHS Foundation Trust on that date.

35 Provisions

Comprising:

	Total £000s	Early Departure Costs £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay (incl. Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2014	**2,023**	1,412	326	0	0	0	285	0
Arising during the year	**346**	33	127	0	0	0	186	0
Utilised during the year	**(466)**	(157)	(25)	0	0	0	(284)	0
Reversed unused	**(8)**	0	(7)	0	0	0	(1)	0
Unwinding of discount	**15**	15	0	0	0	0	0	0
Transfers to NHS foundation trusts (for trusts becoming FTs only)	**(1,910)**	(1,303)	(421)	0	0	0	(186)	0
Balance at 31 January 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Expected Timing of Cash Flows:

Amount Included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:	£000s
As at 31 January 2015	159,685
As at 31 March 2014	102,429

The provision for CRC (Carbon Reduction Commitment) shown in other provisions is £285K, is based on 2013/14 figures. Provision for pension costs is calculated using information provided by the NHS Pensions Agency. Provision for legal claims has been calculated using figures and estimated probabilities supplied by the NHS Litigation Authority, the trust solicitors and the human resources department.

36 Contingencies

The trust has no contingent assets or liabilities.

37 PFI and LIFT – additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

	2014-15 £000s	2013-14 £000s
Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Service element of on SOFP PFI charged to operating expenses in year	**5,834**	6,536
Total	**5,834**	6,536

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No later than one year	**6,872**	6,536
Later than one year, no later than five years	**27,486**	26,145
Later than five years	**134,187**	133,205
Total	**168,545**	165,886

The estimated annual payments in future years are not expected to be materially different from those which St George's Healthcare NHS Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due	2014-15 £000s	2013-14 £000s
No later than one year	**3,841**	3,841
Later than one year, no later than five years	**15,363**	15,363
Later than five years	**71,134**	74,335
Subtotal	**90,338**	93,539
Less: interest element	**(43,749)**	(46,275)
Total	**46,589**	47,264

Present value imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	2014-15 £000s	2013-14 £000s
No later than one year	**857**	810
Later than one year, no later than five years	**4,074**	3,849
Later than five years	**41,658**	42,605
Total	**46,589**	47,264

Number of on SOFP PFI Contracts	
Total Number of on PFI contracts	**1**

Present value imputed "finance lease" obligations for off SOFP PFI contracts due	2014-15 £000s	2013-14 £000s
Analysed by when PFI payments are due	**0**	0
Total	**0**	0

Number of on SOFP PFI contracts	2014-15 £000s	2013-14 £000s
Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**0**	0
Total	**0**	0

On 20th of March 2000 the trust signed a contract for the exclusive use for 35 years of Atkinson Morley wing on the St George's Hospital site. Blackshaw Healthcare Services Ltd, a special purpose vehicle company owned by private consortium, constructed the building which the trust uses primarily to provide cardiac and neurosciences healthcare services. The estimated capital value of the facility on construction was approx. £50m.

	£000
Estimated capital value of the PFI scheme	**50,000**
Contract start date	**20th of March 2000**
Contract end date	**8th of August 2038**

Accounting treatment

The first unitary payment was payable by the trust when the new facility became available for use in August 2003 and the last payment will be payable by the trust in 2038/39. Previously the trust had accounted for this PFI scheme as 'off-balance sheet' however this accounting treatment has changed to on – Statement of Financial Position under IFRIC 12 which is applicable to NHS trusts on the adoption of International Financial Reporting Standards (IFRS).

IFRIC12

Under IFRIC 12 the building is accounted as an asset of St George's Healthcare NHS Trust and the value of the building and fixtures and fittings subject to the contract are included within fixed assets. The contract is classified as a fiancé lease with the unitary payments split into two main components: the imputed finance lease charges (comprising interest payable and lease repayments) and service charge relating to the facilities management services e.g. buildings maintenance, domestics services provided by Blackshaw Healthcare Services Ltd.

Expiration of contract

On the expiration of the contract term in 2038/39 the trust assumes ownership of all the building and equipment assets subject to the contract with BHS for £nil consideration and also assumes responsibility for the provision of the services provided during the contract by BHS.

Termination rights

The trust may at any time within a period of 90 days after an Event of Default (as defined in the contract) by Blackshaw Healthcare Services Ltd terminate the contract without prejudice to any of its other rights and remedies by notice in writing to BHS with effect from 30 days notice.

38 Impact of IFRS treatment – current year

	2014-15 £000s	2013-14 £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)		
Depreciation charges	**1,689**	2,026
Interest expense	**2,526**	3,084
Other expenditure	**5,726**	6,536
Total IFRS expenditure (IFRIC12)	**9,941**	**11,646**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(8,927)**	(10,377)
Net IFRS change (IFRIC12)	**1,014**	**1,269**
Capital consequences of IFRS: LIFT/PFI and other items under IFRIC12		
UK GAAP capital expenditure 2014-15 (reversionary interest)	**145**	165

39 Financial instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with CCGS and the way those CCGS are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

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

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from internally generated resources and where appropriate with external financing. The trust is not, therefore, exposed to significant liquidity risks.

39.2 Financial assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0			**0**
Receivables – NHS		0		**0**
Receivables – non-NHS		0		**0**
Cash at bank and in hand		0		**0**
Other financial assets	0	0	0	**0**
Total at 31 January 2015	**0**	**0**	**0**	**0**
Embedded derivatives	0			**0**
Receivables – NHS		31,252		**31,252**
Receivables – non-NHS		26,428		**26,428**
Cash at bank and in hand		22,256		**22,256**
Other financial assets	0	0	0	**0**
Total at 31 March 2014	0	79,936	0	**79,936**

39.3 Financial liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0		**0**
NHS payables		0	**0**
Non-NHS payables		0	**0**
Other borrowings		0	**0**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 January 2015	**0**	**0**	**0**

Embedded derivatives	0		0
NHS payables		6,171	6,171
Non-NHS payables		52,936	52,936
Other borrowings		582	582
PFI & finance lease obligations		51,651	51,651
Other financial liabilities	0	0	0
Total at 31 March 2014	0	111,340	111,340

40 Events after the end of the reporting period

St George's Healthcare NHS Trust was granted licence by Monitor to become a foundation trust from 1st February 2015.

41 Related party transactions

The Department of Health (DH) is regarded as a related party. During the year, St George's Healthcare NHS Trust has had a significant number of material transactions with the DH, and with other entities for which the DH is regarded as the parent department.

Organisation type	Total (£k) Income 10M 14-15	Total (£k) Expenditure 10M 14-15
NHS foundation trusts	5,747	10,500
NHS trusts	4,520	2,963
Department of Health		0
Public Health England		0
Heath Education England		
CCGs and NHS England	507,579	355
Special Health Authorities	3	7,745
Non-departmental public bodies		12
Other DH bodies	167	11,654
Total intra-NHS balances	**518,016**	**33,229**

2014-15

Department of Health
NHS England
CCGs (Clinical Commissioning Groups)
- Wandsworth Teaching CCG
- Sutton and Merton CCG
- Croydon CCG
- Surrey CCG
- Lambeth CCG
- Kingston CCG
- Richmond & Twickenham CCG
- West Sussex CCG
- Hampshire CCG
- **NHS Foundation Trusts**
- **NHS Trusts**
- **NHS Litigation Authority**
- **NHS Business Services Authority**

2014-15

Department of Health
NHS England
CCGs (Clinical Commissioning Groups)
- Wandsworth Teaching CCG
- Sutton and Merton CCG
- Croydon CCG
- Surrey CCG
- Lambeth CCG
- Kingston CCG
- Richmond & Twickenham CCG
- West Sussex CCG
- Hampshire CCG
- **NHS Foundation Trusts**
- **NHS Trusts**
- **NHS Litigation Authority**
- **NHS Business Services Authority**

Amounts received from the CCGs (Clinical Commissioning Groups) relates to the trust's contracts for patient services. The amount received from NHS London primarily relates to teaching and training.

Non – NHS related party transactions

	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
St George's, University of London	6,606	1,835	1,935	1,445
Wendy Brewer is the joint director of human resources for both St George's Healthcare NHS Trust and St George's, University of London. Eric Munro is the joint director of estates and facilities for both St George's Healthcare NHS Trust and St George's, University of London. Professor Peter Kopelman is the principal of SGUL and also a non-executive director of St George's Healthcare NHS Trust. Transactions with respect to St George's, University of London on behalf of St George's Medical School mainly relates to the provision of clinical staff and overheads costs.				
St George's Hospital Charity	0	604	1	421
Transactions with respect to St George's, University of London on behalf of St George's Medical School mainly relates to the provision of clinical staff and overheads costs. Receipts from the St George's Hospital Charity relate to capital and revenue expenditure to be funded by the charity.				

42 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:	Total value of cases £s	Total number of cases
Special payments	13,061	57
Total losses and special payments	13,061	57

The total number of losses cases in 2013-14 and their total value was as follows:	Total value of cases £s	Total number of cases
Losses	887	2
Special payments	40420	99
Total losses and special payments	41,307	101

Details of cases individually over £300,000
No such payments were made in 2014/15 or 2013/14

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance

	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	10M2014-15 £000s
Turnover	336,896	384,146	410,129	438,979	488,830	604,247	620,411	641,768	664,717	591,613
Retained surplus/ (deficit) for the year	(33,569)	(2,901)	5,972	1,718	10,552	5,020	5,728	3,134	4,696	(9,955)
Adjustment for:										
Timing/non-cash impacting distortions:										
Adjustments for impairments				0	1,083	0	0	1,028	0	0
Adjustments for impact of policy change re donated/ government grants assets							(1,060)	775	67	1,627
Consolidated budgetary guidance – adjustment for dual accounting under IFRIC12*					1,298	1,439	1,433	1,349	1,269	1,014
Break-even in-year position	**(11,573)**	**(2,901)**	**5,972**	**1,718**	**12,933**	**6,459**	**6,101**	**6,286**	**6,032**	(7,314)
Break-even cumulative position	**(35,169)**	**(38,070)**	**(32,098)**	**(30,380)**	**(17,447)**	**(10,988)**	**(4,887)**	**1,399**	**7,431**	**117**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	10M 2014-15 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	-3.44	-0.76	1.46	0.39	2.65	1.07	0.98	0.98	0.91	-1.24
Break-even cumulative position as a percentage of turnover	-10.44	-9.91	-7.83	-6.92	-3.57	-1.82	-0.79	0.22	1.12	0.02

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5 per cent.

43.3 External financing

The trust is given an external financing limit which it is permitted to undershoot.

	2014-15 £000s	2013-14 £000s
External financing limit (EFL)	22,179	4,349
Cash flow financing	18,598	(400)
Unwinding of discount adjustment		26
Finance leases taken out in the year	3,581	1,165
External financing requirement	22,179	791
Under/ (over) spend against EFL	**0**	3,558

The under spend relates to slippage on several capital projects.

43.4 Capital resource limit

The trust is given a capital resource limit which it is not permitted to exceed.

	2014-15 £000s	2013-14 £000s
Gross capital expenditure	30,657	27,219
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	0	(1,299)
Charge against the capital resource limit	30,657	25,920
Capital resource limit	30,657	28,989
(Over)/underspend against the capital resource limit	**0**	3,069

The under spend relates to slippage on several capital projects.

44. Third party assets

St George's Healthcare NHS Trust held cash and cash equivalents on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 January 2015 £000s	31 March 2014 £000s
Third party assets held by St George's Healthcare NHS Trust	8	8

Summary financial report

As a Foundation NHS Trust

1st February – 31st March 2015

Foreword to the Accounts

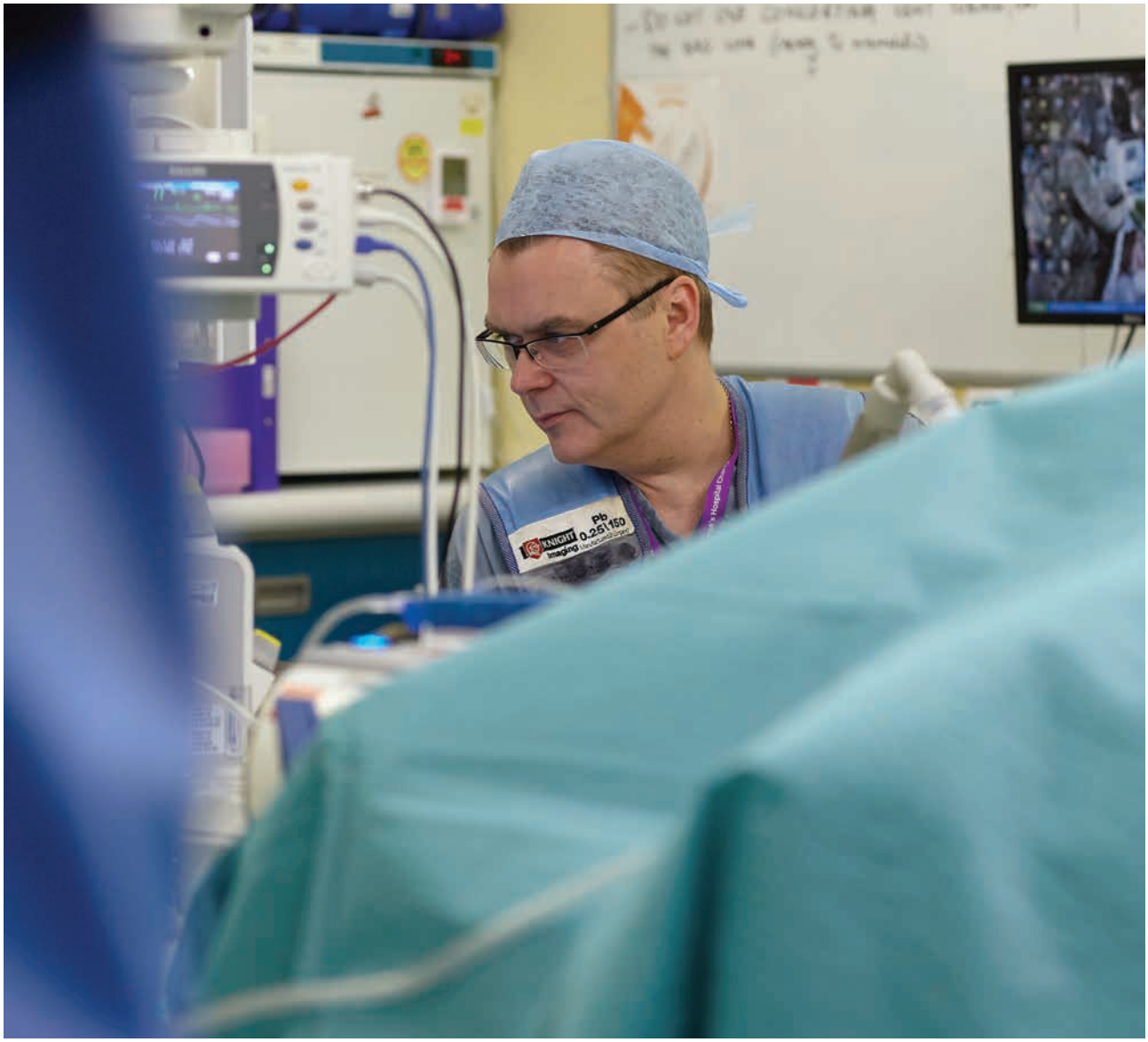
St George's University Hospitals NHS Foundation Trust

These accounts for two months ended 31 March 2015 have been prepared by the St George's University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006.

Signed _____ 28.V.15

Miles Scott, Chief Executive

28 May 2015



Independent auditor's report to the council of governors of St George's University Hospitals NHS Foundation Trust

Our opinion on the financial statements is modified

In our opinion the financial statements:

- give a true and fair view of the state of the financial position of St George's University Hospitals NHS Foundation Trust as at 31 March 2015 and of its income and expenditure for the period then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Emphasis of matter – Going concern

In forming our opinion on the financial statements, we have considered the adequacy of the disclosures made in note 1.0 to the financial statements concerning the Trust's ability to continue as a going concern.

The Trust incurred a deficit of £6.8 million during the two month period ended 31 March 2015 and a combined deficit of £16.8 million for the whole of the 2014/15 financial year. At year end the directors' were seeking additional support from Monitor for 2015/16 of £52.2 million. As disclosed in note 1.0 to the financial statements, Monitor has not provided the Trust with this assurance at the date of our report. These conditions, along with the other matters explained in note 1.0 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the NHS Foundation Trust Annual Reporting Manual 2014/15, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

On this basis, the Trust has adopted the going concern basis for preparing the accounts and has not included the adjustments that would result if it was unable to continue as a going concern.

Who are we reporting to:

This report is made solely to the Council of Governors of St George's University Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of St George's University Hospitals NHS Foundation Trust ('the Trust') for the two month period ended 31 March 2015 which comprise the statement of comprehensive income, the statement of financial position, the statement of cash flows, the statement of changes in taxpayers' equity and the related notes.

The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

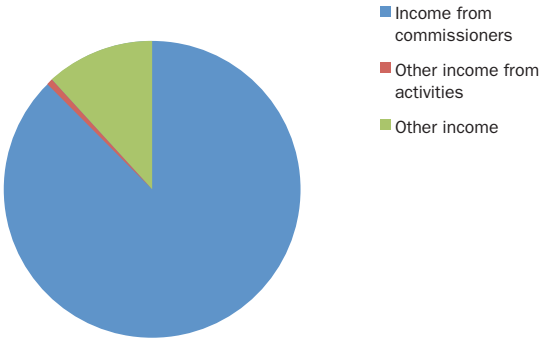
Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that are, in our judgement, likely to be most important to users' understanding of our audit.

Valuation of contract income from commissioning bodies and associated receivables

The risk: The Trust receives a large proportion of its income from commissioners of healthcare services. It invoices its commissioners throughout the year for services provided, and at the year-end estimates and accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the year-end and after the deadline for the production of the financial statements. There is therefore a risk that the income from commissioners (and associated receivables) recognised in the financial statements may be misstated. We identified the accounting for the contract arrangements with commissioning bodies (in particular the consistency of the income with contract terms) as one of the risks that had the greatest impact on our audit strategy.

Operating income 2014/15



Our response: Our audit work included, but was not restricted to, assessing the Trust's accounting policy for revenue recognition, understanding management's processes to recognise this income in accordance with the stated accounting policy, performing walk-throughs of management's key controls over income recognition (for example controls over contract billing, pricing and agreement of contract variations) to assess whether they were designed effectively and substantively testing the income and associated receivables.

Our substantive testing included:

- **testing the reconciliation of the income figures in the financial statements for material contracts with commissioning bodies to signed contracts;**
- **testing a sample of the contract variations to ensure they were accounted for appropriately and are not in dispute; and**
- **testing any significant non-contractual adjustments to commissioning income, such as income for partially completed healthcare activity spells to confirm they have been accounted for appropriately.**

The Trust's accounting policy on revenue recognition is shown in note 1.2 to the financial statements and its analysis of its total operating income is included in notes 2.1 and 2.2.

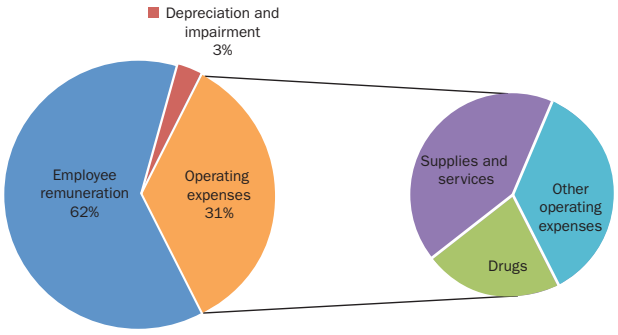
Our findings:

We did not note any exceptions from our work on this income.

Completeness of employee remuneration and operating expenses and associated payables

The risk: The majority of the Trust's expenditure relates to employee remuneration and operating expenses. Together they account for 97% of the Trust's gross expenditure. The Trust pays the majority of this expenditure through its payroll and accounts payable systems and at the year-end estimates and accrues for un-invoiced expenses. Invoices for the final weeks of the year are not received and processed until after the year-end and in many cases after the deadline for the production of the financial statements. There is therefore a risk that the expenses (and associated payables) recognised in the financial statements may be misstated. We identified the completeness of employee remuneration and operating expenses (in particular the understatement of accruals) as risks that had the greatest impact on our audit strategy.

Expenditure 2014/15



Our response: Our audit work included, but was not restricted to, understanding management's processes to recognise payroll and accounts payable expenditure and year-end accruals for unprocessed invoices and expenditure incurred and not yet invoiced (GRNI), walking through management's key controls over recognition of expenditure (for example authorisation of expenditure subsystem interfaces, processing of adjustments and authorisation of payments) to assess whether they were designed effectively and substantively testing expenditure and associated payables.

Our substantive testing included:

- testing the reconciliation of employee remuneration expenditure in the financial statements to the general ledger and payroll subsystems;
- performing a trend analysis of payroll costs to identify any unusual cost variations for follow up;
- testing large or unusual payroll transactions;
- sample testing payroll expenditure to source documents;
- assessing whether the Trust's processes for accruing for GRNIs were sufficiently robust to ensure that uninvoiced expenditure had been accrued for appropriately;
- sample testing accruals to subsequent invoices; and
- testing a sample of post year-end payments to confirm the completeness of accruals.

The Trust's accounting policy for recognition of expenditure is shown in notes 1.3 and 1.4, its analysis of employee remuneration costs is included in note 4.1 and its analysis of operating costs is included in note 3 to the financial statements.

Our findings:

We did not note any exceptions from our work on this expenditure.

Our application of materiality and an overview of the scope of our audit

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the judgement of a reasonably knowledgeable person would be changed or influenced.

We determined materiality for the audit of the financial statements as a whole to be £2,489,000, which is 2% of the Trust's gross operating costs for the two month reporting period. This benchmark is considered the most appropriate because users of the financial statements are particularly interested in how healthcare funding has been spent. We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality.

We determined the threshold at which we will communicate misstatements to the Trust's Audit Committee to be £124,000. In addition we communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

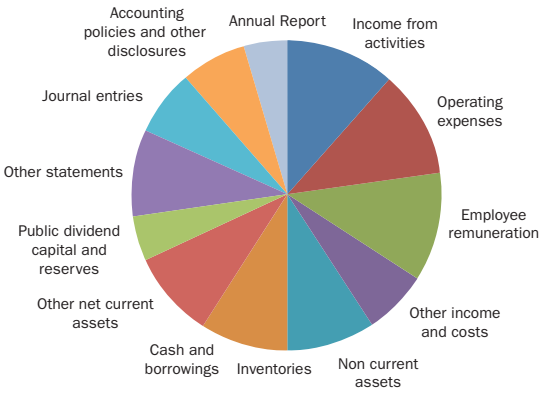
We conducted our audit in accordance with International Standards on Auditing (ISAs) (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code and the ISAs (UK and Ireland) are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained from our audit is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

The Trust uses NHS Employee Staff Records for its HR Services. Accordingly, our audit work was focused on obtaining an understanding of, and evaluating, relevant internal controls at the Trust and its third party service provider.

Allocation of audit fieldwork time



We undertook substantive testing on significant transactions, balances and disclosures in the financial statements, the extent of which was based on various factors such as our overall assessment of the Trust's control environment, the design effectiveness of controls over significant financial systems and the management of risks.

Other reporting required by regulations

Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- the part of the Directors' Remuneration Report subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014-15 issued by Monitor; and

- **the information given in the strategic report and directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.**

Matters on which we are required to report by exception

Under Section 62(1) of the National Health Service Act 2006 and Monitor's Audit Code for NHS Foundation Trusts, we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Audit Code requires us to report if we are not satisfied that the Trust has made proper arrangements.

On 1 May 2015 Monitor issued a notification of decision to open a formal investigation into the Trust's compliance with its licence. Monitor stated that it had opened the investigation due to the rapid deterioration in the Trust's finances post authorisation as a foundation trust and concerns over the delivery of performance targets. The key concerns Monitor raised in its letter are:

- **the Trust out turn position for 2014/15 was a £16.8 million deficit which is a significant deterioration compared to the Trust breakeven forecast at the time of authorisation**
- **the 2015/16 annual plan submission in April 2015 showed a further substantial deterioration, with a forecast deficit of £46 million for 2015/16 and a continuity of service risk rating of one**
- **the Trust may not have sufficient capacity and capability to effect the scale of financial turnaround required**
- **concerns over the delivery of the three referral to treatment standards and the cancer 62 day wait standard.**

In addition, the Trust was authorised with a side letter due to concerns regarding its delivery of the A&E target.

As a result of the matters above, we have been unable to satisfy ourselves that St George's University Hospitals NHS Foundation Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the two month period ended 31 March 2015.

We have nothing to report in respect of the following:

Under the Code we are required to report to you if, in our opinion:

- **the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with the information of which we are aware from our audit; or**
- **the Trust's Quality Report has not been prepared in line with the requirements set out in Monitor's published guidance or is inconsistent with other sources of evidence.**

Under the ISAs (UK and Ireland), we are also required to report to you if, in our opinion, information in the annual report is:

- **materially inconsistent with the information in the audited financial statements; or**
- **apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or**
- **otherwise misleading.**

In particular, we are required to report to you if:

- **we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable; or**
- **the annual report does not appropriately disclose those matters that were communicated to the Audit Committee which we consider should have been disclosed.**

Responsibilities for the financial statements and the audit

What an audit of financial statements involves:

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially inconsistent with the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

What the Chief Executive is responsible for as accounting officer:

As explained more fully in the Chief Executive's Responsibilities Statement, the Chief Executive as Accounting Officer is responsible for the

preparation of the financial statements in the form and on the basis set out in the Accounts Direction issued by Monitor and for being satisfied that they give a true and fair view.

What are we responsible for:

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts issued by Monitor, and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Certificate

We certify that we have completed the audit of the financial statements of St George's University Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

As set out above, we have been unable to satisfy ourselves that St George's University Hospitals NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

Paul Dossett
Partner
for and on behalf of Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
LONDON
NW1 2EP

28 May 2015

Salary and pension entitlements of senior managers

A) Remuneration

	Feb & Mar 2015						2013-14					
Name and title	10 months Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Executive directors												
Mr Miles Scott Chief executive	35-40		0			35-40	210-215	39				215-220
Mr Steven Bolam Chief Financial Officer; Deputy CEO	25-30		0			25-30	160-165					160-165
Mrs Alison Robertson Chief nurse & director of operations (left June 2014)	0		0			0.00	140-145					140-145
Dr Rosalind Given-Wilson Medical director	0		0			0.00	135-140		45-50			185-190
Ms Wendy Brewer Director of human resources	20-25		0			20-25	70-75					70-75
Dr Trudi Kemp Director of strategic development (left Sept 2014)	0		0			0	90-95		5-10			100-105
Mr Neal Deans Director of estates & facilities (left March 2014)	20-25		0			20-25	80-85					80-85
Mr Peter Jenkinson Director of corporate affairs	15-20		0			15-20	110-115					110-115
Ms Jennie Hall Chief nurse and director of infection prevention and control (from June 2014)	20-25		0			20-25	0					0
Dr Simon Mackenzie Medical director (from Jan-15)	30-35		0			30-35	0					0
Mr Eric Munro Director of estates & facilities (from Jun 2014)	20-25		0			20-25	0					0
Mr Martin Wilson Director of delivery and improvement (from August 2014)	20-25		0			20-25	0					0
Mr Rob Elek Director of strategy (from Feb 2015)	15-20		0			15-20	0					0

	Feb & Mar 2015						2013-14					
Name and Title	10 months Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Non-Executive Directors												
Mr Christopher Smallwood Trust chair	0-5		0			0-5	20-25					20-25
Mr Michael Rappolt Non-executive director	0-5		0			0-5	5-10					5-10
Dr Judith Hulf Non-executive director	0-5		0			0-5	5-10					5-10
Professor Peter Kopelman Non-executive director	0-5		0			0-5	5-10					5-10
Ms Kate Leach Non-executive director	0-5		0			0-5	5-10					5-10
MsStella Pantelides Non-executive director	0-5		0			0-5	5-10					5-10
Ms Sarah Wilton Non-executive director	0-5		0			0-5	5-10					5-10
Mr Paul Murphy Non-executive director (left June 2013)	0-5		0			0-5	5-10					5-10

Signed: _____ Date: 28.V.15

Chief Executive

Signed: _____ Date: 28/5/15

Chief Financial Officer; Deputy CEO

Salary and Pension entitlements of senior managers
B) Pension Benefits

Name and title	Real increase in pension at age 60	Real increase in pension and related lump sum at age 60 (bands of £2,500) £000	Lump sum at aged 60 related to accrued pension at 31 January 2015 (bands of £5,000) £000	Total accrued pension at age 60 at 31 January 2015 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 January 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase in Cash Equivalent Transfer Value 31 January 2015 £000	Employers Contribution to Stakeholder Pension To nearest £100
Mr Miles Scott Chief executive	**2.5 to 5**	10 to 12.5	210 to 215	70 to 75	1213	1136	77	
Mr Steve Bolam Chief Financial Officer; Deputy CEO	**2.5 to 5**	10 to 12.5	115 to 120	35 to 40	605	546	59	
Mrs Alison Robertson Chief nurse and director of operations	**0 to 2.5**	0 to 2.5	175 to 180	55 to 60	1027	1021	6	
Dr Rosalind Given-Wilson Medical Director	**0**	0	0.00	0.00	0	1792	0	
Wendy Brewer Director of human resources and organisational development	**0 to 2.5**	7.5 to 10	115 to 120	35 to 40	796	731	65	
Dr Trudi Kemp Director of strategic development	**7 to 10**	30 to 32.5	115 to 120	35 to 40	1	555	0	
Mr Neal Deans Director of Estates & Facilities	**0 to 2.5**	0	0	0	0	0	0	
Mr Peter Jenkinson Director of corporate affairs	**0 to 2.5**	7.5 to 10	60 to 65	20 to 25	344	307	37	
Ms Jennie Hall Chief nurse and director of infection prevention and control	**5 to 7.5**	25 to 27.5	190 to 195	60 to 65	1112	974	138	
Dr Simon Mackenzie Medical director	**0 to 2.5**	0	0	0	0	0	0	
Mr Eric Munro Director of Estates & Facilities	**0 to 2.5**	2.5 to 5	0	5 to 10	68	38	30	
Mr Martin Wilson Director of delivery and improvement	**2.5 to 5**	15 to 17.5	50 to 55	15 to 20	226	179	47	
Mr Rob Elek Director of strategy	**0 to 2.5**	5 to 7.5	60 to 65	20 to 25	362	0.329	362	

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

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 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 result of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures 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 benefit accrued to the member as a result of 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 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 an arrangement which the individual has transferred to the NHS pension scheme) and uses common market valuation factors for the start and end of the period.

Signed: _____ Date: 28.V.15

Chief Executive

Signed: _____ Date: 28/5/15

Chief Financial Officer; Deputy CEO

Statement of the chief executive's responsibilities as the accounting officer of St George's University Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation Trust.

The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

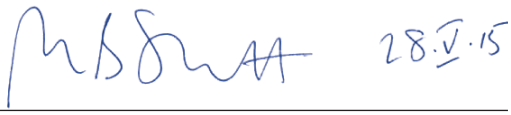
Under the NHS Act 2006, Monitor has directed St George's University Hospital NHS foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of St George's University Hospital NHS foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed  28.V.15

Miles Scott, Chief Executive

Statement of comprehensive income for year ended 31 January 2015

	Note	2014/15 £000
Operating income from patient care activities		**105,315**
Other operating income		**14,131**
Total operating income from continuing operations	2	**119,446**
Operating expenses of continuing operations	3	**(124,474)**
Operating surplus / (deficit)		**(5,028)**

Finance costs

Finance income	8	**92**
Finance expense – financial liabilities	9	**(580)**
Finance expense – unwinding of discount on provisions		**(3)**
PDC dividends payable		**(1,282)**
Net finance costs		**(1,773)**

Share of profit / (loss) of associates / joint arrangements

Surplus/(deficit) from continuing operations		**(6,801)**
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations	6	**0**
Surplus/(deficit) for the year		**(6,801)**

Other comprehensive income

Will not be reclassified to income and expenditure:	
Other recognised gains and losses	**(60)**
Total comprehensive income / (expense) for the period	**(6,861)**
Prior period adjustments	
Merger adjustments	
Total comprehensive income / (expense) for the year	**(6,861)**

Statement of financial position as at 31 March 2015

Statement of financial position

Non-current assets

	Note	31 Mar 2015 £000
Intangible assets	8	17,713
Property, plant and equipment	9.1	312,561
Investment property	12	11
Total non-current assets		**327,351**

Current assets

Inventories	13	7,157
Trade and other receivables	14	75,222
Cash and cash equivalents	16	24,178
Total current assets		**106,557**

Current liabilities

Trade and other payables	17	(90,728)
Borrowings	18	(5,329)
Provisions	19.1	(602)
Total current liabilities		**(96,659)**
Total assets less current liabilities		**337,249**

Non-current liabilities

Borrowings	18	(86,034)
Provisions	19.1	(1,181)
Total non-current liabilities		**(87,215)**
Total assets employed		**250,034**

Financed by Taxpayers' equity

Public dividend capital		133,761
Revaluation reserve	20	101,360
Other reserves		1,150
Income and expenditure reserve		16,697
Total taxpayers' and others' equity		**250,034**

Statement of changes in taxpayers' equity (SOCITIE) 2014/15

		'Taxpayers' equity			
Statement of changes in equity	**Total £000**	**Public dividend capital £000s**	**Revaluation reserve £000s**	**Other reserves £000s**	**Income and expenditure reserve £000s**
At start of period for new FTs Opening balance as at 1st February 2015	**259,380**	133,312	101,740	1,150	23,178
Surplus/(deficit) for the year	**(6,801)**				(6,801)
Other recognised gains and losses	**(60)**		(380)		320
Public dividend capital received	**449**	449			
Taxpayers' and others' equity at 31 March 2015	**252,968**	133,761	**101,360**	**1,150**	**16,697**

Statement of cash flow for two months ending 31 March 2015

Cash flows from operating activities

	Note	2014/15 £000
Operating surplus/(deficit) from continuing operations		(5,028)
Operating surplus/(deficit)		**(5,028)**
Non-cash income and expense:		
Depreciation and amortisation	3	3,681
(Increase)/decrease in trade and other receivables		(6,783)
(Increase)/decrease in inventories		685
Increase/(decrease) in trade and other payables		655
Increase/(decrease) in provisions		(129)
Other movements in operating cash flows		(29)
Net cash generated from/(used in) operations		**(6,948)**

Cash flows from investing activities

Interest received	13
Purchase of intangible assets	(39)
Purchase of property, plant and equipment and investment property	(3,313)
Sales of property, plant and equipment and investment property	150
Cash flows attributable to investing activities of discontinued operations	30
Net cash generated from/(used in) investing activities	**(3,159)**

Cash flows from financing activities

Public dividend capital received	449
Loans received from the Independent Trust Financing Facility	15,000
Loans received from the Department of Health	2,966
Other loans received	1,303
Other loans repaid	(194)
Capital element of PFI, LIFT and other service concession payments	(483)
Interest element of finance lease	(34)
Interest element of PFI, LIFT and other service concession obligations	(505)
PDC dividend paid	(3,898)
Net cash generated from/(used in) financing activities	**14,604**
Increase/(decrease) in cash and cash equivalents	**4,497**
Cash and cash equivalents at 1 April	**0**
Cash and cash equivalents at start of period for new FTs (as at 1st February 2015)	19,681
Cash and cash equivalents at 31 March and 31 March	**24,178**

Notes to the accounts

1. Accounting Policies

1.0 Going concern

The trust incurred a deficit of £6.8 million during the two month period ended 31 March 2015 and a combined deficit of £16.8 million for the whole of the 2014/15 financial year. At year end the directors were seeking interim cash funding support from Monitor for 2015/16 of £52.2 million.

The board has reviewed the proposed 2015/16 plan in detail throughout its development from October 2014 to date. The plan is for a deficit of £46m having taken due account of the realistic underlying financial position going into 2015/16, the risks and cost pressures faced in 2015/16 and the level of cost reduction the organisation can be stretched to deliver. The trust has an existing working capital facility of £25m but this will not be sufficient to meet the cash requirements of the deficit revenue position and the capital plan which has been reduced to the minimum possible requirement. The trust therefore requires additional cash support of £52.2m to maintain normal operating and quality existing standards. The board has a reasonable expectation that this will be agreed with DH with the support of the regulator.

The trust was engaged in discussions with Monitor regarding the level and timing of interim cash support funding at year end however these discussions had not concluded at the time the financial statements were approved. Although these factors represent material uncertainties that may cast significant doubt about the trust's ability to continue as a going concern, the directors, having made appropriate enquiries, still have reasonable expectations that the trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the NHS Foundation Trust Annual Reporting Manual 2014/15, the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the trust will continue to be provided in the foreseeable future.

Therefore the trust has adopted the going concern basis for preparing the accounts and the accounts do not include the adjustments that would result if the trust was unable to continue as a going concern.

1.1 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

Plant, Property and Equipment – Para 1.10 and Note 15

Intangible Assets – Para 1.11 and Note 16

Provision for Impairment of Receivables – Note 22.3

Provisions – Para 1.20 and Note 35

1.2 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.3 Employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The

scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the trust commits itself to the retirement, regardless of the method of payment.

1.4 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the [NHS body];
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their re valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re valued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance

on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- **The technical feasibility of completing the intangible asset so that it will be available for use**
- **The intention to complete the intangible asset and use it**

1.7 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the NHS trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

1.8 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.9 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS trust as lessor

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

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

1.10 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the trust's Statement of Financial Position.

Other assets contributed by the NHS Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value using the [first-in first-out/ weighted average] cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.12 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.13 Provisions

Provisions are recognised when the trust has a present legal or constructive obligation as a result of a past event, it is probable that the trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (1.8% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.14 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.15 Non-clinical risk pooling

The NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised

with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.17 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.18 Financial assets

Financial assets are recognised when the NHS Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

1.19 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.20 Value Added Tax

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

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.22 Public Dividend Capital (PDC) and PDC dividend [NHS trust only]

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5 per cent) on the average carrying amount of all assets less liabilities

(except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.23 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS bodies not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 Joint operations

From 1 April 2015, the trust has participated in South West London Pathology, an arrangement with Kingston NHS Foundation Trust and Croydon University Hospitals NHS Trusts to provide Pathology for all three organisations. The proper treatment of this was reviewed using a flowchart based on IFRS11.

The operation is under joint control: its Board is made up of the three chief executives and finance directors of each trust, none of whom have overall authority. Ownership is divided based on expected usage:

Croydon University Hospitals NHS Trust	25.80%
KIngston NHS Foundation Trust	27.50%
St George's University Hospital NHS Foundation Trust	46.70%

SWL Pathology is not a separate vehicle to the three Trusts, making this a Joint Operation as defined by IFRS11.

Potential treatment	Reason not applicable under IFRS 11
Associate	Trust executives sit on the SWL Pathology Board, giving control over its direction.
Outside group scope	Trust executives sit on the SWL Pathology Board, giving control over its direction.
Subsidiary	The trust shares control with two other organisations
Joint venture	SWL Pathology is not a separate vehicle, for example supplies are ordered via its constitute Trusts.

Note 2.1 operating income (by nature)

Income from activities	2014/15 Total £000s
Acute trusts	
Elective income	31,569
NHS England and CCGs	
Income from CCGs and NHS England	72,766
Income from other sources (e.g. local authorities)	369
All trusts	
Private patient income	611
Total income from activities	**105,315**
Total operating revenue	**14,131**
Total operating income	**119,446**

Note 2.2 operating income (by source)

	2014/15 Total £000
Income from activities	
NHS foundation trusts	**18**
NHS trusts	**27,182**
CCGs and NHS England	**76,540**
Local authorities	**167**
NHS other	**(289)**
Non NHS: Private patients	**611**
Non-NHS: Overseas patients (chargeable to patient)	**210**
NHS injury scheme (was RTA)	**835**
Non NHS: Other	**41**
Total income from activities	**105,315**
Other operating income	
Research and development	**(2,151)**
Education and training	**8,151**
Received from NHS charities: Other charitable and other contributions	
to expenditure	**154**
Received from other bodies: Other charitable and other contributions	
to expenditure	**(13)**
Non-patient care services to other bodies	**7,990**
Total other operating income	**14,131**
Total operating income	**119,446**

Note 2.3 – Overseas visitors (relating to patients charged directly by the foundation trust)

	2014/15 Total £000s
Income recognised this year	210
Cash payments received in-year (relating to invoices raised in current and previous years)	62

3. Operating expenses (by type)

	2014/15 Total £000s
Services from NHS Foundation Trusts	**541**
Services from NHS Trusts	**143**
Services from CCGs and NHS England	**113**
Purchase of healthcare from non NHS bodies	**1,126**
Employee expenses – executive directors	**191**
Employee expenses – non-executive directors	**12**
Employee expenses – staff	**77,226**
Supplies and services – clinical (excluding drug costs)	**15,530**
Supplies and services – general	**2,699**
Establishment	**982**
Research and development – (not included in employee expenses)	**(106)**
Transport (business travel only)	**84**
Transport (other)	**111**
Premises – business rates payable to local authorities	**353**
Premises – other	**8,315**
Inventories written down (net, including inventory drugs)	**1**
Drug costs (non inventory drugs only)	**1,484**
Drugs Inventories consumed	**8,017**
Rentals under operating leases – minimum lease payments	**223**
Depreciation on property, plant and equipment	**3,109**
Amortisation on intangible assets	**572**
Audit fees **payable to the external auditor**	
audit services – statutory audit	**54**
other auditor remuneration (external auditor only) – analysis in note 5.5	**12**
Clinical negligence – amounts payable to the NHSLA (premiums)	**1,654**
Legal fees	**(33)**
Consultancy costs	**667**
Training, courses and conferences	**433**
Patient travel	**897**
Car parking & security	**52**
Publishing	**59**
Insurance	**3**
Other services, eg external payroll	**24**
Losses, ex gratia & special payments – (not included in employee expenses)	**3**
Other	**(77)**
Total	**124,474**
Of which	
Related to continuing operations	**124,474**

Note 4.1 Employee expenses

	2014/15 Total £000s
Salaries and wages	**61,455**
Social security costs	**5,208**
Pension cost – defined contribution plans employer's contributions to NHS pensions	**6,608**
Pension cost – other	**3**
Agency/contract staff	**7,107**
Total gross staff costs	**80,381**
Recoveries from **DH Group bodies** in respect of staff cost netted off expenditure	**(1,476)**
Recoveries from **other bodies** in respect of staff cost netted off expenditure	**(215)**
Total staff costs	**78,690**
included within:	
Costs capitalised as part of assets	
Analysed into operating expenditure	**1,273**
Employee expenses – staff	**77,226**
Employee expenses – executive directors	**191**
Total employee benefits excl. capitalised costs	**77,417**

Note 4.2 Average number of employees (WTE basis)

	2014/15 Total Number
Medical and dental	**1,215**
Administration and estates	**2,048**
Healthcare assistants and other support staff	**613**
Nursing, midwifery and health visiting staff	**3,482**
Scientific, therapeutic and technical staff	**1,877**
Total	**9,235**

Note 4.3 Early retirements due to ill health

	2014/15 £000
Value of early retirements on the grounds of ill health	172
Number of ill-health retirements	1

Note 4.3A Staff sickness absence

	2014/15 Total Number
Total days lost	9757
Total staff years	1272
Average working days lost	**8**

Note 4.4. Off-Payroll

For all off-payroll engagements as of 31 Mar 2015, for more than £220 per day and that last for longer than six months	2014/15 Number of engagements Number
No. of existing engagements as of 31 Mar 2015	15
Of which:	
Number that have existed for less than one year at the time of reporting	4
Number that have existed for between one and two years at the time of reporting	10
Number that have existed for between two and three years at the time of reporting	1

For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2014 and 31 Mar 2015, for more than £220 per day and that last for longer than six months	2014/15 Number of engagements Number
Number of new engagements, or those that reached six months in duration between 01 Apr 2014 and 31 Mar 2015	11

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 Apr 2014 and 31 Mar 2015	2014/15 Number of engagements Number
Number of off-payroll engagements of board members, and/of, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed “board members and/or senior officials with significant financial responsibility”. This figure should include both off-payroll and on-payroll engagements.	18

Note 4.5 Better Payment Practice Code

Measure of compliance

	2014/15 M11-12		2013/14	
	Number	£000	Number	£000
Non NHS Payables				
Total non-NHS trade invoices paid in the year	23,900	49,748	136,028	229,392
Total non-NHS trade invoices paid within target	15,959	31,501	110,250	176,006
Percentage of NHS trade invoices paid within target	66.77%	63.32%	81.05%	76.73%
NHS Payables				
Total NHS trade invoices paid in the year	1,190	8,697	4,717	57,846
Total NHS trade invoices paid within target	198	1,786	2,946	44,580
Percentage of NHS trade invoices paid within target	16.64%	20.54%	62.45%	77.07%

Note 5 Analysis of operating lease expenditure

	2014/15					2013/14			
	Total £000	Land £000	Buildings £000	Plant & machinery £000	Other	Land £000	Buildings £000	Plant & machinery £000	Other
Minimum lease payments	**223**			223		**0**			
Contingent rents	**0**					**0**			
Less sublease payments received	**0**					**0**			
Total	**223**	**0**	**0**	**0**	**0**	**0**	0	**0**	**0**

Based on the Trust's financial performance, Corporation Tax liability for two months ending 31st March 2015 was NIL.

Note 6 Finance revenue

	2014-15 £000
Interest on bank accounts	13
Fair value gains / (losses) on other financial assets held at fair value through the I&E	79
Total	**92**

Note 7 Finance expenses

	Total £000	Business with NHS FTs £000	Business with NHS Trusts £000	Business with DH £000	Business with Public Health England £000	Business with Health Education England £000	Business with CCGs and NHS England £000	Business with Special Health Authorities £000	Business with NDPBs £000	Business with other DH bodies £000	Business with other WGA bodies £000	Business with Local Authorities £000	Business with bodies external to Government £000
Interest expense:													
Working capital loans from the Department of Health	**31**			31									
Commercial loans	**13**												13
Finance leases	**31**												31
Finance costs on PFI and other service concession arrangements (excluding LIFT)													
Main finance costs	**505**												505
Total interest expense	**580**	**0**	**0**	**31**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**549**

Note 8 Intangible assets

	Total	Software licences (purchased) £000	Licenses & trademarks (purchased) £000	Patents (purchased) £000	Information technology (internally generated) £000	Development expenditure (internally generated) £000	Other (purchased) £000	Other (internally generated) £000	Goodwill £000	Intangible assets under construction £000	NHS charitable fund assets £000
Valuation/gross cost at start of period for new FTs	**25,678**	1,165			24,513						0
Additions – purchased / internally generated	**39**	39									
Reclassifications	**1,199**				1,199						
Gross cost at 31 March 2015	**26,916**	**1,204**	**0**	**0**	**25,712**	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation at start of period for new FTs	**8,631**	572			8,059						
Provided during the year	**572**	29			543						
Amortisation at 31 March 2015	**9,203**	**601**	**0**	**0**	**8,602**	**0**	**0**	**0**	**0**	**0**	**0**

Note 9 Property, plant and equipment

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Valuation/ gross cost at start of period for new FTs – 1st February 2015	**441,933**	63,932	211,830		24,817	100,608	144	27,275	13,327
Additions – purchased	**6,769**				6,691	71			7
Additions – leased	**960**				0	960			
Additions – assets purchased from cash donations / grants	**20**					20			
Reclassifications	**(1,199)**		5,082		(6,461)			30	150
Revaluations	**0**								
Disposals/derecognition	**(952)**					(952)			
Valuation/ gross cost at 31 March 2015	**447,531**	**63,932**	**216,912**		**25,047**	**100,707**	**144**	**27,305**	**13,484**
Depreciation at start of period for new FTs	**132,683**		29,273			76,123	144	18,145	8,998
Provided during the year	**3,109**		1,653			925		406	125
Disposals/derecognition	**(822)**					(822)			
Accumulated depreciation at 31 March 2015	**134,970**		**30,926**			**76,226**	**144**	**18,551**	**9,123**

Note 9.1 Property, plant and equipment financing

Net book value at 31 March 2015	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Owned	**234,878**	62,917	124,100		25,047	14,604		8,581	2,563
Finance leased	**8,946**					8,312		127	507
On-SoFP PFI contracts and other service concession arrangements	**46,978**		46,127						851
Off-SoFP PFI residual interests	**0**					649			
Government granted	**2,494**		1,799			916			46
Donated	**16,331**	1,015	13,960					46	394
NBV total 31 March 2015	**309,627**	**63,932**	**185,986**		**25,047**	**24,481**		**8,754**	**4,361**

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000
Additions – purchased	**6,691**		**6,691**					
Total	**6,691**		**6,691**					

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000
Freehold	**63,932**	63,932		
Long leasehold	**185,986**		**185,986**	
Short leasehold	**0**			
NBV Total at 31 March 2015	**249,918**	**63,932**	**185,986**	

Depreciation of PPE assets (excludes charitable fund assets)	**3,109**	**2,771**		**338**

Note 10.1 – Disclosure of reclassification of PPE additions on consolidation of NHS charities

Purchased additions in 2014/15	Total £000	Assets under construction and payments on account £000	Plant & machinery £000	Furniture & fittings £000
Additions – purchased by Trust	**6,769**	6,691	71	7

Note 10.2 – Disclosure of reclassification of Intangible additions on consolidation of NHS charities

Purchased additions in 2014/15	Total £000	Software licences (purchased) £000
Additions – purchased by Trust	**39**	39

Note 10.3 Economic life of intangible assets

	Min life Years	Max life Years
Intangible assets – internally generated		
Information technology	5	10
Intangible assets – purchased		
Software	1	5
Licences & trademarks		

Note 10.3 Economic life of property, plant and equipment

	Min life Years	Max life Years
Land		
Buildings excluding dwellings	3	100
Dwellings	15	80
Plant & machinery	1	25
Transport equipment	5	7
Information technology	3	15
Furniture & fittings	5	25
Stockpiled goods		

Asset Valuations Tables

These tables are used to assist Monitor in the creation of the accounting policies note in the consolidated accounts and consolidating adjustments.

This tables are not required in individual FT accounts. Completion of these tables is compulsory.

Non-property valuations

	Net Book Value covered by each method for determining fair value			
Method for determining fair value	**Plant & machinery £000**	**Transport equipment £000**	**Information technology £000**	**Furniture & fittings £000**
Invoices	24,481		8,754	4,361
Total	**24,481**		**8,754**	**4,361**

Property valuations

NBV of assets covered by valuation method	**Land £000**	**Buildings excluding dwellings £000**
Modern equivalent asset (no alternative site)	60,788	186,196
Total	**60,788**	**186,196**

Note 11 Investment property

The Trust does not have any investment property hence no Investment expense or income.

Note 12 Other assets

	31 Mar 2015 £000
Other assets	11
Total	**11**

Note 13 Inventory movements

	Total £000	**Drugs £000**	**Consumables £000**	**Energy £000**
At start of period for new FTs as at 1st February 2015	6,918	1,557	5,309	52
Additions	**10,723**	8,260	2,463	
Inventories consumed (recognised in expenses)	**(10,483)**	(8,017)	(2,466)	
Write-down of inventories recognised as an expense	**(1)**	(1)		
Carrying value at 31 March 2015	**7,157**	**1,799**	**5,306**	**52**

Table 13.1 Breakdown of inventories recognised in expenses

	2014/15 £000
Total inventories consumed	**10,483**
Charged to:	
Drugs inventories consumed	8,017
Supplies and services – clinical	2,532
Other	(66)
Total	**(10,483)**

Note 14 Trade receivables and other receivables

Current

	31 Mar 2015 £000
NHS receivables – revenue	31,793
Receivables due from NHS charities – revenue	365
Other receivables with related parties – revenue	1,303
Provision for impaired receivables	(4,790)
Prepayments (non-PFI)	3,933

PFI prepayments

Accrued income	11,821
Other receivables – revenue	30,797
Total current trade and other receivables	**75,222**

Note 15 Provision for impairment of receivables

	2014/15 £000
At start of period for new FTs	4,991
Amounts utilised	(201)
At 31 Mar 2015	**4,790**

Note 15.1 Analysis of impaired receivables

	31 Mar 2015 Trade receivables £000
Ageing of impaired receivables	
0-30 days	57
30-60 Days	133
60-90 days	145
90-180 days (was “In three to six months”)	516
over 180 days (was “Over six months”)	6,608
Total	**7,459**
Ageing of non-impaired receivables past their due date	
0-30 days	1,928
30-60 Days	1,447
60-90 days	989
90-180 days (was “In three to six months”)	3,195
over 180 days (was “Over six months”)	7,887
Total	**15,446**

Note 16 Cash and cash equivalents movements

	2014/15 Cash and cash equivalents £000
At start of period for new FTs as at 1st February 2015	19,681
Net change in year	4,497
At 31 March 2015	**24,178**

Note 16.1 Breakdown of cash and cash equivalents

	2014/15 Cash and cash equivalents £000
Cash at commercial banks and in hand	944
Cash with the Government Banking Service	23,234
Total cash and cash equivalents as in SoFP	**24,178**

Note 16.2 Third party assets held by the NHS Foundation Trust

	31 Mar 2015 £000
Monies on deposit	18
Total third party assets	**18**

Note 16.3 Government Banking Service Balances

	31 Mar 2015 £000
Citi Group	23,234
Total	**23,234**

Note 17 Trade and other payables

Current	31 Mar 2015 Total £000
Receipts in advance	0
NHS payables – capital	0
NHS payables – revenue	15,513
NHS payables – early retirement costs payable within one year	0
Amounts due to other related parties – capital	0
Amounts due to other related parties – revenue	0
Other trade payables – capital	3,476
Other trade payables – revenue	48,719
Social security costs	4,612
VAT payable	0
Other taxes payable	4,654
Other payables	9,731
Accruals	4,023
PDC dividend payable	0
NHS charitable funds: Trade and other payables	0
Total current trade and other payables	**90,728**

Note 17.1 – early retirements in NHS payables above

	31 Mar 2015 £000
Outstanding pension contribution	5,826

Note 18 Borrowings

Current

	31 Mar 2015 £000
Capital loans from Department of Health	186
Working capital loans from Department of Health	999
Other loans	932
Obligations under finance leases	2,346
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	866
Total current borrowings	**5,329**

Non-current

Capital loans from Department of Health	8,933
Working capital loans from Department of Health	14,001
Other loans	12,564
Obligations under finance leases	4,949
Obligations under PFI, LIFT or other service concession contracts	45,587
Total non current borrowings	**86,034**

Note 19.1 Provisions for liabilities and charges

	Current	Non-current
	31 Mar 2015	31 Mar 2015
Pensions relating to other staff	144	1,181
Other legal claims	368	0
Other	90	0
Total	**602**	**1,181**

Note 19.2 Provisions for liabilities and charges analysis

	Total £000	Pensions – other staff £000	Other legal claims ** £000	Other £000
At start of period for new FTs as at 1st February 2015	**1,910**	1,303	421	186
Arising during the year	**101**	43	58	
Utilised during the year – accruals	**0**			
Utilised during the year – cash	**(85)**	(24)	(61)	
Reversed unused	**(146)**		(50)	(96)
Unwinding of discount	**3**	3		
At 31 March 2015	**1,783**	**1,325**	**368**	**90**
Expected timing of cash flows:				
Not later than one year	**602**	144	368	90
Later than one year and not later than five years	**545**	545		
Later than five years	**636**	636	0	0
Total	**1,783**	**1,325**	**368**	**90**

Note 19.3 Clinical negligence liabilities

	31 Mar 2015 £000
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust	106

Note 20 Revaluation reserve movements – 2014/15

	Total revaluation reserve £000	Revaluation reserve – PPE £000
At start of period for new FTs as at 1st February 2015	**98,806**	98,806
Other recognised gains and losses	**(380)**	(380)
Revaluation reserve at 31 March 2015	**98,426**	**98,426**

Note 22 Contractual capital commitments

	31 Mar 2015 £000	31 Mar 2014 £000
Property, plant and equipment	16,399	2,279
Total	**16,399**	**2,279**

Note 23 Finance lease obligations

	31 Mar 2015 Total £000
Gross plant and machinery lease liabilities	**7,295**
of which liabilities are due:	
Not later than one year	**2,346**
Later than one year and not later than five years	4,083
Later than five years	866
Finance charges allocated to future periods	0
Net plant and machinery lease liabilities	**7,295**
Not later than one year	2,346
Later than one year and not later than five years	4,083
Later than five years	866
Total net lease liabilities	**7,295**
Not later than one year	2,346
Later than one year and not later than five years;	4,083
Later than five years	866
Total of future minimum sublease payments to be received at the SoFP date	**7,295**

Note 24.1 On-SoFP PFI, LIFT or other service concession arrangement obligations (finance lease element)

	31 Mar 2015 Total £000	31 Mar 2015 PFI schemes £000
Gross PFI, LIFT or other service concession liabilities	**46,453**	**46,453**
of which liabilities are due		
Not later than one year	866	866
Later than one year and not later than five years	4,119	4,119
Later than five years	41,468	41,468
Finance charges allocated to future periods	0	
Net PFI, LIFT or other service concession arrangement obligation	**46,453**	**46,453**
Not later than one year	866	866
Later than one year and not later than five years	4,119	4,119
Later than five years	**41,468**	**41,468**

Note 24.2 On-SoFP PFI, LIFT and other service concession arrangement commitments

Commitments in respect of the service element of the PFI, LIFT or other service concession arrangement	31 Mar 2015 Total £000	31 Mar 2015 PFI schemes £000
Not later than one year	6,872	6,872
Later than one year and not later than five years	27,486	27,486
Later than five years	133,042	133,042
Total	**167,400**	**167,400**

Note 24.3 On-SoFP PFI, LIFT and other service concession arrangement commitments

	31 Mar 2015 Total £000	31 Mar 2015 PFI schemes £000
Number of schemes that the trust has (accounted for on-SoFP)	1	1

Note 24.4 Analysis of amounts payable to service concession operator

	2014/15 Total £000	2014/15 PFI schemes £000
Unitary payment payable to service concession operator (total of all schemes) – This should be the amount payable to the operator – any PFI support income recognised should NOT be netted off	**505**	505
Consisting of:		
– Interest charge	**505**	505
Total amount paid to service concession operator	**505**	**505**

Note 25 Related party transactions

Organisation type

	Total (£k)			
	Income Feb-Mar 15	Expenditure Feb-Mar 15	Receivables 31 Mar 15	Payables 31 Mar 15
NHS Foundation Trusts	2,938	4,653	4,734	4,772
NHS Trusts	2,532	26	2,566	3,530
Department of Health	0	0	0	77
Public Health England	221	0	1,069	13
Health Education England	7,717	0	1,149	38
CCGs and NHS England	77,255	118	30,989	1,027
Special Health Authorities	2,730	1,666	230	14
Non-Departmental Public Bodies	0	0	3	0
Other DH bodies	0	1,704	664	7,499
Total intra-NHS balances	**93,393**	**8,167**	**41,404**	**16,970**

The Department of Health is regarded as a related party. During the year, St George's University Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

2014-15

Department of Health
NHS England
CCGs (Clinical Commissioning Groups)
Wandsworth Teaching CCG
Sutton and Merton CCG
Croydon CCG
Surrey CCG
Lambeth CCG
Kingston CCG
Richmond & Twickenham CCG
West Sussex CCG
Hampshire CCG
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority

Amounts received from the CCGs (Clinical Commissioning Groups) relates to the trust's contracts for patient services. The amount received from NHS London primarily relates to Teaching and Training.

Non – NHS Related party transactions

	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
St George's, University of London Wendy Brewer is the joint director of human resources for both St George's Healthcare NHS Trust and St George's, University of London. Eric Munro is the joint director of estates and facilities for both St George's Healthcare NHS Trust and St George's, University of London. Professor Peter Kopelman is the Principal of St George's, University of London and also a non-executive director of St George's Healthcare NHS Trust. Transactions with respect to St George's, University of London on behalf of St George's Medical School mainly relates to the provision of clinical staff and overheads costs.	2,250	800	963	1303
St George's Hospital Charity Transactions with respect to St George's, University of London on behalf of St George's Medical School mainly relates to the provision of clinical staff and overheads costs. Receipts from the St George's Hospital Charity relate to capital and revenue expenditure to be funded by the charity.	1	301	3	365

Note 26 Statement of comprehensive income

	2014/15			2013/14
	Apr-Jan £000	Feb-Mar £000	Total £000	Total £000
Operating income from patient care activities	507,341	105,315	**612,656**	**594,644**
Other operating income	84,272	14,131	**98,403**	**70,073**
Total operating income from continuing operations	591,613	119,446	**711,059**	**664,717**
Operating expenses of continuing operations	(592,421)	(124,474)	**(716,895)**	**(649,212)**
Operating surplus/(deficit)	(808)	(5,028)	**(5,836)**	**15,505**

Finance costs

Finance income	66	92	**158**	**94**
Finance expense – financial liabilities	(2,693)	(580)	**(3,273)**	**(3,253)**
Finance expense – unwinding of discount on provisions	(15)	(3)	**(18)**	**(26)**
PDC dividends payable	(6,414)	(1,282)	**(7,696)**	**(7,624)**
Net finance costs	(9,056)	(1,773)	**(10,829)**	**(10,809)**
Surplus/(deficit) from continuing operations	(9,864)	(6,801)	**(16,665)**	**4,696**
Surplus/(deficit) for the year	(9,864)	(6,801)	**(16,665)**	**4, 696**

Other comprehensive income

Will not be reclassified to income and expenditure:				
Transfer to retained earnings on disposal of assets	(91)	0	**(91)**	**0**
Other recognised gains and losses	0	(60)	**(60)**	**0**
Total comprehensive income/(expense) for the period	(9,955)	(6,861)	**(16,816)**	**4,696**
Prior period adjustments				
Merger adjustments				
Total comprehensive income/(expense) for the year	(9,955)	(6,861)	**(16,816)**	**4,696**

Note 27 Financial Instruments

Note 27.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the foundation trust has with CCGs and the way those CCGs are financed, the foundation trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the foundation trust in undertaking its activities.

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

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 January 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with primary care trust's, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

Note 27.2 Financial Assets

	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables – NHS		41,404		**41,404**
Receivables – non-NHS		33,818		**33,818**
Cash at bank and in hand		24,178		**24,178**
Other financial assets	0	0	0	**0**
Total at 31 March 2015	**0**	**99,400**	**0**	**99,400**

Note 27.3 Financial Liabilities

	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		16,970	**16,970**
Non-NHS payables		73,758	**73,758**
Other borrowings		37,615	**37,615**
PFI & finance lease obligations		53,748	**53,748**
Other financial liabilities		0	**0**
Total at 31 March 2015	**0**	**182,091**	**182,091**

Giving to St George's

As well as making a donation there are lots of ways you can get involved with the St George's Hospital Charity. To find out more speak to the Giving to George's team.

Telephone **020 8725 4916**
Email **giving@stgeorges.nhs.uk**
Web **www.givingtogeorges.org.uk**

Volunteer

Our volunteers perform a number of varied roles, from manning information desks, general housekeeping, administration and helping patients find their way around. If you would like to volunteer at any St George's, University Hospitals NHS Foundation Trust sites, contact the voluntary services team.

Telephone **020 8725 1452**
Email **zoe.holmes@stgeorges.nhs.uk**

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Annual Report 2014/15 produced by St George's Communications Team

Design and print: www.graphicimpressions.co.uk