St George's University Hospitals NHS
NHS Foundation Trust

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Annual Report and Accounts 2015/16

Excellence in specialist and community healthcare

St George's University Hospitals NHS Foundation Trust

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

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Chairman's foreword

Sir David Henshaw

I introduce this report as the trust's new Chair, having joined the organisation in March 2016.

Since joining, I have been struck by the commitment of trust staff, many of whom are continuing to deliver excellent care despite the challenges the organisation faces. I would like to thank them for the work they are doing.

The challenges we face are significant. We are making progress in a number of areas, but there will be no quick fix to some of the systemic problems the trust faces, many of which are acknowledged in this report.

For example, the hospital estate at St George's, our main hospital site, needs modernising, as does the IT infrastructure, which can often make seemingly straight-forward tasks difficult for staff.

The organisation's financial position is a major concern, both for St George's and the partners we work with, as well as healthcare regulators. We have a plan to address this, although the financial challenges have inevitably had an adverse effect on staff morale, which the board and I are committed to tackling.

In June 2016, we will welcome a team of inspectors from the Care Quality Commission (CQC), as they begin a detailed inspection of our staff and services. This will be an opportunity for us to demonstrate what we do well at the trust, but also to recognise where improvements must be made.

Despite the challenges we currently face, we are still receiving national recognition for many of the services we provide, and the feedback from patients is still very positive. This is down to the hard work and dedication of staff at St George's, many of whom I have been pleased to meet during my short time here. Indeed, a key objective for 2016 is to improve the working experience for our staff, who are our number one asset.

There have also been a number of changes to the executive team in recent months, but I am confident that we are slowly but surely building a team that can guide the trust through what we all know will be a challenging but ultimately successful period.

Sir David Henshaw
Chairman
2nd June

Chief executive's statement

Simon Mackenzie

This has been a very difficult year for St George's and I would like to begin by saying thank you to all our staff for their continuing commitment to patients, to each other and to the trust.

We continue to have significant financial and operational pressures at the trust. This has had a major impact on the organisation, and adversely affected our ability to deliver services in the way we would want to.

In early 2015 Monitor, the health regulator (now NHS Improvement), became concerned with the deterioration in St George's financial position and commissioned a review into our governance and financial processes.

Throughout 2015/16, we have worked hard to implement the recommendations of this review, so as to ensure the trust's financial sustainability going forward, and to strengthen governance and financial management systems. This work is ongoing, and major challenges remain – but we are making progress.

Over the last 12 months, we have seen increasing demand for our services. We are seeing more acutely unwell patients, many of whom have multiple needs and co-morbidities. Whilst we are not alone in this regard, it has made meeting key operational and performance challenges particularly difficult. For example, too many patients are waiting longer than four hours in A&E to be seen, treated and/or discharged. We are working with commissioners and our partners in the community to try and tackle the numerous and varied reasons for this. We have had to cancel too many planned operations, mainly because of pressure on beds resulting from emergency admissions.

On a more positive note, the trust has continued to report low mortality rates according to hospital standardised mortality ratio (HSMR) and summary hospital level mortality Indicator (SHMI). In addition, more than 90% of patients receiving care across a range of settings have told the Department of Health via the friends and family test (FFT) that they would recommend St George's as a place to receive treatment.

I firmly believe that high quality care requires an engaged workforce. Our staff are the people who deliver services, and who see patients day in, day out. The survey results at our disposal show that staff would still recommend St George's as a place for either their friends or family members to be treated. However, we need to do more to engage with our staff, so they truly feel part of the organisation, and what we are trying to achieve for patients and the communities we serve.

We will continue to be open about the challenges we face, but also proud of our achievements. We have developed new services including the new Charles Pumphrey Unit for cardiology elective admissions. We have opened the Wolfson Neurorehabilitation Unit at Queen Mary's Hospital. The Sentinel Stroke National Audit Programme recognised our Hyper Acute Stroke Unit as highly performing, and we completed a long journey this year to be approved to join the VTE Exemplar Network.

Finally, I would like to stress that the trust board are fully committed to supporting our staff, so that they are able to provide our patients with the best care, 24 hours a day, 365 days a year. We are actively addressing the difficult problems we face, which includes major estates, IT and process issues that have accumulated over an extended period of time.

These issues and others will take time to resolve, but some progress is already being made. Our patients deserve the best care possible, and we need to make improvements across the board to ensure they receive it.

Simon Mackenzie
Acting chief executive
2nd June

Performance report

A brief history of St George's

The original St George's Hospital opened on Hyde Park Corner in 1733. St George's Medical School was established later in 1868. The hospital moved from Hyde Park Corner to the Grove Fever Hospital and Foundation Hospital's site in Tooting in 1973. The university followed shortly after in 1976. Her Majesty the Queen officially opened the Tooting site – St George's Group - in 1980, which later became St George's Healthcare NHS Trust in 1993. New developments including, but not limited to, the Atkinson Morley wing, the emergency department, the helipad and the merger with Community Services Wandsworth take us up to 2015 when the trust was authorised as a foundation trust.

Being a foundation trust means we are regulated by NHS Improvement (as of 1st April 2016) using a different regulatory framework to the Department of Health. The trust was regulated by Monitor from February 2015 to March 2016.

As a foundation trust we have a council of governors which 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 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.

The purpose and activities of St George's

The role of St George's is to improve the health and wellbeing of patients, to support patients to become mentally and physically well, to support patients to get better when they are ill and when patients cannot fully recover, and to help them to stay as well as they can to the end of their lives.

St George's provides a range of services, available to all. Our services are designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. We have a duty to each and every individual that we serve. At the same time, we have a wider social duty to promote equality through the services we provide.

We work within a common set of principles and values that bind together the communities and people we serve – patients and public – and the staff who work for us.

2015/16 – a difficult year

The trust acknowledged the scale of the financial challenge at St George's in last year's annual report, and this remains a major issue for the trust.

St George's ended 2014/15 with a £16.8m deficit and its initial forecast deficit for 2015/16 was £46.2m, resulting in the trust being in breach of its foundation trust license. As a result of this, Monitor, the health regulator (now NHS Improvement), commissioned a review into our governance and financial processes.

PricewaterhouseCoopers (PwC) undertook an independent review of our finances to confirm how and why the deficit materialised. The subsequent report from PwC identified serious weaknesses in financial and management systems at St George's, such as budget setting, reporting, forecasting and training for budget holders.

The trust board began a process of addressing the recommendations of the PwC report, which included strengthening our financial and management systems. Over the past year we have been working with our staff, partner organisations and NHS regulators to try and tackle the financial challenges we face, and this work is ongoing.

As well as the financial position of the trust, we have also experienced delays in treating patients as quickly as we would want to. Our operational performance - including emergency department four-hour waits, referral to treatment times and the treatment of cancer patients – is not as strong as it needs to be. We are putting measures in place to improve performance, but this will take time.

This is an issue that the trust board are taking very seriously, and over the coming year we will be working to ensure the trust's IT infrastructure and estates issues are addressed, together with issues around operational and financial performance.

We recognise that immediate improvements in these – and other – areas are required to make the organisation better prepared to deal with the pressures we face. A historical under-investment in our estate and IT infrastructure has resulted in single-points-of-failure being identified towards the end of the year.

2015/16 has had a significant impact on staff morale, which is reflected in the staff turnover rates and in the reported outcomes in the National NHS Staff Survey and the Staff Friends and Family Test. A key objective for 2016/17 is to improve the working experience for our staff. Staff who feel engaged, involved and valued provide for a strong workforce, which is essential to achieve continuous improvement in delivering our services.

As part of our actions to address our financial position in 2015/16, KPMG were brought into the trust to help identify and address the root causes and drivers of the adverse financial position, and begin the process of returning the organisation to financial sustainability. A key output of the turnaround process has been a revised financial forecast for 2015/16 outturn of £55.1m and a high level financial plan for 2016/17.

A major programme of turnaround and transformation is being rolled out to make us fit for the future, and to release much needed savings.

The trust expects benefits from the programme to include:

- helping us address the current ways of working so that we can reduce waste, delays and confusion for patients, whilst saving money and enabling us to treat more patients
- engaging staff in having a greater positive impact in their work and building their transferable skills as we improve services
- offering staff the opportunity to work together to improve the value of the services they provide, giving us a sense of shared purpose, collective success, and real team pride

- improvement in terms of patient care and quality outcomes, as well as staff satisfaction and financial success.

We accept that we still face significant challenges at St George's. Maintaining supportive relationships with our staff, partner organisations and NHS regulators is essential to ensure that St George's can return to a sustainable and successful position.

Measuring our clinical and operational performance

The operational performance of the trust is not where it needs to be and, whilst a number of improvements are in progress, patients are not being seen and treated as quickly as we would want them to be.

2015/16 resulted in sub-optimal performance against a number of targets, including: emergency department (ED) four-hour standard, cancer two-week wait, cancer 62-day standard and 18-week referral to treatment waiting times.

The reasons for the delays are multi-faceted. They include significant winter pressures, an increase in the acuity of patients we see, as well as a high number of unplanned admissions.

Our status as a specialist centre for a range of services – including major trauma and stroke, for example – also puts greater pressure on the day to day delivery of routine, but crucially important, services.

It is positive that we have met some key cancer targets in 2015/16. However, we are still off trajectory in regards to key performance indicators for cancer – including the two week and 62-day waiting targets. We need to do much better, and the trust has implemented a number of action plans - working with commissioners - to bring performance back to target. We have delivered improvements with regard to infection control, our pressure ulcer profile, as well as mixed sex accommodation targets – however, we are not complacent, and there are still improvements to be made.

The trust reviews and monitors performance against key performance indicators (KPIs) via a number of forums as part of its governance processes. Dependent on the nature of the KPIs, performance is monitored, daily, weekly and monthly using a number of reporting tools and online dashboards.

Weekly performance review meetings with operational leads, including executive oversight, are in place to assess recent performance, escalate concerns and actions required to remediate performance and to assess any impact on the delivery of actions plans. Performance is also benchmarked against peer providers to show how the trust compares to similar size organisations and also against organisations within the local health economy.

Monthly reported performance is signed-off by both operational and executive leads. It is then reported to the appropriate sub-committees of the trust board and to the trust board for scrutiny.

In addition to the internal processes, performance against key national indicators is reviewed and scrutinised externally by commissioners via a number of external meetings associated with system resilience. The trust then works

collaboratively with commissioners in agreeing remedial action plans for any recovery required and associated trajectories.

Acting chief executive Professor Simon Mackenzie said: "Our operational performance is not where it needs to be, and we need to tackle this quickly. The services we provide are facing huge demand, but we are not alone in this regard. We are initiating detailed work in key areas to drive up performance quickly, and we will be reviewing this on a daily, weekly and monthly basis to ensure we are delivering the improvements we need to for the benefit of our patients."

Indicator	Target	2015/16 Performance
ED: maximum waiting time of four hours from arrival to admission / transfer / discharge	>=95%	90.44%
RTT - consultant led referral to treatment waiting times incomplete pathways	>=92%	90.25%
62-day wait for first treatment from urgent GP referral for suspected cancer	>=85%	82.50%
62-day wait for first treatment from NHS cancer screening service referral	>=90%	90.40%
31-day wait for second or subsequent treatment - surgery	>=94%	96.50%
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%	97.00%
Cancer: two week wait from referral to date first seen for symptomatic breat patients (cancer not suspected)	>=93%	87.80%
Cancer: two week wait from referral to date first seen for symptomatic breat patients (cancer not initially suspected)	>=93%	93.40%
C.difficile - meeting the C.difficile objective	31	29
MRSA bacteraemias (bloodstream inspections)	(0 within de minimis of 6)	3
Mixed sex accomodation breaches	0	11
Emergency readmissions within 30 days following an elective or emergency spell at the trust	5%	3%
Data completeness: community services, comprising:		
Referral to treatment information	50%	55.50%
Referral information	50%	87.70%
Treatment activity information	50%	70.30%

Financial performance 2015/16

The trust planned to make a deficit of £46.2m in 2015/16, but incurred a deficit of £55.1m, which compares to a deficit of £16.8m for 2014/15.

Income

Key year on year changes in healthcare income from CCGs and NHS England are:

- SLA income has increased in 2015/16 by £8.1m from £603m to £611.1m
- 2015/16 income included £12.2m (£7.3m in 2014/15) of commissioner challenges, and capacity and flow income of £6.6m (£9.5m in 2014/15)
- a new facility opened in 2015/16 (the Nelson Health Centre), which generated income for the trust of £3.9m
- the level of over performance for non-specialist commissioners was £6.5m (£13.4m in 2014/15 and for specialist commissioners was £16.1m (£8.6m in 2014/15)
- the trust had a block contract for emergency services with south west London CCGs for £67.3m – no such arrangement existed in 2014/15.

Expenditure

Expenditure increased more than income year on year by £36m.

Pay costs increased by 3.4% (£15m), due to:

- impact of inflation on pay uplift and incremental increases (£4m)
- nursing – safe staffing levels and additional facilities (£3m)
- medical consultant workforce to provide additional capacity (£4m)
- non-clinical staff – administrative support costs, including turnaround/transformation interim resource (£4m)
- agency usage was unchanged.

Non-pay costs increased by 13% (£31m), due to:

- Clinical Negligence Scheme for trusts cost increase - £5.4m
- professional services (external turnaround support) - £5.5m
- increase in drugs cost related to the pharmacy wholesale dealer licence which commenced in 2015/16 - £6.7m (expenditure is offset by additional 'other' income)
- increase in high cost drugs pass through costs - £7m (expenditure is offset by additional 'SLA exclusions' income)
- increase in premises costs - £6m re: new additions such as the Nelson Health Centre and infrastructure upgrades.

Capital expenditure

The trust incurred capital expenditure totalling £31.1m in 2015/16, compared to £38.4m in 2014/15. These figures include the capital value of new finance leases taken out during the year.

The main components of capital investment in 2015/16 were IT infrastructure £4.9m, medical equipment £9.5m, estate backlog maintenance £2.9m and various major projects £12.1m including a new hybrid theatre, surgical assessments unit (in-progress at year end) and endoscopy unit (in-progress at year end).

The trust took action to constrain capital investment, in order to support its cash flow position, by re-scheduling the completion of some capital projects eg the surgical assessment unit

and endoscopy unit to 2016/17. This action helped the trust to reduce its borrowing requirement for the year and to stabilise the cash position.

Cash and liquidity

The trust ended the year with a cash balance of £7.4m, down from £24.2m at the end of 2014/15.

The income and expenditure deficit of £55.1m put severe pressure on the cash position during the year and consequently the trust borrowed £40.4m in 2015/16 from the Department of Health under an interim revenue support facility to finance the deficit.

The trust had forecast in its annual financial plan, submitted to Monitor in May 2015, that it would need to borrow £52.2m from the Department of Health. However, more effective management of working capital balances (stock, debtors and creditors) and control of capital investment enabled the trust to reduce the borrowing requirement by £11.8m.

As at 31st March 2016, the trust had spent £1.8m on this project, and so the year end cash position includes £11.5m of unspent London Energy Efficiency Fund (LEEF) loan received in 2014/15.

Capital structure

Borrowings from the Department of Health

The trust borrowed £5.6m of capital loans in 2015/16 from the Department of Health, in order to finance specific capital projects started in 2014/15, bringing the total of Department of Health capital loans for these schemes to £14.7m.

The trust received a working capital loan of £15m from the Department of Health in 2014/15, on receipt of its licence as a foundation trust.

In 2015/16 the trust borrowed £40.4m of a possible £48.7m under a new interim revenue support facility agreed with the Department of Health. This is in order to help finance the £55.1m revenue deficit. The £8.3m balance of the facility of is available for drawdown in 2016/17, as and when it is required.

The trust has access to a working capital facility of £25m, which is also available for drawdown in 2016/17. As at 31st March 2016, drawdowns against this facility were zero and therefore the trust has additional secured borrowing capacity for 2016/17 of £33.3m.

Finance leases

The trust uses leasing to supplement capital investment in medical equipment, where appropriate, taking account of implicit rates of interest, the expected useful economic life of the equipment, the residual value of the equipment at the end of the lease term and the expected rate of technological change to ensure value for money.

During 2015/16 the trust took out new finance leases with various leasing companies for equipment with a capital value of approximately £6.2m. This funded two new CT scanners, a new MRI scanner, new equipment for the new hybrid theatre and various other items of medical equipment. The total borrowings under finance leases were £10.7m at 31st March 2016.

Private finance initiative

The trust entered into a private finance initiative contract in March 2000 for the exclusive use of Atkinson Morley wing on the St George's Hospital site over a 35 year term. The capital value of the building is approximately £50m.

All of these loans are included within borrowings in the statement of financial position within the accounts, included separately in this annual report.

Financial sustainability risk rating

The financial sustainability risk rating (FSRR), formerly continuity of service rating (COSR), is the new measure (where a larger number indicates a better rating) used by Monitor to assess the financial viability of foundation trusts.

	Financial criteria	Weight (%)	Metric	Rating categories**			
				1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25x-1.75x	1.75x-2.5x	≥2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	IE margin	≤(1)%	(1)-0%	0-1%	>1%
	Variance from pain	25	Varience in income and expenditure margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

The trust ended the financial year with a FSRR rating of 2, versus plan of 1, due to better variance and liquidity metrics.

Pension scheme

The pension scheme operated by the trust is the NHS Pension Scheme, managed by the NHS Pensions Agency (NHSPA). 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 within operating expenses.

Pensions information for senior managers is disclosed in accordance with the requirements of the Greenbury Report in the enclosed remuneration report, whilst further information on the accounting and valuation policy of the NHS Pension Scheme is given in note 1.5 in the accounts.

Better payment practice code

Better payment practice code - measure of compliance

	2015-16	2015-16	2014-15	2014-15
Non NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	173,651	316,409	170,750	284,344
Total non-NHS trade invoices paid within target	92,908	173,715	101,771	161,376
Percentage of non-NHS trade invoices paid within target	**53.50%**	**54.90%**	**59.60%**	**56.75%**

	2015-16	2015-16	2014-15	2014-15
NHS Payables	**Number**	**£000**	**Number**	**£000**
Total NHS trade invoices paid in the year	4,126	76,612	4,715	55,751
Total NHS trade invoices paid within target	1,437	40,419	1,237	24,721
Percentage of NHS trade invoices paid within target	**34.83%**	**52.76%**	**26.24%**	**44.34%**

The Better Payment Practice Code (BPPC) requires the trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Trust performance

Performance against financial and operational targets has been very mixed, and the scale of the financial challenge at the trust has been considerable and will remain so during 2016/17.

The trust has achieved a number of the key performance targets, for example:

Indicator	Target	2015/16 performance
All cancers: 31-day wait from diagnosis to first treatment	93%+	97%
C.difficile – number of infections per year	31	29
Emergency readmission within 30 days following an elective or emergency spell at the trust	5%	3%

However, against some key measures, the trust has not achieved the performance that it would wish to for its patients, key amongst them are:

Indicator	Target	2015/16 performance
Emergency department: maximum waiting time of four hours from arrival to admission/ transfer/discharge	95%	90.4%
18-week referral to treatment: incomplete pathways	92%	90.25%
62-day wait for first treatment from urgency GP referral for suspected cancer	85%	82.5%

The trust has agreed trajectories with commissioners and regulatory bodies for how it will ensure to improve and meet targets during 2016/17. Delivery against these targets will be a key focus for the trust in the coming year.

The trust has worked hard to meet the financial targets it has set for itself and has ended the year at £55.1m deficit. This is over the planned deficit of £46.2m, but the trust is clear that without the significant steps undertaken during the year, the deficit position of the trust would potentially have been significantly worse. The trust has started to develop a transformation programme to underpin a radical but financially sustainable model of healthcare for the future, which will begin to be implemented during 2016/17.

Our strategy

The trust's 10 year strategy was approved in late 2012 and was reflective of the trust's financial performance in the previous years, its aspiration to become a foundation trust and set out a direction for the organisation for the ten years to 2022. The principles of the strategy remained in force during 2015/16 as the overarching framework within which corporate objectives and other trust proposals were measured and developed.

The two key guiding principles are 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 and client care. 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.

The trust will refresh its strategy during early 2016/17 to take account of the financial challenges the trust faces, the evolving needs of the health economy and the need to begin to implement the five year forward view and the local sustainability and transformation plan (STP). These latter two documents respectively outline the direction of travel for the NHS between 2015 and 2020 and the translation of those aspirations into locally deliverable plans – the STP.

St George's mission and vision

The trust agreed the following mission statement and vision when it developed and approved its strategy in 2012:

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 was developed utilising the guiding principles outlined above and is designed to move the trust towards implementing its vision and delivering its mission:

The following outlines in more detail what each of these statements mean and some of our achievements in 2015/16 to help deliver towards them. Included in the tables are some of the actions we want to take in 2016/17.

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.

What have we done in 2015/16?

1) Worked with Wandsworth CCG to develop and implement the community adult health service (CAHS) model to offer patients in Wandsworth a better, more integrated service offering them greater support in the community.

2) Developed and implemented the frailty model of care, supporting older people to remain in their own homes and speeding their discharge from hospital..

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

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 from 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.

What have we done in 2015/16?

1) Delivered a number of projects that have increased the total number of beds available to patients in cardiology, neurosciences and rehabilitation medicine.

2) Worked with other hospitals, notably Croydon and Kingston, to develop a more networked model of clinical care, in for example services such as urology.

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 St George's 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.

What have we done in 2015/16?

1) Built and opened a new hybrid vascular theatre, where radiology interventions and open surgery can both be undertaken, minimising risk to patients and improving patient outcomes in complex vascular surgery.

2) Created the cardiology clinical academic group, improving the links between the trust and St George's, University of London, with benefits for patients, staff and both St George's, as well as appointed to a new professorship in neurosciences.

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.

What have we done in 2015/16?

1) Participated in around 200 trials with funding attached, with around 50 new trials per year undertaken by St George's bringing in over £1m of income to the hospital.

2) Developed a leadership programme seeking to develop a culture in the organisation where staff, from the top down, deliver the trust values on a daily basis.

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 strategy, the estates strategy, implemented the South West London Pathology service and a well-regarded private patients unit.

What have we done in 2015/16?

1) Implemented electronic document management and electronic referral system for all new outpatient registrations at St George's for all bar one clinical service in the trust.

2) Provided transparency on outcomes by publishing consultant level activity data. Published activity data available for national audits shows no mortality or complication outliers.

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.

What have we done in 2015/16?

1) Undertaken a full review of nursing to ensure the trust has the right number of nurses available on every ward and service within the organisation

2) Undertaken a full review of outpatients, leading to a new outpatient strategy, that is designed to offer patients a better, more patient focussed outpatient experience, and in so doing, improve the morale and job satisfaction of staff working in outpatient services.

3) Undertaken a survey with our doctors to determine how well we engage with them. The outcomes of the Medical Engagement Review will form part of 2016/17 workforce engagement strategy.

St George's business model

St George's is at the heart of a changing healthcare environment in south west London. The six clinical commissioning groups (CCGs) that make up the south west London sustainability and transformation plan area are Wandsworth, Croydon, Kingston, Merton, Richmond 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 made by the trust inform the organisation's business model.

The core local population of the trust is 561,790 people (as measured in the 2011 census) 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.

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 borough	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
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.

St George's, on reviewing the population it serves has made the following judgements:

- the population is growing, across all age groups, and background 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. This will bring an increase in 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 and 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 a major trauma centre with a state of the art emergency department, providing facilities that a young and fluid population are likely to need to access
- has expanded its cardiac and neurosciences services to meet population demand as there will be significantly more people over 65 who will require relatively more cardiac, stroke and neurosciences services as well as improved management of long term conditions.

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 those services that it wishes to grow, for example neurosciences
- has a solid market position for stroke, major trauma and renal transplantation, and is delivering on action plans, for example the helipad for major trauma, to expand capacity on site.

Risks to delivering the 2016/17 operational plan

The trust has a comprehensive governance process that identifies and manages risk within the trust. A number of the challenges, or actions to address those challenges, are covered by the trust's various risk registers and particularly the corporate risk register.

For clarity's sake, however, the following key risks to the delivery of the operational plan have been identified.

Risk	Risk description	Potential impact	Mitigation
Plan delivery	The 2016/17 plan is not achieved. The financial plan could be destabilised by "must-dos" including patient safety, leading to slippage on recovery plans, pressure on cash and non-achievement of in-year plans.	**Key stakeholders lose confidence in the trust and its leadership team.**	Focussed strengthening of management capacity and capability to assure delivery. Continuing emphasis on the continuing need to proceed at pace to deliver change. Continuing dialogue with stakeholders to ensure shared approaches to challenges.
Income and activity	Expenditure reductions and regulatory risks impact on the trust's ability to deliver planned activity. The trust has insufficient capacity to deliver expected levels of activity.	**Strategic transformation and other budgeted income funding are not achieved.** **The financial plan is not achieved.**	Careful balancing of income and expenditure priorities to ensure that activity is delivered. Continuing dialogue with stakeholders including support to commissioner QIPP plans (demand management).
Expenditure	Efficiency programmes will not be sufficient to deliver savings assumed within budgets. Staff do not understand the requirement to deliver agreed expenditure budgets. Risk that the expenditure budgets after efficiency gains are seen as incompatible with the achievement of income targets and/or central/local savings targets are double counted, giving the board a false sense of assurance.	**Cost improvement programme targets are not achieved.** **The expenditure plan is not achieved.**	Minimise risk of double counting by devolving financial targets to divisional levels. Stronger performance management and follow-through of actions. Increase assurance through robust data quality; tight management of vacancies and staff costs.

Regulatory risk	The financial plan is not accepted by NHS Improvement. Care Quality Commission, Royal Colleges and other regulators may require additional investment. NHS Improvement may increase controls over agency and premium costs, leading to staffing constraints.	**The trust does not achieve its income target.** **The trust is required to invest more than its budgeted expenditure plans (capital and/or revenue).** **The trust is unable to manage within the cash resources available.** **The trust's financial plan is not achieved.**	Raise awareness within divisions and develop locally-owned mitigation plans. Develop active communication plans for stakeholders and patients about responses to risks and mitigating actions. More robust performance management to promote improved ownership and mitigations.

Further risks were identified towards the end of 2015/16 and remain relevant, though many form a sub-set of the key headings above.

1) That the lack of capital funding, internal or external, does not allow the trust to progress major infrastructure projects particularly the renal re-provision and children and women's hospital.

2) That unexpected infrastructure failure forces the trust to spend additional monies on the capital programme, so risking delivery of the trust's financial targets.

3) That unexpected additional constraints on capacity mean that plans to improve access target performance as outlined in the plan are not delivered.

4) That staff turnover and vacancy rates remain unchanged or worsen, impacting on the continuity of patient care, the ability to meet the agency cap, and the ability to deliver the workforce savings outlined in this plan.

Important events since the end of 2015/16

There were a number of leadership changes at board level during 2015/16.

Sir David Henshaw was appointed interim Chair in April 2016.

In April 2016, Miles Scott, chief executive, left the trust for a secondment to NHS Improvement. Paula Vasco-Knight, former chief operating officer, became chief executive, but was subsequently suspended due to allegations made against her relating to a previous employment.

The trust asked Professor Simon Mackenzie, medical director, to take on the role of acting chief executive. Professor Andrew Rhodes, deputy medical director, then became acting medical director.

In May 2016, both Martin Wilson (director of transformation) and Rob Elek (director of strategy) left the Trust. Iain Lynam, former Chief Financial Officer (CFO), was made Chief Restructuring Officer, whilst Nigel Carr (who worked with the trust as an employee of KPMG during 2015/16) was made CFO. The directors' report shows the board as it was on 31st March.

Going concern disclosure

The accounts have been prepared on a going concern basis.

The trust incurred a deficit of £55.1m during 2015/16. During the year the trust secured an interim revenue support facility with the Independent Trust Financing Facility for £48.7m and had drawn down £40.4m from this facility by 31st March 2016.

The board has reviewed the proposed 2016/17 plan throughout its development from November 2015 to date. The plan is for a deficit of £17.2m having taken due account of the realistic underlying financial position going into 2016/17, the risks and cost pressures faced in 2016/17 and the level of cost reduction the organisation can be stretched to deliver. The trust has access to further borrowing totalling £33.3m comprising £8.3m from an interim revenue support facility and £25m from a working capital facility. The trust may need to request access to borrowing facilities in addition to these during 2016/17 and the board has a reasonable expectation that this will be agreed with the Department of Health with the support of the regulator should this be necessary.

The trust was engaged in discussions with Monitor regarding the financial plan for 2016/17 and the arrangements to access further borrowing facilities at year end: however these discussions had not concluded at the time the financial statements were approved. Although these factors represent a material uncertainty 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 2015/16, 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 were unable to continue as a going concern.

Equality, diversity and human rights

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 www.stgeorges.nhs.uk/about/living-our-values/equality-andhuman-rights/

Climate Change Act obligations

St George's is committed to meeting its obligations of reducing its emissions by 2050 in line with the Climate Change Act which was introduced in 2008. To assist in reaching our obligations a number of tools have been produced and are being utilised to atttain our targets.

The current sustainable management plan is due to be reviewed in the coming months. This was introduced with the purpose of describing how the trust aims to achieve the recommendation made by the NHS Sustainable Development Unit to support the implementation of carbon reduction and sustainable development agendas.

The trust is developing its wider CSR framework which will encompass wider responsibilities to our community. This plan will form a key part of the framework.

The NHS Carbon Reduction Strategy 2009 sets out clear measurable milestones to measure, monitor and reduce direct carbon emissions, which make a contribution towards this commitment. St George's is committed to working with its NHS partners and other stakeholders to achieve sustainable development and has been working towards this since 2007 when it initiated work with the NHS Carbon Management Programme to reduce the hospital's carbon emissions.

Driven by the NHS Carbon Reduction Strategy the trust has developed this plan to address the dangers that climate change brings as well as achieving ambitious targets to reduce carbon emissions arising from its activities. There are two key actions for board focus:

1) ensure the trust complies with Climate Change Act 2008 and NHS carbon reduction targets

2) provide leadership in promoting the sustainability agenda.

The trust will continue working with staff, patients, visitors and key partners to enable these targets to be achieved, while aiming to provide an example that others may follow.

In addition other subjects for consideration are set out below.

- As the foundation trust is a 24 hours a day, seven days a week business there are numerous environmental issues that need to be advised for an environmental audit. These relate to noise, light, water, waste, thermal, air and effluent.
- The trust is a designated receiver of helicopter emergency medical transfers/admissions.
- In addition the trust only has helicopter flights during daylight hours.
- The trust is investing in the replacement of the existing boiler plant under an energy performance contract with British Gas / Centrica.
- The trust has a transport policy that is available on the trust's intranet.
- The trust actively encourages staff to utilise public transport and staff can also benefit from a bicycle purchase scheme.
- To reduce the impact of water supply in the wider environment, the trust abstracts water from an onsite borehole.

Our clinical services contract with Gibraltar Health Authority

In June 2015, the trust signed a contract with the Gibraltar Health Authority (GHA). The initial contract was agreed for one year, with a review in April 2016.

Gibraltar, a British Overseas Territory, has a population of approximately 30,000 residents. The GHA are dedicated to providing access to high quality, nationally bench marked clinical services and have chosen the trust to deliver these services as their preferred provider.

Clinical monitoring and treatment is delivered in two ways. Firstly by clinicians from St George's visiting Gibraltar to provide outpatient and day case treatment on a regular basis and secondly by providing treatment for Gibraltar patients at St George's.

This year has seen the appointment of a dedicated manager to operationally support the delivery of the contract. The manager has played a key role in organising the delivery of appointments and admissions, as well as providing expert support to our patients and their families.

We have developed close working relationships with the clinicians in Gibraltar allowing effective collaboration and facilitating clinical excellence. This has allowed the exploration and introduction of new services to ensure residents have equal access to a wide range of specialist services.

The first year has been a great success, with the effective and efficient delivery of agreed services leading to positive patient feedback. Following a systematic review of service delivery in April 2016, a new three year contract has now been signed. This will allow GHA to centralise their services, making the patient's care pathway simpler and better supported.

The performance report was approved by the board of directors on 2nd June and signed on its behalf by Simon Mackenzie, acting chief executive.

Simon Mackenzie
Acting chief executive
2nd June

What we do

Introduction

At St George's we want our patients to experience the highest possible quality of care.

With over 9000 staff, 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 shared with St George's, University of London which trains the next generation of healthcare, science and medical students and also carries out medical research. We also share our main site with Kingston University's Faculty of Health and Social Care Sciences.

As well as acute hospital care, we provide a 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 further afield, such as family HIV care and bone marrow transplantation for non-cancer diseases. The trust also has a national 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 to work to improve the quality of services for patients. These include the Royal Marsden Cancer Partners Vanguard, 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 provides an update on how St George's has performed during the year and also looks ahead to next year's priorities.

Facts and figures

- Overall, in 2015/16, the trust saw 636,766 outpatients, delivered 5,186 babies, undertook 28,413 elective inpatient and day case procedures and admitted 47,125 non-elective patients.
- Our emergency department saw 151,257 patients including early pregnancy unit attendances, while Queen Mary's Hospital's minor incident unit saw 16,103 patients
- The trust has a designated large hyper acute stroke unit treating 1,930 stroke patients during 2015/16.
- 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, receiving 2,205 major trauma calls in 2015/16.
- We officially opened our helipad in April 2014 part of our role as a major trauma centre. During 2015/16, we received 91 patients via the helipad.

Our services

Division	Directorates	Clinical services within each directorate						
	Major trauma	Major trauma						
Surgery, theatres, neurosciences and cancer	Surgery	T&O	ENT	Maxillofacial	Plastics	Urology	General surgery	Dentistry
		Audiology						
	Theatres and anaesthetics	Theatres and decontamination	Anaesthetics and acute pain					
	Neurosciences	Neurosurgery and neuro-radiology	Neurology	Neuro-rehab	Pain clinic			
	Cancer	Cancer						
Medicine and cardiovascular	A&E and acute medicine	A&E	Acute medicine					
	Specialist medicine	Lymphoedema	Clinical infection unit	Rheumatology	Diabetes / endocrinology	Chest medicine	Endoscopy and gastroenterology	Dermatology
	Renal, haematology and oncology	Renal transplantation	Renal medicine	Medical oncology	Clinical haematology	Palliative care		
	Cardiovascular	Cardiology – clinical academic group	Cardiac surgery	Vascular surgery and vascular access surgery	Blood pressure unit	Thoracic surgery		
Children's and women's, diagnostics, therapeutics and critical care	Children's	Paediatric surgery	Newborn services and NICU	PICU	Paediatric medicine and community paediatrics			
	Women's	Gynaecology	Obstetrics					
	Therapeutics	Adult critical care	Therapies	Pharmacy				
	Diagnostics	Clinical genetics	Breast screening	Radiology	Laboratory haematology			
	Outpatients	Outpatients						
Community services	Children and family	School and special school nursing	Children's continuing care	Health visiting	Child safeguarding team	Homeless, refugees and asylum seeker team		
	Community adult health service	Complex and scheduled care	Rapid response	Access and co-ordination	Specialist services	Day hospitals	Elderly rehab	
	Rehab and adult therapies	Specialist rehab services	Adult therapy services – physiotherapy, podiatry, dietetics	Community learning disabilities	Maximising independence			
	Offender healthcare	Primary care	Substance misuse	Inpatient care	Primary care mental health			
	Integrated sexual health	Genito-urinary medicine (GUM)	Reproductive sexual health					

We provide healthcare services at:

Hospitals

- 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
- Nelson Health Centre
- Stormont Health Centre
- Tooting Health Clinic
- 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.

Our clinical services are split into four divisions:

- surgery, theatres, neurosciences and cancer
- medicine and cardiovascular
- children's and 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 maxillofacial 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.

It is also one of eight heart attack centres in London.

Appendix one of the annual governance statement 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

Research

At St George's we are committed to 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 we aim to offer patients new drugs and devices and better clinical care.

St George's is collaborating with Genomics England for the '100,000 Genomes Project' and the genetics service has started to recruit patients from our services to contribute data and samples to the project. St George's University Hospitals NHS Foundation Trust runs the South West Thames Regional Genetic Service which provides a specialist service to people living in South West London, Surrey and West Sussex, in 18 hospitals across the region. Initially the focus will be on rare disease, cancer and infectious diseases, but our clinicians are working with the project to identify other key disease areas.

St George's, in its partnership with St George's, University of London, aims to bring new ideas and solutions into clinical practice. The cardiology clinical academic group (CAG) is a new way to manage clinical, educational and research activities through a coherent and skilled clinical group that represents both the university and the trust.

Our relationship with the pharmaceutical industry continues – we recruited the largest number of patients onto commercial trials in South London Clinical Research Network. This enables our clinical staff to keep abreast of the latest developments and our patients to have access to the newest treatments within clinical trials.

There is more information about our research projects and aims for 2016 in the quality report.

Working with our partners

At St George's we work with partners to deliver services. Here are some of our key partnerships, listed alphabetically:

First Touch

First Touch is the neonatal charity for St George's Hospital, funding vital medical equipment, specialist nurse training and a welfare scheme for families on the neonatal unit (NNU).

The charity recruited 'ambassadors' in Tooting, Balham, Wandsworth, Wimbledon, Raynes Park and Colliers Wood to raise the profile of the charity. Actress Martine McCutcheon and her husband Jack McManus are the charity's patrons.

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 aim 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.

Healthwatch

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

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.

Kingston Hospital NHS Foundation Trust

Our working relationship with Kingston Hospital NHS Foundation Trust has continued as there are a number of consultants who have appointments and commitments in 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.

London Cancer Alliance – Royal Marsden Partners Cancer Vanguard

The London Cancer Alliance worked collaboratively with 15 NHS provider organisations and two academic health science networks. It was established in 2011 as the integrated cancer system across west and south London and served a population of over five million. On 31st March 2016, the London Cancer Alliance was disbanded and replaced by the Royal Marsden Partners Cancer Vanguard.

The aim of the Vanguard is to support integration across the entire cancer patient pathway (including public health, primary care and diagnostics), in order to secure improvements in delivering patient-centred, quality and more financially sustainable cancer care.

Ronald McDonald House

Ronald McDonald House 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 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.

St George's Hospital Charity

The work of St George's Hospital Charity enhances the physical environment of our hospitals for patients, staff and visitors. They also fund 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 by our hospitals and local community services each year.

Some of the latest developments supported by the charity include:

- £1m of new medical equipment at St George's and Queen Mary's hospitals
- £425,000 for a major expansion of St George's neonatal high dependency unit, helping to expand high dependency capacity by four cots, increasing to 13 cots in total
- £410,000 expansion of the chemotherapy day unit following the gift of a legacy to improve cancer facilities at St George's and help more patients receive their treatments with greater privacy and dignity
- £250,000 for a patient-led initiative to improve adult wards by making them more dementia friendly
- funding towards installing a new MRI scanner for neurology patients
- two new birthing beds in the Carmen delivery suite at St George's to respond to growing need
- £70,000 for fetal monitors in the delivery suite
- an orthotic foot scanner to instantly capture a 3D image of the shape of the foot, avoiding the need for plaster casts
- force plates and rehabilitation exercise equipment to aid recovery in the Douglas Bader gym at Queen Mary's Hospital
- support for the genetics team at St George's to provide a microbiological safety cabinet for cell cultures used for genetic tests

- three balloon pumps for use for life support in emergency settings in the cardiac catheter labs and cardiac theatres
- £120,000 for four cystocopes to view the interior lining of the bladder and urethra
- £11,500 for rehabilitation equipment for hand injuries
- £104,000 for intensive care at St George's, particularly ventilators and bronchoscopes to provide breathing support.

St George's, University of London

The trust's main site, St George's Hospital in Tooting, is shared with St George's, University of London, one of the country's principal medical schools. The university and hospital offer high quality education, training, research and clinical care. We have joint director posts with St George's, University of London, including the director of estates and facilities.

South London Healthcare Networks

The trust is at the heart of several healthcare networks operating across south London, working 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 is designed to provide high quality care and improved outcomes for patients.

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 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 have 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. St George's University Hospitals NHS Foundation Trust is the host organisation for all the partnership's services.

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.

Children and families

School nursing

As of 1st September 2015, we started providing a school nursing service in Wandsworth which will run for three years. This has a budget of £1.25m and a large number of key performance indicators (KPIs) to deliver, and we are working closely with the local authority to develop and provide a good service to all the schools in Wandsworth.

Family Nurse Partnership (FNP)

Starting in April 2015, this specialist national service works in partnership with the local authority to provide an intense and specific package of intervention to teenage mothers. Intervention begins in pregnancy and continues until the baby is two years old. The service is closely monitored by the national FNP unit and 45 young women have been recruited to the programme so far. Total capacity is 100.

Community adult health services – end of life care (CAHS – EoLC)

Community services are now providing a nurse-led end of life care service in partnership with Royal Trinity Hospice and Marie Curie. A dedicated end of life community nurse provides extra support and advice to both patients and nurses in the community, leading a team of Marie Curie health and personal care assistants offering specialised hands-on care at home. The end of life specialist nurse works closely with the Wandsworth Care Co-ordination Centre based at Royal Trinity Hospice which arranges rapid packages of care and equipment to enable patients to be cared for at home, and acts as a helpline for patients, families and professionals. The service has been operating for one year and has supported over 400 patients so far.

Offender healthcare

HMP Wandsworth is the largest and one of the most complex prisons in the United Kingdom. Healthcare services at this busy and challenging prison are provided by a consortium for which St George's is the lead. Our key consortium partner is South London and Maudsley NHS Foundation Trust. Operationally the service provides primary care, substance misuse and mental health services at the prison through an integrated governance and management structure including an overarching integrated board.

The consortium is soon to enter its third year and while there is no doubt that it is a challenging environment within which to deliver healthcare services, the partnership between the large organisations involved is working effectively.

Mothers Like Me

The Mothers Like Me project won the Positive Practice Award - Innovation in Primary Care in October 2015.

To remove a child from their birth mother is likely to be the hardest decision made by the Family Court. For the child it should mean a brighter future but for the birth mother it is likely to lead to great feelings of loss, bereavement and guilt. Although birth parents are offered post adoption support, research shows that take up of services can vary.

The 18-month Mothers Like Me project (launched in January 2014) supports birth mothers of adopted babies and children in long term care placements to identify factors that contributed to this outcome, and strategies and support that could help prevent it happening in future. This was a joint venture between Health and Children's

Specialist Services funded by the Adoption Reform Grant with the aim of promoting the women's health and wellbeing through both individual and group support to help prevent repeated loss of their children.

The project made contact with birth mothers and listened to what support they felt they needed. A range of services was then developed including: a weekly drop in peer group session, access to community activities and training, individual assessments for psychological therapies and individual counselling sessions, making memory boxes for their children, and health screening which includes contraception advice, signposting and provision. The project has managed to engage with this hard to reach group and has had positive feedback from the mothers involved.

Acorn Service - sexual health advice and screening for people with learning disabilities

People with learning disabilities can find it difficult to access health services, including sexual health. Working in partnership with the Wandsworth Community Learning Disability Team at the Joan Bicknell Centre, the Pearl Service at the West London Centre for Sexual Health and the London Borough of Wandsworth, the Courtyard Clinic has launched the Acorn Service which is a dedicated, easy access service for people with learning disabilities. The Acorn Service offers screening for sexually transmitted infections, contraception and information around sex and relationships.

Patients can refer themselves or can be referred by GPs, family members, carers, case workers and social workers with the patient's consent.

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.

excellent
kind
responsible
respectful

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 2015/2016. 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 provides 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 total number of written complaints received during 2015/16.

	2015/16
Admissions, discharge and transfer arrangements	**22**
Aids and appliances, equipment, premises (including access)	**14**
Appointments, delay/cancellation (outpatient)	**105**
Appointments, delay/cancellation (inpatient)	**30**
Attitude of staff	**67**
All aspects of clinical treatment	**432**
Communication/information to patients (written and oral)	**192**
Consent to treatment	**2**
Patients' privacy and dignity	**6**
Patients' property and expenses	**19**
Personal records (including medical and/or complaints)	**20**
Failure to follow agreed procedure	**1**
Mortuary and post mortem arrangements	**1**
Transport (ambulances and other)	**25**
Policy and commercial decisions of trusts	**1**
Hotel services (including food)	**11**
Others	**27**
Total	**975**

The table below highlights some of the actions in response to feedback:

Concern	Action
Corporate outpatients (communication/ attitude)	Customer care training continues in outpatients and has been expanded to include the use of a short film made in the trust, by staff and patients. In addition one of the service managers is providing customer service training directly to the administrative staff in corporate outpatients.
Neurosciences (bed moves/admission delays)	16 additional neurosurgical beds were opened in October 2015 which has improved patient experience by reducing the numbers of bed moves and delays to patients waiting for admission.
Renal (discharge co-ordination and transport arrangements)	Complaints regarding discharge co-ordination and transport arrangements - there is now a robust system in place to ensure safe discharge and on-going care. Buckland ward now have a specific discharge co-ordinator post which is held by a senior qualified nurse who is responsible for ensuring safe and appropriate discharge of patients.
Specialist medicine (waiting times)	Following complaints relating to appointment waiting times, evening clinics were established in order to accommodate current demand, so that appointments can be offered with less delay.
Children's services (communication)	Educational films which re-enact real complaints are being utilised within children's services and an additional piece of work is being delivered to improve the communication to adolescents.

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 independent 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 of medical treatment for persons detained under the 1983 (Mental Health) Act.

The trust has no conditions placed on it and the CQC has not taken any enforcement action against the trust in 2015/16. 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 a CQC inspection, the trust is measured against the five domains of quality:

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

The CQC rating system has four categories - outstanding, good, requires improvement and inadequate. Trusts are given an overall rating and a range of services within the trust are also given one of these four ratings.

The trust received an overall rating of 'good' with adult critical care and some areas of maternity considered to be 'outstanding' during the trust's last inspection in February 2014. 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.

There were two areas of non-compliance identified and the trust was required to develop an action plan to address:

- the implementation of the Mental Capacity Act at Queen Mary's Hospital (QMH)

- the availability of medical records in the outpatient department.

During 2015/16 the trust has continued to take action to address the two issues identified. 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, and also set out the measures we would take to ensure that staff at QMH have a good level of understanding of the Mental Capacity Act in order to deliver safe, responsive and effective care.

The CQC have announced that they will return to the trust on 21st June 2016 to carry out a full inspection as part of their continued announced inspection regime. The results will be available in early autumn 2016.

There is more information on the CQC within the quality report.

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 caring?

St George's opens new cancer ward

St George's was delighted to announce the opening of a new cancer ward in May 2015.

The ward provides an additional 20 beds in a clean, modern environment to treat a diverse number of patient groups, including those with leukaemia, lymphoma and non-malignant conditions of the blood.

Gordon-Smith ward was officially opened by Dr Anne Rainsberry, NHS England's regional director for London. It is the second step of investment in our cancer services after the opening of the new haematology and oncology outpatients clinic last year.

The ward is named after Ted Gordon-Smith, a retired professor of haematology at St George's, University of London, who joined St George's in 1987. He was instrumental in expanding our clinical haematology service from two beds to a dedicated 13-bed transplant and haematology ward during his 25-year career at the trust.

Dr Anne Rainsberry said: "It is a great honour to open this new ward which will really improve the experience of cancer patients at St George's. Across London, we are committed to ensuring that people with cancer receive world-class care which is centred on their needs at every stage - from prevention and diagnosis, through to treatment and beyond."

New hybrid theatre at St George's Hospital to enhance patient care

St George's has opened a new hi-tech hybrid operating theatre, where state of the art imaging enables less invasive surgery which is safer for patients.

The theatre, on the first floor of St James wing, is equipped with an advanced scanner available at all times where small body parts such as veins and arteries can be visualised and surgeons can be guided to these areas.

Medical equipment like catheters or stents can then be inserted through small holes rather than the patient undergoing more invasive surgery. By minimizing the physical trauma to the patient, non-surgical interventions can improve recovery and shorten hospital stay. If the less invasive route is not successful, surgeons can convert to open surgery under one anaesthetic in a safe theatre environment.

Matt Thompson, professor of vascular surgery, said: "It's a very exciting development for the trust to have a first-class safe environment that combines an operating theatre with an interventional radiology suite. The new treatment options have the potential to enhance patient care and shorten recovery times, reducing the overall cost of treatment."

Renate Wendler, associate medical director and clinical lead for the project, said: "The development of the hybrid theatre was a real group effort. I'd like to thank all staff who worked incredibly hard to make it happen."

The new hybrid suite is used primarily for vascular surgery and interventional radiology procedures, but has the potential to be used for other specialities such as major trauma or cardiology/ cardiac surgery.

Are we safe?

Redthread youth violence intervention at St George's

St George's held a special engagement event in April 2015 to introduce our staff and associated community professionals to Becky and Alex, two Redthread youth workers who have joined our emergency department (ED) team.

Hundreds of teenagers fall victim to gang-related violence every year and without intervention or effective support some become trapped in a cycle of violence. Redthread are leaders in a youth violence intervention program, working closely with ED staff across London to approach victims and provide the help they need to hopefully break that cycle.

Redthread have been embedding youth workers within the major trauma centre at King's College Hospital since 2006, St Mary's from October 2014 and the Royal London Hospital from April 2015. And now, as part of the Mayor's initiative to better support those who fall victim to gang violence, they have started to focus their attention on establishing a partnership with St George's.

Becky Calnan, senior youth worker, is based at St George's full time, whilst Alex Melhuish will divide his time between our ED and King's Hospital.

Their posts have been funded by the Mayor's office, with their primary role being to work with 11-25 year olds who have presented with injuries secondary to violence or who are at risk of violence or sexual exploitation. They will be based in the ED but they will also engage with young people on both the paediatric and adult wards.

Safer test, shorter wait as new Down's screening comes to St George's

St George's announced in June 2015 that it will begin offering an in-house, non-invasive prenatal test (NIPT) for pregnant women in the UK. The test helps expectant mothers to understand the risk of their unborn baby having Down's syndrome and other serious genetic diseases.

Before this, pregnant women in the UK could only access NIPT privately, with blood samples being sent either to the US or China. Not only was this costly, but it also carried a waiting time of up to two weeks for results which are pivotal in helping parents make decisions about their pregnancies.

St George's screening test will be called 'the SAFE test' and St George's will be the only trust to offer NIPT to expectant mothers through the NHS. Based on Premaitha Health's IONA® test, the SAFE test analyses a small sample of the mother's blood to correctly identify over 99% of Down syndrome and other serious genetic disorders.

The focused service will be available to all pregnant women referred to St George's to receive further care after receiving an NHS "high risk" combined test result.

The women will have the choice to undertake either a CVS or the SAFE test – as clinically appropriate.

Are we effective?

Queen Mary's Hospital celebrates rich past and bright future

June 2015 marked 100 years since the first amputee patient was admitted to Queen Mary's Hospital (QMH).

To celebrate a century of care, guests were invited to a special centenary exhibition at QMH which was created by QMH Roehampton Archive and Museum Group.

Former RAF fighter pilot Sam Gallop CBE and Councillor Ravi Govindia, leader of Wandsworth Borough Council, declared the display open.

Sam Gallop, one of our most distinguished patients, lost a leg and was badly burnt in World War II. He praised the staff who treated him and encouraged current patients to seek inspiration from the achievements of the past as illustrated in the exhibition. The exhibition includes historic information and educational interactive displays for patients and visitors.

Two months later in September, the Wolfson Neurorehabilitation Centre was opened by Justine Greening, MP for Putney, Roehampton and Southfields, retired St George's neurosurgeon Henry Marsh CBE and Miles Scott.

The centre, which is the largest of its kind in London, provides specialist neurorehabilitation for adults who have acquired neurological conditions resulting in physical or psychological disabilities. Throughout a patient's stay, of typically three months, there is a strong focus on goals, challenges and getting back home.

The Wolfson was relocated from its original Wimbledon site to Queen Mary's. Now in its new home, designed with the help of service users, the centre has 36 inpatient beds.

Current patients joined 60 guests in celebrating the launch which included tours of the unit.

Are we responsive?

A look into the Recovery at Home service

The St George's Recovery at Home service provides acute care in patient's own homes and is aimed at freeing up bed space within the hospital as well as helping reduce length of stay in hospital beds and improving patient outcomes.

The service, which was launched in January 2016, has already supported over 20 patients and saved 206 acute hospital bed nights. The team consists of specially trained nurses, physiotherapists and healthcare support workers and will in the future also include an occupational therapist.

Patients remain under the care of their consultant but are transferred home where they receive acute care from Recovery at Home staff. The trust will continue to provide pharmacy and pathology services in exactly the same way as if the patient remained in the hospital. Patients are discharged from Recovery at Home only when they have recovered in accordance with their treatment plan set by our consultants. Upon discharge, a summary will be sent to the patients' GP in the normal way.

A patient who was transferred to the service in February, has commended the service saying: "The Recovery at Home service has been brilliant and there are really friendly staff."

Nine out of ten people would recommend St George's to a friend or relative

The NHS Friends and Family Test (FFT) reached a memorable milestone in August by achieving its ten millionth piece of feedback from patients.

St George's University Hospitals NHS Foundation Trust has conducted over 40,000 surveys in the last 12 months. These have been far reaching across the trust – including inpatient wards, outpatient clinics, community and maternity services.

On average, 90.3% of people are "extremely likely" or "likely" to recommend the service they received to a friend or relative.

By conducting the surveys using our own real time survey system we are able to act quickly on the information we receive, and correlate it with other patient experience data such as any complaints we have received.

We are currently using the feedback to focus on the three main issues raised by patients – minimising noise at night, being clearer about the possible side effects of medication we provide, and involving our patients more in the discharge process.

Although the FFT helps identify areas such as these where improvements can be made, most of the feedback has been overwhelmingly positive across healthcare organisations and many of them report that it has provided an unexpected boost to staff morale and created many more opportunities to give well deserved appreciation to individual staff who have given excellent patient care.

Are we well led?

Macmillan and St George's join forces to transform the experience of cancer care for people in south west London

Macmillan Cancer Support and St George's University Hospitals NHS Foundation Trust have announced a three-year partnership which will endeavour to provide people affected by cancer who are treated at St George's with an excellent experience of care.

In 2014 St George's was listed as one of the most improved trusts for cancer patient experience according to a league table released by Macmillan Cancer Support. This led to the trust playing a supporting role in a buddying programme with Shrewsbury and Telford Hospitals NHS Trust to spread and accelerate innovative practice via peer to peer support and learning.

This will be built upon by the St George's Macmillan Partnership to deliver sustainable improvements in the long-term.

Macmillan has already invested £600,000 in the first year of this innovative programme, where healthcare professionals at the hospital and in the community will work alongside patients to improve the current systems of care.

The benefits of the partnership will include:

- increased availability of cancer nurse specialists
- new ways for people affected by cancer to get involved and help shape improvements in care
- specialised training for cancer healthcare professionals which will enable them to deliver more personalised cancer care, as well as help them to empower patients to take control of their own treatment and care.

St George's is one of the main providers of cancer services in south west London, delivering a range of diagnostic, treatment and support services to more than 4,000 new patients each year.

Macmillan has an experienced track record in working with trusts around the country to shape and deliver improved cancer care.

St George's is first major trauma centre in London recognised for its anaesthetic service

In October, the anaesthetic department at St George's Hospital received Anaesthesia Clinical Services Accreditation (ACSA) in recognition of the excellent service it provides.

ACSA is a unique and prestigious scheme run by the Royal College of Anaesthetists (RCoA) that enables departments to demonstrate quality in key areas, including patient experience and safe care. It has received acclaim from national regulators including the Care Quality Commission.

Paul Quinton, clinical director of theatres and anaesthetics at St George's said: "We are delighted to become only the fifth anaesthetic department and the first major trauma centre in London to receive this accolade".

"Our anaesthetic department has more than 105 consultants and more than 40 trainees working in 28 theatres; as well as covering other areas including pain services, maternity and intensive care. This accreditation is testimony to their hard work, dedication and commitment to providing safe and excellent care to patients at St George's Hospital."

Dr J-P van Besouw, former president of the RCoA, stated that the process should help departments to focus on sharing best practice, clinical governance and ultimately improving patient care.

Dr Tony Turley, lead ACSA reviewer, described the department at St George's as "proactive and dynamic", adding that "there was a clear emphasis on patient safety and noteworthy clinical leadership throughout the department". Dr Turley also commented on the examples of excellent service delivery and improvement, which he said would significantly contribute to the ACSA library of best practice.

Staff report

National NHS Staff Survey

The 2015 National NHS Staff Survey took place in all NHS organisations in autumn 2015. St George's had an overall response rate of 31%, which is below the national average. The trust's response rate for 2015 had reduced from 2014 (39%), mirroring a similar reduction in the national response rate . The range of questions remains consistent from year to year, making it possible to benchmark against previous years as well as against other trusts. The survey was communicated to all staff via our internal trust communications channels including our weekly e-newsletter, bi-monthly newsletter and staff forums. There is more information on these channels on the following pages.

Our overall engagement score has decreased slightly this year and is below the national average. In 2015, the trust's top four areas of performance were reported as:

- percentage of staff feeling under pressure to attend work when they are unwell
- quality of non-mandatory training, learning or development
- quality of appraisals
- percentage of staff reporting the most recent incidence of violence.

The bottom four ranked scores were:

- percentage of staff witnessing potential harm, near misses or incident in the last month
- percentage of staff experiencing work-related stress in the last 12 months
- staff satisfaction with resources and support
- staff experiencing harassment, bullying and abuse from other staff.

Our future priorities and targets are informed by the results of the staff survey. The overall objective of our workforce and staff experience action plan 2016/17 is to develop a highly skilled, motivated and engaged workforce by addressing issues that affect the workforce, in particular in the areas of turnover and staff experience. We will focus on:

- a return to greater earned autonomy for the front line
- clearer channels of communication
- enhanced management skills for engaging with staff in a constructive way
- freeing up time for important engagement and a focus on quality.

We will appoint a speak-up champion to supplement our Listening into Action liaison role, established to hear staff concerns and resolve them. Some of the concerns raised by our staff relate to the estate and IT infrastructure and this will be an area of focus.

We are aware that as we address our financial performance staff are continuing to provide excellent clinical services and we want to recognise this. We will ensure our values awards are well publicised so that this excellence is acknowledged. We will also be providing support and opportunities to staff to maintain their health, well-being and safety.

The 'St George's As One' initiative was set up in 2015 to address some issues that arose from the 2014 staff survey, particularly in relation to staff from black and minority ethnic (BME) groups. This work will continue in 2016/17 as we roll out our successful unconscious bias training to all managers who have not yet attended a session. We want to promote openness and transparency regarding appointments, acting up arrangements and promotions and we are changing this process to ensure that all staff have equal opportunities for development.

We will continue to tackle harassment and bullying towards staff by other staff members by reviewing our policy to bring it in line with successful campaigns in other NHS trusts. This will include encouraging early informal resolution of concerns rather than using the formal policy route.

Our managers will participate in a leadership development programme where they will develop clear objectives regarding the management of their staff. This will include encouraging open communication with staff through regular meetings and involving staff in any changes that affect them.

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 identify and tackle bullying. 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 Listening into Action liaison role provides the opportunity for members of staff to be listened to and to raise concerns. 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 are implementing a wellbeing strategy in order to reduce sickness absence and enhance a sense of personal responsibility and engagement amongst staff. During 2015 we ran a successful Global Corporate Challenge with 15 teams taking part to increase their fitness at work. We will be employing a physiotherapist to work in our occupational health service to support staff back to work following muscular skeletal absences, and assist them in maintaining good health. Weekly pilate's sessions have proved to be a success with staff and these will continue.

Our human resources advisers ensure all line managers are fully trained to tackle workforce and employee relations issues. We reviewed all our training programmes in 2015 and managers have access to sessions on holding difficult conversations.

	2014/15		2015/16		
	St George's	National average	St George's	National average	Improvement/ deterioration
Response rate	39%	43%	31%	43%	Deterioration
Top 4 ranking scores					
% of staff feeling under pressure to attend work when not well	56%	56%	57%	58%	Improvement
Quality of non-mandatory training learning and development	N/A	N/A	4.05	4.04	-
Quality of appraisals	N/A	N/A	3.04	3.03	-
% of staff reporting the most recent incidence of violence	56%	-	52%	52%	Deterioration
Bottom 4 ranking score					
% of staff witnessing potential harm, near misses or incidents in the last month	36%	34%	37%	29%	Deterioration
% of staff experiencing work related stress in the last 12 months	41%	37%	43%	36%	Deterioration
% of staff experiencing harassment, bullying and abuse from other staff	31%	23%	33%	24%	Deterioration
Staff satisfaction with resources and support	NA	N/A	3.11	3.30	-

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.

We have an active partnership forum where we meet with our Staff Side colleagues (unions) to discuss issues of concern to staff. Our staff side representatives have been involved in the development of our approach to incremental progression and the new supporting appraisal policy.

We share and discuss the trust's performance reports and chief executive's report at the partnership forum to ensure that staff are aware of our priorities and performance.

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 from the chief executive and they become eligible for entry into our annual awards ceremony. Photos are taken of the presentations and are communicated to all staff via our internal communications channels.

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.

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 continues to be used as a sustainable way of continuously improving our services, using the feedback we get from staff as our focus.

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
- 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 the patient advice and liaison service (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 has been instrumental in making changes in the workplace to improve the working lives of our staff.

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 executive directors.

Valuing and developing our staff

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.

All staff emails

Our all staff email newsletter, 'eG', is issued every Thursday. Work has been undertaken to make it more appealing, including reformatting the layout, limiting word length and including photos.

'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.

Senior leaders' meeting

The senior leaders' meeting takes place on a monthly basis. Senior managers are invited to hear the latest trust news regarding finance, quality and workforce from the executive team. It is also an opportunity for staff to ask any questions they may have so they can relay the answers to their departments.

Ask the CEO

Ask the CEO is a monthly session that all staff can get involved in by attending or by submitting questions for the chief executive to answer. Topics include finance, quality, workforce, estates and IT among others.

Schwartz Rounds

Schwartz Rounds allow staff to discuss the highs and lows of work in a confidential, expertly facilitated environment. It is a chance for staff to talk about the emotional and social aspects of their jobs, led by a panel of employees chosen from across the trust. There is a different theme and panel at each monthly session.

Turnaround Times

This is a monthly newsletter designed to keep staff up to date as we journey towards a firmer financial footing.

Chief nurse surgery

The chief nurse surgery offers all nursing and clinical staff the chance to hear updates from our chief nurse. All clinical areas are represented so that information presented and discussed can be cascaded back to each department.

Consultants' meetings

These meetings occur on a monthly basis and provide the opportunity for consultants to hear key updates from the medical director. They also offer consultants the chance to ask any questions or raise any concerns they may have.

Bespoke staff engagement events

The trust hosts a multitude of bespoke events each year to inform, engage and inspire staff. Such events include International Nurses' Day, CQC briefings and awareness days.

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 offer 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
- coaching
- new leaders programme for consultants, matrons, general managers
- paired learning for doctors and managers
- performance conversations
- responding to complaints
- resolving conflict
- seeing systems for the top 100 leaders
- tailored team diagnostics, team-building and helping teams in trouble

Junior doctors:

- teaching skills
- assessment and supervision in education and training
- developing authority (foundation and dental only)
- authority and impact workshop
- leadership and management (core training programme) aspiring consultant.

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
- effective administrator
- effective customer service
- excel with Excel
- grand rounds
- influencing for impact
- leadership and influencing skills for support staff
- manage your time with Outlook
- mediation (accredited course)
- medical terminology
- resilient thinking for peak performance
- Sage & Thyme
- Schwartz Rounds
- team development
- working with Word
- writing persuasive letters and emails
- writing effective emails and reports.

For healthcare support workers (HCSW) we have a four day development programme, qualification credit framework (QCF) 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 to four and we also support HCSW's to complete nurse training. We developed a trust wide HCSW

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 nationally recognised 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 and Kingston University with a particular focus on mental health training for non mental health professionals.

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.

The trust has developed the role of the physician 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.

Our workforce 2015/16

Our workforce by gender

A breakdown of the senior management by gender at year end is set out in the table below.

Staff group	WTE		%	
	Female	Male	Female	Male
Directors	3	4	42.86%	57.14%
Senior managers (AFC 8c +)	63.6	51.0	55.48%	44.52%
All staff	5794	2161.6	72.83%	27.17%

From April 2015, in line with the rest of the NHS, we adopted a new workforce race equality standard (WRES). The WRES was 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 are required to demonstrate progress against a number of indicators of 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.

Our workforce by contract type

Staff group	Permanent	Fixed term	Bank, agency and locum	Total
Add prof scientific and technical	476.8	92.3	82.0	651.1
Additional clinical services*	723.5	88.8	0.0	812.2
Administrative and estates	1599.9	103.9	336	2039.8
Allied health professionals	552.8	42.1	82	676.9
Healthcare scientists	260.9	10.2	74	345.1
Medical and dental	435.0	712.2	90	1237.3
Nursing and midwifery registered	2674.8	116.4	689	3480.1
Grand total	6716.8	1156.4	1353	9226.3

**Temporary HCA staff are included in nursing and midwifery registered*

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 2015/16:

Staff group	%
Add prof scientific and technical	**3.07%**
Additional clinical services	**6.24%**
Administrative and clerical	**3.86%**
Allied health professionals	**2.26%**
Estates and ancillary	**5.37%**
Healthcare scientists	**1.90%**
Medical and dental	**0.93%**
Nursing and midwifery registered	**3.70%**
Total	3.41%

Occupational health and staff support

The occupational health service supports the wellbeing of staff so that they can work safely and effectively. In 2015, a wellbeing strategy was introduced to promote healthier lifestyle choices for staff, empower staff to manage their own health and wellbeing needs and provide 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 our polices set 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. This supports managers in identifying and managing the causes and effects of stress in the workforce, and help to minimise the impact of work-related levels of stress within the organisation.

Our policy on the employment of disabled people and our recruitment and selection policy set out how we recruit people with disabilities, ensuring that a guaranteed interview is offered to any disabled candidate who meets the essential criteria for the role, and discussing any adjustments that might be required if appointed.

When an existing member of staff becomes disabled we actively seek redeployment where possible, taking advice from our occupational health department as appropriate. This may require offering additional training to a newly disabled member of staff to help them meet the requirements of their new role.

Promoting equal opportunities

The trust serves the diverse local population of south west London and beyond. In common with other major cities, London's population is ethnically diverse, with nearly 50% of its population from non-white British backgrounds and speaking over 300 languages other than English. Among our staff, we are proud to reflect these changes with nearly 50% of our staff being 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 www.stgeorges.nhs.uk/about/living-our-values/equality-and-human-rights/

Over the last few years, the trust has worked in partnership with a local school on 'Project SEARCH'. Project SEARCH is a collaboration between Cricket Green School, Action on Disability and the trust. It is a partnership that aims to put young people with disabilities into work, both within and outside the hospital. St George's supports six trainees annually. All of the trainees from 2015/16 are now in paid employment, one is working in Marks and Spencer at St George's Hospital, others are working in local schools, retail, hospitality and the theatre. The trust has employed five past Project SEARCH trainees since the programme began. In total over the past three years, 80% of Project SEARCH students have been employed compared to a national average of around 7% of people with learning difficulties in paid employment.

In December 2014, the trust issued a policy on the employment of disabled people with input from Staff Side colleagues. The policy includes:

- 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 arranging appropriate training for, employees who have become disabled persons during the period
- 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 for disabled staff. We monitor the responses of disabled staff through the staff survey and going forward the particular needs of disabled staff will form part of the 'St George's 'As One' initiative which focuses on protected characteristics and how we ensure all staff are able to contribute equally at the trust and have their contribution valued.

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 - 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 every effort to ensure we work in partnership with patients, carers and staff. Our Friends and Family Test now includes information on key demographics to ensure we get a cross-representation of feedback from our patients.

Counter fraud

The trust's counter fraud team is committed to providing a zero tolerance culture to fraud, bribery and corruption.

The counter fraud team are accountable to the chief financial officer and monitored by the audit committee. All concerns are professionally investigated in line with guidance from our regulators NHS Protect. Our counter fraud team consists of two accredited local counter fraud specialists.

The trust has anti-fraud and anti-bribery policies, is committed to the elimination of fraud and illegal acts within the trust and ensures rigorous investigation and disciplinary and criminal sanctions as appropriate. In the 2015/16 financial year counter fraud received 120 contacts and opened 12 full investigations. All fraud referrals and investigations are recorded on the NHS Protect FIRST case management system. During 2015/16 we delivered counter fraud awareness sessions targeting all levels of staff.

A representative from the counter fraud team regularly attends the audit committee to provide an update on current or new fraud cases and actions taken as a result of those cases.

The counter fraud team have participated in the National Fraud Initiative, a data matching exercise run by the Cabinet Office. The counter fraud team have undertaken pro-active exercises including misuse of blue disabled badges and identity documents of staff. A number of these types of fraud were identified and staff disciplined accordingly.

The counter fraud team has an excellent working relationship with the Home Office and with the local Safer Neighbourhood Team.

Off-payroll engagements

	8A1
Table 4B: For all off-payroll engagements as of 31 March 2016, or more than £220 per day and that last for longer than six months	**2015/16 Number of engagements**
	Number
Number. of existing engagements as of 31 March 2016	**26**
Of which:	
Number that have existed for less than one year at the time of reporting	**13**
Number that have existed for between one and two years at the time of reporting	**12**
Number that have existed for between two and three years at the time of reporting	**1**
Number that have existed for between three and four years at the time of reporting	**0**
Number that have existed for four or more years at the time of reporting	**0**
Confirmation:	
Please confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	**Yes**

	8A2
Table 4C: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months	**2015/16 Number of engagements**
	Number
Number of new engagements, or those that reached six months in duration between 1 April 2015 and 31 March 2016	**9**
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	
Number for whom assurance has been requested	**0**
Of which:	
Number for whom assurance has been received	
Number for whom assurance has not been received *	
Number that have been terminated as a result of assurance not being received	

**Where an individual leaves after assurance is requested but before assurance is received and instances where trusts are still waiting for information from the individual at the time of reporting this should be included within "No. for whom assurance has not been received".*

Table 4D: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016	8A2 2015/16 Number of engagements
	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
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.	4

All foundation trusts must disclose the number of individuals in the capacity of a board member or senior manager having significant financial responsibility in the year. This includes both on-payroll and off-payroll engagements.

In any cases where individuals are included within the first row of this table, please set out:		Checks
Details of the exceptional circumstances that led to each of these engagements.	1) Appointment of a turnaround director. 2) Appointment of Iain Lynam, chief financial officer	Pass
Details of the length of time each of these exceptional engagements lasted.	1) From June 2015 to March 2016 2) From February 2016 to March 2016	Pass

Expenditure on consultancy

£k	2015/16	2014/15
Consultancy costs	2,503	514

Staff exit packages

The trust had no staff exit packages during the course of the financial year.

Exit packages: non-compulsory departure payments

The trust had no staff exit packages, in respect of non-compulsory departure payments, during the course of the financial year.

Workforce of the future

Simulation suite

Now in its 15th year of operation and second build, St George's Advanced Patient Simulation and Skills Centre (GAPS) trains more than 4,318 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 and skills facilities in the country and has been successful in bidding for educational contracts both regionally and nationally year on year. However, its core business is the training of St George's staff in caring for acutely ill patients by focusing on building resilience of safety within teams as well as individuals. Staff learn in multi-professional teams and reflect by engaging in multi-professional conversations about practice provoked by experiences gained in either the simulated or real clinical 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, the community and more recently, internationally. For the first time GAPS has delivered simulation-based training in local GP and dental practices improving team work and emergency preparedness capacity for staff to respond to life-threatening medical emergencies. This model has now been successfully transferred back into the outlying departments within the hospital setting with good effect.

GAPS is a major provider of skills training and is consistently highly rated by external participants for acute trauma life support, European trauma course, basic and advanced surgical skills, care of the critically ill surgical patient and a host of other Royal College of Surgeons seconded 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, transfer training and critical care. The GAPS team have transferred knowledge and skills to local trainers in almost all specialities allowing in situ and ad hoc training to be delivered in response to identified risk, serious incidents (SIs) and individual training needs. Trainee and expert surgeons are able to use advanced computerised laparoscopic trainers and realistic anatomical part task trainers to maintain specialist skills in their field. GAPS have also designed a cardiac surgical team training course using the latest technology Orpheus cardiac bypass simulator to address the human factors and non-technical skills of teams in cardiac theatres.

GAPS pride themselves on the inter-professional nature of the resource. 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 had 89 participants since it was launched in February 2015 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 and has been the commissioners' choice of faculty development for several years. GAPS has now trained more than 500 healthcare staff in the art of technology enhanced learning and teaching. 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 includes clinical simulation specialists, 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. Recently the simulation specialists of the GAPS team were winners of the South London Simulation Network conference and

the head of department, Nicholas Gosling, won the NHS Development Champion of the Year in the London Leadership awards.

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 in 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.

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. We have focussed on retention over the last year with each division drawing up their own plans to retain their staff. The national shortage of some staff groups, particularly nursing means that we are recruiting from overseas to fill the gaps in our workforce so that our permanent workforce is not overloaded.

A formal period of preceptorship is now embedded across the trust for all newly qualified nurses. The programme consists of the following:

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

We are currently developing an international nursing preceptorship package incorporating acclimatisation.

Accountability report

Directors' report

The primary role of the board of directors 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 comprises a Chairman, six non-executive directors - including a university representative - and nine executive directors (four voting and four non-voting). The four voting directors are the chief executive, the chief nurse, the medical director and the director of finance. The five non-voting executive directors attend board meetings in advisory capacity. 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 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.

The appointment of the Chairman and non-executive directors is approved by the council of governors. 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.

The trust has complied with the cost allocation and charging guidance issued by HM Treasury. The trust did not make any political donations during 2015/16.

At the time that this report has been approved by the board, so far as they are aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware. The board has taken all the steps that they ought to have taken as directors 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.

For information on political donations, the better payment practice code and income disclosures, please see the financial update within the performance report.

Non-executive directors 2015/16

All non-executive directors are independent other than Jenny Higham as she is a representative of St George's, University of London. All non-executive directors are members of the board and the board of directors' nominations and remunerations committee. These director positions are correct up to 31st March 2016, although there have been significant changes to the board since the end of the 2015/16 financial year. More information can be found on page 27.

Sir David Henshaw

Chairman

Sir David joined the trust in March 2016.

Declared interests:
None

Membership of committees:
Finance and performance

About:
Sir David Henshaw has been Chair of Alder Hey Children's Hospital NHS Foundation Trust since 2010. He subsequently become Interim Chair of Morecombe Bay Hospitals NHS Foundation Trust, from 2012 – 2013 and from 2013 – 2014 was Interim Chair at Dorset University Hospital NHS Foundation Trust. Prior to his time in the NHS, Sir David was Chief Executive Officer of Liverpool City Council from 1998 – 2005. In 2004, he was knighted for his services.

Sarah Wilton

Non-executive director

Acting Chair between January – March 2016

Declared interests:

- Non-Executive Director, and Audit and Risk Committee Chair, at Capita Managing Agency Limited
- Non-Executive Director, and Audit and Risk Committee Chair, at Hampden Members' Agencies Limited
- Trustee and Vice Chair at Paul's Cancer Support Centre
- Family and Adult Court Magistrate

Membership of committees:

- Audit
- Quality and risk
- Finance and performance

About:
Sarah qualified as a 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.

Jenny Higham

Representative of St George's, University of London

Jenny joined the board in November 2015.

Declared interests:

- Governor, Kingston University
- Director, INTO – SGUL LLP

- Deputy Chair, London Higher Healthcare Education Group
- UK Higher Education Advisory Committee
- Honorary Consultant Imperial
- Visiting Professor Lee Kong Chain School of Medicine in Singapore

Membership of committees:
Quality and risk

About:
Jenny is the newly appointed Principal at St George's, University of London. She previously had senior roles at Imperial College and the Lee Kong Chian School of Medicine in Singapore. In addition to managerial roles, she continues clinical practice. She has been named "Mentor of the Year" at the Women of the Future Awards, been awarded a President and Rector's Award for Outstanding Contribution to Teaching Excellence and the Imperial College Medal for outstanding leadership.

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
- 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 service 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
- 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.

Kate Leach

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 (GSK). She has won many marketing awards. As a commercial leader, Kate has held director-level positions leading a number of GSK's therapy business units. She has a wealth of experience in commercial excellence, strategic planning, market access, branding and capability development.

Christopher Smallwood

Former Chairman

Christopher left the trust in December 2015.

Declared interests:
None

Membership of committees:
- Finance and performance
- Commercial

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.

Professor Peter Kopelman

Former representative of St George's, University of London

Peter left the board in November 2015.

Declared interests:

- Governor, Kingston University
- Director, INTO - SGUL LLP
- Deputy Chair and 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

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 (2001-2006) and Dean of the Faculty of Health, University of East Anglia (2006-2008).

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. 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 and Innovations Foresight Obesity Project.

Dr Judith Hulf

Non-executive director

Judith left the board in January 2016.

Declared interests:
Responsible Officer and Senior Medical Advisor, General Medical Council

Membership of committees:
- Audit
- Quality and risk

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.

Executive directors 2015/16

Miles Scott
Chief executive

Declared interests:
- Chair of NIHR CLAHRC South London Board
- Chair of South London Clinical Research Network Partnership Board
- Vice Chair of Health Innovation Network

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.

Paula Vasco-Knight
Interim chief operating officer

Declared interests:
None

About:
Paula joined St George's in October 2015 as interim chief operating officer. She began her career as a nurse and has been committed to making a difference to patients, their families and communities, locally, nationally and internationally, over a 20 year period as a leader in the NHS. Paula has held a number of senior positions in different organisations, including: chief executive/chief operating officer; executive director of operations and service improvement; executive director of nursing and midwifery; deputy director of nursing and governance; and senior nurse manager. Paula received a CBE in 2014 and an honorary doctorate in Law from Exeter University.

Iain Lynam
Chief financial officer

Declared interests:
- Partner at the Aaronite Partnership LLP
- Director of Codere Finance UK Limited

About:
Iain is an experienced senior finance professional with particular expertise in corporate and financial restructuring in both the NHS and the private sector.

Simon Mackenzie
Medical director

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.

Jennie Hall

Chief nurse, director of infection prevention and control; Deputy chief executive (from February 2016)

Declared interests:

- Honorary Professor, King's College University London
- 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 and has provided strategic leadership at director/chief nurse level to the nursing and midwifery profession. She 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. Jennie became deputy chief executive in February 2016.

Martin Wilson

Director of transformation
Former director of delivery and improvement

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 director of operations, QIPP and transformation at NHS North East. From 2011-2014, he worked for McKinsey and Company supporting hospitals to improve their quality and sustainability. He re-joined the NHS in 2014 as director of delivery

Rob Elek

Director of strategy

Declared interests:

- Director, Elek Technical & Analytical Ltd
- Senior Advisor, Physitrack Limited

About:

Prior to joining St George's Rob worked at Moorfields Eye Hospital NHS Foundation Trust as the director of strategy and business development. His key achievements include strengthening relationships with commercial and third sector organisations, developing new partnership models for the delivery of NHS patient care and leading. 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. He led the expansion of Moorfields satellite network from 13 to 23 sites. Rob also directed annual planning and business development, managed corporate functions and a new hospital project.

Wendy Brewer

Director of workforce and organisational development

Declared interests:

None

About:

Wendy joined St George's University Hospitals NHS Foundation Trust 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

Director of estates and facilities

Eric left the trust on 1st April 2016. Richard Hancock started in this role on 4th April 2016.

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.

Andrew Burn

Director of turnaround

Andrew left the trust in March 2016.

Declared interests:
- Partner of KPMG LLP

About:
Andrew Burn was appointed as the trust's turnaround director in June 2015. Andrew leads KPMG's Public Sector and Health Restructuring practice (KPMG's specialist financial recovery arm) and is a partner with over 20 years' experience of major change and turnaround situations, across the public and private sector. Andrew has worked with trusts, foundation trusts and CSU's who faced similar challenging circumstances.

Steve Bolam

Former chief financial officer; Former deputy chief executive

Steve left the trust in February 2016 on secondment to NHS Improvement.

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.

Peter Jenkinson

Former director of corporate affairs

Peter left the trust in November 2015.

Declared interests:
None

About:
Peter joined St George's as trust secretary in June 2009 with 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.

Council of governors and membership

Our council of governors

Our council of governors became a full council when the trust was authorised as a foundation trust on the 1st February 2015. The council is comprised of 15 elected public governors; five elected staff governors and eight governors appointed from stakeholder organisations.

Role of the governors

The council of governors is responsible for the appointment of the Chairman and 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 plan 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 their 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.

Meetings of the council

The council held four full meetings in 2015/16.

Constituency name	Governor name	Political and financial interest	Term of office	
Public: Wandsworth	Stuart Godden	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	David Kirk	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	Robin Isaacs	None		2
Public: Regional	Kathryn Harrison	None		2
Public: Regional	Jan Poloniecki	None	3	
Staff: Medical and 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 and Midwifery	David Flood	None	3	
Staff: Allied Health Prof. and Other	Will Hall	None	3	
Appointed: Healthwatch Merton	Brian Dillon	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 Commissioning Group	Dr Patrick Bower	None	3	
Appointed: Merton Clinical Commissioning Group	Dr Tim Hodgson	None	3	
Appointed: Wandsworth Council	Cllr Sarah McDermott	None	3	

Governors' activities

Governors attend board meetings as observers and 'Medicine for Members' health talks where they can meet and talk with trust members. Governors are also able to attend board sub-committee meetings to observe and take part in quality inspections around the trust. The governors have been involved in the selection process for a new clinical non-executive director who will take up post on 1st April 2016.

Members who wish to communicate with governors and/or directors can do so by contacting the membership office via members@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 trust secretary'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 quality dialogue. However due to the high cost of postage and the current cost savings we have to make within the NHS, we are no longer able to post out information to our members on a regular basis. We rely on email to communicate on a regular basis with those members who want updates from us.

During 2015/16 we hosted monthly 'Medicine for Members' talks as a way for the members to learn about key health issues, such as diabetes, sepsis, tinnitus, arthritis, stroke and keeping your heart healthy. We also held a special '24 Hours in A&E' event at the start of the new series where members could meet featured staff and the production team.

All our members are invited to attend the Annual Members' Meeting in October 2016.

Membership by constituency

Staff	**9226**
Public	
Wandsworth	**4,066**
Merton	**3,034**
Rest of England	**4,592**
Lambeth	**604**
Out of trust area	**16**
Total (public)	**12,312**
Total	**21,538**

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 act as 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 responsibility 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 with the trust we 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 is achieved through:

- monthly e-bulletins for public members
- monthly health talks called 'Medicine for Members'
- other events including the Annual Members' Meeting
- dedicated member and governor pages on the trust website
- use of social media including Twitter and Facebook
- governor meetings with members.

Appendix C2 - membership report

Membership size and movements

Public constituency	Last year (2015/16)	Next year (estimated) (2016/17)
At year start (April 1)	**12,375**	12,875
New members	**168**	-
Members leaving	**250**	-
At year end (March 31)	**12,293**	-
Staff constituency		
At year start (April 1)	**8,624**	-
New members	**2,101**	-
Members leaving	**1,758**	-
At year end (March 31)	**8,967**	-
Patient constituency		
At year start (April 1)	**0**	-
New members	**0**	-
Members leaving	**0**	-
At year end (March 31)	**0**	-

Analysis of current membership

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	**9**	114,834
17-21	**535**	28,314
22+	**11,346**	443,343
Ethnicity:		
White	**7,170**	380,440
Mixed	**598**	28,684
Asian or Asian British	**2,424**	75,326
Black or Black British	**1,812**	67,014
Other	**289**	7,464
Socio-economic groupings*:		
AB	**3,761**	76,421
C1	**3,834**	62,462
C2	**1,852**	23,918
DE	**2,805**	31,989
Gender analysis		
Male	**4,932**	284,898
Female	**7,361**	301,591
Patient constituency		
Age (years):		
0-16	**0**	-
17-21	**0**	-
22+	**0**	-

The analysis section of this report excludes:
- 403 public members with no dates of birth, 0 members with no stated ethnicity and 0 members with no gender
- 0 patient members with no dates of birth

General exclusions: Out of Trust Area, Suspended Members, Inactive Members

* Socio-economic data should be completed using profiling techniques (eg: postcode) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make direct contact.

The accountability report was approved by the board of directors on 2nd June and signed on its behalf by Simon Mackenzie, acting chief executive.

Simon Mackenzie
Acting chief executive
2nd June

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 of governor'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 structure was in place prior to becoming a foundation trust in shadow form and has now been operating for a year. 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
- 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 1 of the Annual Governance Statement.

Directors

The directors who held office during 2015/16 can be seen along with their declared interests, skills, expertise and experience in the directors' report. The trust has a separate chairman and chief executive. The chairman is independent.

Chairman

The trust's interim Chairman is Sir David Henshaw. He is a non-executive director and Chair of the council of governors. He was appointed in March 2016. Christopher Smallwood was the trust's Chairman until January 2016 when his term ended. Sarah Wilton was acting Chair of the trust prior to Sir David Henshaw's appointment. The Chairman and non-executive directors regularly meet, without executive directors present. The Chairman conducts annual appraisals of non-executive directors and will, as part of that process, identify any personal development needs. These were completed by Christopher Smallwood prior to his departure.

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 acting chief executive is Simon Mackenzie. Miles Scott was chief executive for the full 12 month period during 2015/16. He was appointed in September 2011 as chief executive and left the trust on secondment in April 2016.

The board

The board of directors is made up of:

- Chairman
- five independent non-executive directors
- one university representative non-executive
- four executive directors
- four 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 (CQC), 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. On-going 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 of directors' standing orders allow any director to have their comments recorded in the minutes. The board of directors confirm their 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 and this is actively managed to ensure effective communication and engagement with each respective stakeholder.

Attendance at board and sub board committee meetings 2015/16

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 and risk committee	Nominations and remunerations committee	Finance and performance committee	Workforce committee
Miles Scott	11/12	1/5		7/7	11/12	
Christopher Smallwood (until January 2016)	9/10	n/a		7/7	8/9	
Sir David Henshaw (started March 2016)	1/1				1/1	
Steve Bolam (until February 2016)	10/11	5/5			9/10	
Iain Lynam (started February 2016)	2/2				2/2	
Jennie Hall	11/12		11/11		8/12	3/4
Simon Mackenzie	12/12		11/11		5/12	1/2
Eric Munro (until March 2016)	11/12		4/11		10/12	
Richard Hancock (started March 2016)	1/1					
Peter Jenkinson (until November 2015)	7/8	4/5	9/11		6/8	3/6
Wendy Brewer	10/12		3/11	7/7	11/12	6/6
Andrew Burn (June 2015 - March 2016)	6/12			1/7	8/10	
Rob Elek	11/12					
Martin Wilson	12/12		6/8		10/12	
Paula Vasco-Knight (From October 2015)	6/6				6/6	
Non-executive director						
Mike Rappolt	11/12	5/5	4/11	6/7	7/12	
Sarah Wilton	11/12	5/5	11/11	7/7	11/12	
Peter Kopelman (until November 2015)	6/10		7/11	6/7		2/6
Stella Pantelides	12/12		1/11	7/7	2/12	6/6
Kate Leach	9/12			7/7		5/6
Judith Hulf (until January 2016)	5/10	2/5	10/11	6/7	1/12	
Jennifer Higham (from November 2015)	3/5	2/5	2/5	3/7	1/12	

Governors are encouraged to attend trust board and committee meetings and are given the opportunity to ask questions or comment.

There have been several workshops or governor induction sessions where board members and governors can meet to discuss various issues. A programme of training sessions has taken place during 2015/16 for governors on the wards.

Governors are encouraged to attend trust board and committee meetings and are given the opportunity to ask questions or comment.

There have been several workshops or governor induction sessions where board members and governors can meet to discuss various issues. A programme of training sessions has taken place during 2015/16 for governors in areas such as finance and equality inspections on the wards.

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 committee includes strategic growth in NHS income as well as non-NHS income. The committee 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 assurance 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 independent non-executive directors, one of whom has financial experience. In the March meeting two members from the council of governors attended alongside the Chairman to ensure it could be constituted as an effective decision making body.

Board of directors' remuneration and nominations committee

The aims of the nominations committee are to:

- develop the remuneration framework for senior management ie non Agenda for Change executive directors
- agree the appropriate remuneration and terms of service for the chief executive officer, executive directors and other senior managers who report to executive directors, whose remuneration is not covered by agenda for change
- 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 non-executive directors.

There have been five new executive director appointments to the board during 2015/16:

- turnaround director, June 2015
- interim chief operating officer, October 2015
- chief finance officer, February 2016
- director of transformation, February 2016
- interim director of estates and facilities, March 2016.

An external search company was used in two of the five appointments.

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 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 the following appointments of non-executive directors:

- Mike Rappolt's three month extension on 14th January 2016
- Professor Sir Norman Williams three year appointment on 3rd March 2016, effective from May 2016
- Sarah Wilton's three year extension on 27th October 2015.

The interim Chairman, Sir David Henshaw was appointed by Monitor using their powers under section 111(5) of the Health and Social Care Act 2012 in March 2016.

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. No non-executive director will serve longer than nine years.

Mike Rappolt has served over nine years as the board recognised the importance of continuity on the board as we prepared for foundation trust status and 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). He was then extended until the end of April 2016 to enable the trust to complete the appointment of new non-executive directors. The council of governors will consider the appointment of non-executive directors and the process for doing so on an individual basis when their term of office comes near to an end.

Removal of the Chairman or another non-executive director shall require 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 should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities. The council of governors are currently conducting a review of their first year of operation with support from the company secretary.

Council of governors

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

The council of governors has met four times in the reporting period (2015/16). After each meeting of the council, the Chairman will feedback 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 NHS foundation 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 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 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. After making enquiries, the board has reasonable expectation that the trust has adequate resources to continue in operational existence for the foreseeable future. Accordingly, the board continues to adopt a going concern basis in preparing the annual report and financial statements.

Trust auditors

The council of governors are 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.

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 is a member of the audit committee and quality and risk committee. The range of areas audited during this year is 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 University Hospitals NHS Foundation Trust for the period April 2015 to March 2016 and up to the date of approval of the annual report and accounts.

We have included information relating to the arrangements in place to govern service quality, quality governance and quality in the annual governance statement.

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; and
  - 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 as the accounting officer of St George's University Hospitals 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 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 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.

Simon Mackenzie
Acting chief executive
2nd June

Annual Governance Statement 2015/16

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust' policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 year ended 31st March 2016 and up to the date of approval of the annual report and accounts.

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 1.

There is an established 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 by:

- 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 head of corporate governance (trust secretary) through the corporate affairs 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. PWC conducted a forensic review and assessment and the Trust has delivered a range of actions in response to the recommendations. Progress has been monitored at Finance and Performance Committee and the Board. The Trust is undertaking a comprehensive review of other Governance arrangements going into 2016/17.

The risk control framework

Risk management is in place throughout all levels of the organisation. Risks are systematically identified via structured risks assessments and documented on local level risk registers. These are scored using a risk scoring matrix and are escalated through to divisional and corporate level as appropriate. Low scoring risks are managed locally and higher scoring risks are managed at progressively higher levels within the organisation. Risk control measures are identified and implemented to reduce the potential for harm.

Incident reporting is encouraged through staff training and is embedded throughout the organisation. Risk identified from serious incidents which impact upon patient and staff safety are identified and managed as described above.

The trust is in the process of developing a new board assurance framework (BAF) and the corporate risk register has been used as the BAF during this financial year.

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**
- **respectful**
- **responsible**

Central to achieving this mission is a 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 chief nurse and the medical director:

- the chief nurse is responsible for clinical and corporate risk, patient safety and patient experience.

- the medical director is responsible for patient outcomes.

Chief nurse and director of infection prevention and control (DIPC)

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 responsibility of risk management and the CQC oversight was moved to the chief nurse in December 2015.

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

- the nominated individual for Care Quality Commission (CQC) and is responsible for ensuring that the quality and care standards are compliant with the regulations set out by the CQC.

Medical director

The medical director, supported by associate medical director (clinical governance) 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

- overseeing the formulation and implementation of medical research and education policies, practise and strategies supported by AMDs for education and training and research

- 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.

Trust secretary

The trust secretary (head of corporate governance) 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. These need to be renewed as part of the wider Board assurance framework. 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 appropriate senior clinician, from each division to ensure that the flow of governance is strong between the divisions and corporate structure of board and sub-committees.

Organisational risk committee (ORC)

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. This committee was chaired by the chief nurse from January 2016.

Board initiatives

The trust is undertaking a comprehensive review of other governance arrangements going into 2016/17.

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, midwives and Allied Health Professionals by the chief nurse/ Director of Infection Prevention and Control , 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 (PIC) 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.

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.

Annual quality report

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. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The quality and 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 ie:

- **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, patient experience trackers

- **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 integrated performance report.

The trust performance report is presented to the finance and performance committee and the quality and risk committee on a monthly basis and to board every month. This report contains a summary of operational performance across all domains of performance, including quality metrics such as infection rates. The quality metrics within the trust performance scorecard are also reviewed monthly by the quality and risk committee. The reporting framework will be simplified and streamlined to enable the committees and the board to assure performance more effectively.

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. The Trust's internal processes for reporting and investigating serious incidents has been strengthened throughout the year to fully reflect new national guidance (April 2016) however work to further improve processes will continue during the coming year to ensure robust investigation and learning from serious incidents.

Care Quality Commission compliance

The trust is 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. (St George's Hospital and 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.

The trust is preparing for a CQC inspection in June 2016.

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 1 provides an effective 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 an organisational framework, underpinned by a 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 devolved 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 2). The we don't have this now do we? 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 trust is developing a new board assurance framework, which will be aligned to the Trust's strategic corporate objectives. The corporate risk register has been used as the board assurance framework in 2015/16. This is a high-level document based on structured and on-going assessment of the principal risks to the trust. 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. Sessions on key risks are undertaken bi-monthly. 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 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. Incident reporting training is part of the trust induction programme.

The trust has had difficulties in further strengthening and developing the risk management framework during the year and this work continues to ensure that devolved risk management is embedded across the organisation at a local level.

Principal risks identified in 2015/16

The following risks were identified by the board as being the principal risks during 2015/16, 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 as follows:

Ref	Description	Rating (at March 2016)
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	20
3.7-06	Failure to meet the minimum requirements of the Monitor risk assessment framework	20
3.14-05	Working capital – the trust will require more working capital than planned due to: - Adverse in year income and expenditure performance - Adverse in year cash-flow performance	20
01-06	Risk to patient safety as patients waiting greater than 18-weeks on elective waiting lists	20
01-07	Risk to patient safety and experience as a result of potential trust failure to meet 95% emergency access standard	20
5.1-01	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost	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 (IG) 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.

One incident has been reported to the information commissioner's office (ICO) in this period. This related to serious incident investigation. The ICO undertook an investigation and there was no formal action as a result.

Data quality

The trust has an information team, reporting to the director of transformation, who oversees the quality of data. The trust has a data quality strategy, to ensure continual improvement in the quality and integrity of data. This is monitored by the data quality board, which reports to quality and risk 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 framework. Performance is reported through a number of key performance indicators (KPIs) through the appropriate regulatory frameworks. At the end of this reporting period, March 2016, the trust was performing positively against a large number of key indicators and was pleased with the improvement made on infection control and mix sex accommodation breach performance. However there remain challenges including the ED four-hour target, cancer two-week wait, cancer 62-day standard and 18-week referral to treatment waiting time's performance. This is set out in more detail in the clinical and operational performance overview on **page 11**.

In July 2015 Monitor ruled that the trust was in breach of its foundation trust license in relation to its attainment of a deficit in 2014/15 and setting of a deficit budget for 2015/16, The trust financial stability rating has been rated as '2' across the reporting year and currently holds a "red" governance rating reflecting the significant financial challenges that the trust faces. The trust appointed Andrew Burn as turnaround director in June 2015 until March 2016 to help manage these challenges. The cost of his salary was charged under a consultancy contract with KPMG and as a consequence the trust incurred a higher cost than for a permanent member of staff.

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 rare 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 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:

- patient safety and service quality reviews: diagnostic test follow up; infection control; capacity planning; and complaints
- governance reviews: board assurance framework and risk management and Care Quality Commission registration
- financial systems reviews: fundamental financial systems audits, cashiers, commissioner fines and challenges and capital assets
- clinical and cost effectiveness: service improvement programme, South West London Pathology Service and the cost improvement programme
- estates, facilities, IT and information: community properties; PFI contract management; consultant attribution data quality; IT strategy follow up; network security pentration testing follow up; and information governance and accreditation
- human resources and payroll: payroll; bank and agency staff; mandatory and statutory training; and locums.

A range of assurances from significant assurance to limited assurance have been given. The limited assurance reports were:

- diagnostic test follow-up
- cost improvement programme
- financial reporting and budgetary control
- mandatory and statutory training
- community properties
- consultant attribution data quality
- network security pentration testing follow-up.

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 3.

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.

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 2015/16 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 remains concerned with the limited assurance previously provided by internal audit in respect of the trust's compliance with fire safety. This area, and the wider estate infrastructure, will be an area of significant focus on 2016/17. An estates plan is under development and will be closely monitored.

The board is concerned with the limited assurance provided on financial reporting and budgetry control and the cost improvement programme. These are critical systems for the trust and have a direct bearing on the trusts ability to address its financial performance ratings. The limited assurance provided on diagnostic test follow up and consultant attribution raise potential issues regarding the adequacy of the controls. The board and relevant sub-committees will ensure these areas and the resultant action plans are appropriately scrutinised.

The board remain concerned with the deficit position and outturn deficit of £55.1m while noting the significant progress in delivering £41.5m of cost savings.

PwC were commissioned to undertake a forensic review and assessment of the significant deterioration of the 2014/15 financial position. The report identified 76 recommendations across a range of areas on 31st July 2015. Of the 76 recommendations, actions have been completed against 62 and 13 have remained open and will continue to be monitored and one was not accepted. However the board is concerned that the external auditors identified significant challenges due to the poor quality of the draft financial statements, the delays in providing supporting working papers for the start of the audit and slow responses to requested audit evidence during the onsite audit. This resulted in a delay in completing the external audit and indicates that further work is required.

The trust has agreed recovery trajectories against key performance targets with commissioners and NHS England and will actively manage these over the year.

As a result of the trust's financial position and the current level of NHS Improvement intervention at the trust, the board is concerned that external auditors have issued an adverse conclusion on the trust's arrangements for securing value for money. Given the challenges that the trust faces across finance, estates, performance and managing risk and the concerns identified above the governance structures and framework will require further strengthening. This will be a key priority over the coming months.

Simon Mackenzie
Acting chief executive
2nd June

Appendix 1 - Governance Framework

TRUST BOARD

TRUST BOARD SUB-COMMITTEES:

- AUDIT COMMITTEE
- WORKFORCE COMMITTEE
- NOMINATIONS AND REMUNERATION COMMITTEE
- QUALITY AND RISK COMMITTEE
- FINANCE AND PERFORMANCE COMMITTEE
- COMMERCIAL BOARD

- PATIENT EXPERIENCE COMMITTEE
- PATIENT SAFETY COMMITTEE
- ORGANISATIONAL RISK COMMITTEE

There is two-way reporting between each of the four clinical divisions and the governance committee framework of patient safety, patient issues and organisational risk committees.

Each of these committees has divisional governance leads as members, with twice yearly reporting from each division.

St George's University Hospitals NHS Foundation Trust has four clinical divisions:

- WOMEN AND CHILDREN, THERAPIES AND CRITICAL CARE
- MEDICINE AND CARDIOTHORACIC SERVICES
- SURGERY, THEATRES, NEUROSCIENCES AND CANCER
- COMMUNITY SERVICES

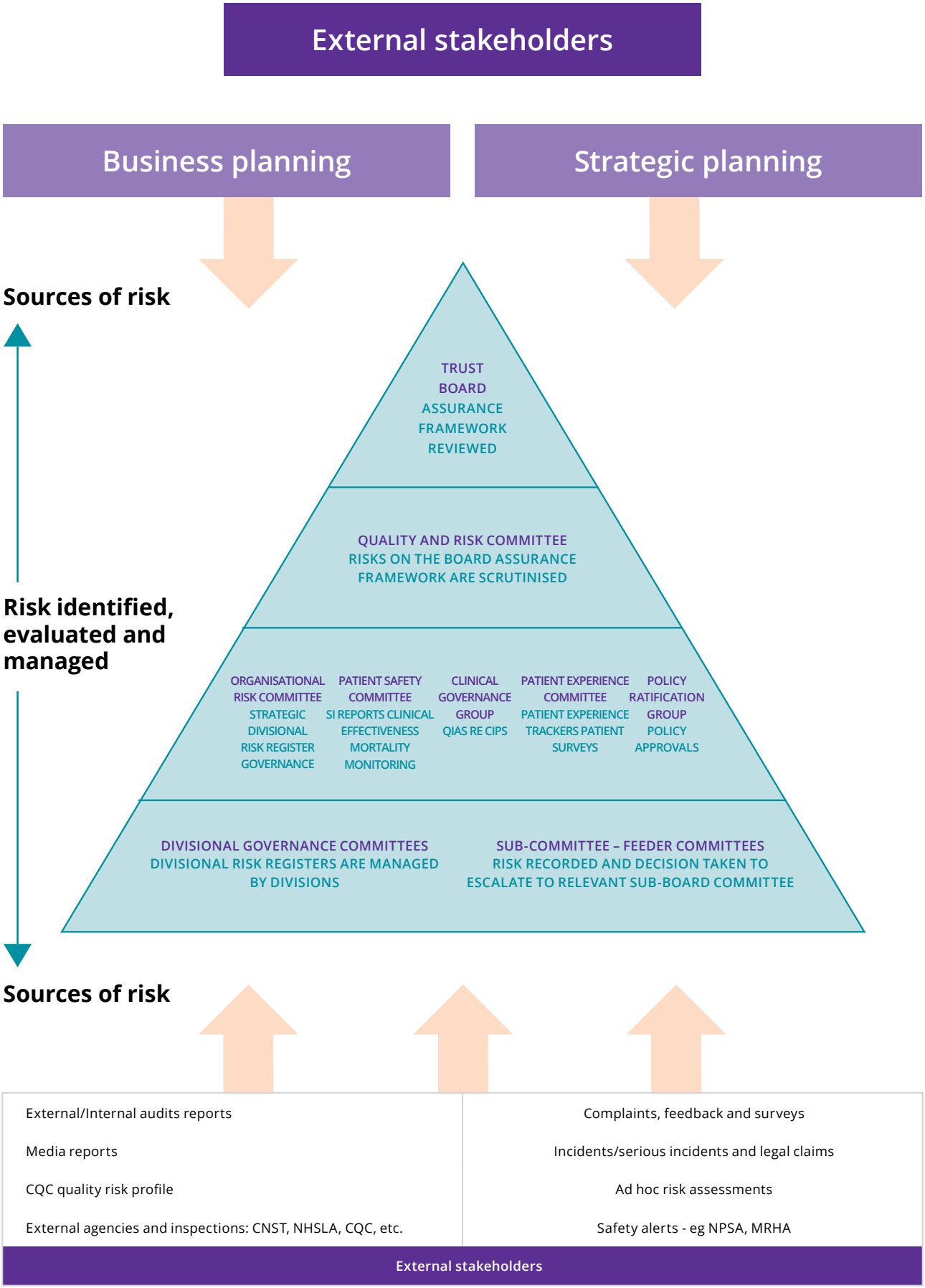
DIVISIONAL GOVERNANCE STRUCTURE:

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.

Appendix 2 - Risk Framework



Appendix 3 - Internal Audit Reports Issued in 2015/16

Topic	Assurance level
Patient safety and service quality	
Diagnostic test follow-up	**Limited**
Infection control	**Reasonable**
Capacity planning	**Reasonable**
Complaints	**Reasonable**
Clinical and cost effectiveness	
Service improvement programme	**Reasonable**
South West London Pathology Service	**Reasonable**
Cost improvement programme	**Limited**
Governance	
Board assurance framework and risk management	**Reasonable**
CQC registration	**Reasonable**
Fundamental financial systems	
Financial ledger	**Significant**
Financial reporting and budgetary control	**Limited**
Accounts payable	**Reasonable**
Income and debtors	**Reasonable**
Cashiers	**Reasonable**
Commissioners fines and challenges	**Reasonable**
Capital assets	**Reasonable**
Human resources and payroll	
Payroll	**Significant**
Bank and agency staff	**Reasonable**
Mandatory and statutory training	**Limited**
Locums	**Reasonable**
Estates and facilities	
Community properties	**Limited**
PFI Contract management	**Reasonable**
IT/Information	
Consultant attribution data quality	**Limited**
ICT strategy follow-up	**Reasonable**
Network security penetration testing follow-up	**Limited**
Information governance and accreditation	**Reasonable**

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 unmodified

In our opinion the financial statements of St George's University Hospitals NHS Foundation Trust (the 'trust'):

- give a true and fair view of the state of the financial position of the Trust's affairs as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and
- have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in 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, which is not modified, we have considered the adequacy of the disclosure made in note 1 'Going Concern' to the financial statements concerning the Trust's ability to continue as a going concern. The Trust incurred a deficit of £55,100,000 for the year ended 31 March 2016. During the year the Trust secured an interim revenue support facility with the Independent Trust Financing Facility for £48,700,000 and had drawn down £40,400,000 from this facility by 31 March 2016. The Trust has access to further borrowing of £33,300,000 and is requesting access to further Department of Health borrowing facilities. These conditions, along with the other matters explained in note 1 'Going Concern' 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. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Who we are reporting to

This report is made solely to the Council of Governors of the 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 for the year ended 31 March 2016 which 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 IFRSs as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the NHS Foundation Trust Annual Reporting Manual (ARM)

and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Overview of our audit approach

- Overall materiality: £8,961,000, which represents 1.25% of Trust's budgeted gross revenue expenditure;

Key audit risks were identified as:

- Occurrence and valuation of healthcare income and existence of associated receivables
- Occurrence of non-healthcare income and existence of associated receivables
- Cut off of healthcare and non-healthcare income
- Cut off of expenditure on goods and services
- Financial support and going concern
- Valuation of property, plant and equipment

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit:

Audit risk	How we responded to the risk
Occurrence and valuation of healthcare income and existence of associated receivables 83% of the Trust's income is from contracts with NHS commissioners of healthcare services. The Trust 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. This can involve further negotiation of contractual adjustments with commissioners. Given the scale of this income stream to the Trust and the extent of estimation applied by management in determining it, we considered this to be an area of heightened risk of material misstatement in the financial statements. We therefore identified occurrence and valuation of healthcare income and the existence of associated receivables as a significant risk requiring special audit consideration.	**Our audit work included, but was not restricted to:** ■ evaluating the Trust's accounting policy for revenue recognition of healthcare income for appropriateness and consistency with the prior year; ■ gaining an understanding of the Trust's system for accounting for healthcare income and evaluating the design of the associated controls; ■ investigating significant differences in income and any associated receivable balances with contracting bodies through the Department of Health agreement of balances tool; ■ agreeing, on a sample basis, amounts recognised in income in the financial statements to signed contracts and invoices, and associated receivables to subsequent cash receipts, ■ agreeing, on a sample basis, income variations to signed contract variations and non-contractual income adjustments to supporting documentation; and ■ testing a sample of receivable balances to supporting information, for example subsequent cash receipts. The trust's accounting policy on healthcare income, including its recognition, is shown in note 1.2 to the financial statements and related disclosures are included in notes 3 (income) and 21.1 (receivables).

Audit risk	How we responded to the risk
Occurrence of non-healthcare income and existence of associated receivables 17% of the Trust's total income is from non-healthcare sources. Income is recognised when the service has been performed. At the year-end, income is accrued for services that have been performed but for which an invoice has not been issued. We therefore identified the occurrence of non-healthcare income and existence of associated receivables as a significant risk requiring special audit consideration.	**Our audit work included, but was not restricted to:** ■ evaluating the Trust's accounting policy for revenue recognition of non-healthcare income for appropriateness and consistency with the prior period; ■ gaining an understanding of the Trust's system for accounting for non-healthcare income and evaluating the design of the associated controls; ■ agreeing, on a sample basis, amounts recognised as non-healthcare income in the financial statements to signed contracts and invoices; and ■ testing of existence of a sample of receivable balances to supporting information, including subsequent cash receipts. The Trust's accounting policy on non-healthcare income, including its recognition, is shown in note 1.2 to the financial statements and related disclosures are included in notes 4 (income) and 21.1 (receivables).

Audit risk	How we responded to the risk
Cut off of healthcare and non-healthcare income Total income for the Trust is £747,383,000. The Trust receives a material amount of non-contract income in the final month of the year that management makes a judgement on the year the income relates to. We therefore identified cut off of healthcare and non-healthcare income being recognised in the incorrect accounting period as a significant risk requiring special audit consideration.	**Our audit work included, but was not restricted to:** ■ gaining an understanding of the Trust's system for accounting for income and evaluating the design of the associated controls around cut-off; ■ reviewing the appropriateness of management's processes for ensuring that cut-off of income is appropriate; and ■ cut-off testing of income either side of the balance sheet date to determine whether income was recorded in the correct period. We tested a sample of cash received in the bank account in March 2016 and post year end up to 28 April 2016 to ensure that income was recorded in the correct period. The Trust's accounting policy on income, including its recognition, is shown in note 1.2 to the financial statements and related disclosures are included in notes 3 and 4.

Audit risk	How we responded to the risk
Cut off and completeness of expenditure on goods and services. Expenditure on goods and services represents 61% of the Trust's total expenditure. Management uses judgement to estimate accruals of expenditure for amounts not yet invoiced at the year-end. We therefore identified cut off of expenditure on goods and services as a significant risk requiring special audit consideration.	**Our audit work included, but was not restricted to:** ■ gaining an understanding of the systems used to recognise non-pay expenditure and year-end accruals, and evaluating the design of the associated controls; ■ documenting and reviewing the appropriateness of management's processes for ensuring that cut-off of expenditure is appropriate; ■ gaining an understanding of the accruals processes for unprocessed invoices and expenditure incurred but not yet invoiced (GRNI) at the year end and testing a sample of these items; and ■ testing, on a sample basis, post year-end payments made in April 2016 to confirm whether transactions are recorded in the correct period. This period to be appropriate as the date of accounts submission was 22 April 2016 and we felt the risk of cut off error after this date was lower than during the closedown period. The trust's accounting policy on expenditure is shown in note 1.4 to the financial statements and related disclosures are included in notes 5.1 and 26.1.

Audit risk	How we responded to the risk
Financial support and going concern The Trust is in receipt of financial support as at 31 March 2016 and received a working capital loan. The Trust incurred a sizeable financial deficit in delivering its services in 2015/16 and management anticipate that it may take some time before the Trust can achieve financial balance on a sustainable basis. We therefore identified financial support and its impact on the going concern assumption as a significant risk requiring special audit consideration.	**Our audit work included, but was not restricted to:** ■ reviewing and concluding on whether management's information and procedures for assessing the on-going financial support and going concern basis of preparation were adequate and covered an appropriate period; ■ reviewing the adequacy of the Trust's disclosures within its financial statements in relation to the financial situation; and ■ reviewing cash-flow forecasts, sensitivity analysis and correspondence with Monitor and NHS Improvement regarding financial support. The Trust's accounting policy in respect of the going concern basis of preparation is shown in note 1 'Going Concern' to the financial statements.

Audit risk	How we responded to the risk

Valuation of property, plant and equipment
 	
The valuation of property, plant and equipment involves estimates which require significant judgements and represents 76% of the total asset value on the Trust's statement of financial position.
 	
We therefore identified the valuation of property, plant and equipment as a risk requiring particular audit attention.
	Our audit work included, but was not restricted to:
	
	■ reviewing the competence, objectivity and expertise of management's valuer;
	
	■ reviewing the instructions issued to the valuer and the scope of their work, including the completeness of the data provided to the valuer;
	
	■ obtaining management's assessment of the valuation of property, plant and equipment and understanding the valuation process including the design of key controls and significant assumptions;
	
	■ reviewing the appropriateness of the methodology and assumptions applied in performance of revaluations and challenging management on its land valuation
	
	■ challenging and obtaining corroborative evidence of the assumptions made by management in relation to:
	
	  ■ the valuation of property, plant and equipment, in particular the use of an alternative site valuation methodology where applied;
	  ■ the useful economic lives of property, plant and equipment;
	  ■ the amount of depreciation charged in the year; and
	  ■ assets not revalued during the year and how management are satisfied that the carrying value of those assets is not materially different to current value.
	
	■ testing, on a sample basis, revaluation adjustments made to the fixed asset register and general ledger to the report of the external valuer to ensure these were correctly processed.
	
	The Trust's accounting policy on property, plant and equipment is shown in note 1.5 to the financial statements and related disclosures are included in note 15.1.

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 economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

We determined materiality for the audit of the Trust financial statements as a whole to be £8,961,000, which is 1.25% of the Trust's budgeted gross revenue expenditure. This benchmark is considered the most appropriate because we consider users of the Trust's financial statements to be most interested in how it has expended its revenue and other funding.

Materiality for the current year is lower than the level that we determined for the period ended 31 March 2015 to reflect our view that a wider range of users of the accounts with a lower view of materiality are expected this year due to the deterioration in the Trust's financial performance and increased public interest in its financial position.

We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 60% of financial statement materiality for the audit of the Trust financial statements.

We also determined a lower level of specific materiality for certain areas such as disclosures of senior manager salaries and allowances in the remuneration report.

We determined the threshold at which we would communicate misstatements to the Audit Committee to be £250,000. In addition we communicated misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

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 Chief Executive as Accounting Officer; 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.

We conducted our audit in accordance with 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 of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards 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 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, and in particular, included an interim visit to

evaluate the Trust's internal control environment including its IT systems and controls over key financial systems.

Overview of the scope of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016 and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified.

In our opinion:

- the part of the Remuneration Report and Staff Report subject to audit have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the NHS Foundation Trust Annual Reporting Manual; and
- the other information published together with the audited financial statements in the annual report is consistent with the audited financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are 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.

Under the Code of Audit Practice 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 ARM or is misleading or inconsistent with the information of which we are aware from our audit.

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

Basis for adverse value for money conclusion

Our review of the Trust's arrangements identified a number of matters:

- The trust delivered a deficit of £55,100,000 in 2015/16, which represents a deterioration compared to its original budget of a deficit of £46,000,000;
- The trust is projecting a deficit of £17,200,000 for 2016/17 which is dependent on achieving transformational savings of £50,100,000 and on receiving Sustainability and Transformation Fund payments £17,600,000, which can only be secured if the Trust meets conditions on financial and quality performance;
- an independent review dated October 2015 commissioned by the Trust highlighted significant deficiencies in the Trust's financial management and governance arrangements; On 29 July 2015, Monitor issued enforcement undertakings against the Trust under Sections 105 and 106 of the Health and Social Care Act 2012 in respect of shortcomings in its corporate governance arrangements and financial management standards, which the Trust needs to rectify.

These identify weaknesses in the Trust's arrangements for:

- setting a sustainable budget with sufficient capacity to absorb emerging cost pressures;
- managing and reporting on performance against its budget and delivery of cost savings;
- managing the delivery of services so that performance targets are achieved on which funding depends responding to the service delivery issues, including financial management and governance arrangements and achievement of performance targets, raised by regulators and from independent reports which have not been fully resolved.

These issues are evidence of weaknesses in proper arrangements for informed decision making and sustainable resource deployment in:

- planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions; and
- acting in the public interest through demonstrating and applying the principles of good governance to support informed decision making.

Adverse value for money conclusion

On the basis of our work under the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, because of the significance of the matters described in the Basis for adverse value for money conclusion paragraph above we are not satisfied that, in all significant respects, St George's University Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:

As explained more fully in the Statement of Accounting Officer's Responsibilities, 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. The Accounting Officer is also responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

What we are responsible for:

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

We are also required under Section 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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 Code of Audit Practice.

Paul Dossett
Partner
for and on behalf of Grant Thornton UK LLP
London
3rd June 2016

Quality report

Chief executive's statement on quality

At St George's, we are committed to providing high quality care and to continuous improvement of our services.

Our task is to make that commitment a reality, a key part of which is to sometimes admit that we do not always get it right.

What do we mean by quality?

There can be no single measure of quality, and a great deal of information is required to build an overall picture across the range of services we provide, to many patients.

It is this complexity that drives the Care Quality Commission's inspection process, which looks at five domains, namely;

- are we safe?
- are we effective?
- are we caring?
- are we responsive?
- are we well led?

We publish this report as we look forward to our next comprehensive CQC inspection in June 2016. The inspection will provide us with a detailed, up to date picture of our services, and whether they are meeting the needs of the people and communities we serve.

A continual journey of improvement

In this report, we have set out to provide three things; a summary of what we do, how well we do it and how we compare to both our own previous performance, and other trusts.

We have also set out some of our plans for improvement whilst also acknowledging that there will undoubtedly be more.

Don Berwick, the world's leading expert on patient safety, articulates clearly the type of approach we want to foster at St George's, namely:

'While "Zero Harm" is a bold and worthy aspiration, the correct goal is "continual reduction". All in the NHS should understand that safety is a continually emerging property, and that the battle for safety is never "won"; rather, it is always in progress'.

With this in mind, the improvements we want to make will be driven not only by building on our successes, but also by acknowledging areas where we are not doing well. Our staff survey results are a real concern and, like all hospitals, even one 'never event' is too many. We absolutely must do better in this regard.

I commit myself, and the staff of St George's, to that continual improvement journey. We will always try to do better. We will always remember that behind every statistic is a real person. Crucially, we will also say sorry when we get it wrong.

Of course, there is much to be proud of in this report. For example, 94.4% of patients reported as having harm free care; 90% of patients said that they would recommend St George's as a place to receive treatment; our mortality rates also continue to be amongst the lowest in the country. We have also seen a 24% reduction in Clostridium difficile infection rates, which is very encouraging.

Since last year's report, we have also opened new facilities for patients. This includes the commissioning of a heart failure unit, an extension of neurosurgical beds to support spinal surgery, and a new neurorehabilitation unit at our Queen Mary's Roehampton site. In addition, we have worked with commissioning colleagues to implement a new community adult health service model to provide care in patients' own homes.

We need to further embed a culture at St George's that is constantly looking at ways in which we can improve. This is evident in many areas of the trust, but needs to be universal. Embedding this culture is particularly challenging due to the financial and performance issues the trust faces.

The executive team know that we need to ensure staff can continue to focus on quality, despite the current and challenged situation we find ourselves in.

Over the coming months, this will be our focus, as will emphasising 'value' and the' importance of getting it right first time' in the day to day delivery of our services.

Simon Mackenzie
Acting chief executive
2nd June

Priorities for improvement in 2016/2017

We have agreed commitments against each domain. These priorities have been determined through a review of activity during 2015/16.

The priorities indicated below are reflected in the quality improvement strategy annual plan for 2016/17 and each element has agreed outcomes with a nominated person accountable for delivery against the priorities.

Improving patient safety

- Ensuring that we are getting patients in the right place first time to improve the safety of care and reduction in length of stay through the trust's flow programme, review of specific clinical pathways, management of cancer pathways and the outpatient programme.
- Agreeing and embedding high quality standardised processes seven days a week through building on existing processes within the trust for the management of deteriorating patients eg use of the National Early Warning Scoring system, management of sepsis and management of results. In addition, the delivery of a reduction in never events outside of the main theatre environment.
- Ensuring we promote an open and transparent culture where we listen, and act on staff concerns by treating staff fairly when they are involved in incidents. This will be done through the re-establishment of a regular staff forum for feedback and follow up, engaging front line staff more closely in the identification of issues from incidents and the planning of actions, encouraging a 'fresh pair of eyes' approach to identify systems that could be improved and ensuring that managers at all levels have systems to listen to staff concerns.

Improving patient experience

- Investing capital resource to reduce clinical risks through the delivery of an environmental programme that addresses both small and large scale projects during 2016/17 including the provision of dementia friendly environments.
- Delivery of end of life care programme to improve the standard of care provision across the trust and in community services.
- An ability to evidence the changes and improvements made as a result of patient feedback with a sustainable change in service delivery standards.

Improving patient outcomes

- Building on our existing mortality programme to encompass avoidable mortality monitoring.
- Providing transparency on outcomes through publication and triangulation of a range of data points.
- Improving the impact of national clinical audits through increasing the quality and completeness of data, and ensuring that each division has a prioritised programme of local and national clinical audit activity.
- Evidence implementation of best practice through improving our NICE compliance profile and conducting audits of key guidance.

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 public board meetings throughout 2016/17.

In last year's Quality Account we identified a number of priorities for improvement during 2015/16 to ensure that we continue to raise quality throughout the trust.

Improvement priority for 2015/16	Progress as of April 2016
Create reliable processes to reduce avoidable harm. Examples of outcome measures: audit of practice against the World Health Organisation (WHO) safer surgery checklist, ward level data eg heat map/safety thermometer to support management action at the front line.	■ We continue to conduct quarterly audits of the WHO safer surgery checklist in both theatre and non-theatre areas. This data is available at team level to support management action at the point of care. This programme will be extended to other areas that carry out invasive procedures to comply with national requirements which will be in place from September 2016. ■ Monthly participation in the 'classic' safety thermometer has continued across the trust and monthly reporting of the level of harm-free care by ward/clinical teams along with details of any old or new harm are communicated to clinical teams. This year the children and young person's safety thermometer has also been launched and local reporting of harms at team level is now becoming embedded. ■ Heat map data goes to the board monthly and is shared through the divisions. ■ A quality observatory has been rolled out to medicine and surgery divisions collecting data on key clinical performance.
Establish strong multidisciplinary teams who communicate clearly across boundaries through development forums for clinical governance leads.	■ Regular meetings set up with the associate medical director and information sent out to support learning.
Give timely and relevant feedback to teams to enable staff to be knowledgeable about patient safety.	■ Upgrade to Datix system to support more robust feedback. ■ CARE folders on wards now include learning section with local and trust-wide lessons from incidents and serious incidents.

Promote an open and transparent culture where we listen and act on staff concerns through the safety forum initiative, and on-going development/ monitoring in relation to the Duty of Candour.	■ Duty of Candour guidance available on all wards through CARE folders. ■ Rolling out enhanced training around Duty of Candour.
Encourage the involvement of patients in patient safety initiatives through the roll out of the patient safety booklet/ films.	■ Booklet was distributed across the trust and the film placed on patientline screens. Training for staff to support patients' understanding and use of booklet.
Listen to and involve people who use our services through further improvement work in relation to the complaints function and monitoring of key metrics.	■ Patient representatives involved in quality inspections to capture patient feedback. ■ Friends and Family Test feedback displayed in clinical areas, comments reflected on and action plans developed.
Use feedback as a vehicle for continuous improvement adopting best practice where possible through triangulation.	■ Complaints pertinent to specific groups shared at meetings eg end of life care and nutrition to ensure areas for development are addressed.
Ensure our patients are cared for in a clean, safe and comfortable environment through the use of the clinical audit programme and ensuring that findings are acted upon.	■ As part of the quality inspection programme, infection control and estates staff joined the inspection team to provide feedback and ensure continuous improvements are made.
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 the clinical care for individual patients.	■ Passports are in use for patients with dementia and learning disabilities to ensure optimum communication.

Evaluate clinical audit results and act on findings to ensure audit contributes to improvements for patients.	■ Key national and local audits are reported on a monthly basis to the board as part of the quality update, helping to drive forward improvements. ■ Summaries of the audit programme are produced each quarter so that divisions may identify key areas for action and escalation.
Support staff to improve outcomes, promoting shared learning and prioritisation of improvement projects.	■ Staff are supported to improve outcomes through the offer of regular training sessions on using clinical audit for quality improvement and also on effective data analysis and presentation. Each division has a dedicated resource to support them in the delivery of priority topics. Our key shared learning event is the annual clinical audit half day which this year was attended by more than 200 staff.
Evidence that we are clinically effective and implementing evidence-based best practice.	■ We have just launched a project to review our approach to NICE implementation, which will help us to improve processes and provide a more complete picture of implementation. This information will help us to better identify and then manage any risks associated with non-compliance. This year we introduced new baseline assessment forms which require the evaluation of risk where full implementation has not been achieved. ■ Reports from confidential enquiries are prepared for the board as part of the quality update, in addition to national audits.

Fully participate in national clinical audits and use results to improve local practice.	■ The reporting structures mentioned above help us to use results to improve local practice, but it is recognised that this could be strengthened and better evidenced. This will remain a key focus of the clinical audit team through the next year. ■ All national clinical audits are included on the annual audit programme, but it is acknowledged that there are challenges particularly in regards to data quality. These must be taken forward through local action planning. Although we participate in a number of elements of the national diabetes audit, there remain strands where we do not participate. This is being taken forward at a divisional level, with corporate support as appropriate, but remains outstanding at year end.
Aspire to achieve best practice across all clinical areas so that patients have the best possible outcome.	■ Through the monitoring of national and local audits and the reporting structures detailed we endeavour to share and celebrate best practice. ■ We continue to build on our strong governance of mortality to ensure that a large subset of deaths are reviewed centrally and are driving the proportionate review of all deaths. Our overall mortality as measured by the hospital standardised mortality ratio (HSMR) remains significantly better than expected, and as measured by the summary hospital-level mortality indicator (SHMI) our mortality is as expected or better than expected, depending on the 12 month period considered.

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 (from 1st April 2016 Monitor and the Trust Development Authority merged and were renamed NHS Improvement).

We must comply with both Monitor's reporting requirements and those set by DH. 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 safety, 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 council of governors, our local Clinical Commissioning Group (CCG), Wandsworth Healthwatch, Merton Healthwatch, Lambeth Healthwatch and Wandsworth Council.

The table below shows the voluntary indicators reported on in this document, and the indicators we will be reporting on in next year's quality account (2016/17). These have also been shared with stakeholders.

The voluntary indicators chosen for 2016/17 reflect some specific issues where the trust wishes to undertake a bespoke programme of work or where there is a need to continue to build on work previously undertaken in 2015/16 to support embedding the learning in practice which is an important element of any programme. The 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.

Voluntary indicators in this report	Voluntary indicators chosen for next year's report (2016/17)
Patient safety	**Patient safety**
Medication errors Patient falls Patient safety thermometer Offender healthcare	Medication errors Patient deterioration Staff learning through incident feedback Learning from never events outside of theatres
Patient experience	**Patient experience**
End of life care Complaints Community learning disability referrals	End of life care Complaints Dementia and delirium
Patient outcomes	**Patient outcomes**
Clinical records Sexual health in secondary schools Clinical outcome measures in community services	Clinical records Mortality

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
- 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 it for all of the indicators in this report against how we performed 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.

Two indicators are mandatory. These are:

1) percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

2) percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

One local indicator needs to be selected by the trust's council of governors. For 2015/16 they have chosen the patient safety thermometer.

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 are 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/

We have continued to update this as part of our collaborative work with the other acute providers in south west London. The reporting format is slightly altered so that a standard may be reported as partially met.

How are we doing?

Our most recent report was in December 2015. In total St George's met 142 of the 176 standards in full, a further nine in part and did not meet 23. There has been improvement in most areas over the year although challenges remain, particularly around adult acute medicine, and paediatric surgery. Whilst the care required is delivered, it is not always as quickly as we would like it to be or consistently through every hour of every day. These difficulties mostly relate to competing demands on staff. It has been difficult to recruit additional acute physicians despite efforts this year.

	RED: not fully met	AMBER: partially met	GREEN: met
Adult acute medicine (22 standards)	4	2	16
Adult emergency general surgery (26 standards)	2	2	22
Emergency department (14 standards)	1	2	11
Critical care (26 standards)	1	0	25
Fractured neck of femur pathway (13 standards)	2	1	10
Paediatric acute medicine (21 standards)	6	0	15
Paediatric surgery (23 standards)	6	0	17
Urgent care centre (31 standards)	1	1	27

What are our aims?

Our aim is to continue to work towards meeting the standards by 2016/17. This is a key aim of the Acute Provider Collaborative with the other acute trusts in south west London (Croydon, Epsom and St Helier, Kingston).

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 2015/16 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 2015/16 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 2015/16.

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

Children's and women's diagnostics, therapeutics and critical care

Children's directorate

- Paediatric surgery
- Newborn services and NICU
- PICU
- Paediatric medicine

Women's directorate

- Gynaecology
- Obstetrics

Therapeutics

- Adult critical care
- Therapies
- Pharmacy

Diagnostics

- Clinical genetics
- Breast screening
- Pathology
- Radiology
- Laboratory haematology

Outpatients

- Outpatients

Community services

Community adult and children's directorate

Community adult health services

- Trauma and orthopaedics
- Ear, nose and throat
- Maxillofacial
- Plastic surgery
- Urology
- General surgery
- Dentistry
- Audiology

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
- Nelson Health Centre
- Stormont Health Centre
- Tooting Health Clinic
- Tudor Lodge Health Centre
- Westmoor Community Clinic

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 central to our success and are well-placed to judge the quality of care we provide to our patients.

How did we do?

Every year we conduct the Friends and Family Test with our own workforce. In quarters one, two and four we give 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?

Quarter three is given over to the annual national NHS staff survey.

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 scores in the Friends and Family Test for staff in 2016.

National NHS staff survey

Our 2016/17 workforce strategy action plan sets out a programme of work that will support the trust to respond to the issues raised in the national NHS staff survey. These include:

Confidence to raise concerns

The 2015 staff survey results showed that the trust had a below average score for staff agreeing they would feel secure about raising concerns about unsafe clinical practice. The trust will be implementing the national 'Freedom to Speak Up' review. We encourage staff to raise concerns and will ensure that they receive support in doing so and feedback on the outcome of the complaint.

Our scores, by quarter, are listed here:

	Staff response	Would recommend for treatment	Would recommend as a place to work
Q1	695	79%	50%
Q2	274	75%	46%
Q4	508	75%	50%
Full year	1502	76%	49%

Tackling poor behaviour and bullying

Trust performance has remained fairly steady with 33% 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, and reviewing our policy to ensure it meets best practice standards.

Discrimination

The trust position has remained the same with regard to members of staff reporting discrimination. Of greatest concern is that 31% of black and minority members of staff report discrimination as compared to 13% of white members of staff. It is of further concern that 35% 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 32% of white members of staff. Our 'St George's as One' inclusion programme was set up in 2015 to help address these issues.

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's 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's 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.

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 use the feedback from staff 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' and the genetics service has begun to recruit patients from our services to contribute data and samples to the project. St George's runs the South West Thames Regional Genetic Services which provides a specialist service to people living in south west London, Surrey and West Sussex, in 18 hospitals across the region. Initially the focus will be on rare disease, cancer and infectious disease, but our clinicians are working with the project to identify other key disease areas.

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 a range of diseases, to develop better ways of diagnosis and tailored treatments. There has been significant investment in new academic clinical appointments in the previous year. We look forward to growth in research activity in neurosciences, cardiology and maternal and fetal health in 2016. In the key research areas of St George's Medical School, University of London, there have important studies across both organisations.

In infection and immunity:

- New diagnostic techniques for TB.
- Pain relief in rheumatoid arthritis.
- Follow-up on babies who had meningitis.
- Looking at the ways different patients respond to antibiotics.
- Developing MRI scan techniques in cancer.
- New physiotherapy techniques for patients with lung disease.

In cardiovascular and cell sciences:

- Studies looking at cardiac problems in otherwise healthy individuals.
- Identifying new genetic influences in cardiac problems.
- New treatments for vascular dementia.
- Developing a renal inpatient nutrition screening tool.
- New ECG techniques in inherited heart conditions.

Our strong relationship with the pharmaceutical industry continues – we recruited the largest number of patients on to commercial trials in South London CRN (clinical research network). This enables our clinical staff to keep abreast of the latest developments and our patients to have access to the newest treatments within clinical trials.

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 2015, there were 198 NIHR adopted trials open and recruiting in St George's, with 7561 patients taking part. This was a decrease from 2014 where 9,021 patients took part in research. However, there were several unusual trials in both years – and having around 5,000 patients would be reasonable for 2016.

We don't have data for the number of patients receiving relevant health services provided or sub-contracted by St George's in 2015/16 that were recruited during the period to participate in research approved by a research ethics committee. This information is not collected as we don't store the number of patients of studies outside the ones already reported on. We also don't have the number of studies that we are recruiting to, only the studies that are active.

II. Approvals:

In 2015, the research office approved 168 new studies to be performed at St George's, a slight decrease (19 in total) from 2014. These range from clinical trials of medicinal products (new drugs) and medical devices, through to service and patient satisfaction studies. Just less than 70% are adopted on the NIHR portfolio, up from 30% in 2013, and 60% in 2014. 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 for studies has been a focus at St Georges in 2014. However, there are national changes in the approval system that has taken effect from 1st April 2016, meaning that approval for studies will be undertaken by the Health Research Authority, not St George's staff. Our staff will only check that we have the ability to undertake the study. Therefore, as yet, we are unclear about the extent of the impact this will have on the number of studies approved at St Georges. Our aim for 2016 is to maintain the number of studies approved and active.

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. We have seen a steady increase in this from 40.3% in December 2013 to 80.0% in December 2014, to 93.2% in December 2015.

We intend to maintain this level in 2016.

IV. Ensuring compliance with 'Good Clinical Practice ' 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 (21 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 2016

I. Increase participation

We intend to maintain and improve upon our patient participation rates in NIHR adopted trials at 2013 levels, understanding that 2014 and 2015 were unusual years. We hope to recruit 5,000 patients or more in 2016.

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 Friday 20th May 2016.

II. Approvals

In 2016, there are significant changes to the national approvals process that could affect the number of studies approved at St Georges. We intend to ensure that we maintain the number of studies approved at St Georges, at 168 with at least 70% being NIHR adopted.

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 90% of relevant trials recruiting their first patient within 70 days.

IV. Ensuring quality

We will continue to review 10% 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.

Participation in clinical audits

During 2015/16, 45 national clinical audits and eight national confidential enquiries covered NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period St George's participated in 88.9% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that St George's was eligible to participate in during 2015/16 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 of 16 national clinical audits were reviewed by trust board in 2015/16. A summary of the actions agreed in response to these audits is given in Appendix B.

The reports of 14 local clinical audits were reviewed by St George's in 2015/16. A summary of the actions agreed is given in Appendix C.

Use of CQUIN payment framework

St George's University Hospitals NHS Foundation Trust's income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and innovation payment framework because of the trust's contract type.

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 fundamental 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 2015/16. St George's has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC inspection framework focuses on 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 improvement** 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	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	**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.

During 2015/16 the trust has continued to take 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 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 was been presented to the trust's commissioners and the CQC on a quarterly basis and both commissioners and the CQC indicated that they assured good progress has been made to improve quality of care where needed. As such the action plan was closed in July 2015, however all actions in the plan continue to be monitored by the trust.

The CQC has announced that they will return to the trust on 21st June 2016 to carry out a full inspection as part of their continued announced inspection regime. The trust has started to prepare for the inspection, the results of which will become available in late 2016.

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.

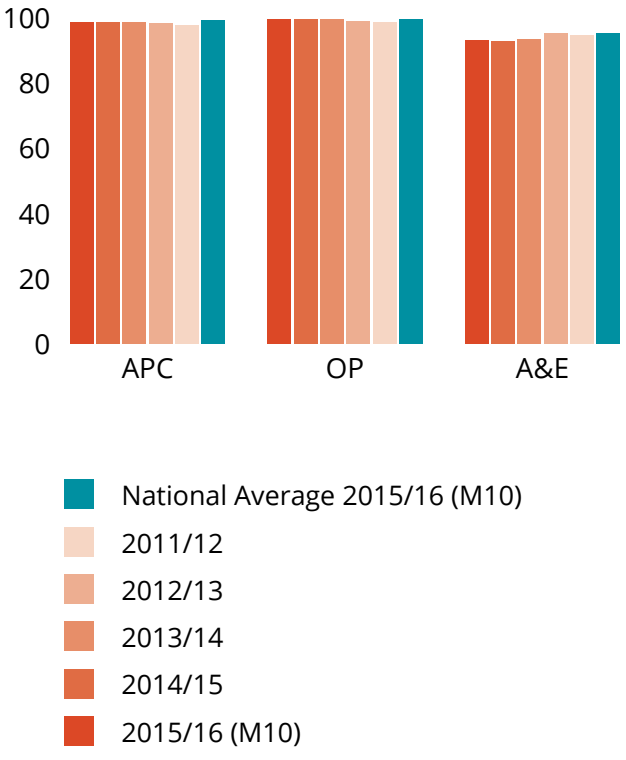
Most data is gathered as part of the everyday activity of frontline and support staff who work throughout the trust in a huge variety of settings. It is important that we accurately capture and record the care we provide and the information in this report aims to demonstrate how well we are doing this. 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 2016 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:

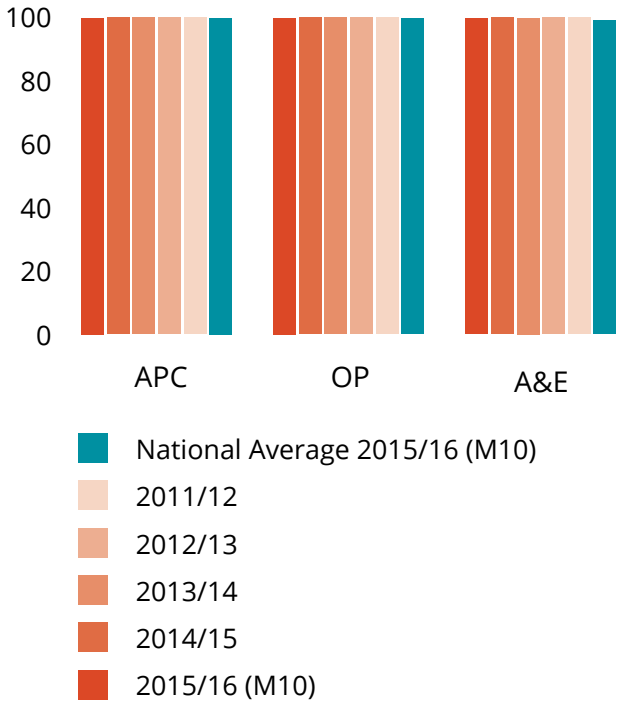
Valid NHS no	APC	OP	A&E
2015/16 (M10)	98.7	99.5	93
2014/15	98.6	99.4	92.7
2013/14	98.7	99.4	93.4
2012/13	98.3	99	95.1
2011/12	97.7	98.6	94.5
National average 2015/16 (M10)	99.2	99.4	95.3



Our NHS number completeness remains good, but is behind the national average for admitted care and A&E. St George's will be taking the following actions to improve data quality. 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:

Valid GP	APC	OP	A&E
2015/16 (M10)	99.9	99.9	99.8
2014/15	100	100	100
2013/14	100	100	99.9
2012/13	100	100	100
2011/12	100	100	100
National average 2015/16 (M10)	99.9	99.8	99.1



Note: The data quality figures shown above are correct as at month 10 (April 2015 to January 2016 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 2015/16 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 is rolling out electronic document scanning across a number of areas 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.

St George's University Hospitals NHS Foundation Trust information governance assessment report overall score for 2015/2016 was 73% 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 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
2015/16	73	Green
2014/15	77	Green
2013/14	79	Green
2012/13	79	Green
2011/12	77	Green

Clinical coding error rate

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Improving patient safety

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 similar characteristics to the community dwelling population, and in addition there are the additional risks around acute illness and sudden change in environment which present 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?

For hospital inpatient services we have:

- implemented an electronic multifactorial falls risk assessment in line with the NICE falls guidelines
- developed an interim paper-based multifactorial falls risk assessment for clinical areas that are not yet electronic
- developed and implemented a bed rails risk assessment tool which must be completed for all adult inpatients on admission to hospital
- conducted an audit of bed rail risk assessment across the trust and have implemented an action plan to improve compliance
- developed patient information leaflets on falls prevention and the use of bed rails
- been running monthly patient simulation study days to promote best clinical practice for falls and other harms.

We have participated in the national inpatient falls audit. The results showed that we are below the national average for falls resulting in moderate/severe harm or death per 1000 bed days (0.03 versus 0.19) and slightly below the national average for number of falls per 1000 bed days (6.12 versus 6.63).

However, the audit showed that in seven key indicators of good falls prevention, we achieved amber status for four areas (assessment of delirium, assessment of continence, call bell in reach, walking aid in reach) and red status for three areas (postural blood pressure measurement, visual assessment and medication review). An action plan to improve practice has been developed and we will be participating again in the autumn.

There has been no significant reduction in the number of inpatient falls across the trust this year.

Community based services:

We have an integrated falls and bone health service (IFS&BH). This is predominantly a prevention-focused service that dovetails with other reactive community services and is fully integrated with the hospital-based sister services such as osteoporosis/orthopaedics/older people services.

Following assessment, optimisation of the patient is a clear target for the team. This requires multiple communications, influencing other health and non-health professionals and implementing a tailored treatment plan in order to address the reversible risk factors for falls and fractures. Assessments are carried out in patients' homes, health venue clinics and at satellite clinics in non-health venues such as sheltered accommodation sites. 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. Another arm of the service is the bone boost provision – an early prevention model targeting the population at risk of fracture This short film explains more about the service: www.youtube.com/watch?v=-dsQ1uIa9hM

Building on the success of joint working with the acute-based services, further development work has continued this year:

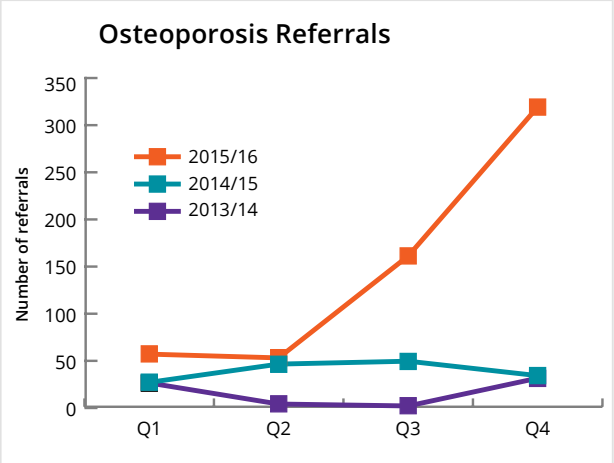
- Development of the Denosumab PGD – an innovative work stream about skilling up the IFS&BH pharmacist and physiotherapists to provide this important injection for the prevention of fractures in community settings for more frail patients.

- Evolution of a niched falls prevention exercise group for our diabetes patients –recognising their more complex needs and a different approach.

- Development of a rapid referral service for vertebral fracture patients – a smooth pathway for immediate access to appropriate vertebral bracing support has been implemented with the orthotics department.

- Monthly integrated falls and fracture meetings between the rheumatology, renal, orthopaedic consultants and head of IFS&BH to ensure service developments and pathway improvements for fragility fracture patients especially with hip fractures.

- Monthly meetings with the dexa scan technician, fracture liaison nurse and the IFS&BH clinical lead to ensure effective and efficient pathway design – accessing patients early with community intervention following a diagnosis of osteopenia/osteoporosis. This early intervention prevention service will help to reduce the burden of fragility fractures further down the line. The graph below shows the significant increase in referrals through closer working together.



This year has also seen the implementation of ARCH – Active Residents in Care Homes – our joint research feasibility trial with St George's and Kingston University. This is an exciting project which will yield some important findings about the prevention of falls and fractures for this population. The clinical team for this £300k research trial funded by the CSP (Chartered Society of Physiotherapists) are all from the IFS&BH team. The trial will continue into 2016/17.

Presentations and posters:

Two clinical audit posters were presented at the trust's clinical governance day.

In addition to our integrated working within our own organisation we have also led on an integrated work stream at Kingston hospital – the falls prevention navigator role which was presented at the CSP conference in Liverpool this year. www.physiotherapyuk.org.uk/programme

Bernadette Kennedy, head of integrated falls and bone health, also presented at the recent Department of Health Global Progress on Safety Summit in Westminster regarding whole systems approaches to falls and fracture prevention: mhforum.org.uk/conferences/progress-on-safety-learning-together-event/

Our aims

- To reduce the admissions for falls and fragility fractures in Wandsworth through our community provision.
- To reduce the current rate of reported falls during an inpatient episode.
- 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.
- We aim to maintain our position as a leading falls and fracture prevention service in the country, continuing to work with our patient populations to deliver innovative services that meet individual and population needs.

Patient safety thermometer

Making sure that patients do not suffer avoidable harm is a key focus for the trust. The 'classic' 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 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 proportion of their patients who are harm-free which gives them a powerful tool for improvement.

In 2015/16 we collected data on 15,478 patients, of which 94.4 per cent were free of the harms being measured in this way. This compares with a national benchmark of 94.2%.

Next year for the 'classic' safety thermometer we will try collecting the data in a slightly different way which will help us to identify where harms have developed. This will make the data more useful to us in identifying areas where care might be improved.

A safety thermometer specific to children and young people has been developed by the national team and we have been piloting this at St George's since June. The harms that are measured include deterioration, extravasation, pain and skin integrity. The process of audit and action planning are becoming embedded. Each month a report is provided to all children's wards and they are asked to report back actions against harms.

During the year there has been a lot of work undertaken to reduce medication errors, and piloting the medication safety thermometer was part of this work.

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 has reported that St George's medication error reporting is higher than the national benchmark for reporting medication incidents. 14.1% of all incidents reported involved medication for St George's in comparison to 10.3% for all acute teaching organisations. In Q1-3 of 2015/16 the trust reported 1202 medication incidents, reflecting a good safety culture. Of these incidents, 93.0% resulted in no harm, 5.6% in low harm and 1.2% in moderate harm. One medication incident (0.08%) resulted in severe harm. The most common types of error were omissions and delays to administer medication and administering the wrong dose of medication.

Degree of harm:

No harm – 93.0%
Low harm – 5.6%
Moderate harm – 1.2%
Severe harm – 0.08%

The trend of reporting medication incidents continued to increase over 2015/16, without an increase in the degree of harm. 94.9% of incidents were no harm in Q3 201/16 compared to 92.1% for Q3 of the previous year.

The pharmacy department has 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, medication handling and medication safety. The pharmacy medication safety team also co-ordinates medication safety monitoring visits to clinical areas to monitor medication safety issues.

During 2015/16 medication safety visits have been conducted in community services, ward and non-ward areas including radiology and endoscopy.

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 (EWS) 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 and subsequently to devise an electronic template so that the EWS is integral to the clinical information system and to patients' medical records.

How did we do?

In 2013/14 the early waning score indicator was successfully implemented at HMP Wandsworth with all patient observation charts on the Jones unit including the indicator. All offender healthcare service staff were trained in the use of the early warning score indicator meaning that any deterioration was identified quickly.

An electronic template was also devised and put into use in quarter four of 2015/16, and the first audit illustrated that the EWS tool was used for patients on 118 occasions. This was significant as not only has it shown an improvement in numbers recorded, but the quality of the assessments were also improved by the electronic nature of the template as it automatically calculates scores so as to remove the opportunity for error.

Our aims

Further work is required in 2016/17 to maintain a consistent approach in the use and recording of EWS, and to subsequently expand its use to cover emergency response and substance misuse observations.

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

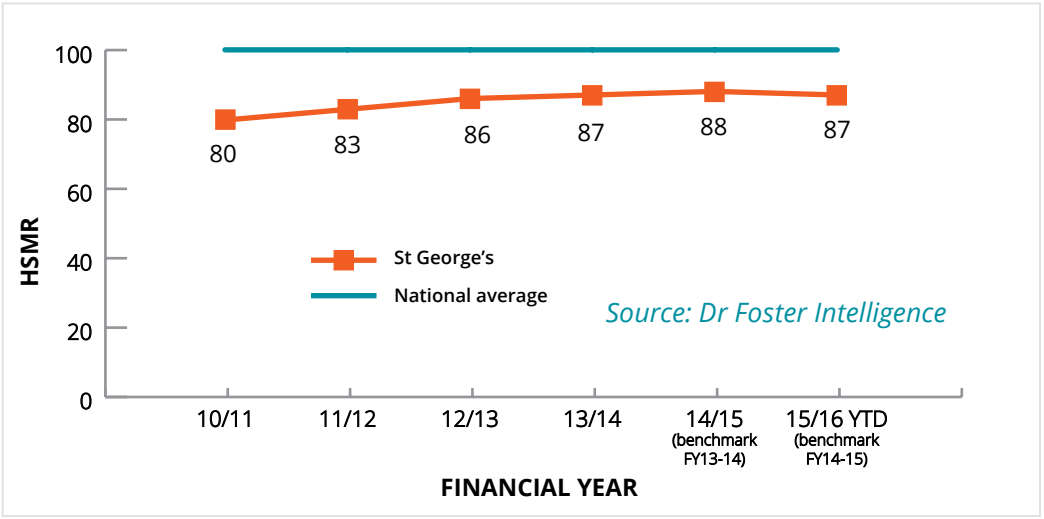
Our SHMI continues to be either lower than expected, or in line with what would be expected. The table below summarises the quarterly publications for this period. As well as considering our overall position we look at this data by diagnosis group and investigate areas where mortality may be higher than expected.

Publication date	Reporting period	Ratio	Banding
April 2015	October 2013 – September 2014	0.86	Lower than expected
July 2015	January 2014 – December 2015	0.89	Lower than expected
October 2015	April 2014 – March 2015	0.92	As expected
January 2016	July 2014 – June 2015	0.90	Lower than expected
March 2016	October 2014 – September 2015	0.91	As 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.

Hospital Standardised Mortality Ratio



St George's considers that this data is as described for the following reasons. 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.

Our aims

The trust intends to take the following actions to improve this indicator and the quality of its services. Our aim for the coming year is to further strengthen our governance of mortality and we hope to achieve a mortality ratio which is lower than expected. We will continue to expand our scrutiny of deaths and to identify opportunities for learning. We are committed to implementing the anticipated national mortality case record review programme.

Publication date	Reporting period	St George's	National
April 2015	October 2013 – September 2014	29.0%	25.3%
July 2015	January 2014 – December 2014	28.8%	25.7%
October 2015	April 2014 – March 2015	29.3%	25.7%
January 2016	July 2014 – June 2015	29.4%	26.0%
March 2016	October 2014 – September 2015	29.6%	26.6%

Source: Health and Social Care Information Centre

Assessing risk of VTE in admitted patients

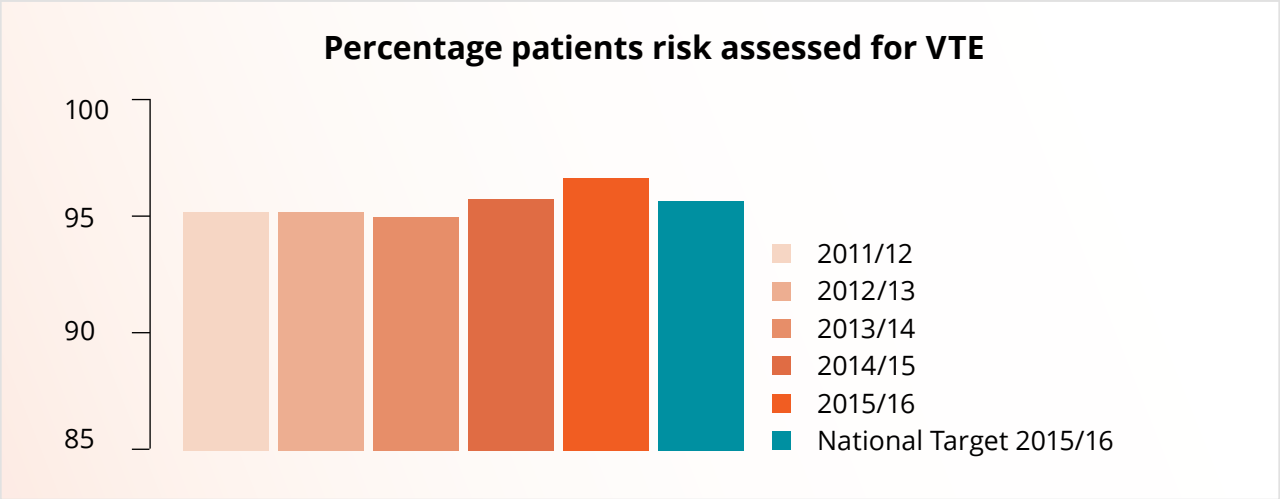
Why is this important?

Venous thromboembolism (VTE) occurs when a deep vein thrombosis (blood clot in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) causes substantial long term health problems or death. VTE is associated with long periods of immobility and can be prevented with appropriate preventative measures at the earliest possible time according to the needs of each patient.

Risk assessments for VTE ensure that we intervene with preventative measures at the earliest possible time, 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.

How did we do?

Every trust in the country is required to report the number of documented VTE risk assessments being conducted on admission as a proportion of the total number of hospital admissions. In addition they are also required to report the proportion of cases where there is a documented risk assessment that appropriate thromboprophylaxis has been prescribed.
In 2015/16 there were 190,362 risk assessed admissions at St George's and Queen Mary's Hospitals and of these 96.7% were given VTE risk assessments, thus exceeding the national target for VTE risk assessments of 95% and our 2014/15 performance of 95.89%.



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 hospital, we also continue to focus on our programme of comprehensive training for staff, stringent hand hygiene and careful use of antibiotics.

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 infections to our patients.

Infections can spread in many different ways. For that reason we use an array of measures to stop the spread of infection to our patients. The success of these measures can be assessed in different ways. In particular we carry out surveillance for several 'alert organisms'. One such organism is Clostridium difficile.

What is Clostridium difficile?

Clostridium difficile (C. difficile) is a bacterium 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 obtain information on how good we are at adhering to high standards of environmental cleanliness, hand hygiene, and isolation of infectious patients. We can also introduce better measures to reduce the risk of infection for all of our patients.

C. difficile is present naturally in the gut of around 3% of adults and 66% 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 no longer common, Older people are most at risk from infection, with the majority of cases (80%) occurring in people over 65.

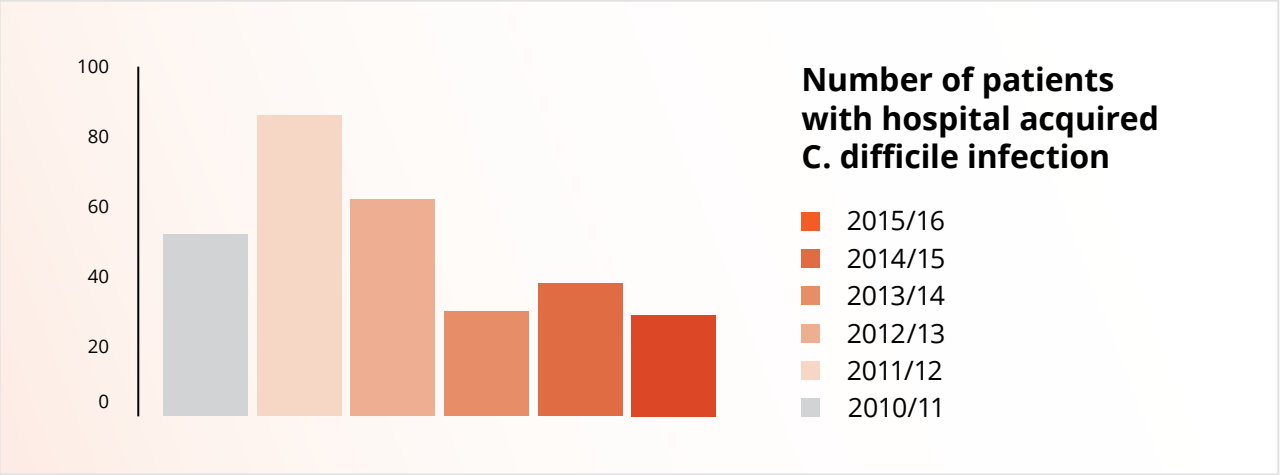
Even with stringent adherence to control measures, it is not possible to prevent all infections with C. difficile.

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

In 2015/16, our aim was to have fewer than 31 hospital-acquired infections with Clostridium difficile. During the year 2015/16 29 patients acquired C. difficile whilst under our care. This represents a decrease of 24% compared to last year.

Year	Number of patients with hospital-acquired Clostridium difficile infection
2010/11	52
2011/12	86
2012/13	62
2013/14	30
2014/15	38
2015/16	29



Our aim

Nationally the number of infections in 2015/16 has increased. Given the national increase, the mandatory target for St George's remains at 31 but our target is to reduce the number of infections further in 2016/17.

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 eg 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 11,216 reported patient safety incidents in 2015/16 compared to 10,187 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 11,216 patient safety incidents there were 38 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
2015/16	**11,216**
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 eight.

Division	Service	Never event
Surgery	Dentistry	Retained foreign object (dental roll)
Surgery	ENT	Wrong site surgery
Surgery	Trauma and orthopaedics	Retained foreign object
Therapeutics	Critical Care	Misplaced NG tube
Therapeutics	Critical Care	Maladministration of insulin
Women's	Obstetrics	Retained foreign object (swab)
Community services	Dermatology	Wrong site surgery
Renal, haematology and oncology	Renal Medicine	Retained foreign object

Community learning disability referrals

Why is this important?

The Wandsworth Community Learning Disability Health Team (CLDHT) is a multi-professional team providing community-based health care for adults with learning disabilities. The service facilitates access to generic NHS services. Where people with learning disabilities are unable to access mainstream services they should be in receipt of specialist learning disability community services to address their complex needs.

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, out 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 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 the receipt of CLDHT services is a time-intensive process that can be delayed by things like 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 for the provision of specialist health services.

If the referral is for somebody who is already known to the CLDHT (for example, a re-referral) 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. The process is:

- review of documentation such as past assessments, IQ tests, reports, statements of educational needs
- initial screening test (the Initial Service Assessment Checklist – Adults or the Learning Disability Screening Questionnaire).
- IQ test (eg Wechsler Adult Intelligence Scale) and Social Functioning Assessment (eg 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% of service users referred between April and June 2013 were assessed within 28 days, increasing to 95% for those referred between January and March 2014.

Ensuring eligibility is assessed and completed within 28 days is challenging due to the requirement to obtain the necessary evidence of a learning disability which can be complex.

During 2015 the CLDHT reviewed their eligibility pathway and introduced a weekly clinic to assist supporting the eligibility process with the aim to ensuring commencement on the eligibility pathway within 28 days of receipt of the referral.

The table below shows that to date during 2015/16 the target of commencing eligibility within 28 days of receipt of referral is 100% with more than 70% of assessments completed within this time frame.

Community Learning Disability Health Team - quarterly account targets

Month/ year	Total number of referrals received for month	Total number of new/eligibility query referrals for month	% of new / eligibility assessments initiated within month	Total number of eligibility assessments completed within month	% of eligibility assessments completed within month
Q1 (April-June)					
Apr-15	30	4	100%	2	50%
May-15	40	4	100%	4	100%
Jun-15	64	9	100%	6	67%
Total	**134**	**17**	**100%**	**12**	**70.58%**
Q2 (July-September)					
Jul-15	55	5	100%	4	80%
Aug-15	67	5	100%	4	80%
Sep-15	59	8	100%	5	63%
Total	**181**	**18**	**100%**	**13**	**72%**
Q3 (October-December)					
Oct-15	28	2	100%	2	100%
Nov-15	31	3	100%	2	66%
Dec-15	47	6	100%	4	66%
Total	**106**	**11**	**100%**	**4**	**72%**
Q4 (January-March)					
Jan-16	18	2	100%	2	100%
Feb-16	27	0	100%	0	0%
Mar-16	45	6	100%	4	66%
Total	**90**	**8**	**100%**	**6**	**75%**

Our overall performance for 2015/2016 ended at 72%

Quarter	Total number of referrals received for quarter	Total number of new/ eligibility query referrals for quarter	% of new / eligibility assessments initiated within quarter	Total number of eligibility assessments completed within quarter	% of eligibility assessments completed within quarter
Q1	134	17	100%	12	70.58%
Q2	181	18	100%	13	72%
Q3	106	11	100%	8	72%
Q4	**90**	**8**	**100%**	**6**	**75%**
Overall % for the year	511	54	100%	39	72%

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 families 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 2015/2016 we received 975 formal complaints, a reduction of 7% compared to 1,052 complaints in 2014/15.

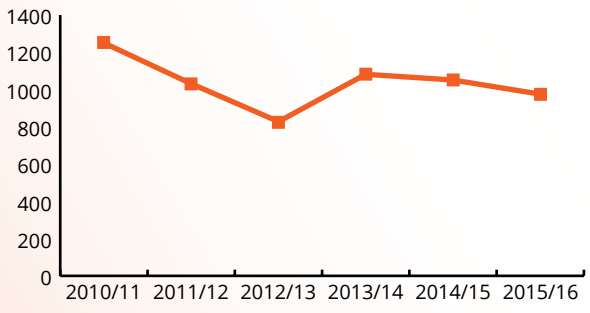
It is very difficult to benchmark complaints against other trusts as there is no uniform way for trusts to record complaints, meaning there is a lot of inconsistency across the NHS.

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.

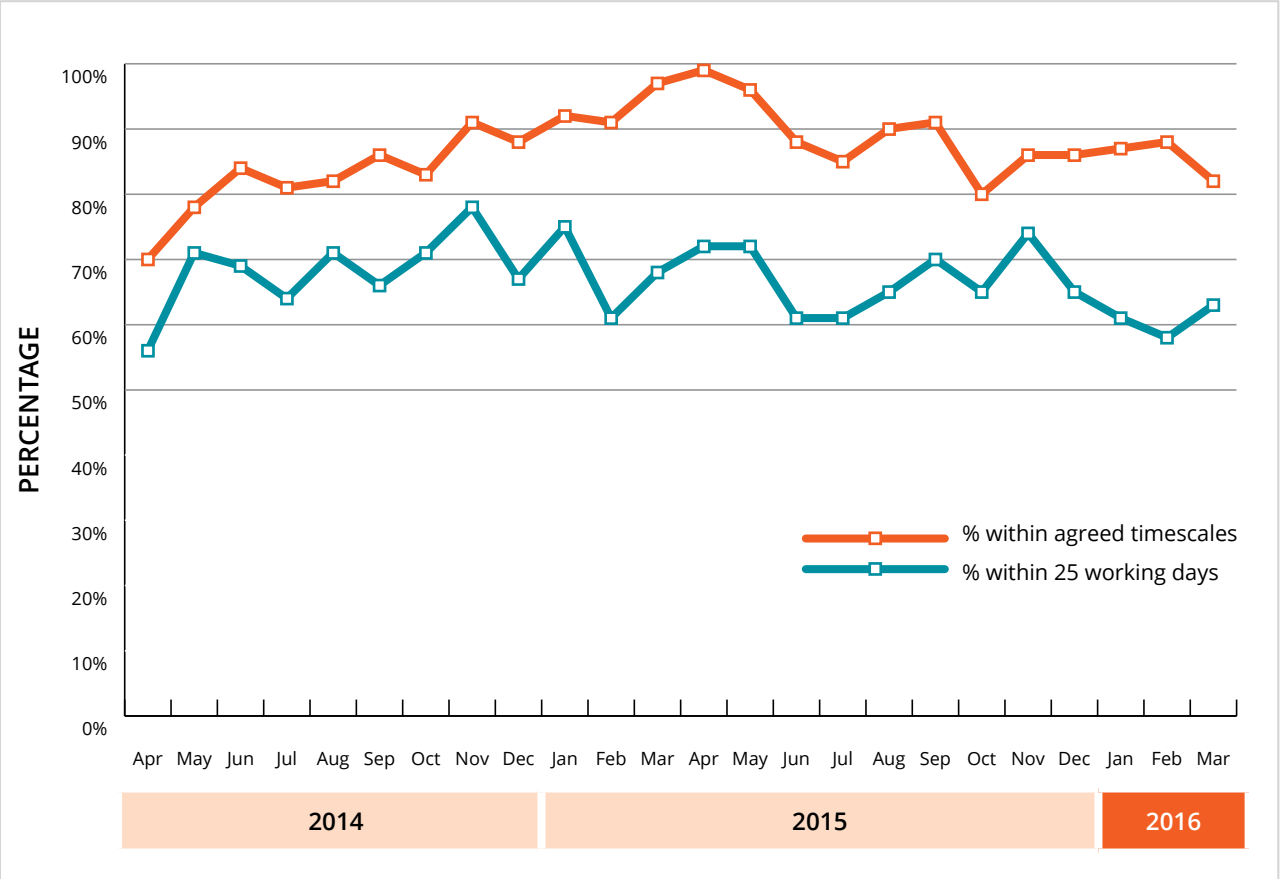
Number of complaints

Year	Number of complaints
2015/2016	975
2014/2015	1052
2013/2014	1083
2012/2013	825
2011/2012	1031
2010/2011	1253

Number of complaints by year



Complaints performance by month



Complaints response rate

We fully responded to 67% of complaints within 25 working days. Our target is that 85% of complaints are fully responded to within 25 working days.

We fully responded to 89% of complaints within 25 working days or an agreed timescale. Our target is that 100% of complaints are fully responded to within 25 working days or an agreed timescale.

The chart below tracks peformance throughout the year. It can be seen that across the year any improvements in performance against the 85% target were not sustained. For complaints received in February 2016 performance dipped below 60% for the first time since April 2014. Action plans have been in place in consistently poorly performing divisions with the aim of improving and delivering performance against internal standards but these are not achieving the desired results. As at May 2016 a new action plan is being developed and this will be presented and monitored at the Quality and Risk Committee in the coming year.

Responding to patients' needs

Why is this important?

Patient experience is a key measure of the quality of care we provide. 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. Every year we take part in the national inpatient survey published by the Care Quality Commission (CQC), as well as others less frequently for A&E, maternity and outpatients. The national inpatient survey is an important indicator of how all NHS trusts in the country are performing, looking at the experiences of more than 70,000 patients each year who were admitted to hospital for at least one night.

In 2013 a new measure was introduced - the Friends and Family Test (FFT).

Friends and Family Test

The Friends and Family Test is a single question asked of patients on discharge about how likely they are to recommend our 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 three years, having been rolled out to A&E and inpatient adult areas for April 2013, maternity in October 2013 followed by outpatient and community services in September 2014.

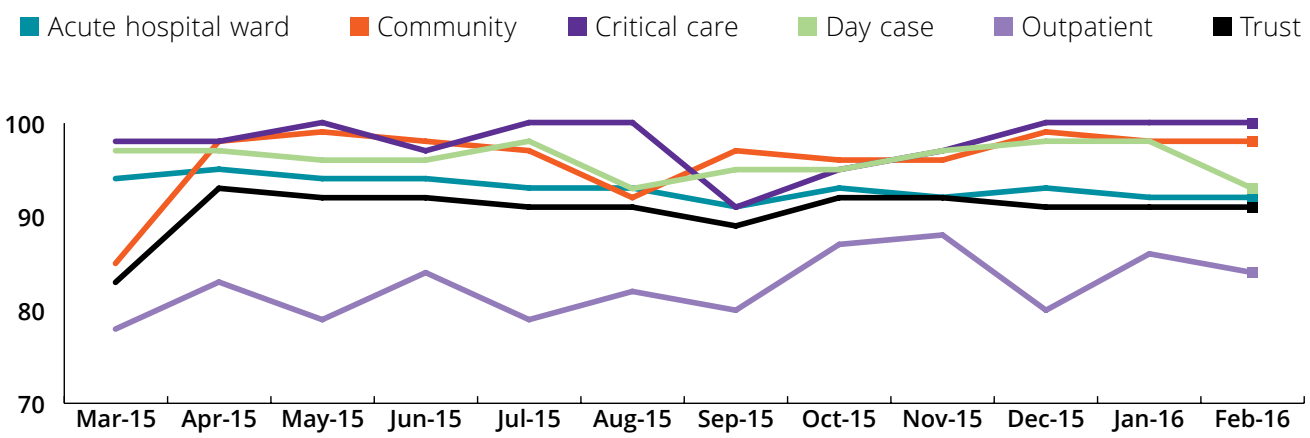
The maternity survey is different from A&E and adult wards as there are four occasions or 'touch points' when women are asked to rate the service (antenatal, birth, postnatal ward and postnatal community) whereas A&E and inpatient adult areas is only once on discharge.

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 below is a summary for the year outlining the additional questions with the percentage relating to positive answers.

Percentage of patients that were "Extremely likely" or "Likely" to recommend the service

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Acute hospital ward	94	95	94	94	93	93	91	93	92	93	92	92
Community	85	98	99	98	97	92	97	96	96	99	98	98
Critical care	98	98	100	97	100	100	91	95	97	100	100	100
Day case	97	97	96	96	98	93	95	95	97	98	98	93
Outpatient	78	83	79	84	79	82	80	87	88	80	86	84
Trust	83	93	92	92	91	91	89	92	92	91	91	91

Percentage of patients that were "Extremely likely" or "Likely" to recommend the service



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 Care Quality Commission has confirmed that the results of the 2015 inpatient survey are under embargo until 8th June, and that this embargo applies to the any document that will be shared outside of the trust before this date, including Quality Accounts.

End of life care

Why is this important?

Providing high quality end of life care services to all patients who are felt to be in the last year of life, continues to be a priority for St George's. This core service currently comprises specialist palliative care input available seven days a week including a rapid discharge service; general palliative care provision from all clinical specialities; a spiritual care team led by chaplaincy; and bereavement and mortuary services. The end of life care programme board was established to take a strategic view of improving this core service in line with the five priorities set out in One Chance to Get It Right (2014), and to recognise that end of life care is everyone's responsibility. The membership of this board has recently been reviewed and an action plan developed to clarify strategic priorities. In order to deliver on this strategic view, a new end of life care operational group was developed to drive through improvements and changes at an operational level.

In recognition of the wider need across the trust for improving end of life care services to all patients in the last year of their life, we're in the process of developing a St George's end of life care strategy. The development of this strategy will include engaging key stakeholders within the trust and ensuring representation at divisional and board level.

What will we do?

Current quality improvements are focused on improving the care of dying adult patients within St George's Hospital and this includes:

- the development of a nursing daily evaluation for patients in the last hours and days of life – education and awareness sessions have accompanied the plan's dissemination
- three cohorts of staff have attended QELCA (Quality End of Life Care for All) training and are sharing their learning with colleagues at St George's, we hope to send an additional three cohorts later this year
- funding has been obtained to run a 'Dying matters' week 9-13th May 2016, to raise awareness of end of life issues with hospital staff, this will coincide with the National 'Dying Matters' events. Mortuary services have had recent approval to fund a £410k project to increase mortuary capacity.

These key issues have been shared with our executive management team and positive contributions by the executive team have been noted, including the appointment of a non-executive with responsibility for end of life care.

The National Care of the Dying Audit 2015/2016 results have been released and St George's is above average on most areas nationally. However we must strive to continue to improve in this area.

Our aims

One of the areas within the audit where the trust needs to improve is in relation to patients' perception about the quality of communication between staff and patients particularly when patients were admitted to the trust.

It is hoped that the introduction of Sage and Thyme (training staff how to listen and respond to patients who are distressed or concerned) will improve general communication skills across the trust and positively impact the National Patient Experience survey.

Sage and Thyme foundation level communication courses are available at St George's. Unfortunately this year we lost 50% of our trained facilitators due to staff leaving the trust. This has meant a reduction in the number of courses being offered and a number of courses being cancelled at short notice. Last year we were able to offer three courses and trained 41 staff across a number of disciplines. We plan to run more courses this year and will hopefully obtain funding to train more facilitators who are outside the palliative care team.

Sexual health in secondary schools

Why is this important?

Supporting young people to grow up with a good knowledge of 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% 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.

Reporting period	Number of young people seen for sexual health advice	Number referred onto sexual health clinics
Q1	18	12
Q2	24	12
Q3	30	17
Q4	39	18

No secondary schools have agreed to the administration of emergency contraception at present.

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.

Clinical outcome measures in community services

As previously reported, it can be very hard to report on clinical outcomes within community services as interventions can extend over a long period of time and care can focus on many different issues. Some services focus not on illness but promoting health and wellbeing. All of these factors can make it hard to measure clinical outcomes in community services and to know when best to do this. 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 2015/16 we have continued to develop our data collection processes to enable us to effectively analyse our community services and see both where we are performing well and where we can make improvements. We have continued to participate in a national programme on community indicator development.

In addition, during 2015/16 we have worked with Wandsworth CCG to jointly develop an outcomes framework for Community Adult Health Services (CAHS). This focus was driven by the recent service redesign to ensure that it provided outcome results.

We set up processes to identify and share 40 patient care plans on a quarterly basis with the CCG as follows:

- 20 joint care plans CAHS/primary care.
- 10 ongoing case management care plans.
- 10 under review/surveillance care plans.

The provision of the 40 anonymised care plans per quarter was to enable CCG-led audits to ensure that appropriate plans are in place and are being followed to allow best outcomes for patients.

This was a developmental piece of work with Wandsworth CCG and we also participated in the evaluation process with the CCG. As a result of the Wandsworth CCG-led audit 'My Wandsworth Shared Care Plan' has been developed by them to support joint care provision for patients on an enhanced care pathway in 2016. The audit process also showed the number of patients with an identified key worker and the extent to which the patient had identified care/treatment goals.

Patient reported outcome 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 trust considers that this data is as described for the following reasons. 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-5DTM 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 (final)		Apr14 – Mar15 (provisional)	
		SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.
Hip replacement (primary)	EQ-5DTM	87.8	87.3	100	89.7	86.4	87.9	87.5	88.3
	EQ-VAS	57.9	63.6	72.2	65.5	65.2	64.2	75.0	65.3
	Specific	93.2	95.7	95.0	97.1	80.8	96.0	100	96.5
Knee replacement (primary)	EQ-5DTM	63.0	78.4	68.8	80.6	60.0	80.3	66.7	80.6
	EQ-VAS	30.0	53.8	53.3	54.9	50.0	54.6	55.6	55.4
	Specific	76.5	91.6	86.7	93.2	80.0	93.0	90.0	92.3
Groin hernia	EQ-5DTM	48.0	49.9	36.4	50.2	37.8	49.7	30.0	49.9
	EQ-VAS	40.2	38.9	32.7	37.7	25.0	37.3	34.1	38.0
Varicose vein	EQ-5DTM	58.2	53.2	48.6	52.7	48.3	51.8	32.4	51.9
	EQ-VAS	50.0	42.0	26.7	40.9	30.4	39.9	36.8	39.2
	Specific	81.5	83.1	79.4	83.3	71.4	82.9	74.3	82.3

Source: Health and Social Care Information Centre
Data notes: Total questionnaire count for survey and procedure type is less than 30.

The latest publication provides provisional data for April 2015 to September 2015. This does not allow us to make comparison to the national picture as the number of completed pre and post-operative questionnaires is too low and is therefore not reflected in the table above.

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 2015/16 and the period is therefore excluded from the table.

Provisional data for 2015/16 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 (final)	Apr14 – Mar15 (provisional)
Hip replacement (primary)	**EQ-5D**	*	*	*	*
	EQ-VAS	*	*	*	*
	Specific	Not outlier	*	*	*
Hip replacement (revision)	**EQ-5D**	-	*	*	*
	EQ-VAS	-	*	*	*
	Specific	-	*	*	*
Knee Replacement (primary)	**EQ-5D**	*	*	*	*
	EQ-VAS	*	*	*	*
	Specific	*	*	*	*
Knee Replacement (revision)	**EQ-5D**	-	*	*	*
	EQ-VAS	-	*	*	*
	Specific	-	*	*	*
Groin hernia	**EQ-5D**	Not outlier	Not outlier	*	*
	EQ-VAS	Not outlier	Negative 95% outlier	Negative 95% outlier	Negative 95% outlier
Varicose vein	**EQ-5D**	Not outlier	Not outlier	Not outlier	Not outlier
	EQ-VAS	Not outlier	Negative 95% outlier	Negative 95% outlier	Negative 95% outlier
	Specific	Not outlier	Negative 99.8% outlier	Negative 95% outlier	Negative 95% outlier

Data notes: ***** *insufficient records*
- *split between primary and revision procedures was not made in 2011/12*
Source: Health and Social Care and Information Centre

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.

	Apr11 – Mar12 (final)		Apr12 – Mar13 (final)		Apr13-Mar14		Apr14-Mar15		Apr15 – Sep15 (provisional)	
	SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.
All procedures	64.5%	74.6%	66.8%	75.5%	77.4%	76.2%	47.1%	75.4%	52.4%	73.1%
Hip replacement	88.2%	82.3%	87.0%	83.2%	137.1%	85.9%	79.4%	85.6%	73.9%	84.1%
Knee replacement	101.7%	89.3%	127.9%	90.4%	137.5%	93.7%	131.6%	94.8%	125.0%	93.4%
Groin hernia	**52.4%**	**60.6%**	**72.1%**	**61.7%**	**69.8%**	**59.9%**	**54.9%**	**58.3%**	**58.6%**	**56.4%**
Varicose vein	68.9%	48.9%	34.3%	44.3%	71.7%	40.5%	30.2%	39.3%	34.4%	31.6%

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.

Our participation rate for the most recent period available (April 2015 to September 2015) is 52.4 per cent, which is below the national average of 73.1 per cent; however, for three of the four procedures our participation rate is above the national average.

The trust has taken the following actions to improve this indicator and so the quality of its services. Local monitoring and regular reporting is in place and whenever a decline in submissions is observed this is addressed with local teams to ensure patients are provided the opportunity to participate. This work will be overseen by the Patient Experience Committee during 2016/17.

Clinical records - driving quality improvement through the use of iCLIP data

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 pre-requisite for holding an operating licence to provide publically 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 by 2018.
- Lord Carter report.

Local drivers:

- Risk management, patient and staff safety.
- Real time reporting.
- Transparency and accountability.
- Aligned with CQUINs (Commissioning for Quality and Innovation) and KPIs (key performance indicators).

How did we do it?

We have deployed electronic clinical documentation and electronic prescribing and medicines management (ePMA) to 44% 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.

Interactive whiteboards

Integrated whiteboards support length of stay management and provide the ability to view the current status of all beds and additional information to support the bed managers in controlling the flow of supply and demand. They also provide a plethora of both demographic and clinical data to inform the clinician and enhance the decision making process, a medications timeline showing past, present and future medications and an events timeline giving access to clinical results: they span across all inpatient locations in the hospital.

Benefits

Enhanced patient safety is the overarching benefit which includes:

- improved access to real-time patient information
- ensuring nursing tasks are completed in a timely manner
- improved patient flow and increased capacity
- reduced length of stay
- improved access to real time clinical information eg early warning scores.

Integrated vital signs monitors

The monitoring devices integrate with the trust-wide acute Electronic Patient Record (EPR) - Cerner Millennium. Vital signs are matched into the patient's clinical record and auto-calculations based on established algorithms (national early warning score - NEWS) are available to provide decision support. Reference text in the electronic record directs the nurse to the NEWS document that codifies the NEWS result and described situation, background, assessment and recommendation (SBAR) communication tool actions.

Benefits

Enhanced patient safety is the overarching benefit which includes:

- keeping the nurse at the bedside whilst 'releasing time to care'
- displays early warning score at the bedside with visual prompt for required escalation
- eliminates the need to transcribe results – saving time and transcription errors
- results are immediately available to clinicians across the trust via the patient's record and on the interactive whiteboard
- eliminates need to access limited number of computers, or move workstations on wheels (WOWs) around with the monitor
- improves the recording of complete sets of observations and correctly scoring the NEWS.

Clinical Exchange Platform (CEP)

Work is progressing to expand the sharing of data between acute, community and primary care through our CEP. So far there is a link established with Wandsworth GPs which gives clinicians in St George's a real time view of data from the GPs. The GPs can also access St George's information from within their EMIS system. Data shared includes certain laboratory results, medications, allergies and discharge summaries.

Benefits

Our local GPs tell us access to patients' hospital records enables them to provide better care for their patients. Including:

- access to hospital records from anywhere (so long as the GPs have the means to access their own clinical system)
- peace of mind that the built-in security and audit trail features allow access to registered patient records only and facilitate monitoring of unauthorised use
- real-time access to a range of information about their patients including appointments, discharge summaries, medications, allergies, diagnostics and problems.

Endorsing results

Endorsement (signing off) of diagnostic test results has always been possible in iCLIP however in 2013/14 the trust had 15 serious incidents where diagnostic tests were not reviewed or followed up in a timely or appropriate manner. Although changes to the way the iCLIP system operates have been introduced to limit endorsement to high risk tests there are still issues with results endorsement. Problems with business processes and incorrect consultant attribution have contributed to this and are being investigated by the data quality board and the associate medical director for transformation.

Benefits

- All radiology and cellular pathology results in a clinician's inbox to be endorsed ensuring the appropriate clinical interventions are actioned in a timely manner.

Offender health

E-drug administration and e-prescribing have been implemented at Wandsworth Prison to enable transmission of drug information between prisons replacing a complex paper process.

Electronic Documentation Management (EDM)

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 relevant information is always available whilst significantly reducing the trust's reliance on paper medical records.

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.

Our aim

In 2016/17 we aim to complete the inpatient deployment of 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
- data captured and data quality.

Reducing hospital readmissions

Why is this important?

An emergency readmission is recorded when a patient has an unplanned re-admission to hospital within 30 days of a previous discharge. 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

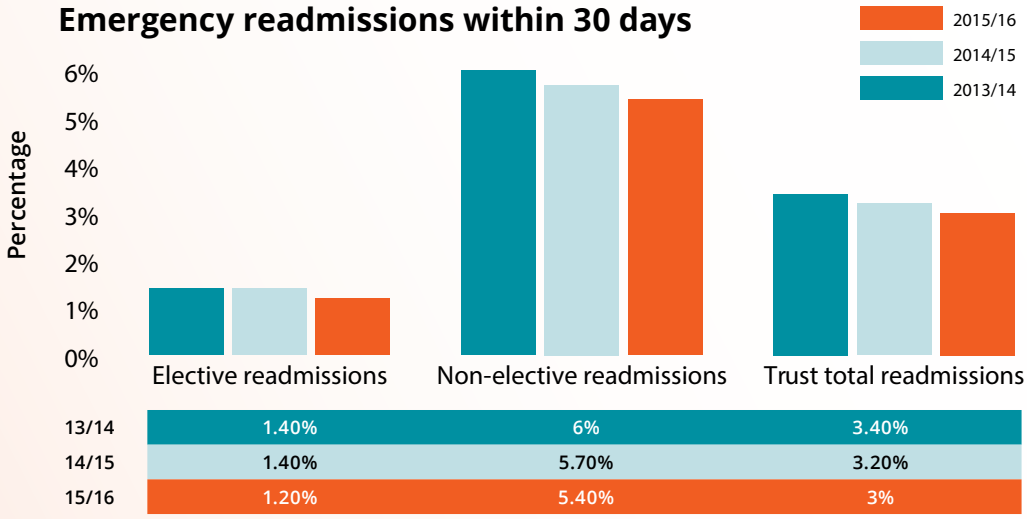
Hospitalisation is costly and re-admissions contribute to that cost however to aim for a readmissions rate of zero is unrealistic and may even indicate poor quality care, as many readmissions are medically appropriate due to an unavoidable change in condition, a medical error, adverse event that occurred during the initial hospitalisation, lack of understanding of discharge instructions, or communication following discharge. These types of avoidable readmissions are those that the trust aims to prevent or reduce.

The quality account refers to emergency readmissions within 30 days rather than Health and Social Care Information Centre compendium indicators' 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 NHS Improvement accountability frameworks.

How did we do?

Reducing emergency readmission remains one of the trusts key priorities and a continued area of focus between St George's, our partners in primary care and local councils. It is a substantial and hugely challenging task given the financial and regulatory constraints, but the potential benefits are enormous to patients.

In 2015/16, 3% of patients were readmitted to hospital within 30 days. In real terms this means that 4459 patients were re-admitted to hospital within 30 days of being discharged from their previous emergency or elective admission. This is an improved position on the previous year when 3.2% of patients were readmitted within 30 days of discharge. **Data to Feb 16*



Elective and emergency readmissions

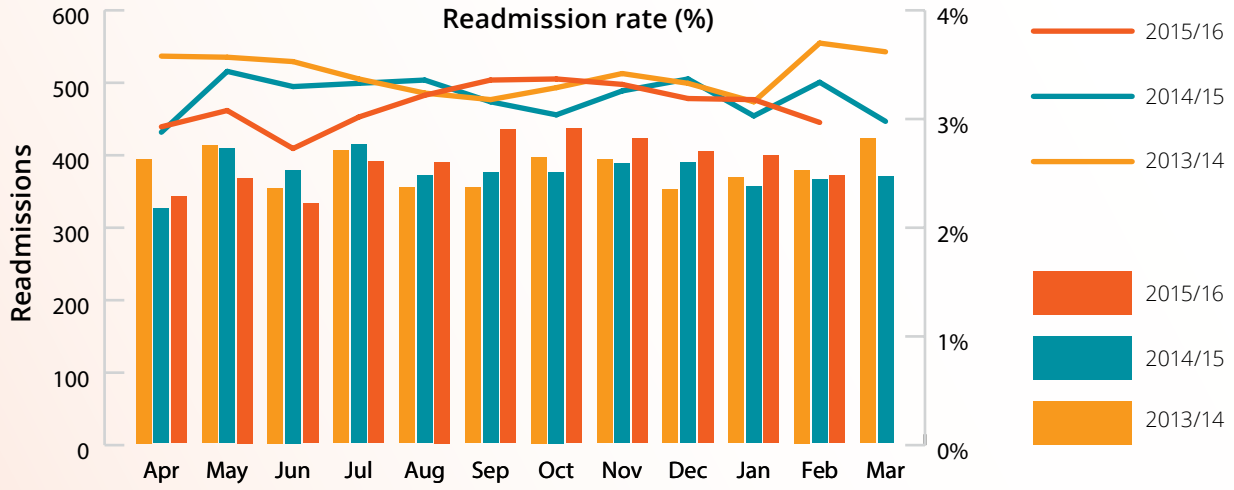
In 2015/16, the trust had 86714 elective admissions compared to 80665 in 2014/15. Despite the increase in admissions the trust saw a reduction in the readmission rate from 1.4% in 2014/15 to 1.2% in 2015/16. For patients admitted for elective care, an important part of this process has been the pre-operative assessment, which has helped to reduce the risk of complications during and following admission.

The number of emergency patients coming to St George's increased in 2014 from 59901 in 2014/15 to 62740 in 2015/16 with the emergency readmission rate reducing from 5.7% in 2014/15 to 5.4% in 2015/16.

St George's considers that this data is as described for the following reasons. St George's Hospital is a regional major trauma centre, hyper-acute stroke unit and heart attack centre and treat seriously ill patients and complex cases from across south west London and Surrey, with some emergency patients coming from as far afield as East Anglia. 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.

A reduction in readmission rates overall reflects the hard work St George's has been doing around trying to ensure that our patients are not discharged before they should. It also highlights our collaborative work with GPs and community services to provide a highly responsive approach to the management of patients with chronic long term conditions in their own homes.

Emergency readmissions within 30 days following an elective admission



Our aim

The trust intends to take the following actions to improve this indicator and so the quality of its services.

In 2016/17 the trust is committed to continuing the reduction in 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. A vital part of this is working collaboratively with community and social services to ensure that services are in place to support patients 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.

Performance table

	Indicator	Target	2014/15	2015/16	2016/17
ACCESS	Referral to Treatment Incomplete	92%	91.33%	90.25%	Specialty level compliance.92% achieved by all specialities
	A&E All Types Monthly Performance	95%	92.14%	90.44%	Improve performance in line with trajectory to achieve 95% target
	62 Day Standard	85%	84.70%	82.50%	Improve performance in line with trajectory to achieve target
	62 Day Screening Standard	90%	91.50%	90.40%	
	31 Day Subsequent Drug Standard	98%	100%	100%	Maintain and continue to improve target
	31 Day Subsequent Surgery Standard	94%	98.50%	96.50%	Maintain and continue to improve target
	31 Day Standard	96%	97.80%	97.00%	Maintain and continue to improve target
	Two Week Wait Standard	93%	95.93%	87.80%	Improve performance in line with trajectory to achieve target
	Breast Symptom Two Week Wait Standard	93%	96.66%	93.40%	
OUTCOMES	Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	38	28	No more than 31 cases of Cdiff during 2016/17
	Incidents of MRSA	0	6	3	Zero MRSA incidents
	Mixed Sex Accomodation	0	16	11	Compliance to achieve the target of zero
	Never Event	0	5	8	No never events in 2016/17
	Mortality	Lower than expected	Lower than expected		Maintain lower than expected mortality rates
	Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Compliant	Yes	Yes	Maintain and continue to improve performance
	Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant	Yes	Yes	
	Referral to treatment- Q4 2015/16	50%	55	56.3	Maintain and continue to improve performance
	Referral Information- Q4 2015/16	50%	88	88.2	
	Treatment Activity- Q4 2015/16	50%	70	70.83	
	Trust Overall Quality Governance Score- Concern Trigger and Under Review			**4**	**Improve our Quality Governance score**

Note: RTT and A&E performance reported is avg YTD for April to March 2015/16 - Cancer performance reported is YTD for April to March 2015/16

Monitor governance thresholds:	
	GREEN: as service perfromance score of >=4.0 or 3 consecutive quarters' breaches of single metric
	Governance concern Trigger and Under Review: a service performance of >=4.0 or 3 consecutive quarters' breaches of single metric monitr undertaking a formal review, with no regulatory action.
	RED: a service performance of >=4.0 or 3 consecutive quarters' breaches of single metric and with regulatory action to be taken.

Note: RTT and A&E performance reported is avg YTD for April to March 2015/16 - Cancer performance reported is YTD for April to March 2015/16

Annex 1: Statements from commissioners, Healthwatch and Overview and Scrutiny Committee

Healthwatch Wandsworth and Healthwatch Lambeth

Introduction

The following comments are submitted on behalf of Healthwatch Lambeth and Healthwatch Wandsworth.

Presentation of report

Two suggestions here. First, to make the report easier to read, could we suggest that a standard format be adopted for each quality indicator, on the lines of:

- why it is important
- the 2015/16 aim/indicator and target
- what we did
- did we meet the target?
- what next?

Some parts of the report are currently formatted in this way, but not others. Second, would it be possible to structure the report so that there is a logical flow to the various sections? The quality indicators (the ten voluntary ones) currently appear in different places, in between statutory reporting, and not always in the same order, so that it was difficult to keep track of them all.

General comments on content

In general, the report confirms our perception that the trust was able to maintain its quality of care over the year 2015/16 despite the considerable pressures it has faced. However, this was possible only because of the continued efforts of staff working beyond what was expected of them. Staffing levels have been relatively protected in the trust, and it is unlikely that they will improve in future. Therefore, the only way in which standards can continue to be maintained, or even improved, is through changes in the ways in which people do their work. This represents a considerable challenge for the coming year and any failure to manage this process well will have serious consequences for patients.

Our impression too is that the trust is also now experiencing the consequences of historic and chronic under-investment in the maintenance and renewal of buildings, equipment and IT infrastructure. This has had a more visible impact on the working experience of the staff to date than on the patient experience, but also affects patients in areas such as the outpatients booking system, and it cannot continue without accumulating negative consequences.

The indications that the trust is keen to involve patients in the re-design of services and facilities are to be welcomed.

Specific comments

Improving patient safety

In order to achieve greater patient safety it is vital that the trust achieves an open and transparent culture of learning and improvement in which staff are encouraged to discuss errors and 'near misses' in a 'no-blame' culture. This does not sit

well with the wording of 'zero tolerance', though we understand and share the underlying ambition this represents. Messages to staff must be clear in promoting a culture in which unsafe practices carried out through ignorance or thoughtlessness can be challenged without blame or unduly negative consequences for staff.

Improving patient experience

The renewed emphasis on listening to patients is welcomed, but it must be recognised that staff need to be given sufficient time in which to listen and to respond appropriately. It must be explicitly acknowledged that this policy will additional require investment in patient-facing staff and this investment needs to be quantified and committed.

We felt also that the wording of this section read somewhat passively: a suggested redraft is annexed.

Tackling poor behaviour and bullying; discrimination

We were disappointed to see no improvement in the numbers of staff reporting that they were experiencing harassment, bullying or abuse since last year. We also noted the disturbing number of staff reporting discrimination, together with a perceived inequality reported by staff from BME backgrounds. That said, the development of a number of strategies and initiatives to tackle this suggests that the trust is taking this issue seriously and we look forward to hearing about your progress.

Reducing patient falls

Despite implementing several interventions to reduce the number of inpatient falls, no improvements have been achieved in 2015/16. Although the trust has an action plan in place to address this, it would be useful to provide a short summary of the learning from the past year to better understand the reasons behind this. Given the importance of this issue and the failure to meet the expected aim, we would suggest that achievements against this indicator are reported again next year.

HMP Wandsworth

We would have liked to see a broader coverage of healthcare services in Wandsworth prison in the report. Healthwatch Wandsworth is planning to engage directly with both prison staff and prisoners in the coming year.

Community learning disability referrals

We commend the trust for its work to provide assessments for people with learning disabilities in the community.

Complaints

This section records details of the timescale in which complaints are responded to. Whilst this needs to be kept to as short a period as reasonable, a much more important measure would be what proportion of complaints were considered as resolved to the satisfaction of the complainant and evidence of learning from complaints such as changes in procedures etc.

Friends and Family Test

This test provides an opportunity to capture more general feedback from patients. We understand that at least in some parts of the trust, patients are given the opportunity to make comments when doing this test. Evidence of the nature of these comments and actions taken beyond the image of the 'word cloud' would be useful (or at least an example of a word cloud from a more challenged area would be informative).

It would also be interesting to know why the trust believes outpatient satisfaction as measured through the test is far lower than in the other services, and what plans are in place to address this.

End of life care

We appreciate that the work on 'end of life' care is in its early stages and will need more time for outcomes to be fully realised. More broadly, a true test of whether these plans and activities have resulted in improvements for the experience of patients can only genuinely be made through sharing feedback from your targeted patients. We would very much welcome more efforts to amplify patient voice here, possibly through the development of patient experience indicators specific to these areas, to be reported in future reports.

In 2014/15 Healthwatch Lambeth noted that we would like to see more emphasis on the views of family and carers and this remains the case.

Clinical outcome measures in community services

We would have welcomed a more substantive report on this. It is not clear what progress was made during the year.

Conclusion

We appreciate the opportunity to comment on this draft, and wish to reiterate our gratitude to the staff of the trust for their dedicated service to the people of Lambeth and Wandsworth.

Dr Clive Norris CB,
Chair, Healthwatch Wandsworth
17/05/16

Healthwatch Merton

Healthwatch Merton is pleased to see that St George's University Hospitals NHS Foundation Trust has performed well across most of its performance indicators and reflects the quality of delivery. We are also happy that the trust has continued tackling the issue of hospital readmissions over the past year and has once again seen a reduction in readmission rates reflecting the hard work done in this area.

It's great to see that St George's has one of the lowest rates of patients acquiring C. difficile whilst under its care in London and has seen a 24% decrease in the last year.

It's also very good to see there has been a significant increase in the number of referrals of people with osteoporosis to early intervention service within the community falls prevention team that is helping reduce fragility fractures.

Notes of caution are the same as we raised in the previous quality account. It is very concerning that a year on one third of staff (identical to a year ago) have once again reported experiencing bullying, harassment and abuse from other staff. Last year we acknowledged the trust had a strategy to tackle this and it would appear this strategy is not quite delivering what it needs to and would ask that St George's fully reviews it and develops a new strategy that has different approaches to hopefully see the number of staff experiencing this reduced in the coming year which would surely benefit all.

On the subject of staff, it is disheartening to read that only 50% would recommend the trust as a place to work and given one of the trust's strategic aims is to be an exemplary employer, we would hope to see an increase in this percentage in the next quality account.

Dave Curtis
Manager, Healthwatch Merton
20/05/2016

Statement from the governors of St George's University Hospitals NHS Foundation Trust

The council of governors is pleased to have the opportunity to comment on the Quality Report.

Firstly, we would like to recognise that it has been a difficult year for St George's and that this report is set against a background of financial instability, which the governors are still seeking clarity and an understanding of, and many changes at board level. In all, this has made it more difficult than it should have been to exercise our statutory duty of holding the non-executive directors to account in terms of quality as well as other aspects of board management. We hope that the coming year will bring some stability, enabling governors to contribute in a more meaningful way.

Governors have welcomed taking part in the internal quality inspections throughout the year and are encouraged that across the trust patients have responded very positively to questions about their care and those who provide it. We have also welcomed the opportunity to observe committee meetings and provide written feedback where appropriate. Members for Medicine talks, the Annual Members Meeting and the recently introduced "Meet the Governors" sessions have all given us the opportunity to hear about quality from a diverse section of the public in a variety of ways. We are pleased that we have been invited to share our views as part of the forthcoming CQC inspection.

We recognise that there is much to do but see the steps that are being taken as positive and shall be considering what we can do as a council to support the new phase that the trust is entering.

Kathryn Harrison
Lead governor
25/05/16

Wandsworth Adult Care and Health Overview Scrutiny Committee

Our statement in the trust's 2014/15 quality account acknowledged the high clinical standard of the trust's services, reflected in the low mortality rates amongst those undergoing treatment at St George's Hospital. It also noted that patient experience of the trust's services, which had consistently been much less satisfactory, was showing signs of improvement, although there were concerns about the trust's performance on measures of access to treatment.

Over the past year, the committee's main concern in relation to St George's has been over the dramatic deterioration in the trust's financial position, and whether this might affect the quality of the services offered. We have yet to be presented with a convincing explanation of the approach the trust will take in prioritising its activities in order to achieve the full savings required without adverse effect on services. We are pleased to note that that the evidence presented in this quality account demonstrates a continuing focus on clinical excellence. However, whilst the mortality rate remains relatively low there appears to have been some deterioration and it is important that reasons for this are explored and addressed.

It is a serious concern that the most recent NHS staff survey shows a sharp deterioration in the morale of staff at St George's. The most recent survey of users of maternity services, published in December 2015, also shows deterioration, reversing some of the gains made in previous years. Whilst we recognise that there are also positive developments on patient experience, with performance on the Friends and Family Test having been maintained and an improvement in the handling of complaints, it is essential that this aspect of the trust's work is a focus of attention in the trust's action to deal with its deficit.

It is also clear that the challenges around access to services remain current, with the continuing failure to meet targets for waiting times from referral to treatment and within accident and emergency, and for adherence to the 62-day standard for cancer. We note that the trust has agreed detailed plans and trajectories for improvement against these targets over the coming year, and we will be monitoring progress against these commitments.

We endorse the commendation of the work of the falls service, which is jointly commissioned by the council with Wandsworth CCG, and forms an important element of our Better Care Fund plan and we note that the council and CCG will be working with St George's over the coming year to review how best to reduce the incidence of falls and fractures in the community.

Finally, we recognise that this is a challenging time for the trust, with a change in leadership and an imminent Care Quality Commission inspection. We are aware that the trust is experiencing difficulties with recruitment and retention of staff, especially in its community services division, and are concerned that the trust should re-establish the strong and stable leadership that is necessary to resolve this. It is important that the pressures the trust faces do not lead to a loss of focus on quality and, especially, the continuing need to improve patient experience of services.

Richard Wiles
Health policy team leader, Wandsworth OSC
16/05/2016

Statement from Wandsworth CCG, Public Health and Surrey Downs

We have consulted with other commissioners in preparing this statement, including from Public Health and Surrey Downs CCG.

The CCG welcomes the trust's commitment to improving quality and specifically to the high level priorities for improvement set out for 2016/17.

We note the continued relatively low mortality rates and the relatively strong performance on harm-free care as measured by the NHS safety thermometer.

The report doesn't address some of the quality challenges the trust has faced in 2015/16, such as the removal of medical training posts from Interventional Radiology and Vascular Surgery (and the subsequent Quality Risk Summit) or the ongoing workforce challenges in community services.

There is no acknowledgement of the quality impact of poor performance against core NHS Constitution standards, in terms of timely patient access to services (ED, cancer, RTT, diagnostics).

The trust has faced and continues to face significant financial challenges, and we will continue to work with the trust to mitigate any impact of addressing these on the quality of services for our patients, including through reviewing the impact of cost improvement programmes.

The priorities for improvement 2016/17 appear aspirational rather than SMART objectives for delivery – we would welcome more detail being presented to the Clinical Quality Review Group.

Sean Morgan
Director of corporate affairs, performance and quality, Wandsworth CCG
25/05/2016

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 2015/16 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 1st April 2015 to 2nd June 2016 and papers relating to quality reported to the board over the period 1st April 2015 to 2nd June 2016
  - feedback from commissioners dated 24/05/2016 - feedback from governors dated 24/05/2016 - feedback from local Healthwatch organisations dated 17/05/2016 - feedback from Wandsworth Overview and Scrutiny Committee dated 16/05/2016 - feedback from Wandsworth CCG dated 24/05/16
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2014/15
  - the latest national patient survey dated 2015 (please note the results are under embargo and cannot be published in this report). The latest national staff survey dated 2015
  - the head of internal audit's annual opinion over the trust's control environment dated 26/05/2016
  - CQC Intelligent Monitoring Report May 2015
- 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.

Simon Mackenzie
Acting chief executive
2nd June

Sir David Henshaw
Chairman
2nd June

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 2015/16, 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.

Title		Relevant	Participating	Submission rate (%) / Comment
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		✓	✓	Ongoing
Adult Cardiac Surgery		✓	✓	Ongoing
Bowel Cancer (NBOCAP)		✓	✓	Ongoing
Cardiac Rhythm Management (CRM)		✓	✓	Ongoing
Case Mix Programme (CMP)		✓	✓	Ongoing
Congenital Heart Disease (CHD) – Adult		✓	✓	Ongoing
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		✓	✓	Ongoing
Diabetes (Paediatric) (NPDA)		✓	✓	100%
Elective Surgery (National PROMs Programme)		✓	✓	Ongoing
Emergency Use of Oxygen		✓	✓	100%
Falls and Fragility Fractures Audit programme	Fracture Liaison Service Database	✓	✓	100%
	Inpatient Falls	✓	✓	100%
	National Hip Fracture Database	✓	✓	100%
Inflammatory Bowel Disease (IBD) programme		✓	✓	>75%
Major Trauma Audit		✓	✓	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	✓	✓	100%
	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	✓	✓	100%
	Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	✓	✓	100%
	Maternal mortality surveillance	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Pancreatitis	✓	✓	100%
	Physical and mental health care of mental health patients in acute hospitals	✓	✓	Ongoing
	Sepsis	✓	✓	100%
	Gastrointestinal Haemorrhage	✓	✓	100%
National Audit of Intermediate Care		✓	x	Difficulty in participation as the Intermediate Service was changing. We will not be participating in 2016 as not relevant to the current structure.

National Cardiac Arrest Audit (NCAA)		✓	✓	Ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary rehabilitation		✓	✓	77%
National Comparative Audit of Blood Transfusion programme	Use of blood in Haematology	✓	✓	100%
	Audit of Patient Blood Management in Scheduled Surgery	✓	✓	100%
National Diabetes Audit - Adults	National Footcare Audit	✓	X	0%
	National Pregnancy in Diabetes Audit	✓	✓	100% of consented women were audited. The consultant lead is seeking to improve the rate of consent.
	National Core	✓	✓	**n = 117** Data was submitted for all patients with an insulin pump, but not for the complete cohort of diabetic patients. A working group has been established to develop an IT solution to allow full participation. Progress with implementation is monitored by the Quality and Risk Committee.
National Emergency Laparotomy Audit (NELA)		✓	✓	**<50%** During the year improved processes have been established to identify relevant patients for the audit
National Heart Failure Audit		✓	✓	Ongoing
National Joint Registry (NJR)	Knee replacement	✓	✓	Ongoing
	Hip replacement	✓	✓	Ongoing
National Lung Cancer Audit (NLCA)		✓	✓	Ongoing
National Prostate Cancer Audit		✓	✓	Ongoing
National Vascular Registry		✓	✓	Ongoing
Neonatal Intensive and Special Care (NNAP)		✓	✓	Ongoing
Oesophago-gastric Cancer (NAOGC)		✓	✓	Ongoing
Paediatric Asthma		✓	✓	100%
Paediatric Intensive Care (PICANet)		✓	✓	Ongoing
Procedural Sedation in Adults (care in emergency departments)		✓	✓	**30%** This audit round the RCEM sample size increased from the usual 50 cases to 100 cases. 30% of data were submitted due to demands on the service.
Renal Replacement Therapy (Renal Registry)		✓	✓	Ongoing
Rheumatoid and Early Inflammatory Arthritis	Clinician/Patient Follow-up	✓	✓	n = 13
	Clinician/Patient Baseline	✓	✓	n = 22
Sentinel Stroke National Audit programme (SSNAP)		✓	✓	Ongoing
UK Parkinson's Audit	Occupational Therapy	✓	X	We did not participate in these elements of the audit due to reconfiguration of the therapies service and a lack of resources
	Speech and Language Therapy	✓	X	
	Physiotherapy	✓	X	
	Patient Management, elderly care and neurology	✓	✓	100% neurology cases
Vital signs in children (care in emergency departments)		✓	✓	**51%** This audit round the RCEM sample size increased from the usual 50 cases to 100 cases.
VTE risk in lower limb immobilisation (care in emergency departments)		✓	✓	**51%** This audit round the RCEM sample size increased from the usual 50 cases to 100 cases

Appendix B:

National clinical audit actions undertaken enquiries

The reports of 16 national clinical audits were reviewed by the provider in 2015/16 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 Audit of Intermediate Care 2014	The intermediate care service is currently being reconfigured as part of the community adult health service redesign. This may affect the classification of some service lines so they may not meet the inclusion criteria as an Intermediate care services in future years.
National Prostate Cancer Audit Report 2014	Results presented by Cancer Network, with St George's included in the South West London network. Data completeness - our network has shown significant improvement, scoring 77% for 2012 compared to 44% in 2006-2008. The national score is 71% in 2012 and 53% in 2006-2008. The trust carried out a self-assessment of current performance against national recommendations and met all those relevant to services provided. High-dose brachytherapy is not available in this trust, however if this is needed, patients are either referred to Royal Marsden or University College Hospital.
National Paediatric Diabetes Audit 2013/14	**1)** Resources: Increased diabetes nurse specialists to 2.5WTE; increased dietician time to 1WTE and also secured 0.6WTE psychology support. Service manager in post to support improved processes of care over appointments and education activities, issuing clinic reminders and HbA1c quality control. Introduced a consultant led formal transition service for 15-19 year olds. **2)** Education: Sessions at home and school, including special sessions for ethnic minorities. **3)** Technology: Changes including pump use, with meter and pump downloads in clinic. Capillary HbA1c testing in clinic with quality control.

National Congenital Heart Disease Audit Report 2011/14	Data submitted to the audit is subjected to rigorous validation comprising site visits by a clinical auditor and clinician. A data quality indicator is calculated, with NICOR's expectation that units will achieve 90 per cent. St George's consistently achieves this standard, with our most recent score being 90.75. Analysis of all hospitals shows an upward trend in survival in the most recent 18 months. St 30 day survival is 100 per cent.
Sentinel Stroke National Audit Programme (SSNAP)	■ Changes have been made to the way bed managers are alerted to ED admissions. ■ Work is in progress developing the stroke nurse role in ED. ■ More information is being added to iClip to minimise the need for paper notes. ■ A 7.15am morning MRI slot had been launched to reduce admissions for MRI. ■ Discussions with local hospitals around improving repatriations are on-going.
British Thoracic Society (BTS) Pleural Procedures Audit 2014	Three national improvement objectives were outlined in the report. ■ Written consent should be taken for greater than 95% chest drains inserted (excluding those placed in an acute emergency) ■ Greater than 95% of chest drains should be placed in a dedicated clean area (procedure room), away from the patient bedside. ■ Patients with chest drains should be nursed on wards with staff specifically trained in chest drain care, in more than 95% of cases. We have a new pleural consultant, a role which will help facilitate any changes needed in order to meet these objectives and to fully contribute to future audits. It is also hoped that this new post will enable management of some of these patients in an out-patient setting.

College of Emergency Medicine - Mental Health in the Emergency Department	■ ED revising mental health risk assessment ■ Reinforcing good clinical documentation is an on-going piece of work in ED, and shall now include emphasis on reporting mental health. Meeting with trainees to discuss documentation. ■ Meeting held between ED and psych liaison team. Liaison team have data showing mean time from referral to being seen was 25 minutes. To improve accuracy of data liaison team have been asked to inform ED co-ordinator when they attend to see a patient ■ Facilities requests have been submitted to make the necessary changes to the assessment room. Requests supported by GM.
College of Emergency Medicine - Assessing for Cognitive Impairment in Older People	■ ED clinical notes to be amended as they currently state that all patients >65 require assessment ■ Information to the GP will require an iCLIP modification so that this information is transferred ■ Further investigation of how information can be given to carers is required and how best practice units are achieving this ■ Nursing input is required to ensure EWS scores are calculated and reported for all patients
National Hip Fracture Database (NHFD) Report 2015	■ Senior health are working with the therapy team to increase one day mobilisation, through dementia and pain assessment training. ■ A new theatre template has been introduced to increase efficiency. As it is the main reason for failure to meet the best practice tariff it is a priority area for improvement. ■ There are now two orthogeriatricians in post and we are achieving 90- 100% medical assessment rates. ■ Quarterly clinical governance presentations, using timely NHFD data to monitor performance and discuss areas of shortfall.

National Audit of Inpatient Falls 2015	■ Falls that result in moderate or severe harm are investigated at a divisional level ■ Replacing stratify tool with a multi-factorial risk assessment tool to be used for all patients at risk of falling. ■ Introduction of new tool to be supported by concurrent training and audited once embedded. ■ Conducting a bed rail audit.
MBRRACE-UK - Perinatal Mortality Surveillance Report Recommendations	Self-assessment conducted against national recommendations, found compliance with all but one relevant item relating to the offer of post-mortems. An audit will be conducted to explore reasons why post-mortem may not be offered and to design actions accordingly.
PICANet (Paediatric Intensive Care Audit Network) – November 2015 Annual report	Recommendations were made for commissioners and providers. Locally, actions are in place to improve our position in relation to staffing. The unit continue to recruit band 5 and 6 staff. External recruitment of Band 6 staff has proven challenging, therefore the unit are trying to grow their own staff by training and developing them.
National COPD Audit Programme: Resources and organisation of Pulmonary Rehabilitation services in England and Wales 2015	Overall we provide a robust service compliant with all the quality standards set out by the BTS. However, the overall number of referrals both nationally and locally is low compared to the number of patients who are likely to benefit from PR and the figure for the uptake of assessments by patients referred is just 69% (this is both the national figure and that for SGH) although the reason for this is not clear. Given the proven benefits of a PR service the report recommends that the pathway is reviewed and enhanced. The local results suggest that we also look at ways to encourage patients to complete their PR. To commissioners it is recommended that steps are taken to ensure providers have a clear, long-term funding framework that will allow programmes to recruit and retain staff with an appropriate skill and seniority mix, this is already in place for SGH and we are currently recruiting permanent staff members.

National Vascular Registry 2015 Annual Report	For indicators where it is possible to compare performance at St George's with overall results we are performing better than the national average. At St George's we are largely compliant and no specific areas have been highlighted for action by the vascular care group.
National Pregnancy in Diabetes Audit 2014	■ Contacted the national project team and HQIP (Healthcare Quality Improvement Partnership) to request local unit reports (with or without benchmarking) to inform local action planning. ■ Improved processes for consenting women to increase the number of cases submitted by St George's. The numbers of women consenting to participate has substantially improved on the first year.
National Head and Neck Cancer Audit 2014	Eight measures were identified and the trust scores were above the national and London Cancer Alliance (LCA) scores for seven. One measure which relates to patient seen by CNS prior to first treatment by MDT scored 50.8% which is lower than the national score (62.9%) and London Cancer Alliance score (61.3%). Discussion is currently on going as to the reasons for this and how to improve. ■ MDT to encourage all clinicians to refer patients to the CNS team as early in the pathway post diagnosis as possible. ■ CNS access to and contemporaneous entry onto Infoflex must be a priority. ■ If patients get diagnosis and treatment plan the same day and go to RMH (Royal Marsden) for first definitive treatment the SGH CNS's do not get to see the patients in clinic as they see the RMH doctors. In this instance the presence of the RMH CNS in the H&N clinic at St George's to register the patients as seen here prior to transfer for RT/CRT.

**Based on information available at the time of publication*

Appendix C:

Local clinical audit actions undertaken

The reports of fourteen local clinical audits were reviewed by the provider in 2015/16 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*
Pressure Ulcer Prevention (PUP) Audit	In total, 334 patients were audited across the trust. Assessment documentation was checked for 329 patients and 73.6% of these had an up to date assessment form, this represents a small decrease from the previous audit. All patients audited were on a pressure relieving mattress, 87% had a repositioning chart, and this was fully completed in an average of 71% of cases, which is an increase from previous audits. Communication sheets (giving ongoing information) were in progress for 35.25% of patients but only 19 (6%) had been given a patient information leaflet. Overall the audit showed that there are pockets of excellent care but also areas where improvements are required. Results were considered alongside details of PU incidents and PU training. Planned actions to facilitate improvements include targeted reviews of the wards where there appears to be most room for improvement and a recheck of some wards where there may be some lesser issues.
Venous Access Device Re-Audit 2014/15	VAD device training is currently being reviewed and practice educators plan to be attend team study days to provide this training. A section about VAD management training is to be included in the Infection control MAST training by end of May 2015.
IV Administration Audit 2014	Recommendations include using existing educational and management forums to increase knowledge of the policy and design of an e-learning tool to promote on going learning and updates of knowledge.

Protected mealtimes, nutrition and hydration audit, March – May 2015	Local action plans developed in accordance with ward results. Wards are required to enforce protected mealtimes and challenge colleagues accordingly. Ward sisters and matrons to review practice to ensure that there is a robust approach to nutritional screening and support, including the use of red trays.
Trust-wide Consent Re-Audit 2014/15	■ Legibility needs to be addressed and adoption of name stamps is recommended. ■ Divisions have received divisional analysis to facilitate local discussion and action planning. ■ The legal services manager will include a summary of the key areas for action as part of a presentation on consent to the STNC division. ■ Associate medical director for governance to recruit a new lead to help drive recommendations and implement action plans.
WHO Surgical Checklist Audit 4th Quarter 2014/15	■ Report circulated to clinical governance leads and findings presented at theatre care group meeting for discussion. ■ Support to be given to three specialties with the lowest results to understand the issues they face and help improve compliance. ■ Clinical lead to visit best performing areas to congratulate them and gain insight into their successful processes, which can then be shared. ■ Focus on improvements to time-out checks, with target of 100% compliance at next audit round. ■ Matrons and team leaders to discuss findings with their local teams. ■ Surgeons and anaesthetists to collect data for quarter 1 2015/16.

Healthcare Records Audit Report Q1 2015/16	■ Local action will be required to improve standards and to this end care group results are available alongside the trust level report ■ A number of measures have been recommended at trust level, particularly around the improved access to patient labels, use of clinician name stamps, patient identification stickers and dividers in ward ring folders. Where the audit revealed that there is no access to a working label printer this has been reported to divisions for local resolution.
End of Life Discharge Home Service Report	The end of life discharge service demonstrated an increased demand in the year 2014/15, and achieved a high number of patients discharged to their PPC/PPD. The palliative care team are working more closely with the ward discharge coordinators and there are proposed changes to the hospital discharge team to help fast track patients. The team are trialling a system of one CNS focusing just on fast tracks for a week at a time to provide better continuity.
Tissue Handling Audit (HTA) 2015	■ Patients encouraged to fully complete the consent form, indicating consent or refusal to all the use of tissue in diagnosis and audit, teaching and research. ■ Recommended staff are formally trained and competency assessed by implementing a training schedule to cover all activities, including information regarding legal requirements. ■ Theatre matrons to schedule regular teaching sessions and presentations. ■ All new staff should be supervised to promote adherence to the protocols and SOPs, ensuring clinical competence. ■ All the SOPs and quarantine procedures for autologous tissues are to be reviewed by the theatre team.
Safe and Secure Handling of Medicines Annual Audit	■ Local actions were taken at the time of completing the audit and further actions are informed by considering detailed local results and feedback. ■ At an organisational level a number of actions are agreed to improve the audit process, thereby providing a full picture of performance and identifying best and poor practice.

Controlled Drugs Check & Stock Audit Quarter 2 2015/16	Pharmacists carried out local education and training of ward staff as issues were identified during the audit process. Furthermore, divisional reports including targeted action plans will be presented at the DGB meetings. In some areas ward pharmacists have identified the need for CD training, to include how to order CDs, entering CDs into registers and calculating the amount of medication required. A training package is being piloted on General Medicine wards in Quarter 3 to address these issues.
Healthcare Records Audit Report Q3 2015/16	The clinical audit department hope to create a report in PIEDW (iCLIP) by which to audit the quality of electronic documentation in those areas that use iClip. This is dependent on training and the format of the electronic record. Standard of documentation as reported by this audit and other data to be considered when formulating the Quality Improvement Strategy for 2016/17.
WHO Surgical Checklist Audit 3rd Quarter 2015/16	■ Peer review audit will be undertaken in the next audit round (4th quarter). ■ This information will be included in the new theatre efficiency project led by Martin Wilson (Director for Transformation) ■ To continue circulating the results to Theatres Care Group and Governance leads.
Controlled Drugs Check & Stock Audit, Quarter 3 2015/16	■ Pharmacists carried out local education and training of ward staff as issues were identified during the audit process. Corrective action was also taken at the time of the audit and this has been reported to divisions for ongoing support. ■ Where pharmacists have identified the need for CD training, to include how to order CDs, entering CDs into registers and managing stock held, mini training sessions are being held to address these issues.

**Based on information available at the time of publication*

Independent Practitioner's Limited Assurance Report to the Council of Governors of St George's University Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of St George's University Hospital NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in Annex 2 to Chapter 7 of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to the limited assurance engagement consist of those national priority indicators as mandated by Monitor:

- RTT – percentage of incomplete pathways over 18 weeks **(page 174)**
- A&E – percentage of unplanned A&E attendances that were admitted, discharged or transferred within 4 hours from attendance **(page 174)**

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the Council of Governors and Practitioner

The Council of Governors are responsible for the content and the preparation of the Quality Report covering the relevant indicators and in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2015/16' issued by Monitor and 'Detailed guidance for external assurance on quality reports 2015/16.

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
- 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 2015/16; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16, 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 2015 to 2 June 2016
- Papers relating to quality reported to the

Board over the period 1 April 2015 to 2 June 2016

- Feedback from Commissioners dated 24 May 2016
- Feedback from Governors dated 24 May 2016
- Feedback from local Healthwatch organisations dated 17 May 2016
- Feedback from Overview and Scrutiny Committee dated 16 May 2016
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2014/15
- The national patient survey dated 2015;
- The national staff survey dated 2015;
- Care Quality Commission Intelligent Monitoring Report dated May 2015;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 26 May 2016; and
- Any other information obtained during our limited assurance engagement.

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.

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

We have complied with the independence and other ethical requirements of the Code of Ethics for Professional Accountants issued by the International Ethics Standards Board for Accountants, which is founded on the fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. 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 Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospital 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 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and St George's University Hospital 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 indicators back to supporting documentation
- comparing the content requirements of the

'NHS Foundation Trust Annual Reporting Manual 2015/16' to the categories reported in the Quality Report; and

- reading the documents.

The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement and consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

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 thereof, 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 2015/16'.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by St George's University Hospital NHS Foundation Trust.

Our audit work on the financial statements of St George's University Hospital NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as St George's University Hospital NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospital NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to St George's University Hospital NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of St George's University Hospital NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than St George's University Hospital NHS Foundation Trust and St George's University Hospital NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

The Trust was unable to provide patient-level populations to support the reported indicator figures in the Quality Report for both of the mandated indicators. We were unable to obtain assurance over the completeness of the datasets provided for audit.

The indicator reporting the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways' did not meet all six dimensions of data quality for the following reasons:

- the trust was unable to provide comprehensive listings of pathways at patient level which were consistent with the numerator and denominator of the indicator as reported in the Quality Report; and

- we identified 4 cases in our testing of 25 cases where it was not possible to agree the duration of the pathway to supporting information provided by the Trust.

Because of the extent of the data accuracy errors, we have not been able to obtain sufficient assurance against the six dimensions of data quality for this indicator.

The indicator reporting the 'percentage of unplanned A&E attendances that were admitted, discharged or transferred within 4 hours from attendance' did not meet all six dimensions of data quality for the following reasons:

- the Trust was unable to provide comprehensive listings of A&E attendances at patient level which were consistent with the numerator and denominator of the indicator as reported in the Quality Report; and
- we identified 5 cases in our testing of 25 cases where it was not possible to agree the time of admission, discharge or transfer reflected in the indicator to the supporting records.

Because of the extent of the data accuracy errors, we have not been able to obtain sufficient assurance against the six dimensions of data quality for this indicator.

Qualified conclusion

Based on the results of our procedures, with the exception of the matters reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the Criteria;
- the Quality Account is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16'; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

Grant Thornton UK LLP
Chartered Accountants
London
3rd June 2016

Remuneration report

Annual statement on remuneration

The trust has two remuneration committees, one dealing with executive pay and appointments and the other with non-executive directors.

The board of directors' nominations and remuneration committee membership includes the Chairman and all non-executive directors. The head of corporate governance 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 head of corporate governance.

There have been no substantial decisions regarding remuneration during 2015/16.

Remuneration policy 2015/16

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.

The trust has maintained a policy of spot rates for executive director remuneration based on publicly available benchmark data and market data available through search companies. The trust is paying at median or below median market rates for its executive director group. Remuneration has been reviewed annually against the available data and in the context of any national pay awards.

In 2015/16 the trust appointed five new executive directors:

- turnaround director
- interim chief operating officer
- interim chief financial officer
- interim director of estates and facilities
- transformation director.

For each new appointment the committee agreed remuneration levels against available benchmarked information.

Senior managers are paid on Agenda for Change pay scales or medical terms and conditions. Senior managers' salaries, benefits and pension entitlements are published in the trust's annual

report. The trust policy on loss of office is in accordance with Agenda for Change terms and conditions.

There are no obligations on the trust which are contained in any senior managers' service contract which could give rise to, or impact on, remuneration payments or payments for loss of office.

Chairman and non-executive directors

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 the 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 remuneration should be set 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, eg 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 2015/16

Governor	Constituency	14/1/16	3/3/16
Ed Crocker	Public Governor	**N**	**N**
Kathryn Harrison	Public Governor	**Y**	**Y**
Mia Bayles	Public Governor	**Y**	**Y**
Fran Gibson	Appointed Governor	**Y**	**N**
Hilary Harland	Public Governor	**Y**	**Y**
Philip Jones	Appointed Governor	**Y**	**Y**
Hilary Rattue	Staff Governor	**N**	**N**
Felicity Merz	Staff Governor	**Y**	**Y**
Jenni Doman	Staff Governor	**Y**	**N**
Anneke de Boer	Public Governor	**Y**	**Y**
J-P Van Besouw	Staff Governor	**N**	**N**
Sue Baker	Public Governor	**Y**	**Y**
Christopher Smallwood	Chairman	**Y**	**Y**

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 some of 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 2015/16, in particular with regards to the emergency department four-hour standard, the national two-week wait and 62-day cancer standards and the referral to treatment (RTT) incomplete pathways within 18-week standard. These are all on-going priority areas for the trust and are regularly reviewed with commissioners as part of system resilience and the trust is proactively engaging with Monitor about actions being taken to improve performance against these targets.

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 (RAF).

From August 2015 Monitor implemented an update to the RAF requiring foundation trusts to assign a financial sustainability risk rating (FSRR) to their current financial performance, to replace the existing continuity of service rating (COSR). The FSRR includes the liquidity and capital servicing capacity metrics of the COSR, supplemented by two new metrics. The trust is required to calculate the income and expenditure margin (the degree to which the organisation is operating at a surplus/deficit) and variance from plan in relation to the income and expenditure margin (the variance between the organisation's plan and its actual margin).

An overview of the assessment is as follows:

2015/16	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	1	2	2	2	2
Financial sustainability risk rating	1	2	2	2	2
Governance rating		Under review	Under review	Under review	Red

In 2015/16 Monitor investigated financial sustainability concerns at the trust, triggered by deterioration in the trust's financial and performance position and formal regulatory action was undertaken in two areas. This included an enforcement undertaking and additional license requirements. The trust submitted a reforecast plan for 2015/16 on 20th November and a two-year recovery plan to 2016/17 by the end of December 2015. The trust also received a regulatory notice to appoint Sir David Henshaw as interim Chair on 15th March which was enacted. Full details of the regulatory notices can be found on the Gov.uk website.

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.

Salary and pension entitlements of senior managers

A) Remuneration and Pension disclosure is based on 12 months figures

Note 1

Andrew Burn held the position of turnaround director from June 2015 to March 2016. No payments were made to Mr Burn directly but the trust paid KPMG LLP £532k under a wider consultancy contract which included the provision of the services of a turnaround director during this period.

Note 2

Sir David Henshaw's expenses for March 2016 are estimated as no information was available at the time this report was approved.

Note 3

Professor Jennifer Higham's salary is estimated as no recharge had been received from her own organisation in respect of her duties as a non-executive director at the time this report was approved.

A) Remuneration and pension disclosure is based on 12 months figures

Name	Job title	Period	2015/16						2014/15					
			Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
Executive directors			(bands of £5000) £000	total to nearest £00	(bands of £5000) £000	(bands of £5000) £00	(bands of £2,500) £000	(bands of £5.000) £000	(bands of £5000) £000	total to nearest £00	(bands of £5000) £000	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5.000) £000
Mr Miles Scott	Chief executive		225-230	0	0	0	282.5-285	**505-510**	35-40		0		10-12.5	**45-50**
Mr Steve Bolam	Chief financial officer and deputy chief executive	left 12th February 2016.	150-155	0	0	0	175-177.5	**325-330**	25-30		0		10-12.5	**35-40**
Mr Iain Lynam	Chief financial officer	from 15th February 2016	25-30	0	0	0		**25-30**						
Mrs Alison Robertson	Chief nurse and director of Operations (left June 2014)	left June 2014							0		0		0-2.5	**0-2.5**
Dr Rosalind Given-Wilson	Medical director	left December 2014							0		0		0	**0.00**
Mr Andrew Burn (Note 1)	Turnaround director	June - March 2016	Note 1					**Note 1**						
Ms Wendy Brewer	Director of human resources and organisational development		120-125	0	0	0	170-172.5	**290-295**	20-25		0		7.5-10	**30-35**
Dr Trudi Kemp	Director of strategic development	left September 2014							0		0		30-32.5	**30-35**
Mr Neal Deans	Director of estates and facilities	left June 2014							20-25		0		0	**20-25**
Mr Peter Jenkinson	Director of corporate affairs	left 24th November 2016	75-80	0	0	0	85-87.5	**160-165**	15-20		0		5-7.5	**25-30**
Ms Jennie Hall	Chief nurse and director of infection prevention control	from June 2014	135-140	0	0	0	222.5-225	**360-365**	20-25		0		25-27.5	**45-50**
Dr Simon Mackenzie	Medical director	from January 2015	195-200	0	0	0	325-327.5	**520-525**	30-35		0		0	**30-35**
Mr Eric Munro	Director of estates and facilities	from June 2014	115-120	0	0	0	5-7.5	**120-125**	20-25		0		2.5-5	**25-30**
Mr Martin Wilson	Director of delivery and improvement	from August 2014	120-125	0	0	0	77.5-80	**200-205**	20-25		0		15-17.5	**35-40**
Mr Rob Elek	Director of strategy	from February 2015	115-120	0	0	0	92.5-95	**210-215**	15-20		0		5-7.5	**25-30**
Ms Paula Vasco-Knight	Chief operating officer	from October 2015	175-180					**175-180**	0				0	
Mr Richard Hancock	Director of estates, facilties and capital projects	from March 2016	15- 20					**15-20**	0				0	
Non-executive directors														
Mr Christopher Smallwood	Chairman	left 31st January 2016	40-45	0	0	0		**40-45**	0-5		0		0	**0-5**
Sir David Henshaw (Note 2)	Chairman	from 16th March 2016	5-10	0-5				**5-10**						
Ms Sarah Wilton	Non-executive director and acting Chair	Acting Chair 1st February to 15th March	15-20	0	0	0		**15-20**	0-5		0		0	**0-5**
Mr Michael Rappolt	Non-executive director		5-10	0	0	0		**5-10**	0-5		0		0	**0-5**
Dr Judith Hulf	Non-executive director	left 31st January 2016	5-10	0	0	0		**5-10**	0-5		0		0	**0-5**
Professor Peter Kopelman	Non-executive director	left 31st January 2016	0-5	0	0	0		**0-5**	0-5		0		0	**0-5**
Professor Jennifer Higham (Note 3)	Non-executive director	from 1st November 2015	0-5					**0-5**					0	
Ms Kate Leach	Non-executive director		10-15	0	0	0		**10-15**	0-5		0		0	**0-5**
Ms Stella Pantelides	Non-executive director		10-15	0	0	0		10-15	0-5		0		0	0-5

Simon Mackenzie
Acting chief executive
2nd June

Nigel Carr
Chief financial officer
2nd June

St George's University Hospitals NHS Foundation Trust payroll 2015/16

Multiples table	
Payroll costs	434,527.0
Whole time equivelant	8,527.0
Median	30.8
Highest paid employee	258.7
Median will fit into highest	8.40 times

The median pay multiples table expresses the salary of the highest paid employee as a factor of the median salary paid for all employees.

In 2015/16 the highest paid employee of the trust was paid 8.4 times the median average salary of all employees.

B) Pension Benefits based on 12 months figures

Name and job title	Period	2015/16							2014/15						
		Real increase in pension at age 60	Real increase in pension and related lump sum at age 60	Total accrued pension at age 60 at 31 March 2016	Lump sum at aged 60 related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2016	Real Increase in Cash Equivalent Transfer Value 31 March 2016	Cash Equivalent Transfer Value at 31 March 2015	Real increase in pension at age 60	Real increase in pension and related lump sum at age 60	Lump sum at aged 60 related to accrued pension at 31 March 2015	Total accrued pension at age 60 at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real Increase in Cash Equivalent Transfer Value 31 March 2015
		(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Mr Miles Scott, chief executive		0	0	70-75	210-215	1,220	0	1,213	2.5 to 5	10 to 12.5	210 to 215	70 to 75	1,213	1,136	77
Mr Steve Bolam, chief financial officer	left 12th February 2016	2.5-5	15-17.5	40-45	130-135	681	69	605	2.5 to 5	10 to 12.5	115 to 120	35 to 40	605	546	59
Mr Iain Lynam, chief financial officer	from 15th February 2016						0	0							
Mrs Alison Robertson, chief nurse and director of operations	left June 2014								0 to 2.5	0 to 2.5	175 to 180	55 to 60	1,027	1,021	6
Dr Rosalind Given-Wilson, medical director	left December 2014								0	0	0.00	0.00	0	1,792	0
Ms Wendy Brewer, director of human resources and organisational development		2.5-5	10-12.5	40-45	125-130	873	67	796	0 to 2.5	7.5 to 10	115 to 120	35 to 40	796	731	65
Dr Trudi Kemp, director of strategic development	left September 2014								7 to 10	30 to 32.5	115 to 120	35 to 40	1	555	0
Mr Neal Deans, director of estates & facilities	left June 2014								0 to 2.5	0	0	0	0	0	0
Mr Peter Jenkinson, director of corporate affairs	left 24th November 2016	0	0	20-25	60-65	346	0	344	0 to 2.5	5 to 7.5	60 to 65	20 to 25	344	307	37
Ms Jennie Hall, chief nurse and director of infection prevention control	from June 2014	0	0	55-60	165-170	986	0	910	5 to 7.5	25 to 27.5	190 to 195	60 to 65	1,112	974	138
Dr Simon Mackenzie, Medical Director	from January 2015	15-17.5	62.5-70	80-85	245-250	1,659	357	1285-1290	0 to 2.5	0	0	0	0	0	0
Mr Eric Munro, director of estates and facilities	from June 2014	0	0	5-10	0	69	1	68	0 to 2.5	2.5 to 5	0	5 to 10	68	38	30
Mr Martin Wilson, director of delivery and improvement,	from August 2014	0-2.5	5-7.5	15-20	55-60	249	21	226	2.5 to 5	15 to 17.5	50 to 55	15 to 20	226	179	47
Mr Rob Elek, Director of Strategy	from February 2015	0-2.5	7.5-10	20-25	65-70	412	45	362	0 to 2.5	5 to 7.5	60 to 65	20 to 25	362	329	362

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangementwhen 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.

The remuneration report was approved by the board of directors on 26th May 2016 and signed on its behalf by Simon Mackenzie, acting chief executive, and Nigel Carr, chief financial officer.

Simon Mackenzie
Acting chief executive
2nd June

Nigel Carr
Chief financial officer
2nd June

Summary Financial Report

Foreword to the accounts

These accounts, for the year ended 31 March 2016, have been prepared by St George's University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Simon Mackenzie
Acting chief executive
2nd June

Statement of comprehensive income

		2015/16	2014/15
	Note	£000	£000
Operating income from patient care activities	3	621,590	105,315
Other operating income	4	129,363	14,131
Total operating income from continuing operations		**750,953**	**119,446**
Operating expenses	5, 7	(795,002)	(124,474)
Operating surplus/(deficit) from continuing operations		**(44,049)**	**(5,028)**
Finance income	10	89	92
Finance expenses	11	(4,256)	(583)
PDC dividends payable		(6,899)	(1,282)
Net finance costs		**(11,066)**	**(1,773)**
Surplus/(deficit) for the year from continuing operations		**(55,115)**	**(6,801)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	13	-	-
Surplus/(deficit) for the year		**(55,115)**	**(6,801)**
Other comprehensive income			
Total other comprehensive income		**-**	**-**
Will not be reclassified to income and expenditure:			
Impairments	6	-	-
Revaluations	17	(1,182)	-
Share of comprehensive income from associates and joint ventures	18	-	-
Other recognised gains and losses		-	(60)
Remeasurements of the net defined benefit pension scheme liability/asset	34	-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments	18	-	-
Recycling gains/(losses) on available-for-sale financial investments	10	-	-
Total other comprehensive income/(expense) for the period		**(56,297)**	**(6,861)**

The comparative figures for 2014/15 relate to the two month period ended 31 March 2015 because the trust assumed foundation trust status on 1 February 2015.

Statement of financial position

		31 March 2016	31 March 2015
	Note	£000	£000
Non-current assets			
Intangible assets	14	17,420	17,713
Property, plant and equipment	15	319,783	312,561
Trade and other receivables	21	10,202	10,784
Other assets	22	11	11
Total non-current assets		**347,416**	**341,069**
Current assets			
Inventories	20	6,238	7,157
Trade and other receivables	21	69,935	64,438
Cash and cash equivalents	25	7,395	24,178
Total current assets		**83,568**	**95,773**
Current liabilities			
Trade and other payables	26	(99,314)	(90,728)
Borrowings	29	(6,357)	(5,329)
Provisions	31	(144)	(602)
Total current liabilities		(105,815)	(96,659)
Total assets less current liabilities		**325,169**	**340,183**
Non-current liabilities			
Borrowings	29	(131,315)	(86,034)
Provisions	31	(1,424)	(1,181)
Total non-current liabilities		**(132,739)**	**(87,215)**
Total assets employed		**192,430**	**252,968**
Financed by			
Public dividend capital		129,520	133,761
Revaluation reserve		100,178	101,360
Other reserves		1,150	1,150
Income and expenditure reserve		(38,418)	16,697
Total taxpayers' equity		**192,430**	**252,968**

Simon Mackenzie
acting chief executive
2nd June

Statement of changes in equity

Statement of changes in equity for the year ended 31 March 2016

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**133,761**	**101,360**	**1,150**	**16,697**	**252,968**
Surplus/(deficit) for the year	-	-	-	(55,115)	**(55,115)**
Revaluations	-	(1,182)	-	-	**(1,182)**
Public dividend capital received	359	-	-	-	**359**
Public dividend capital repaid	(4,600)	-	-	-	**(4,600)**
Taxpayers' and others' equity at 31 March 2016	**129,520**	**100,178**	**1,150**	**(38,418)**	**192,430**

Statement of Changes in Equity for the year ended 31 March 2015

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2014 - restated	**-**	**-**	**-**	**-**	**-**
At start of period for new FTs	**133,312**	**101,740**	**1,150**	**23,178**	**259,380**
Surplus/(deficit) for the year	-	-	-	(6,801)	**(6,801)**
Other recognised gains and losses	-	(380)	-	320	**(60)**
Public dividend capital received	**449**	**-**	**-**	**-**	**449**
Taxpayers' and others' equity at 31 March 2015	**133,761**	**101,360**	**1,150**	**16,697**	**252,968**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increase in asset value arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of cash flows

The comparative figures for 2014/15 relate to the two month period ended 31 March 2015 because the trust assumed foundation trust status on 1 February 2015.

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(44,049)	(5,028)
Non-cash income and expense:			
Depreciation and amortisation	5.1	22,303	3,681
(Gain)/loss on disposal of non-current assets	5.1	791	-
Income recognised in respect of capital donations	4	(741)	(20)
(Increase)/decrease in receivables and other assets		(4,915)	(6,783)
(Increase)/decrease in inventories		919	685
Increase/(decrease) in payables and other liabilities		8,964	655
Increase/(decrease) in provisions		(215)	(129)
Other movements in operating cash flows		-	(29)
Net cash generated from/(used in) operating activities		**(16,943)**	**(6,968)**
Cash flows from investing activities			
Interest received		89	13
Purchase of intangible assets		(24)	(39)
Purchase of property, plant, equipment and investment property		(25,596)	(3,313)
Sales of property, plant, equipment and investment property		150	150
Receipt of cash donations to purchase capital assets		633	20
Investing cash flows of discontinued operations		-	30
Net cash generated from/(used in) investing activities		**(24,748)**	**(3,139)**
Cash flows from financing activities			
Public dividend capital received		359	449
Public dividend capital repaid		(4,600)	-
Movement on loans from the Department of Health		44,729	17,966
Movement on other loans		(932)	1,109
Capital element of finance lease rental payments		(2,788)	-
Capital element of PFI, LIFT and other service concession payments		(867)	(483)
Interest paid on finance lease liabilities		(225)	(34)
Interest paid on PFI, LIFT and other service concession obligations		(2,974)	(505)
Other interest paid		(895)	-
PDC dividend paid		(6,899)	(3,898)
Net cash generated from/(used in) financing activities		**24,908**	**14,604**
Increase/(decrease) in cash and cash equivalents		**(16,783)**	**4,497**
Cash and cash equivalents at 1 April		**24,178**	**-**
Cash and cash equivalents at start of period for new FTs		**-**	**19,681**
Cash and cash equivalents at 31 March	**25.1**	**7,395**	**24,178**

1. Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the FT ARM which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

It is a requirement of IAS 8, para 30 that when the foundation trust has not applied a new IFRS that has been issued but is not yet effective. The trust will be subject at a future date to IFRS 9 and IFRS 15.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern

These accounts have been prepared on a going concern basis. IAS 1 has been adapted for the public sector in that accounts are prepared on going concern basis if services will continue.

The trust incurred a deficit of £55.1 million for the year ended 31 March 2016. During the year the trust secured an interim revenue support facility with the Independent Trust Financing Facility for £48.7m and had drawn down £40.4m from this facility by 31 March 2016.

The board has reviewed the proposed 2016/17 plan throughout its development from November 2015 to date. The 2016/17 plan is for a deficit of £17.2m having taken account of the underlying financial position going into 2016/17. The trust has access to further borrowing totalling £33.3m comprising £8.3m from an interim revenue support facility and £25m from a working capital facility which is sufficient to finance the trust for the year provided the £17.2m planned deficit is not exceeded. There are significant risks to the planned deficit from delivering both the planned activity and the transformation savings. Given these risks, the trust is requesting access to further Department of Health borrowing facilities to provide adequate liquidity headroom.

At the time these financial statements were prepared the trust was engaged in discussions with the regulator regarding the financial plan for 2016/17 and the arrangements to access further borrowing facilities however these discussions had not concluded at the time the financial statements were approved. Although these factors represent a material uncertainty that may cast significant doubt about the trust's ability to continue as a going concern, the directors, having made appropriate enquiries, 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 2015/16, 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 were unable to continue as a going concern.

1.1 Interest in other entities

The trust does not have any subsidiaries and in not part of any joint ventures so IAS 28 paragraph IN8 is not applicable.

1.2 Income

Income 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 income for the trust is contracts with commissioners in respect of health care services. Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on 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 annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme:

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 practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment. "

1.4 Expenditure on other goods and services

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

1.5 Expenditure on employee benefits

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.

Measurement

Valuation:

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at current value.

Land and buildings used for the trust's services or for the administratiive purposes are stated in the statement of financial position at their revalued amounts, being the current 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. Current 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. The trust has applied the alternative site method for the 2015/16 valuation of land. Further detail of this change in land valuation is provided in note 1.6

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 current 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 current 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 off and charged to operating expenses.

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Finance leases:

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 also the private finance initiative (PFI) contract. See paragraphs 1.16 Leases and 1.17 PFI Transactions.

Land valuation:

The trust has updated the valuation of its land and buildings in these financial statements. The valuation report was prepared by an independent valuer, Gerald Eve LLP, a firm of professionally qualified valuers. The valuation is effective from 31 March 2016.

The trust has changed the basis of the valuation of the land on the St George's Hospital site to an alternative site basis. This alternative site basis applies the principle of the modern equivalent asset (MEA) valuation methodology which values land and buildings at the cost that would be incurred if they had to be replaced. The valuation methodology allows the use of feasible alternative sites to value the land required to locate the trust's buildings and still serve the same local population. Gerald Eve LLP have identified an alternative site in Merton and have formulated a valuation for the land using relevant valuation metrics. The trust considers that the Merton site identified by the valuer as the alternative site for valuation purposes is reasonable and consistent with the provision of the services from the current location as it is near the St George's Hospital site in Tooting.

The applicable valuation principles make clear that where specialised buildings eg hospital facilities are involved and re-provision of buildings on the existing site would represent a waste of economic resources then a feasible lower cost site may be valued as an alternative. The trust is satisfied the assumptions underpinning the valuation of the St George's Hospital site on the alternative site basis in these financial statements is reasonable and consistent with the principles of the alternative site valuation method.

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 - note 1.5 and note 15.1
- Intangible assets - paragraph 1.7 and note 14.1
- Provision for impairment of receivables - note 21.2
- Provisions - note 1.16 and note 31.1.

Revenue figures have been adjusted for the impairment of receivables. The trust has made an appropriate, prudent provision for impairment of debts past their due date according to their age and assessment of their collectability.

1.7 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 amortised historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 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

Property, plant and equipment is depreciated as follows:

- Medical equipment is in general depreciated over 5, 10 or 15 years.

- Buildings (excluding dwelling) asset lives range from 3 years to 100 years.
- Plant and machinery asset lives range from 1 year to 25 years
- Transport equipment asset lives range from 5 years to 7 years.
- Information technology assets range from 5 years to 25 years.

Intangible assets are amortised as follows:

The trust applies a range of useful economic lives to intangible assets depending on the expected operational life of the software and associated capitalised development costs. Cerner-related software and development costs are amortised over 10-12 years in accordance with the expected duration of the main Cerner contract. Other software is amortised for 5-7 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

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.

1.9 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.

1.10 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.

1.11 Non-current assets held for sale

Non-current assets eg land and buildings which the trust has plans to sell are disclosed in the accounts under this category. The trust does not have any assets within this category as at 31 March 2016.

1.12 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.

Finance leases are valued in accordance with the applicable accounting standards at the lower of fair value (normally purchase cost) and the net present value of the lease rentals.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at current 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.

Note 1.13 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.

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 current value

in accordance with the principles of IAS 17. Subsequently, the assets are measured at current 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 (eg 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.

1.14 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.

Note 1.15 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 three 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.

Note 1.16 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 3.5%.

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.

Note 1.17 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 31.2.

Note 1.18 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.

1.19 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.

1.20 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.

1.21 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.

1.22 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.

Finance leases are valued in accordance with the applicable accounting standards at the lower of fair value (normally purchase cost) and the net present value of the lease rentals.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.23 Value added tax (VAT)

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. Note 1.24 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 25.2 to the accounts.

1.25 Public dividend capital (PDC)

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. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) 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.

1.26 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).

1.27 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 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 -25.8%
- Kingston NHS Foundation Trust - 27.5%
- St George's University Hospitals NHS Foundation Trust - 46.7%.

South West London Pathology is not a separate vehicle for the three trusts, making this a joint operation as defined by IFRS11. As host organisation , the trust accounts for all the income and expenditure for South West London Pathology on a gross basis.

2. Operating segments

This note is not applicable to for St George's University NHS Foundation 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 47% of the trust revenue with a further 35% 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.

3. Operating income from patient care activities

3.1 Income from patient care activities (by nature)

	2015/16	2014/15
	£000	£000
Acute Trusts		
Elective income	97,239	16,611
Non elective income	120,125	20,520
Outpatient income	90,433	15,448
A&E income	17,137	2,927
Other NHS clinical income	198,190	33,857
NHS England and CCGs		
Community services income from CCGs and NHS England	87,644	14,972
Community services income from other commissioners	2,609	369
All trusts		
Additional income for delivery of healthcare services	4,600	-
Private patient income	3,613	611
Total income from activities	**621,590**	**105,315**

3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2015/16	2014/15
	£000	£000
CCGs and NHS England	592,421	76,540
Local authorities	10,939	167
Department of Health	(103)	-
Other NHS foundation trusts	872	18
NHS trusts	911	27,182
NHS other	1,263	(289)
Non-NHS: private patients	3,613	611
Non-NHS: overseas patients (chargeable to patient)	2,276	210
NHS injury scheme (was RTA)	3,689	835
Non NHS: other	1,109	41
Additional income for delivery of healthcare services	4,600	-
Total income from activities	**621,590**	**105,315**
Of which:		
Related to continuing operations	621,590	105,315

The comparative figures for 2014/15 relate to the two month period ended 31 March 2015 because the trust assumed foundation trust status on 1 February 2015.

3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2015/16	2014/15
	£000	£000
Income recognised this year	2,276	210
Cash payments received in-year	155	62

4. Other operating income

This note is not applicable to for St George's University NHS Foundation 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 47% of the trust revenue with a further 35% 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.

	2015/16	2014/15
	£000	£000
Research and development	5,348	(2,151)
Education and training	42,011	8,151
Receipt of capital grants and donations	2,235	-
Charitable and other contributions to expenditure	685	141
Non-patient care services to other bodies	45,832	7,031
Support from the Department of Health for mergers	-	-
Profit on disposal of non-current assets	-	-
Reversal of impairments	-	-
Rental revenue from operating leases	-	-
Rental revenue from finance leases	-	-
Amortisation of PFI deferred credits	-	-
Income in respect of staff costs where accounted on gross basis	26,794	-
Other income	6,458	959
Total other operating income	**129,363**	**14,131**
Of which:		
Related to continuing operations	129,363	14,131
Related to discontinued operations	-	-

4.1 Income from activities arising from commissioner requested services

	2015/16	2014/15
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	620,865	105,071
Income from services not designated as commissioner requested services	126,518	14,375
Total	**747,383**	**119,446**

4.2 Profits and losses on disposal of property, plant and equipment

The trust disposed of property plant and equipment assets with net book value of £941k and received sale proceeds for some equipment of £150k. Therefore the loss on disposal for the year of asset disposals was £791k.

The comparative figures for 2014/15 relate to the two month period ended 31 March 2015 because the trust assumed foundation trust status on 1 February 2015.

5.1 Operating expenses

		RESTARTED
	2015/16	2014/15
	£000	£000
Services from NHS foundation trusts	6,154	541
Services from NHS trusts	888	143
Services from CCGs and NHS England	256	113
Services from other NHS bodies	79	-
Purchase of healthcare from non NHS bodies	8,405	1,126
Purchase of social care	-	-
Employee expenses - executive directors	2,549	191
Remuneration of non-executive directors	117	12
Employee expenses - staff	482,999	77,226
Supplies and services - clinical	92,252	15,530
Supplies and services - general	16,682	2,699
Establishment	4,807	982
Research and development	75	(106)
Transport	6,457	195
Premises	32,480	5,806
Increase/(decrease) in provision for impairment of receivables	578	-
Inventories written down	425	1
Drug costs	-	1,484
Inventories consumed	68,595	8,017
Rentals under operating leases	17,288	3,085
Depreciation on property, plant and equipment	19,688	3,109
Amortisation on intangible assets	2,615	572
Audit fees payable to the external auditor		
audit services- statutory audit	58	54
other auditor remuneration (external auditor only)	-	12
Clinical negligence	14,384	1,654
Loss on disposal of non-current assets	791	-
Legal fees	592	(33)
Consultancy costs	6,467	514
Internal audit costs	153	153
Training, courses and conferences	1,706	433
Patient travel	694	897
Car parking & security	2	52
Redundancy	441	-
Publishing	637	59
Insurance	387	3
Other services, eg external payroll	-	24
Losses, ex gratia and special payments	29	3
Other	5,272	(77)
Total	**795,002**	**124,474**
Of which:		
Related to continuing operations	795,002	124,474

The figures for 2014/15 have been restated to re-classify rentals payable to NHS Property Services Ltd of approximately £2.9m from premises costs to rentals under operating leases.

The comparative figures for 2014/15 relate to the two month period ended 31 March 2015 because the trust assumed foundation trust status on 1 February 2015.

5.2 Other auditor remuneration

		2 MONTHS
	2015/16	2014/15
	£000	£000
Other auditor remuneration paid to the external auditor:		
Other non-audit services	-	12
Total	**-**	**12**

5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2014/15: £2m).

6. Impairment of assets

There were no impairments in 2015/16 or 2014/15.

7. Employee benefits

		2015/16	2 MONTHS 2014/15
	Other	Total	Total
	£000	£000	£000
Salaries and wages	-	-	61,455
Social security costs	-	-	5,208
Employer's contributions to NHS pensions	-	-	6,608
Pension cost - other	-	-	3
Agency/contract staff	31,540	31,540	7,107
Total gross staff costs	**31,540**	**31,540**	**80,381**
Recoveries in respect of seconded staff	-	-	(1,691)
Total staff costs	**31,540**	**31,540**	**78,690**
Of which			
Costs capitalised as part of assets	-	-	1,273

7.1 Retirements due to ill-health

During 2015/16 there were five early retirements from the trust agreed on the grounds of ill-health (one in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £236k (£172k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - pensions division.

7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2015/16	2014/15
	£000	£000
Salary	**2162**	**178**
Taxable benefits	0	-
Performance related bonuses	**0**	**0**
Employer's pension contributions	**505**	**25**
Total	**2,667**	**203**

Further details of directors' remuneration can be found in the remuneration report.

8. 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.

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 14.3% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

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% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. The employer contributions rate increased to 14.3% with effect from 1 April 2015.

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 AVC's run by the scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

9. Operating leases

Foundation trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where St George's University Hospitals NHS Foundation Trust is the lessee.

		RESTARTED
	2015/16	2014/15
	£000	£000
Operating lease expense		
Minimum lease payments	17,288	3,085
Contingent rents	-	-
Less sublease payments received	-	-
Total	**17,288**	**3,085**

	31 March 2016	31 March 2015
	£000	£000
Future minimum lease payments due:		
not later than one year;	17,288	14,452
later than one year and not later than five years;	69,122	9,687
later than five years.	17,288	-
Total	**103,698**	**24,139**
Future minimum sublease payments to be received	-	-

The trust has operating leases for the use of accommodation to operate clinical facilities at a number of properties managed by NHS Property Services Company Ltd (NHSPS). The most significant operating lease with NHSPS is for the space occupied at Queen Mary's Roehampton for which the trust pays NHSPS approximately £13.1m pa. The leases are subject to annual review and renewal.

In addition the trust has operating leases for office equipment including computers and photocopiers and also for some vehicles with a number of different lessors. These operating leases are for 3-5 years and may be extended on agreement with the lessor as necessary. The trust incurred operating lease expenditure of £1.2m for these leases in 2015/16.

The trust's leases with NHSPS are subject to annual review and renewal and therefore the amount disclosed above as payable later than 5 years is equivalent to one year's rental.

10. Finance income

Finance income represents interest received on assets and investments in the period.

	2015/16	2014/15
	£000	£000
Interest on bank accounts	89	13
Fair value gains / (losses) on other financial assets held at fair value through the income and expenditure	-	79
Recycling of gains / (losses) on available for sale financial instruments	-	-
Other	-	-
Total	89	92

11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2015/16	2014/15
	£000	£000
Interest expense:		
Loans from the Department of Health	819	31
Commercial loans	238	13
Overdrafts	-	-
Finance leases	225	31
Main finance costs on PFI and LIFT schemes obligations	2,974	505
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**4,256**	**580**
Other finance costs	-	-
Total	**4,256**	**580**

11.2 The late payment of commercial debts (interest) Act 1998

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2015/16	2014/15
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

12. Corporation tax

The trust is not liable for corporation tax.

13. Discontinued operations

There are no discontinued operations to report in 2015/16 or 2014/15.

14.1 Intangible assets - 2015/16

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**1,204**	**25,712**	**26,916**
Valuation/gross cost at start of period for new FTs	**-**	**-**	**-**
Additions	24	108	**132**
Reclassifications	-	2,190	**2,190**
Gross cost at 31 March 2016	1,228	28,010	**29,238**
Amortisation at 1 April 2015 - brought forward	**601**	**8,602**	**9,203**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Provided during the year	181	2,434	**2,615**
Amortisation at 31 March 2016	**782**	**11,036**	**11,818**
Net book value at 31 March 2016	**446**	**16,974**	**17,420**
Net book value at 1 April 2015	**603**	**17,110**	**17,713**

The trust applies a range of useful economic lives to intangible assets depending on the expected operational life of the software and associated capitalised development costs.

Cerner-related software and development costs are amortised over 10-12 years in accordance with the expected duration of the main Cerner contract. Other software is amortised for 5-7 years.

14.2 Intangible assets - 2014/15

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	-	-	-
Gross cost at 1 April 2014 - restated	-	-	-
Gross cost at start of period for new FTs	1,165	24,513	25,678
Transfers by absorption	-	-	-
Additions	39	-	39
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	-	1,199	1,199
Valuation/gross cost at 31 March 2015	1,204	25,712	26,916
Amortisation at 1 April 2014 - as previously stated	-	-	-
Amortisation at 1 April 2014 - restated	-	-	-
Amortisation at start of period for new FTs	572	8,059	8,631
Transfers by absorption	-	-	-
Provided during the year	29	543	572
Disposals / derecognition	-	-	-
Amortisation at 31 March 2015	601	8,602	9,203
Net book value at 31 March 2015	603	17,110	17,713

15.1 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	63,932	216,912	25,047	100,707	144	27,305	13,484	447,531
Valuation/gross cost at start of period as FT	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	-	22,143	9,078	-	2	-	31,223
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	18,384	(23,393)	488	-	1,799	532	(2,190)
Revaluations	(15,971)	14,789	-	-	-	-	-	(1,182)
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Disposals/derecognition	-	(235)	(480)	(2,158)	-	-	(12)	(2,885)
Valuation/gross cost at 31 March 2016	47,961	249,850	23,317	108,115	144	29,106	14,004	472,497
Accumulated depreciation at 1 April 2015 - brought forward	-	30,926	-	76,226	144	18,551	9,123	134,970
Depreciation at start of period as FT	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	11,538	-	6,003	-	1,425	722	19,688
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Disposals/derecognition	-	(88)	-	(1,849)	-	-	(7)	(1,944)
Accumulated depreciation at 31 March 2016	-	42,376	-	80,380	144	19,976	9,838	152,714
Net book value at 31 March 2016	47,961	207,474	23,317	27,735	-	9,130	4,166	319,783
Net book value at 1 April 2015	63,932	185,986	25,047	24,481	-	8,754	4,361	312,561

Additions of property, plant and equipment in 2015/16 include £2.2m funded by donated capital grants.

15.2 Property, plant and equipment - 2014/15

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	-	-	-	-	-	-	-	-
Prior period adjustments	-	-	-	-	-	-	-	-
Valuation/gross cost at 1 April 2014 - restated	-	-	-	-	-	-	-	-
Valuation/gross cost at start of period as FT	63,932	211,830	24,817	100,608	144	27,275	13,327	441,933
Transfers by absorption	-	-	-	-	-	-	-	-
Additions-purchased/ leased/ grants/donations	-	-	6,691	1,051	-	-	7	7,749
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	5,082	(6,461)	-	-	30	150	(1,199)
Revaluations	-	-	-	-	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Disposals /derecognition	-	-	-	(952)	-	-	-	(952)
Valuation/gross cost at 31 March 2015	63,932	216,912	25,047	100,707	144	27,305	13,484	447,531
Accumulated depreciation at 1 April 2014 - as previously stated	-	-	-	-	-	-	-	-
Prior period adjustments	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2014 - restated	-	-	-	-	-	-	-	-
Depreciation at start of period as FT	-	29,273	-	76,123	144	18,145	8,998	132,683
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	1,653	-	925	-	406	125	3,109
Disposals/derecognition	-	-	-	(822)	-	-	-	(822)
Accumulated depreciation at 31 March 2015	-	30,926	-	76,226	144	18,551	9,123	134,970
Net book value at 31 March 2015	63,932	185,986	25,047	24,481	-	8,754	4,361	312,561
Net book value at 1 April 2014	-	-	-	-	-	-	-	-

15.3 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned	46,946	139,704	22,827	13,485	-	9,066	2,642	**234,670**
Finance leased	-	-	-	12,422	-	-	412	**12,834**
On-SoFP PFI contracts and other service concession arrangements	-	54,091	-	-	-	-	727	**54,818**
PFI residual interests	-	-	-	-	-	-	-	**-**
Government granted	-	1,791	-	442	-	-	36	**2,269**
Donated	1,015	11,888	490	1,386	-	64	349	**15,192**
NBV total at 31 March 2016	**47,961**	**207,474**	**23,317**	**27,735**	**-**	**9,130**	**4,166**	**319,783**

15.4 Property, plant and equipment financing - 2014/15

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned	62,917	124,100	25,047	14,604	-	8,581	2,563	**237,812**
Finance leased	-	-	-	8,312	-	127	507	**8,946**
On-SoFP PFI contracts and other service concession arrangements	-	46,127	-	-	-	-	851	**46,978**
PFI residual interests	-	-	-	-	-	-	-	**-**
Government granted	-	1,799	-	649	-	-	46	**2,494**
Donated	1,015	13,960	-	916	-	46	394	**16,331**
NBV total at 31 March 2015	**63,932**	**185,986**	**25,047**	**24,481**	**-**	**8,754**	**4,361**	**312,561**

16. Donations of property, plant and equipment

The trust has recognised capital donations receivable towards the cost of the refurbishment of its neo-natal unit and also various items of medical equipment. These donations are receivable from the St George's Hospital Charity, Benjamin Weir Trust and First Touch charities.

17. Revaluations of property, plant and equipment

In 2015/16 the trust commissioned a valuation of its land and buildings by an independent valuer, Gerald Eve LLP, a firm of professionally qualified valuers. The effective date of the revaluation was 31 March 2016 and the results of the valuation are included in these accounts. The valuations were prepared on the modern equivalent asset (MEA) basis applicable to NHS trusts.

The trust has changed the basis of the valuation of the land on the St George's Hospital site to an alternative site basis. This alternative site basis applies the principle of the modern equivalent asset (MEA) valuation methodology which values land and buildings at the cost that would be incurred if they had to be replaced. The valuation methodology allows the use of feasible alternative sites to value the land required to locate the trust's buildings and still serve the same local population. Gerald Eve LLP have identified an alternative site in Merton and have formulated a valuation for the land using relevant valuation metrics. The trust considers that the Merton site identified by the valuer as the alternative site for valuation purposes is reasonable and consistent with the provision of the services from the current location as it is near the St George's Hospital site in Tooting.

Buildings are subject to composite depreciation rates according to their elemental breakdown eg substructure 80 years, internal wall 25 years etc.

- Medical equipment is in general depreciated over 5, 10 or 15 years.
- Buildings (excluding dwelling) asset lives range from 3 years to 100 years.
- Plant and machinery asset lives range from 1 year to 25 years
- Transport equipment asset lives range from 5 years to 7 years.
- Information technology assets range from 5 years to 25 years.

There is no compensation from third parties for assets impaired, lost or given up that is included in the trust's deficit for the year.

18.1 Investments - 2015/16

The trust has no investment property in 2015/16 or 2014/15.

19. Disclosure of interests in other entities

The trust does not have any subsidiaries and is not part of any joint venture.

20. Inventories

	31 March 2016	31 March 2015
	£000	£000
Drugs	1,510	1,799
Consumables	4,676	5,306
Energy	52	52
Total inventories	**6,238**	**7,157**

Inventories recognised in expenses for the year were -£66,803k (2014/15: -£10,483k).

Write-down of inventories recognised as expenses for the year were -£425k (2014/15: -£1k).

21.1 Trade receivables and other receivables

The trust has no investment property in 2015/16 or 2014/15.

		RESTARTED
	31 March 2016	31 March 2015
	£000	£000
Current		
Trade receivables due from NHS bodies	48,443	31,793
Receivables due from NHS charities	280	365
Other receivables due from related parties	1,880	1,303
Capital receivables	-	-
Provision for impaired receivables	(4,348)	(4,790)
Deposits and advances	-	-
Prepayments (non-PFI)	-	3,933
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	245	11,821
Interest receivable	-	-
Other receivables	23,435	20,013
Total current trade and other receivables	**69,935**	**64,438**

Other receivables (current) includes general debtors £8.4m, injury cost recovery debt £2.8m, overseas patient debt £4m, private patient debt £1.9m and local authority debt of £1.9m.

Non-current		
Other receivables - revenue	10,202	10,784
Total	**10,202**	**10,784**

2014/15 figures have been restated to provide a split of non-current and current receivables. The non-current receivables relate to the injury cost recovery scheme.

21.2 Provision for impairment of receivables

The trust has no investment property in 2015/16 or 2014/15.

	2015/16	2014/15
	£000	£000
At 1 April as previously stated	**4,790**	**-**
Prior period adjustments	-	-
At 1 April - restated	**4,790**	**-**
At start of period for new FTs	**-**	**4,991**
Transfers by absorption	-	-
Increase in provision	578	-
Amounts utilised	(1,020)	(201)
Unused amounts reversed	-	-
At 31 March	**4,348**	**4,790**

Bases of impairment: age and collectability

21.3 Analysis of impaired receivables

The trust has no investment property in 2015/16 or 2014/15.

	31 March 2016		31 March 2015	
	Trade receivables	Other receivables	Trade receivables	Other receivables
	£000	£000	£000	£000
Ageing of impaired receivables				
0 - 30 days	571	-	57	-
30-60 Days	395	-	133	-
60-90 days	281	-	145	-
90- 180 days	628	-	516	-
Over 180 days	3,179	-	6,608	-
Total	**5,054**	**-**	**7,459**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,450	-	1,928	-
30-60 Days	893	-	1,447	-
60-90 days	840	-	989	-
90- 180 days	1,943	-	3,195	-
Over 180 days	13,229	-	7,887	-
Total	**18,355**	**-**	**15,446**	**-**

22. Other assets

	31 March 2016	31 March 2015
	£000	£000
Net pension scheme asset	-	-
Other assets	11	11
Total	**11**	**11**

23. Other financial assets

There were no other financial assets in 2015/16 or 2014/15.

24.1 Non-current assets for sale and assets in disposal groups

There were no non-current assets for sale in 2015/16 or 2014/15.

24.2 Liabilities in disposal groups

	31 March 2016	31 March 2015
	£000	£000
Categorised as:		
Provisions	-	-
Trade and other payables	-	-
Other	-	-
Total	**-**	**-**

25.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2015/16	2014/15
	£000	£000
At 1 April	**24,178**	**-**
Prior period adjustments	-	-
At 1 April (restated)	**24,178**	**-**
At start of period for new FTs	**-**	**19,681**
Transfers by absorption	-	-
Net change in year	(16,783)	4,497
At 31 March	**7,395**	**24,178**
Broken down into:		
Cash at commercial banks and in hand	(331)	944
Cash with the Government Banking Service	7,725	23,234
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**7,395**	**24,178**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**7,395**	**24,178**

25.2 Third party assets held by the NHS foundation trust

St George's University Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016	31 March 2015
	£000	£000
Bank balances	-	-
Monies on deposit	14	18
Total third party assets	**14**	**18**

26.1 Trade and other payables

	31 March 2016	31 March 2015
	£000	£000
Current		
Receipts in advance	-	-
NHS trade payables	10,364	15,513
Amounts due to other related parties	-	-
Other trade payables	61,573	48,719
Capital payables	2,934	3,476
Social security costs	5,118	4,612
VAT payable	-	-
Other taxes payable	4,896	4,654
Other payables	9,989	9,731
Accruals	4,440	4,023
PDC dividend payable	-	-
Total current trade and other payables	**99,314**	**90,728**

There were no non-current payables in 2014/15 or 2015/16.

26.2 Early retirements in NHS payables above

	31 March 2016	31 March 2016	31 March 2015	31 March 2015
	£000	Number	£000	Number
The payables note above includes amounts in relation to early retirements as set out below:				
to buy out the liability for early retirements over 5 years	-		-	
number of cases involved		9		-

27. Other financial liabilities

There were no other financial liabilities in 2015/16 or 2014/15.

28. Other liabilities

There were no other liabilities in 2014/15 or 2015/16.

29. Borrowings

	31 March 2016	31 March 2015
	£000	£000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health	1,601	1,185
Other loans	1,478	932
Obligations under finance leases	2,352	2,346
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	926	866
Total current borrowings	**6,357**	**5,329**
Non-current		
Loans from the Department of Health	67,247	22,934
Other loans	11,086	12,564
Obligations under finance leases	8,323	4,949
Obligations under PFI, LIFT or other service concession contracts	44,659	45,587
Total non-current borrowings	**131,315**	**86,034**

Borrowings from the Department of Health

The trust borrowed £5.6m capital loans in 2015/16 from the Department of Health to finance specific capital projects, bringing total Department of Health capital loans borrowed to £14.7m. These capital loans are repayable over 25 years at a fixed interest rate of 2.2%. The trust repaid £0.3m of these loans in 2015/16.

The trust has a working capital loan of £15m from the Department of Health (received in 2014/15) which is repayable over 15 years in equal instalments at a fixed interest rate of 1.38%.The Trust repaid £1m of this loan in 2015/16.

The trust borrowed £40.4m in 2015/16 under a new interim revenue support facility for £48.7m agreed with the Department of Health in February 2016. The balance of the facility of £8.3m is available for drawdown in 2016/17 as and when required. The interest rate on this facility is fixed at 1.5% and the full amount borrowed will have to be repaid in March 2018.

The trust has access to a working capital facility of £25m which is also available for drawdown as and when required in 2016/17. The trust's borrowings under this facility was £nil as at 31/03/16. The interest rate on borrowings made under this facility is 1.5%.

Borrowings from other bodies

London Energy Efficiency Fund

The trust received a loan from the London Energy Efficiency Fund (LEEF) for £13.3m in 2014/15 to finance an energy performance contract capital project with British Gas. The LEEF loan is repayable over 10 years at a fixed interest rate of 0.67% from July 2014 to March 2015 inclusive and a fixed interest rate of 1.81% thereafter.

The trust repaid £0.7m of this loan in 2015/16.

Finance leases

The trust uses leasing to supplement capital investment in medical equipment where appropriate taking into account implicit rates of interest, the expected useful economic life of the equipment, the residual value of the equipment at the end of the lease term and the expected rate of technological change to ensure value for money. During the course of 2015/16 the trust took out new finance leases with various leasing companies for equipment with a capital value of approx £6.2m in 2015/16 in respect of two new CT scanners, a new MRI scanner, new equipment for the new hybrid theatre and various other items of medical equipment. The total borrowings under finance leases were £10.7m at 31 March 2016. The trust made repayments of principal under finance leases of £2.8m in 2015/16.

Private finance initiative on-SoFP scheme

The trust entered into a private finance initiative (PFI) contract in March 2000 for the exclusive use of Atkinson Morley wing on the St George's Hospital site. The capital value of the buildings and equipment encompassed within the PFI contract was approximately £50m. The trust accounts for this PFI contract as an on statement of financial position scheme and includes the value of the buildings and equipment within property plant and Equipment and the associated finance lease creditor within borrowings. The implicit rate of the finance lease is approximately 7.5%. The trust repaid £0.867m of the PFI finance lease creditor in 2015/16.

30. Finance leases

30.1 St George's University Hospitals NHS Foundation Trust as a lessor

Future lease receipts due under finance lease agreements where St George's University Hospitals NHS Foundation Trust is the lessor:

	31 March 2016	31 March 2015
	£000	£000
Gross lease receivables	**-**	**-**
of which those receivable:		
not later than one year;	-	-
later than one year and not later than five years;	-	-
later than five years.	-	-
Unearned interest income	-	-
Allowance for uncollectable lease payments	-	-
Net lease receivables	**-**	**-**
of which those receivable:		
not later than one year;	-	-
later than one year and not later than five years;	-	-
later than five years.	-	-
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

30.2 St George's University Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where St George's University Hospitals NHS Foundation Trust is the lessee:

	31 March 2016	31 March 2015
	£000	£000
Gross lease liabilities	**11,785**	**6,633**
of which liabilities are due:		
not later than one year;	2,581	2,201
later than one year and not later than five years;	7,957	3,678
later than five years.	1,247	754
Finance charges allocated to future periods	(1,110)	662
Net lease liabilities	**10,675**	**7,295**
of which payable:		
not later than one year;	2,352	2,346
later than one year and not later than five years;	7,200	4,083
later than five years.	1,123	866
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

The trust has a number of finance leases for high value capital medical equipment including MRI scanners, CT scanners and ultrasound equipment. The lease terms are for 3 to 7 years. The trust applies the relevant accounting standards to determine the capital value of the equipment which is included within property plant and equipment and the interest costs chargeable to the statement of comprehensive income for each lease. The lease rentals are fixed over the term of the lease and paid on a quarterly or annual basis in advance. The term of the lease may be extended at the end of the primary lease term or a new lease incepted for new replacement equipment.

31.1 Provisions for liabilities and charges analysis

	Pensions - former directors	Pensions - other staff	Other legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2015	**-**	**1,325**	**368**	**-**	**90**	**1,783**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	**-**
Arising during the year	-	-	-	-	-	**-**
Utilised during the year	-	(55)	(160)	-	-	**(215)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	-	-	-	-	-	**-**
Unwinding of discount	-	-	-	-	-	**-**
At 31 March 2016	**-**	**1,270**	**208**	**-**	**90**	**1,568**
Expected timing of cash flows:						
not later than one year;	-	144	-	-	-	**144**
later than one year and not later than five years;	-	545	-	-	-	**545**
later than five years.	-	581	208	-	90	**879**
Total	**-**	**1,270**	**208**	**-**	**90**	**1,568**

The 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's solicitors and the human resources department.

31.2 Clinical negligence liabilities

At 31 March 2016, £205,754k was included in provisions of the NHSLA in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2015: £125,640k).

32. Contingent assets and liabilities

There were contingent liabilities with the NHSLA LTPS scheme of £58,000 in 2015/16.

The trust is a partner in the South West London Elective Orthopaedic Centre (SWLEOC), an NHS joint arrangement hosted by Epsom and St Helier NHS Trust. Under this joint arrangement the trust refers patients for treatment and provides clinical services to SWLEOC for which it receives payment. The trust shares in the risks and rewards of SWLEOC and in 2015/16 the trust received £363k income from SWLEOC in respect of its share of the annual surplus. The trust has a contingent liability for SWLEOC because in the event that SWLEOC incurs an operating loss the trust would be liable for its share of the loss.

33. Contractual capital commitments

	31 March 2016	31 March 2015
	£000	£000
Property, plant and equipment	12,978	16,399
Intangible assets	-	-
Total	**12,978**	**16,399**

Contractual capital commitments include an energy performance contract financed by a loan from the London Energy Efficiency Fund for £11.1m. The trust signed an energy performance contract with British Gas in July 2014. The contract provides for the replacement and upgrade of the trust's energy centre and infrastructure on the St George's Hospital site. The capital cost of the works is approximately £13.3m and is financed by a loan from the London Energy Efficiency Fund. Under the terms of the contract British Gas must deliver savings in the trust's energy costs to minimum guaranteed levels every year over a 15 year period. Capital commitments also include a new surgical assessments unit for £1m and an upgraded endoscopy unit for £0.8m.

34. Defined benefit pension schemes

34.1 Changes in the defined benefit obligation and fair value of plan assets during the year

There were no changes in the defined benefit scheme in 2014/15 or 2015/16.

34.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	2015/16	2014/15
	£000	£000
Present value of the defined benefit obligation at 31 March	**-**	**-**
Plan assets at fair value at 31 March	**-**	**-**
Fair value of any reimbursement right at 31 March	-	-
The effect of the asset ceiling at 31 March	-	-
Net (liability)/asset recognised in the SoFP at 31 March	**-**	**-**

34.3 Amounts recognised in the SoCI

	2015/16	2014/15
	£000	£000
Current service cost	-	-
Interest expense / income	-	-
Past service cost	-	-
Losses on curtailment and settlement	-	-
Total net (charge)/gain recognised in SOCI	**-**	**-**

35. On-SoFP PFI, LIFT or other service concession arrangements

35.1 Imputed finance lease obligations

The trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2016	31 March 2015
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**85,857**	**89,698**
Of which liabilities are due		
not later than one year;	3,841	3,841
later than one year and not later than five years;	15,363	15,363
later than five years.	66,653	70,494
Finance charges allocated to future periods	(40,272)	(43,245)
Net PFI, LIFT or other service concession arrangement obligation	**45,585**	**46,453**
not later than one year;	926	866
later than one year and not later than five years;	4,407	4,119
later than five years.	40,252	41,468

The trust signed a private finance initiative (PFI) contract in March 2000 for the exclusive use of the new Atkinson Morley wing on the St George's Hospital site. The new wing was commissioned in August 2003 and the 35 year lease for the wing started from this date. At the end of the 35 year term the trust has the right to exercise the option to acquire the building at a nominal cost. The contract is with Blackshaw Healthcare Services Ltd, a special purpose vehicle company which is responsible for the maintenance of the building and the availability of the facilities within the building. On the adoption of International Financial Reporting Standards (IFRS) in 2008/09 the trust accounted for the scheme as an on-statement of financial position PFI scheme and therefore the £50m original capital value of the facility was included within property plant and equipment and the associated finance lease creditor within borrowings. The building is depreciated and revalued on a consistent basis with purchased buildings.

The unitary charge payable to Blackshaw Healthcare Services Ltd is approx £10.7m per annum. This includes the rental payment and the cost of 'soft' and 'hard' maintenance services.

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

The trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2016	31 March 2015
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**246,385**	**257,098**
Of which liabilities are due:		
not later than one year;	10,712	10,712
later than one year and not later than five years;	42,850	42,850
later than five years.	192,823	203,536

35.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's expenditure in 2015/16:

	31 March 2016	31 March 2015
	£000	£000
Unitary payment payable to service concession operator	**10,799**	**1,984**
Consisting of:		
Interest charge	2,974	505
Repayment of finance lease liability	867	-
Service element	6,958	1,142
Other	-	337
Total amount paid to service concession operator	**10,799**	**1,984**

36. Off-SoFP PFI, LIFT and other service concession arrangements

St George's University Hospitals NHS Foundation Trust did not incur any charges in respect of off-statement of financial position PFI and LIFT obligations in 2014/15 or 2015/16.

37. Financial instruments

The applicable standards for financial instruments are IAS32/IAS39/IFRS7 and IFRS9.

IAS 32 defines financial instrument as a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Examples of financial assets are cash or a contractual right to receive cash.

37.1 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 trust has with clinical commissioning groups and the way those bodies are financed, the 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 trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the trust in undertaking its activities.

The trust's cash 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 minimal 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 regulator. 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 also borrows from government to finance working capital and to finance operating losses using working capital loans and working capital facilities respectively. These borrowings are at fixed rates of interest. The trust has a loan with the London Energy Efficiency Fund to finance capital expenditure which is also at a fixed rate of interest. Therefore the trust 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 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred primarily under contracts with clinical commissioning groups which are financed from resources voted annually by Parliament. The trust is not, therefore, exposed to significant liquidity risks in terns of the timing of payments for most of its receivables. The trust has incurred operating deficits in the last two financial years however and this has necessitated borrowing from government to maintain liquidity.

37.2 Financial assets

The trust's total future obligations under these on-SoFP schemes are as follows:

Assets as per SoFP as at 31 March 2016

	Loans and receivables	Assets at fair value through the SoCI	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	69,935	-	-	-	69,935
Other investments	-	-	-	-	-
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	7,395	-	-	-	7,395
Total at 31 March 2016	**77,330**	**-**	**-**	**-**	**77,330**

Assets as per SoFP as at 31 March 2015

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	35,154	-	-	-	35,154
Other investments	-	-	-	-	-
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	24,178	-	-	-	24,178
Total at 31 March 2015	**59,332**	**-**	**-**	**-**	**59,332**

37.3 Financial liabilities

Liabilities as per SoFP as at 31 March 2016

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	81,412	-	81,412
Obligations under finance leases	10,675	-	10,675
Obligations under PFI, LIFT and other service concession contracts	45,585	-	45,585
Trade and other payables excluding non financial liabilities	74,871	-	74,871
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2016	**212,543**	**-**	**212,543**

Liabilities as per SoFP as at 31 March 2015

	Other financial liabilities	Liabilities at fair value through the I&E	Restated Total
	£000	£000	£000
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	37,615	-	37,615
Obligations under finance leases	7,295	-	7,295
Obligations under PFI, LIFT and other service concession contracts	46,454	-	46,454
Trade and other payables excluding non financial liabilities	67,708	-	67,708
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2015	**159,072**	**-**	**159,072**

37.4 Maturity of financial liabilities

		RESTARTED
	31 March 2016	31 March 2015
	£000	£000
In one year or less	81,228	73,038
In more than one year but not more than two years	46,503	5,028
In more than two years but not more than five years	17,813	14,497
In more than five years	66,999	66,509
Total	**212,543**	**159,072**

37.5 Fair values of financial assets at 31 March 2016

	Book value	Fair value
	£000	£000
Non-current trade and other receivables excluding non financial assets	129	129
Other investments	-	-
Other	-	-
Total	**129**	**129**

The trust considers that the fair value of financial assets and financial liabilities are the same as book value.

37.6 Fair values of financial liabilities at 31 March 2016

	Book value	Fair value
	£000	£000
Non-current trade and other payables excluding non financial liabilities	-	-
Provisions under contract	-	-
Loans	131,315	131,315
Other	-	-
Total	**131,315**	**131,315**

The trust considers that the fair value of financial assets and financial liabilities are the same as book value.

38. Losses and special payments

	2015/16		2014/15	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	34	316	-	-
Stores losses and damage to property	-	-	-	-
Total losses	**34**	**316**	**-**	**-**
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	5	11	-	-
Special severence payments	-	-	-	-
Ex-gratia payments	62	18	13	4
Total special payments	**67**	**29**	**13**	**4**
Total losses and special payments	**101**	**345**	**13**	**4**
Compensation payments received		-		-

39. Transfers by absorption

This note is not applicable in 2015/16 or 2014/15.

40. Prior period adjustments

There were no prior period adjustments in 2015/16 or 2014/15.

41. Events after the reporting date

There were no events to report post 31 March 2016.

42. Final period of operation as a provider of NHS healthcare

This note is not applicable for 2015/16 or 2014/15.

43. Related parties

	RECEIVABLES		PAYABLES	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
NHS Foundation Trusts	8,201	4,734	3,014	4,772
NHS Trusts	6,525	2,566	2,702	3,530
Department of Health	86	-	104	77
Public Health England	283	1,069	103	13
Health Education England	767	1,149	-	38
CCGs and NHS England	24,015	30,989	1,442	1,027
Special Health Authorities	-	230	-	14
Non - Department Public Bodies	23	3	-	-
Other DH bodies	497	664	236	7,499
Total	**40,397**	**41,404**	**7,601**	**16,970**

NHS Related party transactions

	INCOME		EXPENDITURE	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
NHS Foundation Trusts	17,185	2,938	11,740	4,653
NHS Trusts	15,530	2,532	5,214	26
Department of Health	4,731	-	6	-
Public Health England	1,044	221	73	-
Health Education England	41,567	7,717	-	-
CCGs and NHS England	611,626	77,255	13	118
Special Health Authorities	23	2,730	14,345	1,666
Non - Department Public Bodies	128	-	-	-
Other DH bodies	-	-	10,152	1,704
Total	**691,834**	**93,393**	**41,543**	**8,167**

Non - NHS Related party transactions

	AMOUNTS DUE FROM RELATED PARTY		AMOUNTS OWED TO RELATED PARTY	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
St George's University of London	1,877	1,303	1,765	963
St George's Hospital Charity	280	365	6	3
KPMG LLP	-	-	1,213	33
Total	**2,157**	**1,668**	**2,984**	**999**

	RECEIPTS FROM RELATED PARTY		PAYMENTS TO RELATED PARTY	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
St George's University of London	3,747	800	7,455	2,250
St George's Hospital Charity	3,016	301	12	1
KPMG LLP	-	-	6,139	150
Total	**6,763**	**1,101**	**13,606**	**2,401**

KPMG LLP is disclosed as a related party because Andrew Burn, who was the trust's turnaround director from June 2015 to March 2016, is an employee of KPMG LLP.

The comparative figures for 2014/15 relate to the two month period ended 31 March 2015 because the trust assumed foundation trust status on 1 February 2015.

44. Staff report tables

Average number of employees (whole time equivelant basis)

			2015/16	2014/15
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,143	51	1,194	1,214
Ambulance staff	-	-	-	-
Administration and estates	1,707	337	2,044	2,049
Healthcare assistants and other support staff	622	-	622	613
Nursing, midwifery and health visiting staff	2,802	689	3,491	3,481
Scientific, therapeutic and technical staff	1,587	238	1,825	1,877
Total average numbers	**7,861**	**1,315**	**9,176**	**9,234**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	23

Reporting of compensation schemes - exit packages 2015/16

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**-**	**-**	**-**
Total resource cost (£)	**£0**	**£0**	**£0**

Reporting of compensation schemes - exit packages 2014/15

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**-**	**-**	**-**
Total resource cost (£)	**£0**	**£0**	**£0**

Reporting of compensation schemes - exit packages 2015/16

	2015/16		2014/15	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**-**	**-**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months

	Number of engagements
Number of existing engagements as of 31 Mar 2016	**26**
Of which:	
Number that have existed for less than one year at the time of reporting	13
Number that have existed for between one and two years at the time of reporting	12
Number that have existed for between two and three years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-

The trust reviews off-payroll arrangements on a regular basis and secures assurances that the individuals concerned are responsible for their tax liabilities arising from their off-payroll engagement with the trust.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months

	Number of engagements
Number of new engagements, or those that reached six months in duration between 1 Apr 2015 and 31 March 2016	9
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	-
Number for whom assurance has been requested	-
Of which:	
Number for whom assurance has been received	-
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
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.	4

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Email: giving@stgeorges.nhs.uk
Web: www.stgeorgeshospitalcharity.org.uk

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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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