

St George's University Hospitals NHS Foundation Trust

Annual Report and Accounts 2016/17

Excellence in specialist and community healthcare

St George's University Hospitals NHS Foundation Trust

Annual Report and Accounts 2016/17

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

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Chairman's Statement

Introduction to the Annual Report and Accounts, and Quality Account by Gillian Norton, Chairman

I am pleased to write this introduction to the Annual Report and Accounts, my first as Trust Chairman. I joined the Trust as a Non-Executive Director in June last year, and took over from Sir David Henshaw, our interim Chair, on 1 April 2017.

The past year has been exceptionally difficult for St George's and, whilst we are beginning to make progress, there is still a great deal to do as we end the 2016/17 financial year. The challenges we faced last year are the same as we encounter today - we need to improve services for patients, whilst also reducing the amount of money we spend. Of course, this is going to be difficult, but we aren't the only NHS Trust facing both quality and financial challenges. This is why we need to take a proactive and positive approach to solving the difficult but not insurmountable problems we face here at St George's.

Our staff continue to provide excellent care for our patients, and the Care Quality Commission's inspection report, published in November last year, commended their caring approach. However, the same inspection report also found the Trust overall to be rated as Inadequate, meaning we entered the special measures regime for quality at the end of 2016. This was a major blow for the organisation - and one we are still managing with both staff and key stakeholders, although I am confident we have, and are implementing, a plan to address the weaknesses the CQC found.

We still see excellent standards of care across many of our services, which is huge credit to our staff. For example, our thrombectomy service for stroke started running 24/7 last summer, and is now being used as a model of best practice nationally for other Trusts to follow. Our paediatric surgical team also operated on St George's youngest ever patient - Abigeal Peters, born at 23 weeks gestation - and she is now doing well, which is credit to Abi and the staff who care for her.

Our partnership with Macmillan is also helping improve holistic cancer care at the Trust, and we are grateful to them for their on-going support - as we are to the St George's Hospital Charity, which continues to champion and provide financial support for a range of excellent initiatives across our hospital and community services.

Despite various attempts to tackle our financial challenges, we ended the year with a deficit of £73.9m (£78.7million, after including losses on disposal of fixed assets of £4.9million), which was higher than planned. This led our regulator, NHS Improvement, to place the Trust into special measures for finance in March 2017. We are developing a financial recovery plan for the 2017/18 financial year, which will be ambitious but achievable. It will also be challenging, and we will need to engage our staff and key stakeholders in this crucial piece of work going forward.

As the Trust's new Chairman, I remain, however, optimistic about the future, despite the size and scale of the challenge we face here at St George's. Key to our success is building a stable executive team, which the organisation has lacked in recent times. Jacqueline Totterdell joined as our new Chief Executive in May, and she and the new executive team will provide the leadership we need going forward into what will certainly be a difficult but, I hope, ultimately successful year of stabilisation and progress for the Trust.

Gillian Norton, Chairman



31 May 2017

Performance Report

Chief Executive's Statement

A statement from the Chief Executive

I joined St George's as Chief Executive in May 2017, and I am looking forward to leading this organisation into what I am confident will be a challenging but ultimately rewarding future.

My priority for the coming year is to ensure we meet our quality, financial and performance objectives, as this is the only way we will deliver real and lasting benefits for our staff, patients and the communities we serve.

I know the past year has been a difficult one for St George's, although we have made progress in some areas.

For example, the performance of our Emergency Department at St George's improved significantly last year, meaning more patients are getting the care and treatment they deserve, when they need it. Performance isn't always consistent, however, and embedding more sustainable solutions to help us manage demand will be a key focus for our clinical and managerial teams over the coming year.

The care we provide to trauma patients was rated the best in the country according to data published by the Trauma Audit and Research Network (TARN) in February 2017. This is huge credit to the many staff and clinical teams involved in managing trauma cases – and evidence, where it needed, of the importance of trauma centres like St George's, and the trauma networks of which they are part.

A number of problems with our estate, confirmed by the Care Quality Commission (CQC) during their inspection last year, have been addressed in the past 12 months, including a major decant programme of staff and patient services from buildings on our Tooting site. However, there is still a lot to do, and we need to improve the environment for both patients and staff in many areas across the Trust – but it will take time.

The past year has also been difficult for our staff, and a priority for the coming year is to ensure they are engaged, involved in decision-making and, most important of all, proud to say they work at St George's. Our staff are what make St George's unique, and we need to repay their loyalty to the organisation by making their working lives easier, and by celebrating their achievements, of which there are many.

We are developing quality and financial recovery plans for the organisation, although a single focus on making St George's better – in all areas – must be what drives us over the coming year. Both Gillian Norton, our Chairman, and I have been impressed and inspired by the staff we have met to date and I am confident that, if we work as a team, we can truly make St George's great again, which is what everyone connected with the Trust wants.

Jacqueline Totterdell



Chief Executive

31 May 2017

Purpose and activities of the Foundation Trust

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 organisation 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 10 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

At St George's we want our patients to experience a very high standard of care.

With over 9500 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 clinical staff and also carries out medical research.

As well as acute hospital care, we provide a range of specialist care following the 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 clinicians and support staff 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

During 2016/17, the Trust saw 648,861 outpatients, delivered 5,156 babies admitted 52,562 elective inpatient/day case patients and admitted 48,268 non-elective patients.

Our emergency department saw 153,451 patients including early pregnancy unit attendances, while Queen Mary's Hospital's minor incident unit saw 16,399 patients.

The Trust has a designated large hyper acute stroke unit treating 1,772 stroke patients during 2016/17.

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.

Our services

Division	Directorates	Clinical services within each directorate						
	Major trauma	Major trauma						
Surgery, theatres, neurosciences and cancer	Surgery	T&O	ENT	Maxillo-facial	Plastics	Urology	General surgery	Dentistry
	Theatres and anaesthetics	Audiology	Anaesthetics and acute pain	Neuro-rehab	Pain clinic			
	Neurosciences	Theatres and decontamination	Neurology					
	Cancer	Neurosurgery and neuro-radiology						
	A&E and acute medicine	A&E	Acute Medicine					
Medicine and cardiovascular	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 Therapeutics	Gynaecology	Obstetrics	Pharmacy				
	Diagnostics	Adult critical care	Therapies	Radiology	Laboratory haematology			
	Outpatients	Clinical genetics	Breast screening					
Community services	Children and Family	School and special school nursing	Children's continuing care	Health visiting	Child safeguarding team	Homeless refugee and asylum seeker team		
	Community adult health	Complex and scheduled care	Rapid response	Access and coordination	Specialist services	Day hospitals	Elderly rehab	

service					
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. St George's is also one of eight heart attack centres in London.

Appendix one of the annual governance statement shows the Trust's divisional structure, and the services each division delivers for the differing cohorts of patients who access St George's services.

A full list of our services and the clinicians and healthcare professionals who provide them can be found 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 also 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 has been on rare diseases, cancer and infectious diseases, but our clinicians are now working with the Genomics England project team to identify other key disease areas.

St George's, in 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 – for example, we have recruited the largest number of patients onto commercial trials in South London Clinical Research Network. There is further information about our research projects and aims for 2017/2018 in the Quality Report section within this document.

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 who live in Wandsworth.

Children and families

School nursing

As of 1 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)

We provide 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 Coordination 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.

Living our values

Our mission is to provide excellent clinical care, education and research to improve the health of the populations we serve.

The trust has set itself the following core values:

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

St George's business model

St George's is at the heart of healthcare delivery in south west London.

We also work closely with our six local clinical commissioning groups, namely Wandsworth, Croydon, Kingston, Merton, Richmond and Sutton. We are also actively involved in the development of the south west London Sustainability and Transformation Plan.

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • accident and emergency • acute medical services • full range of surgical services • maternity and paediatrics • diagnostic and therapies
Tertiary	South west London, Surrey and beyond	3.4 M	<ul style="list-style-type: none"> • cardiac surgery and cardiology • paediatric surgery • neurosurgery and neurology • renal services including transplant • trauma
National specialist centre	Primarily south east, south central and	25 M+	<ul style="list-style-type: none"> • family HIV care • lymphoedema

Based on growth estimates from the 2011 Census, the population of south west London and Surrey will increase by 330,000 over the following 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 the management of long-term conditions
- 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 in which it operates, 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

Our strategy

We are in the process of reviewing our strategy, which will give the Trust a clear direction of travel for the future.

The Trust Board agreed a ten year strategy in 2012. It was clear to the Board that a new strategy was required given the changed circumstances. This was endorsed by the CQC during their inspection in June 2016. The Board recognises the need to involve stakeholders, including patients, staff and commissioners and the process to do this was approved by the Trust Board in January 2017 and an initial high level document agreed in April. The strategy is evolutionary rather than revolutionary. It recognises that we are a hospital and community provider, a service for our local community and a specialist centre, a major elective provider and a major trauma centre. Above all it says that whatever our work, we share the same values and approach.

We have developed a framework for a strategy to help us address the challenges we face and will be finalising this over the next year with our staff, governors, partners and other stakeholders.

Our Clinical Vision

To provide high quality patient care for the communities we serve, and specialist services for patients with thriving programmes of education and research.

Our Strategic Priorities

- High Quality Care: to deliver care and treatment for patients which is consistently high quality, safe, effective and person centred.
- Teaching and Research: to become a high quality centre for teaching and world-class research, in partnership with St George's, University of London.
- Modernising our buildings and internal systems: to ensure our buildings and facilities, information technology, and information and processes are sound.
- Valuing our staff: to lead and inspire our staff so they feel valued and recognise St George's as a good place to work.
- Financial sustainability: to manage our finances effectively, so they are truly sustainable.
- Partnership working: To work with commissioners and partner organisations to provide a range of integrated services that are aligned with our clinical vision, and which meets the needs of the communities we serve.

The Trust's current 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 aspirations remain sound: a focus on providing the best possible care for patients; improving operational performance; and working towards making the Trust financially sustainable. The Trust also continues to stress the importance of its values. 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 annual strategy during 2017/18 to take account of the financial and quality 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 – namely, the STP.

Risks to delivering the 2017/18 operational plan

The Trust has a comprehensive governance process that identifies and manages risk within the organisation.

A number of the challenges, or actions to address those challenges, are covered by the Trust's various risk registers, in particular the corporate risk register.

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

Risk	Risk Description	Potential impact	Mitigation
Plan delivery	<p>The 2017/18 plan is not achieved.</p> <p>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.</p>	<p>Key stakeholders lose confidence in the Trust and its leadership team.</p>	<p>Focused strengthening of management capacity and capability to assure delivery.</p> <p>Continuing emphasis on the continuing need to proceed at pace to deliver change.</p> <p>Continuing dialogue with stakeholders to ensure shared approaches to challenges.</p>
Income and activity	<p>Expenditure reductions and regulatory risks impact on the Trust's ability to deliver planned activity.</p> <p>The Trust has insufficient capacity to deliver expected levels of activity.</p>	<p>Strategic transformation and other budgeted income funding are not achieved.</p> <p>The financial plan is not achieved.</p>	<p>Careful balancing of income and expenditure priorities to ensure that activity is delivered.</p> <p>Continuing dialogue with stakeholders including support to commissioner QIPP plans (demand management).</p>
Expenditure	<p>Efficiency programmes will</p>	<p>Cost improvement</p>	<p>Minimise risk of double counting</p>

	<p>not be sufficient to deliver savings assumed within budgets.</p> <p>Staff do not understand the requirement to deliver agreed expenditure budgets.</p> <p>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.</p>	<p>programme targets are not achieved.</p> <p>The expenditure plan is not achieved.</p>	<p>by devolving financial targets to divisional levels.</p> <p>Stronger performance management and follow-through of actions.</p> <p>Increase assurance through robust data quality; tight management of vacancies and staff costs.</p>
Regulatory risk	<p>The financial plan is not accepted by NHS Improvement.</p> <p>Care Quality Commission, Royal Colleges and other regulators may require additional investment.</p> <p>NHS Improvement may increase controls over agency and premium costs, leading to staffing constraints.</p>	<p>The Trust does not achieve its income target.</p> <p>The Trust is required to invest more than its budgeted expenditure plans (capital and/or revenue).</p> <p>The Trust is unable to manage within the cash resources available.</p> <p>The Trust's financial plan is not achieved.</p>	<p>Raise awareness within divisions and develop locally-owned mitigation plans.</p> <p>Develop active communication plans for stakeholders and patients about responses to risks and mitigating actions.</p> <p>More robust performance management to promote improved ownership and mitigations.</p>

Further risks were identified in 2016/17 and remain relevant, though many form a sub-set of the key headings above. They are:

- 1) The lack of capital funding, internal or external, does not allow the Trust to progress major infrastructure projects
- 2) Unexpected infrastructure failure forces the Trust to spend additional monies on the capital programme, so risking delivery of the Trust's financial targets
- 3) Unexpected additional constraints on capacity mean that plans to improve access target performance as outlined in the plan are not delivered
- 4) 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
- 5) Risk of Cyber-attack and major IT disruption, ensuring every effort is made to avoid a recurrence of the May 2017 issues

Going concern disclosure

The 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 £78.7m for the year ended 31 March 2017. During the year the Trust borrowed £87.6m under support facilities provided by the Department of Health.

The Board has reviewed the proposed 2017/18 plan throughout its development from November 2016 to date. The 2017/18 plan is for a deficit of £28.5m having taken account of the underlying financial position going into 2017/18. The Trust has identified in its financial plan submitted to NHS Improvement that further borrowing totalling £38m is required to finance the Trust for the year, provided the £28.5m 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 this Annual Report and Accounts was being prepared the Trust was engaged in discussions with the regulator regarding the financial plan for 2017/18 and the arrangements to access further borrowing facilities. However, these discussions had not been 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 2016/17, 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.

Measuring our clinical and operational performance

The Care Quality Commission's inspection report for St George's, published in November following their visit in June 2016, raised concerns about the quality of care the Trust provides in certain areas, and the Trust was placed in special measures for quality as a result.

Details of the Care Quality Commission findings are contained within the Quality Report on pages 91 to 96 of this Report

The operational performance at the Trust is not where it needs to be, and whilst improvements are in progress, patients are not being seen as quickly as we would want.

However, whilst operational performance has been mixed, we have seen improvements in 2016/17 in a number of areas. For example, more patient episodes were carried out in 2016/17 than in the previous year across all areas: including outpatients, day cases, as well as elective and non-elective procedures. The table below indicates the year to year comparisons.

Indicator	Target	2016/17 Performance	2015/16 Performance
ED: maximum waiting time of four hours from arrival to admission / transfer / discharge	>=95%	91.6%	90.44%
RTT – consultant led referral to treatment waiting times incomplete pathways	>=92%	83.3%	90.25%
62 day wait for first treatment from urgent GP referral for suspected cancer	>=85%	84.9%	82.5%
62 day wait for first treatment from NHS cancer screening service referral	>=90%	93.2%	90.4%
31 day wait for second or subsequent treatment - surgery	>=94%	97.2%	96.5%
31 day wait for second or subsequent treatment – anti cancer	>=98%	99.6%	100%
All cancers: 31 day wait from diagnosis to first treatment	>=96%	97.2%	97%
Cancers 2 week wait from referral date first seen for symptomatic breast patients (cancer not suspected)	>=93%	90.3%	87.8%
Cancers 2 week wait from referral date first seen for symptomatic breast patients (cancer not initially suspected)	>=93%	93.7%	93.4%
C.difficile – meeting the C.difficile objective	31	36	39
MRSA bacteraemias (bloodstream inspections)	0	2	3
Mixed sex accommodation breaches	0	0	11

Emergency readmissions within 30 days following an elective or emergency spell at the Trust	5%	12.1%	11.8%
Referral to treatment information	50%	61%	55%
Referral information	50%	87%	87.7%
Treatment activity information	50%	74%	70.3%

The Trust has introduced a range of measures to improve performance across our key services; this includes a daily demand and capacity meeting, daily reporting from each specialty on activity, plus weekly capacity monitoring linked to all aspects of operational activity and performance.

Unplanned Care

There continue to be significant challenges within the management of unplanned care at the Trust. We did not meet the 4-hour emergency access target of 95% consistently, nor did we meet the annual trajectory target. However, we have improved the performance year on year from 90.44% in 2015/16 to 91.6% in 2016/17. This was achieved despite having removed 54 medical beds from the Trust complement.

The challenges within the Emergency Department have included physical constraints on our ability to assess and refer patients as soon as they arrive. This is now being rectified with alteration works having commenced in April 2017 to expand the Rapid Assessment and Treatment area within the department. Future areas of improvement to assist the ED patient flow will include the expansion of the Medical Ambulatory area.

During the winter period, which can be particularly challenging, we managed to reduce bed occupancy to 85% for the period (in line with the target ambition set by NHS Improvement). This enabled the Trust to achieve increase in elective cases during the same period, in contrast to the national position whereby elective episodes were severely disrupted in a number of Trusts.

The levels of unplanned care volumes were above plan by 12,275 episodes in 2016/17, which were also delivered against a backdrop of 54 fewer beds available within Medicine wards.

In comparison to other acute Trusts in London, St George's finished the year at the top of Tier 3 in relation to unplanned care performance, having progressed from the bottom of Tier 1 in the previous year. This evidences the improvements in the overall ED performance and bed flow, but it is clear that the challenges of achieving the 95% target will be extremely difficult to meet in 2017/18.

Cancer

Cancer performance has been very challenging in 2016/17. We have seen marked improvements in some of these services whilst certain areas of performance have been difficult due to the rising demand for services (notably in endoscopy and dermatology).

However, the introduction of improved management systems in certain areas has enabled us to achieve the trajectory target for cancer performance for each quarter of 2016/17.

Maintaining this level of performance will be challenging, particularly given the high demand for the Trust's cancer services.

Referral to Treatment and Data Quality

In June 2016 the Trust decided to suspend national reporting of RTT data because of concerns about the quality of the data. The Trust could not be confident that we were correctly recording all patients who were waiting for either outpatient or inpatient treatment. We recognised that this is a serious issue which has the potential to delay treatment and even cause harm to patients. The Trust has begun a major piece of work (the Elective Care Recovery Programme) to urgently improve how we record where patients are on their elective care (non-emergency) pathway, and reduce their waiting times. Although this may sound as if it is an administrative task, the objective is to ensure that all patients receive the treatment required.

We are tackling missing and incomplete historical data by checking thousands of electronic patient records. 'Real' time checks aim to ensure we are accurately recording clinical decisions, and we are introducing new processes to support clinical decision making in the future.

Key Elective Care Recovery Programme activities include:

- An external specialist company is checking more than 130,000 historical patient records – those identified as most at risk – where we don't have clinical decisions recorded for inpatient and/or outpatients. We are arranging appointments where needed.
- A St George's team is validating all ongoing inpatient pathway data entered
- High risk patients identified from the checks are assessed, and care arranged, by a dedicated team, including cancer patients and those waiting more than 52 weeks.
- Plans are being developed to tackle our backlog of patients waiting more than 18 weeks.
- We are training outpatient staff using incorrect iCLIP booking methods, to improve data quality. Errors have reduced by more than 70% on average for these staff.
- Mandatory new, standardised outpatients clinic outcomes forms and standard operating procedures are being developed. They will enable us to consistently and accurately record patient pathway clinical decisions and consultation outcomes.

Financial performance 2016/17

The Trust planned to make a deficit of £17.2m in 2016/17, but incurred a deficit of £78.7m, which compares to a deficit of £55.1m for 2015/16.

The Trust's financial performance as measured by the regulator, NHS Improvement (NHSI), excludes losses on disposal of fixed assets and also the impact of the change to IFRS accounting treatment for donated capital grants and depreciation on donated assets. When these items are excluded the Trust's deficit for 2016/17, was £73.9m.

Income

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

- SLA income has increased in 2016/17 by £29.9m from £612.2m to £642.1m
- 2016/17 income included £13.9m (£12.2m in 2015/15) of commissioner challenges, and CQUIN income of £11.9m
- the level of over performance relating to non-specialist commissioners was £12.9m (£6.5m in 2015/16 and in relation to specialist commissioners was £8.7m (£16.6m in 2015/16)

Expenditure

Expenditure increased more than income year on year by £24m.

Pay costs increased by 8% (£37m), due to:

- impact of inflation on pay uplift and incremental increases (£12.3m)
- nursing – safe staffing levels and additional facilities (£3.1m)
- medical consultant workforce to provide additional capacity (£4.6m)
- non-clinical staff – administrative support costs, including turnaround/transformation interim resource, as well as resource to address estates and IT issues (£9.9m)
- agency (including interim) cost increased by £7.3m

Non-pay costs increased by 8% (£27.2m), including:

- Clinical Negligence Scheme for Trusts ('CNST') cost increase - £5.5m
- professional services (external turnaround support) - £5.5m
- increase in drugs cost related to the pharmacy wholesale dealer licence which commenced in 2015/16 - £4.9m (expenditure is offset by additional 'other' income)
- increase in pass-through drugs costs as a result of being a lead provider of the Hepatitis C Operational Delivery Network (offset with SLA income - £3.8m)
- Disposal of assets due to building demolitions (Knightsbridge Wing, Bronte House, Bronte Annex, Wandle Annex, Clare House) - £4.6m

Capital expenditure

The Trust incurred capital expenditure totalling £33.8m in 2016/17, compared to £31.1m in 2015/16. This was the second highest annual level of investment in the history of the Trust. These figures include the capital value of new finance leases taken out during the year. The main components of capital investment in 2016/17 were:

- energy infrastructure project - £6.6m
- re-location of Renal services to better accommodation on the St George's hospital site - £1.6m
- demolition of poor and out-dated buildings and their replacement with new modular facilities - £5m
- improving the IT infrastructure - £8m

Cash and liquidity

The Trust ended the year with a cash balance of £6m, compared to £7.4m at the end of 2015/16.

The income and expenditure deficit of £78.7m put severe pressure on the cash position during the year and consequently the Trust borrowed £87.6m in 2016/17 from the Department of Health under support facilities to finance the deficit.

The Trust pays interest on the borrowings of £87.6m - at 3.5% on £64.3m and 1.5% on £23.3m.

Capital structure

Borrowings from the Department of Health

The Trust borrowed £87.6m of revenue loans in 2016/17 from the Department of Health, in order to finance the deficit.

The Trust has submitted a financial plan to NHS Improvement for a planned deficit of £28.5m in 2017/18 and would require additional support facilities from the Department of Health to finance the deficit.

The Trust secured approval of a capital loan in March 2017 to support the investment in the reconfiguration and updating of the estate infrastructure. The projects financed by this loan will be completed in 2017/18.

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 2016/17 the Trust took out new finance leases with various leasing companies for equipment with a capital value of approximately £1.1m.

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.

Climate Change Act obligations

The recently revised Sustainable Development Management Plan (SDMP) and Sustainable Development Action Plan (SDAP) have been designed to secure reductions in carbon dioxide emissions and increase environmental sustainability in the following areas: governance, energy and carbon, waste, water, transport, climate change adaptation, designing the built environment, workforce development, travel and finance.

A Sustainability Champions Network has been formed, consisting of 20 voluntary members of staff from across the site (including Senior Genetic Technologists, Facilities Managers and Specialists Consultants). The Network will form part of the Sustainability Steering Committee and will contribute towards establishing the policies within the Sustainable Development Management Plan (SDMP) and the specific actions Sustainable Development Action Plan (SDAP). All members have received a description of the role and have provided feedback in relation to identifiable opportunities in their specific lines of work where the Trust can save energy, water and medical equipment/resources.

The Sustainability Champions Network will play an integral role in a behaviour change programme designed to raise awareness of environmental practices at the Trust by acting as key proponents in embedding sustainability awareness to all colleagues. It is also expected that Sustainability Champions will lead their departments as part of a 'Green Ward' Competition, along with proactively supporting the Trust at events such as NHS Sustainability Day.

Alongside the Sustainability Champions Network and relevant members of staff, LCE are seeking to establish a series of behaviour change programmes to enable staff, patients and visitors to effectively reduce carbon dioxide emissions and increase sustainability through resource efficiency measures.

The Trust's existing energy policy has been reviewed in detail and an updated version will be included within the emerging Sustainable Development Management Plan (SDMP). Incorporation into the Trust's main sustainability strategy will enable a more coherent understanding of current energy management policies in practice, alongside future initiatives designed to reduce carbon dioxide emissions.

The Trust is currently producing a local Environmental Legislation and Policy Register as a key tool to ensure that the Trust is fully compliant with all the relevant environmental legislation and policies in place regarding all associated impacts on the environment, sustainable development and climate change. This includes information in relation to key compliance requirements, such as CHPQA, Climate Change Levy (CCL), EU-ETS, alongside obligations issued by the NHS Sustainable Development Unit, and best-practice policies and evidence bases to guide the Trust's wider sustainability agendas.

The Trust has produced a Climate Change Adaption Plan which is due for approval by the Board, in accordance with the requirements of the NHS Sustainable Development Unit.

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 attain our targets.

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 a plan to address the dangers that climate change brings as well as achieving ambitious targets to reduce carbon emissions arising from its activities.

The Trust will continue working with staff, patients, visitors and key partners to enable these targets to be achieved.

In addition other subjects for consideration are set out below.

As the foundation Trust is operational 24 hours a day there are numerous environmental issues that need to be addressed 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. The Trust has installed energy efficient LED landing guidance lights. 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 entered a partnership agreement with British Gas/ Centrica to replace the existing boilers and chillers serving the site with an energy efficient Combined Heat and Power solution. The focus as of March 2017 remains completing the Energy Centre and St James Wing chillers. These are largely intrusive works that need to be carried out whilst the hospital remains fully operational.

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.

The Trust is currently out to tender for the replacement of the entire existing low pressure sodium street lighting with new energy efficient LED units.

Future energy related assessments are due to take place over the next 12 months, with a view of reducing the Trust's energy consumption. These include the following areas.

- review and assessment of demand response opportunities
- power/voltage optimisation
- renewable energy feasibility
- steam survey
- chiller performance review
- building management systems review
- HVAC system inspection

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.

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 NHS staff survey results from 2016/17 also demonstrated that we need to do more to support our BME staff. We addressed this in early 2017 by running Listening into Action events for staff to listen to and act upon their concerns.

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/

Changes to the Board in 2016-17

There have been a number of changes to the Board during 2016-17 and a key priority for 2017-18 is to stabilise the leadership of the Trust. This is now well underway with the completed appointments of a substantive Chairman (Gillian Norton), Chief Executive (Jacqueline Totterdell), and Chief Financial Officer (Andrew Grimshaw). A series of further permanent executive appointments are expected to be made during 2017-18.

A full list of board members can be found in the board report on page 60

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.

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 at the end of 2016/17 comprises a Chairman, six nonexecutive directors - including a university representative - and executive directors (four voting and five 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.

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. 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. The register of interests of board members is described below.

Chairman and Non-executive directors 2016-17

Throughout 2016-17, the Board was chaired by Sir David Henshaw, who was appointed by NHS Improvement (Monitor) using its powers under section 111(5) of the Health and Social Care Act 2012. Sir David is also Chairman of Alder Hey Children's Hospital NHS Foundation Trust. Sir David Henshaw was the Executive Chairman. He was supported by six other independent Non-Executive Directors (though it should be noted that Jenny Higham represents St George's, University of London on the Board):

- Sarah Wilton, a chartered accountant who has held several senior executive positions at Lloyd's of London, delivering major change programmes including restructuring, outsourcing, efficiency and effectiveness reviews, was Deputy Chairman and Audit Chair for most of the year.
- Jenny Higham, representative of St George's, University of London. Jenny is the 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.
- Sir Norman Williams, who joined the Board in March 2016 after retiring as a Consultant Surgeon at Barts Health NHS Trust; he was President of Royal College of Surgeons from 2011-14. Sir Norman chaired the Quality Committee for the majority of the year.
- Gillian Norton joined the Board in June 2016 and last year retired as Chief Executive of the London Borough of Richmond after 17 years. She chaired the Workforce & Education Committee from September 2017, and was appointed by the Council of Governors as Chair Designate at the end of 2016-17.
- Ann Beasley joined the Board in October 2016. She has a background in finance, her most recent role being Director General for the Finance, Assurance and Commercial Group at the Ministry of Justice. Ann has also been Chair of Trustees for the Alzheimer's Society.
- Stephen Collier joined the Board in October 2016. Stephen has worked extensively in the private health sector, including a period as Chair of the NHS Partners Network – the trade association for private providers to the NHS.

A number of Non-Executive Directors left the Board in 2016-17. Mike Rappolt, the Audit Committee Chair, retired on 21 May 2016 after 12 years as a Non-Executive Director at the Trust. Non-Executive Directors Kate Leach and Stella Pantelides resigned their positions on 2 June 2016 and 8 July 2016 respectively. The Board was joined by an Associate Non-Executive Director, Thomas Saltiel, in September 2016 though this is a time limited and non-voting role.

Executive Directors

Professor Simon Mackenzie was the Acting Chief Executive for the majority of 2016-17. He took up the role from his substantive post of Medical Director following the departure of Miles Scott at the beginning of the year, who went on secondment to NHS Improvement. Following the departure of Miles Scott, Paula Vasco-Knight served briefly as Acting Chief Executive until May 2016. New substantive Chief Executive Officer, Jacqueline Totterdell, was appointed at the end of 2016-17 and took up post at the Trust on the 1 May 2017.

While Professor Mackenzie was acting Chief Executive, the role of Acting Medical Director was fulfilled by Professor Andy Rhodes from his substantive role of Deputy Medical Director and Chair of the Children's, Women's, Diagnostics, Therapies and Critical Care Division.

Jennie Hall, our Chief Nurse and Director of Infection Prevention Control, left the Trust in August 2016 to take up a secondment role at NHS Improvement. Jennie was replaced by Suzanne Banks for four months before Avey Bhatia, on secondment for a year from Maidstone and Tunbridge Wells NHS Trust, started in February 2017 as Chief Nurse and Director of Infection Prevention and Control.

Iain Lynam started and finished the year in the role of Chief Financial Officer, although Nigel Carr, an interim Director of Finance from KPMG, and Margaret Pratt, an experienced NHS Director, held the role separately for several months, whilst Iain took on the role of Chief Restructuring Officer. The Trust has now successfully recruited a new permanent Chief Financial Officer, Andrew Grimshaw, who will take up post in June 2017.

The Executive Directors were supported by team of advisory directors and senior managers who attended Board meetings and took lead roles in the areas of HR, workforce, operations (including performance and referral to treatment), estates and facilities, ICT and information governance, transformation, quality governance and communications.

Board of Directors – Register of Interests

St George's is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register of Interests which draws together Declarations of Interest made by members of the Board of Directors and those serving on the Executive Team. In addition, at the commencement of each Board, Committee and Executive Management Team meeting, all present are required to declare any interests. Set out below is the Register of Interests of the Board at 31.03.17.

Sir David Henshaw	Chair
	Appointed by NHS Improvement (Monitor) using its powers under section 111(5) of the Health and Social Care Act 2012
Chairman	Alder Hey Children's Hospital NHS Foundation Trust
Ann Beasley	Non-Executive Director
	No interests to declare
Stephen Collier	Non-Executive Director
Chairman	Integral Medical Holdings/Malling Health
Member, Advisory Board	Healthcare Market News (monthly publication)
Member, Advisory Board	Cielo Healthcare (USA)
Member, Health Leaders Panel	Nuffield Trust
Member, Governance Board	Independent Sector Complaints Adjudication Service (ISCAS)
Trustee	ReSurge Africa (medical charity)
External Advisor	Vdcglobal (medical concierge)
External Advisor	Schoen Klinik (German provider of mental health and surgical services)
Health Sector Advisor	On an occasional basis to entities with an interest in the UK health sector
External advisor and investor	Independent Health Coalition (comprises medical insurers and hospital groups) General Healthcare Senior Staff LP (minority shareholder in General Healthcare Group, owner of BMI Healthcare Limited). These interests have been held by me since 2008 and were granted pursuant to my then employment contract.
Jenny Higham	Non-Executive Director (University Rep)
Trust Board	Kingston University
Principal	SGUL
Visiting Professor	Lee Kong Chain School of Medicine in Singapore
Chair	London Medicine Co
Honorary Consultant	Imperial College London

Chair	Medical Schools Council
LLP Partnership	with INTO
Gillian Norton	Non-Executive Director
Trustee	SE London Relate
Representative	Deputy Lieutenant Richmond
Sir Norman Williams	Non-Executive Director
Consultant	TSALYS Medical Technology start-up company
Senior Clinical Advisor	Secretary of State for Health
Emeritus Professor	QMUL
Chairman	National Patient Safety Board
Non-Executive Director	Private Healthcare Information Network (PHIN)
President	Bowel & Cancer Research
Chairman	Steering Committee Enteric, an NIHR Health Technology Cooperative
Sarah Wilton	Non-Executive Director
Non-Executive Director, and Audit and Risk Committee Chair	Capita Managing Agencies Limited
Non-Executive Director, and Audit and Risk Committee Chair	Hampden Members' Agencies Limited
Trustee and Vice Chair	Paul's Cancer Support Centre
Magistrate	Family and Adult Court
Professor Simon Mackenzie	Acting Chief Executive
	No interests to declare
Avey Bhatia	Chief Nurse and Director of Infection Prevention and Control
Board Nurse	East Surrey CCG
Iain Lynam	Chief Restructuring Officer and Acting Chief Finance Officer

Partner	The Aaronite Partnership LLP, which provides Chief Restructuring Officer services.
Director	Codere Finance (UK) Limited
Andrew Rhodes	Acting Medical Director
Owner/Director	Critical Care Limited
Owner/Director	Dr A Rhodes Limited
Trustee	Life Priority Foundation
Chair	Surviving Sepsis Campaign

Council of Governors and membership

The Council of Governors was established when the Trust was authorised as a Foundation Trust on 01.02.15. The Council is comprised of fifteen elected public Governors; five elected staff Governors and eight Governors appointed from stakeholder organisations.

Council of Governors

The Council of Governors is responsible for the appointment of the Chairman and Non-Executive Directors, agreeing their terms and conditions.

The Council of Governors is required to appoint the external auditor of a Foundation Trust. At its meeting in February 2015 the Governors appointed Grant Thornton as the external auditor until 2017.

The Trust's Internal Audit service is provided by the London Audit Consortium, a specialist NHS Audit Consortium. TIAA (from 1 April 2016).

The strategic internal audit plans are approved annually by the Audit Committee which reviews a number of regular reports from the Internal Auditors. The Head of Internal Audit regularly attends the audit committee. The range of areas audited during this year is included in the Annual Governance Statement.

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.

The Trust held its first Governor elections in 2016-17 and the Register of the Council of Governors as at 31 March 2017 is set out below:

Constituency name	Governor name	Political and financial interest	Term of office
Public: Wandsworth	Stuart Godden	None	3yrs to 31.01.18
Public: Wandsworth	Yvonne Langley	None	3yrs to 31.01.18
Public: Wandsworth	Nigel Brindley, Doulla Manolas (until 31.01.17)	None	3yrs until 31.03.20
Public: Wandsworth	Simon Price, Felicity Merz (until 31.01.17)	None	3yrs to 31.03.20
Public: Wandsworth	Derek McGee	None	3yrs to 31.03.20
Public: Wandsworth	David Kirk	None	3yrs to 31.01.18
Public: Merton	Sue Baker	None	3yrs to 31.01.18
Public: Merton	Anneke De Boer	None	3yrs to 31.01.20
Public: Merton	Khaled Simmons Sheila Eden (until 31.01.17)	None	3yrs to 31.01.20
Public: Merton	Hilary Harland	None	3yrs to 31.01.18
Public: South west Lambeth	Gail Adams	Labour party	3yrs to 31.01.18
Public: Regional	Mia Bayles	Conservative party	3yrs to 31.01.18
Public: Regional	Robin Isaacs	None	3yrs to 31.01.18
Public: Regional	Kathryn Harrison	None	3yrs to 31.01.20
Public: Regional	Stephen Sambrook Jan Poloniecki (deceased)	None	3yrs to 31.01.20
Staff: Medical and Dental	Dr Dagan Lonsdale	None	3yrs to 31.01.18
Staff: Community Services Division	Noyola McNicolls-Washington	None	3yrs to 31.01.20
Staff: Non-Clinical Staff	Jenni Doman	None	3yrs to 31.01.20
Staff: Nursing and Midwifery	David Flood	None	3yrs to 31.01.18
Staff: Allied Health Prof. and	Will Hall	None	3yrs to

Other			31.01.18
Appointed: Healthwatch Merton	Brian Dillon (until Sept 2016) Douglas Guerrero (until Jan 2017)	None	3yrs to 31.01.18
Appointed: Merton Council	Cllr Phillip Jones	None	3yrs to 31.01.18
Appointed: Healthwatch Wandsworth	Mike Grahn	None	3yrs to 31.01.18
Appointed: St George's, University of London	Dr Frances Gibson	None	3yrs to 31.01.18
Appointed: Kingston University	Dr Val Collington	None	3yrs to 31.01.18
Appointed: Wandsworth Clinical Commissioning Group	Dr Patrick Bower	None	3yrs to 31.01.18
Appointed: Merton Clinical Commissioning Group	Dr Tim Hodgson	None	3yrs to 31.01.18
Appointed: Wandsworth Council	Cllr Sarah McDermott	None	3yrs to 31.01.18

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 NHS Improvement and the other Governors and is a main point of contact between the Governors and the Chairman. The Lead Governor throughout 2016-17 is Kathryn Harrison, Public Governor: Regional.

Meetings of the Council of Governors and Other Governor Activities

The Council held six full meetings in 2016-17. Governors were also involved in the Medicine for Members health talks where they met other Trust members and encouraged members of the public to consider being a member of the Trust.

Staff and public Governors supported the recruitment of new Non-Executive Directors, a Chair and a new Chief Executive in 2016-17.

Throughout 2016-17, the Governors were also invited to attend private meetings of the Board and also the Board's Committee meetings.

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 to be inspected during normal office hours at the Trust Secretary's office, and in 2017/18 this will be published on the Trust's website.

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 in the activities of the Trust. Communication with

members must also be a two way process and mechanisms are in place to ensure that members, Governors and the Trust are able to engage in a meaningful dialogue.

During 2016-17 we switched to undertaking as much of our communications as possible on-line and via email, to reduce postage and printing costs.

The monthly Medicine for Members talks remained very popular throughout 2016-17. This is a key way to engage with Members on health topics of particular interest to them. During the year, our programme included talks on dementia, diabetes, sepsis, multiple sclerosis, organ donation and “keeping your heart healthy”. There was a good turn-out at our Annual Members’ Meeting.

Membership by constituency

Staff	8,931
Public	
Wandsworth	4,003
Merton	3,002
Rest of England	4,460
Lambeth	586
Out of Trust area	16
Total (public)	12,067
Total	20,998

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 the strategy are to enable management of the Membership community, for example by defining and communicating with the membership and how resources should be allocated and effectiveness managed.

For 2017-18, given the Trust’s financial position and the general trend amongst Foundation Trusts to concentrate more on the quality than the quantity of Membership, it is proposed that the Trust continues to stabilise Membership numbers at current levels. A programme of Membership events has been developed which builds on last year’s programme but includes events on topics of greatest interest, such as those which attracted the largest number of attendees.

New for 2017-18 is an intention to explore with Governors how we can better capture the work they are doing with Members on a local level and involve Governors much more in the membership drive and attending and introducing the Membership Health Talks.

Communication and engagement activities

Currently we engage with Members through the following channels:

- 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

However, the Governors have expressed an interest in reinstating the Membership Communication and Engagement Committee of the Council of Governors to provide a real focus for our Membership engagement activities.

Appendix C2 - membership report

Membership size and movements	Last year (2016/17)	Next year (estimated) (2017/18)
Public constituency		
At year start (April 1)	12,281	12,875
New Members	427	
Members leaving	641	
At year end (March 31)	1,067	
Staff constituency		
At year start (April 1)	8638	
New Members	1,749	
Members leaving	1,476	
At year end (March 31)	8931	
Patient constituency		
At year start (April 1)	0	
New Members	0	
Members leaving	0	
At year end (March 31)	0	

Analysis of current Membership	Number of Members	Eligible Membership
Public constituency		
Age (years)		
0-16	2	116,925
17-21	360	27,556
22+	11,515	445,576
Ethnicity		
White	6,971	380,440
Mixed	594	28,684
Asian or Asian British	2,425	75,326
Black or Black British	1,777	67,014
Other	281	11,542
Socio-economic groupings*		
AB	3,707	76,421
C1	3,772	62,462
C2	1,820	23,918
DE	2,754	31,989
Gender analysis		
Male	4,814	286,780
Female	7,239	303,275

The analysis section of this report excludes:

- 190 public members with no dates of birth, 19 members with no stated ethnicity and 14 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 (e.g.: postcode) or other recognised methods. To the extent socioeconomic 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 31st May 2017 and signed on its behalf by Jacqueline Totterdell, Chief Executive.”

Jacqueline Totterdell



Chief Executive

31 May 2017

Quality Governance Framework

The Trust is committed to NHS Improvements Quality Governance Framework as follows:

Quality governance being the combination of structures and processes at and below board level to collectively manage Trust-wide quality performance including:

- ensuring required standards are achieved
- investigating and taking action on sub-standard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best practice and
- identifying and managing risks to quality of care

The Quality governance framework aims to achieve positive answers to the following:

- does quality drive the Trust's strategy?
- is the board sufficiently aware of potential risks to quality?
- does the board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?
- does the board promote a quality-focused culture throughout the Trust?
- are there clear roles and accountabilities in relation to quality governance?
- are there clearly defined, well understood processes for escalating and resolving issues and managing performance?
- does the board actively engage patients, staff and other key stakeholders on quality?
- is appropriate quality information being analysed and challenged?
- is the board assured of the robustness of the quality information?
- is quality information being used effectively?

Disclosures relating to quality governance

The Quality Report is contained within pages 89 and 193 of this Annual Report

Better payment practice code - measure of compliance

	2016-17	2016-17	2015-16	2015-16
Non NHS Payables	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	165,225	351,106	173,651	316,409
Total non-NHS trade invoices paid within target	97,344	216,309	92,908	173,715
Percentage of non-NHS trade invoices paid within target	58.92%	61.61%	53.50%	54.90%

	2016-17	2016-17	2015-16	2015-16
NHS Payables	Number	£000	Number	£000
Total NHS trade invoices paid in the year	5,016	75,370	4,126	76,612

Total NHS trade invoices paid within target	1,883	43,038	1,437	40,419
Percentage of NHS trade invoices paid within target	37.54%	57.10%	34.83%	52.76%

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.

Disclosure of information to auditors

The Board of Directors who held office at the date of approval of this Annual Report confirm that, so far as they are each aware, there is no material audit information of which the Trust's auditors are unaware; and each Director has taken all the steps that he/she ought to have taken as a Director to make himself/herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Income from the provision of goods and services

The Trust has met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Remuneration Report

Annual statement on remuneration

Nominations and Remuneration Committee

The Trust has a Board Nominations & Remuneration Committee and a Council of Governors Nominations & Remuneration Committee and both work in tandem to ensure that there remains an appropriate balance of skills and experience on the Board.

These Committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors and give consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them. The Committees aim to evaluate annually the balance of skills, knowledge and experience on the Board of Directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both Executive and Non-Executive Directors, including the Chairman.

During 2016-17, the Council of Governors Nominations & Remuneration Committee recommended the appointment of four Non-Executive Directors and a Chairman to the Council of Governors and the Board Nominations & Remuneration Committee also oversaw a process to recruit a new Chief Executive. Both Committees are responsible for overseeing the implementation and correct application of the Fit and Proper Persons Test for appointments to the Board of Directors and Council of Governors respectively. The Board Nominations and Remuneration Committee is also responsible for determining the remuneration and terms of service for the Trust's Chief Executive, executive directors and very senior managers within the overall pay framework of the Trust.

There have been no substantial decisions regarding remuneration during 2016/17.

Remuneration policy 2016-/17

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.

Changes to the Board in 2016-17

There have been a number of changes to the Board during 2016-17 and a key priority for 2017-18 is to stabilise the leadership of the Trust. This is now well underway with the appointment of a substantive Chair, Chief Executive and Chief Financial Officer. In addition during 2017-18, the Chief Executive will recruit substantively to the posts of HR Director, Chief Operating Officer and Strategy 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.

In 2016/17 the process for remunerating the Chairman was different because a new Chairman was appointed by NHS Improvement as part of the work to help the Trust exit quality special measures. The Chairman's remuneration was set by NHS Improvement as part of this.

For non-executive directors, the council agreed to set their remuneration at a spot rate, £12,000, with effect from 1st February 2015. This was reviewed during 2016/17 as several new non-executive directors were recruited. During 2016/17 the Governors kept remuneration levels for non-executive directors at the 2015/16 level.

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 subcommittees, and therefore agreed that initially there should be a single rate for all non-executive directors. This could be reviewed again in future.

Remuneration Report

Name	Job Title	Period	2016/17						2015/16						
			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	
Mr Miles Scott	Chief Executive	left April 2016	bands of £5000/£000	total to the nearest £00	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	total to the nearest £00	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	total to the nearest £00
Ms Paula Vasco-Knight	Chief Operating Officer/Acting CEO (2 weeks)	left April 2016	20-25	0	0	0	0	0	0	0	0	0	0	0	0
Dr Simon McKenzie	Acting CEO and Medical Director	Acting CEO from May 2016	220-225	0	0	0	380-382.5	0	600-605	0	195-200	0	0	0	325-330
Mr Steve Bolam	Chief financial officer and deputy chief executive	left February 2016	0	0	0	0	0	0	0	0	150-155	0	0	175-180	0
Ms Margaret Pratt	Chief financial officer	interim (Nov 16 to Feb 2017)	155-160	0	0	0	0	0	155-160	0	0	0	0	0	0
Mr Nigel Carr	Chief financial officer	interim (May to Oct 2016)	335-340	0	0	0	0	0	335-340	0	0	0	0	0	0
Mr Ian Lyman	Chief restructuring officer/Acting Chief Financial Officer	from 15th February 2016	200-205	0	0	0	0	0	200-205	0	25-30	0	0	0	25-30
Mr Andrew Burn (Note 1)	Turnaround director (Note 1)	June-March 2016	0	0	0	0	0	0	0	0	0	0	0	0	Note 1
Ms Corinne Siddall	Interim Chief Operating Officer	interim from May 16 to Sept 16)	125-130	0	0	0	0	0	125-130	0	0	0	0	0	0
Ms Wendy Brewer	Director of human resources and organisational development	left June 2016	30-35	0	0	0	195-197.5	0	225-230	0	120-125	0	0	170-177.5	290-295
Ms Karen Chapman	Director of human resources	interim (July to Dec 16)	160-165	0	0	0	0	0	160-165	0	0	0	0	0	0
Mr Mark Gammage	Director of human resources	interim (Dec 16 to Mar 17)	100-105	0	0	0	0	0	100-105	0	0	0	0	0	0
Ms Jennie Hall	Chief Nurse and Director of Infection Prevention and Control	left August 16	55-60	0	0	0	230-232.5	0	285-290	0	135-140	0	0	222.5-225	360-365
Ms Suzanne Banks	Chief Nurse and Director of Infection Prevention and Control	September 2016 to December 2016	55-60	2000	0	170-172.5	0	225-230	0	0	0	0	0	0	0
Ms Amy Bhatia	Chief Nurse & Director of Infection Prevention and Control	February 2017 (secondment)	25-30	0	0	0	0	25-30	0	0	0	0	0	0	0
Dr Andrew Rhodes	Acting Medical Director	from May 2016	200-205	0	0	235-237.5	0	435-440	0	115-120	0	0	0	5-7.5	120-125
Mr Eric Munro	Director of estates and facilities	left March 2016	0	0	0	0	0	0	150-155	0	120-125	0	0	77.5-80	200-205
Mr Martin Wilson	Director of delivery and improvement	left May 2016	70-75	0	0	82.5-85	0	150-155	0	115-120	0	0	0	77.5-80	200-205
Mr Robert Blek	Director of strategy	left July 2016	105-110	0	0	92.5-95	0	200-205	0	115-120	0	0	0	92.5-95	210-215
Mr Mark Gordon	Chief operating officer	interim (from Oct 16)	255-260	0	0	0	0	255-260	0	15-20	0	0	0	0	15-20
Mr Richard Hancock	Director of estates, facilities and capital projects	interim (from March 2016)	430-435	0	0	0	0	430-435	0	0	0	0	0	0	0
Mr Paul Moore	Director of Quality Governance	interim (July 15 to Feb 16)	160-165	0	0	0	0	160-165	0	0	0	0	0	0	0
Mr Larry Murphy	IT advisor to Trust Board	interim (from May 16)	255-260	0	0	0	0	255-260	0	0	0	0	0	0	0
Non-executive Directors															
Mr Christopher Smallwood	Chairman	left 31st January 2016	0	0	0	0	0	0	0	0	40-45	0	0	0	40-45
Sir David Henshaw	Chairman (Note 2)	from 16th March 2016	155-160	24700	0	0	0	180-185	0	5-10	3100	0	0	0	5-10
Ms Sarah Wilson	Non-executive director and deputy chair audit committee	Acting chair (1st February to 15th March)	10-15	0	0	0	0	10-15	0	15-20	0	0	0	0	15-20
Mr Michael Rapoport	Non-executive director	left April 2016	0-5	0	0	0	0	0-5	0	5-10	0	0	0	0	5-10
Dr Judith Huff	Non-executive director	left 31st January 2016	0	0	0	0	0	0	0	0	5-10	0	0	0	5-10
Professor Peter Kopelman	Non-executive director	left 31st January 2016	0	0	0	0	0	0	0	0	0-5	0	0	0	0-5
Professor Jennifer Higham	Non-executive director (Note 3)	from 1st November 2015	0	0	0	0	0	0	0	0	0-5	0	0	0	0-5
Ms Kate Leach	Non-executive director	left June 2016	0-5	200	0	0	0	0-5	0	10-15	0	0	0	0	10-15
Ms Stella Panellides	Non-executive director	left August 2016	5-10	300	0	0	0	5-10	0	10-15	0	0	0	0	10-15
Sir Norman Williams	Non-executive director (Quality committee chair)	from April 2016	10-15	0	0	0	0	10-15	0	0	0	0	0	0	0
Ms Gillian Norton	Chair designate (Workforce & education committee chair)	from July 2016	5-10	0	0	0	0	5-10	0	0	0	0	0	0	0
Mr Thomas Sathiel	Associate Non-executive director	from September 2016	5-10	0	0	0	0	5-10	0	0	0	0	0	0	0
Ms Ann Beasley	Non-executive director	from December 2016	5-10	0	0	0	0	5-10	0	0	0	0	0	0	0
Mr Stephen Collier	Non-executive director	from December 2016	5-10	0	0	0	0	5-10	0	0	0	0	0	0	0

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 includes the provision of the services of a turnaround director during this period.

Note 2 - Sir David Henshaw's expenses for March 2016 were estimated as no information was available at the time of last year's report, however 2016-17 were based on actual.

Note 3 – Jennifer Higham - No recharge has been received from her own organisation for services rendered to the Trust.

Pensions Report

Name and job title	Period	2016/17										2015/16									
		Real increase in pension at age 60 at age 60	Real increase in pension and related lump sum at age 60	Total accrued pension at age 60 at 31 March 2017	Lump sum at aged 60 related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	Real increase in Cash Equivalent Transfer Value 31 March 2017	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension	Real increase in pension at age 60 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	Employer's contribution to stakeholder pension				
Mr Miles Scott, Chief Executive	left April 2016	0	0	0	0	0	1223	0	0	70-75	210-215	1,220	0	1,213	3						
Mr Steve Bohan, chief financial officer	left 12th February 2016	0	0	45-50	120-125	732	21	711	22	2-5-5	130-135	681	69	605	24						
Ms Wendy Brewer, director of human resources and organisational development	left June 2016	5-7.5	22.5-25	45-50	145-150	1,025	152	873	5	2.5	125-130	873	67	796	18						
Mr Peter Jenkinson, director of corporate affairs	left 24th November 2015	0	0	0	0	0	0	0	0	0	60-65	346	0	344	11						
Ms Jeanie Hall, chief nurse and director of infection prevention control	left August 2016	0-2.5	5-7.5	55-60	170-175	1,046	60	986	60	0	165-170	986	0	910	20						
Dr Simon Madenize, CEO	acting CEO from May 2016	1.2.5-15.0	52.5-55	95-100	285-290	1,996	337	1,659	32	15-17.5	245-250	1,659	357	1,285-1,290	29						
Mr Eric Munro, director of estates and facilities	left April 2016	0-2.5	0-2.5	5-10	0	96	3	93	0	0	0	69	1	68	17						
Mr Martin Wilson, director of delivery and improvement	left May 2016	0-2.5	0-2.5	20-25	55-60	285	18	266	11	0-2.5	55-60	249	21	226	18						
Mr Rob Elk, Director of Strategy	left July 2016	0-2.5	0-2.5	20-25	65-70	439	27	412	5	0-2.5	65-70	412	45	362	17						
Ms Suzanne Banks, Chief nurse	from October 2016 to January 2017	2.5-5.0	17-19.5	40-45	125-130	798	99	699	8	0	0	0	0	0	0						
Andrew Rhodes, Medical Director	acting from May 2016 from April to October 2016	6.2.5-6.5	23.5-237.5	60-65	170-175	1,124	1,124	0	25	0	0	0	0	0	0						
Luke Edwards, Trust Secretary	from April to October 2016	0-2.5	0-2.5	0-2.5	0	15	14	1	0	0	0	0	0	0	0						

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a 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.

Attendance at the Board nomination and remuneration committee during the year is set out below:

Remuneration and Nomination Committee Attendance Register 2016-17			
		16-Jun-16	09-Feb-17
Members			
Sir David Henshaw	Chair	✓	✓
Sir Norman Williams	NED	✓	✓
Gillian Norton	NED	✓	✓
Jenny Higham	NED	✓	✓
Sarah Wilton	NED	✓	✓
Stella Pantelides	NED	✓	
Ann Beasley	NED		✓
Thomas Saltiel	Associate NED		✓
Quorate:		Yes	Yes

The remuneration report was approved by the Board of Directors on 31st May 2017 and signed on its behalf by Jacqueline Totterdell, Chief Executive and Ann Johnson, Chief Financial Officer.

Jacqueline Totterdell

Chief Executive

31 May 2017

Ann Johnson

Chief Financial Officer

31 May 2017

Disclosures required by Health and Social Care Act

Our workforce 2016-17 Disclosures

Multiple table	
Payroll costs (£000)	530,479
Whole time equivalent	9,588
Median (£000)	27.3
Highest paid employee (£000)	432
Median will fit into highest	15.8 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 2016-17 the highest paid employee of the Trust was paid 13.2 times the median average salary of all employees.

The figures exclude the number and payments to temporary contractors who represented the cost of 629 whole time equivalent employees on average annual pay of £46k per employee (excluding VAT and expenses).

Total Employee Expenses

Cost	2016/17			2015/16
	Permanently employed	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	394,763	6,681	401,444	381,781
Social security costs	40,308		40,308	30,435
Pension cost - defined contribution plans employer's contributions to NHS pensions	45,403		45,403	42,523
Pension cost - other				30
Temporary staff - agency/contract staff		43,324	43,324	31,540
Total gross staff costs	480,474	50,005	530,479	486,309

Average number of employees (WTE basis)

Type	2016/17			2015/16
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,194	67	1,261	1,194
Administration and estates	1,822	354	2,176	2,044
Healthcare assistants and other support staff	696	198	894	622
Nursing, midwifery and health visiting staff	2,809	507	3,316	3,491
Scientific, therapeutic and technical staff	1,660	281	1,941	1,825
Total average numbers	8,181	1,407	9,588	9,176

Number of employees (WTE) engaged on capital projects	14	10	24	0
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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	5	7	41.67%	58.33%
Senior Managers (AFC 8c +)	55	38	59.43%	40.57%
All staff	5,942	2,239	72.63%	27.37%

Off-payroll engagements

For all off-payroll engagements as of 31 March 2017, or more than £220 per day and that last for longer than six months	2016/17 Number of engagements
Number of existing engagements as of 31 March 2017	58
Number that have existed for less than one year at the time of reporting	45
Number that have existed for between one and two years at the time of reporting	13
Number that have existed for between two and three years at the time of reporting	0
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
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

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months	2016/17 Number of engagements
Number of new engagements, or those that reached six months in duration between 1 April 2015 and 31 March 2016	51
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	0
Number for whom assurance has been requested	0
Of which:	
Number for whom assurance has been received	0
Number for whom assurance has not been received *	0
Number that have been terminated as a result of assurance not being received	0

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	2016/17 Number of engagements
Number of off-payroll engagements of board members, and/or, senior	

officials with significant financial responsibility, during the financial year.	7
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.	15

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.	Pass
Details of the length of time each of these exceptional engagements lasted.	Pass

Staff report

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.

Our workforce is the most important asset the Trust has, and we understand the importance of engaging with our staff and 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, to generate discussions and to provide feedback on different issues that affect us all.

This year we will be introducing values based recruitment for all roles so that we strengthen our appointments processes and only recruit people who can demonstrate that they will work in accordance with our values. The increase in turnover we have experienced in recent years is something that we are working hard to reduce. We now have valuable information from exit questionnaires and exit interviews which reinforce the need for us to develop our staff in ways that help to retain them in the organisation.

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.

National NHS Staff Survey

The 2016 National NHS Staff Survey took place in all NHS organisations in autumn 2016. St George's had an overall response rate of 40%, an improvement from the 2015 response rate of 31%, which is still below the average response for combined acute and community Trusts (42.3%). The range of questions asked remains consistent from year to year, making it possible to benchmark against previous years as well as against other Trusts. The survey was well communicated to all staff via our internal communications channels including our twice weekly e-newsletter, eG, messages from the Chief Executive and a Trust wide awareness raising campaign.

Our overall engagement score has decreased slightly this year to 3.70 (out of 5) compared to the national average for combined Trusts of 3.80. In 2016, the Trust's top five areas of performance were reported as:

- quality of non-mandatory training, learning and development
- quality of appraisals
- percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from the manager, colleagues or themselves
- percentage of staff reporting errors, near misses or incidents witnessed in the last month
- percentage of staff/colleagues reporting most recent experience of violence.

The bottom five ranked scores were:

- organisation and management interest in and action on health and wellbeing
- staff satisfaction with resourcing and support

- staff experiencing harassment, bullying and abuse from other staff
- support from immediate managers
- effective team working

	2015/16		2016/17		Improvement/deterioration
	St George's	National Average	St Georges	National Average	
Response rate	31%	43%	40.4%	42.3%	Improvement
Top 5 ranking scores					
KF13. Quality of non-mandatory training, learning or development	4.05	4.04	4.10	4.07	Improvement
KF12. Quality of Appraisals	3.04	3.03	3.19	3.11	Improvement
KF18. % of staff feeling under pressure to attend work when not well	57%	58%	53%	55%	Improvement
KF29. % of Staff reporting errors, near misses or incidents witnessed in the last month	88%	90%	91%	91%	Improvement
KF24. % of staff/ colleagues reporting most recent experience of violence	52%	52%	68%	67%	Improvement
Bottom 5 ranking scores					
KF19. Organisation and management interest in action on health and wellbeing	3.33	3.59	3.41	3.61	Improvement
KF14. Staff Satisfaction with resourcing and support	3.11	3.72	3.15	3.28	Improvement
KF26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	33%	24%	32%	23%	Improvement
KF10. Support from immediate line managers	3.58	3.72	3.63	3.74	Improvement
KF9. Effective Team Working	3.64	3.77	3.67	3.78	Improvement

Our future workforce priorities and targets are informed by the results of our staff survey.

The overriding objective of our workforce plan is to develop a highly skilled, highly motivated and engaged workforce by addressing issues that most affect the workforce, in particular in the areas of turnover and staff engagement. Our staff survey action plan will focus on three areas. The Corporate action plan will focus on:

- harassment and bullying

- equality and diversity
- staff engagement

Each Division and Corporate Directorate will also be asked to develop their own local plans to take account of any local issues that are identified as a result of the survey.

A working group comprising Divisional, staff group and Staff Side representatives will be responsible for developing the action plan with support from communication colleagues to ensure our workforce is aware of the actions being taken in response to the survey.

In 2016 we appointed a 'Speak-up' champion to supplement our Listening into Action liaison role which was established to hear staff concerns and resolve them. Some of the concerns raised by our staff relate to the estate and IT infrastructure and considerable work is under way to address these over the next few years.

We are aware that as we address our financial performance, staff are continuing to provide excellent clinical services. We want to recognise this and as such we will ensure our values awards are well publicised, so that this excellence is properly acknowledged internally.

As part of the work on improving how staff view equality and diversity, the Staff Network Action Group will work to address some of the key issues highlighted in the 2016 staff survey relating to staff from black and minority ethnic (BME) groups. In 2016/17 we rolled out our successful unconscious bias training to all managers, and this training has now been made part of our mainstream training programme for managers. We want to promote openness and transparency regarding appointments, acting up arrangements and promotions and in 2016 we reviewed all acting up arrangements and all such arrangements are now monitored. In 2017, we will review all appointments in 2016-17 to identify any adverse impact in our recruitment processes and put into place actions to ensure that all staff have equal opportunities for development and promotion.

We will continue to tackle harassment and bullying towards staff by other staff members, building on changes to the policy to encourage early informal resolution of concerns rather than using the formal policy route. Through investigations, we are aware that some members of staff have encountered bullying and harassing behaviour and we are taking formal action where such behaviours occurred. The strategy to tackle bullying includes coaching and training for managers dealing in 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. In addition, we have a bullying and harassment support line run by the staff support service.

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 managers will participate in leadership development programmes 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.

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. In March 2017 we appointed a permanent Staff Wellbeing lead who has developed a wellbeing strategy that includes a wide-range of wellbeing initiatives designed to promote good health. The health and wellbeing lead worked closely with colleagues in the Occupational Health Department, the Chief

Executive and the Medical Director to improve the uptake of the flu vaccine, achieving 72% vaccination rate for patient-facing staff. We have employed 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. Regular Pilates, yoga and other fitness 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 2016 and further work will take place in 2017 to involve trade union representatives in training sessions, in order to improve understanding of not only the policies but also of the respective roles that managers and trade union representatives play in the processes.

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. Details of the award winners 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 and has now been made permanent. 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.

Staff engagement communication channels

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.

Core brief

The core brief is made up of a written summary of the monthly senior leaders briefing provided by the Chief Executive. Every other month the Chief Executive core brief is sent to senior leaders across the Trust to discuss with their teams.

Meet the CEO/Chair

Meet the CEO/Chair is a monthly session that all staff can get involved in by attending or by submitting questions for the Chief Executive or Chair 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.

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 and interviews help inform our plans for strengthening those 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:

- induction for managers
- effective people management
- appraise your staff

- performance conversations
- having difficult conversations
- conflict resolution
- leadership and management training
- aspiring programme in readiness for ward manager, consultant or other clinical leadership role
- new leaders programme for consultants, matrons, general managers including paired learning for doctors and managers and quality improvement
- responding to complaints
- strategy workshop for divisional management teams
- tailored team diagnostics, team-building and helping teams in trouble
- access to a coach

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.
- authority and impact in the workplace

Faculty development:

- advanced clinical communications
- recognising postgraduate supervisors
- accreditation workshop
- professional boundaries
- authority and impact workshop
- trainee in difficulty

All staff:

- assertive communication
- AMSPAR medical terminology
- being your best
- business administration

- effective customer service
- excel with Excel
- grand rounds
- medical terminology
- resilient thinking for peak performance
- Sage & Thyme
- Schwartz Rounds
- team development
- working with Word
- writing persuasive letters, emails and reports
- 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. Additional modules in end of life care and mental health are available to HCSWs from our FE partner, South Thames College.

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 HCSWs 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 are the Lead Employer for the South West London Consortium for the new Nursing Associate role. The programme was successfully recruited to, and the 2 year training programme commenced in January 2017. At the end of the programme the Nursing Associate trainees will be able to work to support registered nurses.

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. We offer placements to staff from the mental health Trust so that they are confident to nurse their patients in the mental health setting.

We have developed a new programme through the simulation laboratory to address mental health issues in end of life.

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. If necessary, accredited in-house mediators can help resolve issues between individuals or teams.

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.

Mandatory and statutory training compliance has improved, but needs to improve further. The Trust successfully piloted a 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, and the new Nursing Associate qualification is being re-designed to be an apprenticeship.

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 2016/17:

Staff group	%
Add prof scientific and technical	2.49%
Additional clinical services	5.43%
Administrative and clerical	4.17%
Allied health professionals	2.7%
Estates and ancillary	5.81%
Healthcare scientists	1.99%
Medical and dental	1.03%
Nursing and midwifery registered	3.63%
Total	3.29%

Total days lost *	66,066
Total staff years (Staff whole time equivalent)*	8,727
Average working days lost*	7.6

**Figures are presented as calendar year figures and not financial year figures.*

When compared to other teaching Trust, the average for the last quarter of the year was 4.1%, where St George’s sickness absence levels were at 3.6%.

Occupational health and staff support

The occupational health service supports the wellbeing of staff so that they can work safely and effectively. In 2017, the Wellbeing lead consulted on a wellbeing strategy 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 policies 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 tackling 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 to help to minimise the impact of work-related levels of stress within the organisation.

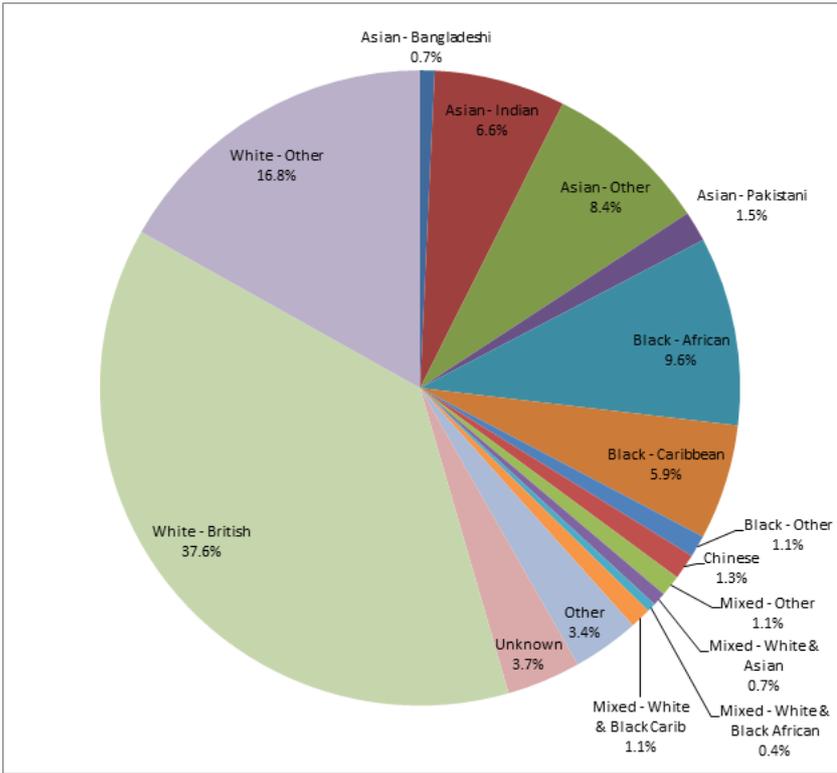
Our policy on the employment of disabled people and our recruitment and selection policy sets out how we recruit people with disabilities, ensuring that a guaranteed interview is offered to any disabled candidate who meets the essential criteria for the role and discussing any adjustments that might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

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 45% of its population from non-white British backgrounds and speaking over 300 languages other than English.

Among our staff, we are proud to reflect the composition of the wider population that we service with nearly 46% of our staff being from non-white populations. That said there is still much more work to do to ensure that this composition is reflected throughout all the grades of staff we employ, as at present our ethnic minority staff are still disproportionately represented in the lower grades.

STAFF PROFILE 2016/17



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.

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 including one working at the Trust. 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.

Our policy on the employment of disabled people 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 at: 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.

Workforce of the future

Simulation suite

Now in its 18th year of operation and second build, St George's Advanced Patient Simulation and Skills Centre (GAPS) is a Trust facility based in Hunter Wing of the University. GAPS train more than 4,000 doctors, nurses, allied health professionals and final year medical students each year through internal, external and specific HEE contracts. It is widely recognised as one of the most innovative inter-professional healthcare simulation and skills facilities in the country delivering courses using a variety of technology enhanced learning initiatives. However, its core business is the training and support of St George's workforce in caring for acutely ill patients by focusing on building resilience of safety within teams as well as individuals. Our staff learn in multi-professional teams and reflect by engaging in inter-professional conversations about practice provoked by experiences gained in either the simulated or real clinical environment.

Simulation-based training takes place both in the GAPS centre and out in clinical areas of the Trust working collaboratively with local clinical experts (e.g. Wards, delivery suite, emergency department, operating theatres, critical care units and satellite areas). GAPS also delivers simulation-based training in the community; local GP and Dental practices focusing on 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 highlighting both good practice and identifying latent errors and issues requiring immediate attention.

GAPS is also a major provider of clinical and surgical skills training and is consistently highly rated by external participants for Advanced trauma life support (ATLS), European Trauma Course (ETC), Basic

Surgical Skills (BSS), Care of the Critically Ill Surgical Patient (CCrISP) and a host of other Royal College of Surgeons' (RCS) seconded courses. In terms of Trust staff skills training 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. 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, allowing St. George's to maintain its place as a leading expert in robotics / minimally invasive surgery and trauma care.

GAPS constantly strive to maintain the inter-professional nature of its resource. These include courses under the GAPS Patient Safety training courses branded 'MEERKATS' - Medical Emergencies, Evaluation, Response and Keeping Attention on Team Communication and Patient Safety. This set of educational programmes is aimed at clinical staff of all grades and professional backgrounds. It combines the essential elements of patient safety with good practice in communication and recognition and management of the acutely unwell patient. All participants in simulation-based team training courses like above learn together, reflect together and discuss together in teams similar to the ones that deliver health care on the wards. Simulation courses include senior and junior doctors, senior and junior nurses, medical and nursing students and health care assistants. Learners participate in the simulation exercises in their normal clinical role and work in realistic clinical teams.

The GAPS Team are a lead in faculty development, delivering Simulation Based Learning & Teaching (Train the Trainers) to the multi-professional clinical experts, with a focus in creating a sustainable educational faculty for localised specialty specific training. This group collaborates with Trust audit, Directorate boards and the recently established Deteriorating Adult Patient group, to identify areas that require support, resource and training to meet the standard in terms of Patient Safety. As a result, the greatest strength of the centre is the teaching faculty base of more than 300 experienced clinical educators, from all disciplines in healthcare.

Despite its considerable educational output, the GAPS core team is relatively small. Seven permanent centre staff includes a Head of Simulation & Skills (Nicholas Gosling), 2 Clinical Simulation Specialists (Jasmine Burnett, Christopher Broom), an experienced Technician/Engineer (Andrew Sykes), Skills Co-ordinator (Robert Colson), Administrative Staff (Philippa Newman & Manana Mudhir) and a Medical Educationalist (Huon Snelgrove). Strategically the centre is co-directed by a further 3 highly experienced Clinical Directors (Argyro Zoumprouli), GAPS Director, Consultant of Neuro-intensive Care & Anaesthesia, (Asanga Fernando), GAPS Co-Director Consultant Liaison Psychiatrist in Oncology and (Mr Duncan Tennent), GAPS Surgical Director Consultant Orthopaedic Surgeon, Honorary Reader in Orthopaedic Education at SGUL and Director of Education at SWLEOC.

The centre offers Clinical Simulation Fellowships to develop trainee doctors as teachers and the use of Technology Enhanced Learning to supplement their clinical development within the specialty training, over a 6/12 month period. Collaboratively the projects and initiatives GAP'S team members produce are regularly presented at national and international meetings. The extended faculty, fellows and educational leads owe a great deal to the enthusiasm and dedication over two decades from Head of Department, Nicholas Gosling, whom won the NHS Development Champion of the Year in the London Leadership awards in 2015.

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 our talented staff is just as important as recruiting them. We have focused 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.

Disclosures set out in the NHS Foundation Trust Code of Governance

Principal activities of the Trust

Information on the principal activities of the Trust, including performance management, financial management and risk, efficiency and the work of the research and development division and International and Private Patient division is outlined in the Performance Report on pages 4 to 11

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 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.

Trust Board

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. The Board of Directors has standing orders, which set out the procedure for meetings and for recording decisions.

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), NHS Improvement 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 has the following Committees:

- Audit Committee
- Nominations & Remuneration Committee
- Quality Committee (formerly a Quality & Risk Committee)
- Finance & Performance Committee
- Workforce & Education Committee

Each Board Committee reports to the Board after each of its meetings on matters that it wishes to bring to the Board's attention or matters of assurance. In addition, each Committee Chair leads an annual evaluation into the effectiveness of the Committee which is also reported to the Board.

The Board agrees its Annual Plan, which set out financial, quality and operating objectives, with input from the Council of Governors. This is then agreed with NHS Improvement and published on our website. The Board regularly monitors progress against its Annual Plan.

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 2016/17

The following tables set out the number of directors' meetings held during the year and the number of board committee meetings attended by each director:

Trust Board Attendance Register 2016-17		07.04.16	05.05.16	02.06.17	16.06.17 (Private)	30.06.17 (Private)	28.07.16	01.09.16	06.10.16	03.11.16	01.12.16	21.12.16 (Teleconf)	22.12.16 (Teleconf)	05.01.17	30.01.17 (Teleconf)	09.02.17	09.03.17
Members																	
NEDs																	
Sir David Henshaw	Chairman	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Jenny Higham	Non-Executive Director	√	Apols	√	√	√	√	Apols	√	√	√	√	Apols	Apols	√	√	√
Kate Leach	Non-Executive Director	√	Apols	√													
Mike Rappolt	Non-Executive Director	√	Apols														
Stella Pantelides	Non-Executive Director	√	√	√	√	√	√										
Ann Beasley	Non-Executive Director									√	√	√	√	√	√	Apols	√
Stephen Collier	Non-Executive Director									√	√	√	√	√	√	√	Apols
Gillian Norton	Non-Executive Director			√	√	√	Apols	√	√	√	√	√	√	√	√	√	√
Sir Norman Williams	Non-Executive Director			√	√	√	Apols	√	√	√	√	√	Apols	√	√	Apols	√
Sarah Wilton	Non-Executive Director	√	√	√	√	√	√	Apols	√	√	√	√	√	√	√	√	√
Associate NED (Non-Voting)																	
Thomas Saltiel	Associate Non-Executive Director							√	√	√	√	Apols	Apols	√	√	√	√
Voting Directors																	
Miles Scott	Chief Executive	Apols															
Paula Vasco-Knight	Interim Chief Executive																
Simon Mackenzie	Chief Executive		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Jennie Hall	Chief Nurse & DIPC	√	√	√	√	√	Apols	Apols	√	√	√	√	√	√	√	√	√
Suzanne Banks	Chief Nurse & DIPC																
Avey Bhatia	Chief Nurse & DIPC																
Iain Lynam	Chief Financial Officer	√	√														√
Nigel Carr	Chief Financial Officer			√	√	√	√	√	√	√	√	√	√	√	√	√	√
Margaret Pratt	Chief Financial Officer																
Simon Mackenzie	Medical Director	√															
Andrew Rhodes	Medical Director		√	√	√	√	√	Apols	√	√	√	√	√	√	√	√	√
In Attendance (Board)																	
Rob Elek	Director of Strategy	√	√														
Martin Wilson	Director of Transformation	√															
Wendy Brewer	Director of Workforce and OD	√	√	√	√												
Karen Charman	Director of Workforce and OD						√	Apols	√	√	√	√	√	√	√	√	√
Mark Gammage	HR Advisor to the Board																
Paula Vasco-Knight	Chief Operating Officer	√															
Corrine Siddall	Chief Operating Officer		√	√	√	√	√	Apols									
Mark Gordon	Chief Operating Officer					√		√	√	√	√	√	√	√	√	√	√
Eric Munro	Director of Estates & Facilities																
Richard Hancock	Director of Estates & Facilities		√	√	√	√	√	Apols	√	√	√	√	√	√	√	√	√
Diana Lacey	Programme Director Elective Care (DQ)																
Iain Lynam	Chief Restructuring Officer			√	√	√	√	√	√	√	√	√	√	√	√	√	√
Paul Moore	Director of Quality Governance																
Larry Murphy	Chief Information Officer				√	√	Apols	Apols	√	√	√	√	√	√	√	√	√
In Attendance (Divisions)																	
Alison Benincasa	Divisional Chair, CSD		√	√	√	Apols	√	√	√	√	√					√	√
Tunde Oduoye	Divisional Chair, SNTC	Apols	Apols	Apols	√	Apols	Apols	Apols	√	Apols	Apols					√	√
Lisa Pickering	Divisional Chair, MedCard	√	Apols	√	Apols	√	√	√	√	√	√	√	√	√	√	√	√
Andy Rhodes	Divisional Chair, CWDT	√															
Justin Richards	Divisional Chair, CWDT		Apols	Apols	Apols	√	√	√	√	√	√	√	√	√	√	√	√
Secretariat																	
Luke Edwards	Corporate Secretary Head of Governance	√	√	Apols	√	√	√	Apols	√								
Fiona Barr	Trust Secretary and Head of Governance									√	√	√	√	√	√	√	√
Quorate:		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Committee Membership 2016-17						
	Trust Board	Quality Committee	Audit Committee	F&P Committee	WEC	RemCom
Terms of Reference						
NEDs						
Sir David Henshaw	✓			✓		✓
Ann Beasley	✓		✓	✓		✓
Stephen Collier	✓			✓	✓	✓
Jenny Higham	✓	✓				✓
Gillian Norton	✓		✓	✓	✓	✓
Sir Norman Williams	✓	✓	✓			✓
Sarah Wilton	✓	✓	✓	✓		✓
ASSOCIATE NED						
Thomas Saltiel	✓	✓	✓	✓		
EXECUTIVE DIRECTORS						
Chief Executive	✓	✓		✓		
Chief Nurse & DIPC	✓	✓	✓	✓	✓	
Chief Financial Officer	✓		✓	✓		
Medical Director	✓	✓		✓		
HR Advisor to the Board	✓			✓		✓
Chief Operating Officer	✓		✓	✓		
Director of Estates & Facilities	✓			✓		
Chief Restructuring Officer	✓			✓		
Director of Quality Governance	✓	✓	✓			
Chief Information Officer	✓					
Programme Director Elective Care (DQ) Recovery (From Nov 2016)	✓			✓		
Improvement Director (From Feb 2017)	✓	✓				
DIVISIONS						
Alison Benincasa	✓					
Tunde Odutayo	✓					
Lisa Pickering	✓					
Justin Richards	✓					
SECRETARIAT						
Corporate Secretary & Head of Governance	✓	✓	✓	✓	✓	✓

Finance & Performance Committee Attendance Register 2016-17														
		27-Apr-16	25-May-16	29-Jun-16	27-Jul-16	24-Aug-16	28-Sep-16	26-Oct-16	23-Nov-16	14-Dec-16	25-Jan-17	22-Feb-17	02-Mar-17	#####
Members	Members													
Sarah Wilton	Non-Executive Director (Committee Chair until Jun 2016)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	✓
Sir David Henshaw	Chairman (Committee Chair from July 2016)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	✓	✓	Apols
Mike Rappolt	Non-Executive Director	Apols												
Ann Beasley	Non-Executive Director							✓	✓	✓	Apols	✓	✓	✓
Stephen Collier	Non-Executive Director							Apols	✓	✓	✓	Apols	Apols	✓
Gillian Norton	Non-Executive Director					✓	Apols	✓	✓	✓	✓	✓	✓	Apols
Paula Vasco-Knight	Acting Chief Executive	✓												
Simon Mackenzie	Medical Director / CEO from May 2016	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols
Nigel Carr	Finance / Chief Financial Officer from May-Oct 2016	✓	✓	✓	✓	✓	✓	✓						
Margaret Pratt	Senior Finance Advisor /Chief Financial Officer from Oct 2016-Feb 2017	✓	✓	✓	Apols	✓	✓	✓	✓	Apols	✓	✓		
Andy Rhodes	Divisional Director / Medical Director from May 2016	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	✓	✓	✓
Wendy Brewer	Director of Workforce and Organisational Development	✓	Apols											
Karen Chaman	Director of Workforce and Organisational Development			✓	Apols	✓	✓	Apols	✓					
Mark Gammage	HR Advisor to the Board									✓	✓	Apols	✓	✓
Jennie Hall	Chief Nurse & DIPC	✓	✓	Apols										
Hazel Tonge	Acting Chief Nurse				✓	✓								
Suzanne Banks	Chief Nurse & DIPC						Apols	Apols	Apols	Apols	Apols			
Avey Bhatia	Chief Nurse & DIPC											✓	✓	✓
Quoratey: At least 3 members including one Executive, two Non-Executives, one of whom will act as Chair		Yes	Yes											

Quality Committee Attendance Register 2016-17									
		03-May-16	26-May-16	30-Jun-16	27-Jul-16	29-Sep-16	23-Nov-16	25-Jan-17	23-Mar-17
Members	Members			NO MTG					
Jenny Higham	Non-Executive Director, (Chair until 03.05.17)	✓	Apols		✓	✓	✓	Apols	✓
Sir Norman Williams	Non-Executive Director (Chair from 26.05.17)		✓		Apols	✓	✓	✓	✓
Sarah Wilton	Non-Executive Director	✓	✓		Apols	✓	Apols	✓	✓
Stella Pantelides	Non-Executive Director	✓	Apols						
Richard Hancock	Director Estates & Facilities	✓	Apols		✓	✓	✓	✓	
Jennie Hall	Chief Nurse & Director of Infection Prevention & Control	✓	✓		Apols				
Suzanne Banks	Chief Nurse & Director of Infection Prevention & Control					✓	Apols	Apols	
Avey Bhatia	Chief Nurse & DIPC								✓
Andy Rhodes	Medical Director		✓		✓	✓	✓	Apols	✓
Hazel Tonge	Deputy Chief Nurse		✓		✓		✓		
Wendy Brewer	Director of Workforce & Organisational Development		✓						
Karen Chaman	Director of Workforce & Organisational Development				Apols	Apols	Apols		
Paul Linehan	Head of Governance						✓	✓	✓
Quoratey: At least six members of the Committee		No	Yes		No	Yes	Yes	No	Yes

Audit Committee Attendance Register 2016-17		26-May-16	15-Sep-16	10-Nov-16	18-Jan-17	15-Mar-17
Members						
Sarah Wilton	Non-Executive Director (Chair)	√	√	√	√	√
Stella Pantelides	Non-Executive Director	√				
Gillian Norton	Non-Executive Director		Apols	√	√	Apols
Ann Beasley	Non-Executive Director				Apols	√
Sir Norman Williams (Ex officio Member)	Non-Executive Director					Apols
Quorate: At least two members of the Committee		Yes	No	Yes	Yes	Yes

Workforce & Education Committee Attendance Register 2016-17		31-May-16	29-Sep-16	24-Nov-16	31-Jan-17	14-Mar-17
Members						
Stella Pantelides	Non-Executive Director (Chair)	√				
Gillian Norton	Non-Executive Director (Chair)		√	√	√	√
Stephen Collier	Non-Executive Director			Apols	√	√
Ann Beasley	Non-Executive Director			Apols	Apols	√
Kate Leach	Non-Executive Director	Apols				
Wendy Brewer	Director of Workforce & OD	√				
Karen Charman	Director of Workforce & OD		√	√		
Mark Gammage	HR Advisor to the Board				√	√
Avey Bhatia	Chief Nurse				Apols	√
Suzanne Banks	Chief Nurse		√	Apols		
Jennie Hall	Chief Nurse	Apols				
Hazel Tonge	Deputy Chief Nurse	√				
Quorate: At least 3 members, of whom at least 1 shall be Non-Executive Directors and at least 2 Executive or Associate Executive Directors		Yes	Yes	Yes	Yes	Yes

Expenditure on consultancy

Expenditure on consultancy	2016/17	2015/16
Consultancy costs (£k)	2581	2503

Off-payroll arrangements

Information about off-payroll engagements can be found on pages 45-46

Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	2	3
£10,001 – £25,000	1	2	3
£25,001 – £50,000	1		1
£50,001 – £100,000 (Note 1)		3	3
£100,001 – £150,000	1		1

£150,001 – £200,000			
Total number of exit packages by type	4	7	11
Total resource cost (£k)	£195	£240	£435

(0 Number and Cost 2015/16)

Exit packages: non-compulsory departure payments

	Agreements Number	Total Value of Agreements £k
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs	1	11
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice (Note 1)	6	229
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval *		
Total	7	£240

(0 Number and Cost 2015/16)

Note 1: Included in these figures were exit packages Martin Wilson – Director of delivery and improvement £62,500, Robert Elek - Director of strategy £60,000 and Steve Bolam - Chief financial officer and deputy chief executive £85,814. These amounts were paid in lieu of notice in relation to their outstanding contracts.

Directors' responsibilities statement and going concern

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 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

Transactions with related parties

Transactions with third parties are presented in the financial accounts on page 47

For the other Board Members, the Foundation Trust's Councillors, or parties related to them, none of them have undertaken material transactions with the Trust.

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

Remuneration of senior managers

Details of senior employees' remuneration can be found in page 39 of the Remuneration Report.

Political and charitable donations

The Trust has not made any political or charitable donations during 2016/17

Countering fraud and corruption

The Trust has a countering fraud and corruption policy.

Counter fraud arrangements are reviewed during the year by the Local Counter Fraud Service (LCFS). The LCFS undertakes an on-going programme of work to raise the profile of counter fraud measures and

carries out ad hoc audits and specific investigations of any reported alleged frauds. This includes the use of fraud awareness presentations and fraud awareness surveys. The Audit Committee receives and approves the Counter Fraud Annual Report, monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

Single Oversight Framework

NHS Improvement’s Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where ‘4’ reflects providers receiving the most support, and ‘1’ reflects providers with maximum autonomy. A foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor’s Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement’s guidance for annual reports.

Segmentation

St George’s University Teaching Hospitals NHS Foundation Trust has been placed in segment 4 – Special Measures and this reflects the latest position as published on the NHS Improvement website - April 7th 2017.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from ‘1’one to four, where ‘1’ reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	[4]	[4]
	Liquidity	[4]	[4]
Financial efficiency	I&E margin	[4]	[4]

Financial controls	Distance from financial plan	[4]	[4]
	Agency spend	[4]	[4]
Overall Scoring		[4]	[4]

Statement of the Chief Executive's Responsibilities as the Accounting Officer

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 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 required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance 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 the NHS Foundation Trust Accounting Officer Memorandum.

Signed



Chief Executive Officer

Date: 31 May 2017

Annual Governance Statement 2016/17

Introduction

The Care Quality Commission's inspection report for St George's, published in November following their visit in June 2016, raised concerns about the quality of care the Trust provides in certain areas, and the Trust was placed in special measures for quality as a result.

On 1 November 2016 the Trust was placed in Quality special Measures and had further conditions imposed on its Licence. In order to address these, the Trust has commissioned an external review of governance to take place early in 2017/18. The results of this will form a significant part of the work of the Board and its committees for the next year. We anticipate this will focus on the development of a unitary board and greater clarity and grip on the Trust's control and assurance framework.

The Trust also received a Financial Improvement Notice in April 2017 though was notified by NHS Improvement that it would be placed into Financial Special Measures on 24th March 2017.

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's 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 on-going 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 31 March 2017 and up to the date of approval of the annual report and accounts.

Board of Directors

Chief Executive

The Chief Executive's role is to lead and manage the development of the Trust to provide a high quality and consistently safe patient-centred service within the resources available; to take executive responsibility for all aspects of the performance of the Trust and; to ensure the Trust aspires to engage and develop its staff and operates in an efficient and effective manner.

The Chief Nurse

The Chief Nurse has 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. In addition the Chief Nurse's responsibilities include:

- 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.
- leading the Trust with respect to complaints, taking overall responsibility for the management and resolution of complaints, and identifying the learning and service improvements the Trust should take from them.
- being 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.

The Medical Director

The Medical Director 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 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, practice and strategies supported by education and training and research.

Finance Director

The Finance Director is an Executive Director and the Chief Finance Officer for the Trust, accountable for the overall financial performance of the Trust. The Finance Director's responsibilities also include developing a clear financial plan to continue the Trust's financial improvement, and developing robust financial control systems.

The Finance Director's responsibilities also include:

- the relationship with the Trust's strategic and commercial partners.
- the Trust's approach to performance management and information within its divisions.
- overall management of procurement services.

The Finance Director also has a key role to play in the management and development of the Trust's charitable resources.

The Director is the financial advisor to the Board, Executive and Clinical Directors and Service Managers. He/she is responsible for all aspects of financial governance, including supporting the Audit Committee and Finance and Performance Committees in discharging their responsibilities, maintaining financial control and systems and ensuring a highly regarded and developed finance function.

Trust Secretary

The Trust Secretary is head of corporate governance and is responsible for the establishment and continuous development of governance arrangements and processes, and for ensuring a flow of high quality information to and from the Board and Directors and the Council of Governors.

Board Committees

The Trust's governance framework sets out the mechanisms by which it leads, directs and controls its functions in order to achieve its organisational objectives. The governance framework sets out the Trust's committee and divisional management structures and the roles and responsibilities. There is a plan to renew these as part of the wider work to move the Trust out of special measures. 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 top of the Board's agenda.

Audit Committee

The role of the Audit Committee is to review and independently scrutinise St George's University Hospitals NHS Foundation Trust systems of clinical governance, internal control and risk management thereby ensuring, through proper process and challenge, that integrated governance principles are embedded and practised across all Trust activities and that they support the achievement of the Trust's objectives.

As part of this the committee undertakes all the statutory duties of a Foundation Trust audit committee. This includes reviewing and seeking assurance on the integrity of key internal and external financial, clinical, fraud and corruption and other policies, reports and assurance functions thereby providing independent assurance on them to the Board of St George's.

During 2016/17 the Audit Committee received internal audit reports on a variety of topics including overseas patients and cyber security. It also reviewed whistleblowing systems and counter-fraud activity, as well as scrutinising waivers to the Trust's Standing Financial Instructions.

In addition the Committee received assurance on provider agreements and approved the Annual Report and Accounts for 2015/16

During 2017/18 the Committee will continue to deliver activities in line with its terms of reference.

Nominations and Remuneration Committee

The Trust has a Board Nominations & Remuneration Committee and a Council of Governors Nominations & Remuneration Committee and both work in tandem to ensure that there remains an appropriate balance of skills and experience on the Board.

These Committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors and give consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them.

The Committees aim to evaluate annually the balance of skills, knowledge and experience on the Board of Directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both Executive and Non-Executive Directors, including the Chairman.

During 2016-17, the Council of Governors Nominations & Remuneration Committee recommended the appointment of four Non-Executive Directors and a Chairman to the Council of Governors and the Board

Nominations & Remuneration Committee also oversaw a process to recruit a new Chief Executive. Both Committees are responsible for overseeing the implementation and correct application of the Fit and Proper Persons Test for appointments to the Board of Directors and Council of Governors respectively.

The Board Nominations and Remuneration Committee is also responsible for determining the remuneration and terms of service for the Trust's Chief Executive, executive directors and very senior managers within the overall pay framework of the Trust.

Quality Committee (formerly the Quality & Risk Committee)

The Quality Committee examines assurances in the following areas. :

- the level of risk to which patients' are exposed
- the extent to which clinical outcomes required by corporate strategy are being met
- the extent to which patient and user satisfaction matches that required by corporate strategy
- the extent to which the Trust can demonstrate learning and improvement; and
- the level of compliance with Fundamental Standards of Care .

Examples of key activity undertaken in 2016/17 include:

- oversight of the risks to quality as set out in the Trust's Board Assurance Framework
- Consider independent assurances from external bodies including royal colleges, NHS Improvement and the Care Quality Commission
- Keeping oversight of the Trust's 'quality dashboard'
- Receiving clinical quality reports on areas such as clinical audit, cancer management, and clinical coding
- Oversight of infection control processes.

Looking forward to 2017/18, the Quality Committee will play a key role in supporting the Trust exit Quality Special Measures and oversee the delivery of the Quality Improvement Programme.

Finance and Performance Committee

The Finance and Performance Committee helps the Trust strike a balance between providing effective and high quality healthcare and current financial constraints. It retains a strong focus on the quality implications of the Trust's financial decisions and achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensure:

- detailed consideration is given to the Trust's financial, investment and associated performance issues to ensure that the Trust uses public funds wisely; and
- adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies and achievement of the Trust's strategic aims and objectives;
- the management of operational performance against national targets and corporate objectives.

The Committee also has a role in in the Trust's performance management framework, receiving recommendations for intervention as part of the agreed escalation process when required.

During 2016/17 the Committee oversaw a range of activities including: operational performance and quality of services; ensuring data quality; governance effectiveness and the delivery of the Trust's financial recovery plan.

During 2017/18 the Committee will continue to deliver activities in line with its terms of reference. A part of this work plan is to maintain grip on deliver of the Trust's financial recovery plan and, although this relates only to 2017/18, exit financial special measures.

Workforce and Education Committee

The Workforce and Education Committee has been established to provide assurance to the Trust Board that there are processes and plans in place to ensure that the trust's key strategic objective of a 'workforce proud to provide excellent care, teaching and research' can be achieved. It's key activities are:

- To review focus, identify priorities and to review progress against implementation of the components of the workforce strategy:
 - maximise the well-being of our staff and their levels of engagement
 - strengthen leadership and line management including the quality of appraisal
 - develop a robust workforce plan to support delivery of the trust strategy
 - improve the efficiency and productivity of the workforce
 - improve patient safety, experience and outcomes through the provision of excellent and innovative education
 - strengthen the sense of engagement and belonging to the trust felt by all community and acute staff
- To set an annual plan for the meeting cycle circulating members
- To receive and monitor reports from the Partnership Forum
- To receive confidential progress reports on 'Maintaining High Professional Standards in the Modern NHS' cases
- To approve draft employment policies and recommend for ratification by the Board
- To receive reports from and to oversee the direction of the Education Board

In 2016/17 the Committee undertook a wide range of activity including: overseeing the implementation of the Friends and Family Test and annual staff survey; ensuring staff are appraised regularly; determining workforce priorities for the Trust; and managing risks relating to the Trust's workforce.

During 2017/18 the Committee will continue to deliver activities in line with its terms of reference.

Attendance at the Trust Board and its Committees is set out on pages 60 - 62 above

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
- The 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.

Divisional Governance

Each division has a Divisional Management Board and a Divisional Governance Board that oversee the implementation of the division's strategies and business plan. Each division has a divisional chair who is accountable for the financial and operational performance of the division, as well as the quality of services and being part of the process that escalates issues and provides assurance from ward to Board level.

Annual Quality Report

The Annual Quality Report is contained within pages 89 and 193 of this report.

Capacity to Handle Risk

The Trust has an approach to decision-making that is informed by a full range of corporate, financial, clinical and quality governance, and ensures compliance with the five main principles of the corporate governance code: leadership, effectiveness, accountability, remuneration and relations with stakeholders.

There is an established governance framework, supported and maintained by a framework of committees. The Trust Board has overall responsibility for the effectiveness of the governance framework and as such requires that each of its 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 Chair in ensuring the effective performance of the Board and its committees. I achieve this in a number of ways by:

- monitoring attendance
- maintaining an overview of the quality of presented information, including agenda items and supporting evidence
- requesting the attendance of representatives from across the Trust when required
- ensuring that there is an annual declaration of interests by the member of the board
- ensuring that each of the board's committees reviews its own performance at least annually.

Senior leadership in corporate governance is provided by the Head of Corporate Governance, who also acts as the Trust Secretary. Governance is embedded across the Trust's directorates and clinical divisions, led by directors or divisional chairs, thus ensuring clear responsibility and accountability across the Trust.

Each division has an established governance structure which reports into the Trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks.

During 2016-17 the Trust undertook a number of reviews of its governance arrangements to ensure they continue to be fit for purpose and support the delivery of key activities. Where areas of weakness were identified these have been prioritised for action.

The Risk and Control Framework

The Trust implements a Ward to Board approach to risk management, whereby risks are identified at directorate and divisional level and escalated as necessary to the Corporate Risk Register. This is overseen by the Trust's Risk Management Committee which in turn provides assurance to the Trust's Audit Committee and the Board. In line with the Trust's divisional management structures outline above, divisional directors are accountable for the identification, evaluation and mitigation of risks to ensure safe, effective and sustainable care is delivered to our patients.

In order to provide maximum assurance to the Board risks are summarised in the Trust's Board Assurance Framework, which aligns risks to the Trust's strategic objectives for 2016/17. Whilst the Trust developed a Board Assurance Framework in 2016/17 it was agreed that this would be reviewed and updated as part of a refreshed approach to risk management in 2017/18.

Risk management is embedded throughout the Trust. 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. Risks with low scores are managed within divisions 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 Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

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 the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and 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 this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Principal Risks Identified in 2016/17

The following risks were identified by the board as being the principal risks during 2016/17, and the associated controls overseen by the Executive Management Team and the Risk Management Committee. The most risks on the Board Assurance Framework are reviewed by the Risk Management Committee at each meeting, following recommendation from the Executive Management Team. They are also overseen by the Audit Committee and the Board.

Risks on the Board Assurance Framework will therefore change during a year. However risks are broadly aligned with the Trust’s Strategic Objectives. As of March 2017 the risks on the Board Assurance Framework were:

Strategic Objective/Risk	Rating
Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets	
The Trust's corporate strategy is not aligned with commissioner or stakeholder intentions.	12
Failing to deliver the financial plan.	25
Ensure our workforce is supported and motivated, and that they understand, and are engaged with, the challenges facing the organisation	
Failing to attract, recruit, retain and motivate the workforce.	20
Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience	
Failing to provide safe, high quality and a satisfactory experience of care for service users.	20
Ensure we make the most of our buildings and estate and maximise efficiency through improving back office and corporate functions	
Failure to provide a suitable environment of care in all patient-facing areas and locations.	25
Prolonged and unrecoverable critical IT system down time.	25
Refresh the Trust’s strategy, to develop a sustainable service model with a clear and consistent message	
Inability to influence key stakeholders.	16
Failure to retain critical community contracts (adult community, sexual health & health visiting)	
Unsatisfactory service user experience.	15
Not linked to a strategic objective	

The demand for services exceeds capacity to deliver them in a safe and clinically effective manner.	20
Failing to achieve key performance targets mandated in the NHS Outcomes Framework and local contracts.	20

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 2017, the Trust was performing positively against a large number of key indicators. However there remain challenges including the ED four-hour target, 18-week referral to treatment waiting time's performance, two week cancer waiting times and the 62 day referral to treatment target for cancer patients. This is set out in more detail in the clinical and operational performance overview on pages 16 & 17.

The Trust financial stability rating has been under review during the reporting year and currently holds a Single Oversight Framework Segmentation rating of 4 – Special Measures reflecting the significant financial and other challenges that the Trust faces. The actions the Trust has identified to address are outlined in the Quality Report.

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 NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report 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 the Quality Committee and a plan to continue to identify and address weaknesses and ensure improvement of the system continues.

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

The overall opinion of the Head of Internal Audit is that limited assurance can be given as based upon our findings that the controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.

The internal audit plan for 2016/17 included reports across the main operational areas of the Trust and details of each report conducted and the level of assurance provided is given at Appendix 3.

The Trust has produced a quality account for 2016/17 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 is concerned that only limited assurance can be given on the controls in place to achieve organisational objectives. Key concerns continue to be the Trust's financial recovery and addressing the issues that resulted in the Trust being placed in special measures. The Board also remained concerned that the Trust achieved an outturn deficit of £74 million which is greater than planned for at the start of the year,

although it noted this was significantly lower than forecast in year. Additional, but linked concerns are the Trust's physical and information technology infrastructure although plans for 2017/18 are in place to sustainably improve the Trust's position in all of these areas.

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 Chief Information Officer as the senior information risk officer and Dr Mark Hamilton, Associate Medical Director, as Caldicott Guardian. The Trust also has an information governance manager and a range of policies, procedures and training to ensure that all 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.

During 2016/7 one level 2 IG incident was reported to the Information Commissioner's Office (ICO). This related to serious incident regarding data that was disclosed in error. Following the Trust's own investigation, the ICO undertook an investigation that determined there was no need for further action.

Conclusion

Despite limited assurance on control systems no significant issues have been identified. As noted previously in this report the Trust experienced challenges in ensuring stable leadership which in turn impacted on the Trust's ability to deliver services and financial management in line with the full terms of its licence. An external review of governance is due to take place early in 2017/18 and we anticipate this will focus on the development of a unitary board and greater clarity and grip on the Trust's assurance framework.

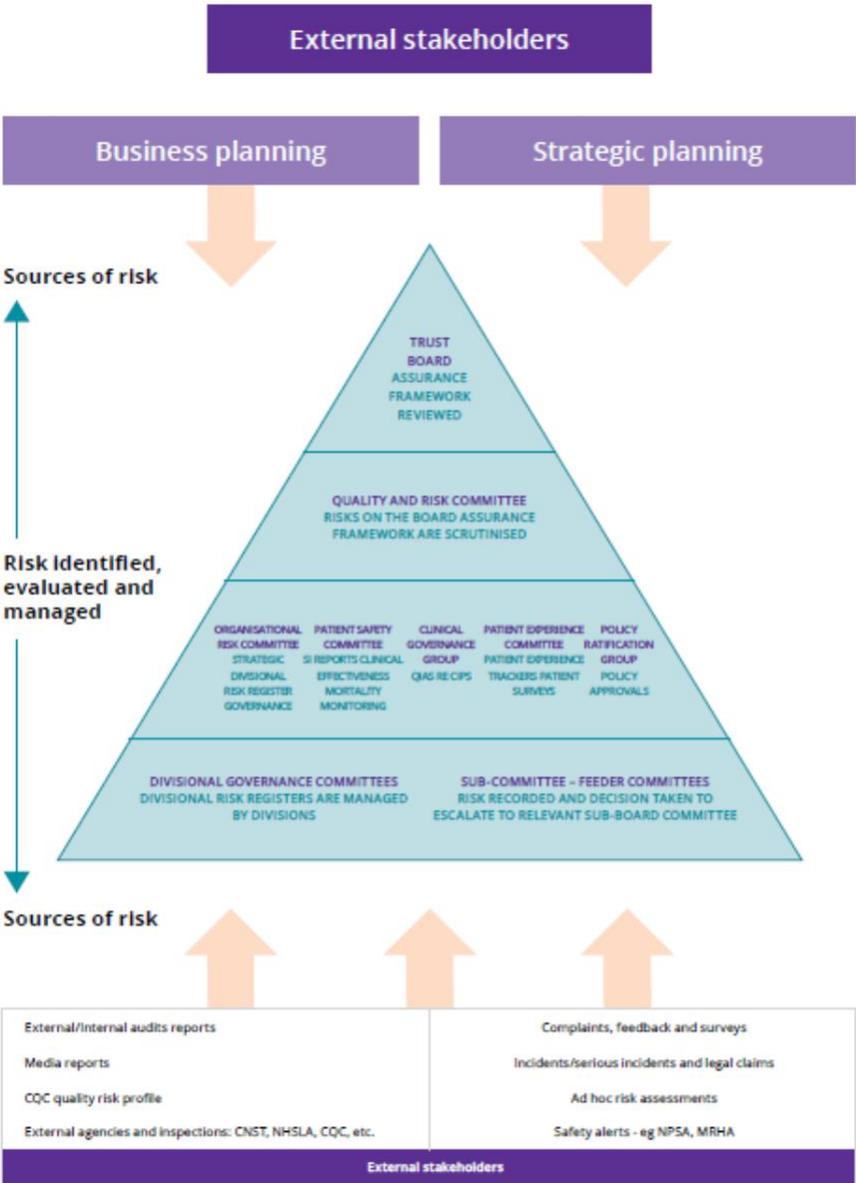
Jacqueline Totterdell



Chief Executive

Date: 31 May 2017

Appendix 1 - Risk Framework



Appendix 2 - Internal Audit Reports Issued in 2016/17

System	Type	Assurance Assessment
Delivery Arrangements Transformation Programme	Compliance	Limited Assurance
Follow Up Reviews (from previous recommendations)	Follow Up	Not Applicable
Agency Cap	Assurance	Limited Assurance
Overseas Patients – Pre-admission	Assurance	Limited Assurance
Data Quality – Key Performance Targets	Assurance	Limited Assurance
Core Financial Systems	Assurance	Limited Assurance
IT – Project Management (E-prescribing)	Operational	Not Applicable
Budgetary Maturity Assessment Survey	Assurance	Limited Assurance
Cyber Security Maturity Assessment	ICT	No Assurance
Use of Bank	Assurance	Reasonable Assurance
Overseas Patients – Pre-admission	Compliance	Limited Assurance
Finance Deep Dive	Operational	Not Applicable
Departmental Review - Mortuary	Operational	Not Applicable
ICT Telecoms and Security	Assurance	Limited Assurance
Procurement Department Review	Assurance	Limited Assurance
Governance Risk Management (Corporate Risks)	Assurance	Reasonable Assurance
Governance - Board Assurance Framework	Assurance	Limited Assurance
Governance - Framework	Assurance	Limited Assurance
Payroll	Assurance	Reasonable Assurance
Follow up	Follow Up	Not Applicable
IG Toolkit	ICT	Limited Assurance
Facilities Management	Assurance	Limited Assurance

Independent Auditors Report to the Council of Governors

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 give a true and fair view of the financial position of the St George's University Hospitals NHS Foundation Trust (the Trust) as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2016/2017 and the requirements 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 to the financial statements concerning the Trust's ability to continue as a going concern. The Trust incurred a deficit of £78.7 million during the year ended 31 March 2017 and at that date had net current liabilities of £74.7 million. The Directors are seeking additional support from the Department of Health for 2017/18 of £38 million. As disclosed in note 1 to the financial statements, the Department of Health has not, at the date of our report, confirmed this support. These conditions, along with the other matters explained in note 1 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 Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

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 2017 which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in equity, the statement of cash flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2016/17.



Overview of our audit approach

- Overall materiality: £9,938,000, which represents 1.25% of the Trust's operating expenses;
-
- We performed a full-scope audit of St George's University Hospitals NHS Foundation Trust
- Key audit risks were identified as:
 - Occurrence of income from patient care activities and existence of associated receivables
 - Finance team capability
 - Going concern material uncertainty disclosures

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 and how we tailored our procedures to address these risks in order to provide an opinion on the financial statements as a whole. This is not a complete list of all the risks we identified:

Audit risk	How we responded to the risk
<p>Occurrence of income from patient care activities and existence of associated receivables</p> <p>96% of the Trust's income from patient care activities is derived from transactions with NHS commissioners, of which 87% is derived from contracts with the Trust's 11 main NHS commissioners. In addition, 2% of the Trust's income from patient care activities is derived from 28 contracts with local authorities. These contracts include the rates for and level of patient care activity to be undertaken by the Trust.</p> <p>The Trust recognises income from patient care activity during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in the contracts with NHS commissioners and local authorities, are subject to verification and agreement of the activity completed by the NHS commissioners and local authorities. It was reported to the Trust Board</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> • evaluating the Trust's accounting policy for recognition of income from patient care activities for appropriateness; • gaining an understanding of the Trust's system for accounting for income from patient care activities and evaluating the design of the associated controls; • obtaining an exception report from the Department of Health (DoH) that details differences in reported income and expenditure; and receivables and payables between NHS bodies; agreeing the figures in the exception report to the Trust's financial records; and for differences calculated by the DoH as being in excess of £250,000, obtaining corroborating evidence to support the amount recorded in the financial statements by the Trust; • agreeing all amounts recognised as income from the 11 main NHS Commissioners and 28 contracts with local authorities in the financial statements in respect of the main baseline monthly contract billings to signed contracts, and associated receivables at year end to subsequent cash receipts or alternative evidence; and • agreeing, on a sample basis, amounts for contract variations relating to under and over-performance of patient care activities on contracts with the main 11 NHS Commissioners and 28 local authorities to contract variations and invoices or alternative evidence; and associated receivables to subsequent cash receipts or

Audit risk	How we responded to the risk
<p>during the year that an internal review had identified significant under-recording of clinical activity due to historic data quality issues, resulting in under-billing of potential income. Management have held initial discussions with the Trust's main NHS commissioners around billing for this historic un-billed patient activity. As such, we have determined that there is the risk that income is recognised for these additional services that is not subsequently agreed to by the NHS commissioners.</p> <p>We therefore identified occurrence of income from patient care activities and the existence of associated receivables as a significant risk requiring special audit consideration.</p>	<p>alternative evidence; and agreeing, on a sample basis, for the remaining population of amounts recognised as income from patient care activities in the financial statements to signed contracts, contract variations and invoices; and associated receivables at year end to subsequent cash receipts or alternative evidence. The Trust's accounting policy on revenue recognition is shown in note 1.2 to the financial statements and disclosures related to revenue from patient care activities are included in note 3. We have noted that the Trust has not recognised any revenue in respect of historic under-billed patient activity.</p>
<p>Going concern material uncertainty disclosures</p> <p>The Trust has received revenue loans totalling £87,649,000 during the 2016/17 financial year to support its cash flow.</p> <p>The Trust incurred a £78,666,000 financial deficit in delivering its services in 2016/17 compared to a budgeted deficit of £17,200,000 and management has forecast deficits of £28,453,000 and £17,954,000 in 2017/18 and 2018/19 respectively. These forecasts assume that £60,000,000 cost savings will be achieved in 2017/18 and £39,500,000 of savings in 2018/19, however the Trust has historically not been successful at delivering forecast savings of this scale. The Trust will therefore require further working capital loans to pay its expenses in 2017/18 and 2018/19. The source and value of these loans has yet to be confirmed. Management have forecast that £38,021,000 of working capital loans are required in 2017/18</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> • determining whether the procedures performed by management for identifying material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern were appropriate; • assessing the appropriateness of the assumptions and judgments underpinning the cash-flow forecasts used by management to assess the existence of material uncertainties related to going concern; • verifying that the disclosures within the financial statements explaining the material uncertainty that casts significant doubt on the Trust's ability to continue as a going concern are appropriate and accurately explain the events and conditions that gave rise to the uncertainty and the assumptions and judgments made by management's in its assessment; and • verifying that the disclosures within the financial statements comply with the reporting requirements detailed in the Department of Health Group Accounting Manual 2016/17. <p>The Trust's accounting policy in respect of the going concern basis of preparation is shown in note 1 to the financial statements.</p>

Audit risk	How we responded to the risk
<p>and £20,547,000 in 2018/19.</p> <p>In the prior year, the Foundation Trust Annual Reporting Manual 2015/16 did not explicitly require disclosure in the financial statements of material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. In the current year, the Department of Health Group Accounting Manual 2016/17 explicitly requires these disclosures.</p> <p>Given the sensitive nature and the updated requirements specifically requiring these disclosures in the financial statements, we have identified this as an area of focus in our audit.</p> <p>We therefore identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust's ability to continue as a going concern in the financial statements as a significant risk requiring special audit consideration.</p>	
<p>Finance team capability</p> <p>In light of the significant issues faced during the prior year audit in relation to the quality and timeliness of working papers prepared by the Trust's finance team, and given the deficiencies in the Trust's finance function noted within the report of PWC dated 1st October 2015, we identified a risk that Trust's the finance team may struggle to provide appropriate and sufficient audit evidence during the 2016/17 audit process.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> • increased sample sizes across all of the main areas of testing as a result of setting a lower performance materiality in response to our concerns that weaknesses in the finance team's capability could lead to a higher level of audit misstatements; • review of aged payable and receivable balances to consider the existence of balances that should be written off; • review of credit notes raised post-year-end up to 30 April 2017 to determine whether these indicate revenue recorded in the financial statements that was not valid; • documentation and consideration of management's controls around cut-off of income and expenditure, as this is an area where misstatement has previously been identified due to errors made by the finance team; and • examination the quality of working papers supporting the financial statements and review the adequacy processes for review of working papers by senior officers.

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's financial statements as a whole to be £9,938,000, which is 1.25% of the Trust's operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding.

Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2016 as we did not identify any significant changes in the Trust's operations or the environment in which it operates.

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 financial statements. We also determined a lower level of specific materiality for disclosures of senior manager remuneration in the Remuneration Report.

We determined the threshold at which we will communicate misstatements to the Audit Committee to be £250,000. In addition we will communicate 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 International Standards on Auditing (ISAs) (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of financial statements of public sector bodies in the United Kingdom'. 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 included an interim visit to evaluate the Trust's internal control relevant to the audit including relevant 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, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, 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 that necessary for us to consider under the Code 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 2017, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code. Based on our risk assessment, we undertook such work as we considered necessary.

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2016/17 and the requirements of the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report for the financial year for which the financial statements are prepared 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 we communicated to the Audit Committee which we consider should have been disclosed.

Under the Code we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2016/17 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above matters except for the following:

Basis for adverse value for money conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust delivered a deficit of £78,666,000 in 2016/17, which represents a significant increase compared to its budgeted deficit of £17,200,000. The Trust is also forecasting a deficit of £28,453,000 for 2017/18 which is dependent on it achieving transformational savings of £60,000,000. The Trust is seeking revenue support from the Department of Health of £38,021,000 in 2017/18.
- On 22 March 2017, NHS Improvement placed the Trust into financial special measures.
- The Care Quality Commission (CQC) inspected the Trust in June 2016 and their inspection report, published on 1 November 2016, issued the Trust an overall rating of 'Inadequate'. The report highlighted concerns in respect of quality, safety and overall governance arrangements, and drew attention to the significant state of disrepair of areas of the Trust's estate.
- As a result of the findings of the CQC inspection, on 28 October 2016 NHS Improvement placed the Trust into quality special measures and issued enforcement and discretionary undertakings under Section 106 of the Health and Social Care Act 2012. NHS Improvement stated that the Trust is in breach of conditions of its licence in respect of quality, governance and RTT breaches, which the Trust needs to rectify.
- In July 2016, the Trust Board took the decision to cease reporting performance against the Referral to Treatment (RTT) performance indicator after an independent review identified significant data quality issues in relation to the recording of patients on incomplete pathways.

These identify weaknesses in the Trust's arrangements for:

- setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services;
- ensuring quality of data maintained in respect of key performance indicators;
- responding to service delivery issues raised by regulators, including deployment of workforce and governance arrangements.

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 principles of good governance to support informed decision making.

Adverse value for money conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in December 2016, 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 2017.

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 the Chief Executive's Responsibilities as the Accounting Officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Directions 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 and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

We are required under Section 1 of Schedule 10 of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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.

Paul Dossett
Partner

For and on behalf of Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London
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31 May 2017

Quality Report

Chief Executive's statement on quality

Providing high quality care to our patients is our number one priority, and we need to ensure we put quality – and the safety of our patients – at the forefront of everything we do.

The Care Quality Commission's inspection report for St George's, published in November following their visit in June 2016, raised concerns about the quality of care the Trust provides in certain areas, and we were placed in special measures for quality as a result. We are developing a Quality Improvement Plan to help us address the issues identified by the CQC. But our plan needs to be about much more than this – we need all 9,000 of our staff, wherever they work, to want to make St George's better for patients, and the communities we serve.

This means engaging staff in the quality improvement process – which involves listening to their concerns, and taking time to truly understand where they feel improvements need to be made. This is a key priority for us over the coming months, and crucial to us achieving the step-change in quality we all believe the organisation needs.

Last year, the Trust set out a range of quality ambitions under the headings of Patient Safety, Patient Experience and Patient Outcomes. As you will read in the report that follows, we have made significant progress in some areas. For example, our Standard Hospital Mortality Rate (SHMR) - which measures whether our mortality rate is higher or lower than expected for a Trust of our size - is currently 81%, showing an improvement from 85% in 2015. We are also prioritising our care for patients with dementia and delirium, and in the past year have established a new and improved delirium pathway.

In all areas, there is still a huge amount to do; for example we still need to deliver much needed improvements to the way in which we handle and manage complaints. Whilst every complaint is one too many, we need to maximise our learning from them so as to help us prevent a recurrence in the future.

Quality priorities for 2017/18

For the coming year, we have set new ambitions, whilst also making sure we build on the work already started. These priorities have been agreed with our stakeholders and governors, who play a crucial role in helping to shape our quality ambitions for the organisation.

Our priorities include:

- Improved levels of Early Warning Score documentation
- Staff survey response increase to 60%
- Reduction of on the day theatre cancellations by 25%
- Ensuring that all patients and their relatives have fully documented discussions and agreed plans for End of Life care.

Given our financial and performance challenges, it is my job, and that of the senior team, to ensure we retain our focus on quality, as that is what our patients rightly expect us to do.

Jacqueline Totterdell



Chief Executive
31 May 2017

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. Some of our services also treat patients from all over the country, including for 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 2016/17 we provided and/or subcontracted 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 2016/17 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 2016/17.

Further information about the services we provide and where they are based is outlined in Appendix F.

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.

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.

St George's University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status overall is 'Inadequate' for quality. St George's has no conditions placed upon its CQC registration.

The Care Quality Commission has also taken enforcement action against St George's during 2016/17, under Section 29A.

St George's University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC Inspection in 2016

The Trust was rated as **good** overall in a 2014 CQC comprehensive inspection. A further comprehensive inspection in June 2016 rated the Trust as **inadequate**. This most recent inadequate rating reflects a marked deterioration in the safety and quality of some of the Trust services, as well as to its overall governance and leadership.

Whilst the CQC have rated the Trust as inadequate overall, they noted good care in several areas and some outstanding practice, including in maternity. The Trust was rated as **good** overall under the CQC 'Caring' domain.

It is important to note that at the time of the inspection, the Trust had introduced a range of supportive and recovery mechanisms as a means of stabilising the organisation. An interim Chair and Chief Executive had been appointed to offer the organisation direction and to develop a robust and deliverable recovery plan. A number of interim appointments had been made to ensure there was focused leadership in place to implement the organisation's recovery plan.

The executive team was clear about the challenges that they and the Trust faced and acknowledged the need for significant improvement across the organisation. Key substantive appointments were made to the non-executive board, which included the appointment of individuals with significant experience and expertise in regards to improving patient safety.

Other contributing factors for the deterioration in the Trust's overall CQC rating include; *neglect of maintenance of its buildings, failure to ensure the requirements of the fit and proper persons regulation had been implemented, and a leadership culture which was weighted towards trying to achieve financial stability, which inadvertently impacted on the quality of services being provided.*

Members of the executive and non-executive recognised that an attitude of 'learnt helplessness' existed across the organisation. Both the Chairman and Chief Executive recognised the need to improve staff engagement, to develop a long term sustainable vision and strategy for the organisation, and to reintroduce accountability and strong leadership across all divisions within the Trust.

Section 29A Warning Notice

Following their June inspection, the CQC issued a letter of intent to the Trust proposing to take urgent enforcement action under Section 31 of the Health and Social Care Act, 2008 due to the state of disrepair of some buildings at St George's Hospital. In response to this action by the CQC, the Trust took appropriate improvement measures which resulted in the CQC enforcement notice being withdrawn.

However, the CQC issued a Section 29A Warning Notice to the Trust in August 2016 for breaches in regulations that required significant improvement regarding *premises and equipment, mental capacity assessments and best interest decisions, good governance and the fit and proper persons requirement.*

Under the 29A Warning Notice, the CQC determined that within the Trust:

1. There were unsafe and unfit premises where healthcare is provided and accommodates staff
2. There was a lack of formal mental capacity assessments and best interest decision making and that some patients had decisions made for them that they were capable of making themselves
3. The design and operation of the governance arrangements were not effective in identifying and mitigating significant risks to patients
4. Risks to the delivery of high quality care were not being systematically identified, analysed and mitigated
5. Staff were not being held to account for the management of specific risks
6. There were a lack of processes in place to provide systematic assurance that high quality care is being delivered; priorities for assurance had not been agreed and were not kept under review. Effective action had not been taken when risks were not mitigated
7. The data used in reporting, performance management and delivering high quality care was not robust and valid
8. There were not suitable arrangements in place for ensuring that directors are fit and proper

The Trust implemented an immediate action plan in response to the Section 29A warning and wrote to the CQC in November 2016, confirming that actions relating to the issues identified had either been completed or were being addressed.

The CQC inspected the Trust in relation to the Section 29A progress on 10, 11 and 22 May 2017. The Trust will receive the CQC's outcome report from these inspections in late June 2017.

Overall CQC inspection rating

The CQC rated 60 specific standards across the Trust during their inspection in June 2016. Out of these:

- 1 was rated as outstanding
- 27 were rated as good
- 23 were rated as requires improvement
- 8 were rated as inadequate

The full breakdown of how our hospitals performed against each of the five CQC essential domains is set out in the following tables.

CQC ratings for St George's Hospital - Tooting

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Urgent and emergency services	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Medical Care	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Outstanding	Good	Good	Good	Good
Services for children & Young People	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
End of Life care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Outpatients and diagnostic imaging	Requires Improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

CQC ratings for Community Services

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Community health services for adults	Good	Good	Good	Good	Requires Improvement	Good
Community health services for children, young people and families	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community health inpatient services	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Community End of Life Care services	Requires Improvement	Inadequate	Good	Requires Improvement	Inadequate	Inadequate
Overall Community	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement

CQC ratings for St George's University Hospitals NHS Foundation Trust

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

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
- NHS Improvement
- NHS England
- Wandsworth Council
- Healthwatch Wandsworth
- Wandsworth CCG
- Merton CCG

In its report on the Trust the CQC highlighted several areas of outstanding practice:

- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were amongst the best in the country
- The outcomes achieved by the specialist medical and surgical services provided by the hospital
- The effectiveness of maternity care delivered by the hospital
- The responsiveness of the neonatal unit to parents whilst their baby was on the unit, and the support provided by the outreach nurse
- The involvement of children of varying ages on the interview panel as part of the recruitment process for ED paediatric nurses

The CQC reported that the Trust must take actions to:

- Develop a long term strategy and vision
- Move towards having a stable, substantive leadership team
- Ensure all premises and facilities are safe, well maintained and fit for purpose
- Ensure all care is delivered in accordance with the Mental Capacity Act, 2005, when appropriate
- Review and implement robust governance processes, so that patients receive safe and effective care. Ensure 18 week Referral to Treatment (RTT) data is robust and accurate so that patients are given appointments and treatment based on their needs and within national targets
- Ensure serial numbers of prescriptions (FP10s) for prescribers are always monitored for use
- Ensure radiographers only administer medication (contrast media) where appropriately authorised
- Patient Group Directions (PGDs) are in place
- Ensure the fit and proper persons' requirement regulations for directors are always complied with
- Ensure the paediatric ward environment, staffing and training requirements are suitable for treating and caring for children and young people with mental health conditions
- Ensure medicines are stored in an appropriate manner, by keeping cupboards locked when not in use
- Ensure the process for decontamination of nasoendoscopes is compliant with guidance

The CQC also reported that the Trust should:

- Maintain patient privacy, dignity and confidentiality at all times

- Review the fluid storage within the ED major incident cupboard to ensure that training equipment is not stored with 'live' equipment
- Ensure that staff consistently follow guidance related to the prevention of healthcare associated infections with specific regard to hand hygiene
- Ensure medical equipment across the Trust stored on is cleaned and that there are systems in place for monitoring the cleanliness of equipment returned to the ward
- Ensure all staff caring for children receive level 3 safeguarding training
- Ensure the process for investigating serious incidents is timely and undertaken by people trained in investigation so they understand the root causes of an incident and identify measurable action
- Minimise the cancellation of operations and when this cannot be avoided, they are rescheduled within 28 days
- Reduce the moves of patients to wards that are not appropriate
- Ensure that staff use the early warning scoring system effectively, including the timely escalation of deteriorating patients to relevant personnel
- Ensure divisional and Trust priorities are shared by personnel of all grades and professions who work together to promote the quality and safety of patient care
- Address the low morale among theatre staff and consultant surgeons
- Replace damaged chairs and furniture within patient areas so that they can be thoroughly cleaned
- Ensure that all patients within the ED 'streaming' area are assessed within a private area
- Ensure staff can observe the patients whilst they are waiting in their outpatient departments
- Ensure patient electronic records are not easily visible or their paper records are not easily accessible by the public
- Improve the percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets
- Communicate effectively with patients when outpatient clinics overrun
- Ensure there are sufficient cystoscopes (to examine the inside of the bladder) to supply day surgery, main theatres and endoscopy
- Ensure all relevant staff are appropriately inducted to the Trust and within clinical environments to which they are allocated to work

Trust Quality Improvement Plan 2017/18

Following the inspection by the CQC the Trust prepared a detailed Quality Improvement Plan (QIP). The plan takes account of pre-existing compliance matters, the Section 29A warning notice from the CQC and all the 'must do' and 'should do' recommendations from the CQC reports which formed the basis for their judgement and rating for the Trust in June 2016.

The Trust's long term aim is to achieve a 'good' or 'outstanding' rating from the CQC by 2019.

The three phases of the QIP:

Phase 1 is expected to conclude on or before 30 September 2017, and essentially addresses the immediate compliance concerns highlighted by CQC. The focus for Phase 1 of the QIP is mandated in accordance with NHS Improvement's (NHSI's) enforcement undertakings. Successful implementation of Phase 1 will lead to the withdrawal, by the CQC, of the Section 29A Warning Notice and, following satisfactory conclusion of NHSI's enforcement undertakings, lead to a recommendation for the Trust to exit special measures for quality.

Phase 2 is primarily concerned with embedding good governance and compliance across Trust acute and community services and is designed to allow the progression from an 'inadequate' rating to a 'requires improvement' rating by quarter 4 of 2018/19. Elements of Phase 2 may require further evolution and refinement following completion of an independent well-led governance review required as part of NHSI's enforcement undertakings.

Phase 3 is primarily concerned with building capability, confidence and competence, allowing the progression from a 'requires improvement' rating to the restoration of an overall Trust rating of at least 'good' by the end of 2019.

The CQC will undertake a full inspection at the Trust as part of their continued announced inspection regime, planned for the financial year 2017/18.

Priorities for improvement and statements of assurance from the board

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 in terms of performance, but also means that we can learn from other Trusts who offer similar services.

The Department of Health (DH) and NHS Improvement 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 NHS Improvement's reporting requirements and additionally those set by the Department of Health. NHS Improvement requires us to produce an annual quality report which includes all of the reporting requirements of the quality account, plus some additional requirements that they have set.

To meet both DH and NHS Improvement's quality reporting requirements, we have consolidated all Trust quality information into one document – known as the 'quality report'. However, for reporting purposes to DH we will call the quality report the 'quality account'.

Priorities for improvement in 2017/18

We have agreed commitments against each of the patient domains outlined below. These priorities have been determined through a review of activity during 2016/17 and via feedback from our stakeholders.

The priorities indicated are reflected in the Trust Quality Improvement Plan for 2017/18 and each element has agreed outcomes with a nominated person accountable for delivery against the priorities.

Improving patient safety

- Improved levels of Early Warning Score documentation
- Rollout of Local Safety Standards for Invasive Procedures (LOCSSIPS)
- A 25% reduction in patient falls resulting in fractures
- No avoidable Grade 4 pressure ulcers in patients
- No avoidable in-patient cardiac arrests (excluding A&E)

Improving patient experience

- Documented discussion and agreed plans for End of Life care
- Staff survey response increase participation from 40.4% to 60% and engagement score from 3.7 to national average (future stretch targets to attain a score of 4)
- Reduction of day theatre cancellations by 25%

Improving patient outcomes

- Improve Trust SHMI and HSMR mortality rates
- A comprehensive clinical review process for in-hospital deaths

<p>Dementia and delirium</p>	<p>complaints are fully responded to within 25 working days or an agreed timescale.</p> <ul style="list-style-type: none"> • Action plans have been put into place in consistently poorly performing divisions within the Trust with the aim of improving and delivering performance against internal standards. • A comprehensive review of the current position is being undertaken and a proposal is being prepared regarding the resetting of targets to take into account the complexity of complaints, improve the quality of responses and better manage complainants' expectations. • A clinical lead for delirium was appointed within the Trust in November 2016. • A new and improved delirium pathway has also been established. • Just under 7000 Trust staff have completed dementia awareness training, with an overall response rate of 84%.
<p><u>Patient outcomes</u></p> <p>Clinical records</p> <p>Mortality</p>	<ul style="list-style-type: none"> • Trust performance against national record-keeping standards are good (>85%) for records being bound, organized and ensuring clinical entries are legible, dated and signed. • The Trust has an Information Governance Toolkit rating of 68%. This is satisfactory, but marginally lower than achieved in 2015/16 and needs improvement. • There are still many wards within the Trust that do not undertake mandatory clinical record audits against the national standards – there needs to be a focus on improvement in this area. • A Trust timeline for full implementation of iClip is to be finalised. The Trust will potentially invest in infrastructure over the next 12 months. Once complete, the Trust will commence an iCLIP deployment project, forecast for 2018/19. • For the two major indicators of mortality, the Trust continues to show better than

	<p>expected performance.</p> <ul style="list-style-type: none"> • Standard Hospital Mortality Rate (SHMR) is 81%, an improvement from 85% in 2015/16. • Summary Hospital Level Mortality Indicator (SHMI) is 0.86, an improvement on 0.91 in 2015/16. • The Trust has fully engaged in the national agenda through participation in the Royal College of Physicians <i>National Mortality Case Record Review</i> pilot. • Trust-wide and local processes have been strengthened to ensure deaths are reviewed in a timely fashion. • The Trust has good mortality from trauma and work undertaken on reviews is positive. • On-line screening and review tools have been built, embracing clinical judgement review to enable data collection and capture learning. • These improvements mean that the Trust is in a strong position to implement the national framework <i>'Learning from Deaths'</i> during 2017/18.
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Reporting against core indicators

Since 2012/13 NHS foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

Further information on the core indicators that are applicable to St George's and performance by each indicator for 2016/17 is available in Appendix G.

Voluntary indicators

NHS Improvement 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 nine this year, to reflect the services we provide and the patients we care for.

We have worked closely 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. The Trust local stakeholders include 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 that we will be reporting on in next year's quality account (2017/18). These have also been shared with stakeholders for review and input.

The voluntary indicators chosen for 2017/18 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 2016/17 to support and embed learning in practice.

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 for 2015/16	Voluntary Indicators chosen for next year's report (2017/18)
<p>Patient safety</p> <ul style="list-style-type: none"> • Medication errors • Patient deterioration • Staff learning through incident feedback • Learning from never events outside of theatres 	<p>Patient safety</p> <ul style="list-style-type: none"> • Improved levels of Early Warning Score documentation identifying patients who are deteriorating – required standard 95% • Rollout of Local Safety Standards for Invasive Procedures (LOCSSIPS) to all relevant departments and services • A 25% reduction in patient falls resulting in fractures • No avoidable Grade 4 pressure ulcers • No avoidable in-patient cardiac arrests (excluding A&E)
<p>Patient experience</p> <ul style="list-style-type: none"> • End of life care • Complaints • Dementia and delirium 	<p>Patient experience</p> <ul style="list-style-type: none"> • Ensure that <u>all</u> patients and their relatives have fully documented discussions and agreed plans for End of Life care • Staff survey response increase participation from 40.4% to 60% and engagement score from 3.7 to national average (future stretch targets to attain a score of 4.) • Reduce on the day theatre cancellations by 25% from 2016/17 levels
<p>Patient outcomes</p> <ul style="list-style-type: none"> • Clinical records • Mortality 	<p>Patient outcomes</p> <ul style="list-style-type: none"> • Improve Trust SHMI and HSMR mortality rates - ensure risk-adjusted mortality remains better than national expected values (SHMI and HSMR), maintaining our 'better than expected' position • Ensure a comprehensive clinical review process for all in-hospital deaths, implementing the Learning from Deaths recommendations (including the openness and publication of mortality data and learning)

Mandatory indicators for auditor assurance

It is a requirement that our external auditors Grant Thornton test certain indicators to provide assurance that there is a robust audit trail within the Trust.

Two indicators are mandatory for the Trust to report against, as set out by NHS Improvement. These are:

- 1) Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway
- 2) A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge

One local indicator needs to be selected by the Trust's council of governors. For 2016/17 they have chosen 'Complaints' as their quality indicator for external audit – namely the percentage of complaints responded to within 25 days.

Grant Thornton has been unable to test the NHS Improvement mandatory indicator relating to 'Referral to Treatment' (RTT). Following publication of the findings of the MBI Health Group review in June 2016, the Trust board took the decision to suspend national reporting against the RTT (18 week) standard.

Further information relating to this decision is outlined in the '*Statement of Directors' Responsibilities for the Quality Report*' section of this document.

As the Trust is not reporting against an RTT indicator within the 2016/17 Quality Account, Grant Thornton has tested the *62 day cancer* indicator, in line with NHS Improvement requirements for when one of the mandated indicators is not being reported. NHS Improvement outlines this indicator as:

- All cancers: 62-day wait for first treatment from:
- Urgent GP referral for suspected cancer
 - NHS Cancer Screening Service referral

Stakeholders

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 at: www.hscic.gov.uk

Duty of Candour

'Duty of Candour' formally came into force on 27 November 2014 for NHS Trusts, Foundation Trusts, and Special Health Authorities in England.

The Trust has a legal duty to be open and transparent when there has been either moderate or severe harm to a patient as a result of care received. This process ensures patients receive accurate, truthful information from hospitals and other healthcare providers and also sets out specific requirements that the Trust must follow when there are issues with patient care and treatment.

The Trust implemented a system in November 2016 that positively assures that all patients receive the written notification, setting out the nature of the incident and providing them with both advice on the follow up investigation and how the Trust will communicate with them on the outcome. Since implementation of this system in November 2016, the Trust has fully met its obligations (100% compliance) under duty of candour.

Staff Friends and Family Test (FFT)

Staff who would recommend the Trust as a place to receive treatment and as a place to work 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 place of excellence to receive healthcare and a positive place to work. All of our staff are core to our success and are well-placed to judge the quality of care we provide to our patients.

How did we do?

Every year we conduct the Friends and Family Test within our own workforce. In quarters one, two and four of the financial year we give all Trust staff the opportunity to complete the survey, which comprises of two important 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 scores for 2016-17 by quarter are listed as follows:

	Staff response	Percentage who would recommend for treatment	Percentage who would recommend as a place to work
Q1 April –	655	79%	50%

June			
Q2			
July – Sept	534	74%	36%
Q4			
Jan - March	403	77%	47%
Full year	1,592	76%	44%

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 as much as possible in identifying where improvements could and should be made across the Trust. The Trust recognises that engagement in this area is an on-going and important priority.

As a result, we are fully engaged with the national *Listening into Action* staff engagement programme. Listening into Action (LiA) launched at St George's in March 2013 and demonstrates the Trust's commitment to working with and engaging all staff at St George's. Listening into Action is focused on achieving a positive shift in the way that the Trust operates and demonstrates leadership, placing our clinicians and staff at the heart of change for the benefit of our patients, staff and the Trust as a whole.

Essentially, Listening into Action is about:

- Engaging the best placed individuals to help deliver better outcomes for our patients, our staff and our Trust
- Aligning ideas, effort and expertise across the Trust to deliver better patient experience, safety and quality of care
- Overcoming widespread challenges that may affect our staff
- Positive and consistent engagement and morale
- Developing confidence and capability in our leaders to help them effectively 'lead through engagement'
- Collaborating across the usual boundaries, and;
- Encouraging a sense of collective ownership and pride across the Trust

Listening into Action complements existing projects and pieces of work that are taking place across the Trust. The change methodologies, systems and experiences that staff develop and gain through Listening into Action is in many cases used to help affect and achieve wider change relating to these projects.

Staff from all departments, levels and roles across the Trust have and continue to work together and talk about what matters to them and what changes should be prioritised. We use staff feedback 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.

Listening Into Action is Staff Engagement (LIAiSE)

At the Trust *Big Conversations* in April and May 2013, the idea of providing a dedicated service for staff, based on our Patient Advice and Liaison Service (PALS), was first discussed. The idea was raised by staff at more than one *Big Conversation* and generated much interest. As a result, the

Listening into Action Sponsor Group devised a staff advisory service known as LIAiSE – *Listening into Action is Staff Engagement*. The service is provided by a LIAiSE Adviser who provides a listening and signposting service to Trust staff, identifying where support is available. This service is provided on a one to one, individual, self-referral basis and additionally to teams who request intervention. The LIAiSE Adviser is also the first *Freedom to Speak up* guardian for the Trust.

Values Awards

Our Trust values are designed to inspire our staff and ensure that we keep patients at the heart of everything we do. Both staff and patients can nominate members of staff for one of the Trust's Values Awards – Excellent, Kind, Responsible and Respectful. The Listening into Action Sponsor Group oversees nominations and each month members of staff that are nominated are presented with their award. Each year, all nominees are put forward for the annual Trust Values Awards, which celebrate both an individual and team for each values category.

National NHS Staff Survey 2016

For the 2016 NHS staff survey St George's had an overall response rate of 40%, an improvement from the 2015 score of 31%, which is below the average response for combined acute and community Trusts (42.3%). 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.

In summary, the Trust performed slightly better than in 2015 but our scores were still lower than the national average for combined acute and community Trusts. Our top 4 ranking and bottom 4 ranking scores are summarised in the table below.

Table 1: Top and bottom four ranking scores for 2016/17

	2015/16		2016/17		Improvement/ deterioration
	St George's	National Average	St Georges	National Average	
Response rate	31%	43%	40.4%	42.3%	Improvement
Top 4 ranking scores					
KF13. Quality of non-mandatory training, learning or development	4.05	4.04	4.10	4.07	Improvement
KF12. Quality of Appraisals	3.04	3.03	3.19	3.11	Improvement
KF18. % of staff feeling under pressure to attend work when not well	57%	58%	53%	55%	Improvement
KF29. % of Staff reporting errors, near misses or incidents witnessed in the last month	88%	90%	91%	91%	Improvement
Bottom 4 ranking scores					
KF19. Organisation and management interest in action on health and wellbeing	3.33	3.59	3.41	3.61	Improvement
KF14. Staff Satisfaction with resourcing and support	3.11	3.72	3.15	3.28	Improvement

KF26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	33%	24%	32%	23%	Improvement
KF10. Support from immediate line managers	3.58	3.72	3.63	3.74	Improvement

For 2017, the Trust has agreed to focus on three key areas:

- Addressing bullying and harassment
- Improving staff engagement
- Improving equality and diversity

Confidence to raise concerns

This year the Trust has improved on the 2015 score for staff feeling secure about raising concerns about unsafe clinical practice but this is still lower than the national average for combined acute and community Trusts. The Trust continues to implement the national *'Freedom to Speak Up'* review. Staff are encouraged to raise concerns and we ensure that they receive support and feedback on the outcome of the complaint. The Trust has also introduced a number of initiatives to improve communication, working practices and team feedback, such as:

- 'Back to the floor Fridays' - senior managers go in to the wards and departments every Friday to engage with staff and discuss concerns
- Road shows - managers travel to various sites across the Trust and provide updates on a variety of Trust issues e.g. service improvement, Trust finance position, etc.
- 'Schwartz rounds' – allowing staff to discuss the highs and lows of work in a confidential, expertly facilitated environment

Tackling poor behaviour and bullying

In the 2016 staff survey, 32% of staff at the Trust reported harassment, bullying or abuse from other staff and the national average for combined community and acute Trusts was 23%. The score in 2015 was 33%, thus performance in this area has not dramatically increased or decreased.

Tackling poor behaviour, bullying and harassment is one of the key areas that the Trust has agreed to focus on this year. The Trust acknowledges that a fundamental change is required, and amongst a variety of initiatives implemented to tackle bullying (such as reviewing the Trust *Dignity at Work – A policy against Bullying and Harassment*, running unconscious bias training sessions and the Bullying and Harassment support helpline), the Trust has made a decision to engage a Bullying & Harassment specialist. The specialist will provide training sessions across the organisation and at the same time address related issues from minor communication issues between colleagues to perceptions of unfair treatment by management. This decision follows a successful case study of the NHS London Ambulance Service Trust.

Discrimination

The staff survey key questions that are required for the Workforce Race Equality Scheme (WRES) showed that when asked if staff believed that the organisation provides equal opportunities for career progression or promotion, 83% of white staff and 63% of black, minority and ethnic (BME) staff agreed. There was no difference in the score for white staff from last year but the score for BME staff had increased from 59% to 63%. This marked difference between white and BME staff is greater

than that for comparator Trusts where the score is 88% and 75% respectively. The Staff Network Action Group will work to address issues in relation to BME staff and ensure that staff have equal access to opportunities.

Health and Wellbeing

As part of Trust 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. In March 2017 we appointed a permanent Staff Wellbeing lead who has developed a wellbeing strategy that includes a wide-range of wellbeing initiatives designed to promote good health. The health and wellbeing lead worked closely with colleagues in the Occupational Health Department, the Chief Executive and the Medical Director to improve the uptake of the flu vaccine achieving 72% vaccination rate for patient-facing staff. We have also employed 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. Regular Pilates, yoga and other fitness sessions have proved to be a success with staff and these initiatives will continue

Research

Why is this important?

At St George's we are committed to innovating and improving the healthcare we offer. A key way to achieve this is by participating in clinical research. Our clinical staff are fully engaged with the latest treatment developments and through clinical trials patients can be offered access to new treatment interventions, leading to better clinical outcomes for patients.

St George's, in its partnership with St George's University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams are collaborating with scientists to investigate the causes of a range of diseases, to develop better ways of diagnosis and tailored treatments. We look forward to growth in research activity in trauma, neurosciences, cardiology and maternal and foetal health in 2017.

The past year has seen the first phase one study in St George's Clinical Research Facility, testing a therapeutic vaccine in chronic hepatitis B infection. The Clinical Research Facility's infrastructure has improved, with a new laboratory opening which will support clinical trials.

Key to our research is the partnership that the Trust has with St George's University of London. Some major areas of research undertaken in the past year include:

- New diagnostic techniques for tuberculosis
- Understanding the pain pathways in osteoarthritis
- Development of antibiotic dosing guidelines for paediatrics
- Developing MRI scan techniques in cancer
- New physiotherapy techniques for patients with lung disease.
- Evaluation of rapid clinical diagnosis for STIs
- Studies looking at cardiac problems in otherwise healthy individuals
- Identifying new genetic influences in cardiac problems
- Development of non-invasive techniques to predict and prevent pre-term birth
- New treatments for vascular dementia
- Developing a renal inpatient nutrition screening tool
- Improving outcomes of spinal injury trauma patients

- New ECG techniques in inherited heart conditions
- A national study of maternity patient awareness in surgery
- The effects of e-cigarettes on health and well being
- Outcome of very old people in intensive therapy units

In the 2014 Research Excellence Framework, 99% of the research outputs submitted by St Georges and the University of London were judged to be of international standard in terms of originality, significance and rigour. The strongest aspects of clinical medical research were cardiovascular research and cell biology/functional genetics. The strong partnership between St George's and its partner University underpins this excellence.

How did we do?

Participation

A key way to offer 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. In 2016 St George's recruited 4452 patients onto the NIHR portfolio adopted studies.

Approvals

At St George's in 2016 we had 575 active research studies registered on our database. 318 of these studies were adopted onto the NIHR portfolio. 249 research applications were received in the Joint Research and Enterprise Office (JREO) in 2016 and St George's opened 173 new research studies.

Trials open to recruitment

There is a national target to recruit the first patient to a trial within 70 days of receipt of the study application pack. In the last quarter, 39% of patients met this target.

Ensuring compliance with 'Good Clinical Practice' (GCP) guidelines for research

The International Council for Harmonisation Good Clinical Practice (ICH GCP) has its origin in the Declaration of Helsinki and is a set of guidelines that contains 13 principles, which form a framework to ensure that the safety, rights and wellbeing of trial participants are protected. All trials require a sponsor to take on the legal responsibility to ensure that the trial is conducted safely and gathers good quality information. All of our clinical trials sponsored by St George's are closely monitored by a team from the JREO. When we 'host' studies that are sponsored by other organisations, we undertake our own system of review (audit), in order to ensure best practice and optimal safety for our patients. Every 3 months the JREO randomly selects a number of active studies and clinical trials to audit, to check the study has been conducted in accordance with the standards as described in the ICH GCP guidelines.

Our aims in 2017:

1. Increase participation

We intend to maintain and improve upon our patient participation rates in NIHR adopted trials. We will do this through better supporting clinical research in a variety of ways.

We are targeting our CRN budget allocation to the clinical research delivery workforce – those research nurses and coordinators who are the mainstay of clinical trials. We are pro-actively working with the CRN and investigators to identify those trials which St George's can support. The JREO – under new leadership – has implemented a new and improved structure and is streamlining processes to provide optimal support to investigators.

Each year on International Clinical Trials Day, the JREO together with the Clinical Research Facility raise awareness about research by hosting facility tours and inviting potential participants interested in volunteering to studies to add their names to our 'volunteer database'. We are planning the 2017 event for 19 May.

2. Approvals

In 2016, a new governance approval process was introduced by the government in England, hosted by the Health Research Authority (HRA). This new process caused significant delays in activating studies across England and here at St George's. The process is now embedded at St George's and this – along with improved structures and processes - will allow us to increase approvals.

3. Trials open to recruitment

We intend to significantly improve on the number of trials which meet the 70 day target for recruiting the first patient, through improved structures and processes.

4. Ensuring quality

We will aim to audit 10% of all active research studies each year to provide assurance of the safety and quality of studies conducted at St George's. We will continue to support our clinicians to develop their research questions into successful grant applications.

Data quality

Why is this important?

The collection of data is vital to the decision making process of any organisation, particularly at NHS Trusts like St George's. It forms the basis for meaningful planning and helps to alert the Trust to any unexpected trends that could affect the quality of our services.

Staff at the Trust who record patient information have a responsibility to the NHS and to our patients to ensure that all data held electronically or on paper is accurate, complete and captured in a timely manner. Accurate data also ensures improved reporting, up to date statistics, correct invoicing and improved decision making.

How did we do?

Most data is gathered as part of the everyday activity of frontline and support staff throughout the Trust, working in a variety of settings. It is vital that we collectively and accurately capture and record the care that we provide. The information provided below demonstrates how well we do this. Throughout 2017 the Trust has been working closely with our IT suppliers to increase the robustness of both our data capture and processing.

Statistics to show % of Patient Demographic Data captured from SUS (Secondary Users Services)

Note: The data quality figures shown below are correct for 2016/17 to month 11.

			2013/14	2014/15	2015/16	2016/17
Data Set		National Benchmark	SGH % Valid	SGH % Valid	SGH % Valid	SGH % Valid
Trust Score		0	90.4	90.8	94.0	94.0
APC	NHS Number	99.2%	98.7%	98.7%	98.0%	97.9%
	Postcode	99.8%	100.0%	99.9%	99.7%	99.5%
	Reg GP Practice	99.9%	100.0%	100.0%	99.8%	99.8%
OP	NHS Number	99.4%	99.4%	99.5%	98.5%	99.1%
	Postcode	99.8%	100.0%	100.0%	99.9%	99.6%
	Reg GP Practice	99.8%	100.0%	100.0%	99.9%	99.9%
A&E	NHS Number	96.4%	93.9%	92.7%	92.3%	93.3%
	Postcode	99.3%	99.8%	99.9%	99.7%	99.9%
	Reg GP Practice	98.8%	99.9%	100.0%	99.4%	99.5%

Overall the Trust figure for NHS numbers remains high, but still marginally short of the National Benchmark set out by NHS England. A high percentage of unrecorded NHS numbers are due to the amount of overseas patients treated by the Trust.

Our aims

St George's University Hospitals NHS Foundation Trust has taken and will be taking the following actions to improve data quality:

- A Data Quality Team was established within the Trust in September 2016 to focus on data cleansing, improving recorded data and reinforcing the importance of data quality to all services across the Trust
- The team work directly with front end users to ensure that they are aware of the importance of capturing good data within our Trust systems.
- The data quality team also work closely with the training team and systems team to ensure that the Patient Administration System (PAS) is robust and that staff are provided with the opportunity to be trained and ask questions
- Data quality dashboards are in the process of being created to monitor how services across the Trust are performing
- The dashboards will inform the data quality team Trust staff and services that require additional support and training

Information governance

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient organisation of services and resources. St George's aims to safeguard patient confidentiality and maintain data security whilst empowering staff within the Trust to perform their role using key information governance principles.

What is Information Governance and why is it important?

Information Governance is the way in which the NHS handles all of its information, and in particular, the personal and sensitive information relating to patients and employees. It provides a framework to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care. It also offers NHS employees a clear structure to deal consistently with the many different rules about how information is handled.

Information Governance Toolkit

The Information Governance Toolkit is a Department of Health Policy delivery vehicle that NHS Digital is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against information governance requirements.

There are different sets of information governance requirements for different organisational types. However all organisations, including St George's, have to assess themselves against requirements for:

- Management structures and responsibilities (e.g. assigning responsibility for carrying out the information governance assessment, providing staff training, etc.)
- Confidentiality and data protection assurance
- Information security assurance
- Clinical information assurance
- Secondary use assurance
- Corporate information assurance

All Health and Social Care service providers, commissioners and suppliers must have regard to the Information Governance Toolkit Standard approved by the Standardisation Committee for Care Information (SCCI).

All organisations that have access to NHS patient data must provide assurances that they are practising good information governance and use the Information Governance Toolkit to evidence this. Where services are commissioned for NHS patients, the commissioner is required to obtain this assurance from the provider organisation and this requirement should be set out in the commissioner-provider contract.

St George's Information Governance Assessment Report overall score for 2016/17 was 68% and was graded a green rating.

The information governance scores for St George's can be found at www.igt.hscic.gov.uk. St George's is listed as an acute Trust and our organisation code is RJ7.

Seven Day Services

Why is this important?

Many patients are admitted to hospitals as emergencies and the treatment they receive in the first hours and days in hospital is crucial. It is also important that patients receive a high level of care no matter what day of the week, or time of the day they need it. A key element of the NHS urgent and emergency care review is that patients requiring services for acute stroke, heart attacks, major trauma, emergency vascular and paediatric intensive care receive consistent, high quality care throughout the seven day week.

The *NHS Operational Planning and Contracting Guidance for 2017-19* (published in September 2016) clearly outlines the ambition that by November 2017, the five network specialist services outlined above meet the four priority standards for seven-day hospital services.

We have been working hard to meet these ambitions by developing our teams and measuring how we are doing against the standards in the five key areas.

What standards are we trying to meet?

First consultant review

All emergency admissions must be seen and receive a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.

Timely access to diagnostics

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Access to consultant directed interventions

Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be:

- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous Coronary Intervention
- Cardiac pacing (either temporary via internal wire or permanent)
- Critical care

On-going review

All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every twenty-four hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

How are we doing?

Our most recent self – audit report (submitted to NHS Improvement) was in September 2016. Whilst we perform reasonably well in most areas there is room for improvement. Nationally we sit just below the average for first consultant review and have been working hard with our teams to make sure that Trust consultants have the time needed in their job plans to be able to see patients in a timely manner.

We will continue to collect data on our performance over the coming year to ensure that we continue to make progress towards our targets.

	Weekday	Weekend
First Consultant review	61%	61%
Timely Access To Diagnostics		
Within 1 hour	92%	66%
Within 12 hours	92%	71%
Access To Consultant Directed Interventions		
Interventional radiology	90%	86%
Interventional endoscopy	95%	90%
Emergency general surgery	100%	100%
Emergency renal replacement therapy	100%	100%
Urgent radiotherapy	73%	39%
Stroke thrombolysis	100%	100%
Percutaneous Coronary Intervention	100%	100%
Cardiac pacing (either temporary via internal wire or permanent)	100%	100%
Critical care	100%	100%
On-going review		
Twice Daily	97%	86%
Once Daily	99%	94%

Data from Trust self-audit report, September 2016

Our aims

Our aim is to work towards fully meeting the standards outlined in the *NHS Operational Planning and Contracting Guidance* by November 2017, for our five urgent networked services. This is a key aim for the Trust and the NHS as a whole, to help deliver care to patients seven days a week.

Mandatory surveillance of healthcare-associated infections

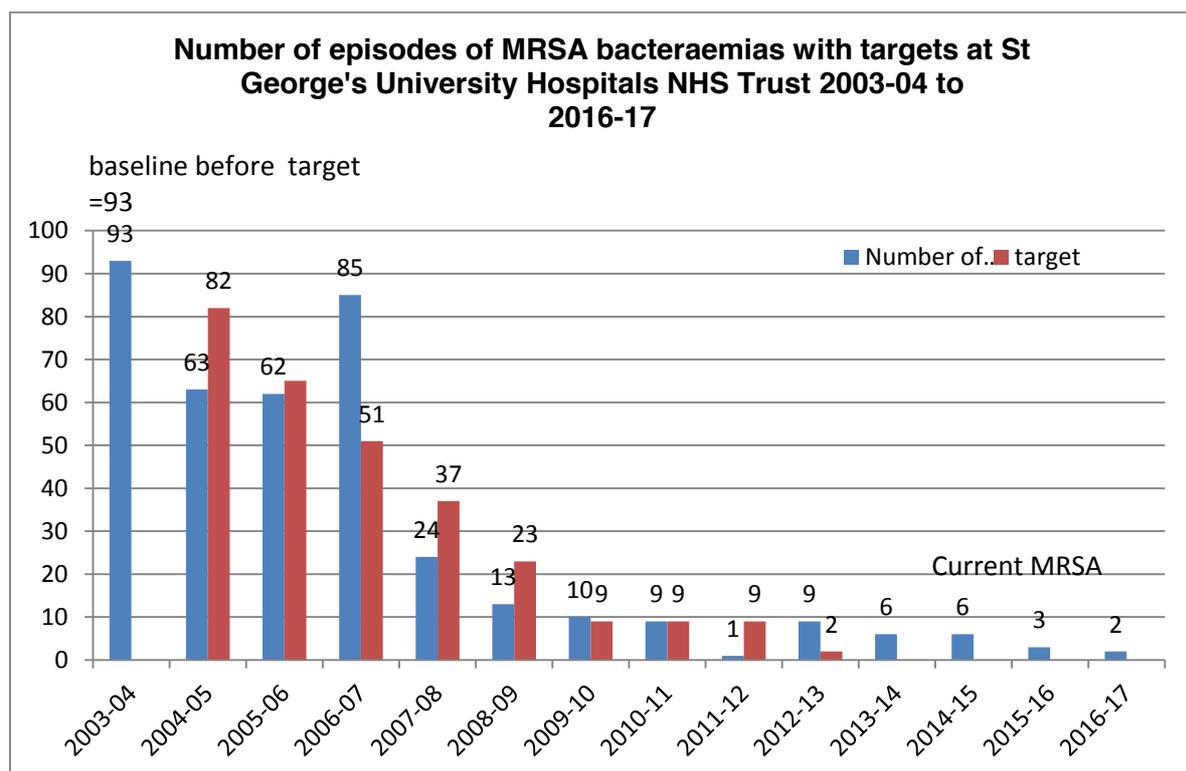
Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia

How did we do?

Since 1 April 2001, all NHS Trusts have been required to report the number of episodes of bacteraemia (bloodstream infection) with MRSA.

In line with the government thresholds, St George's has reduced the number of MRSA hospital assigned bacteraemias significantly since 2002-03, as outlined in the table below. In recent years the number of assigned episodes is as follows:

- 2011/12 - one episode
- 2012/13 - nine episodes
- 2013/14 - six episodes
- 2014/15 - six episodes
- 2015/16 - three episodes
- 2016/17 – two episodes



When compared to other teaching Trusts in London, St George's has low rates of MRSA bacteraemia. These rates are expressed as number of episodes per 100,000 bed days. The rate for 2016-17 was 0.65, which was the lowest for any teaching hospital in London and the sixth lowest for any of the 29 teaching hospital Trusts in England. The worst performing Trust had rates 4 times higher than St George's.

Meticillin-susceptible *Staphylococcus aureus* (MSSA) bacteraemia

How did we do?

From 1 January 2011, NHS Trusts have been required to report all episodes of meticillin susceptible *Staphylococcus aureus* (MSSA) bacteraemia, using similar criteria as employed for MRSA surveillance.

There were 78 episodes in 2016/17 of which 31 were apportioned to the Trust. This compares to 91 episodes in 2015/16 with 39 of these apportioned to the Trust. In 2014-15 the numbers of episodes were 82 and 29 respectively.

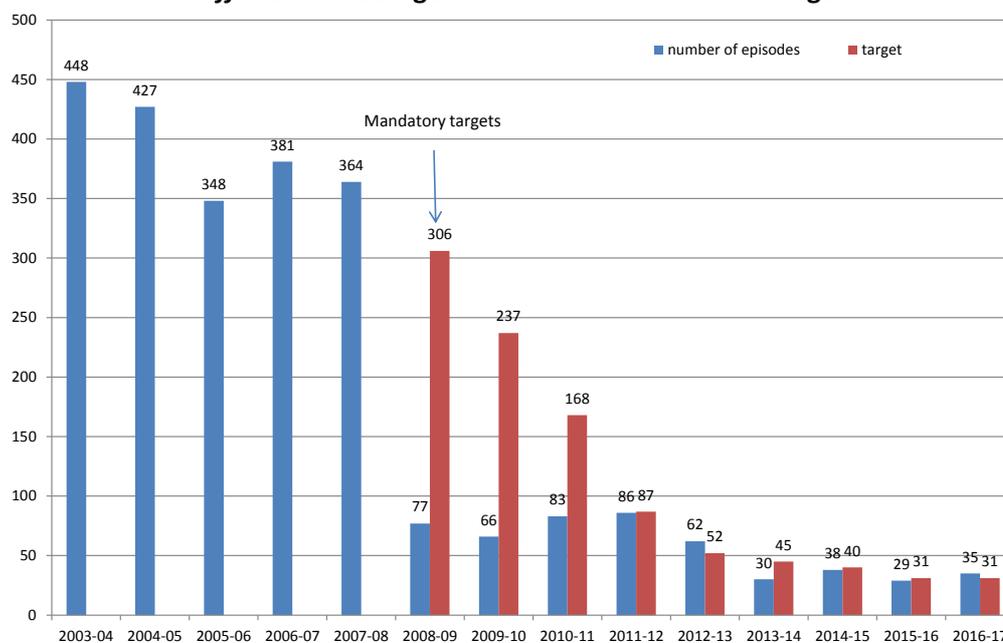
There are no national thresholds for MSSA bacteraemia at present. The 2016-17 rate of Trust-apportioned episodes for St George's is 10.1 per 100,000 bed days and represents the median rate for compared to other similar Trusts in London.

Clostridium difficile infection

Clostridium difficile infection is a major cause of antibiotic-associated diarrhoea, and became widespread in UK hospitals in the late 1990s. In response to this, the Government announced in October 2007 a plan to reduce the number of *C difficile* infections nationally by 30% by the end of the calendar year 2010-11.

Figure 2 indicates the reduction in numbers of episodes since 2002-03. Each year the Trust has a target (threshold) for Trust-apportioned episodes. The targets are individualised for each Trust with a very wide range. The target for St George's in 2016-17 was 31 episodes equating to a rate of 10.2 per 100,000 bed days. Other London Teaching hospital Trusts have targets up to 4 times higher.

Figure 2. Numbers of hospital-acquired infections with *Clostridium difficile* at St George's 2003-04 to 2016-17 with targets



How did we do?

For the first time in three years, the Trust had more episodes of Trust-apportioned *C. difficile* episodes in 2016/17 than the target, i.e. 36 versus a target of 31. This equates to a rate of 11.77 episodes per 100,000 bed days. However the rate for St George's was still lower than the majority of other London Teaching hospitals and was the seventh lowest of all 29 teaching hospital Trusts in England. The best and worst performing Trusts had rates of 8.84 and 33.6 respectively.

Glycopeptide resistant enterococcal bacteraemia

How did we do?

This reporting scheme started on 1 October 2003 and data has been published annually for all hospitals between the months of October to September. St George's figures are illustrated in the table below with figures up to end of September 2016. There are no national thresholds.

St George's has always had very low levels (more than 75% lower than some Trusts) and this trend has continued in the last financial year.

Annual numbers of GRE bacteraemias at St George's Hospital:

Year	Number of patients
October 2009 - September 2010	3
October 2010 - September 2011	4
October 2011 - September 2012	13
October 2012 - September 2013	11
October 2013 - September 2014	12
October 2014 - September 2015	11
October 2015 - September 2016	8

Sepsis

Our aims

Our aim at St George's is to ensure that every patient with sepsis is identified early and has treatment initiated within one hour.

How did we do?

Prior to April 2016 there was no robust system for screening for sepsis in the St George's emergency department or on the wards. During 2016/17, a robust system for screening and early intervention with antibiotics was set up in the emergency department and on four adult wards. Doctors and nurses have also been trained to screen for sepsis and initiate antibiotics early. This training has been supported by the GAPS Simulation centre in the form of the Sepsis 6 course and the Critical Care Liaison project team. A Sepsis Awareness week was also successfully held across the Trust in March 2017.

Sepsis in adults in the emergency department

The Sepsis CQUIN commenced in the Trust in April 2016. Prior to this, there was no robust mechanism to screen for sepsis and no data was collected on screening. Training on screening took place in May and June 2016, with data collection commencing in July.

Figure 1 below shows the marked and encouraging improvement in the percentage of patients meeting the criteria for screening, who were actually screened for sepsis on arrival.

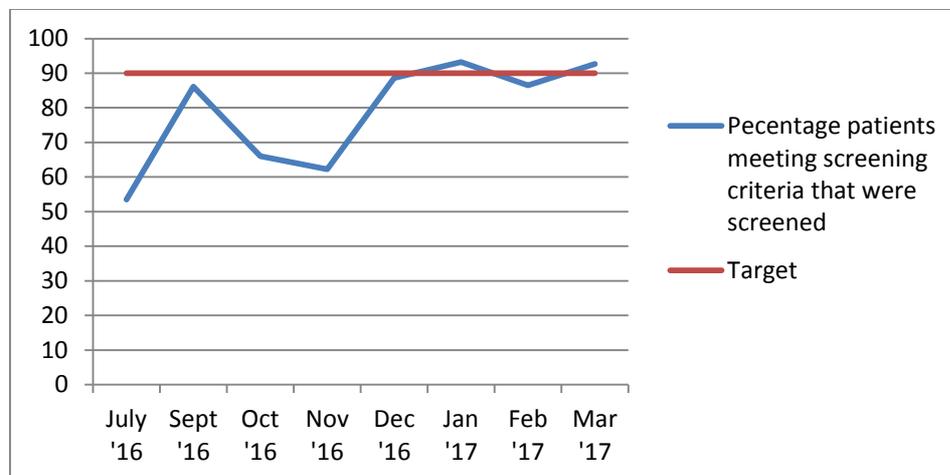


Figure 1: Adult ED patients meeting the screening criteria who were screened on arrival

Antibiotics

An audit of time-to-antibiotics commenced in October 2013. The percentage of adults in the emergency department receiving antibiotics within one hour improved from 25% to 50% by April 2016. With the implementation of the Sepsis CQUIN, the percentage of patients receiving antibiotics within one hour has continued to improve. By the end of March 2017 this figure stood at 86%, as indicated in Figure 2 below.

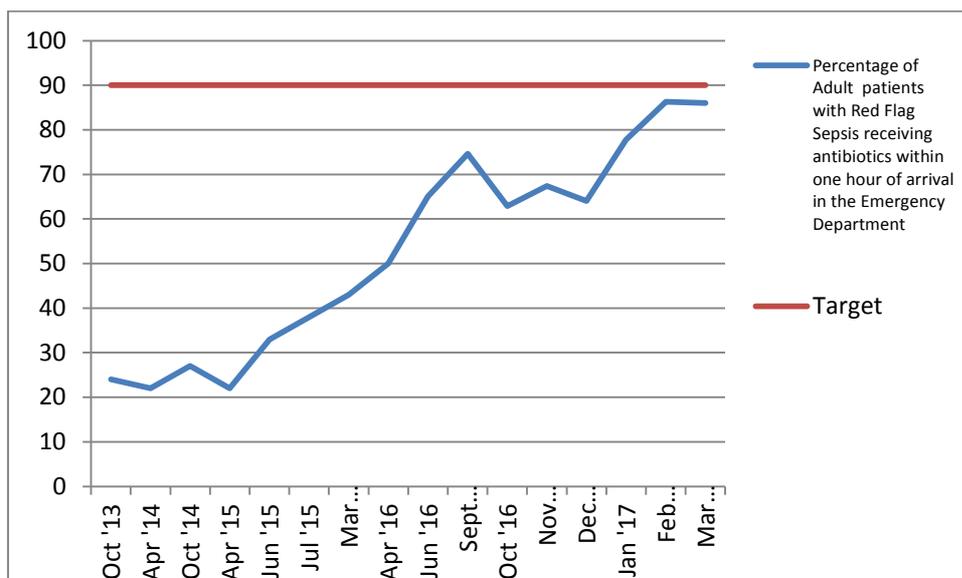


Figure 2: Adult emergency department patients who met Red flag sepsis criteria at triage who received antibiotics within an hour

Sepsis in children in the emergency department

Prior to the implementation of the sepsis CQUIN within the Trust in April 2016, there was no formal system for screening for sepsis nor was there a guideline on sepsis management in children in the emergency department.

No data is available for Q1 of 2016. In Q2, 3 and 4 there were 4, 67 and 105 children respectively, recognised as potentially having sepsis. The number of patients screened improved from 1 in Q2 to 14 and 25 in Q3 and 4, respectively. There were initially issues regarding the logistics and usage of the screening tool. This was resolved by incorporating the screening tool and the Sepsis 6 treatment bundle in the new paediatric emergency department notes.

Approximately 25% of children with sepsis receive antibiotics within one hour of arrival. This is expected to improve with the implementation of the new improved paediatric emergency department notes incorporating the screening tool and the treatment bundle.

Sepsis on the adult wards

Prior to the commencement of the sepsis CQUIN in April 2016, there was no system for screening for sepsis on St George's hospital wards. In Q3 and 4 the Trust invested in three Band 7 Critical Care Liaison Project nurses on 4 wards to screen patients for sepsis and commence treatment. Screening on the wards improved from **0 to 100%** with 1,022 patients being screened for sepsis in Q4. The percentage of patients receiving antibiotics within one hour also improved from 0% to 62.5%.

Sepsis on the paediatric wards

The paediatric wards will be engaged in the Sepsis CQUIN in 2017-18.

Participation in clinical audits

During 2016/17, 50 national clinical audits and 7 national confidential enquiries covered the NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period, St George's University Hospitals NHS Trust participated in 96% 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 2016/17 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 12 national clinical audits were reviewed by Trust board in 2016/17. A summary of the actions agreed in response to these audits is given in Appendix B.

The reports of 8 local clinical audits were reviewed by St George's in 2016/17. A summary of the actions agreed is given in Appendix C.

Use of CQUIN payment framework

A proportion of St George's University Hospitals NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between St George's and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

As at April 2016, St George's has agreed Q3 performance with commissioners. The Trust currently envisage an 81% overall performance against the suite of CQUINs agreed with commissioners. Estimated income will be £12 million.

Further details of the agreed CQUIN goals for 2016/17 and for the following 12-month period are available in Appendix D.

Payment by Results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

Secondary Uses Service

St George's University Hospitals NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data*:

- Which included the patient's valid NHS number was:
 - 98% for admitted patient care
 - 99.2% for outpatient care; and
 - 93.4% for accident and emergency care

- Which included the patient's valid General Medical Practice Code was:
 - 99% for admitted patient care
 - 99.9% for outpatient care; and
 - 99.6% for accident and emergency care

**Source – SUS Data quality reports as at 17/05/2017*

Improving patient safety

Medication errors

Over the years the Trust has worked hard to develop and maintain its strong reporting culture. Following their audit of the Trust in June 2016, the Care Quality Commission (CQC) reported that staff understood how to recognise and report medicines related safety issues. This is reflected in the higher than average reporting rate of medication incidents at the Trust.

How did we do?

In 2016, the National Reporting and Learning System reported that St George's medication error reporting was higher than the national benchmark for reporting medication incidents. 13.7% of all incidents reported by St George's involved medication, in comparison to 10.8% for all acute teaching organisations for the period of April – September 2016.¹

In quarters 1-3 of 2016/17, St George's reported 1420 medication incidents, reflecting a good safety culture at the Trust. Of these incidents 94.4 % resulted in no harm, 4.5% in low harm and 1.1% in moderate harm. No medication incidents 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 – 94.4%

Low harm – 4.5%

Moderate harm – 1.1%

Severe harm – 0%

Trend of reporting medication incidents continued to increase over 2016/17, without an increase in the degree of harm. 94.4% of incidents were no harm in quarters 1-3 of 2016/17, compared to 93.0% for the previous year.

Monitoring

Medicine errors and safety incidents are reported via Datix and these are reviewed by the Trust Pharmacy and the Medicines Optimisation Committee on a quarterly basis. The feedback and learning to staff is communicated through a variety of channels such as newsletters, Trust-wide memos, quarterly meetings with senior nursing staff for each division, divisional governance meetings and face to face meetings with relevant staff.

The Trust 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-ordinate medication safety monitoring visits to clinical areas to monitor medication safety issues.

During 2016/17, medication safety visits have been conducted in community services, ward and non-ward areas including radiology and endoscopy.

References:

1. *National Reporting and Learning System (March 2017) Organisation Patient Safety Incident Reports: 01 April 2016 – 30 September 2016; St Georges University Hospitals NHS Trust.*

Patient deterioration

Why is this important?

St George's outreach service is currently provided by staff from a number of departments. Internal National Early Warning Score (nEWS) and global trigger tool audits have identified some shortfalls in care. A number of Serious Incident (SI) reports have suggested patients may have suffered harm or death due to lack of recognition or escalation of acute physiological deterioration.

Additionally, there have been a growing number of potentially avoidable out of hours' referrals to General Intensive Care Unit (GICU). In 2016 'deteriorating adult' was added to the Trust Risk Register and was subject to a 'deep dive' review in a Trust risk meeting in April 2017.

How did we do?

In May 2016, the Deteriorating Adult Group (DAG) was convened in response to the risk review. The DAG promotes effective and efficient multi-disciplinary care for patients across the trust. This group has wide representation from across the hospital and has highlighted variable practice in some areas of the hospital with regard to:

- Recognition of physiological deterioration
- Local escalation to senior nursing and medical staff
- Lack of routine junior and senior medical input on some wards
- Gaps in consultants review of deteriorating patients
- Poor use treatment escalation plans (TEP) and Did Not Attend (DNA) and Cardio Pulmonary Resuscitation (CPR) orders

Our aims

The Trust will provide high quality safe care for every adult inpatient, with the aim of recognising and escalating timely deteriorating patients. The Trust will provide appropriate treatments according to individualised treatment escalation plans. Our aims are to:

- Reduce avoidable cardiac arrest
- Improve individualised in-patient care
- Improve end of life care

Policy

The policy for the Minimum Standard for Adult In-Patient Observation has been updated to improve the processes of recognition, escalation, management and governance and in particular strengthen the escalation criteria.

National Early Warning Score (nEWS) audit

The Trust audited nEWS in January 2017. The results demonstrated continuous improvement. A full report is provided in Appendix E.

Critical care liaison pilot (CCLP)

This six-month pilot funded via the Sepsis CQUIN came to an end on 31 March 2017. The team of three individuals leading the pilot have worked closely with four wards, identifying and introducing measures to address poor ward handover and knowledge of patients scoring a nEWS ≥ 5 ; poor utilisation of ward whiteboards; poor knowledge of nEWS amongst the HCA group, poor use of treatment escalation plans and Did Not Attend (DNA) and Cardio Pulmonary Resuscitation (CPR) orders.

Serious incident (SI) reporting

SI reporting is now a regular item on the Deteriorating Adults Group agenda. New SI's and closed SI's are discussed to ensure Trust wide dissemination of this knowledge. A thematic analysis of the last years SI's is in progress.

Future Strategy

Our future and long term strategy within the Trust is to:

- Increase awareness and local ownership of risk in every ward
- Embed inpatient care and deteriorating adult care into the governance of every care group
- Improve nEWS monitoring and escalating compliance
- Monitor mortality and incidents and feedback locally
- Create safety work climate by supporting wards with training and change
- Reallocate resources where possible \pm recruitment
- Achieve 100% SAFER compliance in the wards
- Set individual escalation and end of life plans for every patient admitted to the hospital

Staff learning through incident feedback

Why is this important?

The Trust operates a single electronic incident reporting system for all adverse incidents and near misses. Reporting an incident is one of the most important ways that staff can help the Trust learn from things that go wrong. The Trust also has a responsibility to ensure that feedback should be provided to staff who report incidents.

How did we do?

The incident reporting system provides the following mechanisms to enable prompt feedback to staff regarding incidents:

- Confirmation email sent to staff when incidents are reported
- Email communication function, to allow shared communication regarding incidents
- Automated feedback via email when an incident is closed on the system, providing staff with details of how an incident has been followed up – this function has recently been put into place

The Trust has also introduced a number of other learning initiatives and has continued to work towards enhancing some existing mechanisms throughout 2016/17:

- Risk Management input into training programmes, including the new manager's induction and preceptorship nursing, regarding incidents and serious incidents (SIs)

- Increased frequency of root cause analysis (RCA) training from bi-monthly to monthly to enable more staff to understand the importance of learning from incidents and enhanced involvement in the SI investigation process
- Use of a 'safety huddle' initiative to share learning amongst ward staff in some medical wards
- Increased involvement from medical staff in following up incidents
- Implementation of a job description for governance leads signed off by Medical Board
- A monthly governance newsletter circulated to all matrons, governance leads, care group leads and other senior staff
- Reporting of incident/SI data to Board and Board sub-committees, as well as at divisional level
- Raising awareness of how to gain feedback using CARE folders in wards/departments
- Introduction of quarterly analysis report – Complaints, Litigation, Incidents, PALS, Inquests (CLIPi) report and learning from SIs.

Overall the number of reported adverse incidents has increased across the Trust, based on comparison with data from 2015/16. Higher and, or increased levels of incident reporting is considered as a positive indicator for effective risk management culture and systems in the NHS.

The number of SIs declared has decreased, compared with 2015/16. Observed in parallel, a decline in the number of Serious Incident (SIs) reported in 2016/17, together with an increase in the total reported incidents is a good indication that the organisation is improving from learning gained from adverse incidents.

Our aims

- Creating a culture of shared learning - encouraging openness and candour so that staff feel able and confident to raise concerns
- Promoting a positive change culture in order to become a learning environment
- Zero Never Events
- Introduce specific training programme for SI chairs and panels
- Increased involvement of simulation to support education and learning
- Improve incident reporting feedback on incidents at time of closure

Learning from never events outside of theatres

Why is this important?

It is equally as important to learn from never events that occur outside of theatres, because they can be as damaging and harmful as never events that occur during surgery (e.g. radiation incidents, risk of sepsis with retained swabs in obstetrics, wrong biopsies with missed cancer diagnosis).

How did we do?

The Trust has revised its site policy to display outside theatre areas, in line with the current NatSSIP policy. The policy is now named 'Safer Standards for Invasive Procedures' and covers all invasive procedures inside and outside of theatres.

Quarterly audits on Local Safety Standards for Invasive Procedures (LocSSIPs) have been established and the data is monitored by the Patient Safety and Quality Board.

The Trust is extending the auditable database on LocSSIPs monthly.

There have been zero Never Events outside of theatres at the Trust since December 2015, compared with four in the same period during the previous year.

Learning from Never Events is included in the monthly Trust Governance Newsletter and circulated to all matrons, governance leads, care group leads and other senior staff.

Our aims

- Zero Never Events
- Extending the LocSSIPs database
- Regular audit with eventual aim of rotational peer audit long term

Improving patient experience

End of life care

Why is this important?

End of life care is provided to patients by all of our clinical staff with approximately 1750 deaths per annum for patients under our care in our acute and community services.

'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020' states that:

"End of life care is care that affects us all, at all ages, the living, the dying and the bereaved. It is not a response to a particular illness or condition. It is not the parochial concern of a particular group or section of society. When it comes to death the statistics are stark. 100% of us will die...palliative and end of life care must be a priority.

The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

As people, professionals and local leaders within the health and social care system and our communities, we must commit to these ambitions and to the framework that will enable their delivery."

End of life care affects every part of the Trust, from the neo-natal unit to the mortuary. This type of care is about helping people live as well as possible until death, with dignity and according to their wishes. There has always been good and positive direct patient care at St George's, but improved governance and operational oversight has meant that we can now evidence where things are working well, and areas where we can do better.

How did we do?

We have participated in a number of key audits in recent years and have understood what we need to do in order to continually develop our services to deliver good quality accessible end of life care.

The Care Quality Commission (CQC) rated end of life care at the Trust as 'requires improvement' in 2014. We developed an action plan and work was undertaken across the Trust to improve our services.

The CQC inspected the Trust again in June 2016. In November 2016 we were rated as:

- 'Inadequate' for End of Life care overall
- 'Good' for Caring
- 'Requires Improvement' for Safe and Responsive and;
- 'Inadequate' for 'Well Led' and 'Effective' domains

The CQC highlighted that patients were treated with dignity, kindness and compassion and that there was consistently positive feedback from patients and their relatives about the service.

However, the CQC highlighted that there was no integrated strategy for end of life care within the Trust and no leadership and governance framework to support executive oversight of the community

end of life care services. The CQC also highlighted that there was no evidence of joint working and that there was limited evidence of our ability to demonstrate our performance and/or effectiveness of our care. Additionally, there was no assurance provided to the CQC that our staff had access to appropriate training.

From November 2016 we developed a Trust wide end of life care strategy: *'Patients, Families and Carers First: End of Life Care Strategy 2016 – 2020'*.

We nominated a non-executive board member for end of life care and re-established the end of life care Steering Group with divisional and departmental representation and including external stakeholders. We also developed a structured governance framework and confirmed the medical, nursing and management leadership for end of life care.

We now have a detailed implementation plan in place to support the delivery of the strategy which is divided into time specific milestones for end of life care service development and delivery across the divisions and the Trust as a whole.

From January 2017 the Trust has committed to:

- Reviewing and analysing end of life care related complaints and incidents
- Reviewing staff education and training levels
- Reviewing agreed key performance metrics e.g. the numbers of patients who died in their preferred place of death
- Providing and end of life care related audit and;
- Making recommendations for improvement in practice

Our aims

The Trust end of life care strategy is shaped by *'Getting end of life care right'- South West London Sustainability and Transformation Plans* and is informed by the outcome of the CQC inspection in 2016.

It reflects the six ambitions for end of life care, regardless of age, diagnosis or locality and will be delivered seamlessly by our hospital and community services embracing a multi-disciplinary and multi-agency approach to care. Implementation and delivery will take different forms across different specialities and services and will be reflective of the specific needs of discrete populations, such as children or older people.

Our vision is: *End of life care matters to everybody and that people under our care are able to die with choice and dignity.*

The Trust has detailed the following 6 ambitions which are common to all:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is co-ordinated
5. All staff are prepared to care
6. Each community is prepared to help

We will know we are doing well by successfully delivering the following principle objectives in line with our 6 ambitions:

- Promoting the use of Advance Care Planning to enable people to state their end of life care wishes and ensure they are adhered to. To date each division has developed a local process to identify patients who might be entering the last year of life
- Ensuring high quality end of life care. To date we have developed a Trust wide care plan for last days and hours of life aligned to the five priorities of care for the dying person
- Changing the perception of 'death is failure' to 'a good death is a successful care outcome'. To date we have created a staff and patient communication and engagement strategy and we are participating this year again in the Dying Matters national campaign
- Developing transparent processes for access to rapid response 24/7 end of life care. To date each division has implemented guidance for identification of patients in the last hours and days of life
- Ensuring health and social care professionals have access to appropriate and high quality training and education. To date we have successfully secured Health Education England funding to develop and education framework across the Trust and primary care. We are benchmarking our training content with another London Trust and monitoring the levels of our training activity
- Improving the co-ordination of end of life care between varied providers. To date we have agreed that *Co-ordinate My Care* is the electronic End of Life care record for patients in our care. Our community staff participate in the gold standard framework MDT meetings with GPs and colleagues. Our specialist palliative care team have access to *Co-ordinate My Care* to update and create *Co-ordinate My Care* records. Our community and acute colleagues meet on a monthly basis to discuss individual patient care and End of Life care service development

Complaints

Why is this important?

Last year St George's 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 that we can make the necessary changes that are needed to improve.

As well as working with our staff, patients and their friends, family and carers can also discuss any concerns they have with our Patient Advice and Liaison Service (PALS), who will work closely with them and the service involved to resolve any issues. Complaints and compliments can also be formally submitted to our Complaints Department. We aim to investigate and provide a full response to all formal complaints within 25 working days of the complaint being received or within a longer time-frame if agreed with the complainant.

The lessons learned and trends identified from information collected from our complaints process plays a crucial role in improving the quality of our services and the way in which we engage with our patients and visitors.

How did we do?

In 2016/2017 we received 903 formal complaints, a reduction of 8% compared to 975 complaints in 2015/16. In addition we dealt with 533 informal issues and queries via the Complaints Department and received 701 compliments. The Patient Advice and Liaison Service received 7777 contacts of which 3948 were categorised as concerns.

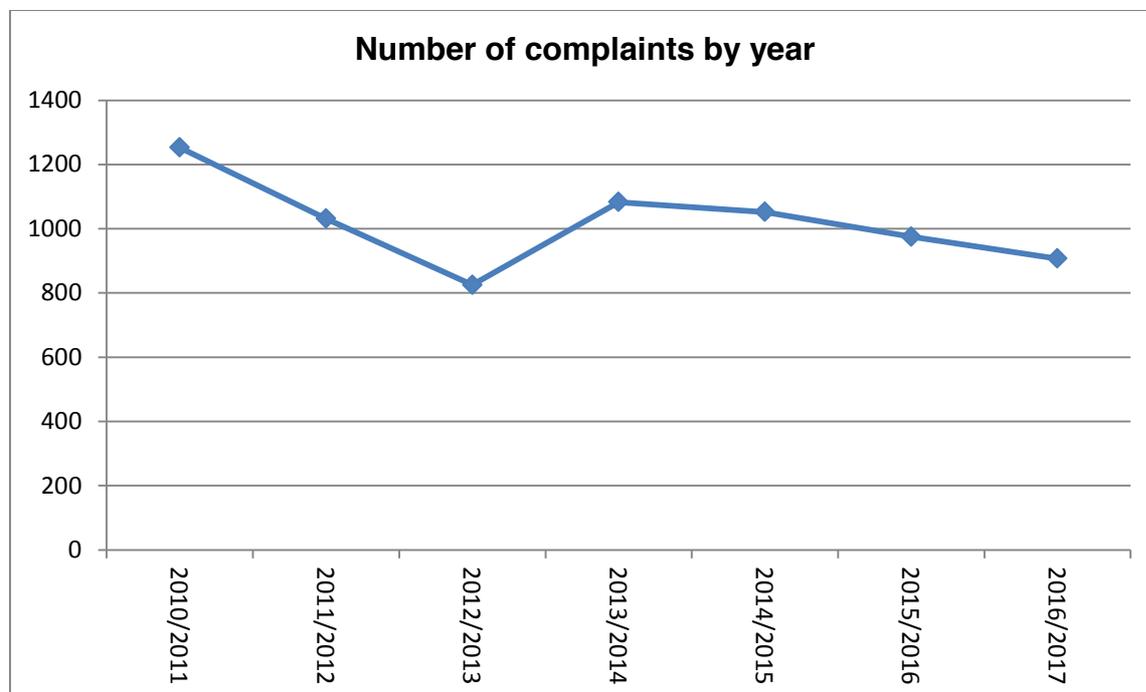
It is currently difficult to benchmark complaints against other Trusts as there is no uniform method for Trusts to record complaints, meaning that there is inconsistency across the NHS.

The Trust views all types of patient feedback as positive and we are consistently assessing how we can encourage patients, carers and families to provide us with their views and feedback.

Number of complaints

Year	Number of complaints
2016/2017	903
2015/2016	975
2014/2015	1052
2013/2014	1083
2012/2013	825

2011/2012	1031
2010/2011	1253



Complaints response rate

The Trust 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.

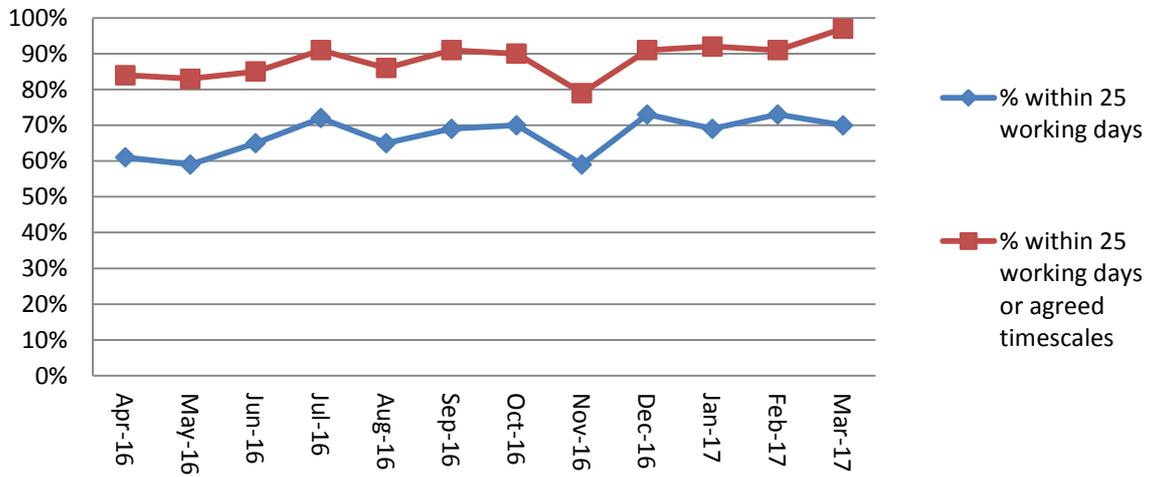
The chart below tracks performance throughout the year. It can be seen that across the year any improvements in performance against the 85% target were not sustained.

For complaints received in November 2016 performance dipped below 60% for the first time since February 2016. There has, however, been an improvement in responses sent within agreed timescales for complaints received in March 2017.

Action plans have been put into place in consistently poorly performing divisions within the Trust with the aim of improving and delivering performance against internal standards, but these are not achieving the desired results in some areas.

A comprehensive review of the current position is being undertaken and a proposal is being prepared regarding the resetting of targets to take into account the complexity of complaints, improve the quality of responses and better manage complainants' expectations.

Complaint response times by month 2016/17



Dementia and delirium

Why is this important?

People living with dementia and/or experiencing delirium are some of our most vulnerable service users. Our focus during 2016/17 has been to bring practice within the Trust in line with the National Institute of Clinical Excellence (NICE) delirium quality standard. This requires us to assess all 'at risk' patients for the presence of delirium, treat delirium appropriately and actively prevent delirium developing in hospital.

To achieve this, we have developed a new delirium pathway which is being implemented across the hospital. In addition, as part of the *Personalised Care Quality Improvement Plan*, we have developed several targets for improving dementia and delirium care in the Trust. We are also committed to listening to carers of people living with dementia through administering and acting on the results of our Dementia Carers Questionnaire. Additionally, we value input from voluntary sector partners, ensuring that the Alzheimer's Society and Wandsworth Carers' Centre are fully represented at the Trust's Dementia Strategy Group.

How did we do?

In recognition of the importance of delirium, the Trust appointed a clinical lead for delirium to work alongside the dementia clinical lead in November 2016.

The nurse-led dementia and delirium team has been supporting the introduction of the new delirium pathway, as well as providing formal and informal training to staff and advising on the care of patients with dementia and/or delirium. Routine referrals of inpatients to the team have increased from an average of 5.4 per week in 2016 (total referrals = 280) to an average of 9.2 per week in 2017 (total referrals to date = 120).

The increase in 2017 does not take into account additional referrals made when the delirium team attended a ward as part of the delirium roll-out strategy (range: 10-20 additional referrals/week). By 31 March 2017, the new delirium protocol had been introduced on 17 wards, including all general medical, acute surgical and senior health wards. Analysis of routine referrals reveals that 90% come from wards where the new delirium pathway has been introduced, compared to 10% that come from wards awaiting roll-out.

Just under 7000 Trust staff have completed dementia awareness training, an overall response rate of 84%.

In May 2016, 32 wards were assessed using the PLACE (Patient-Led Assessments of the Care Environment), which includes measures of dementia-friendliness. Since then 238 dementia clocks, which help patients to maintain orientation in time, have been distributed to 33 wards. We have also introduced a pictorial food menu to make it easier for patients with communication difficulties to select their preferred drinks and meals.

Responses to the Trust Dementia Carers Questionnaire in 2016/17 show that:

- 86% of carers would recommend the ward where the patient was looked after to friends or family, with similar numbers reporting that they received good communication from staff and felt sufficiently involved in the patient's care plan
- 95% of carers reported that the person living with dementia was treated with dignity and respect

- Two-thirds of carers said that they would like the opportunity to stay overnight with the patient, but only one in five had been able to do this

Our aims

During 2017/18 we will:

- Introduce scorecards to allow individual wards and directorates to rate the quality of their dementia care
- Audit compliance with the new delirium pathway
- Audit use of the *Butterfly Scheme* (our identification and care response scheme for people living with dementia) across the hospital
- Ensure that, where appropriate, ward staff offer dementia carers the opportunity to stay overnight with the person they care for
- Launch a new volunteering role providing activities (such as use of "memory boxes") for inpatients with dementia
- Receive our data from the 2016 National Audit of Dementia, and adjust our dementia and delirium strategy accordingly

Improving patient outcomes

Clinical records

Why is this important?

Health records serve many purposes in the modern healthcare environment, but fundamentally they are the foundation of high quality, safe patient care. Clinical practice in the UK increasingly relies upon the electronic storage and communication of patient records and electronic communication of records. Electronic records make handwriting misunderstandings redundant and facilitate improved communication across the healthcare systems. The Trust is currently in transition with the deployment of iClip (Cerner Millennium) that will eventually mean a fully digital record of the patient's care. In the meantime, the Trust conducts regular audits of existing paper-based health records to monitor the quality of record-keeping against published national standards set by the Royal College of Physicians in 2008. There are still many wards within the Trust that do not undertake mandatory audits against the national standards – there needs to be a focus on improvement in this area.

How did we do?

At present 24 out of 35 Care Groups within the Trust continue to rely on paper-based health records for the care of inpatients. Of the Care Groups participating in these audits, performance against record-keeping standards are good (>85%) for records being bound, organized and ensuring clinical entries are legible, dated and signed.

However, across the Trust poor performance (63%) has been noted for the consultant's name or their team not being recorded in patient health records. Additionally, not making use of the patient labels on the history (continuation) sheet has been noted in approximately 50% of records.

Our aims

Until such time as iClip is fully deployed across the entire Trust, we will continue to monitor and feed back to Care Groups about their existing performance against established standards in record-keeping, to ensure that clinical staff remain aware of the importance of good record-keeping in maintaining patient safety.

The terms of a timeline for full deployment and implementation of iClip are to be finalised. The Trust will potentially invest in infrastructure over the next 12 months or so, i.e. cabling, servers, etc. Once this has been done, the Trust will commence an iCLIP deployment project – forecast for 2018/19.

Mortality

Why is this important?

St George's is committed to understanding mortality data and learning from any care issues in patients who die. The Trust has a well-established Mortality Monitoring Committee, chaired by the Associate Medical Director for Mortality. The membership is multi-professional, with representatives from all divisions and external Public Health. Key corporate functions are also represented to ensure development of consistent approaches to clinical coding and information management.

As defined by the terms of reference the primary purposes of the committee are:

- To monitor and report mortality metrics and consider for investigation areas where we appear to be an outlier
- To review all deaths that occur following elective admission
- To benchmark mortality at a procedure and diagnosis level and to provide oversight of investigations where outcomes appear to be statistically significantly different to the national average or appropriate peer group
- To lead and promote effective governance of mortality within divisions through sharing best practice and implementing Trust-wide protocols
- To promote and support care groups to identify learning and actions from the proportionate review of all their in-hospital deaths
- To engage with the evolving national strategy for measurement and learning from mortality. The committee has fully engaged in the national strategy, and the pilot of the Royal College of Physicians National Mortality Case Record Review Programme

How did we do?

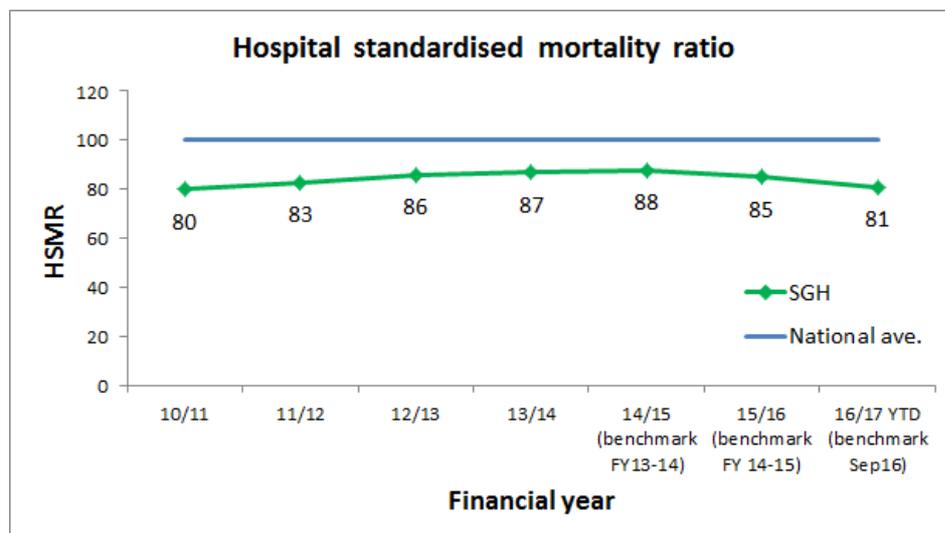
The summary hospital-level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates. It shows whether the number of deaths linked to an organisation is more or less than would be expected, when considered in light of average national mortality figures, given the characteristics of the patients treated there. It also shows whether that difference is statistically significant.

Our SHMI is currently lower than expected. The table below summarises the quarterly publications for this period. As well as considering our overall position we evaluate this data by diagnosis group and investigate areas where mortality may be higher than expected.

Publication date	Reporting period	Ratio	Banding
23 June 2016	January 2015 – December 2015	0.91	As expected
22 September 2016	April 2015 – March 2016	0.90	Lower than expected
15 December 2016	July 2015 – June 2016	0.88	Lower than expected
23 March 2017	October 2015 – September 2016	0.86	Lower than expected

Source: NHS Digital

At St George's we continue to use the hospital Standardised Mortality Ratio (HSMR) in addition to the SHMI to monitor risk-adjusted mortality. The chart below shows our performance over the last six years. With the HSMR, if our mortality matched the expected rate our score would be 100. The HSMR indicates that St George's mortality is consistently significantly better than expected.



Source: Dr Foster Intelligence

Palliative care coding

As it includes all deaths, the SHMI makes no adjustment for palliative care. The Health and Social Care Information Centre publishes contextual indicators to support interpretation of the SHMI, one of which is 'the percentage of deaths with palliative care coding'. This presents crude percentage rates of deaths that are coded with palliative care either in diagnosis or treatment fields.

The data displayed below shows the percentage of deaths with palliative care coding for the Trust compared to the national average.

Publication date	Reporting period	St George's	National
23 June 2016	January 2015 – December 2015	33.4%	27.6%
22 September 2016	April 2015 – March 2016	39.1%	28.5%
15 December 2016	July 2015 – June 2016	42.8%	29.2%
23 March 2017	October 2015 – September 2016	48.9%	29.7%

Source: NHS Digital

Our aims

Learning from Deaths

Following the recent findings of the Care Quality Commission report '*Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England*', the National Quality Board (NQB) published the first edition of '*National Guidance on Learning from Deaths for Trusts*' in March 2017.

The purpose of the guidance is to help standardise and improve the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers in this process.

St George's has a mature mortality review system and will engage in meeting the requirements of this framework in full. An implementation plan was discussed by the Board in April 2017 and a non-executive director has been appointed to provide oversight of progress.

The framework demands that from April 2017, the Trust collects and publishes on a quarterly basis specified information on deaths, which will include the number of in-patient deaths and those deaths subjected to case record review. Of those reviewed we must report an estimate of how many deaths were judged to be more likely than not to have been due to problems in care. There is a particular focus on vulnerable groups, for example patients with learning disabilities or mental health issues. This data and learning will be published in future Quality Accounts.

30 Day Re-admissions

Why is this important?

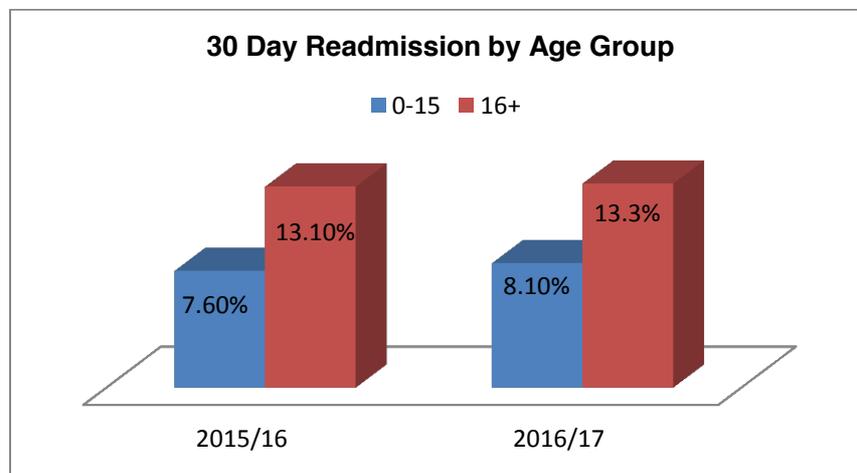
Patients may be readmitted after either a planned or unplanned admission. Some re-admissions are unavoidable but many are avoidable which is why this is used as a measure of quality. Avoidable re-admission can occur for a variety of reasons reflecting care in the hospital, in the community or the transition between them. Avoidable readmissions are undesirable for individual patients and reduce capacity to treat others.

How did we do?

In 2016/17, 12.1% of our patients were re-admitted to hospital within 30 days of discharge. This is a slight deterioration on the previous year when 11.8% of ...1patients were re-admitted. We have compared our performance to the national benchmarks and also analysed by age and type of admission.

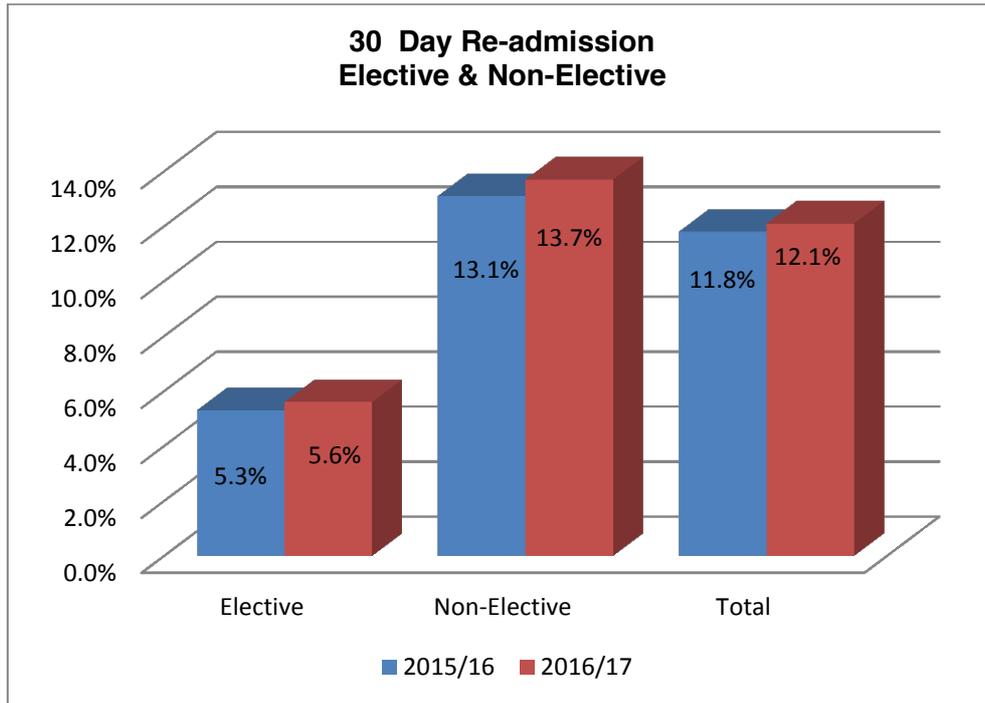
The most recent national data from Dr Foster for the period December 2015 to Nov 2016 shows the national average readmission rate is 6.9% for children* and 9.4% for adults. *Age range on Dr Foster for a child is (0-19yrs). This shows that we have the potential to do better.

Re-admissions do vary depending on the age of the patient. In 2016/17 re-admission rates in the Trust for patients aged 0-15 was 8.1 per cent compared to 13.3 per cent for those aged 16 and over. The comparable figures for 2015/16 were 7.6 per cent for the 0-15 year age group and 13.1 per cent for those aged over 16 years.



Readmission rates also vary depending on whether the first admission was planned or unplanned. In 2016-17 the readmission rate after planned admission was 5.6% (2015-16 figure 5.3%) and after unplanned admission was 13.7% (2015-16 figure 13.1%).

The higher admission rates occurred in patients with diagnosis such as cancers, hematologic conditions, lung disease and mental health disorders.



Our aims for 2017/18

In 2017/18 the Trust is committed to reducing re-admission rates. We will work to ensure that all patients are better prepared for discharge and that there is a coordinated approach with our partners and local authorities to ensuring that the right support is in place following discharge.

Performance table

Theme	Indicator	Target	2014/15	2015/16	2016/17	Rag Rating 2016/17	2017/18
ACCESS	A&E 4 hours waiting time	95%	92.14%	90.4%	91.6%	●	Improve and maintain performance in line with trajectory to achieve compliance
	Cancer 14 Day GP Referral	93%	86%	87.8%	89.9%	●	Improve and maintain performance
	Cancer 14 Day Breast Symptomatic	93%	95%	93.2%	92.5%	●	Improve and maintain performance
	31 Day First Treatment	96%	97%	96.6%	97.2%	●	Maintain compliance and ensure performance remains within target
	31 Day First Subsequent Treatment Surgery	94%	96%	96.0%	96.9%	●	Maintain compliance and ensure performance remains within target
	31 Day First Subsequent Treatment Drug	98%	98%	100.0%	99.6%	●	Maintain compliance and ensure performance remains within target
	62 Day Referral	85%	80%	85.2%	84.7%	●	Improve and maintain performance
	62 Day Screening	90%	93%	90.4%	93.3%	●	Maintain compliance and ensure performance remains within target
	62 Day Consultant Upgrade	85%	88%	92.7%	94.4%	●	Maintain compliance and ensure performance remains within target
Theme	Indicator	Target	2014/15	2015/16	2016/17	Rag Rating 2016/17	2017/18
OUTCOMES	Clostridium Difficile	31	38	28	36	●	To be compliant and ensure performance within target
	MRSA bacteraemia cases	0	6	9	2	●	Zero MRSA incidents.
	Mixed Sex Accommodation	0	16	11	0	●	To be compliant and ensure performance within target
	Total number of Never Events	0	5	8	3	●	No Never Events in 2017/18
	Mortality	100	Lower than expected levels achieved			●	Sustain low mortality rates
Certification of Compliance Learning Disabilities							
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are reasonably adjusted to meet the health needs of these patients?		Yes/No	Yes	Yes	Yes	●	Continue to maintain high levels of performance
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?		Yes/No	Yes	Yes	Yes	●	
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?		Yes/No	Yes	Yes	Yes	●	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?		Yes/No	Yes	Yes	Yes	●	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?		Yes/No	Yes	Yes	Yes	●	
Does the Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?		Yes/No	Yes	Yes	Yes	●	

Note: A&E performance reported is avg YTD for April to March 2016/17. Cancer performance reported is YTD for April to March 2016/17

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

Statement from Healthwatch Wandsworth

Thank you for your letter of 28 April and the draft Quality Account for 2016-17. We very much appreciate the opportunity to comment. I have consulted Healthwatch Wandsworth staff and volunteers, and also sought comments from local Healthwatch colleagues in other boroughs which send patients to Trust services.

This response is submitted on behalf of Healthwatch Wandsworth and Healthwatch Lambeth.

I would like to start with two points which I recognise are obvious but bear brief repetition. First, the Trust and its staff are vital to the health and wellbeing of Wandsworth and its neighbouring boroughs. The committed, sympathetic and professional care which local people receive, day and night, from the Trust's staff is deeply appreciated.

Second, we recognise that in recent years this care has had to be delivered in extremely challenging circumstances. We applaud the resilience and the determination of management, and front-line and support staff, in working through these problems and in striving for improved performance despite all the resource and other constraints that they face.

Proposed quality indicators

We would like to suggest that these be reviewed in order to give a richer range of indicators of patient experience. One indicator relates to the staff survey—we wonder why it is here?—and the others proposed are all process focused. We realise that process indicators can sometimes be more readily measured than outcome indicators, but to cite one example: time taken to respond to complaints is important, but what about the issues being complained about, and how the organisation is learning from them? The NHS category 'Patient Experience', embraces the CQC domains relating to 'Responsive' and 'Caring'. The current proposals seem to relate wholly to the former and we see this as a weakness. One option might be a target relating to conducting Quality Inspections, publishing the results and taking the required action.

Draft Quality Account

Our key point here is that the Trust is required by the CQC to have 'a long term vision and strategy'. We believe that an enduring listening and learning culture, supported by wise and determined governance, is centrally important to this requirement.

There is some evidence in the draft that such a culture is being developed, but it is not yet as embedded or widespread as we would wish and expect to see. The section on complaints (pages 45-7) is, we accept, a summary, but we would have appreciated more depth in the analysis. For all we know, the overall downward trend conceals worsening problems in some areas. That said, one positive example of good practice is on page 48, relating to dementia care, which helpfully reports

feedback from carers about the care being given; and we take some—though limited!—comfort from the inclusion of the ‘Learning from deaths’ section (page 53).

Conclusion

In short, while we realise that the CQC has highlighted areas for improvement in the patient experience, we would hope and expect that the Trust’s own management is making consistent and continuing efforts to find out for itself how this could be improved. That is not clear from the current drafts.

Finally, may I make two linked points about this process. First, I would like to repeat a key point which I made last year,¹ but which is not reflected in this year’s document. For a lay reader, such as many of our members, it helps to have things presented clearly: what is the target, why was it chosen, how are you going to measure performance, and ultimately - did you achieve it (why, why not). The current draft reports on a few chosen ‘activities’, but we have very little narrative explaining how this has improved quality with respect to patient safety, outcomes or experience. Second, we would therefore appreciate the opportunity to contribute to the development of next year’s Quality Account at a formative stage.

Dr Clive Norris

Chair, Healthwatch Wandsworth

15/5/17

¹ My letter of 16 May 2016

Statement from Wandsworth Adult Care and Health Overview Scrutiny Committee

Whilst this statement is submitted on behalf of the Wandsworth Adult Care and Health Overview and Scrutiny Committee, the tight timescale allowed for its submission means that it has not been possible to agree it at a Committee meeting. The comments made reflect the established view of the Committee and its work over the past year, and have been prepared in consultation with its leading members.

The Overview and Scrutiny Committee recognises that, for the past year, the dominant issue for the Trust has been the CQC inspection which took place in the summer of 2016 and the need to address the ensuing 'inadequate' rating. The Overview and Scrutiny Committee received briefings from the Trust on this at its meetings in September and November 2016 and an update on the Trust's Quality Improvement Plan was circulated to OSC Members in March 2017.

Members' discussion of the CQC inspection focused primarily on three issues:

- The very poor physical condition of some of the facilities at St George's Hospital, and the need to make urgent improvements;
- The weaknesses of the Trust's Information Technology and the resultant failure to apply appropriate clinical prioritisation to patients referred to the hospital for treatment;
- The weaknesses in leadership and the need to establish a permanent leadership team with adequate grasp of quality across the organisation.

Whilst the update on the Quality Improvement Plan provided members with reassurance that actions were being taken in response to the specific issues identified in the CQC inspection, consistent and long-term progress will be required to ensure that the above issues are addressed.

The indicators proposed for inclusion in the Quality Account are consistent with the above and reflect comments that the Wandsworth Overview and Scrutiny Committee has made in its Quality Account statements in previous years:

- The Trust's consistent good performance on mortality has been a strength. It was a concern that the 2015/16 data showed some weakening of performance, but the latest figures indicate that this has been rectified. Nevertheless, it is important that this should be a consistent focus of attention.
- The Trust's failure to achieve national targets on its response to complaints has been a concern to the Overview and Scrutiny Committee for a number of years. It is evident that action to date has not been effective and that an enhanced focus on this issue is required.
- The high number of cancelled operations at St George's has been a concern to the Overview and Scrutiny Committee over a number of years and was identified by the CQC as an aspect of the Trust's performance that was unsatisfactory. The specific target for reduction in cancelled operations is welcome.
- The Overview and Scrutiny Committee noted with concern the sharp drop in staff morale evidenced in the NHS staff survey published in advance of the CQC inspection. It is a serious concern that, over the past year, less than half the staff at St George's would recommend the Trust as a place to work. Accordingly, the commitment to secure improved staff engagement, evidenced through NHS Staff Survey results, is strongly welcomed.

Finally, as noted in previous years, the focus of the Quality Account is largely on the acute services provided by the Trust. We are aware that the Trust was not successful in its bid to continue to provide management responsibility for Community Adult Health Services Wandsworth. The transition of

contractual responsibility for services to a new provider entails a degree of uncertainty and a risk that quality issues will be overlooked. It is essential that this is not allowed to happen, and that the Trust maintains a focus on the quality of these services and works with the new provider to achieve a successful handover.

On behalf of the Adult Care and Health Overview Scrutiny Committee

15/5/17

Statement from Wandsworth Clinical Commissioning Group

There is much focus on process within the report with less than ideal clarity on outcomes. Where outcomes are talked about, it is not clear whether these are the highest priorities for patients or the Trust as a whole. There are many issues raised that are not addressed in terms of a clear explanation. There are also some random statements within the account with no evidence to back them up for example;

- Because SGH treat patients across South west London and as far as East Anglia, they are more likely to have readmissions
- Consultant review that has been undertaken – this mentions 61% of consultants' reviewed. It would be useful to provide context to this statement and also provide more clarity

There is detailed and extensive (indeed more than half of the report) on the nEWS and associated action plans – we feel that this is far too much detail. There is no mention of the RTT backlog/data quality issues /F2FU and Clinical Harm processes despite this being a major quality issue in 16/17. We also expected some discussion of long cancer waits, and the clinical harm review process in general.

Additional points to note in relation to the Quality Account 2016/17 are:

- Staffing levels and safe staffing generally was not covered within the report
- Place to work days in relation to staff - is this symptomatic of what's happening in the Trust generally?
- There are some areas where the Trust mentions gaps and issues, but have stated they are either not going to address or implement - what are the reasons?
- The report mentions 12% of patients readmitted to hospital - how does this compare with other areas?
- Overall the Data Quality section is light on detail
- There is no clear sense of the Trust's quality of services throughout the report
- Very little information is provided on the rationale for next year's priorities
- Many of the actions taken (in the last year) are actually actions to take – and many of these are rhetorical
- Much of the report relates to 2015/16 and has not been updated
- The patient experience section needs to be a bit more comprehensive - should information also be included on the Trust patient survey?

Overall comments

The CCG acknowledges that the Trust is in a transition period with new leadership who are producing this report on work that has taken place prior to joining the Trust. It would be useful if this fact is reflected upon and acknowledged in the executive summary.

The report should be able to highlight 3 key issues:

- What are the key points of learning to reflect on?
- What is going to be the culture of the organisation going forwards to enable issues and gaps to be addressed?
- What are the governance arrangements to enable reporting and delivery of actions?

The Trust should also consider providing a summarised version e.g. in power point, being clear on:

- What the priorities were for the previous year and progress against those priorities
- What the priorities are for improvement in the coming year

Nicola Jones

Chair, Wandsworth Clinical Commissioning Group

17/5/17

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 the Trust having been placed in special measures for quality of patient care by the Care Quality Commission and in special measures for financial management by our regulator NHS Improvement.

Under these circumstances it has made it more difficult than it should have been for the Council of Governors to exercise its statutory duty to hold the non-executive directors to account. We have been informed that the Trust has embarked on significant improvement plans in terms of the provision of quality of patient care, financial management and sustainability but having heard this before we reserve our opinion on the effectiveness of these plans until we see tangible results. We welcome that the Trust has recently appointed substantively to the Chief Executive, Executive Director of HR and Executive Director of Finance roles and hope that together with our other longer serving board members they will provide the Trust with the stability and leadership that the organisation needs to achieve against its ambitious quality and financial improvement programme.

We therefore hope that the coming year will enable 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.

Finally, we would like to take this opportunity to pay tribute to the talented and dedicated staff who we acknowledge have been working in the most challenging circumstances. 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

24/5/17

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.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2016 to 31 May 2017
 - papers relating to quality reported to the board over the period April 2016 to 31 May 2017
 - feedback from commissioners dated 17 May 2017
 - feedback from governors dated 24 May 2017
 - feedback from local Healthwatch organisations dated 15 May 2017
 - feedback from Overview and Scrutiny Committee dated 15 May 2017
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2016
 - the latest national patient survey dated 2016 (please note the results are under embargo and cannot be published in this report)
 - the latest national staff survey dated 2016
 - the Head of Internal Audit's annual opinion of the Trust's control environment dated 25 May 2017
 - CQC inspection report dated 1 November 2016
- 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
- As the Trust is currently not reporting performance against the RTT indicator due to data quality issues, the Trust directors have a plan in place to remedy this as outlined in further detail below. The scale of the issues identified means that it is not possible for Trust directors to say at this time when the Trust will return to full national reporting against the RTT standard.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporate the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

Non-reporting disclosure – Referral to Treatment (RTT)

Following a series of performance and data issues, the Trust commissioned a comprehensive review of the systems and processes in place to manage patients along the elective care pathway. The outcome of the review, conducted by MBI Health Group and endorsed by the NHS Improvement Intensive Support Team, identified multiple operational process and technology issues that highlighted significant risks to the quality of care and safety of patients at every stage of their pathway - whether on RTT pathways or not.

The scale and complexity of the challenge is significant and the review recognised that the Trust had neither the required expertise, nor resources to manage the required corrective action. Following publication of the findings of the MBI Health Group review in June 2016, the Trust Board took the decision to suspend national reporting against the RTT (18 week) standard.

In response to the findings and to implement the recommendations of the review the Trust has established the Elective Care Recovery programme to lead the corrective action necessary to return the Trust to reporting.

Led by the appointment of a Programme Director, the plan comprises six work streams which are necessary to improve the Trust IT systems, data quality and operational processes of tracking and which includes the requirement to validate a significant number of pathways on the Trusts systems. The validation process is complex and it is envisaged will take more than a year to be completed.

It is not expected that the Trust will return to national reporting in 2017/18. The scale of the issues identified means that it is not possible for Trust directors to say at this time when the Trust will return to full national reporting against the RTT standard.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

Jacqueline Totterdell



Chief Executive
31 May 2017

Gillian Norton



Trust Chairman
31 May 2017

Appendix A: Participation in national clinical audits and national confidential enquiries

The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, 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)		✓	✓	On-going
Adult Asthma		✓	x	This is not included on the mandatory NCAPOP list. We were unable to participate due to a lack of resource.
Adult Cardiac Surgery		✓	✓	On-going
Asthma (paediatric and adult) care in emergency departments		✓	✓	100%
Bowel cancer (NBOCAP)		✓	✓	On-going
Cardiac Rhythm Management (CRM)		✓	✓	On-going
Case Mix Programme (ICNARC)		✓	✓	On-going
Child Health Clinical Outcome Review Programme	Children with Chronic Neurodisability	✓	✓	100%
	Young People's Mental Health	✓	✓	On-going
	Cancer in Children, Teens and Young Adults	✓	✓	On-going
Chronic Kidney Disease in primary care		x	N/A	Not applicable
Congenital Heart Disease (CHD)		✓	✓	On-going
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		✓	✓	On-going
Diabetes (Paediatric) (NPDA)		✓	✓	On-going
Elective Surgery (National PROMS Programme)		✓	✓	On-going
Endocrine and Thyroid National Audit		✓	✓	100%
Falls and Fragility Fractures Audit Programme	Fracture Liaison Service Database	✓	✓	100%
	Inpatient Falls	✓	✓	Data collection for this audit did not take place nationally in

				2016/17. We participated in 2015/16 and have registered to participate in 2017/18.
	National Hip Fracture Database	✓	✓	98.8%
Head and Neck Cancer Audit		✓	✓	On-going
Inflammatory Bowel Disease (IBD) programme		✓	✓	On-going
Learning Disability Mortality Review Programme (LeDeR Programme)		✓	x	This programme was in pilot phase in 2016/17 and we volunteered, but were not selected as a pilot site. Our LD CNS has completed training and we have registered to begin participation from 1 st May 2017 as required nationally
Major Trauma Audit		✓	✓	On-going
Maternal, New born and Infant Clinical Outcome Review Programme		✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Non-invasive Ventilation (NIV)	✓	✓	100%
	Mental Health in General Hospitals	✓	✓	100%
	Acute Pancreatitis	✓	✓	100%
Mental Health Clinical Outcome Review Programme		x	N/A	Not applicable
National Audit of Dementia		✓	✓	100%
National Audit of Pulmonary Hypertension		x	N/A	Not applicable
National Cardiac Arrest Audit (NCAA)		✓	✓	On-going
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme		✓	✓	On-going
National Comparative Audit of Blood Transfusion	Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	✓	✓	100%
	Re-audit of Patient Blood Management in Scheduled Surgery	✓	✓	On-going
	Audit of Patient Blood Management in Scheduled Surgery	✓	✓	100%
	Audit of the use of blood in Lower GI bleeding	✓	✓	100%

National Diabetes Audit – Adult	Core Diabetes Audit	✓	✓	On-going
	Foot Care	✓	✓	On-going
	Inpatient Audit (NaDia)	✓	✓	100%
	Pregnancy in Diabetes	✓	✓	100%
	Transition	✓	✓	100%
National Emergency Laparotomy Audit (NELA)		✓	✓	On-going
National Heart Failure Audit		✓	✓	On-going
National Joint Registry (NJR)		✓	✓	On-going
National Lung Cancer Audit (NLCA)		✓	✓	On-going
National Neurosurgery Audit Programme		✓	✓	On-going
National Ophthalmology Audit		x	N/A	Not applicable
National Prostate Cancer Audit		✓	✓	On-going
National Vascular Registry		✓	✓	On-going
Neonatal Intensive and Special Care (NNAP)		✓	✓	On-going
Nephrectomy Audit (BAUS)		✓	✓	On-going
Oesophago-gastric Cancer (NAOGC)		✓	✓	81-90%
Paediatric Intensive Care (PICANet)		✓	✓	100%
Paediatric Pneumonia		✓	✓	100%
Percutaneous Nephrolithotomy (PCNL)		✓	✓	100%
Prescribing Observatory for Mental Health (POMH-UK)		x	N/A	Not applicable
Radical Prostatectomy Audit (BAUS)		✓	✓	100%
Renal Replacement Therapy (Renal Registry)		✓	✓	On-going
Rheumatoid and Early Inflammatory Arthritis		✓	✓	Data collection for this audit did not take place nationally in 2016/17. We participated in all previous years.
Sentinel Stroke National Audit Programme (SSNAP)		✓	✓	On-going
Severe Sepsis and Septic Shock – care in emergency departments		✓	✓	100%
Specialist rehabilitation for patients with complex needs		✓	✓	100%
Stress Urinary Incontinence Audit		x	N/A	Not applicable
UK Cystic Fibrosis Registry		x	N/A	Not applicable

Data notes:

Each audit within a programme has been counted separately. Where 'on-going' is stated this implies that the data collection deadline for complete 2016/17 data has not been reached at time of reporting and therefore data submission for the 2016/17 audit period is on-going and cannot be reported.

Appendix B: National clinical audit actions undertaken

The reports of 12 national clinical audits were reviewed by the provider in 2016/17 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 Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	<p>Details of the report were discussed within the care group. A major concern was the amount of resources required to complete the audit which was complex and used a data collection system that was very unreliable.</p> <p>Locally we have started education to GPs to address the need to mention persistent synovitis in referrals.</p> <p>We offer a DMARD service, and are planning earlier DMARD training for patients, although this is dependent on resources.</p> <p>Issues concerning the audit have been fed back to the BSR and a local audit of practise is underway, as it is felt that the published results of the national project do not present an accurate picture of the service we provide.</p>
Adult Community Acquired Pneumonia (CAP) December 2014 – January 2015	<p>The main recommendations of the audit (with 3 year targets) are:</p> <ul style="list-style-type: none"> • to increase the proportion of patients who have a chest radiograph within 4 hours of admission to 90% • to increase the proportion of patients who receive their first dose of antibiotic therapy within 4 hours to 85% • to improve the proportion of adults with moderate and high severity CAP administered combination β-lactam and macrolide therapy to 85% • to improve the proportion of coded CAP cases of pneumonia who have a CXR confirmed pneumonia to 85% (i.e. to improve accuracy of diagnosis) <p>These improvements will be facilitated by better use of the CAP care bundle and this has already been adopted within SGH. There will be no national audit in 15/16 or 16/17 but it is anticipated that progress will be monitored in a local audit.</p>
Neonatal National Audit Programme (NNAP): 2015 Annual Report on 2014 data	<p>The report authors note that nationally completeness of data has improved over recent years, and the same appears to be true here with very few data items missing. This improvement is supported by the clinical lead who reviews the regular national data quality reports. Consideration is also being given to whether further resource is necessary to improve data recording, quality and completeness. Many tertiary units have a data manager to manage this audit and that option will be explored.</p>
National Diabetes Inpatient Audit 2015	<p>Results were discussed within the diabetes care group and a monthly meeting introduced to address areas of concern. The full national report and recommendations will further guide actions and response. Commitment to participate in re-audit in 2016.</p>
National Prostate Cancer Audit Second Year Annual Report 2015	<p>Data management system (Infoflex) to be amended to include additional data fields to meet audit requirements. These data fields are to be completed at the MDT both pre and post treatment. One of the MDT co-ordinators is to complete the metrics as patients are</p>

	<p>discussed in the meeting. This should open the door to better BAUS (national urology audit) submissions also. Infoflex to be our hub for these data collections and submissions to prevent double-filling. The current computers and laptops in the Pathology Seminar room to be upgraded to ensure the hardware is up to speed with our requirements and response in real time.</p>
<p>The End of Life Care (EOLC) Audit – Dying in Hospital 2015</p>	<p>The results of the audit together with the requirements of the new NICE guidelines have been discussed by the palliative care team and the End of Life Care Programme Board. Actions have been planned to address any shortfalls in both care quality indicators and organisational quality indicators. These are detailed below.</p> <p>Care Quality Indicators:</p> <ul style="list-style-type: none"> • We are currently above average national average in 4 out of 5 of the clinical indicators, which is very encouraging. Guidance issued at St. George’s advises all expected deaths should be referred to the palliative care team, so that we could write an ‘individualised EOLC plan’. We will continue to refer all expected deaths to palliative care team and will audit compliance. • To improve our Holistic Assessment of the patient’s needs regarding an individual plan of care we have introduced a guidance document to support nursing staff in writing the patients EOLC plan (Daily Nursing End of Life Care Evaluation Guidance). We are in the process of developing an electronic EOL nursing care plan to support nurses in delivering and evidencing the care they give and developing a medical template for EOL that will support clinicians to ensure the care they give is according to NICE guidance and document this in a structured format, once the whole of the Trust has moved to electronic notes. It is hoped that both electronic documents can be ‘rolled out’ together combined with an education programme provided by the palliative care team. This will depend on the IT strategy and scheduling for the CERNER roll out. • We will audit the use of daily nursing EOLC evaluation guidance in Q3. <p>Organisational Indicators:</p> <ul style="list-style-type: none"> • A board member now fulfils the role of lay member on the Trust Board with a responsibility for EOLC. • As part of the EOLC strategy we are developing an educational strategy, which we anticipate will be completed in Q3. • We are also developing an educational programme for the Trust which will include releasing one CNS per month from clinical responsibilities to devote time to Education and Training. This will include hands on support for staff caring for dying patients. We plan to implement this by Q3. • A survey of bereaved relatives and carers is underway. Initial results will be available in Q3.
<p>National Audit of Percutaneous Coronary Interventions (PCI), January 2014 – December 2014</p>	<p>Door to balloon time: local audit is underway to pinpoint exactly where delays are occurring. This will provide us with a better understanding of where improvements are required.</p> <p>Access: Practice is changing and recent data shows an improving picture. In February 2016 43% of cases used radial access, this increased to 56% in March 2016 and we will continue to monitor.</p>

	<p>Within St Georges any death following PCI is the subject of a review. Consultant level outcomes which are derived from this national audit and reported publically show that none of the St George's operators have outcomes as measured by the major adverse cardiac and cerebrovascular event (MACCE) rate, which are outside of confidence limits.</p>
<p>Sentinel Stroke National Audit Programme (SSNAP)</p>	<p>Increased consultant presence in ED has reduced the waiting time for patients. The TIA (Transient Ischaemic Attack) clinic has increased its activity by 15% in the last year to help reduce the demand on inpatient beds. Continued work with radiology means most patients get a CT scan in the ED within their first hour in hospital. This year, the Trust expects to launch the first 24/7 thrombectomy service in the country. It took part in trials to evidence that this treatment works and have recently appointed two interventional neuroradiologists who make up a team of five specialists doing the procedure. Thrombectomy removes clots from the arteries of blocked vessels and reduces disability in severe stroke. This service will be offered to patients from SW London and our neuroscience network of partner hospitals in Surrey.</p>
<p>Royal College of Emergency Medicine (RCEM): VTE risk in lower limb immobilisation in plaster cast</p>	<p>Following the Care Group presentation of RCEM results, action plans were drawn up, implemented. Re-audit of VTE documentation was conducted after each implemented change.</p> <p>Step 1 – education of staff (24/11/15)</p> <p>Step 2 – reminder sheet added to each CDU folder (17/02/16)</p> <p>Step 3 – Reminder column added to CDU handover sheet (08/03/16)</p> <p>Step 4 – addition of check box for VTE risk assessment on CDU admission sheet (Due 30/07/16).</p> <p>Audit was conducted at each step and demonstrated that improvements followed each implemented change.</p>
<p>Royal College of Emergency Medicine (RCEM): Procedural Sedation audit</p>	<p>Results show that there is a lot of good practice, but as with the national picture there are improvements to be made and ED have presented results locally and commenced their action plan.</p> <ul style="list-style-type: none"> • Re-develop procedural sedation proforma. • Create written patient information leaflet. • Create and deliver teaching plan for doctors and nurses – to be given in formal teaching and/or after induction. • Develop schedule for teaching and assessment of procedural sedation competencies for doctors. • Incorporate code for 'sedation' in discharge communications – liaise with clinical informatics/IT.
<p>National Paediatric Diabetes Audit 2014-15</p>	<p>The service continues to explore ways to improve patient education and lifestyle choices to improve personal management. Education of children will be undertaken jointly between the nurse specialist and dietician. There is a newly appointed dietician in post and a new pump review clinic has been established. Missing data on coeliac disease was due to coding issues. This matter is now rectified. Albuminuria rates are low, on-going action reminding patients to present their urine samples. The service prompts patients on need for eye screening and foot management, but do not provide the services.</p>
<p>Royal College of Emergency Medicine (RCEM) Paediatric Vital</p>	<p>1. Dissemination of results and staff education:</p> <p>Disseminate results to nursing and medical leads, highlighting issues and lead actions.</p>

Signs	<p>Triage vital signs training and nursing education Reinstate POPS (Paediatric Observation Priority Scores).</p> <p>2. IT systems, mandatory fields and alerts: Temp, RR, HR, Oxygen sats, GCS/AVPU & Cap refill mandatory fields on paper light system. iClip Alert on the system for another full set of observations POPS score on iClip as a mandatory field.</p> <p>3. Monitoring & re-audit: Regular monitoring of nursing documentation Those with abnormal vital signs to have a further complete set of observations. Re-audit September 2016.</p>
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**Based on information available at the time of publication.*

Notes:

At the beginning of quarter 3 the approach to reporting to the Trust board was amended, which has resulted in fewer national audits being reported to the board. This gap has been recognised and a new process is to be introduced in 2017/18 to ensure that all national audits are reported to the Patient Safety and Quality Board in the first instance. This will ensure that due attention is given to all national audit results over the coming year and that any relevant reports can be escalated for Trust board attention.

Appendix C: Local clinical audit actions undertaken

The reports of eight local clinical audits were reviewed by the provider in 2016/17 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*
Pre-Operative Fasting Audit – 2016	<ul style="list-style-type: none"> • Information to Patient Pathway Co-ordinators (PPCs) and Surgical Admission Lounge (SAL) staff around fasting so they can share this with patients more easily. • Change patient information leaflets to emphasize negative impact of prolonged fasting. • More prominent information displayed in SAL about availability of water etc. • Longer term project to improve emergency theatre communication with wards to reduce fasting times. • Re-audit upon completion of action points.
Use of nEWS Re-Audit - January 2016	<p>Individual ward results have been disseminated through the divisional structures. Managers on wards with less than 80% compliance in any of the three main target measures must ensure that staff are adequately educated by their nEWS lead and perform monthly re-audits until compliance has reached 80% consistently. These wards are also to provide an action plan for improvement through nursing board. A PowerPoint presentation is already available to wards for training days and utilised in MEERKAT's training and the Harm Free Care study day. Wards scoring poorly for appropriate response should ensure that staff attend this training. As there continues to be an issue with spacing, particularly at night time, more attention needs to be paid to adhering to documented regularity. Wards that are using the Welch Allyn device are encouraged to seek appropriate training.</p>
Venous Access Device Care Annual Audit Report 2016	<p>Immediate feedback was provided at the point of audit if deemed necessary in the area of VAD management. Overall, there was significant improvement in all areas apart from 'dressing dated' which remained unchanged. On-going actions involve the Venous Access Team continuing to work with the clinical areas to improve documentation of the dressing and highlight suboptimal electronic and paper documentation.</p>
WHO Surgical Checklist Audit 4th Quarter 2015/16 (Peer review audit round)	<ul style="list-style-type: none"> • Theatres Care Group Lead to present report at local governance meetings to enable discussion and to agree any actions for improvement in compliance. • Summary report to be presented at Theatres Care Group meeting in April 2016 and Division Governance Board. • Matrons and Team leaders to disseminate results and agreed actions at local team meetings. • On-going programme of quarterly audit in all theatre areas.
Bereavement Survey, June 2016	<p>Positive and negative comments have been studied to identify opportunities for learning and improvement. This has provided valuable insight and so it has been agreed that the survey will continue to run, with quarterly analysis to track progress. Furthermore, the survey has been amended so that any relative/carer that would like a response to</p>

	<p>their comments or concerns can provide their contact details. Any such instances will be reported to the End of Life Programme Board so that an appropriate investigation and response can be provided to the bereaved. This will support a positive experience and will also help us to act on any issues in a timely way.</p>
<p>Health Records audit Q1 2016-17</p>	<ul style="list-style-type: none"> • Patient labels: Continuing to increase the use of patient labels from the current level of 61% is likely to improve the results for patient identifiers on history sheets, in particular the inclusion of the NHS number. • Improve use of dividers in ring folders. • Designation Stamps: Identification of the consultant in charge of the patient's care remains a priority area for action. Using name stamps would improve the recording of name and designation in entries.
<p>Accounting for Swabs, Needles and Instruments - Obstetric Theatres</p>	<ul style="list-style-type: none"> • The team will continue with re-audit to maintain standards for the 3 of 4 phases that had achieved 100%. • To remind staff on using the accepted method for skin preparation and to re-audit to monitor improvement. • Plan to roll out this audit project to other theatre areas in 3rd quarter of 2016/17.
<p>Annual Consent Audit 2015/16</p>	<p>The audit has been shared with clinical colleagues via the Medical Director, and he is supporting the audit team to identify a clinical lead/group to take this project forward. The audit team would propose to carry out smaller, more regular audits focussed on specific aspects of policy where improvement actions have been agreed.</p>

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

Appendix D: Details of Trust CQUIN schemes for 2016/17

Notes: this information is a forecast from Quarter 3 of 2016/17. Quarter 4 performance is currently being reviewed and approved by our commissioners.

CQUIN Goals and Indicators	Achievement	Comments
National CQUIN schemes		
NHS Staff and Wellbeing <ul style="list-style-type: none"> Introduction of staff health & wellbeing initiative (Option 1b) Healthy food for NHSE staff, visitors and patients Improving the uptake of flu vaccinations for front line staff within Providers 	Partially met	72% against a target of 75% or above for uptake of flu vaccinations.
Timely identification and treatment of Sepsis <ul style="list-style-type: none"> Timely identification and treatment for Sepsis in emergency departments Timely identification and treatment for Sepsis in acute inpatient settings 	Fully met	
Antimicrobial Resistance and Antimicrobial Stewardship <ul style="list-style-type: none"> Reduction in antibiotic consumption per 1000 admissions Empiric review of antibiotic prescriptions 	Fully met	
Local CQUIN schemes		
Maternity <ul style="list-style-type: none"> Maintain 1:27 midwife ratio and 24/7 supernumerary midwife 98% of the time 144 hours per week consultant cover 	Partially met	Consultant cover not achieved in Q1, Q2 and Q3.
Global Trigger Tool <ul style="list-style-type: none"> To continue the Institute for Health Improvement Global Trigger Tool with specialty involvement to increase dissemination of learning. 	Fully met	
Paediatric Asthma <ul style="list-style-type: none"> Meet the London Asthma standards for Acute Asthma inpatient admissions. Ensure appropriate follow up for children attending ED/PAU at St George's Develop Outpatient Service for children at High Risk from Asthma Closer integration of primary and secondary care asthma services Set up school programme. 	Fully met	
Children's Services Improvement Programme (CSIP)	Fully met	

<p>for children who are high users of Emergency department and Paediatric Assessment Unit Achieve system-wide improvement through the adoption of a person and family centred model of integrated healthcare.</p>		
<p>Planned Care Service redesign for Gynaecology, Trauma & Orthopaedics, Elderly care and Urology.</p>	Partially met	Delivery of CQUIN requirements met for Gynaecology, Trauma & Orthopaedics and Elderly care only.
<p>Paediatric Outpatient Parenteral Antibiotic Treatment (POPAT) Establish a paediatric outpatient antibiotic treatment service across all paediatric wards, neonatal unit and emergency department. POPAT will be in line with the national and hospital strategy for the reduction of antimicrobial resistance and hospital acquired infections.</p>	Partially met	Extension not met due to late commencement of Consultant nurse to post in Quarter 3.
<p>Ambulatory Emergency Care (AEC)</p> <ul style="list-style-type: none"> To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission are managed to support early discharge in order to free beds To ensure patients are streamed on presentation directly to AEC following timely assessment in emergency department To support a standardised model for AEC across SW London so that patients receive the same treatment regardless of location, and ensuring that there is a consistent 7 day a week service in operation 	Fully met	
<p>Enhanced cancer consultant nurse provision</p> <ul style="list-style-type: none"> Improved access to consultant nurse/key worker support for patients on suspected cancer pathways for lung, gynaecology, urology, head and neck and upper/ lower gastro-intestine Improved pathway co-ordination and support to patients, particularly on the identified pathways Co-ordination of investigations (particularly when commissioned cross-site) to reduce time from first seen to diagnosis Redefining the Cancer consultant nurse role to be more patient facing, and less administratively focused Enhancing the Cancer consultant nurse role, aiding retention and recruitment 	Not met	Unable to recruit to post therefore CQUIN not delivered.

<p>Consultant Advice Service (Kinesis)</p> <ul style="list-style-type: none"> • Incentivise Trust to increase the number of consultants offering a Kinesis advice/consultation service • In key specialties, build a significant sub specialty service <p>Undertake an analysis of the number and type of referrals; the response time; the capacity requirement by individual consultants for types of referrals; the number of Outpatient appointments avoided – as the basis for development of a more sophisticated tariff for 2017-19. Reduction in system costs, cost effective for providers and deliver savings for commissioners.</p> <ul style="list-style-type: none"> • Gather evidence on the conversion rate for Kinesis referral and outpatient attendance; by specialty • Consider and report on the most cost effective way of managing the interface with diagnostic testing • Develop a Kinesis performance dashboard • Gather evidence on the most effective induction for acute consultant staff, education/marketing to primary care and joint workshop sessions that generate the optimal usage of Kinesis to drive improved patient pathways • Align the introduction of Kinesis at the Trust across all SW London commissioners • Be an exemplar for Kinesis across London 	Fully met	
Community CQUIN schemes		
<p>Community Adult Health Services</p> <ul style="list-style-type: none"> • Plan the process as to how the CAHS MDT will be operationalized, and evidence would be collected by working with the new PACT ECP Provider. • CAHS and ECP staff to work together to set-up MDT meetings including required attendance, and develop a checklist to help staff operate weekly MDTs effectively. • Key worker to be made known and entered on care plan. • All care plans to be updated in the MDT and evidence of a plan set for each patient discussed at weekly MDT. 	Fully met	
<p>Special Schools Matrix Tool</p> <p>Refining the dataset to incorporate all pupils at all Special Schools, updating the information as each child is reviewed.</p>	Partially met	Some schools have yet to be mapped to

		the matrix tool
<p>Special Schools Clinical Skills Educator</p> <ul style="list-style-type: none"> • Deliver the necessary range of training/skills so that an increased numbers of Children who qualify for complex care are able to have packages delivered via carers. • Work with the Community Nursing Team to increase the number of children who can have services delivered via carers. • Deliver the training/skills in a cost effective manner to a range of stakeholders including families, care providers, Trust staff and other identified parties. • To ensure that the training/skills give parents confidence in the quality of care that will be provided. 	Partially met	No provision of evidence of training plan or provision of details of the number of parents trained.
<p>Learning Disability</p> <ul style="list-style-type: none"> • Seek to identify people with learning disability, autism and behaviour that challenges who could benefit from receiving a Personal Health Budget by applying specific criteria. • The intention is to improve the experience of service users encourage the development of joint care plans within and across services with service user at the core of the plans. 	Partially met	Requirement to provide further evidence to ascertain how many patients have been mapped across both the Trust and the Mental Health Trust.
NHS England CQUIN schemes		
<p>Hepatitis C Virus (HCV) Improving Treatment Pathways through Operational Delivery Networks (ODNs) Joint scheme with Kings College Hospital NHS Foundation Trust.</p> <ul style="list-style-type: none"> • Governance and Partnership working • Stewardship and NICE compliance 	Partially met	NHSE does not consider that the Trust has fully met the requirements of this CQUIN; however in conjunction with Kings this is being disputed by the Trust.
<p>Nationally Standardised Dose Banding Adult Intravenous Systemic Anticancer Therapy (SACT) A national incentive to standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care</p>	Fully met	

across all NHS providers of SACT in England.		
<p>Clinical Utilisation Review</p> <ul style="list-style-type: none"> • installation and implementation of software; • reduction in inappropriate hospital utilisation; • reporting of results 	Not met	<p>The Trust decided not to implement this CQUIN as there was concern that an embedded system with clinical utilisation data capture was already being used. The Trust, along with others tried to get their own in-house system recognised as being accredited for the CQUIN but not one of them was successful as the CUR software has an embedded decision support tool which other systems do not.</p>
<p>Activation System for Patients with Long Term Conditions (LTCs)</p> <p>Development of a system to measure skills, knowledge and confidence needed to self-manage long term conditions, and with that information to support adherence to medication and treatment and to improve patient outcomes and experience.</p>	Not met	<p>The Trust decided not to implement this CQUIN as it was considered that there are already systems in place which this scheme would</p>

		overlap with and therefore the Trust would not be able to realise the benefits the CQUIN required it to deliver.
<p>Optimal Device</p> <p>Maintenance/improvement in the optimisation of device usage during a year of transition to a centralised national procurement and supply chain arrangement through:</p> <ul style="list-style-type: none"> the enhancement and maintenance of local systems to assure compliance with national policies and specifications; the development of local policies to optimise cost effective device usage and ensuring quality outcomes for patients. 	Fully met	
<p>Adult Critical Care timely discharge</p> <ul style="list-style-type: none"> to reduce delayed discharges from ACC to ward level care by improving bed management in ward based care, thus removing delays and improving flow. to support the removal of delays of more than 4 hours, whilst continuing to encourage more emphatically removal of delays of more than 24 hours. 	Fully met	
<p>HIV Drugs</p> <p>Identify a number of switches of drug regimen making best use of newer forms of antiretroviral drug regimes</p>	Fully met	NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this.
<p>Telemedicine</p> <p>To improve patient experience by reducing the number of times a patient is required to attend a face to face outpatient appointment; but instead has their follow-up care and advice conducted through a non-face to face</p>	Not met	NHS England acknowledged the role of the Trust in the

<p>method.</p>		<p>delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this.</p> <p>The Trust was unable to identify specialties where the number of telephone follow ups could be increased for outpatients which are mostly or wholly commissioned by NHSE. Specifically, Neurology was identified as a possibility but it was found that there was no potential for telephone follow up appointments in this area.</p>
<p>Neo-natal Length of Stay This scheme is designed to improve community nursing support enabling timely discharge for babies <36 weeks gestation.</p>	<p>Fully met</p>	<p>NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage</p>

		e of the CQUIN value to incentivise the Trust to deliver this.
Other CQUIN schemes to deliver QIPP savings	Partially met	<p>NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this.</p> <p>The Trust was able to demonstrate that savings had been on a number of QIPP schemes but commissioners did not consider these to be of a sufficient value to achieve the requirements of the CQUIN.</p>
Offender Healthcare NHS Staff and Wellbeing <ul style="list-style-type: none"> • Introduction of staff health & wellbeing initiative (Option 1b) • Healthy food for NHSE staff, visitors and patients • Improving the uptake of flu vaccinations for front line staff 	Partially met	Target of 75% of staff receiving flu vaccinations not achieved.
Dental <ul style="list-style-type: none"> • Recording of data for oral surgery and 	Fully met	

orthodontics <ul style="list-style-type: none"> • Participate in referral management and triage • Participate in Managed Clinical Networks 		
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Details of Trust CQUIN schemes for 2017/18

CCG schemes Acute and Community schemes (1.5% of total contract value)
<ul style="list-style-type: none"> • Improvement of health and wellbeing of NHS staff • Timely identification and treatment of Sepsis/reduction in antibiotic consumption • Improving services for people with mental health needs who present to A&E • Advice & Guidance E-referrals • Supporting proactive and safe discharge • Preventing ill health by risky behaviours - alcohol and tobacco • Improving the assessment of wounds • Personalised care and support planning • Children's Services: Matrix Children's Services: Dysphagia Learning Disabilities • Consultant Geriatrician Support to the Community
NHSE Specialist schemes (2.8% of total contract value)
<ul style="list-style-type: none"> • Hepatitis C Virus • Improving Pathways through ODNs • Medicines Optimisation (includes Iron Chelation/Hep B) • Cancer Dose Banding • IV SACT Complex Device Optimisation • Paediatric networked care • Neonatal community outreach • Improving Haemoglobinopathy pathways • Spinal Surgery Networks Development of Renal home therapies • Neuro-rehab • Paediatric neuro-rehab Homecare - MS drugs HPN audit

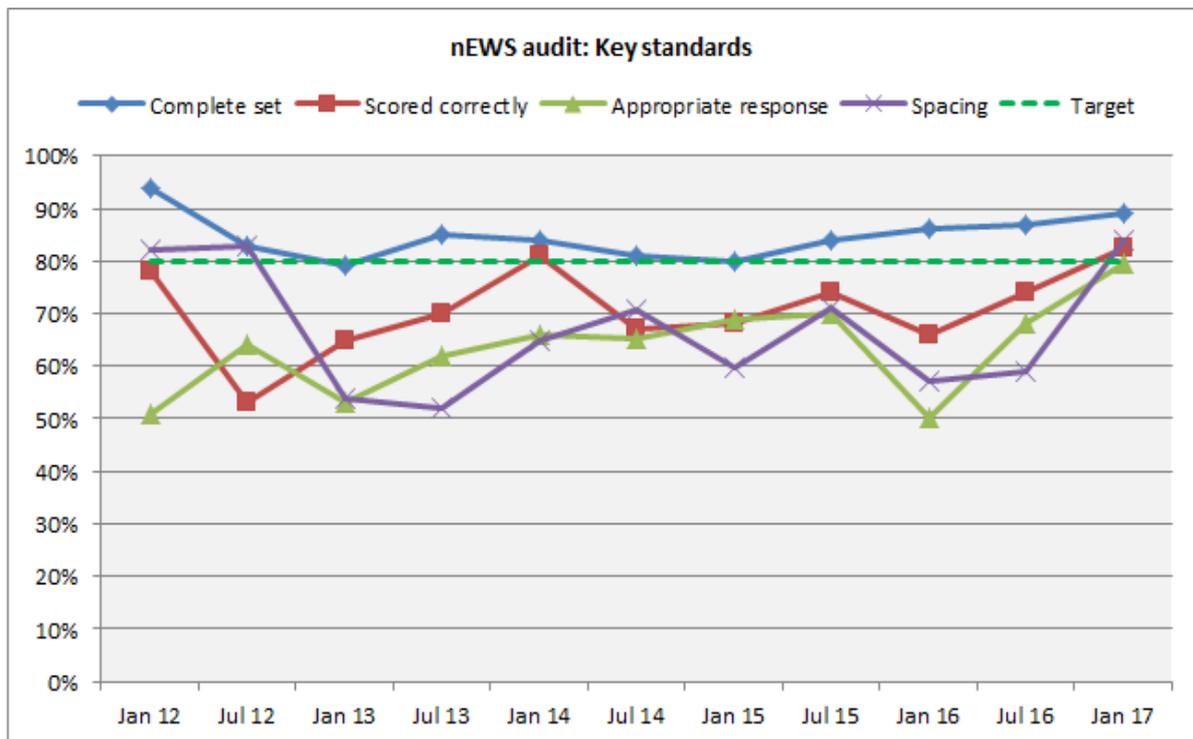
Appendix E: National Early Warning Score (nEWS) Trust audit, January 2017

Summary of results

Main measures of compliance with the National Early Warning Score (nEWS) are summarised in the table below.

Standard	Target	Achieved
Recording a complete set of observations	80%	89%
Scoring nEWS correctly	80%	83%
Appropriate response	80%	80%
Spacing	80%	84%

The following graph shows the comparison with audits conducted since January 2012 when the new version of the nEWS came in to use. There is improvement in all key standards, with the target met across all standards for the first time.



Introduction

NICE states that a graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered locally. To comply with this guideline, St George's has been using EWS chart since 2000 and adopted the national EWS in January 2012.

The chart incorporates a section for reporting concerns using SBAR (Situation, Background, Assessment, and Recommendation). SBAR is a structured mechanism for communicating clinical information, or framing conversations, in order to elicit prompt and appropriate action from another

health professional. The EWS and SBAR tools should help to improve patient care, reduce risk and reduce patient safety incidents, including SIs.

The audit was commissioned by Deborah Dawson, Consultant Nurse Critical Care and Paula O'Shea GICU Liaison Nurse and covered all adult wards in the Trust. At this round of audit the wards using Cerner documentation were also included.

Standards

The current target for each of the criteria audited is 80% compliance. Achieving this standard for complete set of observations and accurate EWS scoring provides evidence of compliance with NICE clinical guideline 50 (July 2007).

Methodology

Thirty four adult wards were included in the audit. For each ward, a number of charts where patients had been on that ward for over 24hrs (where possible) were audited to assess compliance with seven measures. Wards using the CERNER system to record their nEWS (Champneys, Belgrave, Ben Weir and Caroline) were included in this round. Data was extracted from (PIEDW – Power Insight Enterprise Data Warehouse) by an Information Analyst and reviewed by the clinical team.

In the majority of wards 10 patients were audited, but on smaller units this figure was lower. The audit data was collected by a team of senior nurses from critical care, week commencing 9 January 2017.

The full audit criteria were:

1. The chart has a **name**, number [**MRN**]
2. **Regularity** of observations is recorded (where appropriate in line with EWS triggers)
3. Observations are evenly **spaced** throughout the 24 hour period
4. A **full** or **complete set** of observations are recorded on each occasion
5. EWS is **scored correctly** on each occasion
6. Where EWS has triggered, an appropriate **response** is recorded
7. Each set of observations is **signed**

The main measures for the audit were: whether observations are evenly spaced (question 3), whether a complete set of observations was recorded (question 4), whether nEWS was scored correctly (question 5) and, where nEWS has triggered a score, an appropriate response has been documented (question 6). The compliance target was 80% for each of these factors.

Data was directly available from the chart itself with exception of question 6. This required reviewing both nursing and medical notes to check if a response had been recorded. As the patient's nEWS rises it should set off triggers and, various escalation procedures should be implemented. The triggers are divided into low, medium and high risk categories. For audit purposes, we have looked for a cumulative score ≥ 4 or individual parameter score 3, as these represent patients moving from a low to medium risk category.

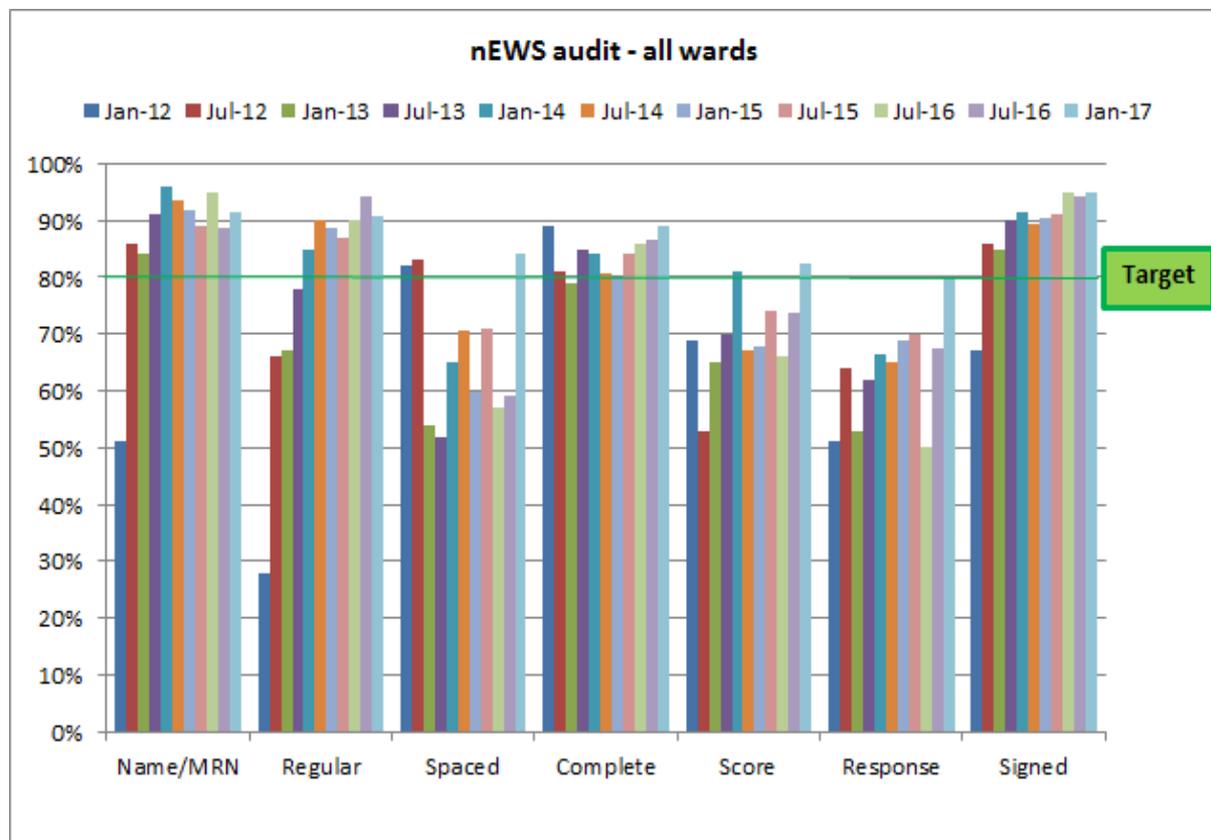
An audit tool was housed on RaTE and data was collected on a combination of paper forms and directly via a tablet. The data was then downloaded and analysed by the clinical audit department.

Results

All adult wards on SGH and QMH were audited. The results for 34 wards, (327 cases), are presented. In this round of audit results for Champneys are compared to Buckland, following the relocation of renal inpatient beds. James Hope was not audited as patients that require an overnight stay are accommodated on the Charles Pumphrey unit, and therefore comparison is between the two areas. The new Nye Bevan unit was audited in place of the Surgical Assessment Unit.

Results for January 2017 compared to previous audits

The following chart summarises the results for all measures and all adult wards. Full achievement of the 80% compliance target is noted for the first time, along with improvement in six out of seven measures. However, the chart also demonstrates variation in compliance between different criteria. There are some elements where best practice appears to be well established, such as recording of patient identifiers and signing of scores; however there are other elements where sustained improvement is sought.



The table below shows results for January 2017 compared to previous audits. RAG ratings have been added, where $\geq 80\%$ is green, 60-79% is amber and $< 60\%$ is red.

Audit Period	Name/ MRN	Regular	Spaced	Complete	Score	Response	Signed	
January 2017	91%	91%	84%	89%	83%	70/88	80%	95%
July 2016	89%	94%	59%	87%	74%	52/77	68%	94%
January 2016	95%	90%	57%	86%	66%	25/50	50%	95%
July 2015	89%	87%	71%	84%	74%	37/53	70%	91%
January 2015	92%	89%	60%	80%	68%	31/45	69%	90%
July 2014	93%	90%	71%	81%	67%	28/43	65%	89%
January 2014	96%	85%	65%	84%	81%	69/104	66%	92%
July 2013	91%	78%	52%	85%	70%	62/100	62%	90%
January 2013	84%	67%	54%	79%	65%		53%	85%
July 2012	86%	66%	83%	81%	53%		64%	86%

Results for January 2017 by ward

The table below shows percentage compliance for each standard, by ward. RAG ratings have been added, where ≥80% is green, 60-79% is amber and <60% is red. Please see Appendix 1 for ward results over time.

Ward	Name/ MRN	Regular	Spaced	Full set	Score correct	Appropriate Response ⁽¹⁾	Signed	Comments	
Allingham (10)	70	100	80	100	100	75	6/8	100	Details missing include hospital number, name, DOB
Amyand (10)	100	90	50	90	70	100	1/1	90	Irregularity mainly at night; in 2 cases frequency should have been changed
Belgrave (10)	100	20	20	90	90	n/a	-	100	Irregularity at night, with no explanation of rationale
Ben Weir (6)	100	17	17	67	67	100	1/1	100	Irregularity at night, with no explanation of rationale
Brodie (10)	100	100	100	80	80	n/a	-	90	
C Hawkins (10)	100	100	90	100	70	100	3/3	80	
Caroline (9)	100	22	22	100	100	0	0/1	100	Irregularity mainly at night, with no explanation of rationale
Cavell (10)	100	100	100	100	100	100	8/8	100	
Champneys (10)	100	90	80	100	100	n/a	-	100	
Charles Pumphrey (7)	100	100	100	71	71	n/a	-	100	
Cheselden (10)	80	90	50	60	50	50	2/4	90	Irregularity at night, with an explanation only given in one case
Dalby (10)	50	100	100	90	80	n/a	-	90	Hospital number missing in 5 cases, and DOB in 1 case.
Florence N (10)	100	90	90	90	70	100	4/4	90	
Gordon Smith (10)	90	100	90	90	80	100	1/1	90	
Gray (10)	90	100	100	100	100	100	2/2	100	
Gunning (10)	100	100	100	80	70	75	3/4	90	
G Holford (10)	100	90	90	100	100	n/a	-	100	
Heberden (9)	100	100	56	78	89	50	3/6	89	Irregularity at night, with no explanation of rationale
Holdsworth (9)	89	100	100	78	67	50	1/2	89	
Keate (9)	89	100	100	89	67	n/a	-	100	
Kent (10)	70	90	50	90	80	14	1/7	100	Details missing include hospital number, name, DOB. Irregularity at day and night.
Marnham (10)	90	100	100	90	90	89	8/9	100	
M Seacole A (10)	70	100	100	90	90	100	1/1	100	Hospital number missing in 3 cases
M Seacole B (10)	70	100	100	100	100	n/a	-	100	Hospital number missing in 3 cases
McEntee (8)	100	100	88	100	88	100	2/2	100	

Ward	Name/ MRN	Regular	Spaced	Full set	Score correct	Appropriate Response ⁽¹⁾	Signed	Comments	
McKissock (15)	100	100	100	87	80	100	1/1	93	
Nye Bevan (7)	100	100	100	100	100	100	2/2	100	
Richmond (10)	90	80	100	100	100	100	8/8	100	
Rodney Smith (10)	100	100	100	90	70	n/a	-	100	
Ruth Myles (10)	100	100	70	100	100	67	2/3	90	Irregularity at night, with no explanation of rationale
T Young (10)	90	90	100	80	70	n/a	-	100	
T Howell (8)	100	100	88	100	100	100	4/4	88	
Vernon (10)	90	90	100	80	50	100	2/2	90	
William Drummond (10)	90	90	100	80	50	100	4/4	90	
Jan 2017 (327)	91	91	84	89	83	80	70/88	95	

Notes: (1) "n/a" means that no nEWS was triggered, therefore no response was required or assessed as to whether appropriate.

Overall there has been improvement in six of seven measures; however, variance between wards is observed. Previously zero compliance with one measure was noted on 5 occasions; this has decreased to 1. Furthermore, 12 wards met the compliance standard of 80% across all measures. Cavell and Nye Bevan achieved full compliance with all standards. Several wards (Cavell, Gray, Mary Seacole B, Nye Bevan and Richmond) achieved 100% in the four main measures; Nye Bevan and Cavell in all seven.

There were improvements in recording of patient identifiers on the nEWS chart, with compliance reaching 91%. 19 wards achieved full compliance. In the 9% of cases (n=28) where name/MRN was missing from the chart the most frequently reported omissions were MRN (26), DOB (7) and name (6). In 9 cases two or more demographic details were missing from the chart.

Scores for regularity of observations decreased slightly, from 94% in July 2016 to 91% at this round. However, spacing of observations improved significantly, from 59% to 84%. At the last round of audit only one ward scored 100% and 13 scored less than 60%; on this occasion 18 wards were fully compliant and 7 scored below 60%. It remains the case that in only a small number of instances was staff able to provide a rationale where there was a discrepancy between the prescribed and observed frequency of observations. As reported previously in a number of cases vital signs were omitted for periods of up to 9 hours, and mostly this occurred overnight.

There was further improvement in recording of a full set of observations on each occasion to 89%. Where a full set of observations has not been recorded it impacts both on the calculation and accuracy of the score. Correspondingly correct scoring also increased, from 74% to 83%. In the 11% of cases (n=36), where a full set of observations had not been recorded the missing details included:

Observation	Temp	HR	BP	Resp	SpO2	Flow rate	Neuro
No. patients missed	11	2	3	11	7	11	10
Frequency missed	1 to 10 times	1	1	1 to 2 times	1 to 2 times	1 to 3 times	1 to 3 times

The appropriateness of the response also improved and the target of 80% was met for the first time since the programme of audit commenced. There remains variation across the wards, but the

proportion scoring 100% has increased from 47% to 63% the proportion rated as red decreased from 41% to 21%. Compliance with the 80% target for the signing of scores was achieved on all wards, with over half reaching 100%.

Divisional results for key measures

Division	Name/ MRN	Regular	Spaced	Complete	Score	Response	Signed	
MC (n=167)	92%	85%	73%	90%	84%	41/51	80%	95%
STNC (n=140)	94%	96%	95%	86%	79%	28/36	78%	95%
CSD (n=20)	70%	100%	100%	95%	95%	1/1	100%	100%
ALL (327)	91%	91%	84%	89%	83%	70/88	80%	95%

Actions:

- A target of 80% was set to provide an achievable goal when ten national EWS system was introduced to St George's. The clinical goal should however be 100% in all measures. Some wards have achieved this in most or all measures. Future audits will be measured against this target.
- This report will be discussed by the project team and reported to the Nursing Board, Patient Safety and Quality Board and the Quality Improvement Board for discussion of organisation level results and discussion of required actions.
- The report will also be sent to the divisional leadership teams for distribution and action through the divisional structures
- Ward managers on wards with less than 80% compliance in any of the three main target measures are responsible for ensuring that staff are adequately educated by their nEWS lead. It is suggested that these wards provide an action plan for improvement through nursing board, this should include education and competency assessment of all HCA and RN staff and more regular re-audit. This is the joint responsibility of matrons, ward managers and practice educators in these areas.
- A programme of monthly audit will be launched starting February 2017; this is already being completed by many wards. The programme of 6-monthly audits by an independent clinical team will continue, supplemented by monthly audits conducted by the wards for 5 month periods.
- It was hoped that with the introduction of the Welch Allyn Vital links device, 100% compliance with accurate scoring could be achieved. Wards who are using this device are encouraged seek appropriate training for staff who are using this device.
- The Policy for the Minimum Standard for Adult In-Patient Observation has just been updated and is available on the Policy Hub. An awareness campaign will highlight these updates to all staff

Ward level results over time for 3 key measures

RAG ratings have been added, where $\geq 80\%$ is green, 60-79% is amber and $< 60\%$ is red.

Champneys results prior to 2017 contain results for Buckland, due to the relocation of renal inpatient beds at the end of 2016. In this round James Hope was not audited, as patients that require an overnight stay are now accommodated on the Charles Pumphrey unit, and therefore comparison is between the two areas. The new Nye Bevan unit was audited in place of the Surgical Assessment Unit.

1: Complete Set (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	90	90	80	100	100	50	70	80	100	100
Amyand	90	90	80	60	100	70	70	100	90	90
Belgrave	80	60	70	90	90	60				100
Ben Weir	100	60	60	90	100	90				67
Brodie									80	80
Caesar Hawkins	100		80	70	80	70	80	80	100	100
Caroline	60	80	60	80	50	70				100
Cavell (formerly Gray)	80	60	50	67	90	50	80	80	60	100
Champneys (formerly Buckland)	80	80	100	50	100	100				100
Charles Pumphrey (prior 2017 James Hope)			80	100		40				71
Cheselden	90	60	100	100	90	90	100	90	90	60
Dalby		90	70	80	90	70	50	70	70	90
Florence Nightingale	90	90	90	100	90	90	90	100	90	90
Gordon Smith								90	90	90
Gray (formerly Cavell)	90	90	80	80	90	60	100	80	100	100
Gunning	80	60	100	80	100	100	100	90	90	80
Gwynne Holford		69	60	100	70	90	90	100	80	100
Heberden	90	70	90	100	100	80	60	90	100	78
Holdsworth	100	90	90	100	90	90	100	70	80	78
Keate	80	90	80	90	100	88	100	90	100	89
Kent		100	40	80	90	80	90	90	70	90
Marnham	80	80	90	100	80	50	50	100	80	90
Mary Seacole A			80	100	20	80	80	100	100	90
Mary Seacole B									100	100
McEntee	80	100	80	90	100	100	80	90	90	100
McKissock			40	60	40	90	70	60	60	87
Nye Bevan (prior 2017 SAU)									100	100
Richmond	100	90	60	100	50	70	60	50	90	100
Rodney Smith	100	100	90	90	100	90	100	80	80	90
Ruth Myles	100	80	75		100	100	67	80	100	100
Thomas Young	100	100	80	100	100	100	80	100	60	80
Trevor Howell	100	90	90	90	80	80	50	70	90	100
Vernon	90	100	100	80	70	100	100	100	90	80
William Drummond			80	57	80	80	90	89	88	60
ALL	89	83	79	85	84	80	80	84	87	89

2: Correct score (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	100	80	70	70	100	50	60	90	90	100
Amyand	80	100	60	50	80	60	60	90	80	70
Belgrave	70	30	70	70	90	60				90
Ben Weir	60	10	60	70	90	80				67
Brodie									70	80
Caesar Hawkins	30		50	30	70	70	60	70	80	70
Caroline	70	30	60	30	50	40				100
Cavell (formerly Gray)	50	40	17	67	80	25	70	80	50	100
Champneys (formerly Buckland)	30	60	90	30	100	80				100
Charles Pumphrey (prior 2017 James Hope)			80	100		40				70
Cheselden	30	60	70	90	80	60	80	80	70	50
Dalby		40	50	80	60	70	50	80	60	80
Florence Nightingale	100	60	70	80	90	60	80	90	80	70
Gordon Smith								80	60	80
Gray (formerly Cavell)	90	90	60	50	90	60	80	80	50	100
Gunning	70	40	70	60	100	90	80	70	90	70
Gwynne Holford		58	70	100	100	90	80	90	70	100
Heberden	80	100	80	90	90	40	50	90	80	89
Holdsworth	70	50	90	90	80	90	90	70	70	67
Keate	20	50	40	90	90	88	100	90	100	67
Kent		50	30	60	90	70	60	70	60	80
Marnham	90	10	70	70	70	30	30	90	40	90
Mary Seacole A			100	90	60	80	60	70	100	90
Mary Seacole B									100	100
McEntee	80	100	80	90	100	70	60	50	80	88
McKissock			30	40	30	70	60	30	50	80
Nye Bevan (prior 2017 SAU)									100	100
Richmond	70	50	50	70	50	60	60	40	80	100
Rodney Smith	60	40	90	90	100	90	80	80	80	70
Ruth Myles	80	30	88		100	86	56	50	90	100
Thomas Young	100	70	80	100	100	100	80	100	60	70
Trevor Howell	90	40	60	70	80	40	40	50	90	100
Vernon	60	70	90	60	70	80	90	90	70	50
William Drummond			40	14	80	80	90	89	50	70
ALL	69	53	63	70	81	67	68	74	74	83

3: Appropriate response ¹ (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	40	100	0	75	100	67	100	100	100	75
Amyand	67	90	25	0	57	100	n/a	100	33	100
Belgrave	50	0	75	33	0	100				n/a
Ben Weir	25	100	80	50	60	n/a				100
Brodie									83	n/a
Caesar Hawkins	50		100	n/a	25	0	100	N/A	100	100
Caroline	57	100	67	17	67	100				0
Cavell (formerly Gray)	20	n/a	0	33	33	n/a	n/a	50	20	100
Champneys (formerly Buckland)	0	100	33	67	50	50				n/a
Charles Pumphrey (prior 2017 James Hope)			100	n/a		n/a				n/a
Cheselden	25	n/a	50	100	100	67	n/a	100	50	50
Dalby		n/a	0	n/a	33	0	100	50	n/a	n/a
Florence Nightingale	100	50	n/a	75	n/a	100	n/a	100	n/a	100
Gordon Smith								67	100	100
Gray (formerly Cavell)	80	n/a	100	20	100	67	n/a	N/A	40	100
Gunning	25	100	33	71	100	0	100	100	n/a	75
Gwynne Holford		0	20	80	90	n/a	n/a	90	n/a	n/a
Heberden	50	100	50	100	n/a	50	50	0	50	50
Holdsworth	40	100	75	100	33	50	n/a	n/a	0	50
Keate	0	n/a	100	n/a	75	n/a	0	n/a	33	n/a
Kent		100	50	n/a	50	0	100	n/a	71	14
Marnham	100	80	50	50	33	63	50	n/a	33	89
Mary Seacole A			70	90	50	100	n/a	20	n/a	100
Mary Seacole B									100	n/a
McEntee	33	83	n/a	50	n/a	n/a	100	75	0	100
McKissock			n/a	n/a	n/a	0	n/a	n/a	100	100
Nye Bevan (prior 2017 SAU)									n/a	100
Richmond	100	100	86	50	67	100	70	83	100	100
Rodney Smith	25	n/a	0	n/a	25	n/a	50	n/a	75	n/a
Ruth Myles	50	80	n/a		n/a	n/a	n/a	n/a	100	67
Thomas Young	0	n/a	100	n/a						
Trevor Howell	83	50	43	50	100	100	50	100	0	100
Vernon	67	0	100	33	100	100	n/a	n/a	100	100
William Drummond			25	100	100	100	100	50	100	100
ALL	51	77	55	62	66	65	69	70	68	80

1: N/A means that an EWS was not triggered, therefore no response was required nor assessed as to whether appropriate.

Appendix F: Review of services and where our services are based

The services that St George's University Hospitals NHS Foundation Trust provides 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 such as 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 such as 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 also within 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
- New born 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 at: www.stgeorges.nhs.uk/services.

Appendix G: Reporting against core indicators

The following core indicators are applicable for St George's University Hospitals NHS Foundation Trust:

- The value and banding of the summary hospital-level mortality indicator (SHMI)
- The percentage of patient deaths with palliative care coded at either diagnosis or speciality level
- The percentage of patients aged 0-15 and 16 or over re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust
- Responsiveness to the personal needs of patients
- Friends and Family Test for staff
- Venous thromboembolism (VTE) risk assessment rates for patients
- Clostridium difficile infection rates
- Patient safety incidents

The tables below set out the Trust indicator performance for 2016/17 and 2015/16, the national average for the indicator as well as the indicator values at NHS Trusts and foundation Trusts with the highest and lowest performance for the same indicator.

Indicator	Reporting period	Ratio	Banding	National Average	Highest/lowest performance for other NHS Trusts
Value and banding of SHMI (summary hospital-level mortality indicator) for the Trust for the reporting period.	January 2015 – December 2015	0.91	As expected	1.00	0.67 1.17
	April 2015 – March 2016	0.90	Lower than expected	1.00	0.68 1.18
	July 2015 – June 2016	0.88	Lower than expected	1.00	0.69 1.17
	October 2015 – September 2016*	0.86	Lower than expected	1.00	0.69 1.16
	*January 2016 – December				

	2016 data to be published by NHS Digital 22nd June 2017				
<p>St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> Data is scrutinised by the Mortality Monitoring Committee and validated through the examination of additional data sources including daily mortality monitoring drawn directly from hospital systems and monthly analysis of Dr Foster data <p>St George's University Hospitals NHS Foundation Trust intends to take the following actions to maintain this indicator, and so the quality of its services, by fully implementing the Learning from Deaths Framework and continuing to strengthen our mortality monitoring processes including developing the timely review of all deaths , ensuring identification and sharing of learning.</p>					

Indicator	Reporting period	Percentage	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	January 2015 – December 2015	33.4	27.6	0.2 54.7
	April 2015 – March 2016	39.1	28.5	0.6 54.6
	July 2015 – June 2016	42.8	29.2	0.6 54.8
	October 2015 – September 2016	48.9	29.7	0.4 56.3
	*January 2016 – December 2016 data to be published by NHS Digital 22nd June 2017			

<p>St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> The clinical coding team and palliative care teams have worked together to increase the accuracy of coding of palliative care and are confident that the improved percentage reflect this work <p>St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by the close collaboration of clinical coding and palliative</p>				
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care teams to improve the accuracy of coding to fully capture the involvement of palliative care services. Since October 2016 we have received a locally agreed tariff for specialist palliative care.

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The percentage of patients aged: (i) 0 to 15 and (ii) 16 or over re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	8.1% 13.1%	7.6% 13.3%	6.9% 9.4%	Highest (0-15) 16.1%, Lowest 1.2% Highest (16 or over) 15.6% Lowest 1.5% Our peers on Dr Foster

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Monitoring emergency re-admission rates help the Trust to prevent or reduce unplanned re-admission into the hospital. An emergency re-admission occurs when a patient has an unplanned re-admission to hospital with 30 days of a previous discharge.

St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by committing to reducing re-admission for all patients irrespective of whether that care is planned or unplanned. We will work to improve our current overall re-admission rate of 12.1% by ensuring that all patients are discharged when it is safe to do so and that there is a coordinated approach with our partners and local authorities to ensure that the right support is in place for them.

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The Trust's responsiveness to the personal needs of its patients during the reporting period: Friends and Family Test scores (percentage of people who said they were "Extremely likely" or "Likely" to recommend our services to friends and	94% (n=30031)	92% (n=29738)	93% (March 2017)	Highest: 100% Lowest: 76% (Feb Inpatient 2017)

family members)				
<p>St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> This data is validated through the Trust's informatics and reporting processes. <p>St George's University Hospitals NHS Foundation Trust intends to take the following actions to maintain and improve this percentage, and so the quality of its services, by continuous and on-going engagement with patients, family, friends and carers.</p>				

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	73%	75%	80%	Highest: 100% Lowest: 44%

<p>St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> The majority of staff are proud of the care that they provide and would recommend the Trust as a provider of care to their family or friends. <p>St George's University Hospitals NHS Foundation Trust intends to improve this percentage, and so the quality of its services, by focusing on staff engagement and quality improvement, listening to staff and addressing their concerns around bullying and harassment and equality and diversity (amongst other issues).</p>				
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Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	96%	96.7%	2015/16: 95.8% *2016/17: 95.6%	2015/16: 100% (highest quarterly rate) 61.5% (lowest quarterly

			*national data is for Q1-Q3 as Q4 data is not yet available via NHS England – to be published in June 2017	rate) *2016/17: 100% (highest quarterly rate) 72.1% (lowest quarterly rate)
<p>St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> This data is validated through the Trust's informatics and reporting processes. <p>St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by maintaining our high risk assessment rate (this is currently higher than the national average).</p>				

Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts
The rate per 100,000 bed days of cases of <i>C.difficile</i> infection reported within the Trust amongst patients aged 2 or over during the reporting period.	11.77	9.45	13.62 (median)	64.1 0.0

<p>St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> The rate for St George's is lower than the majority of other acute London Teaching hospitals and was the 7th lowest of all 29 acute teaching hospital trusts in England. <p>St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by implementation of the following processes; improved recognition of patients at risk of infection by alerting Infection Prevention and Control Team when patients with past history are admitted, improving diagnostic screening of patients at risk and planning that all wards are decanted and deep cleaned on a regular basis.</p>				
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Indicator	2016/17	2015/16	National average	Highest and lowest values for other NHS Trusts and foundation Trusts

<p>The number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death</p>	<p>*12,087</p> <p>27 of these incidents were reported to have resulted in severe harm or death (0.2%)</p>	<p>11,216</p> <p>38 of these incidents were reported to have resulted in severe harm or death (0.3%)</p>	<p>National data for the last 6 months of 2016/17 will not be published by the NRLS until September 2017 (and so cannot be provided at this stage).</p>	<p>National data for the last 6 months of 2016/17 will not be published by the NRLS until September 2017 (and so cannot be provided at this stage).</p>
<p>St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> • This data is validated through the Trust's informatics and reporting processes. <p>St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this number and rate, and so the quality of its services, by introducing a number of learning initiatives and continuing to work towards enhancing existing mechanisms throughout 2016/17. These include: risk management input into training programmes, increased frequency of root cause analysis (RCA) training, increased involvement from medical staff in following up incidents, a monthly governance newsletter and the introduction of quarterly analysis report.</p> <p>*The Trust is in the middle 50% of reporters to the National Reporting and Learning System (NRLS). Data is correct as at 30/05/2017.</p>				

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

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation Trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation Trusts 2016/17' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers. We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation Trust annual reporting manual 2016/17 and supporting guidance;
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation Trusts 2016/17'; 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 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation Trusts 2016/17'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance, 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 2016 to 31 May 2017

- Papers relating to quality reported to the Board over the period 1 April 2016 to 31 May 2017
- Feedback from Commissioners dated 17 May 2017
- Feedback from Governors dated 24 May 2017
- Feedback from local Healthwatch organisations dated 15 May 2017
- Feedback from Overview and Scrutiny Committee dated 15 May 2017
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2016
- The national patient survey dated 8 June 2016
- The local patient survey dated 2016
- The national staff survey dated 2016
- The local staff survey dated 2016
- The Care Quality Commission inspection report dated 1 November 2016
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 25 May 2017

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 are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, 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 Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;

- Comparing the content requirements of the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance.

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 Hospitals NHS Foundation Trust.

Our audit work on the financial statements of St George's University Hospitals 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 Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospitals 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 Hospitals 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 Hospitals 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 Hospitals NHS Foundation Trust and St George's University Hospitals 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.

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- The Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation Trust annual reporting manual 2016/17 and supporting guidance;
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation Trusts 2016/17'; and

- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual 2016/17' and supporting guidance.
-

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
London

Date: 31 May 2017

St George's University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2017

Foreword to the accounts

St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2017, 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.

Signed



Name Jacqueline Totterdell
Job title Chief Executive
Date 31 May 2017

Statement of Comprehensive Income for year ended 31st March 2017

		Restated*	
		2016/17	2015/16
	Note	£000	£000
Operating income from patient care activities	3	652,312	621,590
Other operating income	4	<u>145,778</u>	<u>129,363</u>
Total operating income from continuing operations		<u>798,090</u>	<u>750,953</u>
Operating expenses	5, 7	<u>(861,141)</u>	<u>(794,211)</u>
Operating surplus/(deficit) from continuing operations		<u>(63,051)</u>	<u>(43,258)</u>
Finance income	10	54	89
Finance expenses	11	(5,514)	(4,256)
PDC dividends payable		<u>(5,249)</u>	<u>(6,899)</u>
Net finance costs		<u>(10,709)</u>	<u>(11,066)</u>
Gains/(losses) of disposal of non-current assets	12	(4,906)	(791)
Share of profit of associates/joint arrangements		-	-
Gains/ (losses) arising from transfers by absorption	43	-	-
Movement in the fair value of investment property and other investments	19, 21	-	-
Corporation tax expense	13	<u>-</u>	<u>-</u>
Surplus/(deficit) for the year from continuing operations		<u>(78,666)</u>	<u>(55,115)</u>
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	14	<u>-</u>	<u>-</u>
Surplus/(deficit) for the year		<u>(78,666)</u>	<u>(55,115)</u>
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	-	-
Revaluations	18	(8,832)	(1,182)
Share of comprehensive income from associates and joint ventures	20	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability/asset	37	-	-
Other reserve movements		<u>-</u>	<u>-</u>
Total Other Comprehensive Income		<u>(8,832)</u>	<u>(1,182)</u>
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments	19	-	-
Recycling gains/(losses) on available-for-sale financial investments	10	<u>-</u>	<u>-</u>
Total comprehensive income/(expense) for the period		<u>(87,498)</u>	<u>(56,297)</u>

*The comparative figures for 2015/16 have been restated to show the 'Gains/(losses) of disposal of non-current assets' of (£791k) separately on the face of the Statement of Comprehensive Income under a new requirement set out in the Department of Health Group Accounting Manual. In 2015/16 these values were included within "Operating Expenses".

Statement of Financial Position as at 31st March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	15	16,493	17,420
Property, plant and equipment	16	319,338	319,783
Investment property	19	-	-
Investments in associates (and joint ventures)	19	-	-
Other investments	19	-	-
Trade and other receivables	24	9,739	10,202
Other financial assets	26	-	-
Other assets	25	11	11
Total non-current assets		345,581	347,416
Current assets			
Inventories	23	6,575	6,238
Trade and other receivables	24	92,087	69,935
Other financial assets	26	-	-
Non-current assets for sale and assets in disposal groups	27	-	-
Cash and cash equivalents	28	6,023	7,395
Total current assets		104,685	83,568
Current liabilities			
Trade and other payables	29	(123,845)	(99,314)
Other liabilities	31	-	-
Borrowings	32	(55,207)	(6,357)
Other financial liabilities	30	-	-
Provisions	34	(335)	(144)
Liabilities in disposal groups	27	-	-
Total current liabilities		(179,387)	(105,815)
Total assets less current liabilities		270,879	325,169
Non-current liabilities			
Trade and other payables	29	-	-
Other liabilities	31	-	-
Borrowings	32	(164,523)	(131,315)
Other financial liabilities	30	-	-
Provisions	34	(988)	(1,424)
Total non-current liabilities		(165,511)	(132,739)
Total assets employed		105,368	192,430
Financed by			
Public dividend capital		129,956	129,520
Revaluation reserve		89,103	100,178
Available for sale investments reserve		-	-
Other reserves		1,150	1,150
Merger reserve		-	-
Income and expenditure reserve		(114,841)	(38,418)
Total taxpayers' equity		105,368	192,430

The notes on pages 8 to 47 form part of these accounts.

Signed for and on behalf of the Board

Name
Job title
Date


Jacqueline Totterdell
Chief Executive
31 May 2017

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	129,520	100,178	1,150	(38,418)	192,430
At start of period for new FTs	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	(78,666)	(78,666)
Revaluations	-	(8,832)	-	-	(8,832)
Transfer to retained earnings on disposal of assets	-	(1,660)	-	1,660	-
Public dividend capital received	436	-	-	-	436
Other reserve movements	-	(583)	-	583	-
Taxpayers' and others' equity at 31 March 2017	129,956	89,103	1,150	(114,841)	105,368

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward	133,761	101,360	1,150	16,697	252,968
Prior period adjustment	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2015 - restated	133,761	101,360	1,150	16,697	252,968
At start of period for new FTs	-	-	-	-	-
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

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

Increases in asset values 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.

Available-for-sale investment reserve

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Other reserves

This reserve of £1.15m was created in March 2003 to recognise the portion of land at St George's Grove that had been omitted from the land valuation used to establish the St George's opening PDC capital balance when it became a NHS Trust on 1st April 1993. The associated land has since been sold to TVHA but this reserve remains as an adjustment to the originating PDC Capital balance.

Merger reserve

This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows

	Note	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(63,051)	(43,258)
Non-cash income and expense:			
Depreciation and amortisation	5.1	21,563	22,303
Net impairments	6	-	-
Income recognised in respect of capital donations	4	(582)	(741)
Amortisation of PFI deferred credit	4	-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase)/decrease in receivables and other assets		(21,689)	(4,915)
(Increase)/decrease in inventories		(337)	919
Increase/(decrease) in payables and other liabilities		22,185	8,964
Increase/(decrease) in provisions		(248)	(215)
Tax (paid)/received		-	-
Operating cash flows movement of discontinued operations		-	-
Other movements in operating cash flows		(181)	-
Net cash generated from/(used in) operating activities		(42,340)	(16,943)
Cash flows from investing activities			
Interest received		54	89
Purchase and sale of financial assets		-	-
Purchase of intangible assets		(72)	(24)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(30,384)	(25,596)
Sales of property, plant, equipment and investment property		76	150
Receipt of cash donations to purchase capital assets		582	633
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Net cash generated from/(used in) investing activities		(29,744)	(24,748)
Cash flows from financing activities			
Public dividend capital received		436	359
Public dividend capital repaid		-	(4,600)
Movement on loans from the Department of Health		86,048	44,729
Movement on other loans		(1,478)	(932)
Capital element of finance lease rental payments		(2,604)	(2,788)
Capital element of PFI, LIFT and other service concession payments		(928)	(867)
Interest paid on finance lease liabilities		(242)	(225)
Interest paid on PFI, LIFT and other service concession obligations		(2,913)	(2,974)
Other capital receipts		-	-
Other interest paid		(2,358)	(895)
PDC dividend paid		(5,249)	(6,899)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from/(used in) financing activities		70,712	24,908
Increase/(decrease) in cash and cash equivalents		(1,372)	(16,783)
Cash and cash equivalents at 1 April		7,395	24,178
Cash and cash equivalents at start of period for new FTs		-	-
Cash and cash equivalents transferred under absorption accounting	43	-	-
Cash and cash equivalents at 31 March	28.1	6,023	7,395

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. 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.

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 £78.7m for the year ended 31 March 2017. During the year the Trust borrowed £87.6m under interim revenue support facilities provided by the NHS Independent Trust Financing Facility.

The board has reviewed the proposed 2017/18 plan throughout its development from November 2016 to date. The 2017/18 plan is for a deficit of £28.5m having taken account of the underlying financial position going into 2017/18. The Trust has identified in its financial plan submitted to NHS Improvement that further borrowing totalling £38m is required to finance the Trust for the year provided the £28.5m 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 2017/18 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 material uncertainties 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 2016/17, 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.

Note 1.1 Interests in other entities

The Trust does not have any subsidiaries and is not part of any joint ventures so IAS 28 paragraph IN8 is not applicable.

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.

Note 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.

Note 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.

Note 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.

Note 1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential 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, eg, plant and equipment, then these 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 administrative 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 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

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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 10 years.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

disposals are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales

- the sale must be highly probable i.e.:

- o management are committed to a plan to sell the asset
- o an active programme has begun to find a buyer and complete the sale
- o the asset is being actively marketed at a reasonable price
- o the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- o the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Assets intended for

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

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 predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's statement of financial position.

Other assets contributed by the NHS trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the 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.

Note 1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

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

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Intangible assets - internally generated		
Information technology		12
Development expenditure	10	12
Other	10	12
Intangible assets - purchased		
Software	5	7
Licences & trademarks	5	7
Patents	5	7
Other	5	7
Goodwill	5	7

Note 1.7 Revenue government and other grants

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

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.

Note 1.8 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 1.9 Financial instruments and financial liabilities

Recognition

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade - date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices/independent appraisals/discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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 the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.10 Leases

The Trust as Lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

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

The 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 1.11 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 34.2 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to 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 when the liability arises.

Note 1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

Note 1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.14 Value added tax

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

Note 1.15 Corporation tax

St George's University Hospitals NHS Foundation Trust has no corporation tax liability because under the relevant extant legislation Foundation Trusts are not subject to corporation tax.

Note 1.16 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

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

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

Note 1.17 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 28.2 to the accounts.

Note 1.18 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 Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.19 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.20 Transfer of functions to/from other NHS or local government bodies.

There have been no transfers of functions or assets in the current financial year.

1.21 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 1.10 Leases and 1.5 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 (RICS) qualified valuers. The valuation was effective from 31 March 2017.

The Trust changed the basis of the valuation of the land on the St George's Hospital site to an alternative site basis in 2015/16 and has maintained this basis of valuation in 2016/17. 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 has identified an alternative site in Merton and has 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 e.g. 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.

1.22 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 16.1
- Intangible assets - paragraph 1.6 and note 15.1
- Provision for impairment of receivables – note 24.2
- Provisions - note 1.11 and note 34.1.

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.

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

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

Note 2 Operating Segments

This note is not applicable to 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 account for 47% of the Trust revenue with a further 35% from NHS England. No customer external to the NHS accounts for more than 10% of the Trust's revenue hence there are no other segments.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2016/17 £000	2015/16 £000
Acute services		
Elective income	99,256	97,239
Non elective income	135,426	120,125
Outpatient income	98,349	90,433
A & E income	18,253	17,137
Other NHS clinical income	205,880	198,190
Community services		
Community services income from CCGs and NHS England	82,218	87,644
Community services income from other commissioners	8,243	2,609
All services		
Additional income for delivery of healthcare services		4,600
Private patient income	4,687	3,613
Other clinical income	-	-
Total income from activities	652,312	621,590

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2016/17 £000	2015/16 £000
CCGs and NHS England	625,441	592,421
Local authorities	13,555	10,939
Department of Health	-	(103)
Other NHS foundation trusts	995	872
NHS trusts	655	911
NHS other	1,008	1,263
Non-NHS: private patients	4,687	3,613
Non-NHS: overseas patients (chargeable to patient)	1,619	2,276
NHS injury scheme (was RTA)	3,802	3,689
Non NHS: other	550	1,109
Additional income for delivery of healthcare services	-	4,600
Total income from activities	652,312	621,590
Of which:		
Related to continuing operations	652,312	621,590
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2016/17	2015/16
	£000	£000
Income recognised this year	1,619	2,276
Cash payments received in-year	418	155
Amounts added to provision for impairment of receivables	171	181
Amounts written off in-year	-	316

Note 4 Other operating income

	2016/17	2015/16
	£000	£000
Research and development	4,687	5,348
Education and training	38,401	42,011
Receipt of capital grants and donations	1,316	2,235
Charitable and other contributions to expenditure		685
Non-patient care services to other bodies	59,038	45,832
Income in respect of staff costs where accounted on gross basis	36,294	26,794
Other income	5,491	6,458
Total other operating income	<u>145,227</u>	<u>129,363</u>
Of which:		
Related to continuing operations	145,778	129,363
Related to discontinued operations	-	-

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2016/17	2015/16
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	621,590	620,865
Income from services not designated as commissioner requested services	129,363	126,518
Total	<u>750,953</u>	<u>747,383</u>

Note 4.2 Profits and losses on disposal of property, plant and equipment

During the year the Trust disposed of assets with a net book value of approx £4.982m. A number of old, poor quality buildings were demolished or put beyond use by 31 March 2017 as part of an estates reconfiguration programme. Clinical services which had been provided in one of these buildings, Knightsbridge wing, were re-located to higher quality accommodation in Lanesborough wing. The other buildings that were demolished or put beyond use had been used primarily by administrative staff who have been re-located either to other accommodation on the St George's hospital site or other premises off-site. The Trust received sale proceeds of £76k for some equipment. Therefore the loss on disposal for the year of asset disposals was £4.906m.

Note 5.1 Operating expenses

	2016/17	*Restated 2015/16
	£000	£000
Services from NHS foundation trusts	4,894	6,154
Services from NHS trusts	290	888
Services from CCGs and NHS England	-	256
Services from other NHS bodies	32	79
Purchase of healthcare from non NHS bodies	8,693	8,405
Employee expenses - executive directors	3,239	2,549
Remuneration of non-executive directors	277	117
Employee expenses - staff	527,240	482,999
Supplies and services - clinical	97,866	92,252
Supplies and services - general	18,603	16,682
Establishment	4,832	4,807
Research and development		150
Transport	6,387	6,457
Premises	33,859	32,480
Increase/(decrease) in provision for impairment of receivables	1,086	578
Change in provisions discount rate(s)	18	-
Inventories written down	(231)	425
Drug costs	81,249	68,595
Rentals under operating leases	17,955	17,288
Depreciation on property, plant and equipment	17,891	19,688
Amortisation on intangible assets	3,672	2,615
Audit fees payable to the external auditor		
audit services- statutory audit	70	70
other auditor remuneration (external auditor only)	12	-
Clinical negligence	19,722	14,384
Legal fees	458	592
Consultancy costs	3,907	6,467
Internal audit costs	168	153
Training, courses and conferences	2,571	1,706
Patient travel	689	694
Car parking & security	13	2
Redundancy	227	441
Publishing	873	637
Insurance	512	387
Losses, ex gratia & special payments	39	29
Other	3,776	5,260
Total	860,889	794,286
Of which:		
Related to continuing operations	861,141	794,211
Related to discontinued operations	-	-

*The 2015/16 audit services - statutory audit figure has been restated for comparative purposes.

Note 5.2 Other auditor remuneration

	2016/17	2015/16
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	12	-
Total	12	-

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2015/16: £2m).

Note 6 Impairment of assets

	2016/17	2015/16
	£000	£000
Total net impairments charged to operating surplus / deficit	-	-
Impairments charged to the revaluation reserve	-	-
Total net impairments	-	-

Note 7 Employee benefits

	2016/17	2015/16
	Total	Total
	£000	£000
Salaries and wages	401,009	381,781
Social security costs	40,308	30,435
Employer's contributions to NHS pensions	45,403	42,523
Pension cost - other	-	30
Termination benefits	435	-
Temporary staff (including agency)	43,324	31,540
Total gross staff costs	530,479	486,309
Recoveries in respect of seconded staff	-	-
Total staff costs	530,479	486,309
Of which		
Costs capitalised as part of assets	3,224	761

Note 7.1 Retirements due to ill-health

During 2016/17 there were 8 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £539k (£236k in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 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.

The scheme is subject to a full actuarial valuation every four 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.

d) National Employment Savings Scheme (NEST)

The Trust offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), for those members of staff who do not qualify for the NHS pension scheme.

Note 9 Operating leases

Note 9.1 St George's University Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where St George's University Hospitals NHS Foundation Trust is the lessor.

	2016/17 £000	2015/16 £000
Operating lease revenue		
Minimum lease receipts	-	-
Contingent rent	-	-
Other	-	-
Total	<u>-</u>	<u>-</u>
	31 March 2017 £000	31 March 2016 £000
Future minimum lease receipts due:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	<u>-</u>	<u>-</u>

Note 9.2 St George's University Hospitals NHS 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 FT is the lessee.

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 £13.2m pa. The leases are subject to annual review and renewal.

	2016/17 £000	2015/16 £000
Operating lease expense		
Minimum lease payments	17,955	17,288
Contingent rents	-	-
Less sublease payments received	-	-
Total	<u>17,955</u>	<u>17,288</u>
	31 March 2017 £000	31 March 2016 £000
Future minimum lease payments due:		
- not later than one year;	17,910	17,288
- later than one year and not later than five years;	71,200	69,122
- later than five years.	17,800	17,288
Total	<u>106,910</u>	<u>103,698</u>
Future minimum sublease payments to be received	-	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2016/17	2015/16
	£000	£000
Interest on bank accounts	54	89
Total	54	89

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17	2015/16
	£000	£000
Interest expense:		
Loans from the Department of Health	2,085	819
Commercial loans	214	238
Finance leases	248	225
Interest on late payment of commercial debt	33	-
Other	18	-
Main finance costs on PFI and LIFT schemes obligations	2,913	2,974
Total interest expense	5,511	4,256
Other finance costs	3	-
Total	5,514	4,256

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2016/17	2015/16
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	33	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Gains/losses on disposal/derecognition of non-current assets

	2016/17	2015/16
	£000	£000
Profit on disposal of non-current assets	-	-
Loss on disposal of non-current assets	(4,906)	(791)
Net profit/(loss) on disposal of non-current assets	(4,906)	(791)

During the year the Trust disposed of assets with a net book value of approx £4.982m. A number of old, poor quality buildings were demolished or put beyond use by 31 March 2017 as part of an estates reconfiguration programme. Clinical services which had been provided in one of these buildings, Knightsbridge wing, were re-located to higher quality accommodation in Lanesborough wing. The other buildings that were demolished or put beyond use had been used primarily by administrative staff who have been re-located either to other accommodation on the St George's hospital site or other premises off-site. The Trust received sale proceeds of £76k for some equipment. Therefore the loss on disposal of non-current assets for the year was £4.906m.

Note 13 Corporation tax

	2016/17	2015/16
	£000	£000
UK corporation tax expense	-	-
Current tax expense	-	-
Deferred tax expense	-	-
Total income tax expense in Statement of Comprehensive Income	-	-
Total income tax charge for the year	-	-

Note 14 Discontinued operations

	2016/17	2015/16
	£000	£000
Total	-	-

Note 15.1 Intangible assets - 2016/17

	Software licences £000	Licences & trademarks £000	Patents £000	Internally generated information technology £000	Development expenditure £000	Other £000	Goodwill £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2016 - brought forward	1,228	-	-	28,010	-	-	-	-	29,238
Valuation/gross cost at start of period for new FTs	-	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	72	-	-	-	-	-	-	-	72
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	2,673	-	-	-	-	2,673
Revaluations	-	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(2,087)	-	-	-	-	(2,087)
Gross cost at 31 March 2017	1,300	-	-	28,596	-	-	-	-	29,896
Amortisation at 1 April 2016 - brought forward	-	-	-	11,036	-	-	-	-	11,036
Amortisation at start of period for new FTs	-	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	199	-	-	3,473	-	-	-	-	3,672
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(2,087)	-	-	-	-	(2,087)
Amortisation at 31 March 2017	199	-	-	12,422	-	-	-	-	12,621
Net book value at 31 March 2017	1,101	-	-	16,174	-	-	-	-	17,275
Net book value at 1 April 2016	1,228	-	-	16,974	-	-	-	-	18,202

Note 15.2 Intangible assets - 2015/16

	Software licences £000	Licences & trademarks £000	Patents £000	Internally generated information technology £000	Development expenditure £000	Other £000	Goodwill £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2015 - as previously stated	1,204	-	-	25,712	-	-	-	-	26,916
Prior period adjustments	-	-	-	-	-	-	-	-	-
Gross cost at 1 April 2015 - restated	1,204	-	-	25,712	-	-	-	-	26,916
Gross cost at start of period for new FTs	-	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	24	-	-	108	-	-	-	-	132
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	2,190	-	-	-	-	2,190
Revaluations	-	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2016	1,228	-	-	28,010	-	-	-	-	29,238
Amortisation at 1 April 2015 - as previously stated	601	-	-	8,602	-	-	-	-	9,203
Prior period adjustments	-	-	-	-	-	-	-	-	-
Amortisation at 1 April 2015 - restated	601	-	-	8,602	-	-	-	-	9,203
Amortisation at start of period for new FTs	-	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	181	-	-	2,434	-	-	-	-	2,615
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
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

Note 16.1 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2016 - brought forward	47,961	249,850	-	23,317	108,115	144	29,106	14,004	472,497
Valuation/gross cost at start of period as FT	-	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	55	128	-	29,826	2,966	-	960	-	33,935
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	(2,214)	15,848	113	(19,459)	(19,791)	-	1,664	21,166	(2,673)
Revaluations	120	(52,193)	-	-	-	-	-	-	(52,073)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(11,580)	-	(548)	(851)	-	(17)	(1,173)	(14,169)
Valuation/gross cost at 31 March 2017	45,922	202,053	113	33,136	90,439	144	31,713	33,997	437,517
Accumulated depreciation at 1 April 2016 - brought forward	-	42,376	-	-	80,380	144	19,976	9,838	152,714
Depreciation at start of period as FT	-	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	8,500	-	-	6,221	-	2,397	773	17,891
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	(20,032)	-	-	20,032	-
Revaluations	-	(43,241)	-	-	-	-	-	-	(43,241)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(7,635)	-	-	(482)	-	(9)	(1,059)	(9,185)
Accumulated depreciation at 31 March 2017	-	-	-	-	66,087	144	22,364	29,584	118,179
Net book value at 31 March 2017	45,922	202,053	113	33,136	24,352	-	9,349	4,413	319,338
Net book value at 1 April 2016	47,961	207,474	-	23,317	27,735	-	9,130	4,166	319,783

Note 16.2 Property, plant and equipment - 2015/16

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2015 - as previously stated	63,932	216,912	-	25,047	100,707	144	27,305	13,484	447,531
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 1 April 2015 - restated	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 - as previously stated	-	30,926	-	-	76,226	144	18,551	9,123	134,970
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2015 - restated	-	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

The accumulated depreciation carried forward for buildings of £43,241k as at 31/03/17 is transferred from accumulated depreciation to gross cost in accordance with the accounting requirements for the revaluation of buildings. £42,276k of this total relates to the brought forward balance as at 1st April 2016 and £865k relates to 2016/17. This transfer has no impact on the Statement of Comprehensive Income or on the carrying value of buildings and is effected for disclosure and presentational purposes only.

Note 16.3 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned	44,907	128,419	113	32,609	11,469	-	9,286	3,199	230,002
Finance leased	-	-	-	-	11,015	-	-	318	11,333
On-SoFP PFI contracts and other service concession arrangements	-	60,151	-	-	-	-	-	602	60,753
PFI residual interests	-	-	-	-	-	-	-	-	-
Government granted	-	1,733	-	-	259	-	-	26	2,018
Donated	1,015	11,750	-	527	1,609	-	63	268	15,232
NBV total at 31 March 2017	45,922	202,053	113	33,136	24,352	-	9,349	4,413	319,338

Note 16.4 Property, plant and equipment financing - 2015/16

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2016									
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

Note 17 Donations of property, plant and equipment

The Trust has recognised capital donations receivable towards the cost of various items of medical equipment. These donations are receivable from the St George's Hospital Charity and other various charitable organisations.

Note 18 Revaluations of property, plant and equipment

In 2016/17 the Trust commissioned a valuation of its land and buildings by an independent valuer, Gerald Eve LLP, a firm of professionally (RICS) qualified valuers. The effective date of the revaluation was 31 March 2017 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.

In 2015/16, the Trust 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.

In 2016/17 the Trust has changed the basis of valuation for Atkinson Morley wing to exclude VAT on the grounds that this building is financed by a PFI scheme for which the VAT on the unitary charges payable by the Trust is recoverable. This treatment is permitted under a change in the applicable valuation techniques effective from 2016/17 onwards.

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 10 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.

Note 19.1 Investment Property

	2016/17	2015/16
	£000	£000
Carrying value at 1 April	-	-
Carrying value at 31 March	-	-

Note 19.2 Investment property income and expenses

	2016/17	2015/16
	£000	£000
Total	-	-

Note 20 Investments in associates (and joint ventures)

	2016/17	2015/16
	£000	£000
Carrying value at 1 April	-	-
Carrying value at 31 March	-	-

Note 21 Other investments

	2016/17	2015/16
	£000	£000
Carrying value at 1 April	-	-
Carrying value at 31 March	-	-

Note 22 Disclosure of interests in other entities

The Trust does not have any subsidiaries and is not part of any joint venture.

Note 23 Inventories

	31 March	31 March
	2017	2016
	£000	£000
Drugs	1,635	1,510
Consumables	4,940	4,676
Energy	-	52
Total inventories	<u>6,575</u>	<u>6,238</u>

Inventories recognised in expenses for the year were £114,758k (2015/16: £66,803k). Write-down of inventories recognised as expenses for the year were -£231k (2015/16: £425k).

Note 24.1 Trade receivables and other receivables

	31 March	*Restated
	2017	31 March
	£000	2016
		£000
Current		
Trade receivables due from NHS bodies	55,656	48,443
Receivables due from NHS charities	867	280
Other receivables due from related parties	1,929	1,880
Provision for impaired receivables	(5,508)	(4,348)
Prepayments (non-PFI)	3,704	2,700
Accrued income		245
VAT receivable	6,592	5,507
Other receivables	20,210	15,228
Total current trade and other receivables	83,450	69,935

Other receivables (current) includes general debtors £5.4m, injury cost recovery debt £2.6m, overseas patient debt £5.6m, private patient debt £0.9m and local authority debt of £3.1m.

*The 2015/16 figures for Prepayments (non-PFI) £2,700k and VAT receivable £5,507k have been shown separately for comparative purposes. They were included in Other receivables in the 2015/16 accounts.

Non-current

Other receivables	9,739	10,202
Total non-current trade and other receivables	9,739	10,202

Note 24.2 Provision for impairment of receivables

	2016/17	2015/16
	£000	£000
At 1 April as previously stated	4,348	4,790
Prior period adjustments	-	-
At 1 April - restated	4,348	4,790
At start of period for new FTs	-	-
Increase in provision	1,086	578
Amounts utilised	74	(1,020)
Unused amounts reversed	-	-
At 31 March	5,508	4,348

The Trust determines the provision for impairment of receivables on the basis of the age of the debt and/or the risk of non-collection.

Note 24.3 Analysis of financial assets

	31 March 2017		31 March 2016	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
	£000	£000	£000	£000
Ageing of impaired financial assets				
0 - 30 days	397	-	571	-
30-60 Days	135	-	395	-
60-90 days	65	-	281	-
90- 180 days	581	-	628	-
Over 180 days	4,330	-	3,179	-
Total	5,508	-	5,054	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	2,142	-	1,450	-
30-60 Days	655	-	893	-
60-90 days	1,069	-	840	-
90- 180 days	1,972	-	1,943	-
Over 180 days	12,768	-	13,229	-
Total	18,606	-	18,355	-

Note 25 Other assets

	31 March 2017 £000	31 March 2016 £000
Net pension scheme asset	-	-
Other assets	11	11
Total	11	11

Note 26 Other financial assets

	31 March 2017 £000	31 March 2016 £000
Non-current		
Total	-	-
Current		
Total	-	-

Note 27.1 Non-current assets for sale and assets in disposal groups

There were no non-current assets for sale in 2016/17 or 2015/16

Note 27.2 Liabilities in disposal groups

	31 March 2017 £000	31 March 2016 £000
Total	<u>-</u>	<u>-</u>

Note 28.1 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.

	2016/17 £000	2015/16 £000
At 1 April	7,395	24,178
Prior period adjustments	-	-
At 1 April (restated)	<u>7,395</u>	<u>24,178</u>
At start of period for new FTs	-	-
Transfers by absorption	-	-
Net change in year	<u>(1,372)</u>	<u>(16,783)</u>
At 31 March	<u>6,023</u>	<u>7,395</u>
Broken down into:		
Cash at commercial banks and in hand	(225)	(331)
Cash with the Government Banking Service	6,248	7,725
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	<u>6,023</u>	<u>7,395</u>
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	<u>6,023</u>	<u>7,395</u>

The negative balance shown above of (£225k) for the Trust's commercial bank account does not represent an overdrawn balance but a timing difference: a payment transaction of £400k was processed and recorded in the accounts at the end of March 2017 but did not clear in the bank account until early April 2017.

Note 28.2 Third party assets held by the NHS foundation trust

St George's University Hospitals NHS Foundation Trust held cash and cash equivalents totalling £18,875 which relate to monies held by 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 2017 £000	31 March 2016 £000
Bank balances	-	-
Monies on deposit	19	14
Total third party assets	<u>19</u>	<u>14</u>

Note 29.1 Trade and other payables

	31 March 2017 £000	31 March 2016 £000
Current		
Receipts in advance	-	-
NHS trade payables	12,969	10,364
Amounts due to other related parties	790	-
Other trade payables	83,156	61,573
Capital payables	5,285	2,934
Social security costs	12,866	5,118
VAT payable	-	-
Other taxes payable	5,146	4,896
Other payables	2,376	9,989
Accruals	1,257	4,440
PDC dividend payable	-	-
Total current trade and other payables	<u>123,845</u>	<u>99,314</u>
Non-current		
Total non-current trade and other payables	<u>-</u>	<u>-</u>

Note 29.2 Early retirements in NHS payables above

	31 March 2017 £000	31 March 2017 Number	31 March 2016 £000	31 March 2016 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
- outstanding pension contributions	-	-	6,201	-

Note 30 Other financial liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Total	<u>-</u>	<u>-</u>
Non-current		
Total	<u>-</u>	<u>-</u>

Note 31 Other liabilities

There were no other liabilities in 2015/16 or 2016/17

Note 32 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Loans from the Department of Health	50,301	1,601
Other loans	1,478	1,478
Obligations under finance leases	2,435	2,352
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	993	926
Total current borrowings	55,207	6,357
Non-current		
Loans from the Department of Health	104,595	67,247
Other loans	9,608	11,086
Obligations under finance leases	6,654	8,323
Obligations under PFI, LIFT or other service concession contracts	43,666	44,659
Total non-current borrowings	164,523	131,315

Borrowings from the Department of Health

1. The Trust borrowed £5.6m capital loans in 2015/16 from the Department of Health to finance specific capital projects, bringing total DH 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 £0.6m of these loans in 2016/17.

2. 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 2016/17.

3. 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 was drawn down in 2016/17. The interest rate is fixed at 1.5% and the full amount borrowed will have to be repaid in March 2018.

4. The Trust borrowed £64.272m under an interim working capital facility in 2016/17. The interest rate is 3.5% for all borrowings under this facility. The facility is repayable in full in September 2020.

5. The Trust borrowed £15.073m under an interim working capital loan in 2016/17. The interest rate is 1.5% for all borrowings under this loan facility. The facility is repayable in full in March 2020.

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 £1.5m of this loan in 2016/17.

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 2016/17 the Trust took out new finance leases with various leasing companies for equipment with a capital value of approx £1m in respect of various items of medical equipment. The total borrowings under finance leases were £9.1m at 31st March 2017. The Trust made repayments of principal under finance leases of £2.6m in 2016/17.

Private Finance Initiative on-SoFP scheme

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. The capital value of the buildings and equipment encompassed within the PFI contract was approx £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 approx. 7.5%. The Trust repaid £0.928m of the PFI finance lease creditor in 2016/17.

Note 33 Finance leases

Note 33.1 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 2017 £000	31 March 2016 £000
Gross lease receivables	-	-
Net lease receivables	-	-

Note 33.2 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 2017 £000	31 March 2016 £000
Gross lease liabilities	10,011	11,785
of which liabilities are due:		
- not later than one year;	2,668	2,581
- later than one year and not later than five years;	7,229	7,957
- later than five years.	114	1,247
Finance charges allocated to future periods	(922)	(1,110)
Net lease liabilities	9,089	10,675
of which payable:		
- not later than one year;	2,435	2,352
- later than one year and not later than five years;	6,551	7,200
- later than five years.	103	1,123

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 inceptioned for new replacement equipment.

Note 34.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Other legal claims £000	Equal Pay (including Agenda for Change) £000	Re- structurings £000	Continuing care £000	Redundancy £000	Other £000	Total £000
At 1 April 2016	1,270	208	-	-	-	-	90	1,568
At start of period for new FTs	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	14	3	-	-	-	-	1	18
Arising during the year	209	-	-	-	-	-	54	263
Utilised during the year	(137)	-	-	-	-	-	-	(137)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	(225)	(166)	-	-	-	-	(1)	(392)
Unwinding of discount	3	-	-	-	-	-	-	3
At 31 March 2017	1,134	45	-	-	-	-	144	1,323
Expected timing of cash flows:								
- not later than one year;		45	-	-	-	-	144	189
- later than one year and not later than five years;	-	-	-	-	-	-	-	-
- later than five years.	988	-	-	-	-	-	-	988
Total	988	45	-	-	-	-	144	1,177

The provision for pension costs is calculated using information provided by the NHS Pensions Agency. The provision for legal claims has been calculated using figures and estimated probabilities supplied by the NHS Litigation Authority, the Trust's solicitors and the Trust's Human Resources department.

Note 34.2 Clinical negligence liabilities

At 31 March 2017, £268,976k was included in provisions of the NHSLA in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2016: £205,754k).

Note 35 Contingent assets and liabilities

	31 March 2017 £000	31 March 2016 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(89)	(58)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	(89)	(58)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(89)	(58)
Net value of contingent assets	-	-

Note 36 Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	8,351	12,978
Intangible assets	-	-
Total	8,351	12,978

Contractual capital commitments include £5.192m for an energy performance contract signed 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 total 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. In addition the Trust had capital commitments with contractors for work to complete its demolition and relocations programme totalling approx £3.159m.

Note 37 Defined benefit pension schemes

There are no material disclosures relating to any defined benefit pension schemes as provided by the funds actuary.

Note 37.1 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 2015/16 or 2016/17.

	2016/17	2015/16
	£000	£000
Present value of the defined benefit obligation at 1 April	-	-
Present value of the defined benefit obligation at 31 March	-	-
Plan assets at fair value at 1 April	-	-
Fair value of plan assets at 1 April -restated	-	-
Plan assets at fair value at start of period for new FTs	-	-
Plan assets at fair value at 31 March	-	-
Plan surplus/(deficit) at 31 March	-	-

Note 37.2 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

	2016/17	2015/16
	£000	£000
Present value of the defined benefit obligation at 31 March	-	-
Net (liability)/asset recognised in the SoFP at 31 March	-	-

Note 37.3 Amounts recognised in the SoCI

	2016/17	2015/16
	£000	£000
Total net (charge)/gain recognised in SOCI	-	-

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

Note 38.1 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 2017 £000	31 March 2016 £000
Gross PFI, LIFT or other service concession liabilities	82,016	85,857
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.	62,812	66,653
Finance charges allocated to future periods	(37,357)	(40,272)
Net PFI, LIFT or other service concession arrangement obligation	44,659	45,585
- not later than one year;		926
- later than one year and not later than five years;	4,715	4,407
- later than five years.	38,951	40,252

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.

Note 38.2 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 2017 £000	31 March 2016 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	250,272	246,385
Of which liabilities are due:		
- not later than one year;	11,376	10,712
- later than one year and not later than five years;	45,504	42,850
- later than five years.	193,392	192,823

Note 38.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2016/17:

	31 March 2017 £000	31 March 2016 £000
Unitary payment payable to service concession operator	11,376	10,799
Consisting of:		
- Interest charge	2,913	2,974
- Repayment of finance lease liability	928	867
- Service element and other charges to operating expenditure	7,535	6,958
Total amount paid to service concession operator	11,376	10,799

Note 39 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.

	31 March 2017 £000	31 March 2016 £000
Total	-	-

Note 40 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.

Note 40.1 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. The Trust is not exposed to the degree of financial risk faced by business entities because of the continuing service provider relationship that the Trust has with clinical commissioning groups and the way those bodies are financed. 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

The Trust has low exposure to credit risk because the majority of the Trust's revenue comes from contracts with other public sector bodies. The maximum exposures as at 31 March 2017 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 terms 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.

Note 40.2 Financial assets

	Assets at fair value				Total £000
	Loans and receivables £000	through the I&E £000	Held to maturity £000	Available-for-sale £000	
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	83,054	-	-	-	83,054
Cash and cash equivalents at bank and in hand	6,023	-	-	-	6,023
Total at 31 March 2017	89,077	-	-	-	89,077

	Assets at fair value				Total £000
	Loans and receivables £000	through the I&E £000	Held to maturity £000	Available-for-sale £000	
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets	69,935	-	-	-	69,935
Cash and cash equivalents at bank and in hand	7,395	-	-	-	7,395
Total at 31 March 2016	77,330	-	-	-	77,330

Note 40.3 Financial liabilities

	Liabilities at fair value			Total £000
	Other financial liabilities £000	through the I&E £000		
Liabilities as per SoFP as at 31 March 2017				
Borrowings excluding finance lease and PFI liabilities		165,982	-	165,982
Obligations under finance leases		9,090	-	9,090
Obligations under PFI, LIFT and other service concession contracts		44,659	-	44,659
Trade and other payables excluding non financial liabilities		102,200	-	102,200
Total at 31 March 2017		321,931	-	321,931

	Liabilities at fair value			Total £000
	Other financial liabilities £000	through the I&E £000		
Liabilities as per SoFP as at 31 March 2016				
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
Total at 31 March 2016		212,543	-	212,543

Note 40.4 Maturity of financial liabilities

	31 March 2017	31 March 2016
	£000	£000
In one year or less	157,406	81,228
In more than one year but not more than two years	6,244	46,503
In more than two years but not more than five years	96,678	17,813
In more than five years	61,603	46,503
Total	321,931	192,047

Note 40.5 Fair values of financial assets at 31 March 2017

	Book value £000	Fair value £000
Non-current trade and other receivables excluding non financial assets	83,054	83,054
Total	83,054	83,054

Note 40.6 Fair values of financial liabilities at 31 March 2017

	Book value £000	Fair value £000
Non-current trade and other payables excluding non financial liabilities	102,200	102,200
Loans	165,982	165,982
Total	268,182	268,182

The Trust considers that the fair value of financial assets and financial liabilities are the same as book value.

Note 41 Losses and special payments

	2016/17		2015/16	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	-	-	34	316
Total losses	-	-	34	316
Special payments				
Compensation payments	-	-	5	11
Ex-gratia payments	67	26	62	18
Total special payments	67	26	67	29
Total losses and special payments	67	26	101	345
Compensation payments received				

Note 42 Gifts

	2016/17		2015/16	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Total gifts	-	-	-	-

Note 43 Transfers by absorption

There were no transfers by absorption in 2016/17 or 2015/16.

Note 44 Prior period adjustments

There were no prior period adjustments in 2016/17 or 2015/16.

Note 45 Events after the reporting date

There were no events to report post 31 March 2017.

Note 46 Final period of operation as a provider of NHS healthcare

This note is not applicable for 2016/17 or 2015/16.

Note 47 Related parties

St Georges University Hospitals is a Foundation Trust within the Department of Health. The Department of Health is regarded as a related party. During the year, St George's University Hospitals has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department, as listed below:-

NHS Foundation Trusts
 NHS Trusts
 Department of Health
 Public Health England
 Health Education England
 CCGs and NHS England
 Special Health Authorities
 Non - Department Public Bodies
 Other DH bodies

	Amounts due from Related Party		Amounts owed to Related party	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Non - NHS Related party transactions				
St George's University of London	1,929	1,877	665	1,765
St George's Hospital Charity	867	280	3	6
KPMG LLP	-	-	122	1,213
Total	2,796	2,157	790	2,984

	Receipts from Related Party		Payments to Related party	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Non - NHS Related party transactions				
St George's University of London	3,252	3,747	7,994	7,455
St George's Hospital Charity	1,421	3,016	37	12
KPMG LLP	-	-	4,035	6,139
Total	4,673	6,763	12,066	13,606

The Department of Health is the parent department of the Trust.

KPMG LLP is disclosed as a related party because Nigel Carr, who was the Trust's Chief Financial Officer from May 2016 to October 2016, is an employee of KPMG LLP.

Under the Requirements of IAS 24 (Related Party Disclosures), the Trust has disclosed as a related party where key management services have been provided by another entity such as personal service companies. The total transactions for these companies where key management services were provided are detailed below.

	Amounts due from Related Party		Amounts owed to Related party	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Company				
MR Strategic Limited	-	-	23	-
IT Matters Limited	-	-	32	-
Odgers Interim	-	-	0	-
Hunter Healthcare Resourcing Ltd	-	-	0	-
Corinne Siddall HCIM Ltd	-	-	0	-
Scene One Ltd	-	-	20	-
Dearden HR Ltd	-	-	0	-
Okra Associates Ltd	-	-	0	-
	0	0	75	0

	Receipts from Related Party		Payments to Related party	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Company				
MR Strategic Limited	-	-	303	-
IT Matters Limited	-	-	395	-
Odgers Interim	-	-	327	-
Hunter Healthcare Resourcing Ltd	-	-	470	-
Corinne Siddall HCIM Ltd	-	-	124	-
Scene One Ltd	-	-	1472	-
Dearden HR Ltd	-	-	92	-
Okra Associates Ltd	-	-	340	-
	0	0	3,523	0

MR Strategic Limited provided Mark Gordon in the role of Chief Operating Officer

IT Matters Limited provided Richard Hancock in the role of Director of Estates, Facilities and Capital projects

Odgers Interim provided Karen Charman in the role of Director of Human Resources

Hunter Healthcare Resourcing Ltd provided Paula Vasco-Knight in the role of Chief Operating Officer and Acting Chief Executive.

Corinne Siddall HCIM Ltd provided Corinne Siddall in the role of Interim Chief Operating Officer

Scene One Ltd provided Larry Murphy in the role of IT advisor to Trust Board

Dearden HR Ltd provided Mark Gammage in the role of Human Resources Advisor to the Trust board.

Okra Associates Ltd provided Margaret Pratt in the role of Chief Financial Officer

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the FTC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

Staff costs

	Group		2016/17	2015/16
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	394,328	6,681	401,009	381,751
Social security costs	40,308	-	40,308	30,435
Employer's contributions to NHS pensions	45,403	-	45,403	42,523
Pension cost - other	-	-	-	30
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	435	-	435	-
Temporary staff	-	43,324	43,324	31,540
Total gross staff costs	480,474	50,005	530,479	486,309
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	480,474	50,005	530,479	486,309
Of which				
Costs capitalised as part of assets	-	-	-	761

Average number of employees (WTE basis)

	Group		2016/17	2015/16
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,194	67	1,261	1,194
Ambulance staff	-	-	-	-
Administration and estates	1,822	354	2,176	2,044
Healthcare assistants and other support staff	696	199	894	622
Nursing, midwifery and health visiting staff	2,809	507	3,316	3,491
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	1,660	281	1,941	1,825
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Agency and contract staff	-	-	-	-
Bank staff	-	-	-	-
Other	-	-	-	-
Total average numbers	8,181	1,407	9,588	9,176

Of which:

Number of employees (WTE) engaged on capital projects	14	10	24	-
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Reporting of compensation schemes - exit packages 2016/17

	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	1	2	3
£10,001 - £25,000	1	2	3
£25,001 - 50,000	1	-	1
£50,001 - £100,000	-	3	3
£100,001 - £150,000	1	-	1
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	4	7	11
Total resource cost (£)	£195,000	£240,000	£435,000

Reporting of compensation schemes - exit packages 2015/16

	Number of compulsory	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

Exit packages: other (non-compulsory) departure payments

	2016/17		2015/16	
	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	1	11	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	6	229	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	7	240	-	-
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 Mar 2017, for more than £220 per day and that last for longer than six months

	2016/17
	Number of engagements
Number of existing engagements as of 31 Mar 2017	58
Of which:	
Number that have existed for less than one year at the time of reporting	45
Number that have existed for between one and two years at the time of reporting	13
Number that have existed for between two and three years at the time of reporting	-
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	-

For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months

	2016/17
	Number of engagements
Number of new engagements, or those that reached six months in duration between 01 April 2016 and 31 March 2017	51
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 01 April 2016 and 31 March 2017

	2016/17
	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	7
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.	15

