St George's Healthcare NHS
NHS Trust

Annual Report **2013/2014**

St George's Healthcare NHS Trust

excellent, kind, responsible, respectful

www.stgeorges.nhs.uk


St George's Healthcare

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Foreword

Christopher Smallwood **Chairman**

The last year was another successful one for St George's Healthcare NHS Trust. Hundreds of thousands of patients were treated at St George's Hospital; 600,000 outpatients; 130,000 A&E attendances and nearly 100,000 emergency and elective inpatients. At the same time, we redoubled our efforts to integrate hospital and community services so that as many people as possible can be treated closer to home.

As Chairman of the trust, I am extremely interested in people's experience of their treatment, and spend a good deal of time visiting patients on wards as well as talking to staff to get their views of the quality and safety of our services. In general, the responses are very positive, something which has been borne out objectively by the Department of Health's 'Friends and Family Test' – a set of questions which ask patients whether they would recommend our service to the people they care about most – their family and friends – the ultimate test.

I am pleased to say that 95% of our patients say they would be either likely or extremely likely to recommend us. This is also true of the great majority of staff: the number recommending us as a place to receive treatment or to work puts us in the top 20% of trusts in the country. And, according to the Care Quality Commission, following their recent inspection, most people feel proud to work at St George's.

Despite our best efforts, we sometimes fail patients and particular members of staff, but where this happens we make every attempt to establish why it has happened so as to understand how we can make things better. We carefully analyse all the complaints we receive, as well as the positive feedback, and act on the themes which emerge.

I am always keen to engage with staff to benefit from their experience and appreciate the challenges which they face on a daily basis. It is evident to me that the great majority of our staff embody the trust's values – kind, excellent, responsible, respectful – and that this contributes powerfully to the standard of care we offer. Published mortality ratios show that St George's is one of the very safest places in the country to receive medical care.

The trust makes a major contribution to healthcare across south west London and beyond, as a result of our stroke, cardiac and trauma centres as well as the whole range of exemplary specialist services. We are also continuing to work closely with South West London Collaborative Commissioning – drawing on the extensive work and insights from the Better Services, Better Value review. We expect to play a leading role in developing a sustainable health strategy for south west London in the coming months, moving on to the next stage which is building on the integration of hospital, primary and community care which we have already started.

St George's has a skilled and dedicated Trust Board, fully committed to meeting the challenges of improving and running one of the largest healthcare providers in London. As we move closer to achieving Foundation Trust status, we also have a new Council of Governors to represent the views of our members. This Council will help to ensure that we fulfil the strategic direction the Board has set for the Trust.

If you are on the St George's site, you will notice a lot of building in the coming year as a multi-storey car park is built, freeing up space for other construction projects. Work will start on the Lanesborough wing as we take the first steps towards creating a new, state of the art, women's and children's hospital. Plans will also be progressed to relocate renal services and to increase our capacity by around 100 beds to accommodate the growth we are expecting. And at Queen Mary's Hospital, Roehampton, we will have opened the doors to a new neuro rehabilitation unit by the end of this financial year.

At a time when the NHS is under such pressure, this trust is unusually advantaged; we face an exciting, expansionary future. It is a good place to be.

Introduction

Miles Scott **Chief Executive**

The completion of the new helipad at St George's Hospital in early April was a fitting way to mark the end of another successful and busy year at the trust.

The helipad underlines the importance of the hospital as a major trauma centre – somewhere with the right expertise and facilities to treat the most seriously ill and injured patients.

Whilst we are increasingly well-known for this, it is gratifying that our skills in providing care outside of the hospital setting were also recognised. The trust has secured a new five year contract to continue providing healthcare in HMP Wandsworth. Working in a prison and treating offenders has its own challenges so I am especially proud that our proven ability has won the new tender.

But perhaps the best testament to the quality of our care is the results from the Care Quality Commission (CQC) who undertook a comprehensive inspection of our services in February 2014.

St George's Hospital was rated as 'good' overall in the report issued by England's Chief Inspector of Hospitals. It was rated as 'outstanding' for its maternity, intensive and critical care and 'good' for most other services inspected. End of life care, while found to be effective and caring, was rated as 'requires improvement' because the completion of resuscitation forms requires more work to ensure that people receive the treatment they choose.

Queen Mary's Hospital was rated as 'good' across the three services offered at that site. Neither St John's Therapy Centre nor the community inpatient service at Queen Mary's Hospital have been rated because CQC is not yet rating community services. The full reports are available from; **http://www.stgeorges.nhs.uk/about/performance/cqc**

Inspectors found a number of other areas of good practice across the trust, including:

- **The leadership of intensive care unit and high dependency unit**
- **Services with open and effective team working and a priority given to information, research and training**
- **Maternity care, due to information provided to women, robust midwifery staffing levels and access to specialist midwives**
- **The provision of a comforting environment within the mortuary suite**
- **The hyper-acute stroke unit on William Drummond Ward**
- **The provision of advice at Queen Mary's Hospital minor injuries unit**
- **The neonatal special care baby unit**
- **Multi-professional team working in neurology theatres**
- **The local leadership of Richmond acute medicine unit**
- **Excellent multidisciplinary working, communication across teams and relationship building with patients across community services.**

CQC has told the trust that it must make improvements in these areas:

- **Ensuring a better understanding of the principles of the Mental Capacity Act 2005 across both hospital sites**
- **Ensuring that medical records are always made available to staff working in the outpatient clinics.**

I am proud of the work done by all staff to raise our standards across the board. We know that we will need to continue our efforts to maintain these in 2014/15.

What we do

About us

With nearly 8,000 dedicated staff caring for patients around the clock, we are the largest healthcare provider in south west London.

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

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

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

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

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

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 the quality of services for patients. These include the London Cancer Alliance, the South London Cardiac and Stroke Network and the South West London and Surrey Trauma Network of which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

Our services

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

We provide healthcare services at:

Hospitals

St George's Hospital, Tooting

Queen Mary's Hospital, Roehampton

Therapy centres

St John's Therapy Centre

Health centres

Balham Health Centre

Bridge Lane Health Centre

Brocklebank Health Centre

Doddington Health Centre

Eileen Lecky Clinic

Joan Bicknell Centre

Stormont Health Clinic

Tooting Health Clinic

Tudor Lodge Health Centre

Westmoor Community Clinic

Prisons

HMP Wandsworth

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

Clinical services are split into four divisions:

- **Surgery, Theatres, Neurosciences and Cancer**
- **Medicine and Cardiovascular**
- **Children's & Women's, Diagnostics, Therapeutics and Critical Care**
- **Community Services**

The trust's tertiary services treat the most complex injuries and illnesses. Many specialist services are provided as part of clinical networks for which the trust acts as the clinical hub, for example, the trust is the inpatient centre for paediatric, ear, nose and throat, plastics and maxillo-facial surgery for south west London. The trust became one of the four Major Trauma Centres in London in 2010, and in the same year was designated a Hyper-Acute Stroke Unit (HASU). The trust's stroke service consistently receives excellent reports as part of the Sentinel audit, which shows the service to be in the top quartile nationally.

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

The vast majority of acute services the trust undertakes is delivered at St George's Hospital. The trust believes this is a key strength of the organisation, bringing together the full range of acute clinical services and clinical expertise on a single site. The diagram below shows the divisional structure and the services each division delivers for the differing cohorts of patients who access St George's services.

St George's clinical services

Key

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

Division	Directorates	Clinical Services within each Directorate						
Surgery, Theatres, Neurosciences and Cancer	Surgery & Trauma	T&O	ENT	Maxillo-facial	Plastics	Urology	General Surgery	Dentistry
		Audiology						
	Theatres & Anaesthetics	Theatres & Decontamination	Anaesthetics & Acute Pain					
	Neurosciences	Neurosurgery & Neuro-radiology	Neurology	Neuro-Rehab	Pain Clinic			
	Cancer	Cancer						
Medicine & Cardiovascular	A&E & Acute Medicine	A&E	Acute Medicine					
	Specialist Medicine	Lymphoedema	Clinical Infection Unit	Rheumatology	Diabetes / Endocrinology	Chest Medicine	Endoscopy & Gastroenterology	Dermatology
	Renal, Haematology & Oncology	Renal Transplantation	Renal	Medical Oncology	Clinical Haematology	Palliative Care		
	Cardiovascular	Cardiology	Cardiac Surgery	Vascular Surgery	Blood Pressure Unit			
Children's & Women's, Diagnostics, Therapeutics and Critical Care	Children's	Paediatric Surgery	Newborn Services & NICU	PICU	Paediatric Medicine			
	Women's	Gynaecology	Obstetrics					
	Therapeutics	Adult Critical Care	Therapies	Pharmacy				
	Diagnostics	Clinical Genetics	Breast Screening	Pathology	Radiology	Laboratory Haematology		
	Outpatients	Outpatients						
Community Services	Children & Family	School & Special school nursing	Children's continuing care	Health visiting	Child safeguarding team	Children's therapies & immunisation	Homeless, Refugees and Asylum Seeker team	
	Older People & Neuro-Rehab	Community nursing & Community ward	Intermediate care	Specialist nursing	Older people and neuro therapies	Day hospitals	Elderly rehab	Community learning disabilities
	Adult & Diagnostic	Outpatient services	Minor Injuries Unit	Diagnostics	Integrated sexual health services	Specialist rehab services	Adult therapy services – physiotherapy, podiatry, dietetics	
	Offender healthcare	Primary care	Substance misuse	Inpatient care	Primary care mental health			

St George's 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 of all ages following integration with Community Services Wandsworth in 2010. Community Services have continued their integration with St George's over the past year, improving choices available to local people by providing more care in homes, and reducing unnecessary admissions to hospital and helping patients to leave hospital as soon as is it safe for them to do so.

Project Search

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

Recognition – London Mayor's reception

Staff were invited to meet the Mayor of London at a reception event acknowledging the outstanding work and achievement of members of the community. Around 300 people from Wandsworth and Merton attended the event and staff in senior healthcare received a letter praising their outstanding care of a patient at the hospital.

Annual community open day

Our annual community open day attracted over 1500 visitors in 2013. Young people were invited to look at nursing as a potential career option and children visited the hospitals simulation suite where they could check mannequins pulse and heartbeat, as well as patched teddy bears. More than 60 stalls were set up at the event ranging from advice about healthy eating, heart disease and tuberculosis to local history.

Award nomination

Wandsworth Clinical Commissioning Groups (CCG) Community Wards initiative was shortlisted in the Primary Care and Community Service Redesign category at the prestigious 2013 Health Service Journal (HSJ) awards.

The Wandsworth Community Wards are delivered by St George's Healthcare NHS Trust and aim to improve patient experience, deliver better home-based care and prevent hospital admissions. The Community Wards Programme promotes joint working between health and social care services bringing together a team including consultants, GPs, community nurses and social workers supporting vulnerable patients to receive care in their own homes.

This collaborative and integrative approach has proven to be a success over a 5 year piloting and development phase. Incorporation of innovative adaptations has made the model unique, reducing emergency admissions for vulnerable and high risk patients.

Living our values

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

Our **vision** is to become an excellent integrated provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research.

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

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

Kind

Excellent

Responsible

Respectful

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

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

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

Staff engagement

We understand the importance of engaging with our staff and we are constantly monitoring how well we keep them engaged and informed. In order for us to serve patients and public effectively, we have a number of different channels available to keep staff up to date, generate discussions and provide feedback on different issues that affect us all.

Listening into Action

More than 400 members of staff attended 'Big Conversations' as part of the Listening into Action staff engagement programme. We recorded the issues that staff felt prevented them from providing a quality service and ten 'action' teams were established to work on a range of issues.

Patient safety forums

A series of forums are held with staff on the issue of patient safety. These are presented by senior members of staff, often using an example of a serious incident at St George's. Staff are encouraged to ask questions as to how we can make patients safer at the trust.

All staff emails

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

'By George' staff magazine

The staff magazine is produced by the communications team and contains trust news and information about different teams, as well as positive patient experiences. Copies of the magazine are available for public trust members, GPs in south west London and our stakeholders.

Living our values awards

The awards give staff, patients and public an opportunity to nominate a member of staff or team who they feel demonstrates our values. The awards are held regularly and the names of winners are published on our website.

Emergency planning

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

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

The trust has a Major Incident Steering Group and a Business Continuity Steering Group which meet regularly to discuss continuous improvement options regarding major incident planning, business continuity, exercising of the plans and training for staff with responsibilities within the plans. We also undertake regular evacuation practices and incident scenarios.

RideLondon is an annual cycle event that poses a significant impact on the trust in terms of travel disruption and road closures. The event is held in August and encompasses a weekend of cycle events across London and Surrey. The trust sees most impact as the route passes us twice. To ensure the trust meets its Emergency Planning Risk Register (EPRR) requirements a RideLondon Operational Planning Group looks at how the event impacts us and puts a series of measures in place to ensure that the trust continues to make patients its priority.

Equal opportunities

The trust is an equal opportunities employer and abides by the Equality Act 2010 which consolidated, strengthened and clarified existing anti-discrimination legislation.

The trust abides by the Public Sector Equality Duty (PSED) and its three principles:

To eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act

To advance equality of opportunity between people who share protected characteristics and those who do not

To foster good relations between people who share protected characteristics and those who do not

The term 'protected characteristics' is used to embody the grounds upon which discrimination is unlawful. Under section 4 of the Equality Act, the protected characteristics are:

- **Age**
- **Disability**
- **Gender reassignment**
- **Marriage and civil partnership**
- **Pregnancy and maternity**
- **Race and ethnicity**
- **Religion or belief**
- **Gender**
- **Sexual orientation**

The trust demonstrates its adherence to the three PSED principles outlined in the Equality Act 2010 by:

Removing and minimising disadvantages suffered by people due to their protected characteristics

Meeting the needs of people with protected characteristics

Tackling prejudice and promoting understanding between people with protected characteristics and others

'Maternity Futures' is an initiative run by the trust that aims to empower diverse staff to realise their full potential and deliver improved care. This initiative has been progressing for two years in maternity services. We are also strengthening our governance arrangements in respect of equality and have adopted the Department of Health Equality Delivery System Assessment Framework.

You can view our Equality Reports at **https://www.stgeorges.nhs.uk/about/living-our-values/equality-and-human-rights/**

Responding to your concerns

The trust cared for over one million patients in 2013/14. We accept that among this number of patients, the experience for some will not meet their expectations.

The trust adheres to the Parliamentary and Health Services Ombudsman's Principles for Remedy, which provides guidance on the way in which public bodies respond to complaints and concerns raised by patients and members of the public.

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

In addition, our Patient Advice and Liaison Service (PALS) helps to address any problems or concerns that patients may have regarding the trust's services. PALS staff listen to the views and comments of patients ensuring that feedback is passed on. The service can also provide patients with access to interpreters, signers and other services they may need to improve their experience.

PALS staff also provides customer care training to staff and often assist staff when they are in need of support.

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

Concern	Action
General Surgery (Clinical Treatment, medical care and communication)	Capacity issues in the breast service meant there was a particular strain on Wednesday clinics. The clinic templates have now been changed and stricter management of clinics has been introduced to help alleviate pressure. Regular contacts on wards with senior clinicians are being addressed – there are plans in colorectal to change rotas to give consultants more time to do ward rounds.
Accident and Emergency	Poor communication across the department is being addressed by the Design Council Boards. A 'What If' initiative was launched in August 2013. This initiative gives clear and simple advice regarding patient care, helping staff remember key processes and targets as well as improving the patient's journey and experience. Clinical learning is highlighted and discussed at the bi-monthly clinical governance meetings. Complaints are discussed at the weekly senior operational team meeting to review trends. Sessions about patient experiences are held on nursing team days to support an understanding of the patients' viewpoint.
Waiting Times	The process of tracking medical records has been redesigned and staff have received extra training to track records more accurately. A Patient Access Centre has been introduced which provides a single point of contact for patients who wish to schedule or cancel an appointment.
Offender Healthcare	All patients with complex needs will be allocated a lead nurse who will devise a care plan and conduct regular reviews with patients. This will be actioned by the Head of Healthcare for the Occupational Health Service (OHS) by June 2014. The OHS Healthcare Administration Team is reviewing the current process to follow up routine review appointments with the patient and external provider. This will be actioned by the Head of Healthcare for the (OHS) by June 2014.

Work towards a sustainable NHS

Our energy costs increased by 16% in 2013/14. In 2014 the trust began the process of engaging British Gas to undertake an Energy Performance Contract with the aim of significantly reducing energy consumption and carbon emissions. The project will improve reliability and provide an enhanced healthcare environment and is expected to be completed by March 2016.

As well as financial savings the project will deliver an annual reduction of carbon dioxide emissions of 7,108 tonnes and help the trust to achieve the NHS carbon dioxide emissions reduction target of 34% by 2020 on a 2007/08 baseline.

In 2013/14, the trust procured all its imported electricity from renewable sources, which does not produce carbon emissions. Therefore our measured greenhouse gas emissions have fallen by approximately 30% from the previous year.

Our water consumption was 360,603m^3. This has been reduced by 50,230m^3 from the previous financial year.

The Carbon Reduction Commitment (CRC) Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations. During 2013/14 our gross expenditure on the CRC Energy Efficiency Scheme was £279,432.

Our organisation has an up-to-date Sustainable Development Management Plan. This is a good way to ensure we fulfill our commitment to conducting all aspects of our activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

During 2013/14 the trust recovered or recycled 521.49 tonnes, equivalent to over 17% of the total waste handled, achieving the target of recycling 40% of 2004/5 waste arisings, and includes over 2 tonnes sent for recycling instead of incineration.

We consider the potential need to adapt the trust's buildings and estates as a result of climate change. Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider this when planning how we will best serve patients in the future.

NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment (including the quantification and prioritisation of risk) is an important part of managing complex organisations.

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services.

Our Director of Estates and Facilities is the Board-level lead for sustainability. This ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Our performance

Facts and figures

St George's is a vibrant, multi-faceted and successful organisation. The following is not an exhaustive list, but gives a flavour of the trust, its size, activity, quality and services.

- **In 2013/14 the trust saw 641,569 outpatients, delivered 5,056 babies, undertook 43,183 elective inpatient and daycase procedures, had 131,071 attend A&E, and admitted 43,537 non-elective patients**
- **The trust is the major centre for tertiary services, including cardiovascular, neurosciences, renal, cancer, and specialised children's services for south west London and Surrey**
- **It is one of four Major Trauma Centres in London, and received 1,860 trauma calls in 2013/14**
- **The trust has a designated Heart Attack Centre, and was the first trust in London to provide primary angioplasty services 24 hours a day**
- **The trust has a designated large Hyper Acute Stroke Unit (HASU), providing an extremely high quality service, and received over 2,000 stroke patients in 2013/14**
- **The trust is co-located with, and a partner of, St George's University London (SGUL), in Tooting in the London Borough of Wandsworth**
- **St George's is one of only 14 trusts nationally to have fewer than expected deaths (under both the SHMI and HMSR methodologies)**
- **It had a turnover of £665m in 2013/14, on which it delivered a £4.7m surplus.**

Becoming a foundation trust

Our overall CQC rating of 'good' moved us closer to Foundation Trust Status this year. Becoming a Foundation Trust means that we have greater financial flexibility, are free from central government control and most importantly, will ensure we have stronger and more formalised involvement from our community and stakeholders.

We achieved our set target to reach a total public membership of 11,000 which we believe will give us a good representation of the communities served by the trust. Our staff are also members taking our membership to approximately 20,000 people. 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.

In the autumn of 2013, elections were held for the Council of Governors. A shadow council was established in 2014 and in line with guidance from Monitor, fresh elections were held now the trust is in the final stage of its application to become a Foundation Trust.

2013/14 in review

In February 2014 year the Care Quality Commission (CQC) – the independent regulator of health and social care services in England – undertook a rigorous inspection of services provided at St George's Hospital, Queen Mary's Hospital and St John's Therapy Centre.

The CQC inspectors focused on the following questions whilst scrutinising our services:

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

Trusts are scored either 'outstanding', 'good', 'requires improvement' or 'inadequate'. Around 60 inspectors, including doctors, nurses, hospital managers, members of the public, CQC inspectors and analysts, visited the trust. The CQC also held public events and spoke to stakeholders, staff and patients about their experiences of our services.

The CQC found the overall standard of care to be 'good' across all sites and awarded. St George's NHS Healthcare NHS Trust an overall 'good' rating. Inspectors found that services across the trust were safe and effective, and that patients were generally satisfied with the care they received.

See page 47 for full CQC results.

Below are some of the achievements and successes at St George's over the past year. To put them in to context we have grouped them under the 5 questions we were scrutinised by the CQC.

Are we safe?

Transfusion initiative named finalist in the HSJ Efficiency Awards 2013

The trust was listed as a finalist in the HSJ Efficiency Awards 2013 for an innovative blood transfusion initiative aimed at improving patient safety and saving money.

The project, led by the trust's transfusion team, aimed to improve transfusion practices and reviewed the use of blood in patients undergoing surgery at the trust. The team audited blood usage in all elective surgical cases and implemented a revised blood ordering schedule.

Additionally, patients with iron-deficiency anaemia were offered a nurse-led iron therapy service rather than treatment with a blood transfusion, in line with best practice and carrying a lower risk for patients.

These changes have resulted in a reduction of adverse reactions to transfusions by 30 per cent and savings of £300,000 per year for the trust, significantly reduced waiting times and maximized patient safety by reducing the clinical risks associated with transfusion

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/st-georges-transfusion-initiative-named-finalist-in-2013-hsj-efficiency-awards/**

Pioneering heart valve operation

A pioneering new heart valve that can be placed inside a patient without the need for open heart surgery was used for the first time in the UK by a team of cardiologists and heart surgeons at St George's Hospital.

Led by cardiologist Stephen Brecker and cardiac surgeon Marjan Jahangiri, the team successfully implanted the Medtronic Evolut R valve in two patients. Dr Brecker also acted as clinical advisor in the device's development.

Traditional trans-catheter aortic valve implants have been routinely used for the past six years to replace diseased or damaged valves that control the flow of blood out of the heart. If a valve doesn't fully open, it stems the flow causing excessive strain on the heart muscle, which can lead to heart failure and sudden death.

This new device prevents this and means quicker, safer and minimally invasive procedures with faster recovery time for patients.

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/pioneering-heart-valve-operation-avoids-open-heart-surgery/**

Pioneering new life-saving equipment

St George's Hospital pioneered the use of a new piece of surgical equipment that can control severe bleeding within seconds of being applied, which has helped save lives in the hospital's emergency department.

The 5cm iTClamp seals the edges of a wound creating a small cavity for blood which clots and so prevents further bleeding. This reduces blood loss until the patient undergoes surgery.

Prior to this, medical staff used blood clotting powders and treated bandages to stem haemorrhaging which is a major cause of death in major trauma cases.

St George's was the first emergency department in the UK to use the new Canadian produced equipment.

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/st-georges-pioneers-new-life-saving-equipment/**

Our mortality rates

The summary hospital-level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates for acute and non-specialist NHS trusts. The SHMI gives the ratio between the actual number of patients who die compared to the expected number given the characteristics of the patients treated.

SHMI covers the deaths of all admitted patients who either die in hospital or within 30 days of being discharged, and shows whether the number of deaths at an organisation is more or less than would be expected compared to average national mortality figures. It also shows whether that difference is statistically significant.

How did we do?

This year our mortality rates for both SHMI and HSMR are again amongst the best in the country.

The Dr Foster Hospital Guide 2013 identified St George's as being one of only 19 trusts in the country to have statistically significant lower than expected mortality as measured by the SHMI and the HSMR for 2012/13.

St George's has been named in this elite group of trusts every year since mortality data started to be published, demonstrating that St George's is one of the safest trusts in the country and that the most complex and seriously ill patients are more likely to survive at St George's than at most other trusts in the country.

Are we caring?

Students with learning disabilities supported through work placements

In November 2012 we entered into a partnership with Cricket Green School in Mitcham and Action on Disability to offer a training and employment programme for adults with learning disabilities through Project SEARCH.

The aim of the project is to provide real life work experience for students to build their confidence and ensure they gain competitive and marketable skills, with the ultimate aim of securing paid employment.

As part of their 35 week training, the trainees receive support with literacy, learning about the world of work, how to complete application forms, handle job interviews and apply for work. They

also have a workplace mentor who helps them to learn the basics of the job and provides the necessary support.

During 2013/14, St George's Healthcare NHS Trust supported five trainees in work experience placements across the trust.

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/project-search-students-experience-st-georges-work-placements/**

Patient award for stoma care department for dedication and support for patients

The trust's stoma care department received a Purple Iris Award from the Colostomy Association for its dedication and support to its patients. Nominations for this award are made by patients and their families.

The department was nominated for the award by a patient who had undergone a urostomy and colostomy, in recognition of its outstanding care and exemplary service.

The award was presented at the Colostomy Association's patient open day event in July 2013.

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/st-georges-stoma-care-department-wins-special-patient-award/**

Friends and Family Test figures showed vast majority recommend St George's

On 30 July 2013, the Friends and Family Test results were released nationally and showed that the majority of patients treated at St George's Healthcare NHS Trust, who had fed back via the Friends and Family Test, would recommend the trust to friends or family.

The figures from June recorded that 583 out of 837 former inpatients were 'extremely likely' to recommend treatment at St George's and 214 were 'likely' to.

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/vast-majority-of-patients-recommend-st-georges-to-friends-and-family**

Are we responsible?

Award for osteoarthritis research for consultant rheumatologist

A clinician at St George's Hospital won a national award for her work leading research into osteoarthritis, the world's most common form of arthritis.

Dr Nidhi Sofat, consultant rheumatologist, was awarded the Michael Mason Prize in Rheumatology by the British Society of Rheumatology (BSR) in recognition of her innovative work in rheumatology research.

She undertook research in understanding osteoarthritis pathophysiology over the last 10 years which received national recognition. The research highlighted the importance of understanding the mechanisms underlying this most common arthritic disease.

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/st-georges-consultant-wins-prestigious-award-for-osteoarthritis-research/**

Award for outstanding contribution to the field of paediatric psychology

Head of paediatric psychology, Dr Gillian Colville, at St George's paediatric intensive care unit, was recognised for her outstanding contribution to her field.

Dr Colville received the Judith Houghton Award from the Paediatric Psychology Network, a sub-section

of the British Psychology Society, in recognition of her significant contribution to the development and recognition of this area of practice.

She works with children and their families at the trust and has been involved in research, such as the psychological impact of critical illness on children and their families on the paediatric intensive care unit. Dr Colville has also been awarded funding for a number of projects, including a study examining what children remember about their admission and how commonly they experience hallucinations in this setting. Additionally she has evaluated the benefits of follow-up care on parents' post-traumatic stress symptoms.

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/award-of-excellence-for-st-georges-paediatric-psychologist/**

Campaign by midwife for FGM awareness and support for affected women

A midwife at St George's Hospital began campaigning for more support for women affected by female genital mutilation (FGM).

Denise Henry, a specialist perineal midwife at St George's Hospital, championed a number of initiatives across south west London, including a new publication to educate GPs and practice nurses in Wandsworth about the harmful consequences of FGM, the law relating to this practice and how to report any incidents.

A midwife for 23 years, Denise has supported women who are victims of FGM and have been referred by the antenatal clinic at St George's Hospital. As part of a service she launched in December 2013, twice-monthly sessions were held to give support and advice to pregnant women facing serious health risks as a result of genital mutilation.

Denise has shared her expertise with colleagues at St George's Hospital where she has given comprehensive training on supporting FGM victims to all midwives at the trust. She has also worked on a national level, contributing to guidelines on the prevention and treatment of FGM.

Read the full story: **https://www.stgeorges.nhs.uk/newsitem/st-georges-midwife-campaigns-for-better-fgm-support/**

Are we effective?

International honour for the St George's blood pressure unit

The blood pressure unit at St George's Hospital was recognised as a hypertension centre of excellence in June 2013.

Staff from the unit were commended for their high level of skill and their ability to investigate, diagnose and treat large numbers of patients, some of whom have very complex medical needs.

The prestigious title was awarded by the European Society of Hypertension, an organisation committed to the prevention of hypertension and cardiovascular problems.

There are 154 centres worldwide that currently hold this impressive accreditation. The St George's unit is the only one of its kind in the region and was one of only five units to be awarded the status in 2013.

Dr Tarek Antonios, the unit's lead consultant, said: "This accreditation is an honour and recognises the high standard of care we provide to our patients. It is also a testament to the quality and expertise of our fantastic nursing and medical staff."

UK's first 'Firefly' kidney surgery performed at St George's

St George's Hospital was the site of pioneering world-first surgery in May 2013.

The da Vinci robotic surgical technique was developed to increase the accuracy of removing cancerous tumours from the kidney. It does this by utilising a new 'Firefly' technology which is able to label the tumour blood vessels with a green dye. By knowing the exact pattern of blood supply to the tumour the surgeon can remove the tumour precisely, therefore sparing as much healthy kidney tissue as possible which is turn allows the organ to maintain the highest degree of function it can.

Chris Anderson, consultant urologist at St George's, said: "Partial nephrectomy is a complex operation and requires excision of the tumour and reconstruction of the remaining healthy kidney. Using this latest technology we are able to achieve this better than has been possible in the past. It is an excellent innovation and we are fortunate to have been part of the pioneering process of this technique in the UK."

St George's heart attack team shortlisted for BMJ awards

The St George's heart attack team were one of only five teams shortlisted nationally for the 'Cardiovascular Team of the Year' award at the 2013 British Medical Journal (BMJ) Group Improving Health Awards.

This prestigious category recognises cardiovascular medicine teams, who, with constantly evolving treatments are translating knowledge into improved care for patients suffering from heart and circulatory diseases.

St George's Hospital is one of the biggest and busiest of the seven specialist heart attack centres in the capital. The heart attack centre provides a 24-hour emergency angioplasty service as well as general diagnosis, medical treatment and outpatient services for all heart disorder patients across south west London and east Surrey.

The specialised heart attack team was created in July 2011. Made up of doctors and nurses from cardiology, anaesthetics and intensive care, this multidisciplinary approach to patient care greatly improved outcomes and survival rates for heart attack patients.

Rebuilding faces with new technology

Maxillofacial surgeons at St George's Hospital used innovative computer technology to help rebuild a patient's face.

Ann O'Sullivan, 69, went to see her GP about a sinus problem only to discover she had an aggressive tumour spreading undetected across the left side of her face. Removal of the tumour saved her life but cost a large portion of her jaw, her left eye and numerous teeth.

Surgeons utilised new technology to electronically scan the undamaged side of Ann's face so that they could generate a 3D template, which could act as a guide during the surgery to rebuild her face.

Dr Mr Kavin Andi, one of two St George's surgeons involved in the operation, said the use of 3D imaging meant much of the preparatory work was carried out 'virtually' on a computer so he knew exactly what needed to be done before going into surgery.

He added: "We are lucky at St George's because we are a world leader in this field of work. The 3D imaging means I can look at the tumour from different angles and take the necessary measurements including how and where bone is removed and re-sculpted."

Perfect Week, 26th March – 2nd April

The Perfect Week was a week-long improvement initiative designed to create capacity and improve patient flow across the trust.

The initiative was organised in response to operational difficulties caused by a significant increase in the demand for acute care in the trust.

During the week there was a dedicated team, made up of senior managers, clinical leads, IT and estates staff, responding to issues raised by clinical staff that were blocking a patient from moving on to the next stage of their journey.

This allowed the trust to deliver the most effective care to our patients and provide a better working environment for staff as well as highlighting areas for further improvement. Over the course of the week 359 out of the 389 issues were resolved and escalation beds were clear for the majority of the week.

Are we well led?

New university-NHS alliance to improve healthcare in south London

A strategic alliance sharing best practice in research and the education and training of students and health professionals was agreed between King's Health Partners Academic Health Sciences Centre and St George's Healthcare NHS Trust Board and St George's, University of London in July 2013.

By working together the alliance aims to make a significant and lasting impact on health and healthcare in south London. This will be in part achieved by contributing leadership to new organisations such as Health Education South London (Local Education and Training Board) and the South London Academic Health Sciences Network (AHSN) but also by identifying additional opportunities and synergies which can be delivered through joint work programmes locally.

Miles Scott, chief executive of St George's Healthcare NHS Trust, said: "This alliance further cements St George's position at the forefront of research and innovation and will help us to further improve the quality of our services as well as addressing the important public health issues that face people living and working in south London."

Staff celebrate at awards ceremony

In November 2013 we celebrated the achievements of Tom Magill, Bernard Kelly and Helen Webb who all reached the finals of the NHS Leadership Recognition Awards.

Tom's real-time survey system was shown to help senior nurses deliver better care and was acknowledged as a model of good practice by NHS England and adopted by several other NHS trusts.

The HIV forum, which was set up by Bernard and Helen, meets four times a year, representing the interests of more than 1,600 patients living with HIV who receive treatment and support through St George's Hospital.

Dr Pakianathan a Genitourinary consultant said: "Something we all do at one time or another is make assumptions about what we think other people know and want. The patient forum has helped us focus on what really matters to our patients and respond quickly. Patients have been surprisingly understanding about the pressures we face as a department and offered some good insights into improving our day-to-day working practices."

New Pathology Service formed for south west London

Chief executives on behalf of the Boards of Croydon Health Services NHS Trust, Kingston Hospital NHS Foundation Trust and St George's Healthcare NHS Trust met in March 2014 to sign an agreement which joined their current pathology services to form a new pathology partnership called South West London Pathology.

The service went live in April and is now jointly owned and managed by all three trusts. It provides pathology services to two million people across south west London and has been set up as a 'hub and spoke' delivery model, which was recommended as good practice by the Carter review of NHS pathology and the Modernising Pathology in London Programme.

The main hub laboratory is at St George's Hospital with spoke laboratories or 'hot labs' at both Croydon and Kingston. This way of working enables local knowledge and clinical expertise to be retained within each trust, and improves both the quality and efficiency of pathology services for hospitals and for GPs across south west London.

Training dentists to brush up on their skills

A state-of-the-art dental simulation suite opened at St George's Hospital in December 2013.

The £350,000 facility includes 15 tutor/student work stations along with 'phantom head' simulators linked to video enabled surgical operating microscopes. There is also touch screen technology and internet cameras offering live link teaching with the maxillofacial unit.

It is used to train foundation dentists, dental core trainees, specialist consultants and general dental practitioners.

Peter Briggs, foundation training programme director for south London and a consultant in restorative dentistry, said: "This is a step forward for the hospital which now offers some of the most modern dental training facilities in the capital. The suite offers a safe learning environment where dentists can learn new techniques, fine-tune their skills and bench mark themselves against others".

Quality improvement strategy

In 2013/14 we agreed a new Quality Improvement Strategy which centres on the three essential domains of safety, experience and outcomes. We agreed six commitments against each domain which illustrate how we will achieve improvements in quality at St George's:

Improving patient safety

- **We will promote a culture of zero tolerance through challenging unsafe practice**
- **We will establish strong multidisciplinary teams who communicate clearly across boundaries**
- **We will encourage involvement of patients in patient safety initiatives**
- **We will give timely and relevant feedback to teams to enable staff to be knowledgeable about patient safety**
- **We will promote an open and transparent culture where we listen and act on staff concerns**
- **We will create reliable processes to reduce avoidable harm**

Improving patient experience

- **We will listen to and involve people who use our services**
- **We will use feedback as a vehicle for continuous improvement, adopting best practice where possible**
- **We will ensure that our patients are cared for in a clean, safe and comfortable environment**
- **We will ensure that our most vulnerable patients and service users are listened to and protected from harm**
- **We will protect patients' dignity by ensuring that we comply with the national requirements to eliminate mixed sex accommodation**
- **We will focus on the fundamentals of care that matter to patients (privacy, dignity, nutrition, hydration etc)**

Improving patient outcomes

- **We will evaluate clinical audit results and act on findings to ensure audit contributes to improvements for patients**
- **We will support staff to improve outcomes by provision of training and expert support**
- **We will evidence that we are clinically effective and implementing evidence based best practice**
- **We will communicate outcomes, promoting shared learning and prioritisation of improvement projects**
- **We will fully participate in national clinical audits and use results to improve local practice**
- **We will achieve best practice in all clinical areas so that patients have the best possible outcome**

Our four clinical divisions took these commitments and translated them into Quality Improvement Plans specific to their patients and services. The implementation of these plans will was overseen by our Quality and Risk Committee, which is responsible for monitoring quality at the trust.

Our quality priorities

For 2013/14 our quality priorities were as follows:

Improving patient safety

- **Reduce incidence of hospital related venous thromboembolism (VTE)**
- **Reduce incidence of Healthcare associated infection within agreed targets, MRSA (0) and C diff (52)**
- **Reduce incidence of newly acquired category 2,3 and 4 pressure ulcers**
- **Reduce the number of medication errors causing serious harm**
- **Reduce the number of falls in the community by 5%**
- **Roll out the early warning score indicator system in the Jones Unit at HMP Wandsworth**

Improving patient experience

- **Minimise mixed sex accommodation breaches**
- **Increase the number of patients (who are able and willing) who return real time feedback including FFT by 10% across the trust**
- **Achieve and maintain the initial 15% return rate for the Friends and Family test in 2013/14 and aim to increase in line with agreed national trajectories until 2017**
- **Increase the proportion of patients who would recommend us to a family member or friend (FFT)**
- **Respond to 80% of all complaints within 25 working days or less (100% with an agreed extension)**
- **95% of community learning disability patients to be seen within four weeks of referral**

Improving patient outcomes

- **We will continue to achieve lower than expected mortality rates (less than 100 using the Summary Hospital Mortality Indicator)**
- **Reduce readmissions following a non-elective admission**
- **Reduce readmissions following an elective admission**
- **50% of secondary schools in Wandsworth to have sexual health support at school**
- **Implement clinical outcome measures reporting in community services**

Quality Account

Statement on Quality by Miles Scott Chief Executive

There is no simple way to define quality, especially for a large organisation with such a wide spectrum of services and more than one million patient contacts every year.

However, what is clear is that the people who matter and the organisations that scrutinise us think we are a robust organisation and that the quality of our services is strong beyond doubt. More than 95% of our patients have told the Department of Health that they would recommend St George's as a place to receive treatment and be cared for through the Friends and Family Test.

In the latest edition of the National Staff Survey, our staff ranked as being among the most highly motivated in the country and in the highest band for staff who feel proud of their trust and would recommend that their friends and family receive care there.

The Care Quality Commission has declared that we are meeting every one of the essential domains of care following their latest unannounced inspection.

We achieve these high levels because our culture means that we always look at how we can improve. We have a continuing desire to find ways to make things better for our patients. Sometimes those improvements are significant developments that are noticeable for everybody.

Our new helipad will help the most seriously injured and ill people from across the south east of England receive the expert life-saving care they need sooner. Sometimes the improvements are less obvious but equally important, like improving our discharge planning processes so that patients are less likely to have to return to hospital for further treatment after going home.

2014/15 promises to be one of the most important in our history as we go through the final assessment phase of our application to become a Foundation Trust.

In 2010 we were still paying off the final instalments of a historic debt to the Department of Health. Now we are one of the most financially stable NHS organisations in London, and our financial management over the years has given us the ability to invest in facilities and staff, which lead to improved patient safety, experience and outcomes.

Since the last Quality Account, we have also opened new facilities for patients undergoing surgery, enhanced our already state-of-the-art medical and dental simulation training facilities and added to our leading cardiac intensive care unit and catheter labs. Continued investment in our services at both St George's and Queen Mary's Hospitals and in the community is key to our plans for the future of the trust. More details can be found in the Quality Account 2013/14 **https://www.stgeorges.nhs.uk/wp-content/uploads/2014/07/St-Georges-Healthcare-NHS-Trust-Quality-Account-2013-14.pdf**

As a Foundation Trust we will be formally accountable to our members, who now number more than 20,000. If you are not yet a member, I strongly encourage you to sign up so you can influence our future by contacting our Membership Office on 020 8725 6132 or at members@stgeorges.nhs.uk

Our quality performance

All NHS trusts report the same information which allows us to benchmark our performance against other trusts. This is important for not only letting us know how we are doing, but means that trusts with similar services can learn from each other.

Every year each trust publishes their performance in the annual Quality Account. The Department of Health and Monitor produce guidance on what should be reported in the Quality Account for NHS trusts and NHS Foundation Trusts (FTs). As an aspiring FT, we decided to follow the Monitor guidance, which covers all aspects of the Department of Health guidance plus additional criteria.

Every NHS trust in the country has to report against the mandatory indicators listed below:

- **Review of services**
- **Participation in clinical audits**
- **Research**
- **Use of Commissioning for quality and innovation (CQUIN) payment framework**
- **Statements from the Care Quality Commission**
- **Data quality**
- **Information governance toolkit attainment levels**
- **Clinical coding error rate**
- **Mortality rates**
- **Patient reported outcome measures**
- **Emergency readmissions**
- **Staff who would recommend the trust to friends and family**
- **Cancer referrals**
- **Friends and family test (new for 2013/14)**
- **Responsiveness to patient's needs**
- **Patient safety incidents**
- **Infection control**
- **VTE rates**

Trusts are also encouraged to identify at least three voluntary indicators to include in their Quality Accounts. Because St George's is one of the largest trusts in the country, providing the full range of hospital and community services, for the last three years we have reported on a much larger number of voluntary indicators in a bid to better reflect the services we provide and the patients we care for. This year we have taken the same approach.

We worked with local stakeholders to identify which indicators to include in this year's Quality Account to make sure that the areas that matter most to the people who use and provide our services are covered. These stakeholders included our patient reference group, our staff, local Clinical Commissioning Groups (CCGs), Wandsworth Healthwatch and Wandsworth Council.

The voluntary indicators we have chosen to include in this Quality Account fit into the three essential domains of our Quality Improvement Strategy – improving patient safety, improving patient experience and improving patient outcomes.

Improving patient safety voluntary indicators:

- **Medication errors**
- **Patient falls**
- **Patient safety thermometer**
- **Offender healthcare**

Improving patient experience voluntary indicators:

- **Community learning disability referrals**
- **Complaints**

Improving patient outcomes voluntary indicators:

- **Sexual health in secondary schools**
- **Clinical outcome measures in community services**

As well as grouping the voluntary indicators together under the same three essential domains of our Quality Improvement Strategy, we have also stated which of the CQC's five domains apply to

each indicator. The five CQC domains are:

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

A draft Quality Account was shared with stakeholders throughout its development, 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 Trust Board
- St George's Patient Reference Group
- Wandsworth Healthwatch
- Merton Healthwatch
- South London Commissioning Support Unit
- Wandsworth CCG
- Merton CCG
- Wandsworth Council Adult Care and Health Overview and Scrutiny Committee
- Merton Council Healthier Communities and Older People Overview and Scrutiny Panel

Sharing a draft version of the report with our stakeholders has given them the opportunity to provide a feedback on our performance in a formal statement.

To put our performance into context we have compared our performance for all of the indicators in this report against our own performance over the last two years, and where possible and relevant, against the national average performance as published on the Health & Social Care Information Centre **www.hscic.gov.uk**

Dashboard – our performance against all indicators

The following table details a summary of our performance against all mandatory and voluntary indicators published in the Quality Accounts. We have also stated which of the CQC's five domains apply to each indicator.

You can read the full Quality Account which includes a comparison of our previous years performance for most indicators on our website at **www.stgeorges.nhs.uk/aboutus/news/publications/qualityaccount**

Key

- Achieved our aims and/or targets
- Part achieved our aims and/or targets
- Did not achieve our aims and/or targets
- 123 Page where more information can be found within the Quality Account available from St George's Website
- s Relates to Care Quality Commission 'safe' essential domain
- e Relates to Care Quality Commission 'effective' essential domain
- c Relates to Care Quality Commission 'caring' essential domain
- r Relates to Care Quality Commission 'responsive' essential domain
- w Relates to Care Quality Commission 'well-led' essential domain

Priority	Status	Page	CQC essential domains
London Quality Standards	●	15	s e c r w
Participation in clinical audits	●	25	s e r w
Increase number of patients taking part in research projects	●	26	w
Use of CQUIN payment framework	●	30	s e c r w
Maintain information governance toolkit band	●	31	w
Data quality	●	33	w
Clinical coding error rate	N/A	36	w
Statement from the Care Quality Commission	●	37	s e c r w
Patient safety incident reporting	●	42	s e c r w
Never events	●	43	s e c r w
Improving clinical communication systems	●	44	s e c r
Implement the national safety thermometer	●	44	s e c r
Reducing medication errors	●	44	s e c r
Reducing patient falls	●	49	s e c
Reducing rate of C.diff infections	●	51	s e c w
Reducing rate of MRSA infections	●	51	s e c w
Assessing risk of VTE in admitted patients	●	54	s e c
Root cause analysis of VTE cases	●	54	s e c r
Implement the early warning score indicator at HMP Wandsworth	●	57	s e c r
Reduce grade three and four pressure ulcers	●	58	s e c w
Increase the return rate for Friends and Family Test	●	62	r w
Increase the number of patients who would recommend us to friends and family	●	62	e c w
Respond to 85 per cent complaints within 25 days	●	70	e c r w
Increase number of community learning disability referrals seen within four weeks of referral	●	75	c r w
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	●	78	s e c r w
Staff who would recommend the trust to friends or family	●	79	s e c r w
Maintain lower than expected mortality rates	●	84	s e c r w
Improve participation rates for patient reported outcome measures	●	87	e r
Implement clinical outcome measures in community services	●	87	e r
Increase sexual health support in Wandsworth secondary schools	●	90	e c r
Reduce hospital readmissions	●	92	s e c r

Our clinical and operational performance

The trust continues to work hard to ensure that all aspects of performance improve and the trust is proud, though not complacent, of its progress and achievements over the past years. Being a large and complex organisation – a tertiary centre, a major trauma unit, a large A&E, and a wide ranging portfolio of services – there are greater risks to the routine delivery of day to day operational and financial targets than in many other trusts.

Clinical and operational performance

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

2013/14 was a particularly challenging year across a range of targets, with the trust narrowly failing the A&E 4 hour wait target and the cancer 62 day treatment target. Whilst the total number attending A&E has fallen, following the closure of the trust walk-in centre, the acuity of patients attending has increased, with more non-elective admissions from a smaller number of total attendances. The trust has significantly increased A&E staffing, both medical and nursing, over the last few years, and the trust is working both internally and with external partners, to ensure that it returns to a position of robust delivery of this key target. The trust has put in place an action plan to address the 62 day cancer treatment target, and was pleased to note that in Q4 of 2013/14 the trust achieved the 85% target.

The trust was pleased with its infection control performance and mixed sex accommodation breach performance in 2013/14, all of which showed an improvement on the 2012/13 position. However, with the demand rising, patient expectation rising, complexity of activity increasing and NHS funding remaining broadly static, the trust does not underestimate the challenge on meeting key targets over the coming years and delivering strong financial performance.

The trust met a challenging target to bring its 18 week Admitted Patient Care target back above target. The trust had agreed with local commissioners a trajectory to bring performance back above the 90% target by the end of quarter two 2012/13, and figures for quarter three show the trust has achieved this requirement, and maintained performance since.

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

Measure	Target or Threshold	2013/14 Performance
A&E 4 hour performance	Target	**94.5%** (95%)
Cancelled operations for non-clinical reasons – less than 0.8%	Target	**1.3%** (>0.8)
Admission within 28 days of cancellation – The target is that less than 5% of patients should be admitted after 28 days, with 95% admitted before 28 days	Target	**5.9%** (<5%)
Cancer – patients seen within 14 days of GP referral	Target	**97.5%** (93%)
Cancer – patients receiving first definitive treatment within 31 days of a decision to treat	Target	**97.6%** (96%)
Cancer – patients receiving first definitive treatment within 62 days of original GP referral	Target	**83.7%** (85%)
MRSA Bacteraemias (blood stream infections)	Threshold	**7** (0 with de minimis of 6)
C.difficile cases	Threshold	**30** (45 cases)
Mixed Sex Accommodation	Threshold	**79** breaches (0 breaches)

Date	18 Week Admitted Patient Care	18 Week Non-admitted patient care
Quarter 1 2013/14	90.5	97.9
Quarter 2 2013/14	91.6	97.9
Quarter 3 2013/14	92.6	97.6
Quarter 4 2013/14	90.3	97.1

Leadership

Our board

Setting strategic direction and objectives

Our Board's primary role is to set the trust's strategic direction and objectives, ensure delivery of these within planned resources, and oversee the trust's performance. The Board is made up of a chairman, six non-executive directors and eight executive directors (four voting and four non-voting).

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's 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.

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 fulfill its leadership responsibilities for healthcare of the local community**
- **Ensuring that the Board sets challenging objectives for improving its performance across the range of its functions**
- **Monitoring the performance of the executive team in meeting the agreed goals and improvement targets**
- **Ensuring that financial controls and systems of risk management are robust and that the Board is kept fully informed through timely and relevant information**
- **Accountability to NHS England for the delivery of the trust's objectives and ensuring**

that the board acts in the best interests of its local community

- **Taking part in the appointment of executive and other senior staff**
- **Ensuring that the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business.**

Non-executive directors, including the chairman, are appointed by the Trust Development Authority. Non-executive appointments are approved by the trusts nominations and ruminations committee. All Board appointments are made using fair and transparent selection processes with specialist human resources input. When appointing to the Board, due consideration is given to the range of skills and experience required for the running of the trust.

Each year every member of the Board has a formal appraisal process. During this appraisal the Board member's strengths, aspirations and learning and development needs are reviewed.

Declarations of interest

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is also 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. The following interests are required to be declared by all members of staff, including members of the Board.

Register of interests

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

Executive directors 2013/14

Miles Scott

Chief Executive

Declared Interests

Higher Education Funding Council for England Healthcare Advisory Board

National Institute for Health and Care Excellence

Collaboration for Leadership in Applied Health Research and Care

Clinical Research Network

Health Innovation Network

Health Education South London

Steve Bolam

Director of Finance, Performance & Informatics

Declared Interests

None

Dr Ros Given-Wilson

Medical Director

Declared Interests

Medical Adviser, Gibraltar Health Authority

Peter Jenkinson

Director of Corporate Affairs

Declared Interests

None

Dr Trudi Kemp

Director of Strategic Development

Declared Interests

None

Professor Alison Robertson

Chief Nurse and Director of Operations

Declared Interests

None

Wendy Brewer

Joint Director of Human Resources

(Joint post with St George's University of London)

Declared Interests

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

Neal Deans

Director of Estates and Facilities

(Joint post with St George's University of London from Sept 2012)

Declared Interests

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

Non-Executive directors

Christopher Smallwood

Chairman

Declared Interests

None

Membership of Committees

Nominations of Remunerations

Finance performance and Information

Commercial Board

FT Programme Board

Professor Peter Kopelman

Declared Interests

Governor, Kingston University Director, INTO – SGUL LLP

Deputy Chair & Trustee, London Higher Chair, Faculty Board, Royal Pharmaceutical Society

Membership of Committees

Workforce Quality and Risk Nominations and Remunerations

Mike Rappolt

Declared Interests

Chairman of Wimbledon Civic Theatre Trust (resigned January 2014)

Various Shareholdings (all under 1% of company)

Membership of Committees

Audit

Nominations of Remunerations

Finance, Performance and Information

Sarah Wilton

Declared Interests

Non-executive Director of Capita

Managing Agency and of Hampden Members' Agency.

Director/trustee and Vice Chair of Paul's Cancer Support Centre

Magistrate at South West London Magistrates' Court

Membership of Committees

Audit

Quality and Risk

Nominations and Remunerations

Finance, Performance and Information

FT Programme Board

Dr Judith Hulf

Declared Interests

Responsible Officer and Senior Medical Advisor, General Medical Council

Membership of Committees

Audit

Quality and Risk

Nominations and Remunerations

Stella Pantalides

Declared Interests

Consulting – General Dental Council and various private sector companies.

Membership of Committees

Workforce

Nominations and Remunerations

Finance, Performance and Information

Kate Leach

Associate Non-Executive Director

Declared Interests

Director of Kate Leach Consulting

Membership of Committees

Workforce

Commercial

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 trust also has standing financial instructions (SFIs) that outline individual's authority and duties in any procurement process.

Audit committee

The Audit committee is a committee of the board of directors. The committee has four main roles;

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

Grant Thornton were appointed as our external auditors in November 2012 following a competitive tender process. Prior to this, our external audit service was provided by the Audit Commission. The audit committee reviews the work and findings of the external auditor and considers the implications and management's responses to their work.

Fees for the year are shown below

Expenditure	2013/14	2012/13
External Audit Fees	169,000	188,000
Other External Auditors Renumeration	0	0
Total	169,000	188,000

Directors' statements

Statement of the Chief Executive's responsibilities as the Accountable Officer of the trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

nb: sign and date in any colour except black

Signed..... Chief Executive

Date 6.VI.14

Statement of Directors' responsibilities in respect to the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

nb: sign and date in any colour except black

6.VI.14 Date ..... Chief Executive

06/06/14 Date ..... Finance Director

Annual governance statement 2013/14

Scope of responsibility – Miles Scott – Chief Executive

The Board is accountable for governance in St George's Healthcare NHS Trust. As Accountable Officer and Chief Executive of this Board, I have responsibility for maintaining a sound system of governance including internal control that supports the achievement of the organisation's policies, aims and objectives. I am also responsible for the propriety and regularity of accounting for the public funds entrusted to this organisation as set out in the Accountable Officer Memorandum.

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

This statement covers the financial year April 2013 – March 2014 and the period leading up to the date of the auditor's report (6 June 2014).

Governance Framework

The trust has an integrated governance approach to ensure decision-making is informed by a full range of corporate, financial, clinical and information governance and ensures compliance with the five main principles of the Corporate Governance Code: Leadership, Effectiveness, Accountability, Remuneration and Relations with Stakeholders. This governance framework spans from 'Board to Ward'.

There is an established and robust governance framework, supported and maintained by a framework of committees. The trust Board (the 'Board') has overall responsibility for the effectiveness of the governance framework and as such, requires that each of its sub-committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and process for assessing and monitoring effectiveness.

The Board itself has standing orders, reservation and delegation of powers and standing financial instructions in place which is reviewed annually. As the Accountable Officer, I support the Chairman in ensuring the effective performance of the Board and its sub-committees. I achieve this in a number of ways:

- **Monitoring attendance**
- **Maintaining an overview of the quality of the presented information, including agenda items and supporting evidence**
- **Requesting the attendance of representatives from across the trust as and when required**
- **Ensuring that there is an annual declaration of interests by the members**
- **Ensuring that each of the Board Sub-Committees reviews its own performance and reports this to the Board.**

Senior leadership in corporate governance is provided by the Director of Corporate Affairs through the trust's Compliance Unit. Governance is embedded across the corporate directorates and clinical divisions, led by directors or divisional chairs, thus ensuring clear responsibility and accountability across the trust.

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

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

Quality Governance in St George's Healthcare NHS Trust

As an NHS Trust, patients are at the heart of everything that we do and hence our mission is

"To provide excellent clinical care, education and research to improve the health of the populations we serve."

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

- **Kind**
- **Excellent**
- **Respectful**
- **Responsible**

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

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

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

- **Patient safety – quality care is care which is delivered to reduce or eliminate all avoidable harm and risk to the individual's safety**
- **Patient experience – quality care is care which seeks to give the individual as positive an experience of receiving and recovering from care as possible**

  Patient outcomes (clinical effectiveness) – quality care is care which is delivered according to best evidence as to what is clinically effective in improving an individual's health outcomes.

Roles and responsibilities for Quality Board Members

Responsibilities for quality are shared across the Director of Corporate Affairs, the Chief Nurse and the Medical Director:

- **The Chief Nurse is responsible for patient safety and patient experience;**
- **The Medical Director is responsible for patient outcomes;**
- **The Director of Corporate Affairs is responsible for ensuring that there is a robust governance system in place to support the delivery of quality across these three domains.**

Domains of Quality

Patient Safety (Chief Nurse)

Patient Experience (Chief Nurse)

Patient Outcomes (Chief Nurse)

Supported by

Quality Governance (Director of Corporate Affairs)

Chief Nurse

The Chief Nurse has Board level responsibility for professional nursing and midwifery issues and provides strong leadership to the nursing profession. She also has the role of Director of Infection Prevention and Control for the trust, and is the trust Board lead for adult and children's safeguarding.

The principal responsibilities of the Chief Nurse include the following:

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

Medical Director

The Medical Director, supported by Associate Medical Director (Clinical Governance) has a pivotal role, in partnership with Clinical Directors and Service Delivery Leaders, in extending the influence and understanding of medical staff in the development of the trust. Her role and responsibilities include:

- **Responsibility for the formulation of safe and efficient medical staffing policy and practice supported by the Associate Medical Director for HR**
- **Overseeing the formulation and implementation of medical research and education policies, practise and strategies supported by Associate Medical Director (AMDs) for education and training and research**
- **The trust's Caldicott Guardian and is therefore responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing**
- **Responsible Officer for the trust.**

Director of Corporate Affairs

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

Board Sub-Committees

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

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

Quality and Risk Committee

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

In respect of its role in quality, the committee will also oversee and monitor the implementation of systems to underpin quality (including clinical governance and patient safety). It shall:

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

The main source of assurance for the QRC comes from key components of the trust's quality governance framework – the three governance committees: Patient Safety Committee, Patient Experience Committee and Organisational Risk Committee. They can be considered as the fulcrum of the flow of information between the Divisions and the Board.

Patient Experience Committee and Patient Safety Committee

The Patient Experience and Patient Safety Committees are executive committees established to reduce avoidable harm and to improve the patient experience. Both of these committees are chaired by the Chief Nurse and Director of Operations with membership that reflects the purpose of each committee as described in their respective terms of reference.

The Divisions are represented by the Divisional Directors of Nursing and Governance, or appropriate senior clinician from each Division to ensure that the flow of governance is strong between the Divisions and corporate structure of Board and sub-committees.

Organisational Risk Committee

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

Board initiatives

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

- **Introduction of patients' stories, including incidents and complaints at Board meetings**
- **Divisional presentations presented at public Board meetings, focusing on quality aspects of different services and specialities**
- **Introduction of Quality Inspections.**

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

The divisional management structure

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

- **Evidence-based clinical practice is in place and audited**
- **Accountability for service and financial performance**
- **Good practice is systematically disseminated**
- **Effective management of risk**
- **When adverse incidents and complaints occur they are investigated within the agreed timescales and lessons learnt disseminated and embedded**
- **Poor clinical practice is identified and dealt with to prevent harm to patients**
- **Leadership skills are developed within the clinical team and the organisation**
- **Professional development programmes reflect the principles of clinical governance and support the delivery of the trust's objectives**
- **High quality data are collected to monitor clinical care and performance**
- **Compliance with the Care Quality Commission standards for quality and safety, and other external standards and regulatory requirements.**

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

The Divisional Chair is supported by a Divisional Director of Operations (a full-time manager) and a Divisional Director of Nursing and Governance. Other members of the supporting management team include Clinical Directors, who are responsible for the delivery of clinical services for specific care groups, General Managers, Heads of Nursing, a Management Accountant and a Human Resources Manager.

Professional leadership is provided to medical staff within the Divisions by the Medical Director and Associate Medical Directors, through the Divisional Chairs, where these are doctors. Professional leadership is provided to nurses and midwives by

the Chief Nurse, through the Divisional Directors of Nursing and Governance, the Director of Midwifery or Chief of Therapy.

Divisional management/ governance boards

Each division has a Divisional Management Board (DMB) established to review and monitor the implementation of the Division's strategies and business plans.

Each Division also has a Divisional Governance Board (DGB) established to support the DMB in ensuring an integrated approach to quality, risk and patient safety. The DGB is chaired by the Divisional Chair and is responsible for:

- **Setting and monitoring implementation of the division's quality improvement strategy**
- **Monitoring of all aspects of clinical governance and clinical/non clinical risk within the division and ensuring that lessons are learnt from adverse incidents or complaints and corrective action plans are put in place**
- **Providing leadership, focus and consensus on key aspects of quality, risk and patient safety, based upon expertise within the division**

  Providing assurance to the board that high quality, safe, effective treatments and services are provided to patients and that risk to staff and visitors is minimised
- **Reviewing external sources of assurance and ensuring that compliance with regulations are maintained**
- **Ensuring evidence provided for continued compliance with CQC standards.**

As well as regular reporting to and contribution from each division to Patient Safety Committee (PSC), Patient Experience Committee (PEC) and Organisational Risk Committee (ORC), the divisions present six-monthly reports regarding quality related performance to the PSC and PEC and two monthly reports regarding risk as part of the risk register reviews to the ORC. These reports are presented by the Divisional Directors of Nursing and Governance and provide for the escalation of significant risks and issues up the committee structure, to the trust Board, as appropriate.

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

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

Quality reporting and monitoring

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

The Quality Account

Introduced in 2010, the trust produces an annual Quality Account. This is a quality focused report, approved by the trust Board and published on the trust website. The Accounts look at the three domains of quality: patient safety, clinical effectiveness and patient experience. The primary aim is to support the NHS in improving the quality of healthcare services by improving the organisation's accountability to the public. You can view the full Quality Account at **https://www.stgeorges.nhs.uk/wp-content/uploads/2014/07/St-Georges-Healthcare-NHS-Trust-Quality-Account-2013-14.pdf**

The Quality Report

The trust introduced the Quality Report onto the trust Board agenda in 2010. The purpose of the report is to update the Board on key developments in quality. Like the Quality Account, the report looks at the three domains of quality and focuses on the trust's performance in these areas by looking at several indicators and performance measures:

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

The Quality Improvement Strategy

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

The Trust Performance Report

The Trust Performance Report is presented to the Finance, Performance Committee on a monthly basis and to the Board every two months. This report contains a summary of operational performance across all domains of performance, including quality metrics such as infection rates. Any quality issues identified by the Finance, Performance and Investment Committee are referred to the Quality and Risk Committee for further consideration. The quality metrics within the trust performance scorecard are also reviewed monthly by the Quality and Risk Committee.

Serious incidents

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

External assessment of the trust's Quality Governance Framework

As part of the trust's application for Foundation Trust status, the trust completed a self-assessment of the robustness of this quality governance framework against Monitor's Quality Governance Framework in 2012/13.

This was followed up with an independent assessment by Deloitte, followed up with a second review in April 2013. In the summary conclusions Deloitte state the following:

"It is our view the trust can evidence progress since December 2012, as part of a concerted programme of development. We have assessed the trust at an indicative current score of 3.5 against the Monitor Quality Governance Framework... ...This score represents a significant improvement on the previously scored assessment."

The trust has completed an action plan to address any recommendations made by Deloitte, overseen by the Foundation Trust Programme Board.

Care Quality Commission inspections in 2013/14

In August 2013 the Care Quality Commission undertook an unannounced follow-up inspection of the St George's Hospital site (Tooting), following their previous inspection in January 2013. The Care Quality Commission also undertook a Chief Inspector of Hospitals inspection between 10 and 14 February 2014. The ratings from this inspection are summarised below:

St Georges Hospital (acute)

	Safe	Effective	Caring	Responsive	Well led	Overall
A&E	Good	Not assessed	Good	Good	Good	Good
Medical care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
ITU/CCU	Outstanding	Good	Good	Good	Outstanding	Outstanding
Maternity	Good	Good	Outstanding	Good	Good	Good
Children & Young People	Good	Good	Good	Good	Good	Good
End of Life Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not assessed	Good	Good	Good	Requires improvement
Overall	Requires Improvement	Good	Good	Good	Good	Good

Queen Mary's Hospital (community)

	Safe	Effective	Caring	Responsive	Well led	Overall
A&E (Minor Injuries Unit)	Requires Improvement	Not able to rate	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not able to rate	Good	Requires Improvement	Good	Good
Community Inpatient Services	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time
Overall	Requires Improvement	Good	Good	Good	Good	Good

This inspection confirmed that all previous compliance actions had been completed, but added two new compliance actions:

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

Action plans have been developed in response to these compliance actions and completion will be monitored internally through the Quality and Risk Committee and externally through the Clinical Quality Review Meetings with commissioners.

Risk management

The trust is committed to providing high quality care in an environment which is safe for patients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness. Robust risk management and internal control are an essential part of good governance and is integral to the delivery of this commitment. The governance committee structure shown on page 50 provides an effective and robust system of risk management across the trust.

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

The system of risk management is described in the trust's Risk Management Policy which is accessible to all staff via the trust intranet. It is based on an iterative process of:

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

This is achieved through a sound organisational framework, underpinned by a robust policy framework, which promotes early identification of risk, the co-ordination of risk management activity, the provision of a safe environment for staff and patients, and the effective use of financial resources. It ensures that staff are aware of their roles and responsibilities and outlines the structures and processes through which risk is assessed, controlled and managed. Risks are identified through feedback from many sources such as proactive risk assessments, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, stakeholder/partnership feedback and internal/external assurance assessments.

Key stakeholders are involved in the management of risks via patient and public involvement groups and activities, patient and staff surveys, public Board meetings, the Local Involvement Network and the local Adult Care and Health Overview and Scrutiny Committees.

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

Risk management is embedded within the organisation through the Corporate, Divisional, Directorate and Care Group structures and the reporting and feedback mechanisms are in place (as shown on page 51).

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

The trust's Board Assurance Framework, which is aligned to the trust's strategic corporate objectives, is a high-level document based on structured and on-going assessment of the principal risks to the

trust achieving its corporate objectives. It describes the controls and assurance mechanisms in place to manage the identified risks.

The Executive Management Team and the Quality & Risk Committee (QRC) regularly review the Board Assurance Framework, with the most significant risks being reported to each public trust Board meeting. Divisional and Directorate Risk Registers are reviewed regularly by the Organisational Risk Committee with high-level risks being reported to the QRC.

In addition, the trust uses its Assurance Map to record the outcome of any external accreditation visit or statutory inspection, and assurance that actions are being taken to address any issues identified through these inspections is provided to the Board.

Risk management training is a mandatory requirement for trust staff at induction. Further education is available for trust staff, relevant to their authority and duties; this includes modules within the Clinical Leadership Programme and Senior Staff Induction programme. Expert guidance and facilitation from the Corporate Risk and Assurance Department supports this function.

External assurance as to the robustness of this system is provided through the trust's Level 2 accreditation with the National Health Service Litigation Authority (NHSLA) risk management standards, which provides a comprehensive assessment of how well the policy framework that governs risk management in a NHS organisation is embedded. In February 2013 the trust also achieved level 3 accreditation (the highest level) in the Clinical Negligence Scheme for trusts Maternity Clinical Risk Management standards.

Other assurance regarding the robustness of the trust's risk management framework is provided through the external review of our quality governance assurance framework completed in April 2013 and the CQC Chief Inspector of Hospitals inspection report.

New risks identified in 2013/14

The following risks were identified and added to the Board Assurance Framework during 2013/14, and the associated controls overseen by the Executive Management Team and the Quality & Risk Committee:

O3-01	Ability of the trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)
O1-01	Risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the trust
3.5-05	3.5-05 – Cashflow Risks – Forecast Cash balances will be depleted due to delays in receipt of Major Charitable donations towards the C&W development, Land Sales receipts & Loan Finance
3.6-05	3.6-05 – Cashflow Risks – Operational Finance Forecast Cash balances will be depleted due to Adverse Income & Expenditure performance & delays in receipt of SLA funding from Commissioners
3.7-05	Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality and Governance Indicators/Access Metrics.
3.8-05	Low compliance with new working practices introduced as part of new ICT enabled change programme
01-03	Lack of embedded process for use, provision and maintenance of bed rails
01-04	Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children
01-05	Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the trust
3.7-05	Minimise financial impact of Better Care Fund

Details about those risks that were closed or removed from the Board Assurance Framework in 2013/14 can be viewed on page 53.

The most significant risks on the Board Assurance Framework are reviewed by the Board at each meeting, following recommendation from the Executive Management Team and the Quality and Risk Committee. These risks will therefore change

during the year, however risks that have remained consistently in the list of most significant risks during the year are:

Ref	Description	C	L	Rating (Prev)
A602	Pressures on internal capacity may result in the trust being unable to meet demands from activity, negatively affecting quality, throughout the year	5	4	20
3.2-05	The trust does not deliver its cost reduction programme objectives	5	4	20
A513	Failure to achieve the National HCAI targets	4	4	16

Data security breaches

The trust has not had any Information Commissioner reportable data security breaches in 2013 – 2014.

Performance against national priorities set out in the NHS Operating Framework 2013/14

During 2013/14 the trust has demonstrated strong performance against the key performance indicators. Key achievements this year include:

- **Achievement of minimum thresholds for CDifficile infections**
- **Achievement of the 18-week waiting time target for admitted and non-admitted patients.**

The trust did not achieve its agreed minimum thresholds for MRSA infections or the A&E 4 hour wait target. A comprehensive infection control action plan and refreshed policies are in place to strengthen infection control measures throughout the trust and the trust has implemented action plans to address A&E performance, supported by commissioners and ECIST (Emergency Care Intensive Support Team).

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. I am confident as to the effectiveness of the system described above and that conclusion is informed in a number of ways:

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

In other internal audits carried out, a range of assurances from significant assurance to limited assurance have been given. The limited assurance reports were:

- **Estates Maintenance**
- **Fire Safety**
- **Discharge processes**
- **Data quality: maternity pathways**
- **Data quality: cancer waiting times.**

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

In addition to the Head of Internal Audit opinion, the Audit Committee Chairman provides a written report following each committee meeting to the next meeting of the trust Board, which includes significant conclusions arising from the Committee's work, concerns and recommendations.

Executive Directors and managers within the organisation who have responsibility for the

development and maintenance of the system of internal control provide me with assurance.

The Board Assurance Framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation achieving its principal objectives have been regularly reviewed.

The trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.

The Board has completed a review of its effectiveness and that of its sub-committees through completion of the Board Governance Assurance Framework assessment and the annual effectiveness reviews.

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

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

The trust has produced an Annual Quality Account for 2013/14 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 not identified any issues that fall within the definition of 'significant issue' according to the requirements of this Governance Statement.

However, the Board was particularly concerned with the limited assurance provided by Internal Audit in respect of the trust's compliance with fire safety and estates maintenance, and the limited progress to date in implementing the agreed action plan when reviewed by Internal Audit. I am overseeing the implementation of that comprehensive action plan to address the audit recommendations and other aspects of non-compliance.

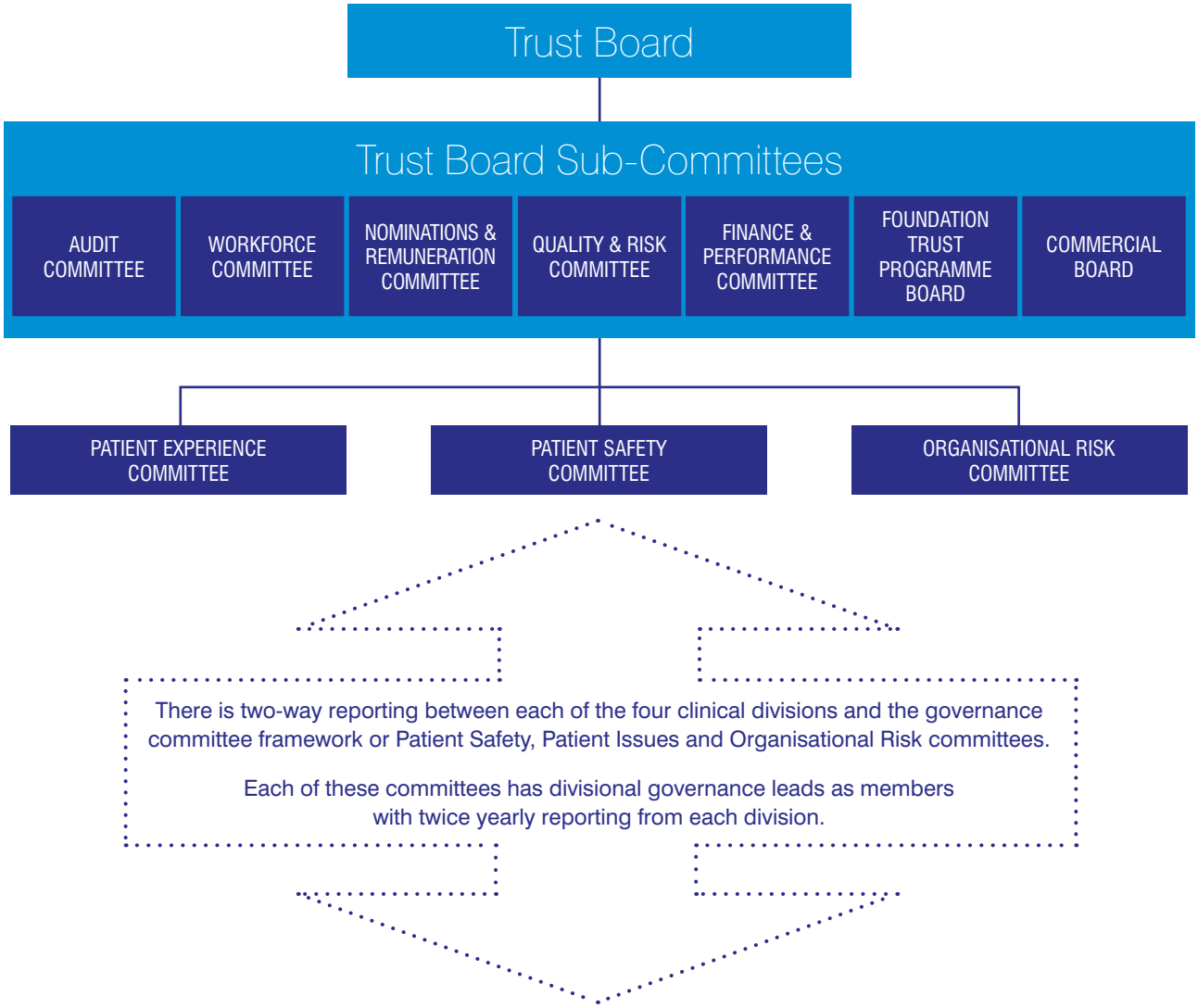
The existing risk on the Board Assurance Framework relating to compliance with fire safety regulations, and the potential impact that this non-compliance might have on patients, has been reviewed in the light of this limited assurance and will be one of the trust's most significant risks until the action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

Progress in implementing this action plan will also continue to be monitored by the audit committee and will be the subject of a follow-up audit in 2014/15.

Miles Scott
Chief Executive
St George's Healthcare NHS Trust
4th June 2014

Annual governance statement appendix 1

Governance framework



St George's Healthcare NHS Trust has four clinical divisions:

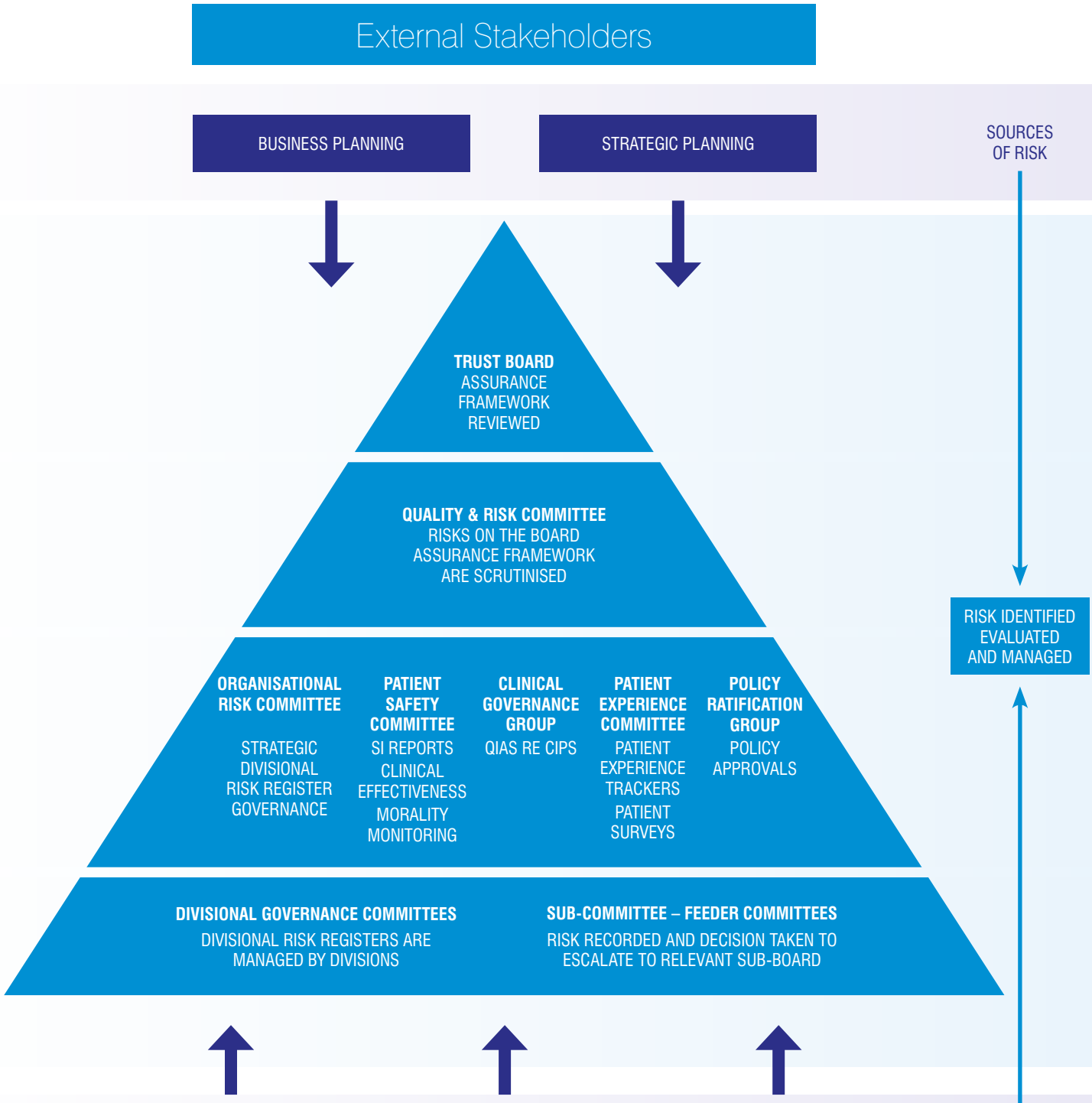
- WOMEN & CHILDREN THERAPIES AND CRITICAL CARE
- MEDICINE AND CARDIOTHORACIC SERVICES
- SURGERY, THEATRES NEUROSCIENCES AND CANCER
- COMMUNITY SERVICES WANDSWORTH

Each of the clinical divisions has an established governance framework, at the top of which each division has a Divisional Management and Divisional Governance Committee.

These committees manage all aspects of governance within each division and seek and receive assurances from across their respective care groups.

Each of the Division Directors of Nursing and Governance are substantive members of the committees of the Patient Safety, Patient Issues and Organisational Risk.

Annual governance statement appendix 2



Annual governance statement appendix 3

Internal audit reports

Topic	Assurance Level
Patient Safety and Service Quality	
Discharge Processes	Limited
Infection Control	Reasonable
Diagnostics Testing	Reasonable
Incidents	Reasonable
Governance	
Assurance Framework and Risk Register	Reasonable
CQC Registration Authority	Reasonable
Counter Fraud Arrangements	Reasonable
Fundamental Financial Systems	
Financial Ledger	Significant
Financial Reporting and Budgetary Control	Significant
Accounts Payable	Reasonable
Efficient Purchasing and Control	Reasonable
Cash Flow and Investment, Borrowing and EFL, and Cashiering	Reasonable
Capital Asset Register/ Capital Charges	Reasonable
Stores – cyclical coverage	Deferred
Income	
Income and Debtors System	Significant
NHS Service Agreements	Significant
Income Collection Feeder Systems – ICD10 and Haemophilia	n/a
Human Resources and Payroll	
ESR Payroll System Management	Significant
Sickness Absence Management	Reasonable
Agency Staff	Reasonable
Estates and Facilities	
Capital Programme Management	Reasonable
Estates Maintenance	Limited
Fire Safety	Limited
Patient Transport	Reasonable
IT/Information	
Information Governance & Security/ Data Accreditation	Reasonable
IG Governance Training	Significant
Change Management & implementation of IT systems	Reasonable
Data Quality: Maternity Pathways	Limited
IT Helpdesk	Reasonable
Contingency	
Data Quality: Cancer Waiting Times	Limited
IT Portal Project	Reasonable

Internal audit reports (continued)

Domain	Principle Risk	Rationale for closure
A462	Failure to achieve year on year savings.	Risk superseded by Risk 3.2-05 – relating to CIP slippage.
4.1-05	Tariff Risk – MPET Review income.	Risk has passed: business case now adjusted to allow for decrease in income.
A506	Failure to achieve alignment between commissioner/trust activity plans.	Commissioner Convergence letters have been received from SW London CCGs, Surrey Downs CCG and Specialised Commissioners. Thus we have commissioner and trust alignment of projections for our five year IBP.
A517	Staff disengagement whilst working towards greater productivity.	Risk has passed. Improved staff survey scores in particular staff recommendation as a place to work: better than average.
A519	Staff survey results do not improve.	Improved survey results and specific risk encompassed with A520.
A609-O7	Risk of criminal proceedings.	Formal notification from CPS of no further action in last remaining case under consideration. This case is now being managed through the normal, robust inquest process. Proximity of these unrelated cases is now spread to the extent that risk is significantly reduced.
A373-02	Failure to maintain compliance with National requirements for same sex accommodation.	Following introduction of CCG validation as to clinically justified breaches the trust has had a zero return for 3 consecutive months. In view of the NTDA requirements now having been updated to align with new CCG validation process, this demonstrates this is not a material risk for the NTDA and the trust. A low residual risk remains inherent and as such, daily monitoring continues.

Summary financial report

Auditor's report

Independent auditor's report to the Board of Directors of St George's Healthcare NHS Trust

Issue of audit opinion on the financial statements

We have audited the financial statements of St George's Healthcare NHS Trust for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable in law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- The table of salaries and allowances of senior managers
- The table of pension benefits of senior managers and related narrative notes
- The narrative on pay multiples.

This report is made solely to the Board of Directors of St George's Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust's directors and the trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of directors and auditors

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of St George's Healthcare NHS Trust's as at 31 March 2014 and of its expenditure and income for the year then ended
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report to be audited has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Trust Development Authority's Guidance
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1988 because we have a reason to believe that the trust, or an officer of the trust, is about to make, or has made a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss of deficiency
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Conclusion on the trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the trust and auditor

The trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance and review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to my attention which prevent us from concluding that the trust has put in place such proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in use of resources

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2013, as to whether the trust has proper arrangements for:

- Securing financial resilience
- Challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for use to consider under the Code of Audit Practice in satisfying ourselves whether the trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2014.

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

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in November 2013, we are satisfied that, in all significant respects St George's Healthcare NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to provide assurance over the trust's annual quality accounts. We are satisfied that this work does not have a material effect on the financial statements or on our value for money conclusion.

Andy Mack

Director, for and on behalf of Grant Thornton UK LLP, Appointed Auditor
Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

6 June 2014

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF ST GEORGES HEALTHCARE NHS TRUST

Issue of audit opinion on the financial statements

In our audit report for the year ended 31 March 2014 issued on 6 June 2014 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the financial position of St Georges Healthcare NHS Trust as at 31 March 2014 and of its expenditure and income for the year then ended; and
- had been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

In our audit report for the year ended 31 March 2014 issued on 6 June 2014 we reported that, in our opinion, in all significant respects, St Georges Healthcare NHS Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

Certificate

In our report dated 6 June 2014, we explained that we could not formally conclude the audit on that date until we had completed the work to provide assurance on the Trust's annual quality account. We have now completed this work. No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave an unqualified opinion and value for money conclusion.

We certify that we have completed the audit of the accounts of St Georges Healthcare NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Andy Mack
Director
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House, Melton Street, Euston Square, London, NW1 2EP

27 June 2014

Forward to the Accounts

These accounts for the year ended 31 March 2014 have been prepared by the St George's Healthcare NHS Trust under section 98(2) of the National Health Service Act 2006 (as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statement of comprehensive Income for the year ended 31 March 2014

	NOTE	2013-2014 £000s	2012-13 £000s
Revenue			
Gross employee benefits	10.1	(408,611)	(393,566)
Other operating costs	8	(240,601)	(234,960)
Revenue from patient care activities	5	594,644	562,414
Other operating revenue	6	70,073	79,354
Operating surplus/(deficit)		**15,505**	**13,242**
Investment revenue	12	94	99
Other gains and (losses)	13	0	156
Finance costs	14	(3,279)	(3,196)
Surplus/(deficit) for the financial year		**12,320**	**10,301**
Public dividend capital dividends payable		(7,624)	(7,167)
Net Gain/(loss) on transfers by absorption		0	0
Retained surplus/(deficit) for the year		**4,696**	**3,134**
Other comprehensive income			
Impairments and reversals taken to the re-valuation reserve		0	(3,313)
Net gain/loss on re-evaluation of property, plant and equipment		0	(9,661)
Total Comprehensive Income for the year		**4,696**	**9,482**
Financial performance for the year			
Retained surplus/(deficit) for the year		4,696	3,134
IFRIC 12 adjustment (including IFRIC 12 impairments)		1,269	1,349
Impairments (excluding IFRIC 12 impairments)		0	1,028
Adjustments in respect of donated gov't grant asset reserve elimination		67	775
Adjusted retained surplus/(deficit)		**6,032**	**6,286**

A trust's reported NHS financial performance position is derived from its retained surplus, but adjusted to take account of the revenue cost of the following items:

(1) Bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) in 2009/10). NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. The additional cost is not considered part of the organisation's financial performance.

(2) Impairments on the revaluation of fixed assets, charged to Other costs, are excluded from the financial performance for the year.

(3) Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as for purchased assets. Gains and losses on revaluations, impairments and sales are as for purchased assets. Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income.

PDC dividend: balance receivable/(payable) at 31 March 2014	0
PDC dividend: balance receivable/(payable) at 1 April 2013	(93)

Statement of financial position as at 31 March 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	15	286,859	282,716
Intangible assets	16	13,466	6,282
Investment property	18	0	0
Other financial assets		0	0
Trade and other receivables	22.1	0	38
Total non-current assets		**300,325**	**289,036**
Current Assets			
Inventories	21	7,149	7,191
Trade and other receivables	22.1	67,856	45,969
Other financial assets	24	0	0
Other current assets	25	11	27
Cash and cash equivalents	26	22,256	24,127
Total current assets		**97,272**	**77,314**
Non-current assets held for sale	27	**0**	**0**
Total current assets		**97,272**	**77,314**
Total assets		**397,597**	**366,350**

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Current liabilities			
Trade and other payables	28	(87,571)	(62,837)
Other liabilities	29	0	0
Provisions	35	(759)	(741)
Borrowings	30	(3,082)	(3,047)
Other financial liabilities	31	0	0
Working capital loan from department	30	0	0
Capital loan from department	30	0	0
Total current liabilities		**(91,412)**	**(66,625)**
Net current assets/(liabilities)		**5,860**	**10,689**
Non-current assets plus/less net current assets/liabilities		**306,185**	**299,725**
Non-current liabilities			
Trade and other payables	28	0	0
Other liabilities	29	0	0
Provisions	35	(1,264)	(1,285)
Borrowings	30	(49,151)	(51,290)
Other financial liabilities	31	0	0
Working capital loan from department	30	0	0
Capital loan from department	30	0	0
Total non-current liabilities		**(50,415)**	**(52,575)**
Total assets employed:		**255,770**	**247,150**
Financed by taxpayers' equity			
Public dividend capital		132,475	131,475
Retained earnings		31,531	21,750
Revaluation reserve		90,614	92,775
Other reserves		1,150	1,150
Total taxpayers' equity:		255,770	247,150

The financial statements were approved by the Board on 6th June 2014 and signed on its behalf by:

Chief Executive: 

Date: 6.VI.14

Statement of changes in taxpayers' equity

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total £000s
Balance at 1 April 2013	131,475	21,750	92,775	1,150	247,150
Changes in taxpayers' equity for year ended 31 March 2013-14					
Retained surplus/(deficit) for the year		4,696			4,696
Transfers between reserves		2161	(2,161)	0	0
Transfers under Modified Absorption Accounting – PCTs & SHAs		2,941			2,941
Transfers under Modified Absorption Accounting – Other bodies		0			0
Reclassification adjustments					
New PDC received – Cash	1,000				1,000
Other movements	0	1,466	(1,483)	0	(17)
Net recognised revenue/(expense) for the year	1,000	11,264	(3,644)	0	8,620
Transfers between reserves in respect of modified absorption – PCTs & SHAs		2,256	1,483	0	3,739
Balance at 31 March 2014	132,475	32,270	90,614	1,150	259,509
Balance at 1 April 2012	131,475	16,360	88,656	1,150	237,641
Changes in taxpayers' equity for the year ended 31 March 2013					
Retained surplus/(deficit) for the year		3,134			3,134
Net gain / (loss) on revaluation of property, plant, equipment			9,661		9,661
Impairments and reversals			(3,313)		(3,313)
Transfers between reserves		2,256	(2,229)	0	27
Net recognised revenue/(expense) for the year	0	5,390	4,119	0	9,509
Balance at 31 March 2013	131,475	21,750	92,775	1,150	247,150

Statement of cash flows for the year ended 31 March 2014

	2013-14 £000s	2012-13 £000s
Cash flows from operating activities		
Operating surplus/(deficit)	15,505	13,242
Depreciation and amortisation	18,994	18,787
Impairments and reversals	0	1,028
Government granted assets received credited to revenue but non-cash	(71)	0
Interest paid	(3,253)	(3,158)
Dividend (paid)/refunded	(7,718)	(6,797)
(Increase)/decrease in inventories	42	(898)
(Increase)/decrease in trade and other receivables	(21,849)	2,679
(Increase)/decrease in other current assets	16	0
Increase/(decrease) in trade and other payables	26,241	(12,997)
Provisions utilised	(472)	(670)
Increase/(decrease) in provisions	443	367
Net cash inflow/(outflow) from operating activities	**27,878**	**11,583**
Cash flows from investing activities		
Interest received	94	99
(Payments) for property, plant and equipment	(19,544)	(12,196)
(Payments) for intangible assets	(8,028)	(2,730)
Proceeds of disposal of assets held for sale (PPE)	0	610
Net cash inflow/(outflow) from investing activities	**(27,478)**	**(14,217)**
Net cash inflow/ (outflow) before financing	**400**	**(2,634)**
Cash flows from financing activities		
Public dividend capital received	1,000	0
Other loans repaid	(388)	(388)
Cash transferred to NHS foundation trusts	0	0
Capital element of payments in respect of finance leases and On-SoFP PFI and LIFT	(2,883)	(2,775)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)	0	8
Net cash inflow/(outflow) from financing activities	(2,271)	(3,155)
Net increase/(decrease) in cash and cash equivalents	(1,871)	(5,789)
Cash and cash equivalents (and bank overdraft) at beginning of the period	24,127	29,916
Effect of exchange rate changes in the balance of cash held in foreign currencies	0	0
Cash and cash equivalents (and bank overdraft) at year end	22,256	24,127

Notes to the Accounts

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013/14 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.4 Hospital charity

St George's Hospital Charity, although a related party, does not fall under common control with the trust. We have therefore retained the previous policy of not consolidating the Charity's accounts.

1.5 Pooled budgets

The trust was not part of any Pooled budget during 2013/14.

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The trust has made a critical judgement regarding the treatment of assets that are finance leases. These Finance leases relate to equipment assets used by the trust and a Private Finance Initiative(PFI). See paragraphs 1.14 Leases and 1.15 PFI Transactions.

The trust has carried out a desktop asset valuation exercise using a District Valuer. However, considering a level of backlog maintenance, a decision was made not to alter asset value. Please note that backlog maintenance was reviewed by an independent assesor.

1.6 .2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Plant, Property and Equipment – Para 1.10 and Note 15
Intangible Assets – Para 1.11 and Note 16
Provision for Impairment of Receivables – Note 22.3
Provisions – Para 1.20 and Note 35

Revenue figures have been adjusted for the Impairment of Receivables. The trust has made an appropriate provision for Impairment of debts past their due date according to their age.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Goods are sold on an incidental basis. Income is recognised at the point the sale transaction occurs.

1.8 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the trust commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000
- 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
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost

valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset

- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the trust expects to obtain economic benefits or service potential from the asset. This is specific to the trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending

to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received
b) Payment for the PFI asset, including finance costs
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the trust's Statement of Financial Position.

Other assets contributed by the trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out valuation method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the trust's cash management.

1.20 Provisions

Provisions are recognised when the trust has a present legal or constructive obligation as a result of a past event, it is probable that the trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (1.8% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.22 Non-clinical risk pooling

The 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 as and when they become due.

1.23 Carbon Reduction Commitment scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.
- The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the trust's surplus. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost.
The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28 Foreign currencies

The trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend [NHS trust only]

Public Dividend Capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.31 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which the trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

For 2012-13 and 2013-14, in accordance with the direct accounting policy from the Secretary of State, the trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.33 Associates

Material entities over which the trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the trust's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.34 Joint ventures

Material entities over which the trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 Joint operations

Joint operations are activities undertaken by the trust in conjunction with one or more other parties but which are not performed through a separate entity. The trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.36 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.37 Accounting standards that have been issued but have not yet been adopted.

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year [detail if not the case]:

IAS 27 Separate Financial Statements – subject to consultation

IAS 28 Investments in Associates and Joint Ventures – subject to consultation

IFRS 9 Financial Instruments – subject to consultation – subject to consultation

IFRS 10 Consolidated Financial Statements – subject to consultation

IFRS 11 Joint Arrangements – subject to consultation

IFRS 12 Disclosure of Interests in Other Entities – subject to consultation

IFRS 13 Fair Value Measurement – subject to consultation

IPSAS 32 – Service Concession Arrangement – subject to consultation

2. Pooled budgets

St George's Healthcare NHS Trust does not have any pooled budget arrangements.

3. Operating segments

This note is not applicable for St George's Healthcare NHS Trust as the organisation does not consider itself to have more than one operating segment that accounts for at least 10% of total revenue.

Income from CCGs accounts for 54% of the trust Revenue with a further 33% from NHS England. No customer external to the NHS accounts for more that 10% of the trust's revenue.

4. Income generation activities

The trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. Please note that this "profit" is used to supplement patient care and does not form part of retained surplus.

None of these are income generated activities where full cost exceeded £1m or were otherwise material.

5. Revenue from patient care activities

	2013-14 £000s	2012-13 £000s
NHS Trusts	1,132	506
NHS England	220,249	0
Clinical Commissioning Groups	358,384	0
Primary Care Trusts	0	550,291
Strategic Health Authorities	0	533
NHS Foundation Trusts	3,841	1,967
Department of Health	265	638
NHS Other (including Public Health England and Prop Co)	607	0
Non-NHS:		
Local Authorities	535	706
Private patients	3,736	3,681
Overseas patients (non-reciprocal)	1,274	880
Injury costs recovery	4,064	3,060
Other	557	152
Total Revenue from patient care activities	**594,644**	**562,414**

Injury cost Recovery income is subject to a provision for impairment of receivables of approx. 9.8% to reflect expected rates of collection

6. Other operating revenue

	2013-14 £000s	2012-13 £000s
Recoveries in respect of employee benefits	5,711	5,779
Education, training and research	48,263	53,670
Charitable and other contributions to revenue expenditure – NHS	0	179
Charitable and other contributions to revenue expenditure -non- NHS	930	145
Receipt of donations for capital acquisitions – NHS Charity	1,299	244
Receipt of government grants for capital acquisitions	0	452
Non-patient care services to other bodies	7,215	16,758
Income generation	2,829	1,829
Rental revenue from operating leases	199	137
Other revenue	3,627	161
Total Other Operating Revenue	**70,073**	**79,354**

Total operating revenue	664,717	641,768

7. Revenue

	2013-14 £000s	2012-13 £000s
From rendering of services	663,569	640,246
From sale of goods	1,148	1,522

8. Operating expenses (excluding employee benefits)

	2013-14 £000s	2012-13 £000s
Services from other NHS Trusts	893	6,875
Services from CCGs/NHS England	146	0
Services from other NHS bodies	0	145
Services from NHS Foundation Trusts	4,784	359
Services from Primary Care Trusts	0	936
Total Services from NHS bodies*	5,823	8,315
Purchase of healthcare from non-NHS bodies	5,131	5,555
Trust Chair and Non-executive Directors	58	83
Supplies and services – clinical	127,628	117,648
Supplies and services – general	15,135	15,021
Consultancy services	3,052	3,039
Establishment	6,765	6,309
Transport	4,649	5,719
Premises	38,779	39,653
Insurance	73	0
Legal Fees – refer to the note below	640	0
Impairments and reversals of receivables	386	660
Depreciation	18,004	17,910
Amortisation	990	877
Impairments and reversals of property, plant and equipment	0	1,028
Audit fees	169	188
Clinical negligence	9,372	9,088
Research and development (excluding staff costs)	1,199	430
Education and Training	1,343	1,160
Other	1,405	2,277
Total Operating expenses (excluding employee benefits)	240,601	234,960

Employee benefits	2013-14 £000s	2012-13 £000s
Employee benefits excluding Board members	407,711	392,622
Board members	900	944
Total employee benefits	408,611	393,566

Total operating expenses	649,212	628,526

Legal Fees incorporates all legal fees except charges for Clinical Negligence. In 2012/13 this category was not separated out.

9. Operating leases

The trust has a number of operating leases for short life office equipment such as photocopiers and pool cars leased by the transport department. The trust has also classified the rent paid to NHS Property Services Ltd and Community Healthcare Partnership for buildings owned by them and used by the Community Services Division to deliver its services.

9.1 Trust as lessee

	Land £000	Buildings £000	Other £000	2013-2014 Total £000	2012-13 £000
Payments recognised as an expense					
Minimum lease payments				14,689	14,579
Contingent rents				0	0
Sub-lease payments				0	0
Total				14,689	14,579
Payable:					
No later than one year	0	14,301	15	14,316	7,274
Between one and five years	0	3,804	7	3,811	28
After five years	0	0	0	0	0
Total	0	18,105	1,483	18,127	7,302
Total future sublease payments expected to be received:				0	0

9.2 Trust as lessor

The trust receives rental revenue from retail outlets on its premises.

Rental revenue	2013-14 £000s	2012-13 £000s
Recognised as income		
Rental revenue	199	137
Contingent rents	0	0
Total	199	137
Receivable in future years under lease contract:		
No later than one year	197	137
Between one and five years	734	548
After five years	0	0
Total	931	685

10. Employee benefits and staff numbers

10.1 Employee benefits

Employee benefits – gross expenditure	2013-14 Total £000	Permanently employed £000s	Other £000s
Salaries and wages	346,514	301,863	44,651
Social security costs	26,825	26,825	0
Employer contributions to NHS BSA – Pensions Division	36,290	36,290	0
Other pension costs	135	135	0
Termination benefits	0	0	0
Total Employee Benefits	409,764	365,113	44,651
Employee costs capitalised	1,153	1,104	49
Gross Employee Benefits excluding capitalised costs	408,611	364,009	44,602
Employee benefits – gross expenditure 2012-13			
Salaries and wages	311,574	275,922	35,652
Social security costs	47,150	47,150	0
Employer contributions to NHS BSA – Pensions Division	34,675	34,675	0
Other pension costs	489	489	0
Termination benefits	861	861	0
TOTAL – including capitalised costs	394,749	359,097	35,652
Employee costs capitalised	1,183	1,132	51
Gross employee benefits excluding capitalised costs	393,566	357,965	35,601

10.2 Staff Numbers

	2013-14		2012-13	
	Total Number	Permanently Employed Number	Other Number	Total Number
Average staff numbers				
Medical and dental	1,083	1,040	42	1,052
Administration and estates	1,843	1,530	313	1,768
Healthcare assistants and other support staff	570	570	0	543
Nursing, midwifery and health visiting staff	3,128	2,492	635	2,944
Scientific, therapeutic and technical staff	1,723	1,642	81	1,694
TOTAL	8,346	7,276	1,071	8,001
Of the above:				
Number of staff whole time equivalent engaged on capital projects	20.2	18.6	1.6	17.0

10.3 Staff sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total days lost	59,030	56,622
Total staff years	7,329	7,203
Average working days lost	8.05	7.86
Number of persons retired early on ill health grounds	5	8
	£000s	£000s
Total additional pensions liabilities accrued in the year	609	333

10.4 Exit packages agreed in 2013-14

	2013-14			2012-13		
	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number
Exit package cost band (including any special payment element)						
Less than £10,000	0	0	0	1	9	10
£10,001-£25,000	1	0	1	1	13	14
£25,001-£50,000	3	0	3	1	6	7
£50,001-£100,000	0	0	0	1	3	4
£100,001-£150,000	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	4	0	4	4	31	35
Total resource cost (£000)	117	0	117	122	739	861

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the trust has agreed early retirements, the additional costs are met by the trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.5 Exit packages other – Departures analysis

	2013-14		2012-13	
	Agreements Number	Total value of agreements £000s	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	31	739
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	0	0	31	739

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% 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.

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.

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.

11. Better payment practice code

11.1 Better payment practice code – measure of compliance

	2013-14 Number	2013-14 £000s	2012-13 Number	2012-13 £000s
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	136,028	229,392	118,770	221,836
Total non-NHS Trade invoices paid within target	110,250	176,006	96,247	174,026
Percentage of NHS trade invoices paid within target	81.05%	76.73%	81.04%	78.45%

NHS Payables				
Total NHS trade invoices paid in the year	4,717	57,846	5,072	63,078
Total NHS trade invoices paid within target	2,946	44,580	3,592	41,427
Percentage of NHS trade invoices paid within target	62.45%	77.07%	70.82%	65.68%

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.

11.2 The late payment of commercial debts (interest) act 1998

	2013-14 £000	2012-13 £000
Amounts included in finance costs from claims made under this legislation	5	1
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	5	1

12. Investment income

	2013-14 £000	2012-13 £000
Rental income:		
PFI finance lease revenue (planned)	0	0
PFI finance lease revenue (contingent)	0	0
Other finance lease revenue	0	0
Subtotal	0	0
Interest income:		
Bank interest	94	99
Subtotal	94	99
Total investment income	94	99

13. Other gains and losses

	2013-14 £000	2012-13 £000
Rental Income:		
Gain on disposal of assets other than by sale (PPE)	0	0
Gain on disposal of assets held for sale	0	156
Total	0	156

14. Finance costs

	2013-14 £000	2012-13 £000
Interest		
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	165	18
Interest on obligations under PFI contracts:		
– main finance cost	3,084	3,133
Interest on late payment of commercial debt	4	1
Total interest expense	3,253	3,152
Other finance costs	0	4
Provisions – unwinding of discount	26	40
Total	3,279	3,196

15. Property, plant and equipment

2013-14	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and poa £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
At 1 April 2013	71,461	177,757	0	12,304	87,773	144	22,685	12,583	384,707
Transfers under modified absorption accounting – PCTs & SHAs	1,015	1,926	0	0	0	0	0	0	2,941
Transfers under modified absorption accounting – other bodies	0	0	0	0	0	0	0	0	0
Additions of assets under construction				10,942					10,942
Additions purchased	0	3,094	0		4,453	0	121	319	7,987
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	127	0	0	272	0	1	14	414
Additions leased	0	0	0	0	1,165	0	0	0	1,165
Reclassifications	0	538	0	(3,791)	1,937	0	0	14	(1,302)
Disposals other than for sale	0	0	0	0	(1,065)	0	0	0	(1,065)
At 31 March 2014	72,476	183,442	0	19,455	94,535	144	22,807	12,930	405,789
Depreciation									
At 1 April 2013	0	10,959	0	0	68,316	144	14,976	7,596	101,991
Charged during the year	0	10,037	0	0	5,560	0	1,625	782	18,004
Disposals other than for sale	0	0	0	0	(1,065)	0	0	0	(1,065)
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2014	0	20,996	0	0	72,811	144	16,601	8,378	118,930
Net book value at 31 March 2014	72,476	162,446	0	19,455	21,724	0	6,206	4,552	286,859

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Asset financing:									
Owned – purchased	71,461	102,152	0	18,571	15,294	0	5,780	2,537	215,795
Owned – donated	1,015	10,345	0	884	1,050	0	46	381	13,721
Owned – government granted	0	1,920	0	0	874	0	0	56	2,850
Held on finance lease	0	0	0	0	4,506	0	380	602	5,488
On-SOFP PFI contracts	0	48,029	0	0	0	0	0	976	49,005
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2014	72,476	162,446	0	19,455	21,724	0	6,206	4,552	286,859

Revaluation reserve balance for property, plant & equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2013	57,924	20,707	3,015	0	9,222	23	307	1,577	92,775
Movements – represents excess depreciation	0	590	0	0	134	0	128	2	(2,161)
At 31 March 2014	57,924	21,297	0	0	9,356	23	435	1,579	90,614

Additions to assets under construction in 2013-14

	£000's
Land	0
Buildings excl dwellings	10,942
Dwellings	0
Plant & machinery	0
Balance as at YTD	10,942

15.2 Property, plant and equipment prior-year

2012-13	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and poa £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation:									
At 1 April 2012	66,944	187,102	0	11,162	86,748	144	20,879	12,290	385,269
Additions – assets under construction	0	0	0	7,640	0	0	0	0	7,640
Additions – purchased	0	2,557	0	0	2,026	0	1,776	93	6,452
Additions – donated	0	0	0	0	151	0	0	0	151
Additions – government granted	0	0	0	0	120	0	0	0	120
Additions leased	0	0	0	0	754	0	0	0	754
Reclassifications	0	4,356	0	(6,498)	4	0	30	200	(1,908)
Reclassifications as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(2,030)	0	0	0	(2,030)
Revaluation & indexation gains	4,517	5,144	0	0	0	0	0	0	9,661
Impairments	0	(3,313)	0	0	0	0	0	0	(3,313)
Reversals of impairments	0	0	0	0	0	0	0	0	0
Transfer to NHS foundation trust	0	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2013	71,461	195,846	0	12,304	87,773	144	22,685	12,583	402,796
Depreciation									
At 1 April 2012	0	18,089	0	0	64,661	143	13,443	6,754	103,090
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(1,948)	0	0	0	(1,948)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	1,028	0	0	0	0	0	0	1,028
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	9,931	0	0	5,603	1	1,533	842	17,910
Transfer to NHS foundation trust	0	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	29,048	0	0	68,316	144	14,976	7,596	120,080
Net book value at 31 March 2013	71,461	166,798	0	12,304	19,457	0	7,709	4,987	282,716

2012-13	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and poa £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Purchased	71,461	166,798	0	12,304	19,457	0	7,709	4,987	282,716
Donated	0	0	0	0	0	0	0	0	0
Government granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	71,461	166,798	0	12,304	19,457	0	7,709	4,987	282,716
Asset financing:									
Owned	71,461	116,866	0	12,304	14,582	0	7,076	3,191	225,480
Held on finance lease	0	0	0	0	4,875	0	633	696	6,204
On-SOFP PFI contracts	0	49,932	0	0	0	0	0	1,100	51,032
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	71,461	166,798	0	12,304	19,457	0	7,709	4,987	282,716

15.3 Property, plant and equipment (cont.)

The trust has recognised capital donations receivable towards the cost of the construction of a helipad, and various items of Medical Equipment. These donations are receivable from the County Air Ambulance Trust, St George's Hospital Charity and First Touch Charity.

The trust's valuation of land and buildings were reviewed in March 2013 by the Valuation Office on the Modern Equivalent Asset (MEA) basis applicable to NHS Trust. The valuation was effective from 31 March 2013.

Since an extensive valuation was carried out on 31 March 2013 and full valuation will be required to be carried out in March 2015, no revaluation exercise was undertaken in March 2014.

Buildings are subject to composite depreciation rates according to their elemental breakdown e.g. substructure 80 years, internal walls 25 years etc. Medical equipment is in general depreciated over 5, 10 or 15 years.

Buildings (excluding dwellings) asset lives from 3 to 100 years

Dwellings asset lives from 15 to 80 years.

Plant & Machinery asset lives from 1 to 25 years.

Transport Equipment asset lives from 5 to 7 years.

Information Technology asset lives from 3 to 15 years.

Furniture & Fittings asset lives from 5 to 25 years.

There is no compensation from third parties for assets impaired, lost or given up, that is included in the trust's surplus.

16.1 Intangible non-current assets

2013-14	IT – in-house & 3rd party software £000	Computer licenses £000	Licenses and trademarks £000	Patents £000	Development expenditure – internally generated £000	Total £000
1 April 2013	10,852	715	0	0	0	11,567
Transfers under modified absorption accounting – PCTs & SHAs	0	0	0	0	0	0
Additions – purchased	6,795	77	0	0	0	6,872
Reclassification – refer to the note below	1,302	0	0	0	0	1,302
At 31 March 2014	18,949	792	0	0	0	19,741
Amortisation at 1 April 2013	4,902	383	0	0	0	5,285
Charged during the year	894	96	0	0	0	990
Transfer to NHS foundation trust	0	0	0	0	0	0
Transfer (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0
At 31 March 2014	5,796	479	0	0	0	6,275
NBV at 31 March 2014	13,153	313	0	0	0	13,466
Asset financing: Net book value at 31 March 2014 comprises:						
Purchased	13,149	313	0	0	0	13,462
Donated	4	0	0	0	0	4
Total at 31 March 2014	13,153	313	0	0	0	13,466
Revaluation reserve balance for intangible non-current assets						
1 April 2013	0	0	0	0	0	0
Movements (specify)	0	0	0	0	0	0
At 31 March 2014	0	0	0	0	0	0

Note – Reclassifications are from AUC in the year as trust holds software development cost in AUC until project stage is complete

16.2. Intangible non-current assets prior year

2012-13	IT – in-house & 3rd party software £000	Computer licenses £000	Licenses and trademarks £000	Patents £000	Development expenditure – internally generated £000	Total £000
Cost or valuation:						
At 1 April 2012	0	6,929	0	0	0	6,929
Additions – purchased	0	2,730	0	0	0	2,730
At 31 March 2013	0	9,659	0	0	0	9,659
Amortisation						
At 1 April 2012	0	4,408	0	0	0	4,408
Charged during the year	0	877	0	0	0	877
Transfer to NHS foundation trust	0	0	0	0	0	0
Transfer (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0
At 31 March 2013	0	5,285	0	0	0	5,285
Net book value at 31 March 2013	0	4,374	0	0	0	4,374
Net book value at 31 March 2013 comprises:						
Purchased	0	6,277	0	0	0	6,277
Donated	0	5	0	0	0	5
Government granted	0	0	0	0	0	0
Total at 31 March 2013	0	6,282	0	0	0	6,282

Note – Reclassifications are from AUC in the year as trust holds software development cost in AUC until project stage is complete

16.3 Intangible non-current assets

For computer software internally generated intangible assets are valued at cost unless assessed as having a fair value which differs to cost.

Software Purchased is amortised on a straight line basis over the life of the asset. Software Assets relating to the trust iClip Patient data system are amortised over 10 years.

All other software assets are amortised over 5 years.

17. Analysis of impairments and reversals recognised in 2013-14

There were no impairments or reversals recognised in 2013-14.

18. Investment property

St George's Healthcare NHS Trust holds no investment property at 31 March 2012.

19. Commitments

19.1 Capital commitments

	31 March 2014 £000s	31 March 2013 £000s
Property, plant and equipment	2,279	1,639
Intangible assets	0	0
Total	2,279	1,639

19.2 Other financial commitments

The trust has not entered into any non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

20. Intra-Government and other balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other central government bodies	25,974	0	6,678	0
Balances with local authorities	557	0	0	0
Balances with NHS bodies outside the departmental group	22	0	230	0
Balances with NHS trusts and foundation trusts	6,876	0	4,161	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	34,427	0	76,502	0
At 31 March 2014	67,856	0	87,571	0
prior period:				
Balances with other central government bodies	17,717	0	17,675	0
Balances with local authorities	212	0	0	0
Balances with NHS bodies outside the departmental group	43	0	38	0
Balances with NHS trusts and foundation trusts	4,751	0	3,606	0
Balances with public corporations and trading funds	955	0	0	0
Balances with bodies external to government	18,729	0	55,038	0
At 31 March 2013	42,407	0	76,357	0

21. Inventories

	Drugs £000	Consumables £000	Energy £000	Other £000	Total £000
Balance at 1 April 2013	**1,858**	**5,208**	**52**	**73**	**7,191**
Additions	0	44	0	0	**44**
Inventories recognised as an expense in the period	(77)	0	0	(9)	**(86)**
Write-down of inventories (including losses)	0	0	0	0	**0**
Balance at 31 March 2014	1,781	5,252	52	64	7,149

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
NHS receivables – revenue	31,252	12,178	0	0
NHS receivables – capital	0	0	0	0
NHS prepayments and accrued income	1,620	8,759	0	0
Non-NHS receivables – revenue	26,428	21,872	0	38
Non-NHS receivables – capital	0	0	0	0
Non-NHS prepayments and accrued income	8,186	6,474	0	0
Provision for the impairment of receivables	(5,177)	(5,664)	0	0
VAT	5,546	2,350	0	0
Other receivables	1	0	0	0
Total	67,856	45,969	0	38

Total current and non current	67,856	46,007

Included in NHS receivables are prepaid pension contributions:	0

The great majority of trade is with Clinical Commissioning Groups . As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Receivables past their due date but not impaired

	31 March 2014 £000s	31 March 2013 £000s
By up to three months	1,384	1,993
By three to six months	2,132	2,298
By more than six months	4,234	8,865
Total	7,750	13,156

22.3 Provision for impairment of receivables

	2013-14 £000s	2012-13 £000s
Balance at 1 April	(5,664)	(5,511)
Amount written off during the year	873	507
Amount recovered during the year	0	(7)
(Increase)/decrease in receivables impaired	(386)	(653)
Balance at 31 March	(5,177)	(5,664)

The trust provides for the impairment of receivables on the basis of historical collection rates information and management assessment on the recoverability of Non NHS debts.

23. NHS LIFT investments

The trust has no LIFT investments.

24. Other financial assets

The trust has no other financial assets.

24. Other financial assets

24.1 Other Financial Assets – Current

The trust has no other current financial assets.

24.2 Other Financial Assets – Non Current

The trust has no other non current financial assets.

25. Other current assets

	31 March 2014 £000s	31 March 2013 £000s
EU Emissions Trading Scheme allowance	0	27
Other assets	11	0
Total	11	27

26. Cash and cash equivalents

	31 March 2014 £000s	31 March 2013 £000s
Opening balance	24,127	29,916
Net change in year	(1,871)	(5,789)
Closing balance	22,256	24,127
Made up of		
Cash with government banking service	22,045	24,058
Commercial banks	211	69
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	22,256	24,127
Bank overdraft – government banking service	0	0
Bank overdraft – commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	22,256	24,127

Patients' money held by St George's Healthcare NHS Trust is not included above	8	8

27. Non current assets held for sale

The trust has no Non current assets held for sale.

28 Trade and other payables

	Current		Non-current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
NHS payables – revenue	6,171	6,606	0	0
NHS payables – capital	0	0	0	0
NHS accruals and deferred income	439	896	0	0
Non-NHS payables – revenue	49,656	27,303	0	38
Non-NHS payables – capital	3,280	4,787	0	0
Non-NHS accruals and deferred income	6,126	9,273	0	0
Social security costs	4,412	4,265	0	0
VAT	0	0	0	0
Tax	4,537	4,410	0	0
Payments received on account	5,031	337	0	0
Other	7,919	4,960	0	0
Total	87,571	62,837	0	0

Total current and non current	87,571	62,837
Included above:		
To buy out the liability for early retirements over 5 years	0	0
Number of cases involved (number)	0	0
Outstanding pension contributions at the year end	5,336	4,805

29. Other liabilities

	Current		Non-current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
PFI/LIFT deferred credit	0	0	0	0
Lease incentives	0	0	0	0
Total	0	0		

Total other liabilities (current and non-current)	0	0

30. Borrowings

	Current		Non-current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Bank overdraft – government banking service	0	0	0	0
Bank overdraft – commercial banks	0	0	0	0
Loans from Department of Health	0	0	0	0
Loans from other entities	388	388	194	581
PFI liabilities:				
Main liability	810	757	46,454	47,263
Lifecycle replacement received in advance	0	0	0	0
Finance lease liabilities	1,884	1,902	2,503	3,446
Total	3,047	3,470	51,290	53,926

Total other liabilities (current and non-current)	52,233	54,337

Loans – repayment of principal falling due in:

	31 March 2014		
	DH £000s	Other £000s	Total £000s
0-1 years	0	3,082	3,082
1-2 years	0	3,454	3,454
2-5 years	0	4,102	4,102
Over 5 years	0	41,595	41,595
TOTAL	0	52,233	52,233

31. Other financial liabilities

The trust does not have any other financial liabilities.

32. Deferred income

	Current		Non-current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Opening balance at 1 April 2013	2,037	1,858	0	0
Deferred revenue addition	1,888	0	0	0
Transfer of deferred revenue	(2,037)	(1,858)	0	0
Current deferred Income at 31 March 2014	1,888	2,037	0	0

Total deferred income (current and non-current)	1,888	2,037

33. Finance lease obligations as lessee

The trust has a number of finance leases for high value capital medical equipment and the Picture Archiving Communications System which is provided under a managed equipment service. In addition the trust accounts for £1.5m capital investment in catering facilities undertaken by Mitie PLC in 2009/10 as a finance lease.

The trust has no Building or land Finance Leases.

Amounts payable under finance leases (Other)	Minimum lease payments		Present value of minimum lease payments	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Within one year	2,010	2,067	1,884	1,902
Between one and five years	2,532	3,582	2,378	3,382
After five years	138	70	125	64
Less future finance charges	(293)	(371)		
Minimum lease payments / present value of minimum lease payments	4,387	5,348	4,387	5,348

Included in:	31 March 2014 £000	31 March 2013 £000
Current borrowings	1,884	1,902
Non-current borrowings	2,503	3,446
	4,387	5,348

Finance leases as lessee	31 March 2014 £000	31 March 2013 £000
Future sublease payments expected to be received	0	0
Contingent rents recognised as an expense	0	0

34. Finance lease receivables as lessor

The trust does not have any finance leases where it is the lessor.

35. Provisions

Comprising:

	Total	Early departure costs	Legal claims	Restructuring	Continuing care	Equal pay (incl. agenda for change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	2,026	1,432	313	0	0	0	281	0
Arising during the year	544	102	157	0	0	0	285	0
Utilised during the year	(472)	(148)	(43)	0	0	0	(281)	0
Reversed unused	(101)	0	(101)	0	0	0	0	0
Unwinding of discount	26	26	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0
Balance at 31 March 2014	2,023	1,412	326	0	0	0	285	0
Expected timing of cash flows:								
No later than one year	759	148	326	0	0	0	285	0
Later than one year and not later than five years	558	558	0	0	0	0	0	0
Later than five years	706	706	0	0	0	0	0	0

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:

	£
As at 31 March 2014	102,429,367
As at 31 March 2013	99,609,828

Provision for CRC (Carbon Reduction Commitment), shown in other provisions as £285k, is based on the 2013-14 figures.

Provision for pension costs is calculated using information provided by the NHS Pensions Agency. Provision for legal claims has been calculated using figures and estimated probabilities supplied by the NHS Litigation Authority, the trust solicitors and the Human Resources Department.

36. Contingencies

The trust has no contingent assets or liabilities.

37. PFI and LIFT – additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	2013-14 £000	2012-13 £000
Total charge to operating expenses in year – OFF SOFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	6,536	6,482
Total	6,536	6,482

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No later than one year	6,536	5,451
Later than one year, no later than five years	26,145	21,234
Later than five years	133,205	82,638
Total	165,886	109,323

The estimated annual payments in future years are not expected to be materially different from those which St George's Healthcare NHS Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due	2013-14 £000	2012-13 £000
No later than one year	3,841	3,841
Later than one year, no later than five years	15,363	15,363
Later than five years	74,335	78,175
Subtotal	93,539	97,379
Less: interest element	(46,275)	(49,358)
Total	47,264	48,021

Present value imputed "finance lease" obligations for on SOFP PFI contracts due analysed by when PFI payments are due	2013-14 £000
No later than one year	810
Later than one year, no later than five years	3,849
Later than five years	42,605
Total	47,264

Number of on SOFP PFI contracts	
Total number of on PFI contracts	1
Number of on PFI contracts which individually have a total commitments value in excess of £500m	0

Present value imputed "finance lease" obligations for off SOFP PFI contracts due analysed by when PFI payments are due	2013-14 £000s	2012-13 £000s
No later than one year	0	
Later than one year, no later than five years	0	
Later than five years	0	
Total	0	0

Number of off SOFP PFI contracts	
Total number of off PFI contracts	0
Number of off PFI contracts which individually have a total commitments value in excess of £500m	0

St George's Healthcare NHS Trust has no LIFT schemes.

On 20 March 2000 the trust signed a contract for the exclusive use for 35 years of Atkinson Morley wing. Blackshaw Healthcare Services Ltd, a special purpose vehicle company owned by a private consortium, constructed the building which the trust uses primarily to provide Cardiac and Neurosciences healthcare services. The estimated capital value The estimated capital value of the facility on construction was approx. £50m

	£000s
Estimated capital value of the PFI scheme	50,000
Contract start date	20 March 2000
Contract end date	8 August 2038

Accounting treatment

The first unitary payment was payable by the trust when the new facility became available for use in August 2003 and the last payment will be payable by the trust in 2038/39. Previously the trust had accounted for this PFI scheme as 'off-balance sheet' however this accounting treatment has changed to on-Statement of Financial Position under IFRIC 12 which is applicable to NHS Trusts on the adoption of International Financial Reporting Standards (IFRS).

IFRIC12

Under IFRIC 12 the building is accounted as an asset of St George's Healthcare NHS Trust and the value of the building and fixtures and fittings subject to the contract are included within fixed assets. The contract is classified as a finance lease with the unitary payments split into two main components: the imputed finance lease charges (comprising interest payable and lease repayments) and service charges relating to the facilities management services e.g. buildings maintenance, domestics services provided by Blackshaw Healthcare Services Ltd.

Expiration of contract

On the expiration of the contract term in 2038/39 the trust assumes ownership of all the building and equipment assets subject to the contract with BHS for £nil consideration and also assumes responsibility for the provision of the services provided during the contract by BHS.

Termination rights

The trust may at any time within a period of 90 days after an Event of Default (as defined in the contract) by Blackshaw Healthcare Services Ltd terminate the contract without prejudice to any of its other rights and remedies by notice in writing to BHS with effect from 30 days of the notice.

38. Impact of IFRS treatment – current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2013-14 £000	2012-13 £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	2,026	2,058
Interest expense	3,084	3,133
Other expenditure	6,536	6,481
Total IFRS expenditure (IFRIC12)	11,646	11,672
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	(10,377)	(10,323)
Net IFRS change (IFRIC12)	1,269	1,349

Capital consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2013-14	0	600
UK GAAP capital expenditure 2013-14 (reversionary interest)	165	149

39. Financial instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with primary care trusts and the way those primary care trusts are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the trust's internal auditors.

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament . The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

39.2 Financial assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0	0	0	0
Receivables – NHS	0	31,252	0	31,252
Receivables – non-NHS	0	26,428	0	26,428
Cash at bank and in hand	0	22,256	0	22,256
Other financial assets	0	0	0	0
Total at 31 March 2014	0	79,936	0	79,936

Embedded derivatives	0	0	0	0
Receivables – NHS	0	11,694	0	11,694
Receivables – non-NHS	0	22,291	0	22,291
Cash at bank and in hand	0	24,127	0	24,127
Other financial assets	0	0	0	0
Total at 31 March 2013	0	58,112	0	58,112

39.3 Financial liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0	0	0
NHS payables	0	6,171	6,171
Non-NHS payables	0	52,936	52,936
Other borrowings	0	582	582
PFI & finance lease obligations	0	51,651	51,651
Other financial liabilities	0	0	0
Total at 31 March 2014	0	111,340	111,340

Embedded derivatives	0	0	0
NHS payables	0	7,502	7,502
Non-NHS payables	0	41,361	41,361
Other borrowings	0	44	44
PFI & finance lease obligations	0	54,337	54,337
Other financial liabilities	0	0	0
Total at 31 March 2013	0	103,244	103,244

40. Events after the end of the reporting period

£000s
0

41. Related party transactions

NHS related party transactions

The Department of Health is regarded as a related party. During the year, St George's Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

2013-14

Department of Health
NHS England
CCGs (Clinical Commissioning Groups)
- Wandsworth Teaching CCG
- Sutton and Merton CCG
- Croydon CCG
- Surrey CCG
- Lambeth CCG
- Kingston CCG
- Richmond & Twickenham CCG
- West Sussex CCG
- Hampshire CCG

NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority

2012-13

Department of Health
NHS Litigation Authority
Strategic health Authorities
- NHS London

Primary care trusts
- Wandsworth Teaching PCT
- Sutton and Merton PCT
- Croydon PCT
- Surrey PCT
- Lambeth PCT
- Kingston PCT
- Richmond & Twickenham PCT
- West Sussex PCT
- Hampshire PCT

NHS trusts
- Kingston Healthcare NHS Trust

Amounts received from the CCGs (Clinical Commissioning Groups) relates to the trust's contracts for patient services. The amount received from NHS London primarily relates to Teaching and Training.

Non-NHS Related party transactions	Payments to related party £'000	Receipts from related party £'000	Amounts owed to related party £'000	Amounts due from related party £'000
2013-14				
St George's University of London *Wendy Brewer was jointly appointed as the Director of HR for both organisations* *Neal Deans became Director of Estates for both organisations from September 2012* *Professor Peter Kopelman is both the Principal of SGUL and a trust non-executive director*	6,285	5,471	1,905	353
St George's Hospital Charity	0	1,010	0	498

Transactions with respect to St George's University of London on behalf of St George's Medical School mainly relate to the provision of clinical staff and overhead costs. Receipts from the Charitable Foundation relate to capital and revenue expenditure to be funded by the Charitable Foundation.

Any outstanding debts will have been Impaired in line with the trust Bad Debt policy.

42. Losses and special payments

The total number of losses cases in 2013-14 and their total value was as follows:	Total value of cases £s	Total number of cases
Losses	887	2
Special payments	40,420	99
Total losses and special payments	41,307	101
The total number of losses cases in 2012-13 and their total value was as follows:		
Losses	10,000	1
Special payments	73,236	74
Total losses and special payments	83,236	75

Details of cases individually over £250,000
No such payments were made in 2013-14 or 2012-13.

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance

	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000	2011-12 £000	2012-13 £000	2013-14 £000s
Turnover	336,896	384,146	410,129	438,979	488,830	604,247	620,411	641,768	664,717
Retained surplus/(deficit) for the year	(33,569)	(2,901)	5,972	1,718	10,552	5,020	5,728	3,134	4,696
Adjustment for:									
Timing/non-cash impacting distortions: Use of pre – 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	0
Adjustments for impairments				0	1,083	0	0	1,028	0
Adjustments for impact of policy change re donated/government grants assets						0	(1,060)	775	67
Consolidated budgetary guidance –adjustment for dual accounting under IFRIC12*					1,298	1,439	1,433	1,349	1,269
Adsorption accounting adjustment						0	0	0	0
Other agreed adjustments	21,996	0	0	0	0	0	0	0	0
Break-even in-year position	(11,573)	(2,901)	5,972	1,718	12,933	6,459	6,101	6,286	6,032
Break-even cumulative position	(35,169)	(38,070)	(32,098)	(30,380)	(17,447)	(10,988)	(4,887)	1,399	7,431

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %
Materiality test (i.e. is it equal to or less than 0.5%):									
Break-even in-year position as a percentage of turnover	-3.44	-0.76	1.46	0.39	2.65	1.07	0.98	0.98	0.91
Break-even cumulative position as a percentage of turnover	-10.44	-9.91	-7.83	-6.92	-3.57	-1.82	-0.79	0.22	1.12

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3 External financing

The trust is given an external financing limit which it is permitted to undershoot.

	2013-14 £000s	2012-13 £000s
External financing limit (EFL)	4,349	10,925
Cash flow financing	(400)	2,634
Unwinding of discount adjustment	26	0
Finance leases taken out in the year	1,165	754
Other capital receipts	0	(8)
External financing requirement	791	3,380
Under/(over) spend against EFL	3,558	7,545

The under spend against EFL was caused by cash receipts received just prior to the year end.

43.4 Capital resource limit

The trust is given a capital resource limit which it is not permitted to exceed.

	2013-14 £000s	2012-13 £000s
Gross capital expenditure	27,219	17,358
Less: book value of assets disposed of	0	(426)
Less: capital grants	0	(45)
Less: donations towards the acquisition of non-current assets	(1,299)	(244)
Charge against the capital resource limit	25,920	16,643
Capital resource limit	28,989	25,643
(Over)/underspend against the capital resource limit	3,069	9,000

The under spend relates to slippage on several capital projects.

44. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS 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 2014 £000s	31 March 2013 £000s
Third party assets held by the Trust	8	8

The third party assets are all related to patient monies.

Contact us

Let us know what you think

Please contact the communications team to provide feedback and help us to improve the information included in next year's report.

Telephone 020 8725 5151
Email communications@stgeorges.nhs.uk

Support from us

Our PALS team offers support, information and assistance to patients, relatives and visitors. The PALS office at St George's Hospital is open 9am to 5pm, Monday to Friday.

Telephone 020 8725 2453
Email pals@stgeorges.nhs.uk

Work for us

If you are interested in working for St George's Healthcare NHS trust, visit our website www.stgeorges.nhs.uk or get in touch with our recruitment services team.

Telephone 020 8725 0600
Email hrrecruitment@stgeorges.nhs.uk

Become a member

We need our patients, local community and members of staff to become members of the trust to help ensure that we meet the needs our patients and local communities. If you would like to become a member, or would like further information you can contact the membership team.

Telephone 020 8622 6132
Email members@stgeorges.nhs.uk

Giving to St George's

As well as making a donation there are lots of ways you can get involved with the St George's Hospital Charity. To find out more speak to the Giving to George's team.

Telephone **020 8725 4916**
Email **giving@stgeorges.nhs.uk**
Web **www.givingtogeorges.org.uk**

Volunteer

Our volunteers perform a number of varied roles, from manning information desks, general housekeeping, administration and helping patients find their way around. If you would like to volunteer at any St George's Healthcare sites, contact the voluntary services team.

Telephone **020 8725 1452**
Email **zoe.holmes@stgeorges.nhs.uk**

Request a printed copy

Contact the communications team if you would like a printed copy of the annual report or quality account.

Telephone **020 8725 5151**
Email **communications@stgeorges.nhs.uk**

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