St George's University Hospitals
NHS Foundation Trust

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Annual Report and Accounts 2017/18

Excellence in specialist and community healthcare

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Chairman's Statement

I am delighted to write this introduction to the Trust's Annual Report and Accounts for 2017/18.

I joined the Trust as a Non-Executive Director in June 2016, and took on the role of Chairman in April. It was clear to me then – as it still is now – that the organisation faces a number of challenges. However, I am confident that we are making progress.

I spent the whole of my career in local government and whilst I worked very closely with Clinical Commissioning Groups and community services, the world of an acute hospital is a new experience for me – but a very positive one. I enjoy my role very much but the best thing about it is meeting staff and seeing the great work they do for our patients and communities.

One of my priorities as Chairman was to bring stability to the Trust Board. I was pleased to appoint Jacqueline Totterdell as Chief Executive in May, and she has since built a new and highly capable Executive Team. I was also delighted that Tim Wright has joined us as a new Non-Executive Director, and his background in IT is already proving helpful and instructive.

Our Foundation Trust Governors continue to play an important role in representing the interests of local people, and I was pleased to welcome new members to the Council of Governors following elections in February 2018. As an organisation, it is sometimes easy to forget what a large role we play locally, both as an employer of thousands of people, as well as a provider of healthcare to millions. Our Governors provide us with a crucial link to these communities, but also challenge us to ensure we are making decisions that are truly in the interests of patients – and long may this continue.

As I said, the organisation faces a number of challenges, and we are still not where we want to be. It is absolutely vital that we reduce our financial deficit – as we have started to do in 2017/18 – whilst also continuing to provide high quality and responsive services.

The performance of our key services, including the Emergency Department at St George's, is still too variable, but I am confident staff are working very hard to manage the increasing demand for services.

One of the Trust's six strategic objectives is to develop tomorrow's treatments today, and it has been exciting for me, as Chairman, to see the many different ways in which our staff are innovating for the benefit of patients. For example, last year, we became the first Trust in the country to provide a surgical treatment for stroke 24/7. Our mechanical thrombectomy service for stroke patients is now the model for others to follow, which is fantastic.

In September, I also had the pleasure of meeting Zahid Mukhtar, Paediatric Surgeon, at our Annual Members' Meeting. Mr Mukhtar spoke at the meeting about the pioneering operation he performed on baby Abi just eight days after she was born at only 23 weeks gestation. The fact we have experts like Zahid within our organisation is inspiring to me, and confirms that we have it in us to truly push the boundaries of what is possible.

I want to pay tribute to the contribution of our volunteers, as we need to ensure we constantly recognise their generosity of time and spirit. I attended the first ever Staff Appreciation Awards in March 2018, hosted by the St George's Hospital Charity, where I was glad to see their efforts recognised alongside those of staff.

In conclusion, the coming year promises to be a challenging one, but I am confident we are heading in the right direction. It will take time, as some of the problems we face have been many years in the making. Equally, there is a real ambition within this organisation to aim high, and truly compete with the best – and that is what I want us to do.

Gillian Norton
Chairman
24 May 2018

Performance Report

Annual performance statement from the Chief Executive

I write this introduction to the Annual Report and Accounts towards the end of my first year as the Trust's Chief Executive. I took up my role as Chief Executive on 2 May 2017, and the past 12 months have been challenging and rewarding in equal measure – as I knew they would be.

I believe we have made progress, although there remains a huge amount still to do. I am confident we are all pushing in the right direction, and there is clearly an appetite amongst staff – and local stakeholders – for St George's to succeed. This is fantastic, and will help maintain morale as we continue to tackle some of the deep-seated challenges we face.

In December, we announced our intention to provide Outstanding Care, Every Time, and this is helping to unite our collective efforts to make things better, as are the six strategic objectives that underpin it.

One of our objectives is to provide the right care, in the right place, at the right time. I am pleased to say that performance in some areas – such as access for cancer services – has improved dramatically, but still not in the uniformly consistent way we would want.

The same is true of waiting times in our Emergency Department at St George's. We need to manage flow better throughout the organisation, for the benefit of both patients and staff. This is a key priority for the coming year.

We have made progress in the way we manage and track patients on our internal administration systems. Our Elective Care Recovery Programme has helped ensure that we now have effective waiting lists, which is a major step forward for the organisation.

I am pleased to say the Care Quality Commission (CQC) lifted their warning notice in May, which was imposed following their last full-scale inspection in June 2016. We underwent an unannounced inspection in March 2018, and we await their final report.

We launched our Quality Improvement Plan in October, with a very successful quality improvement week held at St George's Hospital in November. We have made progress in terms of our quality agenda - from reducing healthcare acquired infections to improving the way we manage medicines.

Of course, we want to go further - which is why we have started working with the Institute for Healthcare Improvement to look at how we can embed a quality improvement culture within the organisation, which is an exciting development for staff and the wider organisation.

One of the things I was most struck by when I arrived was the fact that, between October and December 2016, only 36% of our staff were recommending St George's as a place to work. I am pleased to say that this now stands at 56%, which is a significant improvement. However, we want to be better, and my personal ambition is that this increases to at least 80% - although we should always be looking to aim even higher.

We launched a new staff engagement plan this year, and also held a series of Big Conversations with our staff, which has helped us identify where we need to deliver improvements. A key priority for the coming year is improving training opportunities across the organisation, and we are excited to be working with the King's Fund on a leadership development programme involving our senior managers.

The coming year is going to be challenging, as we have to reduce the financial deficit significantly. We have made progress this year, reducing the deficit from £78.7 million to £53.1 million. But we are still spending more than we bring in each month – and this has to stop.

I have been clear with staff that we will invest in some essential improvements – such as our IT infrastructure and estate at St George's Hospital – but the focus will be on making our many services more efficient as part of our transformation of the organisation.

Our ambition for the coming year is to provide Outstanding Care, Every Time. A big part of this is working to exit the special measures regime that we are currently in, for both quality and finance. This will be difficult, but I am confident we will get there, especially if we continue to work as a team and fully utilise the fantastic skills and commitment at our disposal.

Jacqueline Totterdell
Chief Executive
24 May 2018

Performance Report - Overview and Analysis

St George's University Hospitals NHS Foundation Trust has an international reputation for quality of care, education, research and medical advancement. As an NHS organisation, we are bound by the NHS constitution, and our business is to care for people.

Our goal, irrespective of who uses our hospital and community services, is to improve a patient's health and wellbeing. We support patients to keep mentally and physically fit and to help them to get better when they are unwell.

St George's is community centred, and our staff have strong links to the communities we serve. However, as an internationally recognised organisation leading in research, innovation and cutting edge technology, we also attract individuals from all corners of the globe to work at the Trust.

The Trust has grown to become an accredited centre of excellence for trauma, neurology, cardiology and cancer services, and a national centre for family HIV care and bone marrow transplantation for non-cancer diseases.

Many of our medical staff have trained at St George's, University of London, with whom we share our Tooting site. As the largest healthcare provider in south west London, our two hospital sites at St George's and Queen Mary's serve a population of 1.3 million people across south west London.

A large number of services, such as cardiothoracic medicine and surgery, neurosciences, amputee rehabilitation, 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 specialist services treat patients from even further afield.

- St George's University Hospitals NHS Foundation Trust has 1,083 beds; 995 at St George's Hospital and 88 at Queen Mary's Hospital
- The beds at St George's Hospital comprise 871 general and acute, 67 maternity and 57 critical care
- The beds at Queen Mary's Hospital comprise 46 for people with limb amputations who require neurorehabilitation, and 42 for sub-acute care, treatment and rehabilitation of older people.

A number of our services are part of established clinical networks, which bring together clinicians and support staff from a range of healthcare providers to work to improve the quality of services for patients.

These include the Royal Marsden Cancer Partners Vanguard, the South London Cardiac and Stroke Network, and the South West London and Surrey Trauma Network of which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

Analysis

The Trust has experienced a number of financial, operational, quality and leadership difficulties in recent years. A significant amount of progress has been made during 2017/18, as detailed in this report, but significant challenges remain.

Following the appointment of a new Chair and Chief Executive, the Trust Board has now stabilised, and the organisation has a clear set of organisational objectives to focus energies and drive forward improvements. Staff are more engaged, and feel more valued, as evidenced by the latest NHS Staff Survey results (2017).

We launched our Quality Improvement Plan in October 2017, and this is helping us address key issues that affect our patients, including everything from reducing hospital acquired infections to making sure we learn from incidents when they occur.

The performance of key services is still inconsistent, but we are now able to effectively track patients on their care pathway which, as detailed below, is a significant step forward for the organisation. Work is in progress with our clinical and managerial teams to deliver consistent improvements to cancer and emergency care performance.

The challenge we face

There are still a number of very real challenges to address. Our most recent full-scale Care Quality Commission (CQC) inspection in June 2016 showed that, despite caring staff, the quality of care we provided fell far short of the high standards we would expect.

The CQC report (published in November 2016) resulted in the Trust being placed in quality special measures by NHS Improvement. In addition, the CQC issued the Trust with a Section 29a Warning Notice, which required us to take immediate actions to address the key areas of concerns raised by the CQC.

Due to the Trust forecasting a deficit of £79 million in 2016/17, the Trust was also placed into financial special measures by NHS Improvement in March 2017. As a Trust in special measures, we have been receiving support from NHS Improvement to help recover our financial position.

As the Trust exits 2017/18, we remain in financial and quality special measures. However, despite this, the Trust can point to significant progress over the past 12 months.

Feedback from the quarterly NHS Staff Friends and Family Test (FFT) survey, and internal engagement events held with staff, demonstrates that there is a growing confidence within the organisation that we can overcome our challenges.

Since April 2017, key substantive appointments have been made to the Trust Board. These include the appointment of individuals with significant experience in leading a Trust through a quality and financial improvement journey.

We have made strong progress throughout the year in developing and implementing major improvement programmes, including our Elective Care Recovery Programme, which has led to the introduction of a waiting list management programme at St George's Hospital to address our waiting list issues (referral to treatment). All of our improvement programmes have focused on stabilisation activities, and putting the core building blocks in place for future transformation.

In May 2017, the CQC undertook a focused inspection of our services which showed improvements at the Trust since their last visit. During the inspection, the Trust was assessed as meeting the requirements of the Section 29a Warning Notice, resulting in the warning notice being removed.

However, the inspectors confirmed that there was still more to do, particularly with regard to some of our systems and processes and, most important of all, management of referral to treatment data which remained an area of concern.

At the beginning of 2017/18, we developed a £43.5m cost improvement and efficiencies programme. This was followed by a new Financial Recovery and Transformation Plan, and in October 2017 the revised Quality Improvement Plan.

Our Quality Improvement Plan

Our Quality Improvement Plan is our blueprint for making sure all of our patients across our hospitals and community services receive safe and compassionate care as a matter of course. We listened to the feedback from our staff, our partners and inspectors from the Care Quality Commission (CQC). We put our staff at the heart of change, every step of the way, and they proposed five key areas that we need to address to provide the best possible care for patients. They are:

- Safe and Effective Care – we will consistently deliver the fundamentals of patient care and ensure that improvements we make are sustained in the long term
- Flow and Clinical Transformation - we will make the process and operational changes to improve the flow of patients along their care pathway, from arrival through to discharge
- Quality and Risk – we will handle risk effectively throughout the organisation, using effective systems and processes that are understood by our staff
- Estates and IT – we will improve our systems and environment so that we are making what's right for patients the easiest thing for staff to do
- Leadership and Engagement – we will ensure our current and future leaders are supported and developed to deliver high quality, compassionate care, and that we engage with our staff who know our services best.

By October 2017, the Quality Improvement Team was actively supporting 17 strategic Trust-wide initiatives as well as many local quality improvement projects. Using over 70 indicators and metrics to track progress against the plan, including national measures of performance, such as the NHS Staff Friends and Family Test data, or local indicators that we have set ourselves, we have carefully tracked our progress over the past eight months.

We have also increased and developed our audit programmes, multidisciplinary audits, inspection programme, back to the floor meetings and Trust Board visits to clinical areas. Every ward in the Trust now has a quality dashboard with key quality metrics visible to both patients and staff, so we can identify where we need to improve our performance and show that we are being transparent in the process.

Safe and effective care for our patients

Ensuring we provide the fundamental standards of care makes up a significant portion of the day-to-day activities at the Trust.

We designed the Safe and Effective Care workstream to ensure that we get the basics right for all of our patients. We included everything from ensuring staff wash their hands appropriately through to the management of sepsis, and ensuring we effectively recognise and manage the deteriorating patient.

Throughout the year, we have seen a steady improvement across almost every focus area, and in some areas have seen examples of outstanding performance. For example, between October 2017 and March 2018, none of our patients experienced the most painful Grade 3 & 4 type pressure ulcer as a result of the care they received.

Providing the best care to our most unwell patients

In July 2017, we agreed a very challenging goal of 100% compliance for the four main measures for Early Warning Scores. These scores are used as a graded response strategy for patients who are at risk of clinical deterioration. In January, 34 adult areas and 321 patient cases were audited to determine how well we record, recognise and escalate the care we provide to a deteriorating patient.

We achieved 92% compliance, which is above the 85% national standard. This reflects the significant effort of everyone involved, and a continued improvement over the past eighteen months in the care we provide for our most unwell patients.

Key to these improvements has been the development and training of our staff. In July 2017, the St George's Advanced Patient Simulation & Skills Centre (GAPS) redesigned their innovative set of educational programmes called MEERKATS (Medical Emergencies: Evaluation, Response and Keeping Attention on Team Communication and Patient Safety) to support staff to recognise and treat deteriorating patients.

This innovative programme, aimed at nursing shift leaders, junior and senior medical staff and healthcare assistants, combines the essential elements of patient safety with good practice in communication, and recognition and management of acutely unwell patients. To ensure our staff receive hands-on learning they participate in simulation exercises that reflect their normal clinical role and work in realistic clinical teams communicating with each other in a simulated environment.

Making sure our patients receive their medications on time

In November 2017, we opened a fourth satellite pharmacy dispensary. These local sites can dispense medicines to patients more rapidly than by using the main pharmacy, meaning patients get improved access to their take home medications and can be discharged more quickly.

Throughout the year, the Pharmacy Team has built upon their successes, and featured as an example of best practice in an NHS benchmarking report 'Pharmacy and Medicines Optimisation' in September 2017. A recent audit by our Lead Medicines Management Technician demonstrated that 95% of patients are receiving their medications within the 60 minute national target.

The Medicines Management Programme will continue to deliver significant cost and quality improvements in 2018/19. These will be driven by medicines optimisation, income generation and achieving a reduction in challenges from commissioners for the issuing of high cost drugs to patients.

Only one chance to get it right

During their inspection in 2016, the CQC rated our provision of end of life care as inadequate, and highlighted the Trust's lack of a strategy for the delivery of community end of life care services.

Our Palliative Care Team sees approximately 1,600 patients a year of which 50% have non-cancer diagnoses. 30% of these patients will be reaching the end of their lives.

In May 2017, we launched a new End of Life Care Strategy across the Trust. Based on national guidelines, we have committed to the Six Ambitions for Palliative and End of Life Care. We've embedded this across the Trust and in March 2018 we launched the new 'Achieving Priorities of Care in the Last Hours and Days of Life Nursing Care Plan' to support our staff to provide better care for patients.

We also launched the end of life care bag which is for the carer, family or friend of someone who is in the last stages of life. The bag contains information and practical items at what can be a very difficult and overwhelming time.

Flow and Clinical Transformation

Many of our clinical teams are involved in the large scale Flow and Clinical Transformation programme as part of their day-to-day work. The programme was established to ensure that patients coming for urgent care, emergency care and planned care will have a better quality experience through being able to access their assessment, treatment and care, from arrival through to discharge, in a more timely way.

Over the past year we have been monitoring for improvement against three main performance areas:

- Unplanned and Admitted Care
- Theatres
- Outpatients

Patient experience, safety and outcomes are at the core of these programmes. Our outpatients programme has put people in more control of their care, further involving them in decisions about when to access treatment and giving them choice and control over the NHS services they receive. By doing so we are supporting patients to focus on what matters to them within the context of their lives and making better use of our resources

We have been working to improve our clinical governance, standards, and practices and embedding models which conform to evidence-based best practice and guidelines. We have focused on the root causes of poor flow, which lead to excessive delays and waiting and inefficient care delivery. With this in mind we have been working with our staff, patients and partners to break the problem down to understand the key drivers of variation and performance that affect the overall flow of patients through our system.

Making what's right for the patient the easiest thing for clinicians to do

We have made steady progress towards implementing our Unplanned and Admitted Care Programme, which is a key part of our overall quality improvement and recovery plan.

Three principles underpinned our 2017-18 recovery and transformation plan:

- Making the right thing to do for the patient the easiest thing for clinicians to do
- Aligning our clinical capacity to pathway demand
- Getting our patients to the most appropriate place for their assessment, treatment and care

We opened innovative new Ambulatory care facilities for adults, children and for key specialist services, having secured £1 million of Department of Health funding. These new pathways and services aim to treat patients who do not require inpatient care. This also relieves pressure on emergency and inpatient admissions, and is a vital step in developing a more effective 'Emergency Floor'. New models of care and clinical pathways, such as virtual clinics, open access and straight-to-test appointments, are beginning to help many patients avoid unnecessary hospital appointments, so increasing our ability to see patients.

Patient experience drives Theatres Improvement Plan

Patient experience underpinned the operating Theatres Quality Improvement Programme. In July 2017, we created new patient research panels which highlighted the need to improve patient communications, timeliness of care and patient dignity.

To improve the experience for our patients, we focused on reducing cancellations, particularly on the day of surgery. We achieved this through better booking and scheduling processes, and improved use of pre-operative assessment and day surgery. We also moved the location of our pre-operative assessment unit into fit-for-purpose

accommodation, so that we can ensure our patients are fit for their surgery.

In July 2017 we refurbished two of our main theatres at St George's and maintained overall productivity during this period. Towards the end of the year, we launched an innovative inter-professional patient safety training model, where theatre staff from across all clinical areas come to train together using real-life scenarios.

We were also awarded a £10,000 grant for a maternity theatres project by the Health Innovation Network (HIN). Women who have an operative delivery can have a different experience compared to women who give birth in a midwife-led delivery room. This is especially the case if the decision to deliver in theatre has been made late in pregnancy or during labour. The project, which will look to improve the experience for mothers, takes place over the next year, and is collaboration between a range of maternity staff (including theatre staff, midwives, anaesthetists and obstetricians) and women who have had a baby in theatre.

Prioritising the patient's outpatients experience

During 2017, we put a priority on the experience for patients and staff in our outpatient clinics. We wanted to shorten the time patients were waiting for assessment and treatment.

We have worked hard to introduce better ways of working in order to:

- Reduce the time patients have to wait to receive their diagnosis and treatment
- Reduce the number of times patients attend outpatient appointments
- Prevent patients having to come to the hospital in the first place

We've been doing this by working with services to pilot new and innovative ways of working, some of which have proved successful and are ready to be used more widely. For example, at present, routine patients in gastroenterology outpatients wait up to 16 weeks for a first appointment. Historically patients attended their first appointment and no decision on their treatment was made, as the majority of patients required a test, resulting in a delay in receiving their treatment.

In February 2018 the Gastroenterology Outpatient Service started piloting a new way of working. The pilot involves a consultant reviewing the GP referral and sending the patient for the tests they require. After the test, the consultant reviews the results before deciding if they need to see the patient face to face. We anticipate approximately 20% of patients will not require a face to face appointment. In addition, the patients who do require an appointment should go on to have fewer follow up appointments.

Many of our patients are given follow up appointments as a safety net. A new system we introduced called 'open access' allows the patient to decide if they need to come back to hospital for a follow up appointment. A pilot started in Ear, Nose and Throat in July involved placing patients onto a request list for six months, and provided the patient with the option to make a follow up appointment if they choose via a form on the Trust's website www.stgeorges.nhs.uk. Over 80 appointments have been saved and since the initiative started only three patients have rebooked an appointment. During 2018 we plan to roll this service out to other services including Paediatrics, Vascular and Dermatology at the Nelson Health Centre.

E-Referral scheme helps both GPs and patients, and improves efficiency

An increase in GPs making online referrals is helping us to move all GP outpatient first appointment referrals onto e-RS (e-Referral System, previously known as 'Choose and Book').

Online referrals provide many benefits to patients, GPs and staff, including better patient experience and improved safety. The system is more reliable and safer than post, fax or email, as e-RS has a full audit trail from the moment a GP refers the

patient to hospital, meaning referrals are digitally tracked and are less likely to be lost at any stage. The outcome has been a much quicker patient pathway, with appointments confirmed up to seven days quicker than postal referrals.

100% of St George's outpatient clinics are now available on e-RS. One third of GP referrals are now being made via e-RS, up from just 16% in autumn 2017. The target, in line with national NHS requirements, is 100%, and alternative channels such as email, paper and fax will be 'switched off' in the coming months. e-RS is quick and easy to use for GPs who can see, and tell patients, when appointments are available. We are working closely with Wandsworth and Merton Clinical Commissioning Groups in particular to encourage increased GP use, with training and ongoing support.

The e-RS uptake project is being delivered by the Outpatients Transformation Programme, part of our Quality Improvement Plan. The Trust will benefit through reduced administration, and increase the speed at which a first outpatient appointment for the patient is made. There is also a financial benefit through a CQUIN (Commissioning for Quality and Innovation) payment for moving referrals onto e-RS.

Our transformation work has also extended to equipping managers and clinicians with better information to undertake their roles. A structured approach and dedicated support teams have embedded consistent ward management processes onto a number of wards, including the 'SAFER' standards, designed to ensure patients make daily progress towards a planned discharge.

Quality and Risk

The Quality and Risk Improvement Programme focussed on how we handle risk effectively throughout the organisation, through effective systems and processes that are used and understood by our staff. This includes how we learn when things don't go as well as we expect them too, and how well we respond to complaints.

Learning from incidents

We saw a 25% reduction in Serious Incidents last year, whilst 84% of our staff told us in the NHS National Staff Survey that the Trust actively encourages reporting of errors, and 94% staff say they know how to report incidents. We have revised our governance process for Serious Incidents to ensure that we both respond to and embed the learning from incidents, so as to reduce the repeat occurrences of any issues identified.

Responding to your complaints

The Trust cared for over one million patients in 2017/2018. We accept that, despite our best efforts, the experience for some will unfortunately not meet their expectations, or indeed our own. We take complaints very seriously and are committed to learning from them, so that the same type of incident doesn't happen again. We recognise that over the next twelve months we must improve how quickly we respond to complaints with the agreed timescales.

We adhere to the Parliamentary and Health Service Ombudsman's Principles for Remedy, which provides guidance on the way in which public bodies respond to complaints and concerns raised by patients and their representatives. We are absolutely prepared to change and improve in response to feedback from patients, visitors and other stakeholders. The lessons learned and trends identified from the 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. It advises staff regarding access to interpreters, signers and other services patients may need to improve their experience. PALS staff also provide customer care training to colleagues and often assist staff when they are in need of support.

Complaint type received in 2017/18	2017/2018
Admissions, discharge and transfer arrangements	41
Aids and appliances, equipment, premises (including access)	5
Appointments, delay/cancellation (outpatient)	145
Appointments, delay/cancellation (inpatient)	23
Attitude of staff	75
All aspects of clinical treatment	365
Communication/information to patients (written and oral)	222
Consent to treatment	1
Patients' privacy and dignity	5
Patients' property and expenses	10
Personal records (including medical and/or complaints)	9
Failure to follow agreed procedure	2
Patients' status, discrimination (e.g. racial, gender, age)	2
Transport (ambulances and other)	19
Hotel services (including food)	9
Others	26
Total	959

Our Trust objectives and strategy

The new financial year will see a new Trust Strategy developed with full engagement from our staff and external stakeholders. We will be working closely with our partners in the south west London Health and Social Care Partnership to ensure we work together to improve care and services for people in south west London.

Defining what St George's 'is' and 'does' will bring clarity to all Trust staff about the organisation's longer term direction of travel, and will inform the Trust's decision making on where to focus scarce investment resources.

We have already taken the first steps in its development. In December 2017, we launched our organisational objectives following a series of staff engagement events. Based on our vision to provide Outstanding Care, Every Time, we consolidated our organisational focus and improvement programmes in to six strategic organisational objectives:

- Treat the patient, treat the person
- Right care, right place, right time
- Balance the books, invest in our future
- Build a better St George's
- Champion Team St George's
- Develop tomorrow's treatments, today.

With a focus on the fundamentals of care, financial stability and operational delivery, we believe these are a balanced set of objectives, the combined delivery of which is essential to the organisation's long term future.

Major risks to the Trust objectives

The Board Assurance Framework (BAF) has been developed during the year using the strategic risks identified by the Trust Board at a workshop facilitated by Deloitte in August 2017. The revised strategic risks were agreed at the October 2017

meeting of the Trust Board. The executive lead and the responsible assuring committees have also been agreed.

Relevant sections of the BAF are being taken to each of the agreed assuring committees so that the committees can make an assessment of the assurance rating for their allocated risks, which are then reported to Board. The Board has agreed the strategic risks which are mapped against the Trust's six strategic organisational objectives. Each assuring Trust Board committee reviews the BAF and the strategic risks allocated to the committee. At meetings in January 2017 and February 2018, the risk ratings for the strategic risks were agreed and the strength of the assurances on the effectiveness of the controls were also agreed.

We have established controls or are implementing actions which will continue into 2017/18 to manage these risks, as detailed on **page 75** in the Annual Governance Statement.

Performance against our objectives

We have made progress during the year towards achieving our core objectives, delivering on a Quality Improvement Plan, a significant Cost Improvement Plan and putting in place better processes for financial management, governance and improving the timeliness to care for patients. In the next section you can read some of our key initiatives and progress throughout the past year.

Objective – Treat the patient, treat the person

Treat the patient, treat the person focusses our efforts on providing the fundamentals of good patient care across our hospital and community services.

Every patient we see and treat is an individual, so we need to ensure we meet their medical and psychological needs at all times, and this is a key part of our commitment to treating the patient, treating the person.

A step change in patient and public engagement

In the summer 2016, we agreed a patient and public engagement strategy. In March 2018 we began the process of revising the plan to build a Trust wide patient and public engagement strategy and action plan, through an initial co-design event. This is designed to build on the many examples of patient and public involvement in supporting and developing specific services across the Trust.

At the heart of the strategy is the commitment to ensure patients and the public are able to help shape and input into every aspect of the Trust's work, specifically:

- Develop a culture that places excellent patient experience at the heart of everything we do
- Involve patients as equal partners in their healthcare
- Engage and consult with key stakeholders including those from vulnerable or seldom heard groups
- Ensure our Foundation Trust membership reflects the diversity of our community and that we provide a range of opportunities for members and Patient Partners to be involved.

Patients, staff and partners attended an event in March 2018 to discuss the future of patient involvement at the Trust.

A charter will be launched in 2018. The Trust will also be setting up a Patient Partner Engagement and Experience Group, to encourage the development of good practice across the organisation.

Innovative pre-surgery school for patients launches at St George's

A 'surgery school' designed to support patients mentally and physically with their planned operation and recovery was launched at St George's in 2017.

Patients with cancer, who need major surgery, are invited to attend a 2.5 hour session with a friend or partner. The sessions are run by a multidisciplinary team of staff, who help the patients learn more about their hospital stay and improve their health prior to surgery. This 'prehabilitation' not only gives them a better experience in hospital, but reduces their risk of complications.

At the launch, St George's patients were able to find out more about the topics covered during the 'surgery school', including the benefits of good nutrition, increasing physical activity, smoking cessation and alcohol education with the aim of empowering people to improve their chances of a successful recovery.

The 'surgery school' allows staff to advise a group of patients who would not usually have access to dietetic advice prior to surgery, supporting them in making healthy choices to improve the balance of their diet, promote achievement of ideal body weight and reduce alcohol consumption.

The sessions also cover the psychological side of getting a cancer diagnosis and embarking on major surgery, explain the practicalities of the hospital and seek to answer patient concerns about things such as anaesthesia, pain relief and catheters. Patients have time over coffee to speak to staff informally and to meet the Macmillan Cancer Support Team.

We know from experience that the waiting time before surgery is when patients feel most anxious. As a result of pre-surgery school, we are able to provide help and information to prepare patients both physically and mentally for the challenges ahead.

Approximately 50 patients have attended so far, and feedback has been very positive.

The 'surgery school' is one of a number of innovations being piloted through a partnership between St George's and Macmillan Cancer Support.

Prison team leads the way in London screening programme

Our healthcare team at HMP Wandsworth has been praised by NHS England for its work screening new prisoners for blood borne viruses.

The programme was launched at HMP Wandsworth in April 2017, as part of a London-wide roll out and has been visited by Justice Minister, Dr Philip Lee MP, Health Minister, Lord O'Shaughnessy, and Sir David Amess, MP for Southend West. As a result of this work when prisoners arrive at Wandsworth HMP, they have an initial screening assessment by our Offender Healthcare Service to identify any physical or health risks that need immediate attention.

Secondary screening is then offered to prisoners within their first couple of days. At this point, the team is able to assess the prisoner's healthcare needs in more detail and screen for blood borne viruses in addition to the TB, chlamydia and gonorrhoea. The programme has been identified as an example of good practice by NHS England and the Ministry of Justice.

Objective – Right care, right place, right time

Right care, right place, right time is crucial to providing care and treatment in a timely fashion, and is a major priority for the organisation.

We need to reduce waiting times for key services – including emergency, cancer and elective care – whilst also ensuring patients are treated in the right place, be it in a hospital or community setting.

Health and social care professionals pilot new ways to improve patient discharge

Patients who need ongoing support, and may need further assessment and ongoing healthcare, are being discharged from hospital ten days earlier than the previous average, through successful partnership working in Wandsworth.

The Hospital discharge Continuing Healthcare (CHC) pathway began as a pilot in five of our wards in May 2017. Previously such patients typically stayed in a St George's bed for 35 days even though clinically fit for discharge, awaiting a full assessment of their ongoing healthcare need and eligibility for CHC funding.

St George's, Wandsworth CCG and Wandsworth Council introduced new ways of working so patients receive interim care and are discharged home or to a temporary residential placement some ten days sooner – a 29% improvement. Social care colleagues are involved earlier, and patients' future care needs are assessed while they recover in the community, not in a hospital bed.

The work with colleagues across health and social care means patients have a better experience with a shorter length of stay when acute care is not needed. Once patients are in a more appropriate environment, they can often also make more informed decisions about their ongoing care.

Red bag scheme grows to improve care home residents' hospital experience

A simple initiative designed to help people living in care homes enjoy a better experience when they are admitted to our hospitals in an emergency has been extended to cover Merton and Kingston.

We launched the 'Red Bag' last year with care homes across Wandsworth. Care home patients who are admitted to hospital are accompanied by a red bag with important information about their health, and personal belongings, so it is easily accessible to ambulance and hospital staff.

The red bag should ideally contain full information about the patient's general health, existing medical conditions and medication, and highlight specific current health concerns. This helps us identify the treatment required more quickly.

Bags also have room for personal belongings such as clothes, glasses, hearing aids and dentures, and stays with the patient while in hospital. When patients are ready to go home, a copy of their discharge summary (which details every aspect of the care they received in hospital) is placed in the red bag so care home staff have access to this important information when their residents arrive back home.

Rapid Access Clinic at Queen Mary's Hospital

Following a successful six-month Rapid Access Clinic pilot in October 2016, a full service was commissioned in April 2017.

The clinic assesses older people who have been referred to the service by their GP, community matrons and other healthcare professionals. The Monday to Friday service aims to see patients within 24 to 48 hours of being referred.

The majority of referrals are for quick assessment and investigation of patients that are at risk of acute admission, patients who are unsafe to remain at home and require community bed based rehabilitation, or require urgent geriatrician assessment.

Early assessment can help prevent unnecessary admissions to our Emergency Department, and staff are able to access investigations quickly and provide individualised care plans and follow up.

Objective - balance the books invest in our future

As a result of years of financial challenges, we want to ensure we **balance the books and invest in our future**.

This means working more efficiently as an organisation and generating savings, whilst also continuing to provide safe and high quality care for our patients. By balancing the books, we will be in a better position to invest in key services, and modernise the care we provide for patients.

Significant additional income has been secured during this financial year through specialties working to improve clinical coding.

The Better Coding Team works closely with clinicians and operational management to accurately capture all the clinical work we do. This ranges from actually recording minor procedures in outpatient clinics, through to describing complex elective cases for patients with multiple co-morbidities.

Getting the details right has been worth millions of pounds annually to the Trust. Training and 'real time' checking has helped clinicians see detail they could be recording, and explain things such as the new set of national codes that are now in place.

After validating the coding practices across many outpatient appointments that involved minor procedures, we identified some £847,000 of additional income for appointments up to the end of November 2017 alone.

We continue to work closely with our consultants to identify and include additional detail that reflects the quality and complexity of surgery work. We have provided data awareness support to our administrative staff to capture elective activity more consistently, so helping to ensure we get our waiting lists back on track.

In-depth support has already been rolled out to Ear Nose and Throat (ENT), Renal, Gastroenterology, Gynaecology, Breast Surgery, Urology, Paediatrics, Respiratory Medicine, Neurosurgery, Plastic Surgery, Trauma and Orthopaedics, General Medicine and Dermatology.

Build a better St George's

Building a better St George's is about modernising our estate, IT systems and processes.

By delivering improvements, staff will be able to spend more time and energy doing what they do best – treating patients.

At present, this is not the case, and investment is required to deliver a step-change in the way we manage our systems and processes.

Information Communication and Technology (ICT) plays a key role in working towards our

vision to deliver Outstanding Care, Every Time. Last year saw good progress in stabilising the ICT infrastructure and network across the Trust

During the year, we focussed on stabilising much of the ICT networking infrastructure and applications to reduce the significant ICT risks to which the Trust is exposed. Whilst we were not affected by the global cyber security attacks which took place in May 2017, we have reinforced our security to ensure the Trust is compliant with NHS guidelines.

We have introduced Medxnote, a secure messaging app, which enables clinicians to contact colleagues with any queries regarding patient care. We have also replaced endoscopy software so that we now have one system across the Trust that produces robust data. The Trust now has a clinical systems optimisation plan which will see the rollout of new clinical software being completed across the organisation.

Objective – Champion Team St George's

We employ over 9,000 staff across our hospital and community services, and they are the lifeblood of our organisation.

A major priority for the organisation is to champion team St George's, so as to empower our staff, and prioritise their physical and mental health. You can read more on how we are supporting our staff in the Staff Report on page 37 of this report.

Objective – develop tomorrow's treatments today

By **developing tomorrow's treatments today**, we will help develop new and innovative techniques, and increase participation in clinical trials – which benefits patients and staff.

HSJ Award win for our Blood Pressure Home Monitoring Team

The St George's Pregnancy BP Home Monitoring Team won a Health Service Journal (HSJ) Award in November 2017.

The team was nominated in the 'Using Technology to Improve Efficiency' category for its Home Monitoring of Hypertension in Pregnancy smartphone app (HaMpton).

The app allows women to monitor their blood pressure at home and alerts them if they need to attend hospital for further assessment.

Dr Asma Khalil, Consultant Obstetrician at St George's, led the project after having had the idea as a junior doctor.

HaMpton has been designed to help reduce the need for pregnant women to make frequent hospital appointments, and to empower them to be involved in their own clinical assessment.

After launching in January 2016, the app has helped reduce the number of appointments for hypertension monitoring by 53%, while maintaining the safety of mother and baby.

Team performs Trust's first robotic hysterectomy

Thomas Ind, Gynaecological Surgeon at St George's, led the Trust's first robotic hysterectomy in 2017. The procedure, which took just over an hour, was undertaken using the Da Vinci Robot SI and involved a team of eight people.

This type of surgery means a shorter length of stay for patients, a quicker return to normal activity and fewer complications.

The technique also reduces the length of time operations take as well as giving more flexibility during surgery.

Our team paves the way with UK surgical first

During the year our bariatric surgeons carried out the first day case gastric bypass procedure in the UK.

The procedure would usually involve a two night hospital stay. However, our team has worked hard to streamline the patient pathway, and improved and updated protocols to successfully carry out the procedure as a day case.

By using this procedure, the patient arrived and left hospital within eight hours of having surgery. This is the first operation of its kind to be carried out as a day case, paving the way for more routine bariatric day case operations in the future. The advantages of day case surgery are well documented, with faster recovery and better clinical outcomes.

Magnetic controlled 'growth rods' used in scoliosis spinal surgery at St George's for the first time

In December 2017, our surgeons used adjustable telescopic magnetic rods for the first time to straighten the spine of a young girl with severe scoliosis. The young patient has Russell-Silver syndrome, a congenital condition which restricts growth. The patient was diagnosed with early onset scoliosis, which led to rapid and severe curvature of the spine which traditional methods, including a brace, were unable to correct.

As well as straightening the spine, the rods can be adjusted remotely using a magnet in an outpatient setting to gradually grow the spine. The standard treatment using traditional growing rods requires children to have a general anaesthetic every six months and then manually lengthen the rods to grow the patient, which increases the risk to the patient, as well as the chances of complications such as infection. The magnetic growing rods avoid the need for regular surgery and repetitive general anaesthetic.

New trial of artificial intelligence for pregnancy ultrasound scans

Since February 2018, our fetal medicine unit has been trialling new technology which checks images taken by sonographers during fetal scans against national protocols in real-time. The new technology – called ScanNav - carries out automated, real-time 'peer view' of ultrasound images whilst our patients are being scanned.

All expectant women are advised to undergo a fetal scan at around 20 weeks of pregnancy. During this scan, trained sonographers look for normal growth and development in growing babies.

The use of this technology at St George's to support sonographers in real-time is a world-first. Images are checked against over 50 individual criteria to verify the six views required to be saved as part of the NHS Fetal Anomaly Screening Programme. The technology uses deep learning technology to assess the same features that sonographers look for in ultrasound images. The system "learnt" this using over 350,000 images that were assessed by a panel of senior sonographers. Initial validation studies have shown the AI system is as good as an expert colleague in providing peer review.

This has the potential to radically change the way we check and verify fetal medicine scans in the UK. This does not replace the important and

expert role played by the sonographer – but it does help assist and guide us in how we manage and support women during this key part of their pregnancy.

Performance Report - Clinical Analysis

Our operational performance during 2017-18 reflected a very challenging environment once again.

The Trust's performance is measured against a number of sets of targets, including those set by NHS Improvement, NHS standard contract requirements and measures we agree locally with our commissioners. In addition, we are measured against key national standards which include the four hour emergency care standard, plus referral to treatment for elective procedures.

In addition, our Board of Directors regularly reviews our progress against a range of internal and external metrics through our Integrated Quality and Performance Report. A scorecard with a core set of indicators is also reviewed by the Trust Board at its public meeting each month.

For each indicator, we look at how we are performing against the national standards and our own targets which flow from our various strategies. This helps us ensure we are on track to meet our targets and to deliver our strategic plans, as well as to help us spot issues that might affect the care we provide.

In October 2017, we revised our Quality Improvement Plan and how we support it to deliver improvements. The plan set out a dedicated commitment to improve our performance against the key national indicators, whilst at the same time reducing the amount of patients on our waiting lists due to the long term issues with our referral to treatment data.

Performance	Target	2017/18	2016/17	2015/16
ED: maximum waiting time of four hours from arrival to admission / transfer / discharge	>=95%	87.56	91.6%	90.44%
Consultant led referral to treatment waiting times incomplete pathways	>=92%	n/a	83.3%	90.25%
62 day wait for first treatment from urgent GP referral for suspected cancer	>=85%	82.60	84.9%	82.5%
62 day wait for first treatment from NHS cancer screening service referral	>=90%	90.33	93.2%	90.4%
62 day wait for second or subsequent treatment - surgery	>=94%	94.2	97.2%	96.5%
31 day wait for second or subsequent treatment – anti cancer	>=98%	100.0	99.6%	100%
All cancers: 31 day wait from diagnosis to first treatment	>=96%	97.1	97.2%	97%
Cancers 2 week wait from referral date for patients (cancer not suspected)	>=93%	88.0	90.3%	87.8%
Cancers 2 week wait from referral date first seen for symptomatic breast patients (cancer not initially suspected)	>=93%	93.3	93.7%	93.4%
C.difficile – meeting the C.difficile objective	31	16	36	39
MRSA bacteraemias (bloodstream inspections)	0	5	2	3

St George's trauma care rated best for care in the country

A report published in April 2017 by the Trauma Audit and Research Network (TARN) shows that patients treated within the South West London and Surrey Trauma Network – made up of the Major Trauma Centre (MTC) at St George's and seven trauma units at other hospitals - have a higher than expected survival rate than anywhere else in the country.

The survival rates for patients transferred to our MTC at St George's also show a year on year increase – with 1.2 additional survivors out of every 100 patients during 2016/17 (compared to 0.4 additional survivors out of every 100 patients during 2013/14). Trauma patients have multiple serious injuries that could lead to death or serious disability, including those involved in car accidents, major falls, or violence.

Like Major Trauma Centres around the country, we operate a 24/7 service at St Georges, which is staffed by specialist teams so patients have access to the best diagnostic and treatment facilities, including orthopaedics, neurosurgery and radiology teams.

Emergency Department Performance

Although we aim to provide the highest quality of care in our Emergency Department, we experienced another challenging year, with a yearly average of 87% of our patients being diagnosed, treated or discharged within four hours. We recognise that this must improve during the next financial year (2018/19), and beyond.

The overall number of attendances to our emergency services continued to grow, and there were numerous occasions when the Emergency Department recorded its busiest day ever. Daily attendances over the winter frequently and regularly exceeded 400, with the number of ambulance arrivals often exceeding 80 per day.

In July 2017, we began an innovative partnership between our Emergency Department and specialist mental health provider South West London and St George's Mental Health NHS Trust (SWLSTG).

Mental health nurses were recruited to the Emergency Department and, working alongside the existing Psychiatric Liaison Service, now provide care for all patients who attend our Emergency Department with a primary mental health condition. The use of mental health specialists to make interventions in the Emergency Department improves the care for vulnerable patients, reduces frequent attenders and allows us to treat more patients, more quickly.

As demand for emergency services across London increased, due to winter pressures and an influenza outbreak, our four hour performance dropped to an average of 85% per month from October 2017 to the end of the financial year. Despite our staff working hard to ensure patients were seen and treated as quickly as possible, we recognise this performance was below our expectations.

As part of our response, we implemented a Rapid Assessment and Discharge consultant-led model in late November, resulting in approximately twenty more patients per day being seen, treated or discharged from the Emergency Department.

A point-of-care flu testing device was installed in the Emergency Department in December. The device meant influenza test results were processed and acted upon in just 20 minutes, compared to up to 24 hours when sent to the laboratory. Being able to accurately diagnose influenza at the point of admission meant we were able to allocate patients to side rooms more efficiently, and thus prevent the spread of infection to other patients. It allowed us to create a dedicated ward to concentrate influenza patients together, improve the flow of patients and provide more space and capacity to care for more patients at the right time.

By March 2018, we had achieved a 90% uptake of influenza vaccinated frontline staff, the highest rate of any London Trust. This is a very positive achievement and a tribute to the commitment of staff across the Trust.

A 'Delivery Risk Summit' held in November 2017 identified and agreed a series of immediate remedial actions to improve our emergency care performance. A subsequent 'Risk Summit' on the four hour emergency care standard was held at the end of January 2018, chaired by the Chief Executive, and attended by the Executive Team and 90 clinical staff to review the impact of our performance at specialty level. Some of the actions included ensuring we improved the referral pathway from the Emergency Department, and ensuring specialities respond more quickly to Emergency Department requests.

In March we launched an electronic admission and discharge notification system on our wards, saving staff time and helping social care colleagues to serve the needs of their residents faster. We have also implemented national initiatives to improve patient safety and efficiency. This included implementing the SAFER bundle on four wards which increased the number of patients being discharged before 11am by 4% in February.

The NHS Five Year Forward View committed to providing a comprehensive front-door clinical streaming service in every hospital by October 2017. In spring 2017 there was a recommendation that all Accident and Emergency Departments (A&Es) should follow a national model for streaming patients – which is the process of allocating patients to the most appropriate physical areas of a hospital, and the most appropriate clinical pathways.

Since the recommendation, our streaming model has been reviewed and aligns with the service detailed in the London specification 'Streaming and Redirection: The London Model' (September 2017). It is a robust model that ensures our patients are directed immediately to the most appropriate place of care – getting the right patient to the right place. A part of this work programme included the opening of four ambulatory care units.

New ambulatory care units

In our Quality Improvement Plan published in October 2017, we committed to developing a physical space whereby adult and paediatric patient treatment needs can be met on an ambulatory basis, rather than being admitted to hospital.

After just a few months planning, in March we opened a new Paediatric Ambulatory Care Unit (called the Blue Sky Centre). 10-15% of patients aged 0 to 16 years who currently attend the Emergency Department and who have the appropriate conditions for short urgent ambulatory care will now be cared for by specialist paediatricians in the new Blue Sky Centre.

This was followed in March with the opening of three more Ambulatory Care Units. The Ambulatory Oncology Care Unit (AOCU) is a partnership between St George's and Macmillan, which provides cancer patients rapid access to specialist care when they have experienced complications from their treatment.

A Haematology Ambulatory Care Unit was opened to treat intensive chemotherapy patients who had traditionally been cared for in an inpatient setting. Towards the end of March 2018, we opened a new Ambulatory Assessment Area (AAA) for adults with acute medical conditions. We expect that 30% of adult acute medical admissions will be converted to ambulatory care, thus reducing the number of patients in our Acute Medical Unit and Emergency Department.

Faster access for cancer patients

Our continued efforts to improve the timely access to care for our patients have been reflected by the standard of our cancer referrals. We observed significant improvement throughout the year against the seven cancer standards. In December 2017, we achieved the national referral time to treatment standard across all eight standards for 14, 31 and 62 day cancer referrals.

Between April and December 2017, we improved our urgent 14 day standard cancer referrals by over 20%, which has had a huge impact on the quality of care our patients receive. By December, 99% of patients who required an urgent cancer referral were seen within 14 days. This was the fourth consecutive month we reported above the

national standard. By December 2017 more than 90% of patients with urgent tumour referrals were seen within 14 days. This included lung, breast and children with tumours.

Similar to other cancer centres, we found it difficult to begin treatment for patients within 62 days, particularly when patients are referred to us late in their clinical pathway.

Improving cancer care with Macmillan Cancer Support

St George's and Macmillan Cancer Support are working together to deliver a better experience for people affected by cancer in south west London.

The three-year Macmillan-funded partnership was launched in 2015, and includes four projects and pilots. Achievements of the programme to date include:

- Macmillan Cancer Support Worker Pilot: The funding of six support workers, who can assist and complement the work of Clinical Nurse Specialists, freeing up nurses to spend more time with patients

- Acute Oncology Service Redesign Project: The opening of an Acute Oncology Service, helping to give cancer patients rapid access to specialist care, avoiding the Emergency Department if clinically appropriate.

- Patient and Public Involvement (PPI) Pilot: Pilot funding of a PPI Coordinator to help develop and implement innovative ways to increase patient involvement, plus improve patient awareness of how to provide feedback and drive improvements in patient experience.

- Surgical Pathway Experience Project - Values Based Standards: 'Surgery school' and magnetic information boards piloted for patients who need surgery. Macmillan Values Based Standard framework introduced on surgical wards.

Lung cancer survival rates

A report in 2017 also detailed that survival rates for lung cancer buck the national trend at St George's.

The Society for Cardiothoracic Surgery in Great Britain and Ireland recognised St George's as a 'positive outlier' for patient survival one year following lung cancer surgery. Of 199 patients undergoing lung cancer surgery at the Trust, over 93% were alive 12 months after their operation, in comparison to the national average of 87%.

Surgery for lung cancer is a major operation for any patient, so the fact one year survival rates for patients that have undergone lung cancer surgery at St George's are higher than the majority of other centres in the country is testament to the work and dedication of the clinical teams treating them.

Reducing patient waiting times

In January 2016, we became concerned about the quality and robustness of our data reporting, particularly for how we manage our waiting lists (referral to treatment times).

An external review of our referral to treatment times (RTT) data and patient tracking systems identified serious issues relating to our operational processes and technology.

These issues created significant risks to the quality of care and patient safety as well as flaws with our reporting processes at St George's Hospital.

A subsequent review carried out in April 2017 identified similar problems at Queen Mary's Hospital in Roehampton.

As a result of our concerns we suspended national reporting of our RTT data in June 2016 and made a decision not to recommence reporting until we have full confidence that the information we are providing is reliable.

What we are doing to recover

In September, the newly appointed Chief Operating Officer took over the management of the dedicated waiting list improvement programme called the Elective Care Recovery Programme.

Since the formation of the programme we have undertaken a systemic and detailed audit of the waiting lists for patients at the St George's site. This resulted in an increase in the number of patients reported to be waiting over 18 weeks from referral to treatment. We also identified a number of patients who had been waiting over 52 weeks.

As part of the validation exercise our Medical Director undertook a clinical review led by doctors from across the Trust to ensure patients were not coming to clinical harm as a result of their waits.

In April we launched a 'Better Data, Safer Patients' campaign across the Trust to emphasise the importance of accurate clinical coding and to ensure that this is managed correctly and consistently.

One of the early successes included reducing the number of patients with 'no due date' in our records for endoscopy procedures from 3,200 to zero. Our diagnostics waiting time performance improved to amongst the best levels in England.

Our clinical teams have focused on treating those patients who have waited the longest; they have also improved administrative processes, and increased capacity through additional evening and weekend clinics and operating lists.

Recognising we had a lot of work to do, we also provided mandatory training to 3,500 staff to improve awareness of the significance of waiting list management and other vital metrics for patient care and safety.

Our commitment to manage our referral treatment times resulted in success towards the end of the year. In January 2018 our cancer teams had 99% of clinics and patients recorded with a referral to treatment status. By February we had met the year end April target to record referral to treatment status for 83% patients across all of our clinics.

In early 2018 we introduced a new Patient Tracking List (PTL) for patients awaiting elective care at St George's. The PTL replaced previous versions which were neither accurate nor used consistently. The new single system will improve the speed at which we treat patients, effectively manage waiting times and ensure that we are capturing information accurately and consistently.

In March we introduced a new Patient Tracking List (PTL) for patients awaiting elective care at Queen Mary's Hospital. We are also currently carrying out a scoping exercise to identify the infrastructure required to support the rollout of the iClip (Cerner) System at Queen Mary's Hospital – to ensure both our main hospital sites are using the same system.

We now have 48,000 patients on our waiting lists, with a plan to reduce it to fewer than 40,000 by the end of April 2019. This is a significant step forward as we continue to reduce the waiting list times for our patients.

Diagnostics

Rising demand has also impacted adversely on our ability to ensure that 99% of patients requiring a diagnostic test receive this within six weeks.

While we started the year not meeting the standard, in the second half of the year our performance improved and we met the standard for four consecutive months between December and March. We hope the changes we have made to contribute to this improvement will enable us to achieve this standard consistently in the coming year.

Performance Report - Financial analysis

For the financial year 2017/18, the Trust was in Financial Special Measures at the request of NHS Improvement (NHSI). This followed the Trust reporting a deficit of £78.7m in 2016/17. Financial Special Measures means NHSI undertakes regular oversight and review of the Trust's financial plans and performance.

For 2017/18, the Trust developed a plan to reduce the deficit to £45 million, an improvement of £34 million on the previous year. Actual performance for the year was a deficit of £53.1 million representing an improvement on 2016/17 of £26 million, but an adverse variance from the plan of £8 million.

The Trust has achieved the cost savings and efficiencies target included in the 2017/18 Plan of £43.5million, but experienced a reduction in income of £8 million, comprising £3 million lower than expected elective activity and £5 million due to a number of (income producing) contracts coming to an end.

Our financial performance

NHS Improvement (NHSI) placed the Trust in Financial Special Measures (FSM) at the start of 2017/18. This followed three successive years of reporting deficits from 2014/15, which culminated in a deficit of £78.7m in 2016/17.

At the start of the 2017/18 financial year, the Trust set a plan to reduce the deficit to £45m. NHSI had set a target deficit of £6m for 2017/18. This was not seen as achievable by the Trust Board and after considerable discussion, a level of £45m was agreed with NHSI. The Trust ended 2017-18 with a £53.1 million deficit, which represents an adverse variance of £8 million against our financial plan. The reason for the variance comprised a £3 million shortfall in income resulting from lower than planned income from elective activity, a £5 million loss of income from contracts which ended during the year, ongoing investment and challenges in reducing run rate expenditure patterns across the year.

Cost Improvement Programme

The Trust set itself a cost improvement (CIP) target of £43.5 million for 2017/18. This represented 5.5% of turnover and was seen as a challenging yet achievable level of efficiencies given the need to reduce the overall deficit.

This target was met through a range of efficiency measures and additional income. Local savings at a directorate level were complemented by Trust-wide savings, many of which were delivered through the Trust's Cost Improvement Programme (CIP) to improve quality, safety and efficiency.

Together, these actions enabled the Trust to deliver its planned Cost Improvement Programme of £43.5 million.

Sustainability and Transformation Funding

The Trust did not receive any Sustainability and Transformation Funding (STF) from NHSI as the Trust did not accept the planning target for the year; the funds potentially available to the Trust stood at £18 million. The Trust's plan for 2017/18 excluded these funds so not achieving them did not contribute to the scale of the deficit reported.

Performance against plan

Delivering the 2017/18 financial plan represented a major challenge for the Trust. It required the Trust to stop the trend for increasing overspends and to make material improvements in the financial run rate. As indicated above, the plan was seen as challenging but achievable. Across 2017/18 the Trust reported many positive actions, notably the delivery of cost improvement plans. However, challenges to income recovery from commissioners, the loss of community services contracts following market testing, together with a reduction in elective activity following the challenging winter meant income plans failed

to deliver their full value. This was partly offset by reduced expenditure, some as a result of improved controls, but also partly driven by reduced activity. The Trust was able to identify a range of non-recurrent actions to help support the reported position.

Capital Expenditure

The Trust spent £53.6 million of capital in 2017/18. This was funded from internally generated funds, loans carried forward from 2016/17 and an additional capital allocation of £11.8million received late in the course of the year. The capital funds available to the Trust were used to support ongoing investment in IT, the estate and medical equipment.

The level of funds meant the Trust was unable to address the full investment programme it had hoped to complete. A bid for further funding will be made to NHSI as part of the 2018/19 financial plan to help address this.

Capital Loans

A significant part of the Trust's capital programme is funded from loans provided by the Department of Health (previously the Independent Trust Financing Facility or ITFF). At the beginning of the financial year, the Independent Trust Financing Facility has agreed loans totalling £16.2 million. During the year, the Trust drew down a further net £10.0 million capital, bringing total borrowings to date to £26.2 million. See note 31 in the annual accounts for more details.

Finance Leases

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

During 2017/18 the Trust took out new finance leases with various leasing companies for equipment with a capital value of approximately £1.7 million.

Cash flow

The Trust began the financial year with £6 million of cash and cash equivalents. During the year, cash balances reduced by £2.5 million to £3.5 million, in line with the cash target in place. For details of the Trust's net cash balances, see note 27 in the annual accounts.

Financial performance against plan	2017/18 Actual	2017/18 Plan	Variance
	£ millions	£ millions	£ millions
Total income excluding capital donations	820.0	831.9	-11.9
Expenditure excluding impairments	-873.1	-876.9	3.8
Underlying operating surplus/deficit	-53.1	-45.0	-8.1
Capital donations	0.3	0.0	0.3
Profits on sale of buildings	-0.3	0.0	-0.3
Impairments	0.0	0.0	0.0
Operating Deficit	-53.1	-45.0	-8.1

Financial performance comparison	2017/18 Actual	2016/17 Actual	Change
	£ millions	£ millions	£ millions
Total income excluding capital donations	820.0	798.1	21.9
Expenditure excluding impairments	-873.1	-871.9	-1.2
Underlying operating surplus/deficit	-53.1	-73.8	20.7
Capital donations	0.3	0.0	0.3
Profits on sale of buildings	-0.3	-4.9	4.6
Impairments	0.0	0.0	0.0
Operating Deficit for the year	-53.1	-78.7	25.6

Cash flow	2017/18	2016/17
	£ million	£ million
Operating surplus/deficit before finance and other costs	-43.0	-63.1
Add back non-cash items	12.1	20.7
Net cash generated from operating activities	-30.9	-42.3
Investing activities	-41.4	-29.7
Financing	69.9	70.7
Net increase / decrease in cash	-2.5	-1.4
Total Cash and equivalents at 31 March	3.5	6.0

The reduction in cash during the year partly reflects an operating deficit – after adding back non-cash items, operating activities consumed cash of £30.9 million.

The Trust invested £53.6 million in Capital assets and drew down agreed loan funding –£26.2 million for capital investment and £60.3 million for deficit financing and working capital support. Full details can be found in the Consolidated Cash Flow Statement in the Annual Accounts.

Charitable funding

The Trust received £0.3 million from charitable sources during the year, principally from County Air Ambulance Trust (CAAT) to fund improvements to the Helipad.

Private Finance Initiative

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

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

Revaluation of land and buildings

As part of the preparation of the annual accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of each financial year. The annual revaluation of the Trust's land and buildings led to a £8.8 million increase in value, which reflects changes in the basis of the valuation. This increase was not included in the plan and represents a technical accounting adjustment.

External audit services

Grant Thornton received £96,600 (£70,000 2016-17) in audit fees in relation to the statutory audit of the Trust to 31 March 2018. KPMG has served as the Trust's tax advisor for a number of years. In 2017-18, the Trust incurred costs of £454,000 from KPMG for these services (£108,000 2016-17). For more details, see note 6.1 to the annual accounts.

Events since the end of the financial year

There have been no events since the end of the financial year that have a bearing on the analysis of the performance of the Trust.

In 2018/19, the Trust faces a number of financial risks.

The Trust is working closely with NHSI to ensure a robust financial control environment, which will enable the Trust to exit financial special measures. However, with the current financial systems and processes, there is a risk that the Trust remains in financial special measures.

The Trust has set itself a challenging target to reduce the deficit to £29.7million (a reduction of £24m). This requires the Trust to deliver a cost savings of £50 million in 2018-19. Whilst there is a risk that this is not achieved, every effort is being made to ensure that the level of savings required is delivered.

There is a risk that income and expenditure targets are missed next year.

The Trust has agreed contracts with its principal commissioners and these, in the main, do not include the full estimated costs of meeting national waiting times standards, which creates a financial risk on the planned income. However, to mitigate this risk of over-performance, we have agreed cost and volume contracts with these commissioners.. However, if, despite our best endeavours, commissioners cannot afford to fund the in-year performance required to deliver national waiting times, this would pose a risk to our ability to meet our control total, and would therefore require discussion with NHS England and NHS Improvement.

A range of mitigation actions are in place to ensure we meet our control total next year These include:

- The Trust Board approving the financial plan prior to start of financial year
- Budgets being agreed with all budget holders
- Ensuring Cost Improvement Plans are embedded in budgets and effective financial performance management process is in place.

Processes to manage cash and working capital

There is a risk that the Trust does not have up to date processes to manage cash and working capital and risks having insufficient cash available to pay staff and creditors. The mitigation in place includes, accurate and clear cash forecasting and collection processes, an achievable aged debt recovery plan, clear payments processes for creditors and ensuring we manage stock holdings to agreed levels.

Capital planning

The Trust's capital programme has always underpinned delivery of our strategic ambitions. However, the availability of capital is now at odds with our operational and strategic requirements. We will need to continually balance multiple demands including:

- The urgent need for stabilising and upgrading IT infrastructure, Estates infrastructure, and Theatres
- Increasing diagnostic capacity and upgrades
- maintaining our infrastructure to ensure we provide safe, compliant services

- The need to invest capital and revenue in service transformation that will drive change and more efficient ways of working both internally and with partners (e.g. as part of the south west London Sustainability and Transformation Plan)

- Investment in digital transformation and analytical capacity;

Cost Improvement Programme

Our refreshed Cost Improvement Programme builds on a strong platform and this Trust-wide programme has already supported directorates to deliver numerous quality, safety and efficiency improvements, including over £43.5 million savings 2017-18.

There are high levels of staff engagement with the programme and our collective focus aims to create a culture of continuous improvement where 'everyone does improvement', and staff feel empowered to deliver change and transformation.

During 2018-19 we will take forward significant transformation activities in the following areas Pharmacy, Theatres, Unplanned & Admitted Patient Care, Outpatients, and Maternity under the umbrella of the Transformation Programme which aims to deliver significant cost and quality improvements. We will pursue further improvements in clinical coding to ensure that the Trust receives the correct income for the care delivered.

Delivering the Carter recommendations

We continue to support NHS Improvement with the on-going development and implementation recommendations of the Carter Review. Building on this foundation, the Trust will be working with NHSI, to utilise benchmarking information from the model hospital to identify and realise opportunities in clinical services to improve resource utilisation. We will continue to improve clinical coding to ensure that the Trust received the correct income for the care delivered.

Procurement

The Trust is on track to meet the performance metrics set out in the Carter Review and we are already exceeding the target for purchase order compliance. The focus of Procurement in 2017/18 has been split over three main areas:

- Contract Rationalisation – Making contract and sourcing efficiencies through the consolidation of supplier contracts and the insourcing of key activities removing the reliance on third parties

- Operational Savings – Reducing the operational cost of running the Trust divisions whilst maintaining quality of the service, through the reduction of costs in areas where service requirements can be safely reduced

- Contract Consolidation - Consolidating (bundling) contract requirements and therefore aiding the acquisition strategies that deliver greater value for the organisation.

The Trust complies with the requirement of the Better Payment Practice Code to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance against the code is set out in the table below.

	2017-18	2017-18	2016-17	2016-17
Non NHS Payables	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	143,126	363,940	165,225	351,106
Total non-NHS trade invoices paid within target	62,145	176,481	97,344	216,309
Percentage of non-NHS trade invoices paid within target	43.42%	48.49%	58.92%	61.61%

	2017-18	2017-18	2016-17	2016-17
NHS Payables	Number	£000s	Number	£000s
Total NHS trade invoices paid in the year	4,420	69,888	5,016	75,370
Total NHS trade invoices paid within target	1,265	32,888	1,883	43,038
Percentage of NHS trade invoices paid within target	28.62%	47.06%	37.54%	57.10%

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.

Income from the provision of goods and services

The Trust meets the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for other purposes. For full details see the Annual Accounts. Surpluses from other income that the Trust has received have been used to support the provision of goods and services for the purposes of the health service in England.

Political and charitable donations

The Trust has not made any political or charitable donations during 2017/18.

Countering fraud and corruption

The Trust has a countering fraud and corruption policy. Counter fraud arrangements are reviewed during the year by the Local Counter Fraud Service (LCFS). The LCFS undertakes an on-going programme of work to raise the profile of counter fraud measures and carries out ad hoc audits and specific investigations of any reported alleged frauds. This includes the use of fraud awareness presentations and fraud awareness surveys.

The Audit Committee receives and approves the Counter Fraud Annual Report, monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

Performance Report - Environmental and Sustainability Analysis

The Trust remains committed to acting sustainably to minimise our environmental impact. Guided by our sustainability strategy, we have made significant progress with our aim to be a sustainable healthcare organisation.

As part of this we are committed to meeting our obligations by reducing our emissions by 2050 in line with the Climate Change Act. We understand the importance of embedding sustainability within our daily working lives and are working to secure carbon and financial savings by upgrading our existing systems and infrastructure, identifying energy efficiency measures and improving internal energy management and monitoring procedures.

The Trust's Sustainable Development Management Plan and Sustainable Development Action Plan were designed to secure reductions in carbon dioxide emissions and increase environmental sustainability across key areas including: governance, energy and carbon, waste, water, transport, climate change adaption, redesigning the environment, workforce development, travel and finance.

The NHS Carbon Reduction Strategy 2009 sets out clear measurable milestones to monitor and reduce direct carbon emissions. We are committed to working with our NHS partners and other stakeholders to achieve sustainable development. We have been working towards this since 2007 when we initiated work with the NHS Carbon Management Programme to reduce the hospital's carbon emissions.

We know that being operational 24 hours a day means there are numerous environmental issues that need to be addressed for an environmental audit. These relate to noise, light, water, waste, thermal, air and effluent. We actively encourage staff to utilise public transport and provide a bicycle purchase scheme to assist staff choosing an environmentally better travel option.

Last year we were delighted to achieve 'The Planet Mark' certification for our sustainability initiatives. We were recognised for our achievements in effectively measuring our utilities carbon emissions (electricity, gas, water and transport vehicles), meeting a 5% carbon reduction target for 2017-18, and embedding a culture of continuous improvement by engaging employees and suppliers to drive sustainability improvements.

Gas consumption has increased and electricity decreased due to the Combined Heat and Power working effectively in 17/18, along with improved monitoring and recording of consumption data.

To keep staff involved and up to date we regularly communicate progress via our corporate communication channels, a dedicated section on the staff intranet and through our sustainability champions.

Accountability Report

Staff Report

Staff Report

Last year, we employed around 9,300 staff, clinical and non-clinical, all of whom contribute to providing quality patient care in our hospitals and in the local community. Our staff work hard to improve efficiency and deliver the best possible care to our patients.

The majority of the Trust's staff are permanently employed clinical staff directly involved in delivering patient care. We also employ a significant number of scientific, technical and administrative staff who provide vital expertise and support. The table below provides a breakdown of our workforce.

Average number of employees (WTE basis)	2017/18			2016/17
Type	Other	Total	Total	Total
Non NHS Payables	Number	Number	Number	Number
Medical and dental	1,229	59	1,288	1,261
Administration and estates	1,842	257	2,099	2,176
Healthcare assistants and other support staff	692	158	850	894
Nursing, midwifery and health visiting staff	2,687	422	3,109	3,316
Scientific, therapeutic and technical staff	1,738	224	1,962	1,941
Total average numbers	8,189	1,120	9,309	9,588
Number of employees (WTE) engaged on capital projects	11	11	22	24

Staff Survey

We know that the quality and safety of our services depends on our staff, and that there is a strong link between positive staff engagement and patient experience and safety.

We measure our success in terms of staff engagement and creating a good work environment through the annual NHS Staff Survey and the Staff Friends and Family Test, which is undertaken three times a year. These survey and test results are closely monitored and discussed at the Trust Executive Committee and Trust Board meetings.

The Staff Friends and Family Test results for

2017/18 have been very positive. For the fourth reporting quarter in a row, we have seen an improved response from staff recommending the Trust as both a place to work and to receive care. Although we recognise there is a lot more to do, this has seen the Trust move from one of the worst positions in the country, to working towards the national average for staff recommending the Trust as a place to work.

How likely are you to recommend this organisation to friends and family...	Quarter 2 (July–Sept 2016)	Quarter 4 (Jan–Mar 2017)	Quarter 1 (April-June 2017)	Quarter 2 (July-Sept 2017)	Quarter 4 (January-March 2018)
as a place for treatment?	74% would recommend	77% would recommend	77% would recommend	79% would recommend	83% would recommend
as a place to work?	36% would recommend	47% would recommend	44% would recommend	51% would recommend	56% would recommend

The NHS Staff Survey results for 2017 were also positive and showed an improvement in staff recommending the Trust as place to work. We also saw improvements in other key areas such as; fairness and effectiveness of procedures for reporting errors, near misses and incidents; staff health and wellbeing, and communication between senior managers and staff.

Further encouraging outcomes were reported in relation to patient care and experience, with an increase in staff reporting effective use of patient/service feedback, and staff reporting recognition and feeling valued by managers and the organisation

Although the Trust's score has improved, some areas require improvement. The Staff Engagement Group, reporting to the Workforce and Education Committee, reviewed the findings and in July 2018 will relaunch the Staff Engagement Plan to build on the progress over the past year.

	2016/17		2017/18		
	St George's	National Average	St George's	National Average	Improvement/ deterioration
Response rate	40.4%	42.3%	51.5%	43.0%	Improvement
Top 5 ranking scores					
KF13. Quality of non-mandatory training, learning or development	4.10	4.07	4.11	4.06	Improvement
KF12. Quality of appraisals	3.19	3.11	3.19	3.11	No change
KF24. % of staff /colleagues reporting most recent experience of violence	68%	67%	71%	67%	Improvement
KF3. % of Staff agreeing that their role makes a difference to patients/service users	90%	91%	91%	91%	Improvement
KF32. Effective use of patient/service user feedback	3.56	3.68	3.70	3.69	Improvement
Bottom 5 ranking scores					
KF25. % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	29%	26%	32%	27%	Deterioration
KF26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months	32%	23%	30%	24%	Improvement
KF23. % of staff experiencing physical violence from staff in last 12 months	3%	2%	3%	2%	No change
KF10. Support from immediate line managers	3.63	3.74	3.65	3.76	Improvement
KF28. % of staff witnessing potentially harmful errors, near misses or incidents in last month	34%	29%	33%	29%	Improvement

Equality and Diversity

The Trust serves the diverse local communities of south west London, as well as caring for patients from further afield.

The Board of Directors agreed a new Workforce Race Equality Standard strategy with a set of revised equalities objectives. These objectives set out our priorities to drive improvements in patient care, staff experience and reduce inequalities for our diverse workforce.

Our Director of Human Resources and Organisational Development takes overall responsibility for monitoring our operations against these priorities and for reporting on our performance.

Respecting and protecting the human rights of our patients, staff and members are at the heart of everything we do.

Safeguarding training is given to all staff as part of the Trust's training programmes. We participate in our local, multi-agency Safeguarding Boards and aim to safeguard vulnerable people through a partnership approach.

Care and treatment is provided to all patients with their consent, and for patients who cannot consent to treatment, care is provided in their best interests in accordance with the Mental Capacity Act 2005.

The Trust provides a comprehensive patient information and language support service to meet the needs of our diverse population, and can provide interpreters for patients and their carers. We provide telephone interpreting services in most common languages and many of our core information leaflets are in an Easy Read format.

A multi-faith spiritual care team is available to support patients, and reflects the diverse faiths and beliefs of our local population.

Staff profile

Asian – Bangladeshi	1.00%
Asian – Indian	7.12%
Asian - Other	9.24%
Asian – Pakistani	1.74%
Black – African	9.17%
Black – Caribbean	5.61%
Black - Other	1.04%
Chinese	1.31%
Mixed - Other	1.35%
Mixed - White & Black African	0.40%
Mixed - White & Black Caribbean	1.05%
Mixed - White Asian	0.83%
Not stated	3.17%
Other	3.70%
White – British	36.32%
White – Other	16.95%
Others	26
Total	959

Senior management by gender at year end

Staff group	WTE		%	
	Female	Male	Female	Male
Directors	7	8	46.67%	53.33%
Senior Managers (AFC 8c +)	55	43	56.19	43.81%
All staff	5899	2340	71.6%	28.4%

Staff sickness numbers

Staff group	%
Additional scientific and technical	2.99%
Additional clinical services	5.07%
Administrative and clerical	4.57%
Allied health professionals	2.07%
Estates and ancillary	4.91%
Healthcare scientists	2.68%
Medical and dental	1.33%
Nursing and midwifery registered	3.94%

Off-payroll engagements

Staff group	%
Number of existing engagements as of 31 March 2017	14
Of which...	
Number that have existed for less than one year at the time of reporting	11
Number that have existed for between one and two years at the time of reporting	3
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

For all new off-payroll engagements, or those that reached six months duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	2017/18
Number of new engagements, or those that reached six months in duration between 1 April 2017 and 31 March 2018	24
Of which...	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	2017/18
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	11

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

In any cases where individuals are included within the first row of this table, please set out:	Checks
Details of the exceptional circumstances that led to each of these engagements.	0
Details of the length of time each of these exceptional engagements lasted.	0

Expenditure on consultancy

Expenditure on consultancy	2017/18	2016/17
Consultancy costs (£k)	13,969	2,581

Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	2	2
£10,001 – £25,000	0	2	2
£25,001 – £50,000	0	1	1
£50,001 – £100,000 (Note 1)	0	1	1
£100,001 – £150,000	0	1	1
£150,001 – £200,000	0	0	0
Total number of exit packages by type	0	7	7
Total resource cost (£k)	£0	£313,000	£313,000

Exit packages: non-compulsory departure payments

	Agreements Number	Total Value of Agreements (£k)
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice (Note 1)	6	287
Exit payments following Employment Tribunals or court orders	1	26
Non-contractual payments requiring HMT approval *	0	0
Total	7	£313,000

	2017/18			2016/17
	Permanently employed	Other	Total	Total
Salaries and wages	£0	£0	£0	£0
Social security costs	411,961	0	411,961	401,444
Pension cost - defined contribution plans employer's contributions to NHS pensions	41,547	0	41,547	40,308
Pension cost - other	47,071	0	47,071	45,403
Temporary staff - agency/contract staff	0	0	0	0
Total gross staff costs	0	19,978	19,978	43,324

Improving our staff's health and wellbeing

In 2017 we appointed a permanent Staff Health and Wellbeing Lead who has developed a wellbeing strategy that includes a wide-range of initiatives designed to promote good health and drive the Trust's ambition to become a health promoting Trust. The Health and Wellbeing Strategy focuses on five key areas:

- Improving and maintaining good musculoskeletal (MSK) health
- Improving and maintaining good mental health, including the management of stress
- Improving and maintaining good physical health
- Improving the uptake of the flu vaccine
- Improving access to healthy food options.

Musculoskeletal Health

The Trust has invested in the provision of an Occupational Health Physiotherapist to aim to reduce the number of sickness absences and reduce agency spend across the Trust.

Events

The Trust has held events to mark European Health and Safety Week, and has run an event to publicise desk-based exercises.

Wellbeing Classes

The Trust also facilitates regular classes to help improve and maintain good MSK health such as pilates, yoga and other fitness sessions such as reggaecize, circuits and gardening club.

Our Trust objectives and strategy

Training

The Trust has focused on this area in great detail. As a result, we have developed an all staff mental health awareness training exercise, which is part of the Trust's MAST programme. We have run a number of face-to-face training sessions on mental health awareness, communication, assertiveness and conflict resolution.

Mental Health Booklet

The Trust has developed an all-staff booklet on managing common conditions which can cause emotional distress or a mental health condition. This booklet provides easy to understand advice and information on common mental health conditions, as well as information on where to access further support if required. It is envisaged that every member of staff across the Trust will have a copy, as an aide memoir, should they ever require it.

Wellness Action Plans

As part of the Trust's ongoing commitment to improve engagement and encourage a healthy environment, in which 'staying well' is a key priority, Wellness Action Plans have been developed. A Wellness Action Plan is a document filled out by staff with their line manager as part of our annual appraisal, and provides information on what courses of action to take to prevent emotional distress (e.g. taking lunch breaks, taking a walk if they feel distressed) as well as what support to provide for their physical health (e.g. asking for help from colleagues to lift items).

Events

All-staff events celebrating World Mental Health Day (October 2017) and Time to Talk Day (February 2018) have been held at both our St George's and Queen Mary's sites. The events aimed to help break down the stigma and discrimination

associated with poor mental health, and to get people talking about their mental health. Organisations from across the community were invited to take part. The events were widely attended, with over 2,000 staff attending the St George's event in October, and over 200 staff attending the Queen Mary's event in February.

Mindfulness Application

The Trust has agreed to take part in a research project, in conjunction with St George's, University of London, to understand the efficacy of an app-based mindfulness intervention on stress on healthcare staff. The app (Headspace) has already been proven to lower stress and reduce feelings of anxiety and depression in previous populations. This app was available for free to all staff who took part in the research project.

Staff Support Service

All staff requiring further support can refer themselves to the staff support service, which provides a wide range of interventions, including 1:1 counselling. In 2017 the Staff Support team saw 404 new referrals for counselling, a 3% increase on 2016. It dealt with the range of issues from addressing work related stress and conflict, through to mediation services. We saw a major increase in group interventions in response to organisational change. We delivered 22 workshops on topics including conflict resolution, resilience and team building, 11 trauma debriefs, 99 reflective practice sessions, 29 groups to support staff through change of ward locations and 61 mindfulness sessions. We also provided managers with coaching opportunities to gain help with challenging conversations, assertiveness, problem-solving, and conflict and stress management. Our team has ensured that all staff are seen within 10 days of first making contact, irrespective of service pressure.

Physical Health

Flu

The Health and Wellbeing Lead worked closely with colleagues in the Occupational Health and Communications Department, the Chief Executive and the Medical Director to improve the uptake of the flu vaccine achieving 91% vaccination rate for staff, the highest achieved in London.

Food

The Trust is committed to ensuring that staff have access to healthy food options, inclusive of those who work shift patterns/unsociable hours. In order to achieve this, we have been working closely with all food and drink retailers on their premises to ensure that the advertisement and allocation of sugary drinks and snacks is reduced. The Trust has also been working alongside on-site catering teams to ensure that food and drink options provided to staff are healthy.

Smoking

We have a dedicated stop smoking advisor to assist staff in quitting smoking.

Physical activity

We are committed to having a healthy and happy staff force. In order to do this, discounts have been negotiated with local gyms surrounding the main hospital and community sites of the Trust. In addition, there are many onsite exercise classes (please see above for further information).

Our Sickness Absence Management Policy and Policy on the Employment of Disabled People have both been reviewed with input from our Staff Side representatives. The policy on the Employment of Disabled People sets out our commitment to employing disabled people from the point at which they are recruited, through to circumstances

where an employee becomes disabled during their employment. We are committed to making all reasonable adjustments and if necessary finding alternative employment for staff who become disabled during their employment.

Staff engagement

Our workforce is the most important asset we have. We understand the importance of engaging with our staff, because an engaged workforce delivers better patient outcomes. We are constantly monitoring how well we keep our employees engaged and informed.

In order for us to serve our patients and the public effectively, we have a number of different channels available to keep staff up to date, generate discussions and provide feedback on different issues that affect us all.

This year we developed a comprehensive Staff Engagement Plan in response to feedback from staff and in support of our ambition to provide Outstanding Care, Every Time for our patients. One of our six strategic objectives for the next eighteen months is to champion Team St George's, a big part of which is improving the working lives of our 9,000 staff.

By engaging effectively with our staff, we believe people will be proud to say they work at St George's, and recommend it to others as a place to develop their career and, as important, to be treated here. In order to better understand what it is like to work at St George's, we gathered and analysed data from many sources including the 2017 NHS National Staff Survey and the quarterly Staff Friends and Family Test.

A new Staff Engagement Group was created and four Listening into Action Big Conversations were held in the autumn of 2017.

The Staff Engagement Group identified three target areas to improve the way we work with each other:

- Improve overall staff engagement
- Address bullying and harassment
- Improve equality and diversity.

The Staff Engagement Group considered that the following key behaviours and principles need to be in place:

- Regular, active listening and action on what staff are telling us where we can
- Consistency and stability in leadership and engagement
- Empowering staff at every possible level in the Trust
- Leading by example.

We have recruited staff engagement champions from across our services who will support and monitor the delivery of our staff engagement plan, and ensure that changes are happening on the ground.

We have an active partnership forum where we meet with our Staff Side colleagues (unions) to discuss issues of concern to staff. Our Staff Side representatives have been involved in the development of our Staff Engagement Plan and progress is discussed at the Partnership Forum each time we meet. We share and discuss the Trust's performance reports and Chief Executive's report at the Partnership Forum to ensure that staff are aware of our priorities and performance.

Listening into Action and Staff Awards

The values awards give staff, patients and the public an opportunity to nominate a member of staff or team that they feel demonstrates our values of Excellent, Kind, Responsible, Respectful.

Winners are awarded with a certificate and badge in a team presentation from the Chief Executive, and they become eligible for entry into our annual awards ceremony. Photos are taken of the presentations and are communicated to all staff via our internal communications channels.

This year we introduced our Staff Appreciation awards. The awards, hosted and made possible by

the St George's Hospital Charity, were held on 15 March and help celebrate the steps our staff take to provide Outstanding Care, Every Time for our patients, and the communities we serve.

We recognise that as well as listening to our patients, it is also important that we listen to our staff and involve them when we try to identify where improvements could and should be made.

We launched the Listening into Action programme in 2013 with the aim of achieving a fundamental shift in the way we work and lead by putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the Trust as a whole. Listening into Action continues to be used throughout the Trust and was successfully used by the Trust board in 2017 as way to engage with staff.

Essentially, Listening into Action is about:

- Engaging all the right people around delivering
- Better outcomes for our patients, our staff and our Trust
- Aligning ideas, effort and expertise
- Patient experience, safety and quality of care
- Overcoming widespread challenges around staff engagement and morale
- Developing confidence and capability of our leaders to 'lead through engagement'
- Collaborating across the usual boundaries
- Generating a sense of pride.

We have a staff advisory service called LiAiSE (Listening into Action is Staff Engagement). The LiAiSE adviser provides a listening and signposting service, identifying where support is available. This has proved to be a success in busy departments such as the Emergency Department and has been instrumental in making changes in the workplace to improve the working lives of our staff. Our LiAiSE Advisor is also our Freedom to Speak up Guardian and someone who staff can raise issues with in confidence, knowing they will be treated seriously and sensitively.

Consultants meetings

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

Bespoke staff engagement events

In addition to the normal communications channels, we also hold a number of bespoke events each year to inform, engage and inspire staff. Such events include International Nurses' Day, CQC preparation briefings and awareness days.

Bullying and harassment

As part of our commitment to tackle unhelpful behaviours and role model behaviours at all levels, we introduced values based recruitment training.

The first session was held in July 2017 and was very well attended by a varied mix of staff groups from different divisions across the Trust. Values based recruitment is proven to change behaviours systematically, by building empathy and developing a 'can-do' attitude both within and outside of the recruitment process. The training, which encourages staff to recruit individuals who demonstrate our values, has been rolled out further across the Trust as part of our recruitment and selection training. We have also reviewed and promoted our Values and Behaviours policy.

The standards of behaviour we expect of our staff are also set out during the induction process and reinforced during 1:1s and appraisals. The aim is to build a culture of openness and standards of behaviours for all staff employed in the Trust. Through our Staff Engagement Plan, we have increased the profile of our Freedom to Speak Up Guardian and publicised support mechanisms for staff. With this, each division has been tasked to identity a lead.

At the end of November 2017, as part of anti-bullying awareness week, we re-launched and promoted our internal bullying and harassment helpline and staff support service LiAiSE.

We know that mediation can help to increase dialogue between individuals and resolve conflict at an early stage. We have Trust-wide mediators who are trained and supervised every six weeks with a success rate, in 2017, of 81%. Our Staff Support lead, as a member of a number of equality and diversity workstreams, provides information and monthly updates on current caseload and activity.

For our middle and senior managers, we have introduced 360º reviews and, between March and June 2018, development centres will be held for the top 250 senior managers in the Trust run by the King's Fund. This will enable each manager to receive a 360º review including a self-reflection and peer feedback.

In terms of bullying and harassment encountered by staff from patients, relatives or the public, our Staff Support Service offers a debrief service. This service has been involved in Schwartz Rounds, a group reflective practice forum which provides an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. Our Health and Safety Management team, which holds quarterly Violence and Aggression taskforce meetings, is attended by a member of the Human Resources management team.

Equality and Inclusion

As part of our focus on improving understanding of equality and diversity, we set out our policies at Trust induction, to ensure all staff are equipped with knowledge of their role in complying with the policy, and the added value that brings. This also means that our policies will be used more effectively at every level.

In order to have strong, consistent leadership and to empower all staff in equality and diversity issues we have identified a Board level lead (Non-Executive Director) and an executive lead to take a lead and drive our equalities ambition. Our executive leads regularly attend working parties that support equality and diversity issues.

We have a Workforce Race Equality Standard (WRES) 2017/18 action plan in place that has been agreed by the Trust Board. This action plan has been communicated to all staff and can be downloaded from our intranet and external website. This includes a plan to recruit a Diversity and Inclusion Manager in April 2018. We also have a WRES working party and invite staff, from all backgrounds, to become champions and attend these meetings. In particular, we have benefitted from the input of our Staff Network Advisory Group which ensures we reflect issues that are of concern to staff.

We want to tell our story powerfully and positively and make equality and diversity part of our story. To this end, we launched our Staff Engagement Plan during our Quality Improvement Week. Staff were provided with printed documentation, supported by posters and leaflets, and a dedicated section has been built into our intranet. One of the key aims of this plan is to improve on equality and diversity within the Trust.

Directors Report

The Trust Board

As a Board of Directors we must ensure we collectively and individually uphold the qualities that make the NHS what it is, whilst also helping to define the future for a healthcare system in the face of rapid and ongoing social, demographic and technological change.

As set out in the 2018 NHS England mandate, the aspiration must be for exceptional healthcare, whenever, wherever, delivered by an NHS with the money, buildings and people it needs.

The most immediate challenge is managing the increased demand on our healthcare system. The NHS at 70 is seeing more people, more quickly than at any point in its history, including nearly half a million more being treated within 18 weeks of referral compared to five years ago.

As a Board we are accountable, through the Chairman, to NHS Improvement and are collectively responsible for the strategic direction and performance of the Trust. The Board has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

The most significant change to the Board over the past year has been the recruitment of a permanent Executive Team, which has brought much needed leadership stability to the Trust. The new members of the Trust Board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies (nationally and internationally) and the private sector. The Trust Board is confident that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability.

Both the Board selection process and the Board Development Programme are in place to ensure that the Directors and Non-Executive Directors have the appropriate skills and level of understanding to undertake their roles, and that the Board has the capability and experience necessary to deliver the Trust's strategic objectives. The governance structure the Trust has in place is appropriate and provides assurance to the Board of this delivery. The Board Development Programme has been largely 'task and issue' focussed in order to address the challenges facing the Trust. This aims to ensure that the Board is: fit to govern the Trust; able to set and review performance standards in all areas of responsibility; operates as a unitary body; is aware of, and successfully manages competing priorities and future challenges against the Trust's strategic objectives; and can assure itself on aspects of clinical quality.

In compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, all Trust Board Directors have been assessed as being fit and proper persons to be Directors of the Trust.

The performance of all Directors is reviewed in an annual appraisal which forms the basis of their individual development plan: for Executive Directors, by the Chief Executive; for Non-Executive Directors and the Chief Executive, by the Chairman; and for the Chairman, by the senior independent non-executive director.

Leading through a clear vision and strategy

Our vision is to provide Outstanding Care, Every Time and to be a world leader in transforming health through innovation in patient care, education and research.

The objectives developed to deliver this vision are also outlined on page 16 of this report. These objectives continue to reflect our long-term commitment to improve the quality of care we provide, stabilise our financial position, and to ensure that it is delivered to our patients by a skilled, motivated, educated and diverse workforce.

The objectives are supported by our values (described in the performance report) and will be delivered though our key improvement programmes. As an organisation, the Trust believes it is essential to progress longer-term

developments as well as tackle immediate challenges if it is to provide the very best care, both now and in the future.

The Trust's Quality Improvement Plan sets out our definition of quality under the Care Quality Commission domains of safe, caring, effective, responsive and well-led, and describes our quality vision and direction. The plan is designed to ensure we are providing safe, high-quality care and can achieve an improved rating in our next CQC inspection, while striving for 'outstanding'.

The Quality Improvement Plan was developed following an extensive consultation period with clinical staff and external stakeholders to ensure it meets national, local and Trust priorities. Our Quality Improvement Plan will support the developing South West London Health and Care Partnership, by ensuring we provide safe, high quality, sustainable acute services, while working with our partners to deliver better care across south west London.

Developing our leaders

Staff told us in the 2016 national NHS Staff Survey that they were less likely than previously to recommend the Trust as a place to work and that they didn't feel valued or recognised. They also said that they were less happy with the level of training available and that team working needed improving.

In May 2017, the Board approved a new Leadership Development Strategy as part of our commitment to invest in our leadership and our teams. We committed to provide each leader with an individual tailored personal development plan and to build a talent pipeline. We also committed to use the overall themes emerging from the process to gain a picture of the strengths and development needs within the existing leadership structure.

In December 2017, we awarded a contract to The King's Fund to design and run new leadership development centres with us. Between March and May 2018, the top 250 leaders at St George's will take part in a leadership development programme specifically designed to simulate the challenges facing the Trust. The outcomes from the programme will be reviewed by the Trust Board and the learning on each individual will be built in to their personal development plans.

A culture of continuous learning and improvement

We are committed to helping staff to continuously improve the quality of care we provide to our patients. As part of this commitment, last year we established a Quality Improvement Academy to train and develop our staff.

The aim for the academy is to build on the successes of our Quality Improvement Plan launched in October 2017. This set out our aspiration to provide care of the highest quality, in collaboration with those who use our services. Achieving this means we had to think differently, be innovative, and consider how we give everyone at the Trust who is involved in quality improvement the skills they need to lead change.

Since mid-2017, in partnership with the Institute of Healthcare Improvement (IHI), we have been holding workshops with internal staff and external partners to understand how we can build this culture of continuous improvement across the Trust.

The partners who contributed include; St George's, University of London, Kingston University, Faculty of Health, Social Care and Education Foundation, St George's Advanced Patient Simulation & Skills Centre, The Centre for Public Engagement, The Health Foundation, the Institute for Healthcare Improvement and the Health Innovation Network.

This work culminated in the launch of the Quality Improvement Academy at St George's in early 2018. As the academy grows, we are building a community of connected people at St George's and beyond who are involved in and who have worked on quality improvement programmes.

Improved engagement by the Board

Throughout the year we have put a significant focus on improving the direct engagement between the Board and staff. A monthly schedule of visits by the Board and a programme of weekly clinical 'back to the floor' visits to different areas of the Trust sees the team visiting up to 60 areas and services each month. We run monthly Teamtalk sessions, where any member of staff can meet as part of a group for an informal chat with the Chairman and Chief Executive about anything to do with life at St George's.

We have also established 'email free Friday' on the last Friday of every month, which provides the opportunity for staff to get away from their desks, and speak directly to teams and colleagues. The improvement in communications between senior managers and staff was reflected in the 2017/18 NHS Staff Survey Results as detailed in the Staff Report on **page 32**.

Staff Engagement

Leading organisations recognise the potential and power that fostering the right culture can generate. The culture of an organisation affects how well it performs, delivers strategic change and promotes shared purpose. As effective leaders, we pay close attention to this as it impacts all aspects of the Trust and correlates directly to employee engagement, talent attraction and retention, and ultimately how the public perceives the work we do.

One of our six strategic objectives for the next eighteen months is to Champion Team St George's, a big part of which is improving the working lives of our staff. To better understand what it is like to work at St George's, we formed the Staff Engagement Group. They gathered and analysed data from many sources, including the results of the 2016 National NHS Staff Survey and the quarterly Staff Friends and Family Test, and considered the feedback from Chief Executive drop-in sessions, lunch time staff feedback sessions, as well as the 'Big Conversations' held in autumn 2017. In November we launched the Staff Engagement Plan which set out our commitment to develop the Trust as one of which all staff want to be a part of.

As well as this, we have also prioritised the health and wellbeing of our staff, by launching a Trust wide health and well-being programme. We are also tackling the behaviours which don't align with our Trust values, which are to be Excellent, Kind, Responsible, and Respectful.

Patient and Public Engagement

With increasing demand and ever tighter budgets, we are under pressure to improve health outcomes, deliver quality services and make good use of resources. Patient and public participation is key to understanding what matters to people and helps ensure we deliver services to best meet the needs and preferences of the populations we serve.

In March 2018, we held an event to prioritise and reset the future of patient involvement at the Trust. The Chief Executive, Chairman and members of the Board attended the event and drew from their personal experiences of being a patient and the relative of a patient in hospital. Attendees also heard from Ashley Brooks, NHS Patient Champion, who spoke about his gratitude to the NHS, and how engagement and partnership working leads to more responsive services.

In summer 2018, a new Patient Charter will be launched. This will set out our commitment to address issues relevant to patients, service users, carers and the public, involve them in discussions and reflect their views. The recently formed Patient Partner Engagement and Experience Group, will help to focus the Trust around the principles and benefits of patient engagement and involvement.

Ensuring effective governance

In June 2017, we appointed an external consultancy to carry out a review of governance arrangements at the Trust. This followed concerns raised by the Care Quality Commission about Board to ward governance, and the processes that underpinned this.

We welcomed the external perspective provided by the review. As a result of this, we have clarified and strengthened our Board committee structures and are now reviewing the governance structures that sit below this. Informed by the review, we have also embarked on the development of a new strategy for the Trust, and the Board agreed the approach and timescales for this at its meeting in March 2018. Given the IT challenges at the Trust, we have also responded to the review by strengthening the Board through the appointment of a new Non-Executive Director with IT expertise. In parallel, we are also enhancing our approach to Board and executive development to help ensure the Trust is well-led.

South West London Health and Care Partnership (previously called the Sustainability and Transformation Plan, STP)

We have been actively working as a partner within the South West London Health and Care Partnership (SWLHCP) over the last year. During 2017-2018 we have been working through the SWLHCP to develop borough level plans for how to better integrate health and social care for our local population. Different models of care will help us deliver more effective care across NHS and social care workforce in south west London, ensuring that we deliver the best possible outcomes for our patients and the population.

A key focus is on living well and staying well. In November 2017 the plan was refreshed and as a result there is more focus at borough level, which for St George's means a Merton Local Health and Care Plan, and a separate one for Wandsworth. These are under development and are due to be launched in September 2018, with final plans published in November 2018. As the leading provider of healthcare services in the area, we are heavily involved in and at the heart of all SWLHCP activity.

Key areas of involvement for St George's are the Acute Provider Collaboration Programme (between the four acute hospital providers in south west London, namely Kingston, Croydon, Epsom and St Helier and St George's), the Planned Care Delivery Board (focussed on redesigning the way that out-patient services are delivered), the Cancer Delivery Group and major digital initiatives across south west London.

During the past year, working closely with our Clinical Commissioning Groups and local GPs we have focused on specific clinical services and improving patient experience. Some of the achievements include:

- Ear, Nose and Throat (ENT) 'open access' appointments mean patients who do not need an automatic follow-up can instead book appointments any time in the following six months. This creates more capacity and helps reduce the backlog of patients waiting to be seen, as well as allowing patients a choice in when they are seen.

- 'Virtual ENT clinics' provide improved patient experience and help with capacity as they free up clinicians' time and mean patients do not have to travel to hospital for appointments unnecessarily. Test results are reviewed and those patients who do not need further care receive a discharge letter and condition management plan. As a result. patients receive results sooner and further investigations are scheduled more quickly.

- Our pilot Gastroenterology Clinical Assessment Service (CAS) has been designed to manage GP referrals for common conditions more effectively and is already reducing some patient waiting times by several months. Results can be given to an estimated 20% of patients who will not need further care, without a face to face appointment.

Research

As a leading teaching hospital, clinical research is of vital importance to the development of better health and care for our patients, as well as to the development of the next generation of doctors, nurses and health professionals.

We know that the outcomes for our patients are better in organisations which are active in clinical research, and the benefits extend to patients who are participating in research as well as to all patients who are treated here.

St George's is highly active in clinical research, with ongoing clinical research studies in all areas of our hospitals. We host clinical research studies, including complex clinical trials. Our staff are undertaking clinical research, ensuring that the benefits of new treatments, drugs and therapies lead to improved quality of care for our patients.

In 2016/17, a total of 5,040 patients were recruited into 222 clinical trials at St George's, placing St George's 20th out of 155 Acute NHS Trusts in England for clinical trial patient recruitment. This number excludes a small number of patients recruited into trials which were not adopted by the National Institute for Health Research (NIHR); that is, those funded outside of a competitive funding process or funded by industry but not recognised by the NIHR. Provisional patient recruitment for 2016/17 shows an improvement to 6,300 patients, which is an excellent performance given the loss of research associated with the Genito-Urinary Medicine (GUM) clinic. Patient recruitment is projected to increase by more than 50% in 2018/19.

Overall, the large majority of trials were led from external organisations, with 16 trials led by St George's recruiting 1016 patients.

£2m Medical Research Council (MRC) Programme Grant

Over the past 15 years, clinicians from the Paediatric Primary Lymphoedema Clinic have worked closely with researchers in the St George's, University of London Genetics Centre to identify the genetic faults that affect the development or functioning of the lymphatic system in lymphoedema patients.

The collaboration has led to the discovery of eight genes associated with primary lymphoedema and a prestigious MRC programme grant award in August. With the expertise in the team and the financial support from the MRC, the group is developing state-of-the-art techniques such as MRI lymphography and immune-profiling to improve understanding of causal mechanisms and underlying gene mutations in this disorder.

Cardiology CAG article on "post-mortem genetic testing in cases of sudden arrhythmic death syndrome" published in the Journal of the American College of Cardiology

Last year, the Cardiology Clinical Academic Group published over 30 papers, including an article in the prestigious cardiovascular diseases journal, the American College of Cardiology In the article, the team reported the largest study of molecular autopsy and its clinical utility in a cohort of 302 sudden arrhythmic death syndrome (SADS) cases that had been tested for a large panel of 77 genes that are associated with primary electrical diseases and cardiomyopathies. Their data highlighted the important role of the RYR2 gene in SADS.

Through research we will make a real and lasting difference to the quality of clinical care provided by St George's, building on existing strengths and exploiting new opportunities, in partnership with our colleagues in the universities and research networks.

Our community services

In June 2015, Wandsworth Clinical Commissioning Group approved the development of a Multi-Specialist Community Provider (MCP) service model to provide services including Community Adult Health Services (CAHS) across Wandsworth. This exercise led to the appointment of Battersea Healthcare Community Interest Company, also known as a GP Federation, as lead provider. Following this appointment, the MCP undertook a procurement process for Wandsworth CAHS.

In December 2106, Wandsworth Local Authority put the integrated sexual health services (reproductive sexual health and genitourinary medicine) for Wandsworth, Merton and Richmond out to competitive tender. In February 2107 the Trust decided not to bid for the service, and in

April 2017 the contract was awarded to Central London Community Healthcare NHS Trust (CLCH). All staff at the Trust, who worked in integrated sexual health services, were transferred to CLCH under TUPE regulations. The Trust retained HIV outpatient services, which were previously part of the integrated sexual health services.

In April 2017, the provision of CAHS for Wandsworth was awarded to CLCH. In October 2017 all St George's staff working in CAHS transferred to CLCH under TUPE regulations.

Our Partners

RM Partners

St George's is a partner in RM Partners, the Cancer Alliance across north west and south west London which covers a population of 3.9 million people.

As part of the partnership, in 2017/18 St George's has been able to secure a share of national cancer funding to support the implementation of projects to improve survival and experience for patients with cancer or suspected cancer. Working at scale through RM Partners, the Trust has delivered a number of innovative improvements, including that patients referred to hospital to rule out cancer have a speedy and effective diagnostic pathway.

Clinicians at St George's have participated in work to redesign a number of high volume cancer pathways, ensuring that patients benefit from the latest technologies and innovations available in diagnostics and treatment. Working with colleagues in north central London, north east London and Greater Manchester as part of the "National Cancer Vanguard", clinicians have written new national guidance for prostate, lung, and colorectal pathways and piloted new services before they are rolled out across England.

- Queen Mary's Hospital in Roehampton is one of only three sites in the world piloting an innovative new prostate cancer diagnostic service. RAPID (Rapid Assessment Prostate Imaging and Diagnosis) provides a 'one stop shop' for men with suspected prostate cancer. The service uses new cutting edge FUSION technology to ensure clinicians carry out targeted, precise biopsies only on those men who require one, reducing the risk of side effects such as life-threatening sepsis.

- St George's is one of the first Trusts in the country to implement the National Optimal Lung Cancer Pathway. The Trust is working with local GP surgeries to diagnose patients with suspected lung cancer faster, including fast-tracking patients at risk to have a CT scan. This means that treatment can begin more quickly, improving patient outcomes.

- St George's is also preparing to launch RM Partners' new colorectal diagnostic service. Specialist nurses are trained in a new algorithm to support patients and ensure they have the most appropriate diagnostic test. The new pathway has been shown to improve patient experience, provide a speedier diagnosis, and avoid unnecessary invasive tests.

- Working with RM Partners gives St George's patients access to world-leading clinical trials, such as NICE FIT (Faecal Immunochemical Test). This research study examines the effectiveness of FIT, an innovative non-invasive test, in ruling out bowel cancer, reducing the need for patients to have unpleasant and invasive colonoscopies. Through trials like this, St George's clinicians and patients have the opportunity to contribute to important national research programmes, improving outcomes for future generations.

The success of the RM Partners work in 2017/18 has enabled it to secure funding for a further year, ensuring that St George's staff and patients continue to benefit from being at the cutting-edge of cancer care.

South West London Pathology

South West London Pathology Services provides comprehensive and extensive pathology services from the main 'hub' laboratory at St George's University Hospitals NHS Foundation Trust, with local 'spoke' laboratories at Croydon Health Services NHS Trust and Kingston Hospital NHS Foundation Trust.

The service offers an extensive range of diagnostic testing and provides comprehensive explanations of results to healthcare professionals.

Centre for Health and Social Care Research

The Faculty of Health, Social Care and Education is a joint enterprise between Kingston University and St George's, University of London, that trains nurses, including mental health nurses, occupational therapists, social workers, midwives, other allied health professionals and teachers school.

South London Cardiac and Stroke Network

The South London Cardiac and Stroke Network (SLCSN) works with patients, carers, clinicians and other healthcare professionals to create high quality cardiac and stroke services that focus on the patient and are available to all. It provides general information to empower patients towards improved health and the prevention of cardiovascular disease and stroke.

The South West London & Surrey Trauma Network

The South West London & Surrey Trauma Network has been operating since April 2010 and consists of a Major Trauma Centre at St George's Hospital and seven Trauma Units. These are based at: Croydon University Hospital, Kingston Hospital, St Helier Hospital, Royal Surrey County Hospital, Frimley Park Hospital and St Peter's Hospital and East Surrey Hospital.

Health Innovation Network (HIN) and South London NHS Genomics Network Alliance

The Genomics Network Alliance serves a population of more than seven million people. The three-year programme, which started in 2015, has the potential to transform the future of healthcare. The national programme focuses on cancer and rare diseases and will enable pioneering research to decode 100,000 human genomes, a scale not seen anywhere else in the world. If successful it could improve the prediction and prevention of disease, enable new and more precise diagnostic tests, and allow personalisation of drugs and other treatments.

It is a partnership between:

- St George's University Hospitals NHS Foundation Trust, King's College Hospital NHS Foundation Trust and South London and Maudsley NHS Foundation Trust
- Two universities: King's College London and St George's University of London and;
- Two patient organisations: Macmillan Cancer Support and Genetic Alliance UK
- Two Academic Health Science Networks: covering South London (Health Innovation Network) and Kent, Surrey and Sussex
- One Academic Health Science Centre: King's Health Partners

The NHS Trusts, including St George's are responsible for recruiting suitable patients and their relatives to the programme. Macmillan Cancer Support and Genetic Alliance UK, as well as partners and networks across South London and Kent, Surrey and Sussex, help with patient

engagement and communications to the public. The universities play a key part in genomic research and education.

South West London Elective Orthopaedic Centre (SWLEOC)

SWLEOC is managed and run in conjunction with neighbouring Trusts on a partnership basis from Epsom and St Helier NHS Trust. This NHS centre provides orthopaedic services to patients of St George's, Croydon Health Services, Kingston and Epsom and St Helier hospitals. SWLEOC currently provides a total of 65 beds (two 25-bed post-operative wards and a 15-bed recovery suite with high dependency and critical care facilities) and has five state-of-the-art orthopaedic operating theatres.

St George's Hospital Charity

St George's Hospital Charity is the official charity supporting the Trust. Working closely with our staff and patients, the charity exists to provide additional support through fundraising and donations. New equipment, research funding, staff support, new facilities, and training are all made available thanks to the generosity of supporters. St George's Hospital Charity is an independent charity run by independent Trustees and ensures all grants and donations are applied to projects over and above that which the NHS can provide. In January 2018 one of the Trust's Non-Executive Directors was appointed a Trustee of the charity in order to help align the charity's fund raising objectives with the Trust's strategy and key priorities.

Jacqueline Totterdell
Chief Executive
24 May 2018

Remuneration Report

Name	Job Title	Period	2017/18						2016/17					
			Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
Executive directors			(bands of £5000) £000	total to nearest £00	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	total to the nearest £00	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Ms Jacqueline Totterdell	Chief Executive	From 1st May 2017	200-205	0	0	0	380-385	580-585	0	0	0	0	0	0
Dr Andrew Rhodes	Medical Director	From May 2016	220-225		0	0	0 (*Note 2)	220-225	200-205	0	0	0	230-232.5	430-435
Mr Andrew Grimshaw	Chief Financial Officer	From 19th June 2017	120-125	0	0	0	202.5-205	325-330	0	0	0	0	0	0
Mr Ellis Pullinger	Chief Operating Officer	From 12th June 2017	120-125	0	0	0	45-47.5	165-170	0	0	0	0	0	0
Ms Avinderjit Bhatia	Chief Nurse and Director of Infection Prevention Control	Secondment from February 17 to November 17. Permanent from December 2017	130-135	0	0	0	110-112.5	240-245	25-30	0	0	0	0	25-30
Mr Harbhajan Brar	Director of Human Resources and Organisational Development	From 2nd May 2017	145-150	100	0	0	0	195-200	0	0	0	0	0	0
Mr James Friend	Director of Improvement	From 28th April 2017	120-125	0	0	0	30-32.5	150-155	0	0	0	0	0	0
Mr Kevin Howell	Director of Estates, Facilities and Capital Projects	From 2nd January 2018	30-35	0	0	0	82.5-85	115-120	0	0	0	0	0	0
Ms Suzanne Marsello	Director of Strategy	From 2nd January 2018	25-30	0	0	0	117.5-120	145-150	0	0	0	0	0	0
Mr Stephen Jones	Director of Corporate Affairs	From 5th March 2018	5-10	0	0	0	0-2.5	10-15	0	0	0	0	0	0
Leavers														
Mr Mark Gordon	Chief Operating Officer	Interim (from October 16 to April 17)	155-160	0	0	0	0	155-160	255-260	0	0	0	0	255-260
Mr Richard Hancock	Director of Estates, Facilities and Capital projects	Interim (from March 16 to Dec 17)	300-305	0	0	0	0	300-305	360-365	0	0	0	0	360-365
Ms Ann Johnson	Chief Financial Officer	Interim (April 17 to June 17)	30-35	0	0	0	270-272.5	300-305	0	0	0	0	0	0
Dr Simon Mackenzie	Acting Chief Executive	Acting CEO from May 2016 to April 2017	20-25	0	0	0	0-2.5	20-25	220-225	0	0	0	380-382.5	600-605
Mr Iain Lynam	Chief Restructuring Officer	From 15th February 2016 to 16th May 2017)	25-30	0	0	0	0	20-25	200-205	0	0	0	0	200-205
Mr Miles Scott	Chief Executive Officer	Left April 2016	0	0	0	0	0	0	15-20	0	0	0	0	15-20
Ms Paula Vasco-Knight	Chief Operating Officer	Left April 2016	0	0	0	0	0	0	55-60	0	0	0	0	55-60
Ms Margaret Pratt	Chief Financial Officer	Interim (November 16 to February 2017)	0	0	0	0	0	0	155-160	0	0	0	0	155-160
Mr Nigel Carr	Chief Financial Officer	Interim (May to Oct 2016)	0	0	0	0	0	0	335-340	0	0	0	0	335-340
Ms Corinne Siddall	Interim Chief Operating Officer	Interim (May 16 to Sept 16)	0	0	0	0	0	0	125-130	0	0	0	0	125-130

Ms Wendy Brewer	Director of Human Resources and Organisational Development	Left June 2016	0	0	0	0	0	0	30-35	0	0	0	195-197.5	225-230
Ms Karen Chairman	Director of Human Resources	Interim (July 2016 to Dec 2016)	0	0	0	0	0	0	160-165	0	0	0	0	160-165
Mr Mark Gammage	Director of Human Resources	Interim (December 2016 to March 2017)	0	0	0	0	0	0	100-105	0	0	0	0	100-105
Ms Jennie Hall	Chief Nurse and Director of Infection Prevention Control	Left August 2016	0	0	0	0	0	0	55-60	0	0	0	230-232.5	285-290
Ms Suzanne Banks	Chief Nurse	September 2016 to December 2016	0	0	0	0	0	0	70-75	2000	0	0	170-172.5	240-245
Mr Martin Wilson	Director of Delivery and Improvement	left May 2016	0	0	0	0	0	0	70-75	0	0	0	77.5-80	150-155
Mr Robert Elek	Director of Strategy	left July 2016	0	0	0	0	0	0	105-110	0	0	0	92.5-95	200-205
Mr Paul Moore	Director of Quality Governance	Interim (July 15 to Feb 2016)	0	0	0	0	0	0	160-165	0	0	0	0	160-165
Mr Larry Murphy	IT advisor to Trust Board	Interim (from May 16 to March 2017)	0	0	0	0	0	0	255-260	0	0	0	0	255-260
Non-Executive Directors														
Ms Gillian Norton	Chairman (Chair Nominations and Remuneration Committee)	From July 2016 (Non-Executive Director from June 2016)	60-65	100	0	0	0	60-65	5-10	0	0	0	0	5-10
Ms Ann Beasley	Non-Executive Director (Chair Finance and Investment Committee)	From October 2016	10-15	0	0	0	0	10-15	0-5	0	0	0	0	0-5
Mr Stephen Collier	Non-Executive Director (Chair Workforce and Education Committee)	From October 2016	10-15	0	0	0	0	10-15	0-5	0	0	0	0	0-5
Mr Timothy Wright	Non-Executive Director	From 25th September 2017	5-10	0	0	0	0	5-10	0	0	0	0	0	0
Ms Sarah Wilton	Non-Executive Director (Chair Audit Committee)	From September 2016	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Mr Norman Williams	Non-Executive Director (Chair Quality and Safety Committee)	From April 2016	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Ms Jennifer Higham	Non-executive Director	From 1st November 2015 (see note 1)	0	0	0	0	0	0	0	0	0	0	0	0
Leavers														
Mr Thomas Saltiel	Associate	From Sept 2016 to June 2017	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Mr Michael Rappolt	Non-Executive Director	Left April 2016	0	0	0	0	0	0	0-5	0	0	0	0	0-5
Ms Kate Leach	Non-Executive Director	Left June 2016	0	0	0	0	0	0	0-5	200	0	0	0	0-5
Ms Stella Pantelides	Non-Executive Director	Left August 2016	0	0	0	0	0	0	5-10	300	0	0	0	5-10
Mr David Henshaw	Chairman	From 16th March 2016 to March 2017	0	0	0	0	0	0	150-155	24700	0	0	0	170-175

Pension scheme

The pension scheme operated by the Trust is the NHS Pension Scheme, managed by the NHS Pensions Agency (NHSPA). Employer and employee contributions to the scheme are collected and paid over to the NHSPA on a monthly basis. Therefore, the cost of membership of the scheme is included within operating expenses.

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

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a result of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional benefit accrued to the member as a result of purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Remuneration of senior managers

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

Our workforce 2017-18 Disclosures

Multiple table	
Payroll costs (£000)	522,536
Whole time equivalent	9,254
Median (£000)	35.8
Highest paid director (£000)	302
Median will fit into highest	8.4

The Trust is required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The median pay multiples table expresses the salary of the highest paid director as a factor of the median salary paid for all employees.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The banded remuneration of the highest paid director in the financial year 2017-18 was £302k (2016-17, £432k).

This was 8.4 times (2016-17, 15.8 times) the median remuneration of the workforce, which was £35.8k (2016-17, £27.3k). The highest paid director was employed on an interim basis and left the Trust in December 2017.

During the financial year 2017/18 the Trust reduced its workforce due to the changes in the commissioning of some contracts for community services moving to other providers.

Notice period and duties on termination

If a Director decides to leave the Trust's employment they must give us six months' written notice. If the Trust terminates a Director's employment we will give six months' written notice.

If the Trust terminates the Director's employment for gross misconduct or breach of a statutory enactment we will not give the Director any notice.

In some circumstances the Trust may decide to pay a Director in lieu of basic salary only subject to prior deductions for tax and national insurance contributions for the whole or part of their notice period. For the avoidance of doubt the sum paid in lieu of notice shall not include any element in respect of holiday entitlement that would have accrued during the period for which the payment is made.

During the notice period the Director may be required to remain away from work, regardless of which party gave notice. Whilst on paid notice the Director may not work on an employed or self-employed basis without written permission from the Chief Executive.

In the event of the Director's employment terminating, they will immediately deliver to the Trust all documents, papers, drawings and copies relating to the Trust's activities as well as keys, equipment and other property of the Trust which may be in their possession or under your control including computers, telephones, keys, security passes, identity cards, correspondence, documents, specifications and software storage media. The Director must also inform us of any passwords required to access their work.

The Director shall irretrievably delete any information relating to the Trust stored on any magnetic or optical disk or memory and all matter derived from such store which is in their possession or under their control outside the Trust's premises.

The Director must agree that notwithstanding the termination of their appointment and employment they will whenever called on to do so at reasonable times and on reasonable notice assist the Trust in responding to, defending, pursuing or otherwise dealing with any complaint, investigation, inquiry or litigation involving the Trust and relating to matters within their knowledge. The Director shall be entitled to be paid reasonable out of pocket expenses for the provision of such assistance which shall include but not be limited to helping investigators or lawyers instructed by the Trust, perusing documents, preparing and signing witness statements, attending meetings with lawyers or counsel and giving evidence.

	Salary/fees	Taxable benefits	Annual performance related bonus	Long term related bonus	Pension related benefits
Support for the short and long-term strategic objectives of the Foundation Trust	Ensure the recruitment/ retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	n/a	n/a	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives
How the commponent operates	Paid monthly	None disclosed	n/a	n/a	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme
Maximum payment	As set out in the Remuneration table- salaries are determined by the Trust's Nominations and Remuneration Committee	None disclosed	n/a	n/a	Contributions are made in accordance with the NHS Pension Scheme
Framework used to assess performance	Trust appraisal system	None disclosed	n/a	n/a	n/a
Performance measures	Based on individual objectives agreed with line manager	None disclosed	n/a	n/a	n/a
Performance period	No performance related payment arrangements	None disclosed	n/a	None paid	n/a
Amount paid for minimum level of performance and any further levels of performance	Any sums paid in error may be recovered	None disclosed	Any sums paid in error may be recovered	None paid	n/a
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any sums paid in error may be recovered		Any sums paid in error may be recovered	None paid	n/a

Consideration of employment conditions elsewhere in the Trust

The Trust uses benchmarking information from the NHSI data on combined acute Trust salary data for very large acute Trusts. All Directors are employed within the relevant range. Submissions are made to NHS Improvement in line with the process for agreeing Directors' salaries when the amount is over £142,500.

Directors

The start date for each Director is listed below. None of the Directors is on a fixed-term contract so they do not have an unexpired term.

Expenditure on consultancy

Executive Name	Start date	Notice Period
Jacqueline Totterdell	May 2017	6 months
Andrew Grimshaw	May 2017	6 months
Andrew Rhodes	February 1991	6 months
Avey Bhatia	December 2017	6 months
Ellis Pullinger	June 2017	6 months
Harbhajan Brar	May 2017	6 months
James Friend	April 2017	6 months
Kevin Howell	January 2018	6 months
Stephen Jones	March 2018	6 months
Suzanne Marsello	January 2018	6 months

Expenditure on consultancy

Cost	2017/18			2016/17
	Permanently employed	Other	Total	Total
	£0	£0	£0	£0
Salaries and wages	411,961	0	411,961	401,444
Social security costs	43,526	0	43,526	40,308
Pension cost - defined contribution plans employer's contributions to NHS pensions	47,071	0	47,071	45,403
Pension cost - other	0	0	0	0
Temporary staff - agency/contract staff	0	19,978	19,978	43,324
Total gross staff costs	502,558	19,978	522,536	530,479

Transactions with related parties

Transactions with third parties are presented in the annual accounts. For the other Board Members, the Foundation Trust's Councillors, or parties related to them, none of them have undertaken material transactions with the Trust

The remuneration report was approved by the Board of Directors on 24th May 2018 and signed on its behalf by Jacqueline Totterdell, Chief Executive and Andrew Grimshaw, Chief Financial Officer.

Jacqueline Totterdell
Chief Executive
24 May 2018

Andrew Grimshaw
Chief Financial officer
24 May 2018

Organisational structure and Annual Governance Statement

Our Council of Governors

Our Council of Governors became a full council when the Trust was authorised as a Foundation Trust on 1 February 2015. During most of 2017/18 the Council was comprised of 15 elected public governors; five elected staff governors and eight governors appointed from stakeholder organisations.

The Council of Governors is responsible for the appointment of the Chairman and Non-Executive Directors, agreeing their terms and conditions, as well as the appointment of the external auditor. Each financial year, the Council of Governors is consulted by the Board on the Trust's forward plan and receives the Annual Accounts, auditors' report, annual report and quality report. Governors are unpaid; however, they are entitled to receive reimbursement of their expenses. Our Council of Governors is responsible for holding our Non-Executive Directors to account, individually and collectively, for the performance of the Board. In 2017/18 the Council of Governors agreed a process for undertaking and appraising the Chairman and Non-Executive Directors. Appraisals for the Non-Executive Directors performance was undertaken in April and May 2017 and the Council of Governors has certified that the Non-Executive Directors are performing effectively.

The Trust held elections to the Council of Governors in January 2018 with nine new Governors elected and two existing Governors re-elected. The Council of Governors selects one of their elected members to be the Lead Governor of the Council. The Lead Governor is responsible for co-ordinating communication between NHS Improvement and the other governors, and acts as the main point of contact for the Chairman. Kathryn Harrison is our current Lead Governor.

As part of the election process and to reflect changes in the Trust's services and the balance of membership across council constituencies, from 1 February the Council of Governors has 26 members, with four staff governors (one fewer), 15 elected public governors, and seven (one fewer) appointed governors. The Council of Governors met five times in 2017/18

The Annual Members Meeting was held in September, 78 people attended. There have been several workshops or governor induction sessions where Board members and governors can meet to discuss various issues. A programme of training sessions has taken place during 2017/18 for governors in areas such as finance and equality inspections on the wards.

Our public membership is currently 13,175, an increase of 894 from the previous year (12,281). The Council of Governors engages with members through a variety of ways, including a monthly newsletter, bespoke Medicines Matters events and public meetings.

Council of Governors meeting attendance

Name	Description	Actual/ possible attendance
Gillian Norton	Chairman	5/5
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	2/5
Anneke de Boer	Public Governor, Merton	4/5
Bassey Williams	Staff Governor, Allied Health Professionals	1/1
Dagan Lonsdale	Staff Governor, Doctors and Dental	3/4
Damian Quinn	Public Governor, Rest of England	1/1
David Flood	Staff Governor, Nursing & Midwifery	2/4
David Kirk	Public Governor, Wandsworth	3/4
Derek McKee	Public Governor, Wandsworth	5/5
Donald Roy	Appointment Governor, Healthwatch Wandsworth	1/1
Doulla Manolas	Public Governor, Wandsworth	0/1
Dr Anup Sharma	Staff Governor, Medical & Dental	1/1
Dr Clive Studd	Public Governor, Merton	1/1
Emir Feisal	Public Governor, Wandsworth	1/1
Francis Gibson	Appointed Governor, St George's University	3/5
Gail Adams	Public Governor, South West Lambeth	1/4
Helen McHugh	Staff Governor, Nursing & Midwifery	1/1
Hilary Harland	Public Governor, Merton	4/5
Jenni Doman	Staff Governor, non-clinical	4/5
John Hallmark	Appointed Governor, Healthwatch Wandsworth	0/1
Kathryn Harrison	Lead Governor, Rest of England	5/5
Khaled Simmons	Public Governor, Merton	5/5
Mia Bayles	Public Governor, Rest of England	3/5
Mike Grahn	Appointed Governor, Healthwatch Wandsworth	4/4
Nigel Brindley	Public Governor, Wandsworth	4/5
Noyola McNicolls-Washington	Staff Governor, Community Services	1/3
Patrick Bower	Appointed Governor, Wandsworth CCG	4/5
Philip Jones	Appointed Governor, Merton Council	4/5
Richard Mycroft	Public Governor, South West Lambeth	1/1
Robin Isaacs	Public Governor, Rest of England	2/4
Sarah McDermott	Appointed Governor, Wandsworth Council	3/5
Sheila Eden	Public Governor, Merton	3/3
Simon Price	Public Governor, Wandsworth	3/5
Stephen Sambrook	Lead Governor, Rest of England	4/5
Stuart Goodden	Public Governor, Wandsworth	0/4
Sue Baker	Public Governor, Merton	1/1
Tim Hodgson	Appointed Governor, Merton CCG	0/4
Val Collington	Appointed Governor, Kingston University	5/5
Will Hall	Staff Governor, Allied Health Professionals	3/3
Yvonne Langley	Public Governor, Wandsworth	2/4

Our Membership

The Trust is committed to involving patients, families and carers, as well as members of the Trust, in the delivery and development of services. Our governors and members ensure that we are accountable and listen to the needs and views of our patients.

Our membership groups are split into three categories:

- Public members; the Trust's public members will include patients, volunteers and all other members of the public (non-staff). All public members are required to opt in to membership. Public members are divided into four geographical constituencies, Wandsworth, Merton, south west Lambeth and Regional (England and Wales).

- Staff members: All staff members are automatically opted into membership, unless they actively inform the Trust that they do not wish to be. Staff membership is also open to all individuals employed by the Trust on permanent contracts or on fixed term contracts of 12 months or more.

A voice for younger people

The Trust provides significant children's and young people's services and with the population growth trends in south west London and Surrey these services will play a key part in the Trust's strategic development. The Trust is therefore committed to ensuring that young people are enabled to access and actively participate in membership and that their views are fully represented.

In view of the above trends the Trust has reviewed its original minimum age level for membership. The minimum age for membership is 14 years of age. In line with our regulatory requirements, the minimum age for members to stand as a governor is 16 years of age.

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

We communicate with our members using the following methods:

- The Trust's monthly magazine for all staff

- The Trust's twice-weekly e-bulletin for staff and regular e-bulletins for public members

- A programme of regular member events (including the Trust's Annual Members Meeting)

- Dedicated member and governor page within the Trust website

- Social media including Twitter and Facebook

- Governor constituency meetings with members.

The Trust will continue to set out its membership offer and outline the benefits of membership in a clear and consistent manner, encouraging all those eligible to play a full and active part in the Trust.

Code of Governance

The Board of Directors of the Trust attaches great importance to ensuring that the Trust operates to high ethical and compliance standards. In addition, it seeks to observe the principles of good corporate governance as set out in the NHS Foundation Trust Code of Governance.

The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained and is accountable for the performance of the Trust.

The Council of Governors' role is to hold the non-executive directors of the Trust to account and to engage with their respective members to ensure their views are reflected. It also carries out other statutory and formal duties, including the

appointment of the Chairman and Non-Executive Directors of the Trust and the appointment of the external auditor.

The Code of Governance confirms there are no material inconsistencies between:

- The Annual Governance Statement
- Annual and Quarterly Board statements required by the Single Oversight Framework, the corporate governance statement submitted with the Annual Plan, the Quality Report, and Annual Report
- Reports arising from Care Quality Commission planned and responsive reviews of the NHS Foundation Trust and any consequent action plans developed by the Trust

The Board of Directors

The Board of Directors is made up of:

- The Chairman (non-executive)
- Six independent Non-Executive Directors including one representing St George's University of London
- Four Executive Directors (voting)
- Non-voting Executive Directors who attend the Board regularly
- No Executive Director currently holds a non-executive role in another Foundation Trust or comparable organisation.

During 2017/18 the Trust has reformed its leadership capability and capacity by making substantive appointments to Executive Director positions. The Trust has undertaken a review of both its senior management leadership and leadership within the divisions and is working to implement those results to build further on its work in 2017/18 to ensure it is well-led.

The Board and its committees have undertaken a review of their effectiveness, terms of reference and cycle of business. To ensure the Trust has arrangements to ensure it is well-led, we have reviewed and developed the Board Assurance Framework, including the development of new strategic risks and an analysis of the Trust's risk appetite. Strategic risks are now owned by committees of the Board which review them regularly in order to receive substantial assurance that they are being effectively mitigated.

Non-Executive Directors

All Non-Executive Directors are independent, although Jenny Higham is a representative of St George's, University of London. All Non-Executive Directors are members of the Board and the Board of Directors' Nominations and Remunerations Committee.

Executive Directors

The Board meets monthly and has a formal schedule of matters specifically reserved for its decision. This includes high level matters relating to strategy, business plans and budgets, regulations and control, the Annual Report and Accounts, audit, and monitoring how the Trust's strategy is implemented at operational level. The Board delegates other matters to the Executive Directors and senior management within the Trust.

Regular contact, including with the Non-Executive Directors, is maintained between formal meetings. Board meetings follow a formal agenda, which includes a review of quality and patient care, strategy, clinical governance, operational performance and performance against quality indicators set by the Care Quality Commission (CQC), NHS Improvement and by management, such as infection control targets, patient access to the Trust and Emergency Department waiting times.

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

The Board has standing orders, which set out the procedure for meetings and for recording decisions. The standing orders allow any Director to have their comments recorded in the minutes. The Directors confirm their code of conduct on an annual basis, which includes the Nolan Principles of Public Life. The Trust has arranged NHS Resolution indemnity cover for Directors.

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

The Board agrees financial, quality and operating objectives in public on an annual basis, following input from the Council of Governors. The Board will then monitor and seek assurance on progress against those objectives on an ongoing basis.

Trust Board Attendance Register 2017-18

Name	Description	Actual/ possible attendance
Gillian Norton	Chairman	12/12
Ann Beasley	Non-Executive Director	12/12
Jenny Higham	Non-Executive Director	9/12
Sarah Wilton	Non-Executive Director	12/12
Sir Norman Williams	Non-Executive Director	12/12
Stephen Collier	Non-Executive Director	12/12
Tim Wright	Non-Executive Director	6/6
Thomas Saltiel	Associate Non-Executive Director	3/3
Executive Directors		
Simon Mackenzie	Chief Executive	1/1
Jacqueline Totterdell	Chief Executive	10/10
Andrew Grimshaw	Chief Financial Officer	6/7
Andrew Rhodes	Medical Director	9/12
Ann Johnson	Interim Chief Financial Officer	2/3
Anna D'Alessandro	Director, Financial Performance/Deputy CFO	1/1
Avey Bhatia	Chief Nurse and DIPC	12/12
Executive Directors (non-voting)		
Ellis Pullinger	Chief Operating Officer	7/7
Harbhajan Brar	Director of Workforce & Organisational Development	9/12
Iain Lynam	Chief Restructuring Officer	0/1
James Friend	Director of Delivery, Efficiency & Transformation	8/9
Karen Daly	Associate Medical Director & Responsible Officer	1/1
Kevin Howell	Director of Estates & Facilities	3/3
Larry Murphy	Chief Information Officer	3/8
Mark Gammage	HR Advisor to the Board	1/1
Mark Gordon	Chief Operating Officer	1/1
Richard Hancock	Director of Estates & Facilities	6/7
Sandra Shannon	Deputy Chief Operating Officer	1/1
Stephen Jones	Director of Corporate Affairs	1/1
Suzanne Marsello	Director of Strategy	3/3

Governance structure

The Trust is open and transparent with the community through the public Council of Governor meetings, public Board meetings, the various health events held during the year, the Trust's Freedom of Information service, and the large amount of information available on our website.

The Trust Board has a number of committees:

- Audit Committee
- Finance and Investment Committee
- Quality and Safety Committee
- Nominations and Remuneration Committee
- Workforce and Education Committee

Audit Committee Attendance Register 2017-18

The Audit Committee provides the Board of Directors with an independent review of financial and corporate governance and risk management. It provides assurance through independent external and internal audit; ensuring standards are set and monitors compliance in the non-financial, non-clinical areas of the Trust.

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek any information it requires from staff. In 2017, the Committee reviewed the draft Annual Report and Accounts, including the Quality Accounts, and approved their submission to the auditors before being laid before Parliament.

Name	Description	Actual/possible attendance
Sarah Wilton (Chair)	Non-Executive Director	5/5
Ann Beasley	Non-Executive Director	5/5
Sir Norman Williams (Ex officio Member)	Non-Executive Director	4/5
Tim Wright	Non-Executive Director	1/2

Finance & Investment Committee Attendance Register 2017-18

The Committee assists the Trust to maximise its healthcare provision subject to its financial constraints. The Committee considers patient safety to be of paramount importance. It achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensures that detailed consideration is given to the Trust's financial, investment and associated performance issues to ensure that the Trust uses public funds wisely. It also ensures that adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies and achievement of the Trust's strategic aims and objectives.

Name	Description	Actual/possible attendance
Ann Beasley (Chair)	Non-Executive Director	11/11
Andrew Grimshaw	Chief Financial Officer	8/8
Andrew Rhodes	Medical Director	11/11
Ann Johnson	Acting Chief Financial Officer	3/3
Avey Bhatia	Chief Nurse & DIPC	10/11
Gillian Norton	Chairman	10/11
Jacqueline Totterdell	Chief Executive	10/11
Mark Gammage	HR Advisor to the Board	1/1
Sarah Wilton	Non-Executive Director	8/10
Simon Mackenzie	Chief Executive	1/1
Stephen Collier	Non-Executive Director	11/11

Quality & Safety Committee Attendance Register 2017-18

The Quality Committee is responsible for examining and providing assurances on the level of risk to which patients are exposed and the extent to which clinical outcomes required by corporate strategy are being met.

The Committee also looks at the extent to which patient and user satisfaction matches that required by corporate strategy and whether the Trust can demonstrate learning and improvement and the level of compliance with Fundamental Standards of Care.

Name	Description	Actual/possible attendance
Sir Norman Williams (Chair)	Non-Executive Director	7/7
Andrew Rhodes	Medical Director	7/7
Avey Bhatia	Chief Nurse & DIPC	7/7
Gillian Norton	Chairman	3/7
Jacqueline Totterdell	Chief Executive	4/7
Jenny Higham	Non-Executive Director	6/7
Sarah Wilton	Non-Executive Director	7/7

Remuneration and Nomination Committee Attendance Register 2017-18

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

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

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

Name	Description	Actual/possible attendance
Gillian Norton (Chair)	Chairman	8/8
Ann Beasley	Non-Executive Director	8/8
Jenny Higham	Non-Executive Director	7/8
Sarah Wilton	Non-Executive Director	8/8
Sir Norman Williams	Non-Executive Director	7/8
Thomas Saltiel	Associate Non-Executive Director	1/1
Jacqueline Totterdell	Chief Executive	8/8

Workforce & Education Committee Attendance Register 2017-18

The Workforce and Education Committee provides the necessary assurance to the Trust Board that there are processes and plans in place to ensure that the Trust's key strategic objective for the Trust's workforce is achieved by reviewing progress against implementation of the components of the workforce strategy.

Name	Description	Actual/ possible attendance
Stephen Collier (Chair)	Non-Executive Director	3/3
Gillian Norton	Chairman	2/3
Ann Beasley	Non-Executive Director	3/3
Harbhajan Brar	Director of Human Resources & Organisational Development	2/3
Avey Bhatia	Chief Nurse & DIPC	1/3

Our Board

Gillian Norton, Chairman

Gillian Norton was appointed Chairman in April 2017, having been a Non-Executive Director since June 2016. She spent her executive career in local government, serving as Chief Executive for a total of 23 years, the last 17 of which were in London Borough of Richmond. She is also Representative Deputy Lieutenant for Richmond and was awarded an OBE for services to local government.

Jacqueline Totterdell, Chief Executive

Jacqueline Totterdell joined St George's as Chief Executive in May 2017. Jacqueline is an experienced NHS leader, having previously been Chief Executive of West Middlesex University NHS Trust, where she helped steer the organisation through its merger with Chelsea and Westminster Hospital NHS Foundation Trust. She has also been Chief Executive of Southend University Hospital NHS Trust, where she spent five years. She has also been Chief Operating Officer at Barts Health and The Hillingdon Hospital NHS Trust.

Non-Executive Directors

Ann Beasley, Non-Executive Director (Deputy Chair)

Ann Beasley joined St George's as a Non-Executive Director in October 2016. She has a background in finance, her most recent role being Director General for the Finance, Assurance and Commercial Group at the Ministry of Justice. Ann has also been Chairman of Trustees for the Alzheimer's Society. Ann was awarded a CBE in 2010.

Stephen Collier, Non-Executive Director

Stephen has worked extensively in the private health sector, including a period as Chairman of the NHS Partners Network – the trade association for private providers to the NHS. He is also a Trustee of ReSurge Africa, a Scottish medical charity working in Ghana and Sierra Leone. Stephen took up the role of Non-Executive Director in October 2016.

Jenny Higham, Non-Executive Director

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

Professor Sir Norman Williams, Non-Executive Director (Senior Independent Director)

Professor Norman Williams is a leading honorary consultant at Barts Health NHS Trust. He was President of the Royal College of Surgeons between July 2011 and July 2014. He is also Professor of Surgery and Director of Innovation at Queen Mary's School of Medicine and Dentistry, Director of the National Centre for Bowel Research and Surgical Innovation and Co-Clinical Director of the National Institute for Health Research (NIHR) Enteric Bowel Function Healthcare Technology Cooperative.

Sarah Wilton, Non-Executive Director

Sarah qualified as a chartered accountant with PricewaterhouseCoopers. She has held several senior executive positions at Lloyd's of London, as well as has Non-Executive Director appointments at two Lloyd's agencies, Capita Managing Agency

since 2004 and Hampden Agencies Limited since 2008, Chairman of the audit and risk committees. She is a Magistrate at Wimbledon Magistrates Court and a Trustee of the Paul D'Auria Cancer Support Centre.

Tim Wright, Non-Executive Director

Tim joined the Department for Education as Chief Information Officer in 2007, a position he held for almost six years. Tim also worked across government, with local authorities, the Cabinet Office and the Government Digital Service. Prior to joining government, Tim worked for 20 years in the oil and gas industry in IT development, consulting and senior IT leadership roles. He is a Fellow of the British Computer Society and a Member of the Institution of Mechanical Engineers.

Executive Directors

Professor Andrew Rhodes, Medical Director

Andrew Rhodes is Medical Director, and a Consultant and Professor in Intensive Care Medicine and Anaesthesia. He has research interests in the fields of surgery, sepsis, haemodynamics and outcomes related to Peri-operative and Intensive Care Medicine. Andrew is a Council member of the Faculty of Intensive Care Medicine (FICM), a past president of the European Society of Intensive Care Medicine (ESICM) and is the current co-Chairman of the Surviving Sepsis Campaign.

Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control

Avey joined St George's as our Chief Nurse in February 2017. Avey was previously Chief Nurse at Maidstone and Tunbridge Wells NHS Trust, before which she was Deputy Chief Nurse at South London Healthcare NHS Trust from 2010-2013. Avey is also our Director of Infection Prevention and Control. Prior to joining South London Healthcare, Avey held senior nursing and management positions at St George's.

Andrew Grimshaw, Chief Financial Officer

Andrew Grimshaw joined St George's as our Chief Financial Officer in June 2017. Andrew was previously Director of Finance at London Ambulance Service, and was also Acting Chief Executive at LAS between January and June 2017. Prior to joining LAS, Andrew worked at a number of teaching, specialist and district general hospitals, having joined the NHS as a trainee accountant in 1989.

Harbhajan Singh Brar, Director of Human Resources and Organisational Development

Harbhajan Singh Brar has been Director of Human Resources and Organisational Development at St George's since May 2017. He joined St George's from Sodexo UK, where he was Director of Human Resources from 2011. Harbhajan has also held roles at the Department of Health, Kingston Hospital NHS Foundation Trust and Barnet and Chase Farm NHS Hospitals Trust. In 2016, Harbhajan was listed in the Top 100 Black Asian Minority Ethnic executives across the USA, Ireland and the UK, published in the Financial Times.

Ellis Pullinger, Chief Operating Officer

Ellis started as our Chief Operating Officer in June 2017. He joined St George's from Imperial College Healthcare NHS Trust where he was Assistant Chief Executive. Prior to this he was Divisional Director of Operations for the Trust's Division of Investigative Sciences and Clinical Support. Ellis runs day-to-day operations, manages capacity and demand, and ensures we continue to provide quality services for patients.

James Friend, Director of Delivery, Efficiency and Transformation

James Friend joined as our Director of Delivery, Efficiency and Transformation in April 2017. James joined St George's from the Department of Health, where he was an advisor to the Secretary of State for Health. James is an experienced NHS and commercial Director, having held roles in NHS commissioning, as well as at West Middlesex University NHS Trust, and Chelsea and Westminster NHS Foundation Trust.

Kevin Howell, Director of Estates and Facilities

Kevin started in post in January 2018. He joined St George's from West Hertfordshire Hospitals NHS Trust, where he was Director of Environment from 2014. Kevin has over 30 years' experience in the NHS, and has held a number of senior and executive estates and facilities roles in the London area – including at the Princess Royal University Hospital, Barnet and Chase Farm and North Middlesex University Hospital.

Stephen Jones, Director of Corporate Affairs

Stephen joined the Trust as Director of Corporate Affairs in March 2018. Stephen was previously Chief of Staff and executive lead for corporate governance at the General Medical Council. Prior to this, Stephen worked as Stakeholder Engagement Director on Co-operation and Competition policy at Monitor (now NHS Improvement). He also held a number of senior policy roles within the Department of Health, including on provider policy, the NHS Constitution and legislative reform, and served as Senior Private Secretary.

Suzanne Marsello, Director of Strategy

Suzanne joined at St George's as Director of Strategy in January 2018. Suzanne joined St George's from neighbouring South West London and St George's Mental Health NHS Trust, where she was Director of Strategy and Commercial Development from March 2015 to December 2017. Suzanne is no stranger to St George's, having previously held a number of senior operational and strategic roles within the organisation.

Board of Directors – Register of Interests

St George's is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish a Register of Interests on our public website which draws together Declarations of Interest made by members of the Board of Directors and those serving on the Executive Team.

In addition, at the commencement of each Board, Committee and Executive Management Team meeting, all present are required to declare any interests.

Declarations of interest

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

The primary responsibility applies to all NHS staff, including the Executive Team and Non-Executive Directors. Members of the Board are asked to declare any interests they have before the start of each Board meeting.

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Gillian Norton	**Chairman**
Trustee	SE London Relate
Representative Deputy Lieutenant Richmond	Greater London Lieutenancy
Jacqueline Totterdell	**Chief Executive**
Partner	NHS Interim Management and Support
Ann Beasley	**Non-Executive Director**
Independent Financial Adviser	ACAS Audit Committee
Stephen Collier	**Non-Executive Director**
Member, Advisory Board	Healthcare Market News (monthly publication)
Member, Advisory Board	Cielo Healthcare (Milwaukee, USA)
Member, Health Leaders Panel	Nuffield Trust
Member, Governance Board	Independent Sector Complaints Adjudication Service (ISCAS)
Trustee	ReSurge Africa (medical charity)
External Advisor	Schoen Klinik (German provider of mental health and surgical services)
External Advisor	Imperial College, in relation to potential academic/research-led medical & technology developments/collaborations on the new White City campus
Chairman and investor	Eden Futures (supported living provider)
External advisor and convenor	Independent Health Coalition (comprises medical insurers and hospital groups)
Jenny Higham	**Non-Executive Director (University Rep)**
Board Governor	Kingston University
Principal	SGUL
Visiting Professor	Lee Kong Chain School of Medicine in Singapore
Honorary Consultant	Imperial College London
Chairman	Medical Schools Council
Sir Norman Williams	**Non-Executive Director**
Consultant	TSALYS Medical Technology start-up company
Senior Clinical Advisor	Secretary of State for Health
Non-Executive Director	Private Healthcare Information Network (PHIN)
President	Bowel & Cancer Research
Chairman	Steering Committee Enteric, an NIHR Health Technology Cooperative
Sarah Wilton	**Non-Executive Director**
Non-Executive Director, and Audit and Risk Committee Chairman	Capita Managing Agency Limited
Non-Executive Director, and Audit and Risk Committee Chairman	Hampden Members' Agencies Limited
Trustee and Vice Chairman	Paul's Cancer Support Centre
Magistrate	South West London Magistrates Court and Central London Family Court
Tim Wright	**Non-Executive Director**
Director	Owner/Director Isotate Consulting Limited
Director	Monterey Wharf (Eastbourne) Ltd (Ended Jan 18)
Director	Monterey Wharf (RTM) Ltd (Ended Jan 18)
Trustee	St George's Hospital Charity
Avey Bhatia	**Chief Nurse, Director of Infection Prevention and Control**
No interests to declare	Chief Finance Officer
Andrew Grimshaw	**Acting Medical Director**
Director	L.S.O Consulting (Design Consultancy)
Andrew Rhodes	**Acting Medical Director**
Trustee	Critical Care Limited
Owner/Director	Dr A Rhodes Limited
Owner/Director	Life Priority Foundation
Chairman	Surviving Sepsis Campaign

Annual Governance Statement

Statement of the Chief Executive's responsibilities as the accounting officer of St George's University Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of St George's University Hospitals NHS Foundation Trust. This includes responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts as set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require St George's University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of St George's University Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, I can confirm we comply with the requirements of the Department of Health Group Accounting Manual and in particular:

- We have observed the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- We have made judgements and estimates on a reasonable basis
- We have met the applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) and have followed, disclosed and explained any material departures in the financial statements
- Ensured that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepared the financial statements on a going concern basis.

As accounting officer I can confirm we keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and enable me to ensure that the accounts comply with requirements outlined in the above mentioned Act. I can confirm that we have safeguarded the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Statement of Compliance with the NHS Foundation Trust Code of Governance

The Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. 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 standards of business conduct policy, which requires all budget holders to complete declarations of interest on an annual basis.

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

The accounts have been prepared on a going concern basis. IAS 1 has been adapted for the public sector in that accounts are prepared on going concern basis if services will continue. The Trust incurred a deficit of £53.1m for the year ended 31 March 2018. During the year the Trust borrowed £60.3m under support facilities provided by the Department of Health.

The Board has reviewed the proposed 2018/19 plan throughout its development from November 2017 to date. The 2018/19 plan is for a deficit of £29m having taken account of the underlying financial position going into 2018/19. The Trust has identified in its financial plan submitted to NHS Improvement that further borrowing totalling £29m is required to finance the Trust for the year, provided the £29m planned deficit is not exceeded. There are significant risks to the planned deficit from delivering both the planned activity and the transformation savings. Given these risks, the Trust is requesting access to further Department of Health borrowing facilities to provide adequate liquidity headroom.

At the time this Annual Report and Accounts was being prepared the Trust was engaged in discussions with the regulator regarding the financial plan for 2018/19 and the arrangements to access further borrowing facilities. However, these discussions had not been concluded at the time the financial statements were approved. Although these factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern, the directors, having made appropriate enquiries, have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the NHS Foundation Trust Annual Reporting Manual 2017/18, the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the accounts and has not included the adjustments that would result if it were unable to continue as a going concern.

The Board of Directors considers that it was compliant with the provisions of the revised NHS Foundation Trust Code of Governance. The Council of Governors retains the power to hold the Non-Executives to account for their performance in achieving the Trust's objectives.

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

Jacqueline Totterdell
Chief Executive
24 May 2018

Introduction

The Care Quality Commission's inspection report for St George's, published in November 2016 following their inspection in June 2016, raised concerns about the quality of care the Trust provides in certain areas.

On 1 November 2016 the Trust was placed in Quality special measures and had further conditions imposed on its Licence. In order to address these, the Trust commissioned an external review of governance to take place in 2017/18.

The Trust also received a Financial Improvement Notice in April 2017 though was notified by NHS Improvement that it would be placed in to Financial special measures on 24 March 2017.

Scope of responsibility

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, and the Quality and Safety Committee and a plan to continue to identify and address weaknesses and ensure improvement of the system continues.

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

The overall opinion of the Head of Internal Audit is that reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

The internal audit plan for 2017/18 included reports across the main operational areas of the Trust and details of each report conducted and the level of assurance provided are included in the plan.

The Trust has produced a quality account for 2017/18 and the governance system described above has been used to validate its content and the data on which it is based. Through review of these assurances, the Board has considered any issues that fall within the definition of 'significant issue' according to the requirements of this governance statement.

Key concerns continue to be the Trust's financial recovery and addressing the issues that resulted in the Trust being placed in special measures. The Board also remains concerned that the Trust achieved an outturn deficit of £53.1 million which is greater than planned for at the start of the year, although it noted this was significantly lower than the previous year. Additional, but linked concerns are the Trust's physical and information technology infrastructure although plans for 2018/19 are in place to sustainably improve the Trust's position in all of these areas.

The purpose of the system of internal control

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

The system of internal control has been in place in St George's for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

The risk and control framework

The Risk Management Framework and supporting procedures set out the key responsibilities for managing risk within the organisation, including ways in which the risk is identified, evaluated and controlled.

A risk management matrix is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and incidents. The Trust's appetite for risk is articulated through the boundaries within the risk evaluation matrix that have been defined by the Board of Directors. Risks assessed as significant are monitored to ensure mitigating actions are undertaken to reduce risks to an acceptable level. The process for the management and monitoring of risk assessments is defined within the Risk Management framework and supporting procedures. All serious incidents and serious risks are reported to the Board of Directors via the established governance committee structures.

The Board Assurance Framework sets out the principal risks to delivery of key priorities and the Trust's overarching strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The Board Assurance Framework identifies the assurances available to the Board of Directors in relation to the achievement of the Trust's key objectives. The principal risks to the delivery of these objectives are mapped to key controls.

The Board Assurance Framework supports the process for monitoring ongoing compliance with the requirements for registration set by the Care Quality Commission (CQC), with mapping of the regulations to strategic priorities. The Board plays a role in procurement as outlined in the scheme of delegation as part of compliance with the Trust's policies and procedures to ensure that resources are used efficiently and effectively.

Capacity to handle risk

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

There is an established governance framework, supported and maintained by a framework of committees. The Trust Board has overall responsibility for the effectiveness of the governance framework and as such requires that each of its committees has agreed terms of reference which describe the duties, responsibilities and accountabilities, and describe the process for assessing and monitoring effectiveness.

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

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

Senior leadership in corporate governance is provided by the Directory of Corporate Affairs who also acts as the Trust Secretary. Governance is embedded across the Trust's Directorates and clinical divisions, led by Directors or Divisional Chairman, thus ensuring clear responsibility and accountability across the Trust.

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

During 2017-18 the Trust undertook a number of reviews of its governance arrangements to ensure they continue to be fit for purpose and support the delivery of key activities. Where areas of weakness were identified these have been prioritised for action.

Risks to the Trust

As with all NHS organisations, balancing the need to deliver high quality care in the context of increasing demand and acuity, while increasing productivity, represents an ongoing challenge. The NHS is in a period of long term financial constraint. This context is important in understanding both St George's risks, and some of the drivers for those risks, as well as the constraints on the mitigations on which the Trust can necessarily call on. This is against a backdrop of constraints on our ability to invest in additional physical and staffing capacity.

The Board identified major risks for 2017-18 during strategic planning activities in year and will continue to reconsider key risks which may impact on strategic objectives in 2018-19.

The following key risks to delivery of the Trust's objectives are recorded in detail in the Board Assurance Framework as at March 2018. These are monitored monthly by the Board or its committees and are available in full via the Board papers on the Trust's website. In 2017-18 some of the key risks with potential impact on achieving our objectives are described in the table below.

Trust Objective	Risk Description	Mitigation
Treat the patient, treat the person	NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing). We are unable to develop new roles, changes in skill mix and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could impact upon the care we provide.	We are working to improve our vacancy rate and the time taken to recruit. We have implemented a workforce strategy including approaches to recruitment and retention, and health and well-being to mitigate the risk of workforce shortages.
	Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway need to be more robust and effective.	We have made good progress in the management of our waiting lists through our Elective Care Recovery Programme. The Unplanned Admitted Care Programme will improve control of this risk, and throughout 2018/19 we plan to improve performance against key performance indicators and national indicators.
Right care, right place, right time	Our pathways are not well integrated with, nor supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.	Work continues to develop relationships and pathways with our partners, and the Unplanned Admitted Care Programme will improve mitigation of this risk.
Balance the books, invest in our future	Financial efficiency, forecasting and accountability are not seen as a priority for service managers or our wider workforce which results in overspending, and further regulatory action.	Since early 2018 all departments and individuals, both clinical and non-clinical, who are responsible for managing financial matters, have been receiving training. Our cost improvement programmes (CIPs) are closely monitored by the appropriate committees and the board. We are putting additional effort into developing robust CIPs and moving them to a delivery position as soon as possible.
	Ensure we have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories.	As of April 2018 the financial and operational plan for 2018-19 is in the final stages of development. This risk will be mitigated once we have provided assurance that we can effectively report against the plan for the first quarter of 2018/19.
Build a better St George's	Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative or does not foster accountability amongst our workforce.	Our NHS Staff Survey 17/18 results have moved in a positive direction and we are delivering on our Staff Engagement Plan The plan is regularly reviewed and we monitor closely delivery at appropriate committees and at board meetings.
	We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction, which can affect the care we provide to patients.	Key performance indicators for mandatory and statutory training and appraisal are provided to the appropriate committee so that they can be assured we are mitigating this risk. An operational restructure designed to clarify roles, responsibilities and accountabilities is being implemented in early May 2018 and the Kings Fund leadership development programme is underway.
Develop tomorrow's treatments today	We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clinical service priorities and consequently a lack of engagement in the future success of the Trust.	The Board agreed the Trust strategy development process and timescales in the March Board meeting.
	A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.	The Board receives assurance through the partnership highlight report for this risk. The Director of Strategy has built relationships with key stakeholders both within and outside south west London. The CEO continues to provide a lead role within the Acute Provider Collaborative at the SWL Health and Care Partnership system-wide Programme Board.

Information Governance

The Board is aware of the importance of maintaining high standards of information governance, including protecting the confidentiality of patients and staff information. The Trust has a Chief Information Officer as the senior information risk officer and Dr Mark Hamilton, Associate Medical Director, as Caldicott Guardian.

The Trust also has an information governance manager and a range of policies, procedures and training to ensure that all staff are aware of information governance requirements. The informatics governance (IG) group oversees the completion of the information governance toolkit on an annual basis, as well as reviewing any information governance incidents. The IG toolkit rating for the reporting period was satisfactory.

During 2017/8 two level 2 IG incidents were reported to the Information Commissioner's Office (ICO). They related to two serious incidents regarding data that were disclosed in error. Following the Trust's own investigation, the ICO undertook investigations that determined there was no need for further action.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to the Annual Report and other performance information available to me. The Board and its committees have met regularly throughout the year and have kept arrangements for internal control under review.

On behalf of the Board, the committees regularly review the Integrated Quality and Performance report from the perspective of their committee. The monthly report details national priority and regulatory indicators including safety, clinical effectiveness and patient experience. The Integrated Quality and Performance report is supplemented by more detailed briefings on any areas of adverse performance. The Report is backed up by more detailed reports reviewed by Board committees; in In addition to this the Divisional Directorates holds monthly performance review meetings with the care groups and individual services.

The Audit Committee provides the Board of Directors with an objective review of financial and corporate governance and internal financial control within the Trust, thereby providing independent assurance on them to the Board. In addition they review and independently scrutinise the Trust's systems of clinical governance, internal control and risk management thereby ensuring, through proper process and challenge, that integrated governance principles are embedded and practiced across all the Trust's activities and that they support the achievement of the Trust's objectives. They also review the integrity of financial statements prepared by the Trust.

During the year the Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements. An internal audit report in September reviewed the effectiveness of our Board Assurance Framework and management of our procurement function, agency spend, Fit and Proper Persons Test, the use of Interims and how we would impose the new IR35 regulations. Reports are then issued to and followed-up with the responsible Executive Directors and the results are reported to the Audit Committee. Internal audit reports are also made available

to the external auditors, who may rely on them in arriving at their annual opinion. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern.

The Board

The Executive Directors and managers have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

The Board assurance framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation in achieving its strategic objectives have been regularly reviewed. The Trust's committee structures ensure sound monitoring and review mechanisms to make certain that the systems of internal control are working effectively. Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports and mortality monitoring; reports from external assessments. I am confident as to the effectiveness of the system described above and that conclusion is informed in a number of ways. The head of internal audit has provided me with reasonable assurance that the internal controls are operating effectively within the fundamental financial systems as a whole. That opinion is that overall reasonable assurance could be provided, both controls are generally sound and operating effectively, and that the internal controls are operating effectively within the fundamental financial systems. The Trust has produced a quality account for 2017/18 and the governance system described above has been used to validate its content and the data on which it is based. Through review of these assurances, the Board has considered any issues that fall within the definition of 'significant issue' according to the requirements of this governance statement.

The Board remains concerned with the deficit position and outturn deficit of £53.1m while noting the significant progress in delivering cost savings.

Jacqueline Totterdell
Chief Executive
24 May 2018

Single Oversight Framework

All hospitals are required to report against NHS Improvement (NHSI) Single Oversight Framework. The Single Oversight Framework:

- Provides one framework for overseeing NHS Trusts and NHS foundation Trusts
- Sets out how the NHSI will identify potential support needs, under five themes, as they emerge
- Allows NHSI to tailor our support packages to the specific needs of providers in the context of their local health systems
- Is based on the principle of earned autonomy.

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

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

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

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Segmentation

St George's has been placed in segment 4 – Special Measures and this reflects the latest position as published on the NHS Improvement website on April 17th 2018.

Finance and use of resources

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

Area	Metric	2017/18 scores				2016/17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	[4]	[4]	[4]	[4]	[4]	[4]
	Liquidity	[4]	[4]	[4]	[4]	[4]	[4]
Financial efficiency	I&E margin	[4]	[4]	[4]	[4]	[4]	[4]
Financial controls	Distance from financial plan	[2]	[3]	[2]	[4]	[4]	[4]
	Agency spend	[1]	[1]	[1]	[1]	[4]	[4]
Overall Scoring		[4]	[4]	[4]	[4]	[4]	[4]

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

Performance is monitored monthly by the Finance and Performance Committee and the Board, via the monthly quality and performance framework. Performance is reported through a number of key performance indicators (KPIs) through the appropriate regulatory frameworks.

At the end of this reporting period, March 2018, the Trust was performing positively against a large number of key indicators. However there remain challenges including the ED four-hour target, 18-week referral to treatment waiting time's performance, two week cancer waiting times and the 62 day referral to treatment target for cancer patients. This is set out in more detail in the clinical and operational performance overview on page 23.

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

Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust

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

The system of internal control has been in place in St George's for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of St George's University Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and Notes to the Accounts, including Accounting policies and other information. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other

purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1 in the financial statements, which indicates that the Trust incurred a deficit of £53.1 million during the year ended 31 March 2018 and borrowed £60.3 million from the NHS Independent Trust Financing Facility in 2017/18 under interim revenue support facilities. As stated in note 1, the Trust has identified that further loans of £30.7 million will be required in 2018/19 to finance the Trust for the year and is requesting access to further Department of Health and Social Care borrowing facilities to provide adequate liquidity headroom. At the date of our report these discussions have not yet concluded

In addition, the Trust has also identified that a Department of Health and Social Care loan for £48.7m that falls due in March 2019 will require to be refinanced for the Trust to be able to avoid defaulting on the loan. The Department has advised the Trust that it is expected the Trust will be able to access borrowing to fully finance the repayment of this facility but that this will not be confirmed until later in the 2018/19 financial year.

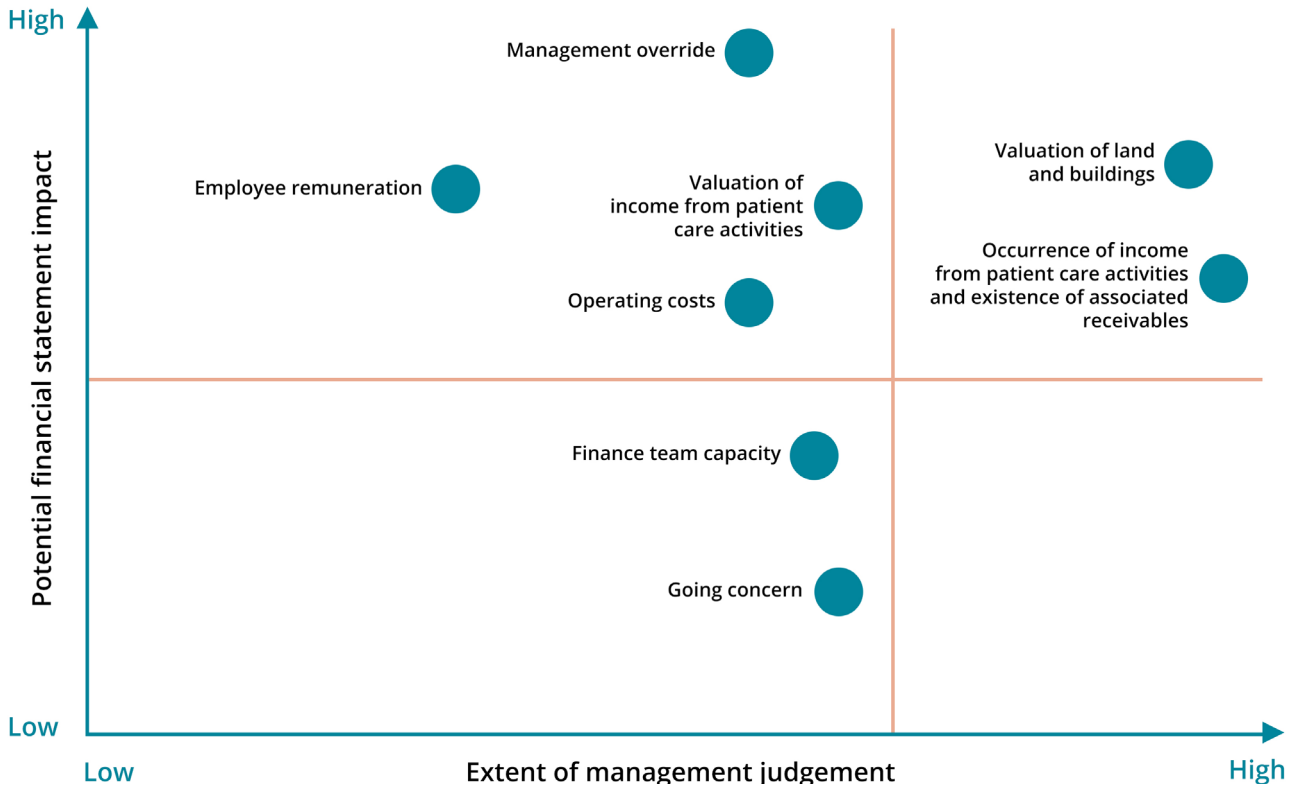
These events or conditions, along with the other matters explained in note 1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Overview of our audit approach

- Overall materiality: £12,917,000 which represents 1.5% of the Trust's gross operating expenses;
- Key audit matters were identified as:
- Material uncertainty related to going concern
- Occurrence of income from patient care activities and existence of associated receivables; and
- Valuation of land and buildings.
- We have tested the Trust's material income and expenditure streams and assets and liabilities covering 100% of the Trust's income, 100% of the Trust's expenditure and 98% of the Trust's net assets.

Key audit matters

The following graph depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the Material Uncertainty Related to Going Concern section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key Audit Matter	How the matter was addressed in the audit
Occurrence of income from patient care activities and existence of associated receivables 82% of the Trust's income from patient care activities is derived from transactions with	Our audit work included, but was not restricted to: ■ evaluating the Trust's accounting policy for recognition of income from patient care activities for appropriateness and compliance with the Department of Health and Social Care (DHSC) Group Accounting Manual; ■ gaining an understanding of the Trust's system for accounting for income from patient care activities and evaluating the design of the associated controls;

NHS commissioners, of which 93% is derived from contracts with the Trust's 10 main NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust.

The Trust recognises income from patient care activity during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in the contracts with NHS commissioners are subject to verification and agreement of the activity completed by the NHS commissioners.

We therefore identified occurrence of income from patient care activities and the existence of associated receivables as a significant risk, which was one of the most significant assessed risks of material misstatement.

- obtaining an exception report from the DHSC that details differences in reported income and expenditure; and receivables and payables between NHS bodies; agreeing the figures in the exception report to the Trust's financial records; and for differences calculated by the DHSC as being in excess of £250,000, obtaining corroborating evidence to support the amount recorded in the financial statements by the Trust;

- agreeing amounts recognised as income from the 10 main NHS Commissioners in the financial statements, in respect of the main baseline monthly contract billings, to signed contracts;

- agreeing, on a sample basis, amounts for under and over-performance of contracted patient care activities with the main 10 NHS Commissioners to invoices or alternative evidence;

- agreeing, on a sample basis, income from residual patient care income sources to invoices or alternative evidence;

- agreeing, on a sample basis, receivables for patient care income to invoices and subsequent cash receipts or, for cases in our sample where cash was yet to be receipted, to alternative evidence.

The Trust's accounting policy on recognition of income from patient care activities is shown in note 1.2 to the financial statements. Disclosures related to income from patient care activities are included in note 3 and disclosures related to associated receivable balances are included in note 24.

Key observations

From our testing of trade receivable balances with NHS bodies, we identified one balance for £10,180 that we do not consider is recoverable and should have been written off. We have extrapolated this error and calculated an extrapolated error of £4,506,808. This is below our level of performance materiality and hence we are satisfied that despite the error identified, we have obtained sufficient assurance in respect of the existence of NHS trade receivables.

We obtained sufficient audit evidence to conclude that:

- the Trust's accounting policy for recognition of income from patient care activities complies with the DHSC Group Accounting Manual 2017/18 and has been properly applied; and

- income from patient care activities is not materially misstated.

Key Audit Matter	How the matter was addressed in the audit

Valuation of land and buildings

The Trust re-values its land and buildings on an annual basis to ensure that the carrying value is not materially different from current value. This represents a significant estimate by management in the financial statements.

Management has applied a judgement in valuing land and buildings at the St George's Hospital site using the "alternative site" basis of valuation for specialised hospital buildings. assumption that were the hospital to be rebuilt as at the 31 March 2018 to a modern specification, the hospital would be built on a site in Wimbledon rather than at the current location in Tooting. This judgement has a material impact on the overall valuation of land and buildings in the financial statements.

We therefore identified the valuation of land and buildings, in particular revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement.

Our audit work included, but was not restricted to:

- assessing the competence, objectivity and capabilities of the Trust's external valuer, Gerald Eve LLP;
- evaluating management's processes and assumptions for the calculation of the estimate;
- assessing the appropriateness of the instructions issued to the valuer and the scope of their work;
- obtaining and challenging evidence for the assumptions made by management and the external valuer in relation to the valuation of land and buildings, including the assumptions made around the use of an "alternative site" basis of valuation for specialised hospital buildings at the St George's Hospital site;
- for a sample of assets revalued in the year, agreeing the valuation in the valuer's report to the Trust's asset register and the financial statements; and
- assessing the overall reasonableness of the valuation movement for the year through comparison of the percentage movements in asset values to relevant national property indices.

The Trust's accounting policy on property, plant and equipment, including land and buildings, is shown in note 1.6 to the financial statements and related disclosures are included in note 12.

Key observations

We obtained sufficient audit assurance to conclude that:

- the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimate were reasonable;
- the valuation of land and buildings disclosed in the financial statements is reasonable.

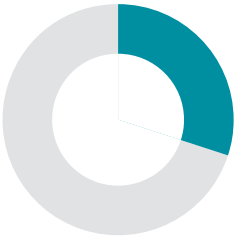
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£12,917,000, which is 1.5% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding. We materiality threshold used for the audit from a level of 1.25% of the Trust's gross operating costs determined for the year ended 31 March 2017. This is to reflect our view that while the Trust remains in financial and quality special measures, it now has a more stable management structure in place and has had less adverse media coverage during 2017/18. These factors hence draw less special attention to the Trust's financial statements than in the previous year.
Performance materiality used to drive the extent of our testing	70% of financial statement materiality
Communication of misstatements to the Audit Committee	£250,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The following graph illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



Overall materiality - Trust

- Tolernace for potential uncorrected mistatements
- Performace materiality

An overview of the scope of our audit

Our audit approach was based on a thorough understanding of the Trust's business, was risk based and included an evaluation of the Trust's internal controls including relevant IT systems and controls over key financial systems.

Our work involved obtaining evidence about the amounts and disclosures in the financial statements to give us reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. The scope of our audit included:

- gaining an understanding of and evaluating the Trust's internal controls environment including its financial and IT systems and controls during an interim audit visit before the year end;
- obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams covering 100% of the Trust's revenues;
- obtaining supporting evidence, on a sample basis, for 100% of the Trust's operating expenses and 95% of the Trust's finance costs;
- obtaining supporting evidence, on a sample basis, for property plant and equipment and 97% of the Trust's other assets and liabilities.

In performing our work, we made the following change to the scope of the audit compared to the prior year:

- for the audit of the financial statements for the year ended 31 March 2016/17, we identified accounting for income and expenditure in the correct accounting period as an area requiring special audit consideration. For the audit of the financial statements for the year ended 31 March 2018, we have removed this as a risk because no findings were noted in relation to this risk during the prior year audit.

Other Information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's

performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or

- Audit Committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or

- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation

of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements - Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects St George's University Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

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

- The Trust delivered a deficit of £53.1 million in 2017/18, which represents a significant overspend compared to its budgeted deficit of £28.5 million. The Trust has set a forecast deficit of £29.0 million for 2018/19, which requires delivery of £50.0 million of transformational savings.

- On 22 March 2017, NHS Improvement placed the Trust into financial special measures.

- The Care Quality Commission (CQC) inspected the Trust in June 2016 and their inspection report, published on 1 November 2016, gave the Trust an overall rating of 'Inadequate'. The report highlighted concerns in respect of quality, safety and overall governance arrangements at the Trust, and drew attention to the significant state of disrepair of areas of the Trust's estate. Following publication of the CQC report the Trust was placed into quality special measures. The Trust remained quality in special measures throughout 2017/18.

- In July 2016, the Trust Board took the decision to cease reporting performance against the Referral To Treatment (RTT) performance indicator after an independent review identified significant data quality issues in relation to the recording of patients on incomplete pathways. In 2017/18, the Trust has continued to not report RTT performance due to ongoing data quality issues.

These matters identify weaknesses in the Trust's arrangements for:

- setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services;

- ensuring quality of data maintained in respect of key performance indicators;

- responding to service delivery issues raised by regulators, including deployment of workforce and governance arrangements.

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

- planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions;

- acting in the public interest through demonstrating and applying the principles and values of sound governance to support informed decision making; and

- planning, organising and developing the workforce effectively to support the delivery of the Trust's strategic priorities.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency

and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of St George's University Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Paul Dossett
Partner
for and on behalf of Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG
24 May 2018

Quality Account

Chief executive's statement on quality

As Chief Executive I see, every day, the positive impact we have on patients and the communities we serve. This is down to the 9,000 staff who work across our hospitals and community services.

This quality report sets out the approach we are taking to continuously improve the quality and safety of care we provide our patients at St George's. Our ultimate goal is to provide Outstanding Care, Every Time, and this vision is helping to drive forward the improvements we want to make.

During my first year at St George's, it has been very rewarding to see how much goodwill there is locally for St George's to succeed. This includes our patients, their families, and the many partner organisations that we work with.

This inspires me to help move the Trust out of our current Care Quality Commission rating, to become a Trust recognised for the excellent care we provide and the staff we develop.

In September, we refreshed our Quality Improvement Plan which reflected a renewed focus, and a longer term ambition, to become an outstanding Trust. This new plan covers everything we do; from improvements in end of life care, dementia care, outpatient services, to learning from the findings of the NHS Friends and Family Test. We also set ourselves stretching targets to ensure we put patient safety at the heart of St George's so ensuring our services are organised to meet people's needs, and to prevent delays to treatment.

We did not achieve all of our national performance targets, but we have achieved a number of the targets that we set ourselves as we work towards consistently achieving national targets. We continued to make considerable progress in improving the care which we provide to our patients and we will build on this progress during 2018-19. Our priority is to provide high quality, safe care for all patients, and to learn from our mistakes if we fall short of these standards.

We also set out to consistently improve our performance against the national performance standards. This is an ongoing process and performance in some areas, such as against the four hour emergency care standard, is still not where it needs to be.

This year's quality account shows, however, that we have made progress in the past year through the delivery of our Quality Improvement Plan, which is credit to staff, particularly given the financial challenge we have also set the organisation.

We are pleased that the CQC recognised the progress we have made during their focused inspection in July 2017. Following their visit, the warning notice received after our last full inspection in November 2016 was lifted by the CQC. The CQC carried out an unannounced inspection of our hospital and community services in March 2018, and we await their report.

We Trust that this quality report illustrates the progress we have made to deliver safe and compassionate care to our patients. To the best of our knowledge, the information in this document is accurate and accountable.

I would like to thank our dedicated staff who work tirelessly every day to provide Outstanding Care, Every Time for our patients.

Jacqueline Totterdell
Chief Executive
24 May 2018

Our quality priorities for 2018/19

Our vision is to provide outstanding care, every time. This ambition is reflected in our strategic objectives. In October 2017 we published our Quality Improvement Plan (QIP) which describes the change projects we will deliver through 2018-19 to move us closer to our goal of providing outstanding care, every time.

The programmes that make up the QIP will help us to improve the provision of healthcare to our patients and to mitigate any risks to quality that arise from our challenging financial plans. We view quality, safety and efficiency as intrinsically linked and our commitment to this underpins the Quality Improvement Plan.

The breadth of our quality ambition is described in the QIP and the priorities selected for the Quality Report are specific objectives within an improvement programme.

Each priority comes under one of three quality themes:

- Patient safety: having the right systems and staff in place to minimize the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes.
- Clinical effectiveness: providing the highest quality care, with world class outcomes whilst also being efficient and cost effective.
- Patient experience: meeting our patients' emotional as well as physical needs

Our quality priorities and why we chose them

Improving patient safety

Reduce the impact of serious infections (CQUIN)

This priority builds on our 2017/18 priority to improve response to the early warning score and identification of the deteriorating patient. It continues to be a priority to meet the national CQUIN goals to reduce the impact of serious infections. The aim is to ensure the timely identification and treatment of sepsis and a reduction of clinically inappropriate antibiotic prescription and use. We will screen all patients for whom sepsis screening is appropriate and rapidly initiate intravenous antibiotics for patients with suspected severe sepsis, red flag sepsis or septic shock. Sepsis is a common and potentially life-threatening condition that can cause inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which may reduce blood supply to vital organs such as the brain, heart and kidneys. Sepsis is recognised as a significant cause of poor outcomes and death and is almost unique among acute conditions in that it affects all age groups.

What success will look like: We will meet the 2018-19 national CQUIN goals for the identification and treatment of sepsis.

Reduce patient falls resulting in significant harm

We continue to work to reduce the risk of falls and to reduce the harm caused by falls, recognising that our population is frailer and the risk of falls is increasing and is likely to continue to increase. We now have a falls co-ordinator in post and have put systems in place to verify our falls data to support learning. We will assure ourselves that all no harm falls are being reported to ensure that we learn from these no harm events.

What success will look like: We will reduce the number of falls that result in any significant harm by 30% against the number of falls with significant harm in 2017-18. Significant harm will include all fractures and head injury.

Reduce acquired grade 3 pressure ulcers

In 2017/18 we achieved our priority for this fundamental of care and no patient acquired an

avoidable grade 4 pressure ulcer in our care. In 2017/18 we have seen an increase in the number of acquired grade 3 pressure ulcers, the majority have been found to be unavoidable. We want to assure ourselves that all possible steps are being taken to prevent patients acquiring grade 3 pressure ulcers in our care and we want to reduce the total number of grade 3 pressure ulcers acquired in our hospitals.

What success will look like: We will reduce the total number of grade 3 pressure ulcers acquired in our hospitals by 20% against the number for 2017-18.

Improving patient experience

Provide a responsive, high quality complaints service

We want to provide a complaints service based on the principles in 'My expectations for raising concerns and complaints' (Parliamentary Health Service Ombudsman and others) so that complainants are able to say: 'I felt confident to speak up and making my complaint was simple.

I felt listened to and understood. I felt that my complaint made a difference.'

What success will look like: We will reduce the number of complaints where local resolution is not achieved by the first response to 4% from 8%. We will achieve our targets for responding to complaints.

Build a patient partnership structure to enable patients to be involved in improvement work from the earliest stage

We want to put working in partnership with our patients and the public at the centre of all that we do. We want to encourage the active participation of patients in their individual care and treatment and also give them a voice and enable their participation in the planning and development of services.

What success will look like: We will have a patient partnership forum and be able to demonstrate that patients have been involved in service development, improvement or change projects.

Improve immediate feedback from patients through the FFT by increasing response rates for both inpatient and outpatient services

We want to hear from our patients about their experience so we can ensure that actions we take are directed at areas they are concerned about. At present we have a very low response rate in our outpatient services. We will identify ways of getting feedback that engage a significant number of our patients and improve response rates in outpatient and inpatient services.

What success will look like: We will achieve a response rate of 20% by the end of 2018-19 to our outpatient FFT.

Improving effectiveness and outcomes

Improve services for people with mental health needs who present to the Emergency Department. (CQUIN)

People with mental ill health are three times more likely to present to the Emergency Department than the general population. More than one million presentations are currently recorded as being directly related to mental ill health. People with known mental ill health are five times more likely to be admitted to acute hospitals and 80% of these emergency admissions are recorded as being primarily for physical health reasons. This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one.

What will success look like: We will meet the 2018-19 national CQUIN goals for services to patients with mental health needs in the ED.

Improve the effectiveness of our discharge process ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support.

We know from the national patient survey that we can improve the way we discharge patients so that they feel fully involved in their own care and treatment and are equipped with the information they need.

What will success look like: We will see an improvement in the response to these questions on our local patient survey and in the national patient survey in 2019.

Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by St Georges NHS Foundation Trust. These are common to all quality reports and accounts and can be used to compare us with other organisations.

A review of our services

St George's is the largest healthcare provider in south west London, and one of the largest in the country. St George's serves a population of 1.3 million people across south west London. A number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, providing care for about 3.5 million people in total.

Most of our services are provided at St George's Hospital in Tooting, but we also provide services from Queen Mary's Hospital in Roehampton and health centres in Wandsworth and Merton. We also provide healthcare services for residents of HMP Wandsworth.

We provide care for patients from a larger catchment area in south east England for specialist services such as complex pelvic trauma. A number of our services treat patients from across England these include family HIV care, bone marrow transplantation for non-cancer diseases and penile cancer.

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

During 2017/18 we provided 54 NHS services. A detailed list is available in the Statement of Purpose on our website www.stgeorges.nhs.uk.

We have reviewed data available on the quality of care in all of these services through our performance management framework and our assurance processes.

The income generated by the NHS services reviewed in 2017/18 represents 100 per cent of the total income generated from the provision of NHS services by St George's University Hospitals NHS Foundation Trust for 2017/18.

Participation in clinical audit and National Confidential Enquiries

During 2017/18, 56 national clinical audits and two national confidential enquiries covered relevant health services provided by St George's University Hospitals NHS Foundation Trust.

During that period, St George's University Hospitals NHS Trust participated in 98% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate.

The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust was eligible to participate during 2017/18 are shown here, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title		Relevant	Participating	Submission rate (%) / Comment
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		✓	✓	**Ongoing**
Adult Cardiac Surgery		✓	✓	**Ongoing**
BAUS Urology Audits: Cystectomy		✓	✓	**Ongoing**
BAUS Urology Audits: Nephrectomy		✓	✓	**Ongoing**
BAUS Urology Audits: Percutaneous Nephrolithotomy		✓	✓	**Ongoing**
BAUS Urology Audits: Radical prostatectomy		✓	✓	**Ongoing**
BAUS Urology Audits: Urethroplasty		✓	✓	**Ongoing**
BAUS Urology Audits: Female stress urinary incontinence		✗	**N/A**	**N/A**
Bowel cancer (NBOCAP)		✓	✓	**Ongoing**
Cardiac Rhythm Management (CRM)		✓	✓	**Ongoing**
Case Mix Programme (ICNARC)		✓	✓	**Ongoing**
Child Health Clinical Outcome Review Programme	Children with Chronic Neurodisability	✓	✓	**100%**
	Young People's Mental Health	✓	✓	**87.5%**
	Cancer in Children, Teens and Young Adults	✓	✓	**87.5%**

Title		Relevant	Participating	Submission rate (%) / Comment
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		✗	N/A	N/A
Case Mix Programme (ICNARC)		✓	✓	Ongoing
Diabetes (Paediatric) (NPDA)		✓	✓	Ongoing
Elective Surgery (National PROMS Programme)		✓	✓	Ongoing
Endocrine and Thyroid National Audit		✓	✓	Ongoing
Falls and Fragility Fractures Audit Programme	Fracture Liaison Service Database	✓	✓	Ongoing
	Inpatient Falls	✓	✓	90%
	National Hip Fracture Database	✓	✓	Ongoing
Fractured Neck of Femur (RCEM)		✓	✓	100%
Head and Neck Cancer Audit		✓	✓	Ongoing
Inflammatory Bowel Disease (IBD) programme		✓	✓	10%
Learning Disability Mortality Review Programme (LeDeR Programme)		✓	✓	100%
Major Trauma Audit		✓	✓	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	✓	✓	Ongoing
	Perinatal Mortality and Morbidity confidential enquiries	✓	✓	Ongoing
	Maternal Mortality surveillance and mortality confidential enquiries	✓	✓	Ongoing
	Maternal morbidity confidential enquiries	✓	✓	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Acute Heart Failure	✓	✓	Ongoing
	Peri-operative diabetes	✓	✓	100%
Mental Health Clinical Outcome Review Programme		✗	N/A	N/A
National Audit of Anxiety and Depression		✗	N/A	N/A
National Audit of Breast Cancer in Older Patient (NABCOP)		✓	✓	Ongoing

Title		Relevant	Participating	Submission rate (%) / Comment
National Audit of Dementia		✓	✓	**100%**
National Audit of Intermediate Care		✓	✓	**36 forms returned – unable to give percentage as the denominator is not defined**
National Audit of Psychosis		✗	**N/A**	**N/A**
National Audit of Rheumatoid and Early Inflammatory Arthritis		✗	**N/A**	**This audit was not operational in 2017/18. We have signed up to participate in 2018/19 when the project relaunches.**
National Audit of Seizures and Epilepsies in Children and Young People		✗	**N/A**	**This audit was not operational in 2017/18. We have signed up to participate in 2018/19 when the project relaunches.**
National Bariatric Surgery Registry (NBSR)		✓	✓	**Ongoing**
National Cardiac Arrest Audit (NCAA)		✓	✓	**Ongoing**
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	✓	✓	**100%**
	Secondary care	✓	✓	**Ongoing**
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)		✓	✓	**100%**
National Comparative Audit of Blood Transfusion	Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	✓	✓	**100%**
	2017 National Comparative Audit of Transfusion Associated Circulatory Overload	✓	✗	**We were unable to participate in this audit due to resource. This audit is not mandated.**
National Diabetes Audit – Adult	Core Diabetes Audit	✓	✓	**Ongoing***
	Foot Care	✓	✓	**Ongoing**
	Inpatient Audit (NaDia)	✓	✓	**100%**
	Pregnancy in Diabetes	✓	✓	**Ongoing**
National Emergency Laparotomy Audit (NELA)		✓	✓	**Ongoing**
National End of Life Care Audit		✗	**N/A**	**This audit was not operational in 2017/18. We have signed up to participate in 2018/19 when the project relaunches.**
National Heart Failure Audit		✓	✓	**Ongoing**

Title	Relevant	Participating	Submission rate (%) / Comment
National Joint Registry (NJR)	✓	✓	**Ongoing**
National Lung Cancer Audit (NLCA)	✓	✓	**Ongoing**
National Maternity and Perinatal Audit	✓	✓	**100%**
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	✓	**Ongoing**
National Ophthalmology Audit	✗	**N/A**	**Not applicable**
National Vascular Registry	✓	✓	**Ongoing**
Neurosurgical National Audit Programme	✓	✓	**Ongoing**
Oesophago-gastric Cancer (NAOGC)	✓	✓	**Ongoing**
Paediatric Intensive Care (PICANet)	✓	✓	**Ongoing**
Pain in children (RCEM)	✓	✓	**26%**
Prescribing Observatory for Mental Health (POMH-UK)	✗	**N/A**	**Not applicable**
Procedural Sedation in Adults (care in emergency departments)	✓	✓	**59%**
Prostate cancer	✓	✓	**Ongoing**
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	**Ongoing**
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	✓	✓	**Ongoing**
UK Parkinson's Audit	✓	✓	**100%**

Data notes:

Each audit within a programme has been counted separately. Where 'Ongoing' is stated this indicates that the data collection deadline for complete 2017/18 data has not been reached at time of reporting and therefore data submission for the 2017/18 audit period is ongoing and cannot be reported.

***** *Data for the Diabetes Core Audit was submitted to NHS Digital; however, our data is not presented in the associated national report due to an error in the submission file which was not communicated to us for resolution. We continue to collect data for this audit.*

The reports of national clinical audits were reviewed by St George's University Hospitals in 2017/18 and we intend to take the following actions to improve the quality of healthcare provided.

National audit of dementia

This report has seven themes - governance, assessment, nutrition provision, discharge, information and communication, and the overall carer rating of care.

The Trust did better than the national average in staff and carer communications. However, overall scores were below the national average for governance, nutrition, discharge planning and assessment.

The Trust has taken or is taking the following actions to improve: The dementia carer passport has been introduced to facilitate extended visiting hours, including to enable families to help patients at mealtimes; ensuring food options for patients with dementia are in line with best practice; identification of dementia champions at directorate level; targeted audits of pain and pressure ulcer risk documentation in patients with dementia; dementia advisor available in the hospital two days a week to provide support and advice to dementia carers; creation of a dementia hub to provide an enhanced and dedicated space where people with dementia and their carers can receive support and advice; electronic flag to identify those with a dementia diagnosis to ensure they receive the support they need.

Local clinical audits

The reports of over 125 local clinical audits were reviewed in 2017/18 by care groups and directorates and in the following table are examples of some of the actions St George's University Hospitals intends to take to improve the quality of healthcare provided.

Local clinical audit	Action to improve quality / Comment
Surgical Antibiotic Prescribing Audit	■ Promote the Microguide application which provides easy access to local guidelines. ■ Share the audit outcomes to raise awareness of the gap between practice and gold standard and highlight the role of the guidelines. ■ Incorporate antibiotic guidance into induction for new doctors. ■ Re-audit to test the effectiveness of the action taken.
Sepsis in obstetric HDU	■ This audit of compliance with the Sepsis 6 care bundle was carried out after a week-long educational initiative to improve management and recognition of sepsis in obstetrics. Following this week which included drop in workshops, in situ simulation work and daily teaching session compliance with the bundle was reaudited. ■ Compliance improved significantly achieving 85% compliance with administration of antibiotics within 1 hour and 100% of patients received intravenous fluids, a similar improvement in compliance was seen across all components of the Sepsis 6 care bundle. ■ The effectiveness of the week of intensive educational activities was demonstrated.
Post-operative pain management in paediatrics	■ A cohort of children having a surgical procedure that required an overnight stay were looked at to audit the effectiveness of post-operative pain management. ■ The majority of patients had good pain control and satisfaction amongst the children and parents was generally high. The audit recommendations are to continue to improve the consistency of analgesic prescriptions for all post-operative children and to maintain a focus on documenting pain scores.

Local clinical audit	Action to improve quality / Comment
nEWS Audit January 2018	■ In 2017-18 the Trust has increased its compliance target with the National Early Warning Score to 100% to stretch performance as we have been consistently achieving over 80% for each criteria. The outcome of the Jan 2018 audit continues to show improvement in compliance with an overall Trust score of 93%. ■ To continue to improve all wards that scored below 100% will provide an action plan, this will include education and competency assessment of all staff and participation in monthly ward level.
Annual Consent Audit 2017/18	■ The audit has been shared with clinical colleagues and presented at the Quality and Safety Board Committee. Improving our consent process is a project in the Quality and Safety programme and is led by a senior clinician. ■ The project links with the Outpatients work stream and seeks to improve practice by moving consent to the outpatient clinic as our waiting times improve.

Our participation in clinical research

At St George's we are committed to innovating and improving the healthcare we offer. A key way to achieve this is by participating in clinical research. Our clinical staff are fully engaged with the latest treatment developments and through clinical trials patients can be offered access to new treatment interventions, leading to better clinical outcomes for patients. St George's, in its partnership with St George's University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams are collaborating with scientists to investigate the causes of a range of diseases, to develop better ways of diagnosis and tailored treatments.

In the 2014 Research Excellence Framework, 70% of the research submissions from St George's were judged to be of international standard in terms of originality, significance and rigour. The strongest aspects of clinical medical research were cardiovascular research and cell biology/functional genetics. The strong partnership between St George's and its partner University underpins this excellence.

A key way to offer new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR), which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. In 2016/17 St George's recruited 5,040 patients onto the NIHR portfolio adopted studies. Provisional recruitment for 2017/18 shows a significant improvement to 6,300 patients.

Approvals

At St George's in 2017 we had 575 active research studies registered on our database. 318 of these studies were adopted onto the NIHR portfolio. 249 research applications were received in the Joint Research and Enterprise Office (JREO) in 2017 and St George's opened 173 new research studies.

Our Commissioning for Quality and Innovation (CQUIN) performance

A proportion of St George's University Hospitals NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals. These are agreed between St George's University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2017/18 over £15 million of our income is conditional on achieving quality improvement and innovation goals. In 2016/17 the income achieved for achieving quality improvement and innovation goals was £12 million.

Further details of the agreed CQUIN goals for 2017/18 and our goals for 2018/19 are available via the St George's website: **www.stgeorges.nhs.uk**.

Our registration with the Care Quality Commission (CQC)

St George's University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions or restrictions".

Our services were assessed by the CQC in June 2016; the outcome of this inspection was an overall rating for the Trust of 'inadequate'. There were services that were rated as 'good' and in the caring domain we were pleased to receive a rating of 'good', our maternity services were rated 'outstanding' in the 'effectiveness' domain. The table below shows some of the detail behind our overall rating.

Overall rating	Inadequate

Safe	Inadequate		
Effective		Requires improvement	
Caring			Good
Responsive		Requires improvement	
Well led	Inadequate		

The Care Quality Commission took enforcement action against St George's following the June 2018 inspection issuing a Warning Notice under Section 29A of the Health Act 2008. This Warning Notice remained in place until September 2017, at this time the CQC was assured following an inspection in May 2017 that the necessary action and improvements had been made.

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

Previous reports of inspections for St George's University Hospitals are available on the CQC website **www.cqc.org.uk**.

Our data quality

St George's University Hospitals NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: *

Which included the patient's valid NHS number was:

- 98% for admitted patient care
- 99.2% for outpatient care; and
- 93.4% for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

- 99% for admitted patient care
- 99.9% for outpatient care; and
- 99.6% for accident and emergency care

* Source – SUS Data quality reports

Information governance toolkit

The Information Governance Toolkit sets out the standards for management of information in the NHS, organisations carry out a self-assessment against the standards each year. In 2017/18 the St George's Information Governance Assessment Report overall score was 66% and was graded green and satisfactory. In late 2017/18 we identified gaps in our self-assessment that may have an impact on our overall percentage score. These gaps were reported to the May 2018 Audit Committee and are being addressed in readiness for the Data Security and Protection Toolkit submission in October 2018.

Payment by results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18.

Improving data quality

In January 2016, we became concerned about the quality and robustness of our data reporting; particularly the management of our waiting lists (referral to treatment times).

An external review of our referral to treatment times (RTT) data and patient tracking systems identified serious issues relating to our operational processes and technology. These issues created significant risks to the quality of care and patient safety as well as flaws with our reporting processes at St George's Hospital. A subsequent review carried out in April 2017 identified similar problems at Queen Mary's Hospital in Roehampton.

As a result of our concerns we suspended national reporting of our RTT data in June 2016 and made a decision not to recommence reporting until we have full confidence that the information we are providing is reliable.

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

In September 2017 the newly appointed Chief Operating Officer took over the management of the dedicated waiting list improvement programme, the Elective Care Recovery Programme. Since the formation of the programme we have undertaken a systemic and detailed audit of the waiting lists for patients at the St George's site. This resulted in an increase in the number of patients reported to be waiting over 18 weeks from referral to treatment. We also identified a number of patients who had been waiting over 52 weeks. As part of the validation exercise our Medical Director undertook a clinical review led by doctors from across the Trust to ensure patients were not coming to clinical harm as a result of their waits.

In April 2017 we launched a 'Better Data, Safer Patients' campaign across the Trust to emphasise the importance of accurate clinical coding and to ensure that this is managed correctly and consistently. One of the early successes included reducing the number of patients with 'no due date' in our records for endoscopy procedures from 3,200 to zero.

Our clinical teams have focused on treating those patients who have waited the longest; they have also improved administrative processes, and increased capacity through additional evening and weekend clinics and operating lists. We have also provided mandatory training to 3,500 staff to improve awareness of the significance of waiting list management and other vital data to ensure patient safety.

In early 2018 we introduced a new Patient Tracking List (PTL) for patients waiting for elective care at St George's. The new single system will improve the speed at which we treat patients, effectively manage waiting times and ensure that we are capturing information accurately and consistently.

In March 2018 we introduced a new Patient Tracking List (PTL) for patients waiting for elective care at Queen Mary's Hospital. We are also currently carrying out a scoping exercise to identify the infrastructure required to support the rollout of the iClip (Cerner) System at Queen Mary's Hospital – to ensure both of our main hospital sites are using the same system and so improve data quality.

We now have 48,000 patients on our waiting lists, with a plan to reduce it to fewer than 40,000 by the end of April 2019. This is a significant step forward as we continue to reduce the waiting list times for our patients.

The Trust has identified significant opportunities to improve existing clinical coding processes. There are being addressed through a change programme. The data quality team focuses on data cleansing, improving recorded data and reinforcing the importance of data quality to all services across the Trust. The team works closely with front line users to ensure that they are aware of the importance of capturing good data within our systems. The data quality team also works closely with IT trainers to ensure that the patient administration system (PAS) is robust and that staff are provided with appropriate levels of training. Data quality dashboards are in place to monitor how services are managing data.

Learning form deaths

During 2017/18 1,760 of St George's patients died. This comprised the following number of deaths which occurred in each quarter of this reporting period:

Number of deaths 2017/18	Q1	Q2	Q3	Q4
	374	385	449	552

By 31 March 2018 1244 case record reviews and 233 investigations have been carried out in relation to 89% of the deaths in table 1.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Case record review or investigation	Q1	Q2	Q3	Q4
	328	287	393	469

233 representing 15.7% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

Problems in healthcare	Q1	Q2	Q3	Q4
Number	52	40	60	81
% of all deaths	13.9%	10.4%	13.4%	14.7%

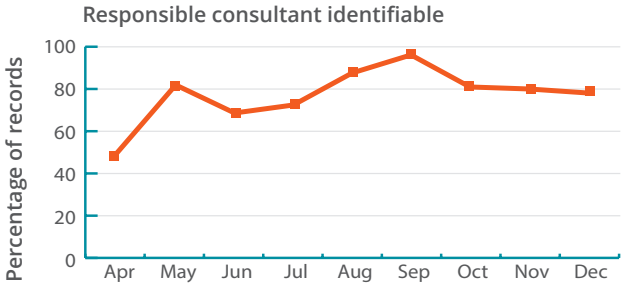
These numbers have been estimated using our locally developed online screening tool and structured review based on the Royal College of Physicians (RCP) tool. We have a dedicated independent team supporting the bereavement office, and reviewing deaths in a timely way. All patients where a care issue may have contributed to death are escalated to the risk team on the same day and included in our serious incident decision meeting (SIDM) discussions. A judgement regarding avoidability of death is made for all reviews.

Some problems in healthcare may occur with excellent care, others may occur and not affect the outcome, or the problem may not have affected the clinical course of events in any way. The majority, 96.3% of deaths, were assessed as being 'definitely not avoidable', and no deaths were thought to be 'definitely avoidable'. Any death where review suggests it may have been avoidable is escalated to the risk team to consider possible investigation and rapid response through our serious incident process. Any significant problem of care, whether or not it affected outcome, is brought to the attention of the clinical team for discussion and learning at the local morbidity and mortality meeting

What we have learnt and action taken

Responsible consultant

When the process of independent review began the identification of responsible consultant in the healthcare record was flagged as an issue. This was escalated to divisional teams for action and to care group leads for areas identified as needing particular improvement. Ongoing monitoring shows improvement in this area.



DNACPR discussions

Although a large number of patients had good and early discussions about resuscitation, reviews continue to identify patients where such discussions should have occurred, or could have occurred earlier. Clinical teams have been asked to consider their practice and discuss this at their morbidity and mortality meetings.

Monthly data allows us to look in more detail at practice across the Trust and to track performance. This theme is one of the focuses of the End of Life (EOL) steering group and has highlighted the essential role of our palliative care team. A high proportion of patients dying in our Trust (52.4%, July 16 - June17) are coded as having specialist palliative care input; this is much better than the national average (31.1%).

Issues that have been highlighted to care groups include the appropriateness of inter-hospital transfer and the need for consultant-level discussion; ward frequency of consultant review; multi-disciplinary team (MDT) discussion and decision making between teams; ceilings of care and appropriateness of DNACPR decisions.

Cases have been referred to our deteriorating adults group for investigation as they have occurred following a cardiac arrest outside of an intensive care area. For the majority of these cases there was no clear end of life plan and this is linked to the work around DNACPR discussions.

Guardian of safe working

We have appointed a Guardian of Safe Working to ensure our doctors are always working a safe number of hours. The Guardian acts as the champion of safe working hours and receives reports and monitors compliance against our doctor's terms and conditions. Where necessary the Guardian escalates issues to the relevant executive director for decision and action to reduce any risk to our patients' safety. Gaps in the rota for medical staff are monitored and managed at service level. Information on unfilled shifts is not available at Trust level, but is monitored by individual services. The Trust plans to implement a central roster system during 2018/19.

National Core Set of Quality Indicators

In 2012 a statutory core set of quality indicators came into effect. Eight indicators apply to acute hospital Trusts. All Trusts are required to report their performance against these indicators in the same format with the aim of making it possible for the reader to compare performance across similar organisations.

For each indicator our performance is reported together with the national average and the performance of the best and worst performing Trusts.

Mortality

The summary hospital level mortality indicator (SHMI) is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 100, a score below 100 denotes a lower than average mortality rate. The SHMI is not a measure of quality of care but a higher than expected number of deaths should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance. It is recognised that the SHMI cannot be used to directly compare mortality outcomes between Trusts and for this 'reason 'best' and 'worst' Trusts are not shown for this indicator.

Summarised hospital level mortality indicator (SHMI)	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - June 17	Oct 16 - Sep 17
SHMI	90.6	89.5	88.2	86.5	84.4	83.6	83.8	82.5
Banding	As expected	Lower than expected	Lower than expected	Lower than expected	Lower than expected	Lower than expected	Lower than expected	Lower than expected
% Deaths with palliative care coding	33.4%	39.1%	42.8%	48.9%	51.3%	51.1%	52.4%	50.9%

St George's University Hospitals consider that this data is as shown for the following reasons. Our data is scrutinised by the Mortality Monitoring Committee and validated through the examination of additional data including daily mortality monitoring drawn directly from our own systems, and monthly analysis of information from Dr Foster. When validated internally we submit data on a monthly basis to NHS Digital. The SHMI is then calculated by NHS Digital with results reported quarterly for a rolling year. Our coding team work closely with our palliative care team to continually improve the accuracy of coding to fully capture the involvement of palliative care services and this is reflected in the increase in the percentage of deaths with a palliative care coding.

We have taken the following actions to improve our SHMI and so the quality of our services:

We have fully implemented the Learning from Deaths Framework and have been recognised as an exemplar Trust. We will continue to strengthen our mortality monitoring process and review of all deaths to ensure we identify every opportunity to learn, and in sharing learning to improve the care our patients receive. We also monitor our outcomes using information from national audits and mortality alerts from external agencies. For example the National Institute for Cardiovascular Outcomes Research (NICOR) has written to the Trust about the results of the recent National Cardiac Surgery Audit and while the Trust is not a published outlier, we are currently investigating survival rates that are below the national average.

Patient reported outcome measures

Patient reported outcome measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of four clinical procedures. We are reporting on patients who have had a hip replacement or a knee replacement.

We believe our data is as shown for the following reasons:

Patients who have had these procedures are asked to complete a short questionnaire which measures a patient's health status or health related quality of life at a moment in time. The questionnaire is completed before, and then some months after surgery, and the difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient. It should be noted that at St George's we perform only a small number of complex cases of knee and hip replacements, with the majority of routine cases being referred to the South West London Elective Orthopaedic Centre for treatment.

The complexity of the cases carried out at St George's may be reflected in a slightly lower perception of improvement after surgery than the national average.

Percentage of patients reporting an increase in health following surgery		2012-13		2013-14		2014-15		2015-16		2016-17 (provisional)	
		SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average
Hip replacement	EQ-5D™	100	89.7	86.4	87.9	90	88.2	100	88.4	75	88.8
	EQ-VAS	72.2	65.5	65.2	64.2	80	65.1	58.3	65.6	72.2	67.2
	Specific	95	97.1	80.8	96	100	96.4	94.4	96.5	76.5	96.4
Knee replacement	EQ-5D™	68.8	80.6	60	80.3	60	80.5	69.2	80.7	57.1	80.9
	EQ-VAS	53.3	54.9	50	54.6	50	55.3	33.3	56.4	25	57.5
	Specific	86.7	93.2	80	93	81.8	93.2	84.6	93.6	87.5	93.5

For both procedures the EQ-5DTM and EQ-VAS scores give the patients view of their general health improvement, the specific score comes from questions about improvement related to the hip or the knee replacement, higher scores are better.

Readmission within 28 days of discharge

The most recent information available from NHS Digital is for 2014-15. Using our own data we are able to access full year information for 2017-18.

	2015-16			2016-17			2017-18		
Readmissions	Under 16	16+	Total	Under 16	16+	Total	Under 16	16+	Total
Discharges	9961	31918	41879	14102	46946	61048	14201	47572	61773
28 day readmissions	618	3511	4129	659	4236	4895	651	4428	5079
28 day readmissions rate	6.2%	11%	9.86%	4.67%	9.02%	8.02%	4.58%	9.31%	8.22%

We consider our data is as shown for the following reasons: Monitoring emergency re-admission rates helps the Trust to prevent or reduce unplanned re- admission into the hospital. An emergency re-admission occurs when a patient has an unplanned re-admission to hospital with 30 days of a previous discharge.

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

Patient experience

Our score for the five questions in the national inpatient survey relating to responsiveness and personal care is consistent with the national average as shown below. The data compared to average, highest and lowest performers and our own previous performance is shown below:

Patient experience	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
St George's University Hospitals	66.1	66.6	68.8	68.6	67.9	66
National Average	67.4	68.1	68.7	68.9	69.6	68.1
Highest (best)	85	84.4	84.2	86.1	86.2	85.2
Lowest	56.5	57.4	54.4	59.1	58.9	60

We consider that the data is as shown as it is validated through the Trust's informatics and reporting processes. St George's University Hospitals NHS Foundation Trust intends to take the following actions to maintain and improve this percentage, and so the quality of its services, by continuous and on-going engagement with patients, family, friends and carers.

Staff recommendation to friends and family

We consider that this data is as described for the following reasons: we outsource the collection of data for the Staff Survey; it is collected and submitted annually to the Staff Survey Co-ordination Centre. The data shows that we are in a band with the majority of Trusts for staff recommendation achieving an average score.

Staff recommendation	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
St George's University Hospitals	70%	67%	73%	71%	70%	73%
Average for acute	60%	66%	68%	70%	68%	69%
Highest acute Trust	86%	94%	93%	93%	95%	86%
Lowest acute Trust	35%	40%	36%	46%	48%	47%

St George's University Hospitals NHS Foundation Trust intends to improve this percentage, and so the quality of its services, by focusing on staff engagement and quality improvement, listening to staff and addressing their concerns.

Patient recommendations to friends and family

Friends and Family Test	2015-16		2016-17		2017-18	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	24.3%	27.74%	23.1%	30.76%	20.19%	25.5%
% would recommend	84.29%	93.57%	83.8%	95.81%	84.26%	96.24%
% would not recommend	11%	1.62%	10.51%	1.29%	10.39%	1.08%

** 2017-18 data to Feb 18*

Infection control

We continue to implement a range of measures to tackle infection and improve the safety and quality of our services. These include a strong focus on antibiotic stewardship and improved environmental hygiene, supported by continuous staff engagement and education.

We consider that the data is as described for the following reasons, the Trust has a process in place for collating data on C.difficile cases, the data is collated internally and submitted to Public Health England.

Cdifficile	2014-15	2015-16	2016-17	2017-18
Trust apportioned cases	38	29	36	14
Trust bed-days	254213	273493	287962	296981
Rate per 100,000 bed days	14.9	10.6	12.5	4.7
National average	33.7	33.7	30.2	
Worst performing Trust	121	139	116	
Best performing Trust	0	0	0	

St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by implementation of the following processes; improved recognition of patients at risk of infection by alerting the infection prevention and control team when patients with past history are admitted, improving diagnostic screening of patients at risk and planning that all wards are decanted and deep cleaned on a regular basis.

Patient safety incidents

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: this data is validated through the Trust's informatics and reporting processes.

Patient safety incidents	Oct 14 - Mar 15	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16 -Mar 17	Apr 17 - Sep 17
Trust reported incidents	5188	5353	5453	5964	5928	5548
Rate per 100,000 bed days	34.1	33.2	32.8	36.5	37.6	34.2
National average (acute non-specialist)	37.1	39.3	39.6	40.8	41.1	42.8
Highest reporting rate	82.2	74.7	75.9	71.8	69	111.7
Lowest reporting rate	3.6	18.1	14.8	21.1	23.1	23.5

Patient safety incidents	Oct 14 - Mar 15	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16 -Mar 17	Apr 17 - Sep 17
Incidents causing Serious Harm or death	16	23	20	15	13	14
% Incidents causing Serious Harm or death	0.31%	0.43%	0.37%	0.25%	0.22%	0.25%
% National average (acute non-specialist)	0.5%	0.43%	0.79%	0.38%	0.37%	0.35%
% Highest reporting rate	5.1%	1.96%	1.33%	1.38%	1.09%	
% Lowest reporting rate	0.05%	0.09%	0%	0.02%	0.03%	

St George's has taken the following actions to improve this number and rate, and so the quality of its services, by introducing a number of learning initiatives and continuing to work towards enhancing existing mechanisms throughout 2017/18. These include: risk management input into training programmes; increased frequency of root cause analysis (RCA) training; increased involvement from medical staff in following up incidents; human factors training with multidisciplinary teams with the support of the simulation centre; a monthly governance newsletter and the introduction of quarterly analysis report and thematic learning.

Venous thromboembolism

St George's considers that this data is as described for the following reasons: this data is validated through the Trust's informatics and reporting processes.

VTE Assessments	2014-15	2015-16	2016-17	2017-18
St George's University Hospitals	95.89%	96.77%	96.64%	95.90%
National Average	96.10%	95.76%	95.61%	Not available
Best performing trust*	100%	100%	100%	Not available
Worst performing trust*	79%	78.1%	63%	Not available

***** *position as at Q4*

St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by maintaining our high risk assessment rate (this is currently higher than the national average).

Progress against priorities for 2017-18

The progress we have made in delivering our quality priorities for last year is set out in the following tables. All the data used to assess our success in achieving our objectives has been derived from the Trust performance management systems and, where applicable, the indicators are consistent with national definitions.

Patient Safety		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
Improve levels of Early Warning Score (EWS) documentation identifying patients who are deteriorating	Accurate documentation in a minimum of 95% of patients	**We achieved this.** This indicator is also being used to monitor delivery of the deteriorating patient workstream of the QIP. We are tracking, 'full set of observations recorded' and 'observations correctly scored'; both continue to show improvement in compliance with our stretch targets. We have been exceeding the NICE standard for some years and have now set ourselves a stretch target of 100% compliance and we are showing steady progress towards this. In January2018 the compliance with 'full set of observations recorded' was 98.4% and with 'observations correctly scored' was 99.4%.

Roll out of Local Safety Standards for Invasive Procedures to all applicable services and locations	Registers of procedures in place in all applicable services	**We partially achieved this.** Registers of procedure that have a Local Safety Standard are in place for the majority of services and are held in the divisions.
Reduce falls resulting in harm	Achieve a 25% reduction in patient falls resulting in a fracture	**We have partially achieved this.** The falls coordinator has carried out a detailed review of falls for a defined period to verify the data. Verification of incident reports is going to be managed at department level in the future to ensure the information is consistent.
Zero grade 4 pressure ulcers		**We achieved this.** We have had zero avoidable grade 4 pressure ulcers
No avoidable inpatient cardiac arrests (exclude Emergency Department)		**We partially achieved this.** Audit tool developed and a process to assess avoidable cardiac arrest baseline data commenced. This work is being carried out in the deteriorating patient workstream of the QIP

Patient experience		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
Documented discussion and agreed plans for end of life care		**We achieved this.** End of Life Care is a workstream in the Safe and Effective Care Programme of the QIP. Implementation of a care plan aligned to the '5 Priorities of Care for the Dying Person' is an action within the End of Life Care Strategy. The care plan has been piloted for use across the Trust.
Increase participation in the staff survey		**We achieved this.** Staff engagement is an enabling programme of the QIP. The staff survey for 2017 saw increased participation with 45% of staff completing the survey.
Reduction in on the day cancellations of surgery by 25%		**We partially achieved this.** Theatres Improvement is a workstream in the Flow and Clinical Transformation Programme of the QIP. Work to reduce the number of same day cancellations includes the development of standard operating procedures (SOPs) to help create suitable theatre lists in advance of surgery. These have been developed by the multi-disciplinary teams involved and will mean that patients, staff and equipment are better prepared and in the right place at the right time. As the SOPs become embedded and are used consistently we will continue to monitor the number of on the day cancellations.

Clinical effectiveness		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
Improve Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)		**We achieved this.** The latest HSMR data for the Trust shows mortality remains significantly better than expected for our patient group and the SHMI is lower than expected when benchmarked against national comparators. Both indicators also show an improvement trend.
Implement a comprehensive clinical review process for in hospital deaths		**We achieved this.** We published our policy relating to responding to deaths of patients in our care in September 2017. Since April 2017 members of the Mortality Monitoring Committee have carried out independent reviews of deaths using a structured judgement review tool.

Our performance against the NHS Improvement Single Oversight Framework

NHS Improvement uses a number of national measures to assess access to services and outcomes, and to make and assessment of governance at NHS foundation Trusts. Performance against these indicators acts as a trigger to detect potential governance issues and we are required to report on most of them every three months.

Our performance against these indicators can be seen in the table below.

Key performance indicators

Referral to treatment times	Non-reporting	Target	Annual performance
ED access	95% of patient wait less than 4 hours	95%	87.56%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	85%	82.6%
	% patients treated within 62 days from screening referral	90%	90.33%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	1%	0.2%

Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to 24 May 2018
  - papers relating to quality reported to the board over the period April 2017 to 24 May 2018
  - feedback from commissioners dated 22 May 2018
  - feedback from local Healthwatch organisations dated 18 May 2018
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2017
  - the latest national patient survey dated 5 March 2018 (please note the results are under embargo and cannot be published in this report
  - the latest national staff survey dated 3 March 2018
  - the Care Quality Commission inspection reports dated 1 November 2016 and 3 August 2017; and
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 21 May 2017.
- The Quality Report presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- As the Trust is currently not reporting performance against the RTT indicator due to data quality issues, the Trust directors have a plan in place to remedy this as outlined in further detail below. The scale of the issues identified means that it is not possible for Trust

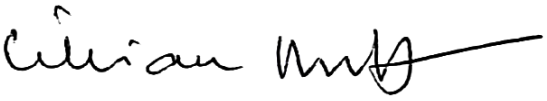
directors to say at this time when the Trust will return to full national reporting against the RTT standard. An Elective Care Recovery programme has been established to lead on the action necessary to return the Trust to reporting.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporate the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board



Gillian Norton
Chair
24 May 2018

Jacqueline Totterdell
Chief Executive
24 May 2018

2017/18 limited assurance report on the content of the Quality Reports and mandated performance indicators

Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

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

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
- We refer to these national priority indicators collectively as the 'Indicators'
- Respective responsibilities of the directors and Practitioner
- The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.
- Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
- The Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to 24 May 2018
- Papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018
- Feedback from commissioners dated 22 May 2018
- Feedback from local Healthwatch organisations dated 18 May 2018
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 1 September 2017
- The national patient survey dated 5 March 2018
- The national staff survey dated 3 March 2018
- The Care Quality Commission inspection reports dated 1 November 2016 and 3 August 2017
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information. The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and St George's University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance.

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

Our audit work on the financial statements of St George's University Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as St George's University Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006.

Our audit work is undertaken so that we might state to St George's University Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of St George's University Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than St George's University Hospitals NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
London

Statement from Wandsworth Clinical Commissioning Group (on behalf of local CCGs)

Wandsworth CCG has worked in close partnership with St George's University Hospitals NHS Foundation Trust during 2017/18. We have worked together to address the quality issues that were identified by the Care Quality Commission in 2016/17. We were pleased to note that the warning notice issued in 2016 under Section 29A of the Health Act 2008, was lifted following the CQC inspection in May 2017.

There have been robust arrangements in place to agree the priorities, monitor the action plan and review the quality of its services. The Clinical Quality Review Group meets monthly and brings together GPs, senior clinicians and managers from both St George's University Hospitals NHS Foundation Trust, Wandsworth CCG, associate commissioners, NHS England and NHS Improvement. We have received assurance that the necessary action and improvement in relation to the CQC warning notice had been made. We have also received assurance throughout the year from the trust in relation to other key quality issues, both where quality and safety has improved and where it occasionally fell below expectations, with remedial plans put in place and learning shared wherever possible.

The development of the Trust Quality Improvement Plan, with the ambition to provide outstanding care, every time, has helped to consolidate the quality areas of concern identified at the CQC inspection. The Plan also identifies quality priorities from the Trust strategic objectives, in a single dashboard that has been regularly monitored by the Clinical Quality Review Group. Wandsworth CCG recognises that the Quality Improvement Plan is an ambitious programme, and that there are areas where further work is required in order to improve the quality of service provision.

On review of the Quality Account for 2017/18, the CCG commends the Trust on the good progress made in delivering the quality priorities set for 2017/18, and acknowledges the hard work that has been put into delivering the specified areas.

The CCG welcomes the continued focus on patient safety, clinical effectiveness and patient experience and is pleased to note that most of the outstanding areas of work relating to quality have been incorporated within the priorities for 2018/19.

We would have liked to have seen a greater emphasis on the Referral to Treatment Target issues that the Trust has faced, with more emphasis on the role of the Clinical Harm Group in monitoring the impact of these issues on patient safety. The Trust has been open about these issues and has worked closely with the CCG. As a result the harm to patients of the long patient waits has been kept to a minimum, and managed appropriately where harm has been identified. A significant amount of work has been undertaken during 2017/18 to address this issue so this could have been highlighted within the data quality section of the report.

This remains an area of concern as there is still some work to be done to ensure that a fully functioning and effective patient tracking system is in place at both the Trust and Queen Mary sites. The CCG would therefore like to see this prioritised in 2018/19, and aligned with the Outpatient Transformation Programme which has been set up to address a number of the outpatient related issues identified.

Staff engagement is an essential part of providing high quality services for patients. This has not been covered in the report although the Trust

has undertaken some work on staff engagement as part of the Quality Improvement Plan. The CCG would support a greater focus on workforce, particularly staff engagement, as part of the priorities for 2018/19.

Overall comments

The new leadership team within the Trust is now embedded and has worked closely with Wandsworth CCG to address a number of the quality concerns at the Trust in 2017/18.

The CCG acknowledges the improvements made in 2017/18, and commends the Trust on the production of a clear quality report that sets out the key priorities for 2018/19. It is in agreement with the priorities as specified in the report and would like to see the following areas also reflected:

- Improvements in data quality to address Referral To Treatment/patient tracking issues
- Workforce/staff engagement

We will continue to work closely with the Trust and look forward to supporting it to deliver the priorities reflected in the quality report in the year to come

Dr Nicola Jones MBE
MBChB DRCOG MRCGP MBA
Chair, Wandsworth Clinical Commissioning Group
22 May 2018

Statement from Healthwatch Wandsworth

Healthwatch Wandsworth is once again grateful for the opportunity to comment on the draft Quality Account. This year's draft version is a significant improvement on last year's, being readable and clearly presented within the prescribed format. It also reflects the Trust's journey towards fresh confidence in what it does well, where progress has been made and openness to aspects still needing improvement.

We are pleased to have been kept up-to-date at regular Quality Committee meetings that oversee and scrutinise quality monitoring and improvement. Moreover, several members of our volunteer team have taken part in and supported Patient Led Assessments of the Care Environment and Mock Quality Inspections. Over the year there has been a concerted effort to move the Trust forward from the Care Quality Commission's 'inadequate' rating in 2016, including the removal of a warning notice. There is coherence in the Quality Account about continuing improvements needed, such as patient falls and avoidable ulcers, and in all cases where progress has been partial in 2017-18, remedial work will continue.

Looking ahead in to the next year we welcome the 2018-9 Quality Priorities that include a focus on engagement with patients and fresh work to do more to involve patients in work from earlier stages, including planning and development of services. We have been asking local people about their experiences at the hospital and there have been many positive comments, but there are still a few less positive comments, particularly around communication which is also reflected in the Trusts own data. Working more closely with patients, we hope will begin to reveal how improvements can be made in this area and it will allow patients to help the Trust in its quality improvement intentions. Aims to improve complaints processes and feedback received via the National Inpatient Survey and the Friends and Family Test will help support this.

We have been consulted on ambitious plans for a new Patient Partnership and Engagement Group (PPEG) to involve patients in service development, improvement and change. This will require clear and effective governance which will need careful crafting. We are interested to see how details of

the structure, objectives, strategy and impact assessment develop. The PPEG might be invited to have some input into the ongoing work to improve the quality of complaints responses given that the main themes of communication with the patient, carers and between clinical teams have persisted.

Another major piece of work to sustain patient involvement is the Outpatients Transformation programme, which could prove invaluable to the Trust. Although it is not detailed in the draft of the report, if successful it will go some way to improving patient experiences shared with us around appointments and communication. Apart from the overall effectiveness of access arrangements one particular focus could be on the work to embed patient consent earlier in treatment. Patient representatives could also make a contribution, for example on how best different service users receive information.

With regard to the focus on liaison psychiatry in the Emergency Department we understand this has been undertaken as a national initiative to help identify frequent attenders with mental health needs as well as physical needs to provide for dual diagnosis, treatment and referral. This is to be welcomed as timely and we note that progress will be measured by meeting the national CQUIN targets. A broader measure though could look at further integration of community care for mental health needs when urgent and crisis care might be needed and how the Trusts work together with other partners, including Public Health. Patient information sharing between the services still seems to provide some barriers to joined up care and local protocols would be beneficial if national ones have not been devised. We are also very interested to know how carers will be involved. The focus on dementia care and the steps outlined for implementation following the National Dementia Audit should provide all round improvement benefiting patients, families and staff. We conducted an Enter and View visit to a number of senior health wards in 2017 which revealed how communication and interactions with patients and carers was an important part of care in these wards. We hope to see how carers are increasingly involved as important participants in a patient's care across the hospital.

Following the involvement and communication theme it is encouraging to see a priority given to improving the effectiveness of the discharge process, 'ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support'. This is possibly a complex piece of work given the many considerations needed during discharge, perhaps even extending to areas like patient transport. Getting discharges right will bring significant benefits, not least enabling patients to better manage their situation to help prevent future issues as well as ensuring improvements in recovery and outcomes.

Finally, we have seen determined and exemplary work undertaken for Learning from Deaths and End of Life Care work which should provide a firm foundation for continuing service improvement. It is to be hoped that next year the Trust will be able to focus on developments and progress for more long term and sustainable quality improvements after having developed their close management of quality in the past year. We are pleased to see that there is some progress in bringing patients in as partners in the process. We also hope that the hospital will be able to increasingly work with other local stakeholders on improvements, for example, looking at how services can work better together and simplifying pathways and access. This could be beneficial for many of the quality priorities, such as improving effective discharges.

Clive Norris
Chair Healthwatch Wandsworth
18 May 2018

St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018

This representation letter is provided in connection with the limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 for the purpose of reporting on the Quality Report and certain performance indicators contained therein (the "Quality Report") in accordance with the 'Detailed requirements for external assurance for quality reports 2017/18' published by NHS Improvement.

We have fulfilled our responsibilities, as set out in the terms of the limited assurance engagement letter dated 16 May 2018, for the content and preparation of the Quality Report in accordance with the requirements of the Health Act 2009 (the "Act") and the requirements set out in the National Health Service (Quality Accounts) Regulations 2010 (the "Regulations") and subsequent amendments and the requirements set out in the 'NHS foundation trust annual reporting manual 2017/18' (the "NHS FT ARM") and supporting guidance, and the 'Detailed requirements for external assurance for quality reports for 2017/18'.

We confirm to the best of our knowledge and belief having made such enquiries (including, where appropriate, of other members of management and staff with relevant knowledge and experience or inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the following representations to you:

i We have complied with the relevant requirements as set out in the Statement of Directors' Responsibilities in preparing the Quality Report.

ii We acknowledge our responsibility for the design, implementation, maintenance and monitoring of internal controls over the collection and reporting of the measures of performance included in the Quality Report.

iii We have provided you with:

- **a)** access to all of the Trust's Quality Report performance records and all other records and related information, including the minutes of all directors' and governors' meetings and ensured that there is no relevant performance information of which you are unaware;
- **b)** additional information that you have requested from us for the purpose of this limited assurance engagement; and
- **c)** unrestricted access to persons within the Trust from whom you determined it necessary to obtain evidence.

iv We have communicated to you all deficiencies in internal controls relevant to the Quality Report contained therein that are not clearly trivial and inconsequential of which we are aware.

v We have disclosed to you all our knowledge of any actual, suspected or alleged intentional non-compliance with the Act, the Regulations or the NHS FT ARM, or misstatement of information contained within the Quality Report and confirm that the indicators contained within the Quality Report are free from such misstatement.

vi The disclosures within the Quality Report fairly reflect our understanding of the Trust's performance over the period covered and have been prepared in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and the 'Detailed requirements for external assurance for quality reports 2017/18' issued by NHS Improvement.

Yours faithfully

Signed on behalf of the Council of Governors and Board of Directors by:

Gillian Norton
Chairman
St George's University Hospitals
NHS Foundation Trust
24 May 2018

Jacqueline Totterdell
Chief Executive
St George's University Hospitals
NHS Foundation Trust
24 May 2018

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

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to 24 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
- feedback from commissioners dated 22 May 2018;
- feedback from local Healthwatch organisations dated 18 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 1 September 2017;
- the national patient survey dated 5 March 2018;
- the national staff survey dated 3 March 2018;
- the Care Quality Commission inspection reports dated 1 November 2016 and 3 August 2017; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and St George's University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement.

The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

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

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

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
London
24 May 2018

Annual Finacial Accounts

Foreword to the accounts

St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by St George's University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Jacqueline Totterdell
Chief Executive
24 May 2018

Statement of Comprehensive Income for the year ended 31 March 2018

			Restated
		2017/18	2016/17
Statement of Comprehensive Income for the year ended 31 March 2018	**Note**	**£000**	**£000**
Operating income from patient care activities	3	672,625	653,162
Other operating income	4	147,610	145,778
Operating expenses	6, 8	(863,250)	(861,991)
Operating surplus/(deficit) from continuing operations		(43,015)	(63,051)
Finance income	11	61	54
Finance expenses	12	(8,465)	(5,514)
PDC dividends payable		(1,369)	(5,249)
Net finance costs		(9,773)	(10,709)
Other gains / (losses)	13	(302)	(4,906)
Share of profit / (losses) of associates / joint arrangements	20	-	-
Gains / (losses) arising from transfers by absorption		-	-
Corporation tax expense		-	-
Surplus / (deficit) for the year from continuing operations		(53,090)	(78,666)
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	-	-
Surplus / (deficit) for the year		(53,090)	(78,666)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	-
Revaluations	18	8,842	(8,832)
Share of comprehensive income from associates and joint ventures	20	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability / asset	37	-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available-for-sale financial investments	13	-	-
Recycling gains / (losses) on available-for-sale financial investments	13	-	-
Foreign exchange gains / (losses) recognised directly in OCI	13	-	-
Total comprehensive income / (expense) for the period		(44,248)	(87,498)

The 2016/17 comparatives for Operating income from patient care activities and Operating expenses have been restated to transfer £850k of bad debt expense from income to expenditure.

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	Restated 31 March 2017 £000
Non-current assets			
Intangible assets	15	22,384	16,493
Property, plant and equipment	16	354,841	319,338
Investment property	19	-	-
Investments in associates and joint ventures	20	-	-
Other investments / financial assets	21	-	-
Trade and other receivables	24	9,935	9,739
Other assets	25	11	11
Total non-current assets		387,171	345,581
Current assets			
Inventories	23	6,444	6,575
Trade and other receivables	24	102,328	91,237
Other investments / financial assets	21	-	-
Other assets	25	-	-
Non-current assets held for sale / assets in disposal groups	26	-	-
Cash and cash equivalents	27	3,541	6,023
Total current assets		112,313	103,835
Current liabilities			
Trade and other payables	28	(132,596)	(122,995)
Borrowings	31	(57,710)	(55,207)
Other financial liabilities	29	-	-
Provisions	33	(197)	(335)
Other liabilities	30	(2,049)	-
Liabilities in disposal groups	26	-	-
Total current liabilities		(192,552)	(178,537)
Total assets less current liabilities		306,932	270,879
Non-current liabilities			
Trade and other payables	28	-	-
Borrowings	31	(241,665)	(164,523)
Other financial liabilities	29	-	-
Provisions	33	(950)	(988)
Other liabilities	30	-	-
Total non-current liabilities		(242,615)	(165,511)
Total assets employed		64,317	105,368
Financed by			
Public dividend capital		133,153	129,956
Revaluation reserve		97,945	89,103
Available for sale investments reserve		-	-
Other reserves		1,150	1,150
Merger reserve		-	-
Income and expenditure reserve		(167,931)	(114,841)
Total taxpayers' equity		64,317	105,368

Jacqueline Totterdell
Chief Executive
24 May 2018

The 2016/17 comparatives for Trade and other receivables and Trade and other payables have been restated to transfer £850k of bad debt provision from Trade and Other Payables to Trade and other receivables.

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
Statement of Changes	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	129,956	89,103	-	1,150	-	(114,841)	105,368
Surplus/(deficit) for the year	-	-	-	-	-	(53,090)	(53,090)
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Revaluations	-	8,842	-	-	-	-	8,842
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-
Public dividend capital received	3,197	-	-	-	-	-	3,197
Public dividend capital repaid	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2018	133,153	97,945	-	1,150	-	(167,931)	64,317

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

Statement of Changes	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	129,520	100,178	-	1,150	-	(38,418)	192,430
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' equity at 1 April 2016 - restated	129,520	100,178	-	1,150	-	(38,418)	192,430
Surplus/(deficit) for the year	-	-	-	-	-	(78,666)	(78,666)
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Revaluations	-	(8,832)	-	-	-	-	(8,832)
Transfer to retained earnings on disposal of assets	-	(1,660)	-	-	-	1,660	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-
Public dividend capital received	436	-	-	-	-	-	436
Public dividend capital repaid	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-
Other reserve movements	-	(583)	-	-	-	583	-
Taxpayers' equity at 31 March 2017	129,956	89,103	-	1,150	-	(114,841)	105,368

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Other reserves

This reserve of £1.15m was created in March 2003 to recognise the portion of land at St George's Grove that had been omitted from the land valuation used to establish the St George's opening PDC capital balance when it became an NHS Trust on 1st April 1993. The associated land has since been sold but this reserve remains as an adjustment to the originating PDC Capital balance.

Merger reserve

This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows for the year end 31 March

	Note	2017/18 £000	Restated 2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(43,015)	(63,051)
Non-cash income and expense:			
Depreciation and amortisation	6.1	20,930	21,563
Net impairments	7	-	-
Income recognised in respect of capital donations	4	(286)	(582)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(9,358)	(20,839)
(Increase) / decrease in inventories		131	(337)
Increase / (decrease) in payables and other liabilties		1,009	21,335
Increase / (decrease) in provisions		(178)	(248)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		(182)	(181)
Net cash generated from / (used in) operating activities		(30,949)	(42,340)
Cash flows from investing activities			
Interest received		61	54
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(3,365)	(72)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(38,371)	(30,384)
Sales of property, plant, equipment and investment property		-	76
Receipt of cash donations to purchase capital assets		286	582
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		(41,389)	(29,744)
Cash flows from financing activities			
Public dividend capital received		3,197	436
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		83,307	86,048
Movement on other loans		(1,478)	(1,478)
Other capital receipts		-	-
Capital element of finance lease rental payments		(2,936)	(2,604)
Capital element of PFI, LIFT and other service concession payments		(993)	(928)
Interest paid on finance lease liabilities		(198)	(242)
Interest paid on PFI, LIFT and other service concession obligations		(2,848)	(2,913)
Other interest paid		(4,896)	(2,358)
PDC dividend (paid) / refunded		(3,299)	(5,249)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		69,856	70,712
Increase / (decrease) in cash and cash equivalents		(2,482)	(1,372)
Cash and cash equivalents at 1 April - brought forward		6,023	7,395
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		6,023	7,395
Cash and cash equivalents transferred under absorption accounting	44	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	27.1	3,541	6,023

The 2016/17 comparatives for (Increase) / decrease in receivables and other assets and Increase / (decrease) in payables and other liabilties have been restated to transfer £850k of bad debt provision movement from payables to receivables.

1) Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Going concern

These accounts have been prepared on a going concern basis. IAS 1 has been adapted for the public sector in that accounts are prepared on going concern basis if services will continue. The Trust incurred a deficit of £53.1m for the year ended 31 March 2018. During the year the Trust borrowed £60.3m under interim revenue support facilities provided by the NHS Independent Trust Financing Facility.

The board has reviewed the proposed 2018/19 plan throughout its development from January 2018 to date. The 2018/19 plan is for a deficit of £29m having taken account of the underlying financial position going into 2018/19. The Trust has identified in its financial plan submitted to NHS Improvement that further borrowing totalling £30m is required to finance the Trust for the year provided the £29m planned deficit is not exceeded. There are significant risks to the planned deficit from delivering both the planned activity and the transformation savings. Given these risks, the Trust is requesting access to further Department of Health borrowing facilities to provide adequate liquidity headroom.

In addition to the access requested to borrowing facilities of £30.7m to finance the planned 2018/19 deficit, the Trust is also requesting that the Department of Health provides borrowing facilities of £48.7m to finance the repayment of an existing DH borrowing facility in March 2019. The Department of Health and Social Care has advised the Trust that it is expected the Trust will be able to access borrowing to fully finance the repayment of this facility but that this would not be confirmed until later in the 2018/19 financial year.

At the time these financial statements were prepared the Trust was engaged in discussions with the regulator regarding the financial plan for 2018/19 and the arrangements to access further borrowing facilities to finance the planned deficit and finance the repayment of the facility maturing in March 2019 however these discussions had not concluded at the time the financial statements were approved. Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the directors, having made appropriate enquiries, have reasonable

expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the NHS Foundation Trust Annual Reporting Manual 2017/18, the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

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

1.1 Interests in other entities

The Trust does not have any subsidiaries and is not part of any joint ventures so IAS 28 paragraph IN8 is not applicable.

Joint operations

From 1 April 2015, the Trust has participated in South West London Pathology, an arrangement with Kingston NHS Foundation Trust and Croydon University Hospitals NHS Trust to provide pathology services for all three organisations.

The operation is under joint control: its board is made up of the three chief executives and finance directors of each trust, none of whom have overall authority, Ownership is divided based on expected usage:

- Croydon University Hospitals NHS Trust 25.8%
- Kingston NHS Foundation Trust 27.5%
- St George's University Hospitals NHS Foundation Trust 46.7%

South West London Pathology is not a separate vehicle for the three trusts, making this a joint operation as defined by IFRS11. As host organisation, the Trust accounts for all the income and expenditure for South West London Pathology on a gross basis.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme:

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Trust
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Measurement

Valuation:

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

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

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust has applied the alternative site method for the 2015/16 valuation of land. Further detail of this change in land valuation is provided in note 1.6

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the statement of comprehensive income."

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Property, plant and equipment is depreciated as follows:

- Medical equipment is in general depreciated over 5, 10 or 15 years.
- Buildings (excluding dwelling) asset lives range from 3 years to 100 years.
- Plant and machinery asset lives range from 1 year to 25 years
- Transport equipment asset lives range from 5 years to 7 years.
- Information technology assets range from 5 years to 10 years.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposals are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.:
  - management is committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which are to be scrapped or demolished do not qualify for recognition as 'held for sale' and instead are retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has

imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Services received

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

PFI asset

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

PFI liability

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

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

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

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

Lifecycle replacement

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

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

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when

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

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

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's statement of financial position.

Other assets contributed by the NHS trust to the operator

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

1.6 Intangible assets

Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which

is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life	Max life
Intangible assets - internally generated	**Years**	**Years**
Information technology	10	12
Development expenditure	10	12
Other	10	12
Intangible assets - purchased	**Years**	**Years**
Software	5	7
Licences & trademarks	5	7
Patents	5	7
Other	5	7
Goodwill	5	7

1.7 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Carbon Reduction Commitment Scheme (CRC)

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

1. 8 Inventories

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

1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which

are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade - date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health and Social Care are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive

Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices/independent appraisals/discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

1.10 Leases

The Trust as Lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building

component and the classification for each is assessed separately.

The Trust as Lessor

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

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

1.11 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 34.2 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated

at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.14 Value added tax

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

1.15 Corporation tax

St George's University Hospitals NHS Foundation Trust has no corporation tax liability because under the relevant extant legislation Foundation Trusts are not subject to corporation tax.

1.16 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 27.2 to the accounts.

1.18 Losses and special payments

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

functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.19 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.20 Transfer of functions to/from other NHS or local government bodies.

There have been no transfers of functions or assets in the current financial year.

1.21 Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

Finance leases:

The Trust has made a critical judgement regarding the treatment of assets that are finance leases. These finance leases relate to equipment assets used by the Trust and also the private finance initiative (PFI) contract. See paragraphs 1.10 Leases and 1.5 PFI Transactions.

Land valuation:

The Trust has updated the valuation of its land and buildings in these financial statements. The valuation report was prepared by an independent valuer, Gerald Eve LLP, a firm of professionally (RICS) qualified valuers. The valuation was effective from 31 March 2018.

The Trust changed the basis of the valuation of the land on the St George's Hospital site to an alternative site basis in 2015/16 and has maintained this basis of valuation in 2017/18. This alternative site basis applies the principle of the modern equivalent asset (MEA) valuation methodology which values land and buildings at the cost that would be incurred if they had to be replaced. The valuation methodology allows the use of feasible alternative sites to value the land required to locate the Trust's buildings and still serve the same local population. Gerald Eve LLP has identified an alternative site in Merton and has formulated a valuation for the land using relevant valuation metrics. The Trust considers that the Merton site identified by the valuer as the alternative site for valuation purposes is reasonable and consistent with the provision of the services from the current location as it is near the St George's Hospital site in Tooting.

The applicable valuation principles make clear that where specialised buildings e.g. hospital facilities are involved and re-provision of buildings on the existing site would represent a waste of economic resources then a feasible lower cost site may be valued as an alternative. The Trust is satisfied the assumptions underpinning the valuation of the St George's Hospital site on the alternative site basis in these financial statements is reasonable and consistent with the principles of the alternative site valuation method.

1.22 Key sources of estimation uncertainty

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

- Plant, property and equipment - note 1.5 and note 16.1
- Intangible assets - paragraph 1.6 and note 15.1
- Provision for impairment of receivables – note 24.2
- Provisions - note 1.11 and note 33.1.

Revenue figures have been adjusted for the impairment of receivables. The Trust has made an appropriate, prudent provision for impairment of debts past their due date according to their age and assessment of their collectability.

1.23 Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2) Operating Segments

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

Income from CCGs accounts for 44% (2016/17: 47%) of the Trust revenue with a further 35% (2016/17: 35%) from NHS England. No customer external to the NHS accounts for more than 10% of the Trust's revenue hence there are no other segments.

3) Operating income from patient care activities

3.1 Income from patient care activities (by nature)

		Restated
	2017/18	2016/17
Acute services	£000	£000
Elective income	109,671	99,256
Non elective income	158,670	135,426
First outpatient income	44,782	47,209
Follow up outpatient income	48,511	51,140
A & E income	22,350	18,253
High cost drugs income from commissioners (excluding pass-through costs)	42,097	36,453
Other NHS clinical income	203,071	170,277
Community services		
Community services income from CCGs and NHS England	32,144	82,218
Income from other sources (e.g. local authorities)	5,778	8,243
All services		
Private patient income	3,533	4,687
Other clinical income	2,018	-
Total income from activities	672,625	653,162

3.2 Income from patient care activities (by source)

		Restated
	2017/18	2016/17
Income from patient care activities received from:	£000	£000
NHS England	285,559	276,772
Clinical commissioning groups	364,375	349,519
Department of Health and Social Care	-	-
Other NHS providers	1,364	1,650
NHS other	2,090	1,008
Local authorities	8,770	13,555
Non-NHS: private patients	3,533	4,687
Non-NHS: overseas patients (chargeable to patient)	1,740	1,619
NHS injury scheme	5,026	3,802
Non NHS: other	168	550
Total income from activities	672,625	653,162
Of which:		
Related to continuing operations	672,625	653,162
Related to discontinued operations	-	-

The comparative figures for 2016/17 for NHS England and Clinical commissioning groups above have been updated to show separately the amount receivable from NHS England so they are consistent with the figures for 2017/18.

The 2016/17 comparatives for income from Clinical commissioning groups have been restated to transfer £850k of bad debt expense from income to expenditure.

3.3 Overseas visitors (relating to patients charged directly by the provider)

		Restated
	2017/18	2016/17
Overseas visitors	£000	£000
Income recognised this year	1,740	1,619
Cash payments received in-year	398	418
Amounts added to provision for impairment of receivables	807	1,021
Amounts written off in-year	-	-

The 2016/17 comparative for Amounts added to provision for impairment of receivables has been restated to transfer £850k of bad debt expense from income to expenditure.

4) Other operating income

	2017/18	2016/17
Other operating income	£000	£000
Research and development	4,709	4,687
Education and training	35,584	38,401
Receipt of capital grants and donations	286	1,316
Charitable and other contributions to expenditure	688	551
Non-patient care services to other bodies	60,407	59,038
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and transformation fund income	-	-
Rental revenue from operating leases	-	-
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis	40,066	36,294
Other income*	5,870	5,491
Total other operating income	147,610	145,778
Of which:		
Related to continuing operations	147,610	145,778
Related to discontinued operations	-	-

*Other income includes property rental income, pharmacy production income, car parking income and estates services income.

4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

		Restated
	2017/18	2016/17
Income from activities arising from commissioner requested services	£000	£000
Income recognised this year	673,318	622,440
Cash payments received in-year	144,938	129,363
Amounts added to provision for impairment of receivables	818,256	751,803

The 2016/17 comparative figure for Income from services designated as commissioner requested services has been restated to transfer £850k of bad debt expense from income to expenditure.

4.2 Profits and losses on disposal of property, plant and equipment

2017/18

In 2017/18 the Trust disposed of old plant and equipment with a net book value of £302k.

2016/17

In 2016/17 the Trust disposed of assets with a net book value of approx £4.982m. A number of old, poor quality buildings were demolished or put beyond use by 31 March 2017 as part of an estates reconfiguration programme. Clinical services which had been provided in one of these buildings, Knightsbridge wing, were re-located to higher quality accomodation in Lanesborough wing. The other buildings that were demolished or put beyond use had been used primarily by administrative staff who have been re-located either to other accommodation on the St George's hospital site or other premises off-site. The Trust received sale proceeds of £76k for some equipment. Therefore the loss on disposal for the year of asset disposals was £4.906m.

5) Fees and charges

	2017/18	2016/17
Income from activities arising from commissioner requested services	£000	£000
Income	-	-
Full cost	-	-
Surplus / (deficit)	-	-

6.1 Operating expenses

		Restated
	2017/18	2016/17
Operating expenses	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,627	5,216
Purchase of healthcare from non-NHS and non-DHSC bodies	3,510	8,693
Purchase of social care	-	-
Staff and executive directors costs	522,536	530,479
Remuneration of non-executive directors	129	277
Supplies and services - clinical (excluding drugs costs)	97,583	97,866
Supplies and services - general	18,482	18,603
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	82,910	81,249
Inventories written down	-	(231)
Consultancy costs	9,215	3,907
Establishment	4,960	5,705
Premises	33,453	26,324
Transport (including patient travel)	7,908	7,076
Depreciation on property, plant and equipment	17,157	17,891
Amortisation on intangible assets	3,773	3,672
Net impairments	-	-
Increase/(decrease) in provision for impairment of receivables	1,312	1,936
Increase/(decrease) in other provisions	29	-
Change in provisions discount rate(s)	-	18
Audit fees payable to the external auditor		
audit services- statutory audit	96	70
other auditor remuneration (external auditor only)	18	12
Internal audit costs	140	168
Clinical negligence	23,306	19,722
Legal fees	426	458
Insurance	63	512
Research and development	118	252
Education and training	3,062	2,571
Rentals under operating leases	18,224	17,955
Early retirements	-	-
Redundancy	-	227
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	7,535	7,535
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-	-
Car parking & security	15	13
Hospitality	-	-
Losses, ex gratia & special payments	38	39
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	4,625	3,776
Total	863,250	861,991
Of which:		
Related to continuing operations	863,250	861,991
Related to discontinued operations	-	-

The 2016/17 comparative figure for Increase/(decrease) in provision for impairment of receivables has been restated to transfer £850k of bad debt expense from income to expenditure.

6.2 Other auditor remuneration

	2017/18	2016/17
Other auditor remuneration paid to the external auditor:	£000	£000
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	14	12
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	4	-
Total	18	12

6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £2m).

7) Impairment of assets

	2017/18	2016/17
Impairment of assets	£000	£000
Total net impairments charged to operating surplus / deficit	-	-
Total net impairments	-	-

8) Employee benefits

	2017/18	2016/17
	Total	Total
Other auditor remuneration paid to the external auditor:	£000	£000
Salaries and wages	411,798	401,009
Social security costs	41,547	40,308
Apprenticeship levy	1,979	-
Employer's contributions to NHS pensions	47,071	45,403
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	163	435
Temporary staff (including agency)	19,978	43,324
Total gross staff costs	522,536	530,479
Recoveries in respect of seconded staff	-	-
Total staff costs	522,536	530,479
Of which		
Costs capitalised as part of assets	-	-

8.1 Retirements due to ill-health

During 2017/18 there were 6 early retirements from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £227k (£539k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

9) Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared.

The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

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

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

d) National Employment Savings Scheme (NEST)

The Trust offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), for those members of staff who do not qualify for the NHS pension scheme.

10) Operating leases

10.1 St George's University Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where St George's University Hospitals NHS Foundation Trust is the lessor.

	2017/18	2016/17
Operating lease revenue	£000	£000
Total	-	-

	31 March 2018	31 March 2017
Future minimum lease receipts due:	£000	£000
Total	-	-

10.2 St George's University Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where St George's University Hospitals NHS Foundation Trust is the lessee.

The Trust has operating leases for the use of accommodation to operate clinical facilities at a number of properties managed by NHS Property Services Company Ltd (NHSPS). The most significant operating lease with NHSPS is for the space occupied at Queen Mary's Roehampton for which the Trust pays NHSPS approximately £13.2m pa. The leases are subject to annual review and renewal.

	2017/18	2016/17
Operating lease expense	£000	£000
Minimum lease payments	18,224	17,955
Contingent rents	-	-
Less sublease payments received	-	-
Total	18,224	17,955

	31 March 2018	31 March 2017
Future minimum lease payments due:	£000	£000
- not later than one year;	18,103	17,910
- later than one year and not later than five years;	71,974	71,200
- later than five years.	17,983	17,800
Total	108,060	106,910
Future minimum sublease payments to be received	-	-

11) Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
Finance income	£000	£000
Interest on bank accounts	61	54
Total	61	54

12.1 Finance expenditure

Finance expenditure represents interest and other charges incurred on all borrowing.

	2017/18	2016/17
Interest expense:	£000	£000
Loans from the Department of Health and Social Care	5,201	2,085
Other loans	187	232
Overdrafts	-	-
Finance leases	198	248
Interest on late payment of commercial debt	29	33
Main finance costs on PFI and LIFT schemes obligations	2,848	2,913
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	8,463	5,511
Unwinding of discount on provisions	2	3
Other finance costs	-	-
Total finance costs	8,465	5,514

12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	29	33
Compensation paid to cover debt recovery costs under this legislation	-	-

13) Other gains / (losses)

	2017/18	2016/17
Other gains / (losses)	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(302)	(4,906)
Total gains / (losses) on disposal of assets	(302)	(4,906)

2017/18

In 2017/18 the Trust disposed of old plant and equipment with a net book value of £302k.

2016/17

In 2016/17 the Trust disposed of assets with a net book value of approx £4.982m. A number of old, poor quality buildings were demolished or put beyond use by 31 March 2017 as part of an estates reconfiguration programme. Clinical services which had been provided in one of these buildings, Knightsbridge wing, were re-located to higher quality accomodation in Lanesborough wing. The other buildings that were demolished or put beyond use had been used primarily by administrative staff who have been re-located either to other accommodation on the St George's hospital site or other premises off-site. The Trust received sale proceeds of £76k for some equipment. Therefore the loss on disposal of non-current assets in 2016/17 was £4.906m.

14) Discontinued operations

	2017/18	2016/17
Discontinued operations	£000	£000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	-	-

15.1 Intangible assets - 2017/18

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Total
Intangible assets	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	1,300	-	-	28,596	-	29,896
Transfers by absorption	-	-	-	-	-	-
Additions	271	-	-	3,094	-	3,365
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	1,274	-	-	4,995	-	6,269
Transfers to/ from assets held for sale	-	-	-	-	-	-
Disposals / derecognition	(681)	-	-	(1,711)	-	(2,392)
Gross cost at 31 March 2018	2,164	-	-	34,974	-	37,138
Amortisation at 1 April 2017 - brought forward	981	-	-	12,422	-	13,403
Transfers by absorption	-	-	-	-	-	-
Provided during the year	331	-	-	3,442	-	3,773
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	922	-	-	(952)	-	(30)
Transfers to / from assets held for sale	-	-	-	-	-	-
Disposals / derecognition	(681)	-	-	(1,711)	-	(2,392)
Amortisation at 31 March 2018	1,553	-	-	13,201	-	14,754
Net book value at 31 March 2018	611	-	-	21,773	-	22,384
Net book value at 1 April 2017	319	-	-	16,174	-	16,493

15.2 Intangible assets - 2016/17

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	1,228	-	-	28,010	-	29,238
Prior period adjustments	-	-	-	-	-	-
Valuation / gross cost at 1 April 2016 - restated	1,228	-	-	28,010	-	29,238
Transfers by absorption	-	-	-	-	-	-
Additions	72	-	-	-	-	72
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	-	-	-	2,673	-	2,673
Transfers to/ from assets held for sale	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(2,087)	-	(2,087)
Valuation / gross cost at 31 March 2017	1,300	-	-	28,596	-	29,896
Amortisation at 1 April 2016 - as previously stated	782	-	-	11,036	-	11,818
Prior period adjustments	-	-	-	-	-	-
Amortisation at 1 April 2016 - restated	782	-	-	11,036	-	11,818
Transfers by absorption	-	-	-	-	-	-
Provided during the year	199	-	-	3,473	-	3,672
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(2,087)	-	(2,087)
Amortisation at 31 March 2017	981	-	-	12,422	-	13,403
Net book value at 31 March 2017	319	-	-	16,174	-	16,493
Net book value at 1 April 2016	446	-	-	16,974	-	17,420

16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	45,922	202,053	113	33,136	90,439	144	31,713	33,997	437,517
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	11,099	-	25,397	11,987	-	1,783	151	50,417
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	222	1,360	-	-	-	-	-	-	1,582
Reclassifications	-	7,272	-	(23,059)	8,468	-	987	63	(6,269)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(147)	(33,020)	(144)	(14,122)	(24,138)	(71,571)
Valuation/gross cost at 31 March 2018	46,144	221,784	113	35,327	77,874	-	20,361	10,073	411,676
Accumulated depreciation at 1 April 2017 - brought forward	-	-	-	-	66,087	144	22,364	29,584	118,179
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	7,260	5	-	6,586	-	2,552	754	17,157
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(7,260)	-	-	-	-	-	-	(7,260)
Reclassifications	-	-	-	-	30	-	-	-	30
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(32,912)	(144)	(14,122)	(24,093)	(71,271)
Accumulated depreciation at 31 March 2018	-	-	5	-	39,791	-	10,794	6,245	56,835
Net book value at 31 March 2018	46,144	221,784	108	35,327	38,083	-	9,567	3,828	354,841
Net book value at 1 April 2017	45,922	202,053	113	33,136	24,352	-	9,349	4,413	319,338

16.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	47,961	249,850	-	23,317	108,115	144	29,106	14,004	472,497
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2016 - restated	47,961	249,850	-	23,317	108,115	144	29,106	14,004	472,497
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	55	128	-	29,826	2,966	-	960	-	33,935
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	120	(52,193)	-	-	-	-	-	-	(52,073)
Reclassifications	(2,214)	15,848	113	(19,459)	(19,791)	-	1,664	21,166	(2,673)
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(11,580)	-	(548)	(851)	-	(17)	(1,173)	(14,169)
Valuation/gross cost at 31 March 2017	45,922	202,053	113	33,136	90,439	144	31,713	33,997	437,517
Accumulated depreciation at 1 April 2016 - as previously stated	-	42,376	-	-	80,380	144	19,976	9,838	152,714
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2016 - restated	-	42,376	-	-	80,380	144	19,976	9,838	152,714
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	8,500	-	-	6,221	-	2,397	773	17,891
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(43,241)	-	-	-	-	-	-	(43,241)
Reclassifications	-	-	-	-	(20,032)	-	-	20,032	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals/ derecognition	-	(7,635)	-	-	(482)	-	(9)	(1,059)	(9,185)
Accumulated depreciation at 31 March 2017	-	-	-	-	66,087	144	22,364	29,584	118,179
Net book value at 31 March 2017	45,922	202,053	113	33,136	24,352	-	9,349	4,413	319,338
Net book value at 1 April 2016	47,961	207,474	-	23,317	27,735	-	9,130	4,166	319,783

The depreciation charge for buildings of £7,260k for 2017/18 is transferred from accumulated depreciation to gross cost in accordance with the accounting requirements for the revaluation of buildings.

This transfer has no impact on the Statement of Comprehensive Income or on the carrying value of buildings and is effected to comply with the DHSC Group Accounting Manual.

16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Net book value at 31 March 2018	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	45,129	157,576	108	35,269	27,528	-	9,522	3,604	278,736
Finance leased	-	-	-	-	9,348	-	-	-	9,348
On-SoFP PFI contracts and other service concession arrangements	-	51,636	-	-	-	-	-	-	51,636
PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - government granted	-	2,184	-	-	25	-	-	19	2,228
Owned - donated	1,015	10,388	-	58	1,182	-	45	205	12,893
NBV total at 31 March 2018	46,144	221,784	108	35,327	38,083	-	9,567	3,828	354,841

16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Net book value at 31 March 2017	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	44,907	128,419	113	32,609	11,469	-	9,286	3,199	230,002
Finance leased	-	-	-	-	11,015	-	-	318	11,333
On-SoFP PFI contracts and other service concession arrangements	-	60,151	-	-	-	-	-	602	60,753
PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - government granted	-	1,733	-	-	259	-	-	26	2,018
Owned - donated	1,015	11,750	-	527	1,609	-	63	268	15,232
NBV total at 31 March 2017	45,922	202,053	113	33,136	24,352	-	9,349	4,413	319,338

17) Donations of property, plant and equipment

The Trust has recognised capital donations receivable towards the cost of various items of medical equipment. These donations are receivable from the St George's Hospital Charity and other various charitable organisations.

18) Revaluations of property, plant and equipment

In 2017/18 the Trust commissioned a valuation of its land and buildings by an independent valuer, Gerald Eve LLP, a firm of professionally (RICS) qualified valuers. The effective date of the revaluation was 31 March 2018 and the results of the valuation are included in these accounts. The valuations were prepared on the modern equivalent asset (MEA) basis applicable to NHS trusts.

In 2015/16, the Trust changed the basis of the valuation of the land on the St George's Hospital site to an alternative site basis. This alternative site basis applies the principle of the modern equivalent asset (MEA) valuation methodology which values land and buildings at the cost that would be incurred if they had to be replaced. The valuation methodology allows the use of feasible alternative sites to value the land required to locate the Trust's buildings and still serve the same local population. Gerald Eve LLP have identified an alternative site in Merton and have formulated a valuation for the land using relevant valuation metrics. The Trust considers that the Merton site identified by the valuer as the alternative site for valuation purposes is reasonable and consistent with the provision of the services from the current location as it is near the St George's Hospital site in Tooting.

In 2016/17 the Trust has changed the basis of valuation for Atkinson Morley wing to exclude VAT on the grounds that this building is financed by a PFI scheme for which the VAT on the unitary charges payable by the Trust is recoverable. This treatment is permitted under a change in the applicable valuation techniques effective from 2016/17 onwards.

Buildings are subject to composite depreciation rates according to their elemental breakdown eg substructure 80 years, internal wall 25 years etc.

- Medical equipment is in general depreciated over 5, 10 or 15 years.
- Buildings (excluding dwelling) asset lives range from 3 years to 100 years.
- Plant and machinery asset lives range from 1 year to 25 years.
- Transport equipment asset lives range from 5 years to 7 years.
- Information technology assets range from 5 years to 10 years.

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

19.1 Investment Property

	2017/18	2016/17
Investment Property	£000	£000
Carrying value at 1 April - brought forward	-	-
Carrying value at 31 March	-	-

19.2 Investment property income and expenses

	2017/18	2016/17
Investment property income and expenses	£000	£000
Carrying value at 1 April - brought forward	-	-
Carrying value at 31 March	-	-
Total investment property expenses	-	-
Investment property income	-	-

20 Investments in associates and joint ventures

	2017/18	2016/17
Investments in associates and joint ventures	£000	£000
Carrying value at 1 April - brought forward	-	-
Carrying value at 31 March	-	-

21 Other investments / financial assets (non-current)

	2017/18	2016/17
Other investments / financial assets (non-current)	£000	£000
Carrying value at 1 April - brought forward	-	-
Carrying value at 31 March	-	-

21.1 Other investments / financial assets (current)

	31 March 2018	31 March 2017
Other investments / financial assets (current)	£000	£000
Total current investments / financial assets	-	-

22) Disclosure of interests in other entities

The Trust does not have any subsidiaries and is not part of any joint venture.

23) Inventories

	31 March 2018	31 March 2017
Inventories	£000	£000
Drugs	1,963	1,635
Consumables	4,481	4,940
Total inventories	6,444	6,575
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £82,128k (2016/17: £114,758k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: -£231k).

24.1 Trade receivables and other receivables

		Restated
	31 March 2018	31 March 2017
Current	£000	£000
Trade receivables	54,567	58,452
Capital receivables (including accrued capital related income)	-	-
Accrued income	21,270	8,637
Provision for impaired receivables	(8,347)	(6,358)
Deposits and advances	-	-
Prepayments (non-PFI)	4,728	3,704
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	1,930	-
VAT receivable	6,806	6,592
Corporation and other taxes receivable	-	-
Other receivables	21,374	20,210
Total current trade and other receivables	102,328	91,237

Other receivables (current) include general debtors £5.7m, injury cost recovery debt £2.5m, overseas patient debt £8m, private patient debt £2.4m and local authority debt of £1.3m.

24.1 Trade receivables and other receivables

		Restated
	31 March 2018	31 March 2017
Non-current	£000	£000
Other receivables	9,935	9,739
Total non-current trade and other receivables	9,935	9,739
Of which receivables from NHS and DHSC group bodies:		
Current	54,765	55,414
Non-current	-	-

Other receivables (non-current) relate to the injury cost recovery scheme for which there is a relatively long lead time from invoicing the debt to its collection.

The 2016/17 comparative figure for the Provision for impaired receivables has been restated to transfer £850k of bad debt provision from Payables to Provision for impaired receivables.

24.2 Provision for impairment of receivables

		Restated
	31 March 2018	31 March 2017
Non-current	£000	£000
At 1 April as previously stated	6,358	4,348
Prior period adjustments	-	-
At 1 April - restated	6,358	4,348
Transfers by absorption	-	-
Increase in provision	1,310	1,936
Amounts utilised	677	74
Unused amounts reversed	2	-
At 31 March	8,347	6,358

The Trust determines the provision for impairment of receivables on the basis of the age of the debt and the risk of non-collection.

The 2016/17 comparative figure for Increase in provision has been restated to transfer £850k of bad debt provision from Payables to Provision for impaired receivables.

24.3 Credit quality of financial assets

	31 March 2018		Restated 31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	182	-	397	-
30-60 Days	246	-	135	-
60-90 days	161	-	65	-
90- 180 days	414	-	581	-
Over 180 days	7,344	-	5,180	-
Total	8,347	-	6,358	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	408	-	2,142	-
30-60 Days	1,224	-	655	-
60-90 days	676	-	1,069	-
90- 180 days	1,931	-	1,972	-
Over 180 days	15,201	-	11,918	-
Total	19,440	-	17,756	-

The Trust determines the provision for impairment of receivables on the basis of the age of the debt and the risk of non-collection.

The 2016/17 comparative figure for Increase in provision has been restated to transfer £850k of bad debt provision from Payables to Provision for impaired receivables.

25) Other assets

	31 March 2018	31 March 2017
Current	£000	£000
Total other current assets	-	-
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	11	11
Total other non-current assets	11	11

26) Non-current assets held for sale and assets in disposal groups

There were no non-current assets for sale in 2017/18 or 2016/17.

26.1 Liabilities in disposal groups

	31 March 2018	31 March 2017
Liabilities in disposal group	£000	£000
Total	-	-

27.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	31 March 2018	31 March 2017
Current	£000	£000
At 1 April	6,023	7,395
Prior period adjustments	-	-
At 1 April (restated)	6,023	7,395
Transfers by absorption	-	-
Net change in year	(2,482)	(1,372)
At 31 March	3,541	6,023
Broken down into:		
Cash at commercial banks and in hand	68	(225)
Cash with the Government Banking Service	3,473	6,248
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	3,541	6,023
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	3,541	6,023

The negative balance shown above of (£225k) for the Trust's commercial bank account for 2016/17 does not represent an overdrawn balance but a timing difference: a payment transaction of £400k was processed and recorded in the accounts at the end of March 2017 but did not clear in the bank account until early April 2017.

27.2 Third party assets held by the trust

The Trust held £6,381 in cash and cash equivalents which relate to monies held on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
Third party assets held by the trust	£000	£000
Bank balances	-	-
Monies on deposit	(302)	(4,906)
Total third party assets	(302)	(4,906)

28.1 Trade and other payables

	31 March 2018	31 March 2017
Current	£000	£000
Trade payables	94,412	96,065
Capital payables	15,406	5,285
Accruals	5,262	998
Receipts in advance (including payments on account)	-	-
Social security costs	13,043	12,866
VAT payables	-	-
Other taxes payable	1,581	5,146
PDC dividend payable	-	-
Accrued interest on loans	779	259
Other payables	2,112	2,376
Total current trade and other payables	132,596	122,995
Non-current		
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	17,177	12,964
Non-current	-	-

The 2016/17 comparative figure for Trade Payables has been restated to transfer £850k bad dept provision to Provision for impairment of receivables.

28.1 Trade and other payables

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018		31 March 2017	
Early retirements in NHS payables above	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	-	-	-	-
- number of cases involved	-	-	-	-
- outstanding pension contributions	-	-	-	-

29) Other financial liabilities

	31 March 2018	31 March 2017
Current	£000	£000
Operating income of discontinued operations	-	-
Non-current		
Total	-	-

30) Other liabilities

	31 March 2018	31 March 2017
Current	£000	£000
Deferred income	2,049	-
Total other current liabilities	2,049	-
Total other non-current liabilities	-	-

31) Borrowings

	31 March 2018	31 March 2017
Current	**£000**	**£000**
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Social Care	52,921	50,301
Other loans	1,478	1,478
Obligations under finance leases	2,249	2,435
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,062	993
Total current borrowings	57,710	55,207
Non-current		
Loans from the Department of Health and Scoial Care	185,283	104,595
Other loans	8,130	9,608
Obligations under finance leases	5,647	6,654
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	42,605	43,666
Total non-current borrowings	241,665	164,523

Borrowings from the Department of Health and Social Care

DHSC capital loans

1. The Trust drew down a DHSC capital loan of £14.7m in 2014/15 and 2015/16. This capital loan is repayable over 25 years at a fixed interest rate of 2.2%. The Trust repaid £0.6m of these loans in 2017/18. As at 31/03/18 the balance owed by the Trust on this loan is £13.2m.

2. The Trust drew down a capital loan of £16.2m during 2016/17 and 2017/18. This capital loan is repayable over 10 years at a fixed interest rate of 0.56%. As at 31/03/18 the balance owed by the Trust on this loan is £14.6m.

3. The Trust drew down a capital loan of £10m in March 2018. This capital loan is repayable over 10 years at a fixed interest rate of 1.26%. As at 31/03/18 the balance owed by the Trust on this loan is £10m.

DH working capital loans and working capital facilites

4. The Trust has a working capital loan of £15m from the Department of Health of Social Care (received in 2014/15) which is repayable over 15 years in equal instalments at a fixed interest rate of 1.38%.The Trust repaid £1m of this loan in 2017/18. As at 31/03/18 the balance owed by the Trust on this loan is £12m.

5. The Trust borrowed a total of £48.7m during 2015/16 and 2016/17 under an interim revenue support facility agreed with the Department of Health and Social Care in February 2016. This facility was originally repayable in full in March 2018 however before the end of the 2017/18 financial year the Department of Health deferred the repayment of the facility to March 2019 and so the repayment of this facility is classified as a

current liability for the second successive year in 2017/18. The interest rate is fixed at 1.5% and the full amount borrowed of £48.7m is repayable in March 2019. As at 31/03/18 the balance owed by the Trust on this facility is £48.7m.

6. The Trust borrowed £64.3m under an interim working capital facility in 2016/17. The interest rate is 3.5% for all borrowings under this facility. The facility is repayable in full in September 2020. As at 31/03/18 the balance owed by the Trust on this facility is £64.3m.

7. The Trust borrowed £15.1m under an interim working capital loan in 2016/17. The interest rate is 1.5% for all borrowings under this loan facility. The facility is repayable in full in March 2020. As at 31/03/18 the balance owed by the Trust on this facility is £15.1m.

8. The Trust borrowed £34.5m interim working capital facility loans in the period July - October 2017. The interest rate is 6% for all borrowings under these loan agreements. These loans are repayable in full in the period July 2020 to October 2020 inclusive. As at 31/03/18 the balance owed by the Trust on these loans is £34.5m.

9. The Trust borrowed £25.8m interim working capital facility loans in the period November 2017 to March 2018. The interest rate is 3.5% for all borrowings under these loan agreements. These loans are repayable in full in the period November 2020 to March 2021 inclusive. As at 31/03/18 the balance owed by the Trust on these loans is £25.8m.

Borrowings from other bodies

London Energy Efficiency Fund

10. The Trust received a loan from the London Energy Efficiency Fund (LEEF) for £13.3m in 2014/15 to finance an energy performance contract capital project with British Gas. The LEEF loan is repayable over 10 years at a fixed interest rate of 0.67% for the period July 2014 to March 2015 inclusive and a fixed interest rate of 1.81% thereafter. The Trust repaid £1.5m of this loan in 2017/18. As at 31/03/18 the balance owed by the Trust on this loan is £9.6m.

Finance leases

11. The Trust uses leasing to supplement capital investment in medical equipment where appropriate taking into account a number of factors including implicit rates of interest, the expected useful economic life of the equipment, the residual value of the equipment at the end of the lease term and the expected rate of technological change, to ensure value for money. During the course of 2017/18 the Trust took out new finance leases with a number of leasing companies for equipment with a capital value of approx £1.7m in respect of various items of medical equipment. The Trust made repayments of principal under finance leases of £2.9m in 2017/18. As at 31/03/18 the capital balance owed by the Trust for finance leases is £7.9m.

Private Finance Initiative on-SoFP scheme

12. The Trust entered into a Private Finance Initiative contract in March 2000 for the exclusive use of Atkinson Morley wing on the St George's hospital site. The capital value of the buildings and equipment encompassed within the PFI contract was approx £50m. The Trust accounts for this PFI contract as an on-Statement of Financial Position scheme and includes the value of the buildings and equipment within Property Plant and Equipment and the associated finance lease creditor within Borrowings. The implicit rate of the finance lease is approx. 7.5%. The Trust repaid approx £1m of the PFI finance lease creditor in 2017/18. As at 31/03/18 the capital balance owed by the Trust for the PFI scheme lease creditor is £43.7m.

32) Finance leases

32.1 St George's University Hospitals NHS Foundation Trust as a lessor

Future lease receipts due under finance lease agreements where St George's University Hospitals NHS Foundation Trust is the lessor:

	31 March 2018	31 March 2017
St George's University Hospitals NHS Foundation Trust as a lessor	£000	£000
Gross lease receivables	-	-
Net lease receivables	-	-

32.2 St George's University Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where St George's University Hospitals NHS Foundation Trust is the lessee.

	31 March 2018	31 March 2017
St George's University Hospitals NHS Foundation Trust as a lessee	£000	£000
Gross lease liabilities	8,671	10,011
of which liabilities are due:		
- not later than one year;	2,466	2,668
- later than one year and not later than five years;	5,919	7,229
- later than five years.	286	114
Finance charges allocated to future periods	(775)	(922)
Net lease liabilities	7,896	9,089
of which payable:		
- not later than one year;	2,249	2,435
- later than one year and not later than five years;	5,389	6,551
- later than five years.	258	103
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as an expense in the period	-	-

The Trust has a number of finance leases for high value capital medical equipment including MRI scanners, CT scanners and ultrasound equipment. The lease terms are for 3 to 7 years. The Trust applies the relevant accounting standards to determine the capital value of the equipment which is included within property plant and equipment and the interest costs chargeable to the Statement of Comprehensive Income for each lease. The lease rentals are fixed over the term of the lease and paid on a quarterly or annual basis in advance. The term of the lease may be extended at the end of the primary lease term or a new lease incepted for new replacement equipment.

33.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
Provisions for liabilities and charges	£000	£000	£000	£000	£000	£000
At 1 April 2017	1,134	45	-	-	144	1,323
Transfers by absorption	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-
Arising during the year	66	8	-	-	-	74
Utilised during the year	(207)	-	-	-	-	(207)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-
Reversed unused	-	-	-	-	(45)	(45)
Unwinding of discount	2	-	-	-	-	2
At 31 March 2018	995	53	-	-	99	1,147
Expected timing of cash flows:						
- not later than one year;	197	-	-	-	-	197
- later than one year and not later than five years;	-	-	-	-	-	-
- later than five years.	798	53	-	-	99	950
Total	995	53	-	-	99	1,147

The provision for pension costs is calculated using information provided by the NHS Business Services Authority. The provision for legal claims has been calculated using figures and estimated probabilities supplied by the NHS Resolution, the Trust's solicitors and the Trust's Human Resources department.

33.2 Clinical negligence liabilities

Obligations under finance leases where St George's University Hospitals NHS Foundation Trust is the lessee.

34) Contingent assets and liabilities

	31 March 2018	31 March 2017
Value of contingent liabilities	£000	£000
NHS Resolution legal claims	(38)	(89)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	(38)	(89)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(38)	(89)
Net value of contingent assets	-	-

The contingent liability relates to member's costs of potential insurance claims under the Liability to Third Parties scheme managed on the Trust's behalf by NHS Resolution who assess the probability of claims.

35) Contractual capital commitments

	31 March 2018	31 March 2017
Contractual capital commitments	£000	£000
Property, plant and equipment	2,297	8,351
Intangible assets	-	-
Total	2,297	8,351

The capital commitments total of £2.297m as at 31/03/18 relates to the refurbishment of the Ophthalmology facilities in Lanesborough wing. The comparative total for 2016/17 includes £8.3m for a capital project relating to an energy performance contract signed with British Gas in July 2014. This contract provided for the replacement and upgrade of the Trust's energy centre and infrastructure on the St George's Hospital site and this capital project was completed in 2017/18.

36) Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018	31 March 2017
Other financial commitments	£000	£000
Other financial commitments	£000	£000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	-	-

37) Defined benefit pension schemes

There are no material disclosures relating to any defined benefit pension schernes as provided by the funds actuary.

37.1 Changes in the defined benefit obligation and fair value of plan assets during the year

Obligations under finance leases where St George's University Hospitals NHS Foundation Trust is the lessee.

	2017/18	2016/17
Changes in the defined benefit obligation and fair value of plan assets	£000	£000
Present value of the defined benefit obligation at 1 April	-	-
Present value of the defined benefit obligation at 1 April - restated	-	-
Present value of the defined benefit obligation at 31 March	-	-
Plan assets at fair value at 1 April	-	-
Fair value of plan assets at 1 April -restated	-	-
Plan assets at fair value at 31 March	-	-
Plan surplus/(deficit) at 31 March	-	-

37.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2018	31 March 2017
Reconciliation of the present value	£000	£000
Net (liability) / asset recognised in the SoFP	-	-

37.3 Amounts recognised in the SoCI

	2017/18	2016/17
Amounts recognised in the SoCI	£000	£000
Total net (charge) / gain recognised in SOCI	-	-

38) On-SoFP PFI, LIFT or other service concession arrangements

38.1 Imputed finance lease obligations

St George's University Hospitals NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018	31 March 2017
Imputed finance lease obligations	£000	£000
Gross PFI, LIFT or other service concession liabilities	78,175	82,016
Of which liabilities are due		
- not later than one year;	3,841	3,841
- later than one year and not later than five years;	15,363	15,363
- later than five years.	58,971	62,812
Finance charges allocated to future periods	(34,508)	(37,357)
Net PFI, LIFT or other service concession arrangement obligation	43,667	44,659
- not later than one year;	1,062	993
- later than one year and not later than five years;	5,045	4,715
- later than five years.	37,559	38,951

The Trust signed a private finance initiative (PFI) contract in March 2000 for the exclusive use of the new Atkinson Morley wing on the St George's Hospital site. The new wing was commissioned in August 2003 and the 35 year lease for the wing started from this date. At the end of the 35 year term the Trust has the right to exercise the option to acquire the building at a nominal cost. The contract is with Blackshaw Healthcare Services Ltd, a special purpose vehicle company which is responsible for the maintenance of the building and the availability of the facilities within the building. On the adoption of International Financial Reporting Standards (IFRS) in 2008/09 the Trust accounted for the scheme as an on-statement of financial position PFI scheme and therefore the £50m original capital value of the facility was included within property plant and equipment and the associated finance lease creditor within borrowings. The building is depreciated and revalued on a consistent basis with purchased buildings.

38.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The Trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2018	31 March 2017
Total on-SoFP PFI, LIFT and other	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	238,896	250,272
Of which liabilities are due:		
- not later than one year;	11,376	11,376
- later than one year and not later than five years;	45,504	45,504
- later than five years.	182,016	193,392

38.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18	2016/17
Analysis of amounts payable to service concession operator	£000	£000
Unitary payment payable to service concession operator	11,376	11,376
Consisting of:		
- Interest charge	2,848	2,913
- Repayment of finance lease liability	993	928
- Service element and other charges to operating expenditure	7,535	7,535
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	-	-
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	11,376	11,376

39) Off-SoFP PFI, LIFT and other service concession arrangements

St George's University Hospitals NHS Foundation Trust did not incur any charges in respect of off-statement of financial position PFI and LIFT obligations in 2016/17 or 2017/18.

	31 March 2018	31 March 2017
Off-SoFP PFI, LIFT and other service concession arrangements	£000	£000
Total	-	-

40) Financial instruments

The applicable standards for financial instruments are IAS32/IAS39/IFRS7 and IFRS9.

IAS 32 defines financial instrument as a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Examples of financial assets are cash or a contractual right to receive cash.

40.1 Financial risk management

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

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

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has minimal overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure subject to affordability as confirmed by the regulator. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust also borrows from government to finance working capital and to finance operating losses using working capital loans and working capital facilities respectively. These borrowings are at fixed rates of interest. The Trust has a loan with the London Energy Efficiency Fund to finance capital expenditure which is also at a fixed rate of interest.

Therefore the Trust has low exposure to interest rate fluctuations.

Credit risk

The Trust has low exposure to credit risk because the majority of the Trust's revenue comes from contracts with other public sector bodies. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred primarily under contracts with clinical commissioning groups which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks in terns of the timing of payments for most of its receivables. The Trust has incurred operating deficits in the last two financial years however and this has necessitated borrowing from government to maintain liquidity.

40.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
Assets as per SoFP as at 31 March 2018	£000	£000	£000	£000	£000
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	86,411	-	-	-	86,411
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	3,541	-	-	-	3,541
Total at 31 March 2018	89,952	-	-	-	89,952

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
Assets as per SoFP as at 31 March 2017	£000	£000	£000	£000	£000
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	82,204	-	-	-	82,204
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	6,023	-	-	-	6,023
Total at 31 March 2017	88,227	-	-	-	88,227

40.2 Carrying values of financial assets

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
Liabilities as per SoFP as at 31 March 2018	£000	£000	£000
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	247,812	-	247,812
Obligations under finance leases	7,896	-	7,896
Obligations under PFI, LIFT and other service concession contracts	43,667	-	43,667
Trade and other payables excluding non financial liabilities	111,798	-	111,798
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	411,173	-	411,173

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
Liabilities as per SoFP as at 31 March 2017	£000	£000	£000
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	165,982	-	165,982
Obligations under finance leases	9,090	-	9,090
Obligations under PFI, LIFT and other service concession contracts	44,659	-	44,659
Trade and other payables excluding non financial liabilities	102,200	-	102,200
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2017	321,931	-	321,931

40.4 Fair values of financial assets and liabilities

The Trust considers that the fair value of financial assets and financial liabilities are the same as book value.

	31 March 2018	31 March 2017
Maturity of financial liabilities	£000	£000
In one year or less	169,508	157,406
In more than one year but not more than two years	24,150	6,244
In more than two years but not more than five years	148,754	96,678
In more than five years	68,761	61,603
Total	411,173	321,931

41) Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
Losses	Number	£000	Number	£000
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	-	-	-	-
Total losses	-	-	-	-
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	76	239	67	26
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	76	239	67	26
Total losses and special payments	76	239	67	26
Compensation payments received	-	-	-	-

42) Gifts

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
Gifts	Number	£000	Number	£000
Total gifts	-	-	-	-

43) Related parties

St Georges University Hospitals is a Foundation Trust within the Department of Health and Social Care. The Department of Health and Social Care is regarded as a related party.

During the year, St George's University Hospitals has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department, as listed below:

- NHS Foundation Trusts
- NHS Trusts
- Department of Health and Social Care
- Public Health England
- Health Education England
- CCGs and NHS England
- Special Health Authorities
- Non - Department Public Bodies
- Other DH bodies

	Amounts due from Related Party		Amounts owed to Related party	
	2017/18	2016/17	2017/18	2016/17
Non - NHS Related party transactions	£000	£000	£000	£000
St George's University of London	1,291	1,929	1,218	665
St George's Hospital Charity	328	867	-	3
KPMG LLP	-	-	-	122
Total	1,619	2,796	1,218	790

	Receipts from Related Party		Payments to Related party	
	2017/18	2016/17	2017/18	2016/17
Non - NHS Related party transactions	£000	£000	£000	£000
St George's University of London	4,945	3,252	6,032	7,994
St George's Hospital Charity	1,545	1,421	33	37
KPMG LLP				4,035
Total	6,491	4,673	6,065	12,066

KPMG LLP was disclosed as a related party in 2016/17 because Nigel Carr, who was the Trust's Chief Financial Officer from May 2016 to October 2016, is an employee of KPMG LLP.

Under the Requirements of IAS 24 (Related Party Disclosures), the Trust has disclosed as a related party where key management

services have been provided by another entity such as personal service companies.

The total transactions for these companies where key management services were provided are detailed below.

	Amounts due from Related Party		Amounts owed to Related party	
	2017/18	2016/17	2017/18	2016/17
Company	£000	£000	£000	£000
MR Strategic Ltd				23
IT Matters Ltd				32
Scene One Ltd				20
Dearden HR Ltd				0
Total	0	0	0	75

	Receipts from Related Party		Payments to Related party	
	2017/18	2016/17	2017/18	2016/17
Company	£000	£000	£000	£000
MR Strategic Ltd			150	303
IT Matters Ltd			37	395
Scene One Ltd				1,472
Dearden HR Ltd				92
Odgers Interim				327
Hunter Healthcare Resourcing Ltd				470
Corinne Siddall HCIM Ltd				124
Okra Associates Ltd				340
Total	0	0	187	3,523

2017/18 Related parties

- MR Strategic Ltd provided Mark Gordon in the role of Chief operating officer from Oct 16 to April 17
- IT Matters Ltd provided Richard Hancock in the role of Director of estates, facilties and capital projects from March 2016 to March 2017

2016/17 Related parties

- Scene One Ltd provided Larry Murphy in the role of IT advisor to Trust Board from May 2016 to March 17
- Dearden HR Ltd provided Mark Gammage in the role of Human Resources advisor to the Board from Dec 16 to Mar 17
- Odgers Interim provided Karen Charman in the role of Director of Human Resources between Jul 16 to Dec 16
- Hunter Healthcare Resourcing Ltd provided Paula Vasco-Knight in the role of Chief Operating Office and Acting Chief Executive up to April 16
- Okra Associates Ltd provided Margaret Pratt in the role of Chief Financial Officer between Nov 16 to Feb 17
- Corinne Siddall HCIM Ltd provided Corinne Siddall in the role of Interim Chief Operating Officer between May to Sept 16

44) Prior period adjustments

There were no prior period adjustments in 2017/18 or 2016/17.

45) Transfers by absorption

There were no transfers by absorption in 2017/18 or 2016/17.

46) Events after the reporting date

There were no events to report post 31 March 2018.

47) Final period of operation as a provider of NHS healthcare

This note is not applicable for 2017/18 or 2016/17.

Contact us

Giving to 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 4917**

Email: giving@stgeorges.nhs.uk

Web: www.stgeorgeshospitalcharity.org.uk

Volunteer

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

Telephone: **020 8725 1452**

Email: alexandra.dennis@stgeorges.nhs.uk

Request a printed copy

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

Telephone: **020 8725 5151**

Email: communications@stgeorges.nhs.uk

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Annual Report 2015/16 produced by St George's communications team.

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