Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust

Annual Report and Accounts 2019/20

St George's University Hospitals NHS Foundation Trust

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Chairman's Statement

As I write this introduction to the Trust's Annual Report and Accounts for 2019/20, staff across the NHS and care sectors are responding to the unprecedented challenge that Coronavirus has brought.

The purpose of this introduction is to reflect on the events of the past year. However, I also wanted to take this opportunity to acknowledge the incredible efforts of St George's staff in recent weeks; and as we enter a new financial year, it is already very clear that Coronavirus will be an ever present reality for the Trust and the wider NHS over the next 12 months, and possibly longer.

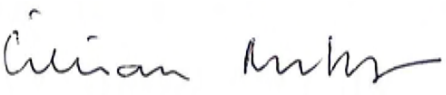
Turning to the past year, I believe we have made significant progress, in particular exiting NHS Improvement's special measures regime for the quality of services we provide. This was announced in March 2020, following a recommendation by the Care Quality Commission in December 2019. Of course, the organisation is committed to providing outstanding care, every time, and we know there is a huge amount more to do – but this was an important milestone in our improvement journey, having entered quality special measures in November 2016.

The Trust launched its five year strategy in April 2019 and this is helping to bring a real focus and drive to what we do. One of our four key strategic priorities set out in our strategy is 'closer collaboration', and this is particularly important for me as Chairman, given my role as Chairman-in-Common at Epsom and St Helier University Hospitals NHS Trust and the importance I place on making sure we work collaboratively for the common good, at local, regional and national level. The way we work with other hospitals – as well as primary care providers – has improved immeasurably in recent years, and I believe this to have been mutually beneficial. With the establishment of the South West London Integrated Care System from 1 April 2020, close collaboration is integral to how St George's will work with our partners in the year ahead.

As ever, I remain grateful to the Trust Board for their hard work, advice and the constructive challenge they bring to the organisation. Over the past year, we have seen changes in the membership of the Board. Among our Non-Executive Directors, Sarah Wilton has moved to pastures new, after ten years on the Board at St George's, and Professor Sir Norman Williams stepped down to take up a new role as Chair of the Government's Independent Reconfiguration Panel. Sarah and Sir Norman made significant contributions to the organisation in their respective roles, and I am grateful to them both. In February 2020, we welcomed two new Non-Executive Directors and an Associate Non-Executive Director to the Board. Professor Dame Parveen Kumar DBE and Elizabeth Bishop joined as Non-Executive Directors, whilst Dr Pui-Ling Li took up the role of Associate Non-Executive Director. At the same time, among the Executive Directors on the Board, we have seen changes in the posts of Chief Operating Officer and Chief Nurse.

We continue to receive fantastic support from the communities we serve, as evidenced once again in recent weeks during the Coronavirus outbreak. St George's Hospital Charity is helping to co-ordinate much of this work, and their support throughout the year is making a big difference to patients and our staff. We also have over 300 volunteers contributing their time in different roles across the Trust – from musicians to way finders. Our volunteers play an important role in hospital life, and I am grateful that so many people want to be connected to the organisation in this way.

Finally, I would like to thank our Governors for the enormous commitment they bring to their roles, and the organisation as a whole. In July 2019, Richard Mycroft took on the role of Lead Governor from Kathryn Harrison, who had held the role for several years, and I am grateful to both Richard and Kathryn for their support and advice. In February 2020, we welcomed six new Governors to the Trust following elections the previous month. We are extremely fortunate to have such an active and engaged group of Governors who care deeply about St George's, and are committed to ensuring we continue to progress and take the organisation forward, which is an ambition I share as Chairman.



Gillian Norton
Chairman
25 June 2020

Our Hospitals

Since the opening of the original St George's Hospital on Hyde Park Corner in 1733, St George's has built an international reputation for quality of care, education, research and medical advances.

We share our main hospital site in Tooting with St George's, University of London, and together we train future generations of the NHS workforce.

Our organisation is large – with more than 9,000 staff – but retains a strong sense of community. We have strong links with the local populations we serve, but are also recognised nationally and internationally for being a leader in research and innovation. This enables us to attract staff from all corners of the globe.

Five years ago, in February 2015, St George's became an NHS Foundation Trust. As the largest healthcare provider in south west London, our two hospital sites at St George's Hospital and Queen Mary's Hospital in Roehampton serve a population of 1.3 million across south west London. As a provider of many tertiary services, such as neurosciences and paediatric medicine, we also offer care for significant populations in Surrey and Sussex, totalling around 3.5 million people.

Even further afield, we provide care for patients from across the south west of England in specialties such as complex pelvic trauma. Other services are even more specialist, and our family HIV care service and expertise in bone marrow transplantation for non-cancer diseases mean we treat people from across the country.

St George's is one of the four major trauma centres for London, and home to hyper acute stroke and heart attack centres. We operate one of London's four helipads, which means we treat some of the most unwell and severely injured patients from across the south of England.

We are a major centre for cancer services: St George's Hospital is one of only two designated children's cancer centres in London, and the seventh largest centre for cancer surgery/chemotherapy in London.

We are one of London's largest children's hospitals, with one of only four paediatric trauma units in London. St George's Hospital also hosts the only paediatric intensive care unit in south west London. We are one of the top three centres for specialist paediatric surgery in London, and a centre of excellence in foetal medicine.

St George's is also a major centre for neurosciences, and the third largest provider in London for neurosurgery. We also offer many innovative treatments for patients – for example, we were the first centre in the country to provide a 24/7 mechanical thrombectomy service, which involves surgically removing blood clots from the brain for patients who have had a stroke.

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

St George's in numbers:

We have 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.

*In late March and April 2020, in response to the developing Covid-19 pandemic, the Trust took a number of steps to increase temporarily its critical care capacity in order to meet the demand for ICU beds from patients requiring ventilation.

Performance Report

Performance Report – Overview

Annual performance statement from the Chief Executive

As ever, I am proud to say I am Chief Executive of St George's University Hospitals NHS Foundation Trust. As I write this introduction, it is incredible to think another 12 months have already passed. We have made significant progress as an organisation during the last year – although I am equally aware that further improvements are required.

During the closing weeks of 2019/20, St George's, like all NHS organisations across the country, faced the unprecedented challenge of responding to the global Covid-19 pandemic. I am proud of how our staff responded to that challenge, how they stepped up our critical care capacity at pace to ensure we could care for our most unwell patients, and how they have worked tirelessly to keep our patients safe. Covid-19 has already had a profound impact on the Trust in the short-term, but its effects will be felt even more so over the coming months and years as we embrace far greater cross-system working, cooperation with other hospitals and with primary and community care, to integrate services for patients, make greater use of technology and expand our provision of virtual clinics.

In this overview of our performance over the past year, I set out a short, high-level summary of our vision and strategy as an organisation, our objectives and how we have met them – and where we have fallen short and have work still to do. I hope this provides a helpful summary for you to understand St George's, our purpose, the key risks we face to the achievement of our objectives, and how we have performed during the year.

Outstanding Care, Every Time

In April 2019, we published our new five-year strategy which set out our vision to provide outstanding care, every time for our patients, staff and the communities we serve. Our strategy is founded on four key priorities; establishing strong foundations by getting the fundamentals in place, particularly in relation to culture and quality improvement; delivering excellent local services to the people of Wandsworth and Merton, with care built around our patients' lives and using the latest technology; closer collaboration with our partners to deliver joined-up and sustainable services for people across south west London; and being a provider of leading specialist healthcare for people in south west London,

In April 2019 we published our five year strategy

Surrey, Sussex and beyond. During 2019/20, our Board has approved a range of supporting strategies that will assist us in realising our ambitions, and we have already started the implementation of our new quality and safety, workforce, education, research, IT, outpatients strategies and are in the process of developing our new estates strategy. St George's is a great organisation, with a proud past, a world-class offering for patients today, and a bright future – and our new strategy sets out how we will realise our vision of providing outstanding care, every time.

The NHS is undergoing a period of very significant change. The Government's Long Term Plan for the NHS, published in January 2019, reset many of the accepted norms in healthcare and this, coupled with the impact of the ongoing Coronavirus pandemic, is already leading to radical changes in the way in which services have traditionally been delivered.

Our strategy, and our developing response to Covid-19, is reshaping how we provide care to our patients and serve the needs of our local population. But we also know that we have historic, long-term challenges we need to address if we are to realise our vision. Our ageing estate at St George's Hospital, and our fragile information technology infrastructure across all of our sites will not be solved overnight. Over the past year we have made progress in addressing these, but very significant challenges remain and targeting investment in these key areas remains a priority in the year ahead. To realise our strategy, we also need to invest in our staff, who are – without question – our most valuable asset. In the past year, we have made some progress, but we know that to realise our vision we need to radically change

the culture of our organisation – to empower our staff to perform to their best and build an open and inclusive culture that celebrates and embraces our diversity.

Care Quality Commission report and exiting quality special measures

In December 2019, the Care Quality Commission (CQC) published its detailed inspection report following their unannounced visit to the Trust earlier in the year.

The CQC praised our staff for the 'significant improvements' that had been put in place since their last inspection, and recommended the Trust exit the special measures regime for the quality of services we provide. The CQC's recommendation was later ratified by NHS Improvement, the regulator of NHS Trusts and Foundation Trusts, and this represented a major step forward on our improvement journey as an organisation and is testament to the commitment and hard work of staff across the organisation.

I was also delighted that our services for children and young people were rated outstanding by the CQC – and it was also great to see our surgery services rated good, and outpatients upgraded to a requires improvement rating. The quality of services we provide for patients is something we have continued to focus on day in, day out this year; and rightly so, as the very best organisations are constantly looking to improve, and actively seek out better ways of working.

We are not yet an outstanding organisation – and the CQC's inspection report, while greatly encouraging, also highlights areas where we know we need to do better. Investment in our estate, an issue highlighted by the CQC, is important to ensure the safety of our patients and staff. Improving the storage of records and increasing performance in mandatory training are also key. Likewise, the CQC highlighted the need to improve vacancy, sickness and turnover rates among our staff, and take further steps to address bullying and harassment and improve equality and diversity.

At the same time, if we are to be a truly sustainable organisation, we need to balance the books. Quality, operational and financial performance are inherently interdependent; while we have made great strides in improving the quality of our services and have made progress in our performance, we also need to deliver financially. For now, our CQC rating remains "requires improvement" but as we continue to implement our strategy and continue delivering the improvements to our clinical governance, operational and financial performance, estates and IT, and begin to change the culture of the organisation, I am confident that we will achieve our vision of providing outstanding care, every time.

> "I was also delighted that our services for children and young people were rated outstanding by the CQC."

Patient access to our services

Like all Trusts, we also want to ensure all patients are seen in a timely way – whatever their condition, or reason for accessing our services. The past year has seen us maintain and build on positive progress in some areas – such as cancer, where we met four of the seven core standards, namely: 31 day wait to first treatment; 31 day wait for subsequent surgical treatment; 31 day wait for subsequent drug treatment; and 62 day wait from GP referral to treatment.

However, we have yet to see the consistent and sustained improvements in performance that we need. This includes emergency care, with only 83.2% of patients being seen, treated and either admitted or discharged within four hours of visiting our emergency department at St George's during the year. This is below the national target of 95%, which very few Trusts are consistently delivering – and it is also below our own performance trajectory for emergency care agreed with our regulator at the start of the year, which is a concern and an issue we are actively addressing. We know the speed with which we see and treat our patients is key both to the effectiveness of the services we provide and to the experience of our patients.

It is now more than 12 months since we returned to reporting our 18 week referral-to-treatment data on the St George's site and over six months since Queen Mary's Hospital data was included in this. Returning to reporting was a significant milestone for the Trust and this ensures that we can better manage our waiting lists and make sure our patients receive the timely care and treatment they

need. Despite working hard to reduce the number of patients waiting more than 18 weeks for treatment, our year end position is 84.2% against a national target of 92%. Over the past year we have committed significant time and resource to tackling this challenge, but we recognise that we have more to do to make sure all our patients have timely access to the care and treatment they need. Linked to this, we continue to focus on reducing to an absolute minimum the number of people waiting more than a year for treatment.

The impact of Covid-19 during March and April 2020 on our waiting lists, however, has been significant, and means more patients than we would wish are waiting longer than they should for planned treatment.

Cardiac surgery

In March 2020, NHS England and NHS Improvement published a report by an independent external mortality review. The review, which was carried out by an independent panel of medical and surgical experts, examined the deaths of 202 patients who were looked after by the cardiac surgery service between 1 April 2013 and 1 December 2018. It concluded that there were failings in the care provided to 102 patients at St George's, and that for 67 patients these care failings either definitely, most likely or probably contributed to their deaths. The report, and a parallel report by the independent scrutiny panel for cardiac surgery at St George's, set out a number of recommendations for improving the service. The Trust accepted the recommendations in full and offered an unreserved apology for the serious failings in care, and for the fact that the care patients received fell way short of the high standards they deserved.

Queen Mary's Hospital staff (pictured) supported the emergency department at St George's during Covid-19

Since it received its first mortality alert for cardiac surgery in May 2017, the Trust has taken a number of steps to strengthen and improve the cardiac surgery service. This has included changes to improve clinical practice across the whole care pathway for cardiac surgery patients, improvements in clinical governance, strengthened leadership of the service, and work to improve culture, behaviours and professional standards. The CQC documented a number of these improvements in its inspection report of December 2019 and the fact the service is safe has been confirmed by the latest data published by the National Institute for Cardiovascular Research (NICOR) which demonstrates that the service is no longer an outlier for mortality. We have invested a huge amount of time and energy into addressing challenges within this service, and the positive changes we have seen demonstrate what can be achieved in a relatively short space of time. At the same time, we know that further improvements are needed to embed the positive changes that have been made and we are committed to this in the year ahead and will continue to provide assurance on this to NHS England and NHS Improvement and to the Care Quality Commission.

Improving our culture

Organisational culture has always been a key focus of mine, and towards the end of the year, we embarked on a project to improve the way we work at St George's, as well as to make the organisation a better place to work for staff. This work has only just begun, and it will take time to deliver results. However, we cannot simply fix our organisational culture in short order, nor should we try; and while the staff survey results published in February 2020 show some positive signs of improvement in some areas, we all feel there is still some way to go.

Investing in our estates and information technology

We recognise that our ageing estates and information technology infrastructure poses significant challenges for our staff and our patients. In 2019/20, we have continued to invest in both, with £56.6 million of capital investment committed in the past 12 months. Ward refurbishments have progressed, and we have been fortunate to benefit from

the generous support of the St George's Hospital Charity, for example in the refurbishment of Heberden ward earlier this year. We have continued to invest in addressing backlog maintenance, improving water and fire safety, taking action to respond to identified risks, for example in the refurbishment of McEntee Ward and the upgrade of its ventilation systems. Our IT infrastructure has also benefitted from investment. Not only did we complete the roll out of iClip – our new electronic patient record – to Queen Mary Hospital in September 2019, we also took steps to mitigate some of our highest risks relating to information security and resilience, and have embarked on a programme of work to implement Microsoft Office 365 across the Trust. These essential investments have helped improve our estates and IT but we know we have more to do in the coming year. But we start from a better position having also taken steps in 2019/20 to improve our assurance oversight of estates, supported by an independent estates governance review, and this has ensured we better understand and have an increased grip on the ongoing areas of risk.

Covid-19

Finally, I want to touch on Covid-19, and the short, medium and long-term impact this is going to have on the way we deliver services, and work across the health and care sector. As I write, we have just come out of the first 'surge' of Covid-19 patients through our hospitals, which staff across the organisation have coped admirably with. However, it is already very clear that Covid-19 is here to stay, and that St George's – and other hospitals and healthcare providers – will need to work in very different ways going forward.

Two of our vascular surgeons during the height of the pandemic

During 2020/21, continuing to tackle the disease will bring a number of quality, operational and financial challenges. Having stood a number of services down to expand our critical care capacity during the first peak of the pandemic, we now need to safely stand those services back up. We know that many people were fearful of coming to hospital during this time who may have needed our care; the number of patients attending our emergency department in April 2020, for example, was almost 60% lower than at the same time the previous year. A key priority in the coming weeks and months is to encourage patients to seek the care they need and ensure we provide that care in a timely way and in a safe environment. The exact impact of these changes on our financial and operational performance is difficult to predict accurately. However, there is a strong likelihood, for example, that we will need to invest in our hospital buildings and estate to account for social distancing and to ensure we are well equipped for any future surges in Covid-19 cases. This will inevitably have financial implications. The same is true of our operational performance, which might be challenged by increased demand for services, particularly in the second quarter of 2020/21 and going forward, as people start to access hospital services again following the relaxation of the lockdown.

Collaboration has never been more important, and even at this early stage it is clear that one of the long-term impacts of Covid is likely to be far greater cooperation and joint working between hospitals and across primary and secondary care, and more integrated approaches to the provision of care and patient pathways across south west London.

How we all manage and address this new reality – and the quality, operational and financial challenges it brings – is going to be the number one priority for everyone at St George's over the next year, and possibly longer. I am pleased to say, however, that it is a challenge that our excellent staff are ready for, of whom I am incredibly proud.

Jacqueline Totterdell
Chief Executive
25 June 2020

Performance report: Our objectives

In April 2019 we published Delivering Outstanding Care, Every Time – our five year clinical strategy for the Trust. It sets out how we plan to deliver our ambitions for patients, staff, and the communities we serve. Throughout the year we have also published supporting strategies in a range of areas to help make our aims a reality. You can read more about these strategies in the Accountability Report.

On a day-to-day basis, we also have six key strategic objectives which support the delivery of the strategy and are set out below, including why each is important, and what we are doing to make them happen. At the end of each objective, we have highlighted a specific project 'in focus' which encapsulates our aims. These range from our efforts to give all non-elective patients a treatment escalation plan, to our commitment to improve diversity and inclusion across the organisation.

We track our quality and operational performance against a number of key performance indicators and the Board scrutinises these on a monthly basis. Our integrated quality and performance report to the Board sets out the Trust's performance against a range of productivity measures, such as length of stay, theatre usage and discharge before 11am. It also sets out our performance on a variety of quality metrics including our safety thermometer, mortality and morbidity, incidence of serious incidents and never events, infection control, complaints, and patient feedback. We measure our financial performance through our monthly finance reporting to the Board, considering our position against our agreed control total for the year, delivery of our cost improvement plan targets, and our monthly run rate. Likewise, we consider our performance against a range of workforce metrics which include staff turnover, sickness absence, retention and agency usage. At the same time, we have established ways of reporting on our progress in implementing our strategy and delivering on our objectives through quarterly reporting to the Board.

Objective 1: Treat the patient, treat the person

Treat the patient, treat the person is one of our most important objectives, and is designed to help us provide outstanding care, every time for our patients. It is about making sure we recognise the person, not just the diagnosis, and are all individually motivated to keep patients safe at all times. It's also about ensuring we anticipate and manage the risks involved in providing patient care, including taking account of vulnerabilities such as dementia or learning disabilities, understanding our legal duty of candour, and being open when we have made mistakes. Treat the patient, treat the person is a key organisational objective, which supports the Trust's strategic priority of building strong foundations.

> "Treat the patient, treat the person is one of our most important objectives, and is designed to help us provide outstanding care, every time for our patients."

Our quality priorities

At the start of the year, we identified four quality priorities for 2019/20 to help us deliver safe, patient-centred care. These were chosen by reviewing themes highlighted from several sources, including our ward accreditation programme, progress against last year's Quality Improvement Plan, information from our Care Quality Commission (CQC) inspections, national surveys, and local and national audits. The priorities were:

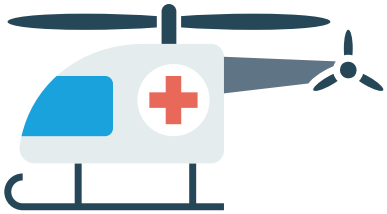
- all non-elective adults to have a treatment escalation plan within 24 hours of admission
- appropriate response and treatment for the deteriorating patient
- proper protection and care for patients who lack mental capacity
- to map, standardise, support and improve our department-level governance of quality, safety and learning.

Progress has been made against these priorities, leading to better patient care, experience and outcomes. You can read more about this in our Quality Report, but a summary is below.

At the end of March 2020, treatment escalation plans were added to iClip, our electronic documentation system. While data on its use is not yet available at the time of writing this report, the process has driven better documentation and communication between teams about an individual's care, and has also encouraged clinicians to have early conversations with our patients about their wishes in the event of their health deteriorating.

Further work on responding appropriately to deteriorating patients has seen the setting up of our critical care outreach service, which assists in the early recognition of patients becoming acutely unwell. You can read more about this service at the end of this objective section.

Work to improve the application of the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS) has continued, which is important for our most vulnerable patients and their ability to consent to care and treatment. By March 2020, 2,095 clinical staff had completed at least one of our two bespoke eLearning modules focussing on these areas. In March 2020, we planned to launch a quarterly staff knowledge audit, which was developed in partnership with our south west London partners. The audit was delayed due to the Coronavirus outbreak, but once revisited will enable us to benchmark staff knowledge of MCA and DoLS with other local organisations



1,445

helipad landings since its launch

While we have made important progress towards achieving our clinical priorities in 2019/20, we recognise that we have more to do. That is why we are continuing with the same priorities into 2020/21 so that we get these right and appropriately embedded in the organisation.

Our neotatal unit with the first UNICEF baby friendly accreditation in London

Patient-centred care

Outside our clinical priorities, outstanding examples of patient-centred care are taking place every day. In 2019/20 our neonatal unit received the first UNICEF baby friendly accreditation in London; we were revealed to have the highest patient survival rates following a kidney transplant in the country; and our surgeons performed our first ever total wrist replacement.

Our Quality Improvement Programme

Our wider Quality Improvement Programme 2019/2020 has been integrated with the work of our Quality Improvement Academy to support a shift in fostering a culture of continuous improvement. The programme continues to focus on the key areas in our previous quality plan of: strategy and transformation; culture and engagement; leadership; estates and IT; safe and effective care; flow and patient experience; quality and risk. You can read more about the work of our Quality Improvement Academy in the Accountability Report.

Alongside this work, and with the support of NHS England and NHS Improvement, we commissioned an independent review of our clinical governance. The first output of this work was in June 2019 which identified steps we needed to take to improve and standardise the work of multi-disciplinary team meetings and mortality and morbidity meetings. While recognising areas of good practice, the review made a number of recommendations

which we agreed and are now in the process of implementing. A second output of this work in December 2019, concerned clinical governance support at a corporate level, and recommended investment in the support available to the Chief Nurse and Chief Medical Officer, and to a range of corporate services including risk management and legal services. The Board approved the recommendations of these reviews and is now overseeing their implementation.

Our focus on improving quality and safety has seen our Care Quality Commission inspection rating improve from Inadequate in 2016 where we were placed in quality special measures, to Requires Improvement in 2019 – with a recommendation from the CQC that the Trust should be removed from quality special measures, a recommendation accepted by NHS England and NHS Improvement in March 2020. Exiting quality special measures represents an important step for the organisation and is testament to the commitment and work of staff across the Trust. However, there is more to do to tackle the areas that the CQC found were not up to the standard they should be. This includes making sure patient records are stored securely, that patient consent is effectively documented, and that all staff receive an annual appraisal. Improvement in these areas will be a major focus in 2020/21.

Members of our critical care outreach service

In focus: Critical care outreach service

In December 2019 we launched a new critical care outreach service which offers support for our deteriorating patients. The service has been introduced to ensure these patients on our wards receive the care they need quickly, and are assisted by specially trained staff.

Patients are referred to the team of critical care doctors, nurses and consultants who can share their expertise and provide a timely clinical response for patients. It also helps streamline and simplify the critical care pathway, and can empower ward staff from the referring team to manage the patient. The team receives all unplanned referrals for any adult critical care unit, including for patients that have undergone emergency surgery.

Dr Mo Ahmed, Lead Consultant for Critical Care Outreach, and Susan Reynolds, Matron for Critical Care Outreach, said: "After a year of development, we are delighted to launch the critical care outreach service at St George's.

"Improving care for deteriorating patients is one of the Trust's clinical priorities, so it's great news that we can now start to share our critical care expertise for the benefit of adult patients on our wards.

"The service will take time to grow and adapt to the needs of staff, but we're looking forward to expanding the team over the coming months."

"The service will take time to grow and adapt to the needs of staff, but we're looking forward to expanding the team over the coming months."

The outreach team is now working with our IT department to get a whole Trust view of patients with National Early Warning Scores (NEWS) scores greater than 5 which will enable the team to be more proactive.

Members of our outpatient department team

Objective 2: Right care, right place, right time

Every patient deserves the best possible care we can provide – and a big part of this involves making sure they are seen on time and in the right place. This objective is about making the process and operational changes to improve the flow of patients along their care pathway, from arrival to discharge, thereby giving them a better experience with us.

Streamlining treatment

Each year there are approximately 650,000 outpatient appointments at St George's, and improving these services has been a major priority for the Trust over the past 12 months. Our outpatient strategy, which we developed through the year, was agreed in February 2020 and its aim is for outpatient services to fit around our patients' lives, using the latest technology. We are making progress; with a greater use of digital capabilities and the introduction of new models to streamline care. This includes:

- the roll out of iClip (Cerner Millenium) to both St George's and Queen Mary's Hospitals, creating a single electronic record for the Trust
- more than 325,000 text reminders for appointments were sent from October to December 2019, an increase of 25,000 from the previous quarter
- the introduction of voice reminders about upcoming appointments to patients' home and mobile phones. Sample analysis conducted in December 2019 indicated that a patient who hears a voice reminder is 6% less likely to miss their outpatient appointment.

Same day emergency care

Going beyond outpatient care, we have continued to develop ambulatory services so that we can deliver more treatment on the day, meaning fewer patients have to stay in hospital overnight after planned or emergency care. In June 2019 we opened a gastroenterology and liver day unit. Evaluation has shown that it's enabled a 70% reduction in inpatient length of stay, meaning patients have to spend less time away from home. Services like these are better for the patient, and help reduce pressure on our emergency services – one of the priorities in the NHS Long Term Plan and our own five-year strategy.

Another initiative with the same aim was the re-launch of our internal professional standards in August 2019 which are designed to improve the way the whole organisation responds to the challenge of seeing hundreds of patients in our emergency department (ED) each day. The standards range from making sure the department always refers patients to the appropriate specialty; to ensuring all new patients are seen by a specialty team within 30 minutes of an ED referral being made.

Despite this progress, there are areas relating to this objective that require more work. Most significantly, we have not met the national four hour emergency care performance target throughout the year, nor have we achieved our own trajectory for emergence care performance agreed with our regulator. Against the 95% national standard, only 83.2% of patients were seen, treated and either admitted or discharged within four hours. In September 2019 the regional Emergency Care Intensive Support Team (ECIST) started to work with us to help identify the reasons for this, putting us in a better position to implement the changes we need to make to improve care for our patients. The Board has been concerned with the Trust's performance against the four hour emergency care standard and has maintained a close focus on this throughout the year.

As well as this analysis work, we are looking at innovative ways to ease the pressure on our ED, and this year we prototyped an electronic queue management system for the department where visible waiting times will improve the experience of patients and reduce interruptions for our front-line teams. We also piloted a system where patients send information about their

symptoms to doctors before their consultation in ED, saving valuable clinical time.

While 2019/20 saw us complete our first year of returning to reporting on our 18-week referral-to-treatment times, we know that further work is required to meet the national standards. Against a national standard of 92%, only 84.2% of our patients received treatment within 18 weeks of their referral. During 2019/20, we committed significant time and resource to improving our performance to ensure we provide safe and effective care, as we know that timely access to treatment is key. However, we accept there is more to do here and over the coming year will be focusing on reducing waiting times further and improving our performance. At the same time, it is clear that Covid-19 will have an effect on waiting times in 2020/21 as a result of needing to step down certain services to increase our critical care capacity during the initial surge of Covid-19 cases and because of patients' understandable concerns about attending hospital during the pandemic. In the coming weeks and months, we will be working hard with our partners to ensure patients receive the care and treatment they need and to reassure patients that they are safe to attend the Trust for treatment.

You can read an overview of our clinical performance, including emergency care, in the Quality Report.

In focus:
First major trauma centre to launch a specialist clinic

In November 2019, St George's became the first major trauma centre in the UK to launch a fully multidisciplinary major trauma clinic for our patients. The consultant-led clinic sees adult patients with multiple trauma injuries who have been discharged, and require follow up outpatient appointments within a number of specialties.

The idea of the clinic is to improve patient experience by enabling patients to see all the specialists relevant to their care within one clinical appointment to minimise the number of times they need to come to hospital, and streamline their recovery in a well-led and coordinated way. The clinic reviews patients and their rehabilitation needs, assessing bone healing as well as their psychological needs. It also allows for referrals into complex inpatient musculoskeletal rehabilitation as needed.

The team includes a consultant and specialist registrar, specialist nurse for major trauma, major trauma consultant physiotherapist, clinical psychologist and specialist rehabilitation consultants.

Stephen Friend, Major Trauma Consultant Physiotherapist, said: "This is an excellent development in our major trauma service and importantly it will improve the patient pathway by using a holistic approach. We now have the ability to improve access to the multidisciplinary team and streamline our rehabilitation referrals."

> "This is an excellent development in our major trauma service and... it will improve the patient pathway by using a holistic approach."

Some of the major trauma clinic team

Continuing to invest: McKentee ward reopens after ventilation upgrade

Objective 3: Balance the books, invest in our future

This objective is a crucial part of our longer-term ambitions, and underpins a lot of what we are trying to achieve. It is so important because if we can return to financial balance then we can invest more in our future and modernise our estate, systems, and services. It means working more efficiently as an organisation, while also continuing to provide safe and high quality care for our patients.

Our financial position

At the start of the financial year, we agreed with NHS Improvement (NHSI) a target deficit of £3 million by year end (known as a control total), achievement of which would entitle the Trust to £34.7 million in provider sustainability funding (PSF), financial recovery funding (FRF), and marginal rate emergency tariff (MRET). The Trust ended 2019/20 with a £13.3 million deficit. Although our deficit was £10.3 million more than we had agreed, we were able to receive the full PSF/FRF/MRET income due to the south west London financial position being in line with its financial plan as a whole.

You can read our detailed Annual Financial Accounts at the end of this report.

Despite this, it was extremely disappointing that the Trust missed its target deficit for the year. Achieving unsupported financial balance is a key strategic priority for the Trust and our inability to meet our target deficit this year demonstrates the scale of the challenge we continue to face in order that we can manage our finances and invest in the development of our services and estates. A deficit of £13.1 million for 2019/20 does represent an improvement on our financial position in 2018/19 (where the deficit was £45.1 million), 2017/18 (where the deficit was £53.1 million), and 2016/17 (where the deficit was £73.9 million). However, it is clearly not where we would like – and need – to be. The higher than planned deficit is mainly due to shortfalls in our cost improvement plans during 2019/20, as well as higher clinical costs linked to operational pressures than anticipated at the start of the year. Despite this, the Trust delivered £42.8m of cost improvements in 2019/20 while also providing a safe, high quality service for our patients. This included a range of efficiency measures at directorate level and additional income. Living within agreed budgets, delivering fully on our cost improvement plans, and achieving wider efficiency savings are key to becoming financially sustainable and being able to invest to improve our services and our infrastructure and this will remain a key priority in 2020/21. Having been very disappointed with the Trust's inability to meet its financial targets in 2019/20, the Board will closely monitor performance in 2020/21 to ensure we deliver financial balance.

£56.6 million

of capital investment during the year

Reducing expenditure

All the evidence tells us that we can be more efficient – from the way we manage rotas through to the way we order everything from drugs to furniture – so there are opportunities to use our resources better. Another priority area for us is to ensure we are getting the best possible use out of our operating theatres every day, and coding operations effectively to ensure we get paid for every procedure we carry out. In some areas we are making real progress. For example, spending

on agency staff is significantly down compared to the same time last year.

Going forward, a focus in this area will be utilising the Model Hospital and Getting it Right First Time (GIRFT) initiatives to drive greater efficiencies as well as improvements in patient care. We will also embrace digital technologies to support transformational change across our services, particularly in relation to how outpatient services are delivered.

Investing in our future

Our overriding objective is return to a financial surplus, so that we can invest in key services, invest in our estate and infrastructure and improve and modernise the care we provide for patients. Although we have not yet achieved financial surplus, we have still invested in important service improvements this year, with £12 million put aside for projects including our critical care outreach service which you can read more about in the Performance Report. We have also invested in our buildings and estates infrastructure, with £56.6 million worth of capital investment delivered in 2019/20.

In focus: New eRoster tool for all medical staff

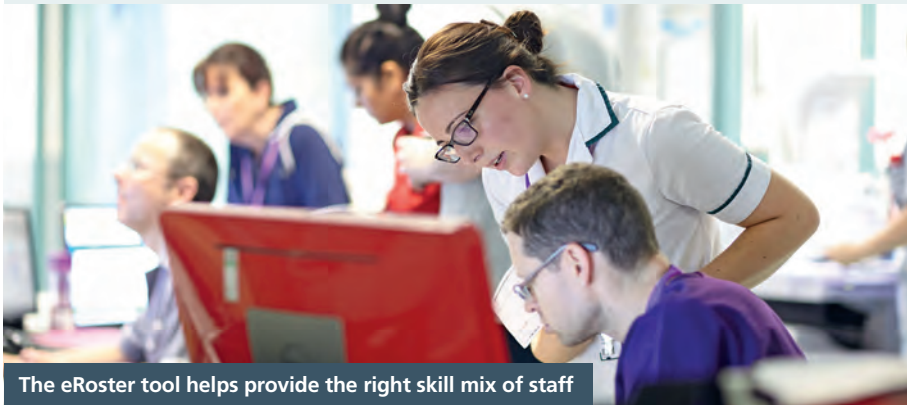
The roll out this year of an eRoster system for medical staff is a great example of how we can save money by using our workforce more efficiently, while also improving patient safety by ensuring the right mix of skilled staff are working at the right time. The fully mobile software helps manage doctors' availability, including leave, study leave, and on call rotas.

Managers can now review rosters weeks in advance and make informed decisions on future staffing requirements, with the added bonus of removing reliance on agency and Bank staff. The tool also helps increase a department's control over its spend by helping to understand how rostering decisions impact on budgets.

In addition, by giving the Trust real-time information on staff absences, managers can ensure wards are adequately staffed and shifts are allocated according to staff availability – which again is crucial to providing the best patient care possible.

For our medical staff the tool is particularly helpful as it allows the scheduling of any clinical activity – clinics, ward rounds or theatre sessions – and assigns a lead for the activity plus other supporting staff such as junior doctors, specialist and nurses. It also helps manage the impact of cancelled activities on all assigned staff. The software will continue to be rolled out to approximately 1600 medical staff across all 63 of our services.

"Managers can now review rosters weeks in advance and make informed decisions on future staffing requirements, with the added bonus of removing reliance on agency and Bank staff."



The eRoster tool helps provide the right skill mix of staff

Objective 4:
Build a better St George's

We have invested in our IT infrastructure

This objective is about improving everything from our buildings and IT infrastructure to the systems and tools our staff use. Getting these right make a big difference to staff in their day to day working lives, and ultimately help us provide outstanding care, every time for our patients. Building a better St George's is also about listening to our partners and stakeholders so that we can address our challenges together, and be more responsive to the communities we serve.

Investing in our estate

We face significant historical issues with our ageing hospital estate on our Tooting site, which we are taking action to address. Investing in the quality of our buildings, maintaining operational stability, functionality and statutory compliance is essential for us to be able to deliver safe and effective care for our patients. During this year, we have invested a total of £56.6 million of capital spending which has helped to support core infrastructure upgrades, including fire safety, water and electricity, plus theatre ventilation. A year ago water safety was a particular concern, and we have given a particular focus to efforts to make improvements here over the past year.

Major works in clinical areas have also taken place, most notably the refurbishment of Heberden ward at St George's, with the generous assistance of the St George's Charity, which you can read more about below, plus investment in our cardiac catheter laboratories.

Alongside this investment, we have also taken action to improve our governance on estates issues to ensure that we understand fully the sources of assurance, ongoing areas of material risk, and the progress on actions to address these. The Board has played a key role in this process. In April 2019, we established a sub-group of the Finance and Investment Committee to scrutinise and provide enhanced oversight of our estates governance and assurance. This proved effective and this additional oversight has ensured that the Board has a clearer view of our estates challenges and the actions needed to address them. This has enabled the Board to conclude the work of this dedicated group and re-integrate oversight of estates issues within the Finance and Investment Committee. At the same time, executive oversight of estates has been taken on by the Deputy Chief Executive and Chief Finance Officer, and a new Director of Estates and Facilities joins the Trust in May 2020.

Looking ahead, we have been developing an estates strategy for St George's in support of our clinical services strategy. Work on this is ongoing, which necessarily needs to take account of the impact of Covid-19 both on the Trust itself and the wider south west London system. We plan to publish our new estates strategy in 2020/21.

Secure and stable systems

As well as investing in our buildings, we have also made sure that our IT infrastructure is secure and stable, enabling us to increase network reliability and roll out iClip (Cerner Millenium) to St George's and Queen Mary's hospitals. As referenced above, the completion of the roll out of iClip in September 2019 was a significant moment that ensured the Trust has in place a single electronic patient record across the organisation, making it easier for staff to store patient records securely and, by supporting better management of our waiting lists, ensuring we provide safe and effective care for our patients in future. Going beyond this, a Trust-wide upgrade to Microsoft 365 and Windows 10 is underway, as is the planning and design of our new intranet which will launch in summer 2020, and the redevelopment

> "...We have also made sure that our IT infrastructure is secure and stable, enabling us to increase network reliability and roll out iClip..."

46,800

hours given by our volunteers during the year

of our learning management system which will all make the working lives of our staff easier. Covid-19 has highlighted further the importance of effective and stable IT systems, and significant work has already been undertaken to support staff working remotely and to facilitate significantly increased use of videoconferencing across the Trust during the pandemic and to introduce a wider range of virtual appointments and virtual clinics. We envisaged the latter in our outpatients strategy, which we published in February 2020, but in responding to Covid-19, we have made far quicker progress than we could have imagined only a matter of weeks earlier.

Despite this progress, many of the issues with we face with old buildings and outdated technology are long-standing and will not be solved overnight. Delivery of this objective will be reliant on our ability to further target investment into these areas so that our staff can continue to deliver some of the best care and treatment both nationally and internationally.

Working with patients and the public

St George's is committed to working with our patients and the public, so that their views help us build a better Trust. Our five year strategy – launched in April 2019 – was shaped by many, with more than 500 members of the public, staff, governors and our stakeholders attending a total of 26 engagement events. Listening to a wide range of people is so important, and we are grateful to those who have their honest views about what we do well, and where we need to improve.

In July 2019, in partnership with the Council of Governors, we launched our new membership strategy, which is designed to encourage more local people to have a voice in the running of the services the Trust provides and to enhance the quality of our engagement with our members. In March 2020 we ran our first set of Question Time events, where the public had a chance to meet our Governors and members of the Trust Board, and ask questions about how our services are run.

Our Patient Partnership and Engagement Group (PPEG) seeks to engage our patients in improvement work from the earliest stage. The group's role also includes acting as a hub to receive wider patient feedback, and evaluating areas of the Trust as part of our Ward Accreditation Programme.

More broadly, the objective also relates to our work with partners locally, regionally and nationally to provide high quality and integrated care for our patients. During 2019/20, we worked collaboratively with our partners across south west London to ensure that services responded to our patients' needs and were better designed around their lives. Closer system working is a key feature of the NHS Long Term Plan and this has been further highlighted by the response to the Covid-19 pandemic. From 1 April 2020, six local clinical commissioning groups came together and a new South West London Integrated Care System (SWL ICS) was launched, replacing the previous South West London Health and Care Partnership. Our role as an active partner with the SWL ICS will be critical in the year ahead.

You can read more about our work with partners in the Accountability Report.

One of our patient user groups

Heberden ward was refurbished to improve the environment for older patients and staff

In focus: Heberden ward refurbishment

In January 2020, Heberden, a senior health ward at St George's Hospital, was renovated with help from St George's Hospital Charity to improve the environment for our older patients and staff.

The transformation saw a larger staff base area; beach-themed patient bays and side rooms; new patient showers; new flooring; and improved lighting and heating systems. All renovations are dementia friendly, and are intended to benefit older patients during their stay.

The ward also includes a day room which is a great way to help our patients become more active and reduce isolation, and in addition there is an ice cream and hot drinks station. These areas give patients the opportunity and freedom to be able move around which can often help to drive recovery.

Tessa Longney, Head of Nursing for Specialist Medicine and Senior Health, said: "The refurbishment has made such a huge difference to both staff and patients. The newly designed bays look less clinical, and are beach-themed and colourful to help make our patients feel more relaxed and comfortable during their stay.

"I am so pleased to say we now have two walk-in showers on the ward – we didn't have any shower facilities previously. Their larger size makes them more accessible for patients who struggle in smaller spaces."

Louise Clancy, Senior Sister, added: "The ward also includes a day room which is a fantastic way to help our patients become more active and reduce isolation. Patients can use the day room to socialise and have a chat, play games, watch old films or listen to music together.

"Feedback from staff, patients and their families has been overwhelmingly positive and we are so grateful to everyone who has been involved in the transformation."

"Feedback from staff, patients and their families has been overwhelmingly positive."

We strive for a culture that celebrates diversity

Objective 5: Champion Team St George's

Our staff are our most valuable asset, and are consistently seen as such by the public and our wider stakeholders. Delivering this objective means investing in and supporting our staff, and becoming an employer of choice in south west London. Both our workforce and education strategies were published in 2019/20, and they set out our ambition to have an empowered workforce that is both modern and flexible, with a culture that empowers and supports people to deliver their best and which values and celebrates our diversity. The Staff Report provides more detail about how we are responding to the outcomes of this year's NHS Staff Survey.

One of the objectives in our workforce strategy is to maximise the opportunities of new roles. This year we have introduced and continued to invest in ground breaking training programmes for roles that will play a significant part in supporting our medical staff. Some of these are outlined below.

Advanced Clinical Practice

We support our non-medical workforce to operate at the top of their licence at an advanced clinical level with the Advanced Clinical Practice MSc funded by the apprenticeship levy. Staff from dietetics, physiotherapy, occupational health, and nursing have taken the course this year.

Nursing Associate Programme

Our Nursing Associate Programme continues to go from strength to strength. It is designed to bridge the gap between existing health care assistants and registered nurses. Nursing associates are registered with the Nursing and Midwifery Council (NMC). We continue to be the lead employer in the south west London Nursing Associates Consortium. This year, a further 18 of our nursing associates registered with the NMC. 2019 also saw our first cohort of seven direct entry nursing associate students from Kingston University.

Physician Associate Programme

We continue to support the personal and professional development of physician associates. They are healthcare professionals specifically trained in the medical model to deliver care to patients, under the supervision of, and in partnership with, our doctors. This year, the London Affiliation of Physician Associates conference was hosted at St George's.

Senior Nurse/ AHP Manager Development Programme

2019/20 has seen the development of our senior ward sisters and team leaders with the roll out of another cohort of the Band 7 Leadership Programme. This year we have broadened out applications to ensure a 50:50 split between nurses and allied health professionals, ensuring a strong multi professional focus.

Developing our leaders

The St George's Leadership Academy supports managers across the Trust who want to develop their skills, and staff who are interested in progressing to become a leader. Courses range from the entry-level, one-day Introduction to Management, right through to the degree-level Apprenticeship in Leadership.

Apprenticeships

In October 2019, we applied to be on the Register of Apprenticeships Training Providers (RoATP) to become a supporting provider. Working with South Thames College, we are now

Staff attending one of our Black History Month events

4,923

staff completed the 2019 NHS Staff Survey

entitled to run the new, Level 4 Mammography standard, which attracts students from all across the country.

Other new apprenticeships introduced this year include Pharmacy Level 2; Clinical Leadership Level 7; Advanced Leadership Level 7; and Graduate Information Management and IT Level 4.

These apprenticeships are a great way to upskill our staff, and will also help us reach our public sector target of employing an annual average of 2.3% of our workforce as apprentices.

Equality and diversity

Although many staff say that St George's is a good place work, they also tell us that there are recurrent key issues that we need to address – embracing equality and diversity, improving staff engagement, and ensuring we create a culture of zero tolerance to bullying and harassment. While we have made some progress over the past year, this has been not quick enough or of the scale we want – and need – to achieve. So for 2020/21 one of the Trust's foremost priorities will be to drive the meaningful change that is needed across the organisation and take decisive action to tackle discrimination of all types and ensure we develop the inclusive culture that the Board is committed to achieving.

In 2019/20, we re-launched four staff networks, namely Women's; Disability and Wellbeing; Black, Asian and Minority Ethnic (BAME); and LGBTQ+. These networks, which are sponsored by members of the executive team, have organised some very popular events celebrating the diversity of St George's including Diwali, Black History Month, International Women's Day, and NHS Rainbow badge launches. You can read more about diversity and inclusion at St George's in the Accountability Report.

"We want our staff to feel safe and supported in speaking up about concerns. In the past year we've made it easier to raise concerns..."

We want our staff to feel safe and supported in speaking up about concerns. In the past year we've made it easier to raise concerns, including to our Freedom to Speak Up Guardian, and have run a poster campaign that highlights our approach to zero tolerance and signposts people to our Bullying and Harassment Listening Service. Despite progress in this area, we still have much work to do in creating a workplace where all staff feel valued and respected and able to raise concerns safely and without detriment. We want to become an organisation that demonstrates outstanding speaking up practice, but we know from the NHS Staff Survey that our staff have concerns about speaking up. This will be a major focus in the year ahead.

We are reviewing our Freedom to Speak Up function and putting in place plans to address staff responses in the annual NHS Staff Survey.

In focus: Culture champions – Driving change at St George's

In January 2020 we launched our culture change programme. The purpose of the programme is to properly understand and improve our culture at St George's.

To date, a team of 20 volunteer culture champions have put themselves forward to meet regularly with our Chief Executive and wider staff to help design ways of identifying what our organisational culture is – including its strengths and weaknesses – and where we need to make positive changes.

At the beginning of the initiative, some of our culture champions stated what they hope to achieve in their news roles.

"I want to work in a happy place, where people get on. I love my job, but if people aren't enjoying theirs, I want to do my bit to help." – Orthopaedic Consultant.

"I am really interested in organisational culture, and the relationship between staff and patients. Happy staff should mean happy patients - and this is what I want to try and support." – Volunteer, Emergency Department.

"I really want to be part of the process of change – and making sure Queen Mary's staff are involved in the process."
– Medico-legal Officer, Queen Mary's Hospital.

> "Many of our staff tell me how much they enjoy working here, but I also know some of them feel our organisational culture puts barriers in their way."

The team will analyse its findings, present back to the Trust Board, and then focus on action – the concrete steps that must be taken at every level if we want real change to happen.

Chief Executive Jacqueline Totterdell said: "This is so important to our future, and it is something that I've felt we've needed to do for some time. Many of our staff tell me how much they enjoy working here, but I also know some of them feel our organisational culture puts barriers in their way. I want to create a team of culture champions to help understand this better, so helping us deliver the changes we all want to see."

Our culture champions (pictured) will work on understanding and improving the culture at St George's

Our trauma and orthopaedic team was the first in the UK to use a new tibial nail

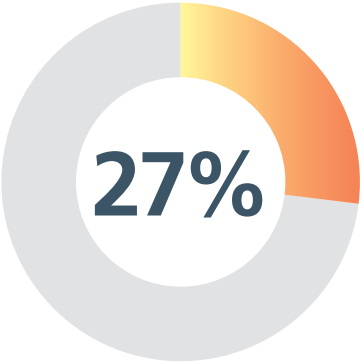
Objective 6: Develop tomorrow's treatments today

Our sixth and final objective is about our commitment to research, innovative practice, and pioneering care. We have a proud history of being at the forefront of developing cutting edge treatments for the benefit of our patients, and to help us attract the best people into the organisation. In January 2020, we published our five year research strategy which commits to making research everybody's business, and aims to make St George's a more supportive environment for conducting research work. Delivering this objective means working closely with our partners at St George's University of London and we are fortunate to be co-located, and have such strong links at all levels, with the medical school.

Growing our clinical studies

In July 2019, the National Institute of Health Research (NIHR) announced that St George's has grown its portfolio of research studies by 27% over the past three years. In 2018/19, we had 274 ongoing clinical studies, up 36 from 238 in 2017/18. In 2016/17, we supported 215 studies. We were also placed fourth for the number of research participants we recruited. In 2018/19, 13,102 participants took part in clinical studies – an increase of 107% on the previous year and the most ever during a 12 month period.

More recently, according to National Institute for Health Research (NIHR) data, the Trust, in partnership with St George's, University of London, is leading the country for urgent public health studies into Covid-19. At the time of writing there are 13 studies being carried out on our site, bringing together clinicians and researchers from across both organisations to improve the treatment, prevention and diagnosis of Covid-19. Along with research into developing vaccines and testing different treatments, St George's is also leading on studies to develop rapid antibody tests and understanding whether pregnant mothers can pass Covid-19 onto their babies in the womb.



increase in research studies over three years

Tomorrow's treatments

These trials may be the treatments of tomorrow, and there have been examples this year of St George's being at the forefront of patient care. In December 2019, a baby with a very rare cyst in its mouth was safely delivered, with specialists removing the mass shortly afterwards so it could feed. In March 2019, our trauma and orthopaedic team became the first in the UK and second in the world to use a new type of tibial nail on a patient involved in a lorry accident. Our reputation for being at the cutting edge of care and treatment was further cemented in September 2019 when St George's was named Innovative Trust of the Year by the Health Innovation Network (HIN) at their annual awards ceremony.

While we are pushing the boundaries in some areas, there is more do be done in the domain of research and development. Currently, the vast majority of research is consultant

led, with limited numbers of allied health professionals (AHPs) and nurses leading studies. To address this, we are taking part in a national programme (NIHR 70@70) aimed at increasing the involvement of these staff groups in research, as well as leading a Trust-wide project to support uptake in these areas.

Strengthening partnerships

Our key relationship with St George's, University of London, enables us to work together on clinical research, where we have a growing role. In August 2019 we strengthened another partnership when our Chief Executive Jacqueline Totterdell was appointed Chair of the Clinical Research Network (CRN) South London Partnership Board. This will mean closer working on the network's plans to develop clinical research across south west London.

In focus:
First ever total wrist replacement at St George's

In June 2019, St George's performed its first ever total wrist replacement. Our Trust is one of the few centres in the UK to offer this type of surgery, which is complex and requires enormous precision. Our surgical team worked for four hours to remove damaged cartilage and bone in the patient's wrist and insert an artificial metal joint. Traditionally, the only surgical option available has been to fuse the wrist, which removes the pain but also restricts wrist-movement. Offering this type of surgery is life-changing for patients, and enables the patient to use their hand again after years of pain. Patient Julie Richardson, said: "I'm delighted with the result and so grateful to Miss Umarji and the whole team at St George's who were involved in my surgery and aftercare. For years I struggled to do everyday tasks, so to have a wrist I'm able to move again is really life-changing.

Patient Julie and the surgeons who performed her total wrist replacement

> "The consultants explained to me that it was going to be the first ever time they'd carried out this type of procedure but it didn't worry me..."

"The consultants explained to me that it was going to be the first ever time they'd carried out this type of procedure but it didn't worry me at all – I trusted them and knew they wanted it to be a success just as much as I did."

Major risks to Trust's objectives

Successful delivery of our strategy means understanding and taking steps to manage and mitigate key strategic and organisational risks. The Trust maintains both a Board-level Board Assurance Framework and a Corporate Risk Register, which is informed by risk assessments across the organisation. This is supported by our risk management policy and processes.

The purpose of the Board Assurance Framework (BAF) is to provide the Trust Board with assurance in relation to the risks to the delivery of the Trust's strategic objectives when considered alongside the Trust's risk management processes, the Annual Governance Statement and the programme of internal audit.

The BAF is reviewed by the relevant Board Committee on a monthly basis and the Trust Board reviews it on a quarterly basis, looking at the key risks in relation to the Trust's six strategic objectives. We revised the BAF to reflect the risks associated with delivering our strategy published in April 2019 and as we start 2020/21, that process of refreshing the BAF in light of developments internally and in our external environment is underway. In 2019/20, the sixteen strategic risks from the BAF as identified by our six organisational objectives were:

1. Treat the patient, treat the person

- Our ability to create an environment and embed an approach to quality improvement which minimises the occurrence of harm to our patients.
- Our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care.

2. Right care, right place, right time

- Our patients wait too long for treatment.
- Our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated.
- We fail to make progress in delivering our clinical services strategy.
- We do not make progress in increasing integrated and transformed services as a system across south west London in line with the South West London Health and Care Partnership priorities.

3. Balance the books, invest in our future

- We do not develop plans to achieve unsupported financial balance within three years.
- We are unable to source sufficient capital funds to support investment in areas of material risk.

4. Build a better St George's

- We are unable to deliver an estates strategy that supports the delivery of our clinical services strategy.
- We do not improve our estate to provide a safe and compliant environment for our patients and staff.

5. Champion team St George's

- We are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care.
- We are not seen as a diverse and inclusive employer by our staff.
- We are unable to sufficiently address issues of harassment and bullying.
- We are unable to recruit, train and sustain (retain) an engaged and effective workforce.
- We are unable to develop new and innovative roles/ways of work to deliver our Trust clinical strategy.

6. Develop tomorrow's treatments today

- We cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.

Strategic risks on the Board Assurance Framework are assigned to Committees of the Board which provide oversight of the risks and actions being taken to mitigate them. The Committees report on their role in overseeing the risks assigned to them in their reports to the Board. In 2019/20 the Board directly oversaw two strategic risks – progress in implementing the clinical strategy and working across the system to provide integrated care. The Board received the full BAF at its private meetings and high level updates at its public meetings. Following feedback from the CQC, we have adjusted our processes and now present the full Board Assurance Framework at our public Board meetings.

Performance Report: Financial analysis

For the financial year 2019/20, the Trust remained in financial special measures at the request of NHS Improvement (NHSI). This followed us reporting a deficit of £73.9 million in 2016/17, £53.1 million in 2017/18, and £45.1 million in 2018/19. Financial special measures means NHSI undertakes regular oversight and review of our financial plans and performance.

For 2019/20, we developed a plan to reduce the deficit to £3 million, an improvement of £42.1 million on the previous year. Actual performance for the year was a deficit of £13.1 million (including Provider Sustainability & Financial Recovery Funding) representing an improvement on 2018/19 of £31.8 million, but an adverse variance from the plan of £10.1 million.

St George's achieved £42.8 million cost savings and efficiencies target, £3 million short of the 2019/20 plan of £45.8 million. The Trust was £0.9 million short of plan in income, and expenditure was overspent by £9.4 million, which related to shortfalls in pay cost improvement programmes (CIPs) and overspends in medical pay budgets.

Cost Improvement Programme 2019/20

The Trust set itself a cost improvement plan (CIP) target of £45.8 million for 2019/20. This represented 5% of our turnover. This was set as a challenging yet achievable level of efficiencies given the need to reduce the overall deficit.

This target was substantially 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 our cost improvement programme to improve quality, safety and efficiency. Together, these actions enabled the Trust to deliver a cost improvement programme of £42.8 million.

Provider Sustainability Funding (PSF), Financial Recovery Fund (FRF) and Marginal Rate Emergency Tariff (MRET)

The Trust received the annual PSF/FRF/MRET from NHSI following acceptance of the £3.0 million planning deficit.

Performance against plan

Delivering the 2019/20 financial plan represented a major challenge for the Trust. It required us to make material improvements to the financial run rate. As indicated above, the plan was seen as challenging but achievable. Across 2019/20, we reported many positive actions, notably the delivery of the majority of cost improvement plans. However, the challenges in elective activity and overspends in medical pay, caused the plan to be missed. The Trust was able to identify a range of non-recurrent actions to help support the reported position.

Capital expenditure

The Trust spent £56.6 million of capital in 2019/20. This was funded from internally generated funds, capital loans and additional one off funding. The capital funds available to us were used to support ongoing investment in IT, our estate and medical equipment.

This level of funds meant that the Trust was able to address a full investment programme.

Finance leases

We used 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 2019/20 we took out new finance leases with various leasing companies for equipment with a capital value of approximately £3.1 million.

Cash flow

We began the financial year with £3.2 million of cash and cash equivalents. During the year, cash balances increased slightly by £0.2 million to £3.4 million, in line with the cash target in place. For details of our net cash balances, see the Financial Accounts at the end of this report.

Financial performance against plan

	2019/20 Actual £ millions	2019/20 Plan £ millions	Variance £ millions
Total income excluding capital & PSF	871.0	837.4	+33.6
Expenditure excluding donated	-919.0	-875.1	-43.9
Adjusted financial performance	-48.0	-37.7	-10.3
Capital donations/depreciation/prior PSF	+0.2	-0.3	+0.5
PSF/FRF/MRET	34.7	34.7	-
Surplus deficit including PSF/FRF/MRET	-13.1	-3.3	-9.8
Adjusted financial performance incl PSF/FRF/MRET	-13.3	-3.0	-10.3

Financial performance comparison

	2019/20 Actual £ millions	2018/19 Actual £ millions	Change £ millions
Total income excluding capital & PSF	871.0	836.7	+34.3
Expenditure excluding donated	-919.0	-888.7	-30.3
Adjusted financial performance	-48.0	-52.0	+4.0
Capital donations/depreciation/prior PSF	+0.2	-0.3	+0.5
PSF/FRF/MRET	34.7	6.9	+27.8
Surplus deficit including PSF/FRF/MRET	-13.1	-45.4	+32.3
Adjusted financial performance incl PSF etc	-13.3	-45.1	+31.8

Cash flow

	2019/20 £ million	2018/19 £ million
Operating surplus/deficit before finance and other costs	-1.4	-34.9
Add back non-cash and expense	22.8	23.3
Increase/decrease in operating activities	-23.6	11.8
Net cash generated from operating activities	-2.2	0.2
Net cash generated from investing activities	-34.4	-34.1
Net cash generated from financing activities	36.8	33.6
Net increase / decrease in cash	0.2	-0.3
Total Cash and equivalents at 31 March	3.4	3.2

Charitable funding

We received £0.6 million from charitable sources during the year, principally from St George's Hospital Charity.

Private Finance Initiative

We entered into a Private Finance Initiative (PFI) contract in March 2000 for the exclusive use of Atkinson Morley wing on the St George's Hospital site over a 35 year term. The capital value of the building is approximately £53.4 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, we are required to assess the value of our land and buildings. This exercise is carried out at the end of each financial year. The annual revaluation of our land and buildings led to a £2.9 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 £104,100 in audit fees in relation to the statutory audit of the Trust to 31 March 2020.

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 our performance.

One of our many wards that had to be transformed in response to Covid-19

Contracts with commissioners

Following the emergence of Covid-19, operational planning guidance has been suspended and commissioning contracts set at block values for each commissioner. This provides secure income to Trusts while the pandemic is in effect.
This arrangement has been preliminarily put in place for the first four months of the financial year 2020/21. Guidance from NHS England and NHS Improvement (NHSE&I) is that Trusts will be funded for all Covid-related costs and are not expected to have deficits, or require working capital loans. Funding provided is calculated so that Trusts can break even after the impact of inflation, and without an efficiency requirement.

A range of mitigation actions are in place to ensure the Trust meets its break even control total next year. These include:

- the Trust Board approving the financial plan prior to the start of financial year
- budgets being agreed with all budget holders
- exploring the methodology for setting 'top-ups' for the Trust to break even.

These are based on monthly run rates (M8-10) where significant non-recurrent benefits are included.

Processes to manage cash and working capital

There is a risk that we do not have up to date processes to manage cash and working capital and risk 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

Our 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 Health and Care Partnership)
- investment in digital transformation and analytical capacity.

Cost Improvement Programme 2020/21

CIPs are not required as part of the suspended operational planning guidance for Covid-19 in 2020/21 as mentioned above.

Procurement

We are continuing to improve our performance against Model Hospital metrics and this has been reflected in the Procurement League Table position which has improved from 69th to 25th – the top quartile.

The focus of procurement in 2019/20 has been split over the following main areas:

- Contract management – Creating and beginning to implement a contract management framework to ensure that maximum value is driven out of the contracts the Trust awards, and that the effective re procurement activities take place prior to contract expiry. This also includes consolidation of supplier contracts including with partners across south west London.
- Operational savings – Reducing the operational cost of running the Trust divisions whilst maintaining quality of our services, through the reduction of costs in areas where service requirements can be safely reduced. We are performing well within the price benchmarking element of Model Hospital. Price performance is above peer and national median targets.
- Improving data quality and systems – new systems have been implemented that have enhanced the spend and contract data available to the Trust. In addition, we have implemented a new Inventory Management System across the Trust and in theatre environments to manage our stock levels and reduce over stocked items. This enables more efficient identification of cost improvement opportunities or for commercial advantage.
- Collaboration – Working with other acute Trusts across south west London, strengthening collaborative and joint working, including shaping the future strategy and operating model of procurement across the sector. In addition, supporting to shape the national strategy with partners at NHS Supply Chain.

Recurring savings initiatives

In 2019/20 the Trust achieved recurring savings initiatives through a range of pay, non-pay and income savings plans. These included savings on medicines optimisation, procurement, workforce programmes in nursing, AHP, medical and administration, and increases in patient care and non-patient care income. The Trust also led and participated in the south west London pathology and procurement networks, which contributed to our and other Trusts' cost improvement programmes.

> "In 2019/20 the Trust achieved recurring savings initiatives through a range of pay, non-pay and income savings plans."

Political and charitable donations

We have not made any political or charitable donations during 2019/20.

Countering fraud and corruption

We have a counter fraud and corruption policy. Counter fraud arrangements are reviewed

during the year by the Local Counter Fraud Service (LCFS). The LCFS undertakes an ongoing 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.

Transactions with related parties

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

Remuneration of senior managers

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

Anti-bribery and fraud policies and issues

One of the fundamental objectives of public sector organisations is the appropriate use of public funds. The vast majority of people who work in the NHS are honest and professional; they believe that fraud and bribery are wholly unacceptable. Besides the impact on professional morale, bribery and fraud ultimately leads to a reduction in the resources available for patient care.

NHS Counter Fraud Authority (NHSCFA) and St George's are committed to taking all necessary steps to prevent fraud, bribery and corruption or, failing that principal objective, detect it early to minimise the consequences. To meet its objectives, the Trust applies a policy with a four-stage approach developed by NHSCFA to tackle fraud and bribery.

Statement of 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 £13.1 million for the year ended 31 March 2020 (after adjusting for donated capital income and donated depreciation). During the year the Trust borrowed £32.8 million under interim revenue support facilities provided by the NHS Independent Trust Financing Facility.

The 2020/21 plan is for a break even financial position, having taken account of the underlying financial position going into 2020/21 and the block contract arrangements in place in relation to the Covid-19 pandemic.

> "...the directors have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future."

Currently the Trust is exploring the methodology used to calculate the appropriate funding allocated, as at present a gap exists that would cause a material risk to delivery of this plan. From a cash perspective, there is not expected to be any risk to the financial plan in the early months as two months of block payment have been received in April 2020. As the financial year progresses this risk may increase again depending on progress with the gap mentioned above.

The Trust has received notification that loans will be converted to PDC from April 2020. Total loan value converted to PDC is £51.6 million for Capital Loan and £263.4 million for Working Capital, a total of £315 million. This will attract the PDC charge of 3.5%. The Trust is not expecting to borrow any revenue support loans in 2020/21.

After making enquiries, the directors 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 2019/20, 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.

The Trust is in the process of producing a green plan

Performance Report: Environmental analysis

In 2019/20 the Trust's electricity and gas costs were £5.0 million, which was an increase of £209,000 in comparison to 2018/19. However, across our sites there was a 2.6% rise in consumption of gas and electricity utilities this year, and along with the inflating gas and electricity price, reflecting the increase in cost.

The Trust produced over 45m kWh of electricity, of which we exported 2.4m kWh back to the national grid, contributing towards the combined energy savings of £1 million for the year. We are also on track to reduce our emissions by 2050 to meet national demands.

The Trust is in the process of producing a green plan which will provide energy reduction schemes throughout the Trust in order to meet our carbon reduction plan.

Our Energy Centre opened in June 2018 has been in operation providing not just financial savings for the Trust, but also ambitions of carbon reductions. It houses two combined heat and power (CHP) units that deliver almost all of the energy requirements to run St George's Hospital.

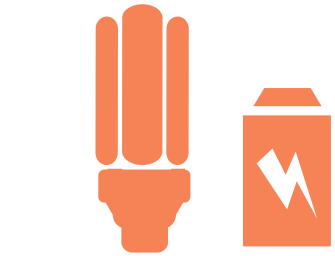
> "As part of our Energy performance Contact, we installed four new boilers, which had been in place for 40 years."

As part of our Energy Performance Contract, we also installed four new boilers, which had been in place for 40 years, a highly efficient chiller system and more energy efficient lighting and controls.

As part of our developing schemes, we have recently upgraded our existing plate heat exchangers to utilise more available low temperature hot water from the CHPs. This upgrade has further simplified our controls in place increasing the efficiency of our hot water systems across the site.

We continue to invest in our infrastructure, replacing existing 40% of the St George's Hospital site with new LED lighting, with a view to installing LED lighting throughout the hospital over the next three to four years.

We have appointed a sustainability manager and along with our Assistant Director of Estates and Facilities, provide the Board level lead for sustainability. This ensures that sustainability issues have visibility and ownership at the highest level of the organisation.



£1 million of energy savings during the year

Jacqueline Totterdell
Chief Executive

25 June 2020

Accountability Report

Accountability Report: Directors' report

Delivering outstanding care, every time

Our vision is to provide outstanding care, every time for our patients, staff, and the communities we serve. It reflects our commitment to continually improve the quality of care we provide, achieve financial sustainability, and ensure that care is delivered to our patients by an engaged, empowered and highly skilled workforce.

As well as guiding the organisation in achieving this ambition, the Board ensures the Trust upholds the qualities that make the NHS what it is, while also adapting to a period of significant social, demographic and technological change. The NHS Long Term Plan has re-set accepted norms in healthcare delivery, and the Trust's strategic priorities take account of this national agenda to give patients greater access to personalised care and treatment.

We are also dealing with financial, operational and quality challenges. As noted above, the Trust remains in financial special measures, and will report a deficit of £13.3 million in 2019/20.

However, as set out in the Performance Analysis section of this report, St George's has also seen a number of areas of improvement during 2019/20 and we have an ambition to build on these, taking our workforce with us. Throughout this report are many examples of the arrangements in place to ensure our services are well-led, and that we can continue our improvement journey during 2020/21 and beyond.

Leadership through strategic direction

The Trust's Board of Directors are accountable, through the Chairman, to NHS England and NHS Improvement and to our Council of Governors, and we are collectively responsible for the strategic direction and performance of the Trust.

Our five year strategy – Delivering outstanding care, every time – was published in April 2019. It is founded on four key priorities: providing strong foundations; delivering excellent local services; closer collaboration; and offering leading specialist healthcare. These are the priorities that will drive the focus of the Board, and inform the key decision we make.

During 2019/20, the Board agreed a number of supporting strategies to help us make these priorities a reality. These supporting strategies cover research; digital; workforce; education; quality and safety; and outpatients; with an estates plan also being developed.

At the same time, as noted above, we recognise the challenges of turning both the NHS plan and our own strategy into reality. Many of the long-standing issues we face – including our aging estate at St George's Hospital, and fragile information technology infrastructure cannot be solved quickly; and the delivery of our supporting strategies will be dependent on our ability to target investment in key aspects of patient care.

The Trust Board is confident that all directors are appropriately qualified to discharge their functions effectively, including 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 skills and experience necessary to deliver the Trust's vision and strategic objectives.

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.

Our regulatory position

The Care Quality Commission (CQC) published its latest inspection report for St George's on 18 December 2019 following its unannounced inspection of core services in July 2019 and its well-led review in September 2019. The Trust maintained its overall CQC rating of Requires Improvement, but we welcomed the news that the CQC recommended to NHS England and NHS Improvement that St George's be taken out of quality special measures, a recommendation endorsed by NHS England and NHS Improvement in March 2020.

The CQC found 'significant improvements' in many services across the Trust, in particular, services for children and young people which were rated Outstanding. Surgery at St George's improved its overall rating to Good. Our outpatient

Jungle ward paediatric team. Our children's services were praised by the CQC

service – a key focus area for the organisation in recent years – improved its rating to Good for safety and Requires Improvement for well-led.

A number of other services improved their ratings, with many examples of best practice highlighted in the CQC's report. Our emergency department at St George's was praised for the team's approach to research, the department's blood testing 'hot lab', as well as the 'point of care' flu testing service. The inspectors also noted innovations in surgery, such as the Trust's Get Set 4 Surgery initiative for patients awaiting operations, plus the use of the latest tibial nail technology in orthopaedic surgery.

As well as areas of good practice, the CQC also identified some areas for improvement – including making sure patient records are stored securely, and that patient consent is effectively documented. The Trust developed responses to two requirement notices and submitted these to the CQC, as required, by 16 January 2020. A wider plan to address areas for improvement has been developed and put into action, with close oversight from the Board's Quality and Safety Committee. You can access the CQC's full report here: https://www.cqc.org.uk/location/RJ701#accordion-1

The CQC's report is testament to how far we have come in recent years, and shows that we are pushing closer to delivering outstanding care, every time. However, the challenges facing us remain, particularly in relation to our financial position, and achieving consistency in the levels of quality across all of our services.

"The CQC's report is testament to how far we have come in recent years, and shows that we are pushing closer to delivering outstanding care, every time."

Cardiac surgery services at St George's

As we have set out in previous Annual Reports, one of the key services in which we have been making significant changes to improve safety, governance and culture is our cardiac surgery service. During 2019/20, the Trust continued to take steps to deliver improvements within cardiac surgery.

The service was inspected by the Care Quality Commission (CQC) in July 2019, as part of a wider unannounced inspection of the Trust. The CQC's inspection report was published in December 2019. In its report, the CQC found that the Trust had taken action to improve all aspects of the leadership and culture of the cardiac surgery service. The CQC also found that 'there had been significant improvements to the leadership of the service' and that 'following several years of cultural challenges in cardiac surgery, the situation was much improved'.

The cardiac surgery service at St George's is safe. This was confirmed during 2019/20 by the National Institute for Cardiovascular Outcomes Research. The institute confirmed that the Trust was no longer in alert status for the period April 2015-March 2018, the latest period for which national data has been published. The Trust has previously received two NICOR alerts – in May 2017 and April 2018 – because, at that time, our three year rolling survival rate outcomes for cardiac surgery were two standard deviations below the national mean. As a

result of improvements within the service, cardiac surgery outcomes are now back within the expected range, when compared with the 31 other centres nationally performing cardiac surgery.

In March 2020, NHS England and NHS Improvement published the findings of an independent mortality review of cardiac surgery services at St George's. The review was commissioned by NHS Improvement in December 2018, and carried out by an independent panel of medical and surgical experts who examined the deaths of 202 patients who underwent heart surgery at St George's between April 2013 and December 2018. The panel's report concluded there were failings in the care provided to 102 patients at St George's during this period, and that for 67 patients these care failings either definitely, most likely or probably contributed to their deaths.

The Trust wrote to the relatives of heart surgery patients included in the review in early 2019. Families were contacted by the Trust again prior to publication of the report – to both inform them of the panel's findings in relation to individual patients, as well as to offer support and a meeting.

The Trust accepts in full the findings of the review and apologises unreservedly for the failings in care that occurred in the past, and while the service is now safe, we remain committed to delivering further improvements, for the benefit of patients and staff.

Changes introduced at St George's over the past two years include the appointment of a senior cardiac surgeon from outside the organisation to lead the service; all new heart surgery cases being reviewed by a multi-disciplinary team of healthcare professionals; plus the introduction of a new system enabling the Trust to monitor mortality and morbidity data in real-time.

NHS England and NHS Improvement also published a report published by a separate independent scrutiny panel set up in October 2018 to act as a 'critical friend' to support and challenge the Trust as it implemented a series of actions to improve the service, and maintain safety. We accepted the recommendations of the panel, have made good progress in implementing them, and are grateful for the support we received.

A patient meets our Trust Governors

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 engagement is key to helping us ensure we deliver services to best meet the needs and preferences of the populations we serve.
Since we reset our approach to patient involvement at St George's in 2018, our Patient Partnership and Experience Group has continued to help us focus on the principles and benefits of patients working as partners with the Trust. Over the year we have increased the number of our condition-specific user groups so that patients can join to become more involved in shaping the services they use. We have also held various listening events, and an Experience of Care Day that showcased how patients are helping to improve our services.

Being an NHS Foundation Trust means we can also draw on the views of our members. The St George's membership community includes more than 12,000 patients and members of the public, who play an important role in ensuring the hospital meets the needs of the people it serves, as well as the 9,000 staff who are also members of the Trust. Our members elect the majority of our Council of Governors who will represent the views of the membership to our Board. Further details about our engagement with the Trust's

Our focus is on being efficient while still providing high quality care

members, including details of our new membership strategy are set out in the Organisational Structure and Governance section.

Embedding quality improvement

Although there is a real desire within the organisation to make our services safer and better for patients, it is clear that staff have not always had access to the tools and techniques they need to make this happen in a sustainable way.

However, over the past year, the work of our Quality Improvement Academy (QIA) has continued to make progress in embedding a quality improvement culture within the Trust, and not just for those holding formal leadership positions. The QIA, in partnership with the Institute of Healthcare Improvement (IHI) has held workshops, training, and coaching sessions for staff on how to create the right culture for continuous improvement across the organisation. This year we have supported a growing number of improvement projects that help address our quality, operational, and financial priorities.

At a senior level, the QIA has helped in the development of a divisional leadership accountability framework.

Response to Covid-19

Although we are well prepared for local and national emergencies, no strategy or training programme could have foreseen the Covid-19 pandemic that hit in March 2020. The outbreak was the biggest public health emergency in a generation, and the Trust's executive team worked at pace to ensure we developed a robust and effective response to support patients and our staff.

This involved establishing a new management structure in order to respond quickly to events as they unfolded; co-ordinating actions and assessing their impact; and ensuring staff understood and had sight of the decisions we were making.

Staff on our helipad

At a time where intensive care capacity was required on an unprecedented level, with significant implications for the delivery of other services at the Trust, and supporting national guidance was changing, clinical teams faced the challenge of adapting with similar speed. We saw incredible levels of agility and collaboration across role, function and organisational boundaries. The Board would like to thank everyone in the Trust for their dedication and commitment to helping build the strongest possible response to this challenge.

> "The Board would like to thank everyone in the Trust for their dedication and commitment to helping build the strongest possible response to this challenge."

Thank you cards from local schools

Closer collaboration and system leadership

Part of being a well-led organisation means being a proactive partner as well as a system leader in the wider health and care system, and this closer collaboration is reflected as one of the four central themes in our five year strategy. Responding to Covid-19 has also demonstrated the heightened importance of collaboration and cross-system working with our partners. As the NHS responds to this unprecedented challenge we can expect to see radical changes to the ways in which services are provided. Only by working more closely together can the NHS respond to the challenges we face to provide the best possible care for our patients. Increasingly, this will involve collaborative solutions and responses across south west London.

Even before Covid, however, we were already working more closely with our partners to ensure that patients get the right care, in the right place, at the right time. Some of these most significant partnerships are outlined below.

South West London Health and Care Partnership

We continued our work this year as a key partner within the South West London Health and Care Partnership, which is where the NHS, local councils, and the voluntary sector come together to deliver better care for the people of the region. Common themes are emerging, with more emphasis on wellbeing and prevention and on breaking down the barriers between organisations.

At system level, the Trust has been fully involved in the partnership's Programme Board; in the formation of the Integrated Care System (ICS), which was launched formally on 1 April 2020 with the coming together of the six clinical commissioning groups in the region; and in cross-system governance arrangements in areas such as urgent and emergency care, mental health, cancer, estates, workforce, and digital.

Our part in the Acute Provider Collaborative (APC) has seen us work together with other Trusts in the region where it makes clinical and financial sense to do so, turning the aims of joint working into real, tangible benefits for the four providers involved. We are continuing to see real progress in some areas. An example is South West London Pathology, set up by host Trust St George's, plus Kingston and Croydon hospitals, which this year has continued to work in partnership to provide 24/7 pathology services across south west London and beyond.

Similarly, the South West London Elective Orthopaedic Centre (SWLEOC) established by the four south west London acute Trusts and based at Epsom Hospital, is continuing to treat more than 5,000 patients a year with excellent outcomes, low complication rates and high patient satisfaction.

As well as clinical collaboration, the APC aims to tackle the region's workforce challenges, and achieve better value for taxpayers, and work is progressing on joint procurement and payroll systems across the Trusts.

At borough level, and through Local Transformation Boards, St George's has been involved in the development of local health and care plans for Merton and Wandsworth over the course of 2019/20. These focus on prevention, developing more community-based models of care, and on avoiding unnecessary trips to hospital.

West London Cancer Alliance

St George's continues to be an active and engaged member of RM Partners, the West London Cancer Alliance hosted by The Royal Marsden. As a partner, St George's has access to the national cancer funding to support innovative transformation projects which help improve survival and quality of life for local people.

Operational Delivery Networks

We are also increasingly collaborating with partner hospitals in through Operational Delivery Networks (ODNs) which focus on coordinating patient pathways between providers to make sure patients have access

The generosity of St George's Hospital Charity was particularly evident during Covid-19

to the specialist support and expertise they need. London ODNs we are part of include critical care, major trauma, renal, Hepatitis C, and neurosciences.

Clinical Research Network (CRN) South London

In August 2019, our Chief Executive Jacqueline Totterdell was appointed Chair of the Clinical Research Network (CRN) South London Partnership Board. CRN South London is part of the National Institute for Health Research and helps to increase opportunities for patients to take part in clinical research, which will lead to better treatments now and in the future.

In the last three years St George's has grown its portfolio of research studies by 27%, placing us fourth nationally for increasing the number of clinical research studies we support. One of the Trust's priorities is to develop our strength in research, as outlined in our five year strategy.

St George's Hospital Charity

2019/20 has seen renewed energy in our partnership with St George's Hospital Charity. Working closely with our staff and patients, the charity provides additional grants and donations over and above that which the NHS can provide. This year new equipment, research funding, staff support, new facilities including a staff intranet, and training have all been made available thanks to the generosity of their supporters. That generosity was particularly evident in the wake of the Covid-19 pandemic and the Charity has been hugely supportive to the Trust throughout in providing support to our staff and to our patients.

Health Overview and Scrutiny Committees

A representative from St George's has attended every quarterly Wandsworth Health Overview and Scrutiny Committee meeting since June 2017. This is to give assurance on our quality improvement work, as well as any other significant updates. Members of the Committee also receive our monthly stakeholder bulletin which provides an update on major programmes of work, and challenges facing the Trust. In addition to this, we proactively brief the Chair of the Committee in advance of any major announcements or adverse media stories being published. Our clinical service changes during this time have not required consultation or input from the Committee, but members have been made aware of them via the channels outlined above, and had the opportunity to get involved if required.

Organisational Structure and Governance

Some of our Governors discuss Trust membership

Our governance framework comprises our membership, the Council of Governors and our Board of Directors. The Trust's members are drawn from our patients, staff and individuals from the communities we serve. Our Council of Governors is elected by the members and also has appointed Governors in accordance with our Constitution. The Council of Governors represent the members and the public and play a key role in holding the Non-Executive Directors to account for the performance of the Board of Directors. Led by the Chairman, the Board of Directors sets the strategy for the Trust, determines objectives and priorities, oversees quality, operational and financial performance and shapes the culture of the organisation. The Board is responsible for ensuring that there are effective systems of governance and internal control in place. The Board is supported in its work by a number of Board Committees.

Our Council of Governors

Our Council of Governors forms an integral part of our governance framework and is led by the Trust Chairman. Our Council of Governors represents our membership body, and during the reporting period its activities helped to ensure that the Trust could continue to provide high quality services and care to its patients and that any decisions made by the Trust did not adversely impact on the experience of the patients. Through its appointment of new and re-appointments of existing Non-Executive Directors in 2019/20, the Council also helped to ensure that the Board of Directors had the right balance of skills and knowledge to lead the Trust.

The members of the Council of Governors are elected from the Trust's membership body – which includes members of the public and our staff – and appointed local authority, university and Healthwatch stakeholder representatives. A total of 32 Governors served on the Council of Governors during the period. Governors were appointed from the constituencies set out in the Trust's Constitution, and the size of the Council was sufficient to enable Governors to give effect to their key duties. The names and terms of the members of the Council of Governors can be found in table 1 below.

Table 1: Constituency and terms of Governors

GOVERNOR	CONSTITUENCY/OFFICE	TERM	ELECTED/RE-ELECTED/ APPOINTED	PERIOD IN OFFICE
Gillian Norton	Trust Chairman	N/A	N/A	N/A
ELECTED PUBLIC GOVERNORS				
Nasir Akhtar	Merton	First	01 February 2020	01 February 2020 - 31 January 2023
Anneke de Boer	Merton	Third	01 February 2020	01 February 2020 - 31 January 2021
Hilary Harland	Merton	Second	01 February 2018	01 February 2018 - 31 January 2021
Nasir Javed Khan	Merton	First	01 February 2020	01 February 2020 - 31 January 2023
Afzal Ashraf	Wandsworth	First	01 February 2020	01 February 2020 - 31 January 2023
Nick de Bellaigue	Wandsworth	First	20 July 2018	20 July 2018 - 31 January 2021
John Hallmark	Wandsworth	First	01 February 2018	01 February 2018 - 31 January 2021
Basheer Khan	Wandsworth	First	01 February 2020	01 February 2020 - 31 January 2023
Doulla Manolas	Wandsworth	First	01 February 2018	01 February 2018 - 31 January 2021
Ataul Qadir Tahir	Wandsworth	First	01 February 2020	01 February 2020 - 31 January 2023
Mia Bayles	Rest of England	Second	01 February 2018	01 February 2018 - 31 January 2021
Sandhya Drew	Rest of England	First	01 February 2020	01 February 2020 - 31 January 2023
Damien Quinn	Rest of England	First	01 February 2018	01 February 2018 - 31 January 2021
Stephen Sambrook	Rest of England	Second	01 February 2020	01 February 2020 - 31 January 2023
Richard Mycroft	South West Lambeth (Lead Governor)	First	01 February 2018	01 February 2018 - 31 January 2021
ELECTED STAFF GOVERNORS				
Jenni Doman	Non-Clinical	Third	01 February 2020	01 February 2020 - 31 January 2023
Marlene Johnson	Nursing & Midwifery	First	01 April 2019	01 April 2019 - 31 January 2021
Bassey Williams	Allied Health Professionals	First	01 February 2018	01 February 2018 - 31 January 2021
Anup Sharma	Clinical & Dental	First	01 February 2018	01 February 2018 - 31 January 2021
APPOINTED STAKEHOLDER GOVERNORS				
Alfredo Benedicto	Healthwatch Merton	First	01 February 2018	01 February 2018 - 31 January 2021
Val Collington	Kingston University	Second	01 February 2018	01 February 2018 - 31 January 2021
Frances Gibson	St George's University	Second	01 February 2018	01 February 2018 - 31 January 2021
Rebecca Lanning	Merton Council	First	01 February 2018	01 February 2018 - 31 January 2021
Sarah McDermott	Wandsworth Council	Second	01 February 2018	01 February 2018 - 31 January 2021
Sangeeta Patel	Merton/Wandsworth Clinical Commissioning Group	First	01 February 2018	01 February 2018 - 31 January 2021
Donald Roy	Wandsworth Healthwatch	First	01 February 2018	01 February 2018 - 31 January 2021
PAST GOVERNORS – LEFT OFFICE IN 2019/20				
Kathryn Harrison (End of Term)	Rest of England (Lead Governor)	Second	01 February 2017	01 February 2017 - 31 January 2020
Derek McKee (End of Term)	Wandsworth	Second	01 February 2018	01 February 2017 - 31 January 2020
Simon Price (End of Term)	Wandsworth	First	01 February 2017	01 February 2017 - 31 January 2020
Khaled Simmons (End of Term)	Merton	First	01 February 2017	01 February 2017 - 31 January 2020
Clive Studd (Resigned)	Merton	First	01 February 2017	01 February 2017 - 24 September 2019

We held elections to the Council of Governors in 2019/20 and in February 2020 six new Governors joined the Council and we welcomed back three of our long serving governors who were re-elected (see table 2 below). The Trust will hold its next elections in January 2021.

Table 2: Governors elected and re-elected in 2019 election

GOVERNOR	CONSTITUENCY	TERM	
NEWLY ELECTED			
Nasir Akhtar	Merton	Public	01 February 2020 - 31 January 2023
Nasir Javed Khan	Merton	Public	01 February 2020 - 31 January 2023
Afzal Ashraf	Wandsworth	Public	01 February 2020 - 31 January 2023
Basheer Khan	Wandsworth	Public	01 February 2020 - 31 January 2023
Ataul Qadir Tahir	Wandsworth	Public	01 February 2020 - 31 January 2023
Sandhya Drew	Rest of England	Public	01 February 2020 - 31 January 2023
RE-ELECTED			
Anneke de Boer*	Merton	Public	01 February 2020 - 31 January 2021
Stephen Sambrook	Rest of England	Public	01 February 2020 - 31 January 2023
Jenni Doman	Non-Clinical	Staff	01 February 2020 - 31 January 2023

*Clive Studd resigned his post with one year remaining on his term. The Council of Governors decided to include the vacant post as part of the 2019 election and Anneke de Boer was successfully elected into the post.

We also said goodbye to five long serving Governors who came to their end of term or resigned. This information can be found in the table below. The turnout for the 2019 election was good with all seats contested. An analysis of the elections is set out in the public papers of the Council of Governors which is available on the Trust's website.

Table 3: Governors who left during 01 April 2019 - 31 March 2020

GOVERNOR	CONSTITUENCY	TERM
Kathryn Harrison (End of Term)	Rest of England (Lead Governor)	01 February 2017 - 31 January 2020
Derek McKee (End of Term)	Wandsworth	01 February 2017 - 31 January 2020
Simon Price (End of Term)	Wandsworth	01 February 2017 - 31 January 2020
Khaled Simmons (End of Term)	Merton	01 February 2017 - 31 January 2020
Clive Studd (Resigned)	Merton	01 February 2017 - 24 September 2019

With the departure of Kathryn Harrison, who came to the end of her term in January 2020, the Council of Governors appointed Richard Mycroft to take on the role of Lead Governor from October 2019. The Lead Governor is responsible for co-ordinating communication between NHS Improvement and the other Governors, particularly where it may not be appropriate to communicate via the normal channels (via the Chairman or Trust Secretary or equivalent), and acts as the main point of contact for the Chairman. The Lead Governor meets regularly with the Trust Chairman and the Chief Corporate Affairs Officer and inputs into the development of agendas for each Council of Governors' meetings.

Council of Governors: role and duties

Our Council of Governors works collegiately with the Board of Directors and benefits from sharing the same leadership in the Trust Chairman, but there is clear distinction between the role of the Board and the Council. The over-riding role of the Council of Governors is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and to represent the interests of Trust members and the public. The schedule of matters reserved for the Board and the Council of Governors is set out in Trust's Constitution and is reflected in the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions. The Council of Governors has key decision making responsibilities in addition to holding the Non-Executive Directors, collectively and individually, for the performance of the Board and representing the interests of members and the public.

These include:

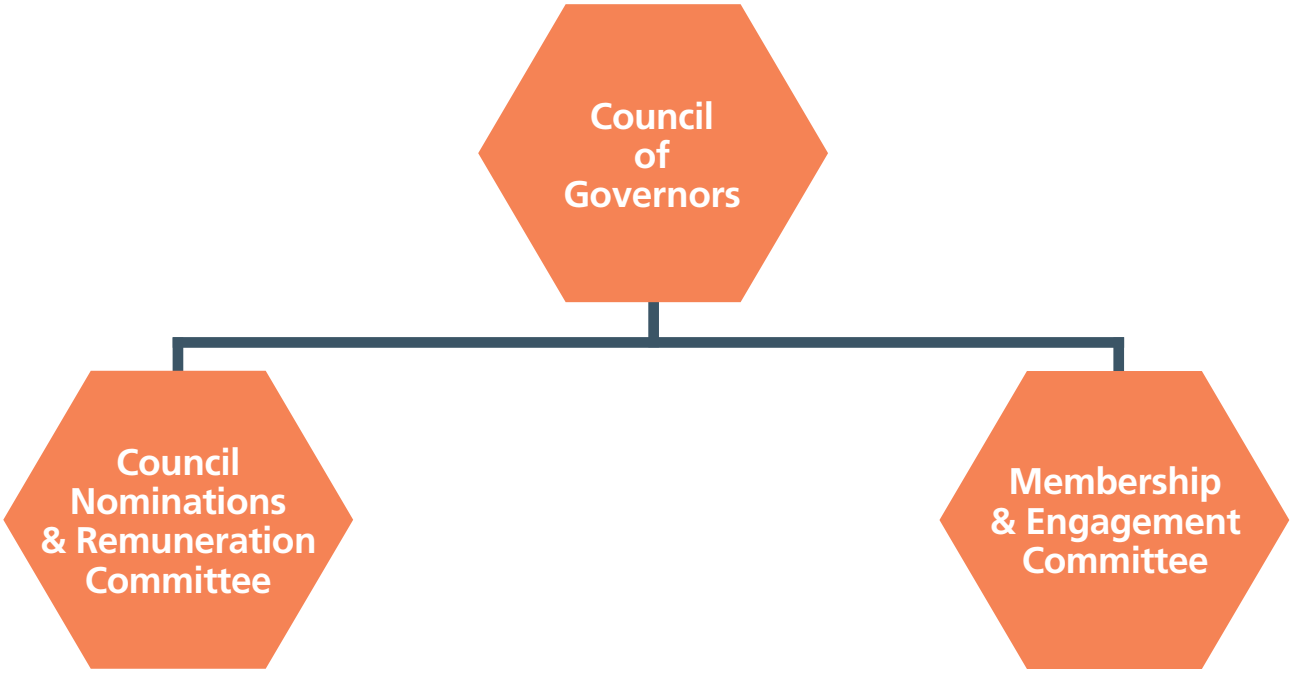
- appointment of the Non-Executive Directors and setting their terms and conditions
- appointment of the external auditors and setting their terms and conditions
- approving the appointment of the Chief Executive by the Non-Executive Directors
- any proposals which significantly change the services the Trust offers, including significant transactions and proposals such as mergers, acquisitions and de-mergers
- any proposals to increase the services provided to private patients which make an income over 5% of the total Trust income
- changes to the Trust's Constitution.

During 2019/20, the Council of Governors has exercised some of these functions, including: the re-appointment of the Chairman and three other Non-Executive Directors; the appointment of two new Non-Executive Directors and an Associate Non-Executive Director; and approving a temporary change to the Trust's Constitution to make the role of Chief Operating Officer a voting member of the Board of Directors.

The Council also inputs on the Trust's strategies and annual forward plan, supports the development of the annual quality priorities, receives the annual report and accounts, and develops and delivers the programme for engaging members.

The Council of Governors reviews its own collective effectiveness annually, and undertook its most recent review in December 2019. The Council considered all aspects of its effectiveness and of the effectiveness of the arrangements in place to support the Council and, based on this, it agreed a development programme for 2020/21.

In addition to its formal meetings, the Council of Governors has established two sub-committees to support it in completing its role.



The Council Nominations and Remuneration Committee is responsible for supporting the Council of Governors in ensuring that the Board of Directors has sufficient skills and knowledge. The Committee met twice during the period. With the support of this Committee the Council was able to:

- appoint two Non-Executive Directors and one Associate Non-Executive Director in January 2020
- reviewed and revised the Trust policy for appraisals of the Chairman and Non-Executive Directors in line with new national guidelines
- reappointment of the Chairman and three Non-Executive Directors
- receive and endorse the appraisal of the Chairman and other Non-Executive Directors
- agreed the revised remuneration package for the Non-Executive Directors under the new framework agreed by NHS England/Improvement
- agreed the Chairman could undertake the role of Chair-in-Common with Epsom and St Helier's Hospital NHS Trust.

The Committee is led by the Trust Chairman and the members are all Governors. During the period the following Governors were members of the Committee:

MEMBERS	
Gillian Norton	Trust Chairman (Committee Chair)
Mia Bayles	Public Governor, Rest of England
Valentina Collington	Appointed Governor, Kingston University
Anneke de Boer	Public Governor, Merton
Jenni Doman	Staff Governor, non-clinical
John Hallmark	Public Governor, Wandsworth
Hilary Harland	Public Governor, Merton
Richard Mycroft	Public Governor, South West Lambeth

The Council's Membership and Engagement Committee is responsible for supporting and delivering the Trust's membership strategy. The Committee met four times during the year and considered:

- the membership strategy 2019-2023: communications/launch plan, year one implementation plan and updates
- the review of issues raised by members and the public
- plans and progress for engagement events and activities including: Annual Members Meeting, constituency events, implementation of tiered membership.

The Committee is led by the Lead Governor and its members are all Governors. During the period the following Governors were members of the Committee:

MEMBERS	
Richard Mycroft	Public Governor for South West Lambeth (Committee Chair)
Mia Bayles	Public Governor for Rest of England
Alfredo Benedicto	Appointed Governor for Healthwatch Merton
Jenni Doman	Staff Governor – Non Clinical
John Hallmark	Public Governor for Wandsworth
Hilary Harland	Public Governor for Merton
Marlene Johnson	Staff Governor – Nursing & Midwifery
Doulla Manolas	Public Governor for Wandsworth
Stephen Sambrook	Public Governor for Rest of England
Bassey Williams	Staff Governor for Allied Health Professionals

The Council of Governors met five times during 2019/20.
Attendance of individual Governors is set out in table 4 below.

Table 4: Council of Governors' attendance at meetings

GOVERNOR	CONSTITUENCY/OFFICE	MEETINGS ATTENDED (ACTUAL/ELIGIBLE ATTENDANCE)
Gillian Norton	Trust Chairman	5/5
ELECTED PUBLIC GOVERNORS		
Nasir Akhtar	Merton	1/1
Anneke de Boer	Merton	3/5
Hilary Harland	Merton	5/5
Nasir Javed Khan	Merton	1/1
Afzal Ashraf	Wandsworth	1/1
Nick de Bellaigue	Wandsworth	4/5
John Hallmark	Wandsworth	4/5
Basheer Khan	Wandsworth	0/1
Doulla Manolas	Wandsworth	1/5
Ataul Qadir Tahir	Wandsworth	1/1
Mia Bayles	Rest of England	5/5
Sandhya Drew	Rest of England	1/1
Damien Quinn	Rest of England	4/5
Stephen Sambrook	Rest of England	4/5
Richard Mycroft	South West Lambeth (Lead Governor)	5/5
ELECTED STAFF GOVERNORS		
Jenni Doman	Non-Clinical	4/5
Marlene Johnson	Nursing & Midwifery	3/5
Anup Sharma	Clinical & Dental	3/5
Bassey Williams	Allied Health Professionals	4/5
APPOINTED STAKEHOLDER GOVERNORS		
Alfredo Benedicto	Healthwatch Merton	2/5
Val Collington	Kingston University	4/5
Frances Gibson	St George's University	2/5
Rebecca Lanning	Merton Council	2/5
Sarah McDermott	Wandsworth Council	3/5
Sangeeta Patel	Merton/Wandsworth Clinical Commissioning Group	5/5
Donald Roy	Wandsworth Healthwatch	5/5
PAST GOVERNORS		
Kathryn Harrison (End of Term)	Rest of England (Lead Governor)	3/4
Derek McKee (End of Term)	Wandsworth	2/4
Simon Price (End of Term)	Wandsworth	3/4
Khaled Simmons (End of Term)	Merton	4/4
Clive Studd (Resigned)	Merton	1/2

Some of the key matters considered by the Council included:

MAY 2019	JULY 2019	OCTOBER 2019	DECEMBER 2019	FEBRUARY 2020
Patient Partnership Engagement Group Update	Information Technology Update	Appointment of a new Senior Independent Director	Staff Engagement & Culture Update	Quality Priorities Update and Quality Accounts Planning
Process for selecting quality indicator for external audit	Volunteer Update	Nomination and Remuneration Committee Report: Non-Executive Director appointments	Strategy Development: Quality & Safety; Education	Care Quality Commission Inspection Report - Action Plan
Getting it Right First Time (GIRFT) & Model Hospital	External Auditors and Trust Annual Report and Accounts 2018-19	Council of Governors Training and Development	Council of Governors Effectiveness Review	Strategy Development: Digital, Outpatient
Nomination & Remuneration Committee Report and Non-Executive Directors Appraisals Report	Membership Engagement Committee Report	Governor elections update		Membership Engagement Committee Report
Membership Engagement Committee Report	Annual Members meeting Plan	Chief Executive Update		Governor Election Report
Council of Governors Training and Development in 2018-19. Annual Self-Assessment of Compliance with Foundation Trust Licence	Non-Executive Director Appointments: Update on process and timetable	Strategy Development: Workforce, Research		Nominations & Remuneration Committee Report
	Council of Governor Elections 2020			Proposed Revision to Trust Constitution relating to the Trust Board
				Council Effectiveness Review Action Plan and Proposed Forward Plan

There are clear processes and procedures for the Council to engage with the Trust Board to raise any issues, with the Senior Independent Director and Lead Governor acting as key conduits to ensure that these are appropriate and effective. During 2019/20, the Council of Governors was consulted on the appointment of a new Senior Independent Director following the departure of Sir Norman Williams in September 2019. With input from the Council, the Board appointed Ann Beasley, Vice Chair of the Trust, as Senior Independent Director in October 2019.

The Trust's Constitution sets out the procedures for resolving any disputes between the Board and Governors. Information on the constitution can be found on our website at: https://www.stgeorges.nhs.uk/about/living-our-values/nhs-constitution/. The Council of Governors did not need to make use of these procedures during 2019/20.

Non-Executive Directors are invited to attend all meetings of the Council of Governors both to assist the Council in their role of holding the Non-Executives to account for the performance of the Board and to ensure that the Non-Executive Directors understand the views of Governors. Governors are likewise invited to attend meetings of the Board and have an opportunity to ask questions. Executive Directors are also invited to attend meetings of the Council on matters related to their portfolio. The following Directors attended the Council of Governors:

NAME	TITLE	DATE
Jacqueline Totterdell	Chief Executive Officer	October 2019, December 2019
Avey Bhatia	Chief Nurse	May 2019
James Friend	Chief Transformation Officer	May 2019
Richard Jennings	Chief Medical Officer	October 2019, December 2019
Stephen Jones	Chief Corporate Affairs Officer	May 2019, July 2019, October 2019, December 2019, February 2020

Governor development

Governors are afforded the opportunity to attend NHS Provider training courses and networking events and we seek to match these opportunities to identified training needs of our Governors. In September 2019, the Trust hosted an NHS Providers London Governors conference which was attended by 10 members of our Council of Governors and chaired by the Trust Chairman. In December 2019, the Council undertook a review of its effectiveness and identified a number of areas for further improvement which have informed a Council development plan for 2020/21 which was agreed at its meeting in February 2020. In February 2020, an induction event was held for newly elected Governors. As part of the Trust's self-certification against its provider licence, the Council of Governors agreed that the Trust should certify that it had provided appropriate training to Governors in 2019/20. There are two programmed development events for Governors during 2020/21, as well as regular seminar sessions. Although these were paused as the NHS addresses the Covid-19 pandemic, we are committed to continuing with these, virtually if necessary.

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 our services. Our Governors and members ensure that we are accountable, and listen to the needs and views of our patients and the communities we serve.

We have a combined membership of around 22,000 members, broken down as below:

Membership constituency	Total number (as at 30 March 2020)
Total Public Members	**13,038**
Lambeth	*555*
Merton	*3,412*
Wandsworth	*4,130*
Rest of England	*4,941*
Total Staff Members	**9000**

Public members: Our public members include patients, friends and family of patients, volunteers and all other members of the public who reside in one of four geographical constituencies, Wandsworth, Merton, South West Lambeth and Regional (England). To become a public member, no special skills or experience are required, as long as the individual is over 14 years old.

Staff members: Any member of staff employed by the Trust on permanent contracts, fixed term contracts of 12 months or longer, or employed through one of our service partners (including transport, catering and cleaning staff) are eligible to become staff members. While permanent and fixed term contract staff automatically become members, all other category of staff must apply to become a member.

Our membership strategy aims to give local people a voice in shaping St George's

In July 2019, St George's launched a new membership strategy designed to encourage more local people to have a voice in the shaping of the services the Trust provides. We want to ensure we have an engaged and vibrant membership community and the Trust benefits enormously from the input of our members. Our vision is to build on our engagement with members to create an active and vibrant membership community that is representative of the diverse populations we serve and of the staff who work here, and one that has a real voice in shaping the future of the Trust and the services it provides. To achieve this vision, our membership strategy for 2019-2022 sets out three overarching aims:

- To improve the quality of engagement and communication with members.
- To work to ensure the membership is representative of the diverse communities the Trust serves.
- To maintain and where possible increase the overall size of the Trust's membership.

We have already made progress in meeting the aims set out in the strategy – for example we have improved the way in which we engage with members by introducing a new monthly bulletin rounding up key news stories and ways to get involved with the Trust. In March 2020 we also held the first of a series of 'Question Time' events in community spaces where the public had the chance to meet their local Trust Governor, hear from a member of our Board, and ask questions about our services. To achieve the vision set out in our strategy, we know we have more to do. We have a programme of exciting membership engagement events planned for 2020/21, and while the social distancing requirements related to Covid-19 pose challenges, we want to improve the quality of our engagement with our members and will be exploring how we can do this virtually in the event that face-to-face engagement is not possible. As part of this, we also want to ensure that our membership is truly representative of our diverse community.

The Council of Governors is responsible for the delivery of the membership strategy, and through its Membership Engagement Committee it has monitored the implementation and delivery of the year one milestones in the membership strategy. As part of this the Council as a whole and the Membership Engagement Committee receive regular reports on the extent to which the membership of the Trust is representative of the communities we serve.

We continue to welcome the views and opinions of our members. Our Board of Directors and Council of Governors meetings are held in public and there are opportunities at the end of each meeting to raise questions in person or via email.

Our members can contact our Council of Governors by email via members@stgeorges.nhs.uk and can submit questions to the Board of Directors by email via board@stgeorges.nhs.uk.

More information on our membership can be found on the Trust's website here: https://www.stgeorges.nhs.uk/about/foundation-trust/members/

The Trust is open and transparent through our 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 of Directors

The Trust is led by our Board of Directors. The Board has three principal roles:

- Formulating strategy.
- Shaping a positive culture for the Board and the organisation.
- Ensuring accountability by holding the organisation to account for the delivery of strategy and through seeking assurance that systems of control are robust and reliable.

Executive members of the Trust Board are full time employees of the Trust, with a notice period of six months. Non-Executive Directors are appointed by the Council of Governors for three year terms of office (or two years in the case of Associate Non-Executive Directors.

Trust Board membership

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 OBE for services to local government. In October 2019, Gillian also became Chaiman of Epsom and St Helier University Hospitals NHS Trust. In May 2020, Gillian was reappointed as Chairman of St George's by the Trust's Council of Governors for a further three-year term of office on 1 April 2020.

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 Chair of Trustees for the Alzheimer's Society. Ann was awarded a CBE in 2010 and in September 2018 was appointed as Chair of South West London and St George's Mental Health NHS Trust. Ann is Vice Chair of the Trust and, since October 2019, has served as Senior Independent Director.

Non-Executive Directors (cont.)

Elizabeth Bishop,
Non-Executive Director

Elizabeth Bishop is a Fellow of the Institute of Chartered Accountants. Her most recent executive role was as Director of Finance and Resources with the Cystic Fibrosis Trust, having also held executive roles at The Nuffield Trust, as well as charities Shelter and Toynbee Hall. Elizabeth joined St George's as a Non-Executive Director in February 2020. She remains a Non-Executive Director at Epsom and St Helier University Hospitals NHS Trust, a role she has held since 2013.

Stephen Collier,
Non-Executive Director

Stephen is currently the Chair of NHS Professionals and recently served as a member of the independent inquiry panel into the issues raised by Ian Paterson. Stephen has worked extensively in the private health sector, including a period as Chair of the NHS Partners Network – the trade association for private providers to the NHS. He is 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.

Professor Jenny Higham,
Non-Executive Director

Professor 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 and served as president of the UK's Medical Schools Council. 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 Dame Parveen Kumar,
Non-Executive Director

Professor Dame Parveen Kumar joined St George's as a Non-Executive Director in January 2020. She is a Consultant in Gastroenterology and a General Physician and Professor of Medicine and Education at Barts and the London, Queen Mary University of London. Professor Kumar has worked in the NHS for 43 years in North East London. She has held a number of national roles, including as President of the Royal Society of Medicine and of the British Medical Association. Professor Kumar is the co-founder and co-editor of Kumar and Clark's 'Clinical Medicine', and has authored and edited several other medical books. She was awarded CBE for her services to medicine in 2001, and DBE in 2017 for services to medicine and medical education.

Dr Pui-Ling Li,
Associate Non-Executive Director

Dr Li joined St George's as an Associate Non-Executive Director in January 2020. Dr Li is a Consultant in Public Health, with over 20 years of experience in the delivery of health, service improvements and system change. She first trained as a General Practitioner, before completing her training as a public health physician. Dr Li has been a Fellow of the Faculty of Public Health since 2001, and has held a number of executive director and Board level roles.

Tim Wright,
Non-Executive Director

Tim is a Chartered Mechanical Engineer and also a Fellow of the British Computer Society. He worked for 20 years in the oil and gas industry on major engineering and construction projects undertaking global consulting and senior IT leadership roles at BP, Halliburton and Amec before joining the Department for Education as Chief Information Officer in 2007. In the public sector Tim led technology programmes across government, with local authorities, the Cabinet Office and the Government Digital Service. He has been a Non-Executive Director at the Trust since September 2017, and a Trustee of St George's Hospital Charity since January 2018.

Executive Directors (voting)

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 Hospital 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.

Andrew Grimshaw,
Chief Financial Officer/ Deputy Chief Executive

Andrew Grimshaw joined St George's as Chief Financial Officer in June 2017. Andrew was previously Director of Finance at London Ambulance Service (LAS), 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. Andrew was also appointed Deputy Chief Executive in May 2019.

Dr Richard Jennings,
Chief Medical Officer

Dr Richard Jennings joined the Trust in December 2018 as Chief Medical Officer. Richard joined St George's from Whittington Health NHS Trust, where he had been Executive Medical Director for four years. Dr Jennings specialises in infectious diseases and acute medicine, and underwent his training at the London School of Hygiene and Tropical Medicine. Before becoming Executive Medical Director at the Whittington, he held the posts of Clinical Director for medicine and then Deputy Medical Director.

Avey Bhatia,
Chief Operating Officer

Avey Bhatia joined St George's as 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 to 2013. Prior to joining South London Healthcare, Avey held senior nursing and management positions at St George's. For much of 2019/20, Avey served as Chief Nurse and Director of Infection Prevention and Control. In February 2020, she became interim Chief Operating Officer.

Robert Bleasdale,
Acting Chief Nurse and Director of Infection Prevention and Control

Robert Bleasdale became Acting Chief Nursing Officer and Director of Infection Prevention and Control at St George's in February 2020. Robert was previously Deputy Chief Nurse at St George's in 2017, having previously held a number of other senior nursing roles at the Trust since joining in 2014. Robert started his nursing career in acute medicine, before moving into emergency care. He is an advanced trauma nursing course instructor, and completed his nursing degree at Oxford Brookes University. He also has a Masters in Senior Healthcare Leadership from Birmingham University.

Non-voting Board members

Harbhajan Singh Brar,
Chief People Officer

Harbhajan Singh Brar joined the Trust in May 2017 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.

James Friend,
Chief Transformation Officer

James Friend joined the Trust 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.

Stephen Jones,
Chief Corporate Affairs Officer

Stephen joined the Trust 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 to the Minister for Quality.

Suzanne Marsello,
Chief Strategy Officer

Suzanne joined St George's in January 2018 from neighbouring South West London and St George's Mental Health NHS Trust, 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.

Other Directors who served on the Board during 2019/20

During 2019/20, four other Directors – two Executive Directors and two Non-Executive Directors – served on the Trust Board who have since left the Trust.

Professor Sir Norman Williams,
Non-Executive Director (until end September 2019)

Sir Norman served on the Board of St George's from April 2016 to September 2019 as Chair of the Quality and Safety Committee. He was Professor of Surgery at Queen Mary's School of Medicine and Dentistry, honorary consultant at Barts Health NHS Trust and Director of the National Centre for Bowel Research and Surgical Innovation up to 2016. From 2011-14 he was President of The Royal College of Surgeons of England. He was Senior Clinical Advisor to the Secretary of State for Health and Social Care from 2015-18. He left the Board in September 2019 to become Chair of the Independent Reconfiguration Panel.

Sarah Wilton,
Non-Executive Director (until end January 2020)

Sarah Wilton served on the Board of St George's for nine years until January 2020. Sarah qualified as a chartered accountant with Price Waterhouse Coopers and held several senior executive positions at Lloyd's of London. She held Non-Executive Director appointments at two Lloyd's agencies and served both as chair of the audit and risk committee. She is a Magistrate at Wimbledon Magistrates Court and the Central London Family Court and is a Trustee of the Paul D'Auria Cancer Support Centre.

Kevin Howell,
Director of Estates and Facilities (until June 2019)

Kevin served on the Board from January 2018 to June 2019. 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.

Ellis Pullinger,
Chief Operating Officer (until end February 2020)

Ellis Pullinger served as the Trust's Chief Operating Officer until February 2020. He joined St George's from Imperial College Healthcare NHS Trust where he was Assistant Chief Executive in June 2017. Prior to this he was Divisional Director of Operations for the Trust's Division of Investigative Sciences and Clinical Support.

Trust Board Attendance Register 2019/20

BOARD OF DIRECTORS	APPOINTED ROLE	ELIGIBLE PERIOD	ACTUAL/ELIGIBLE ATTENDANCE
VOTING NON-EXECUTIVE DIRECTORS			
Gillian Norton	Chairman	01 April 2019 - 30 March 2020	11/11
Ann Beasley	Non-Executive Director	01 April 2019 - 30 March 2020	11/11
Elizabeth Bishop	Non-Executive Director	01 February 2020 - 30 March 2020	2/2
Stephen Collier	Non-Executive Director	01 April 2019 - 30 March 2020	9/11
Prof. Jenny Higham	Non-Executive Director	01 April 2019 - 30 March 2020	9/11
Dame Professor Parveen Kumar	Non-Executive Director	13 January 2020 - 30 March 2020	3/3
Dr Pui-Ling Li	Associate Non-Executive Director	13 January 2020 - 30 March 2020	3/3
Sir Norman Williams*3	Non-Executive Director	01 April 2019 - 30 September 2020	5/6
Sarah Wilton	Non-Executive Director	01 April 2019 - 31 January 2020	10/10
Tim Wright	Non-Executive Director	01 April 2019 - 30 March 2020	10/11
VOTING EXECUTIVE DIRECTORS			
Jacqueline Totterdell*1	Chief Executive	01 April 2019 - 30 March 2020	8/11
Andrew Grimshaw	Chief Financial Officer/ Deputy Chief Executive	01 April 2019 - 31 December 2020	6/8
	Acting Chief Executive	01 January 2020 - 29 February 2020	2/2
	Deputy Chief Executive	01 March 2020 - 30 March 2020	1/1
Avey Bhatia	Chief Operating Officer	29 February 2020 - 30 March 2020	2/2
	Chief Nurse & Director of Infection & Prevention Control	01 April 2020 - 30 March 2020	9/10
Robert Bleasdale	Acting Chief Nurse/ Director of Infection & Prevention Control	01 April 2019 - 30 March 2020	2/2
Dr Richard Jennings*3	Chief Medical Officer	01 April 2019 - 30 March 2020	10/11
Tom Shearer	Acting Chief Financial Officer	01 January 2020 - 30 March 2020	3/3
NON-VOTING MEMBERS			
Harbhajan Brar	Chief People Officer	01 April 2019 - 30 March 2020	10/11
James Friend	Chief Transformation Officer	01 April 2019 - 30 March 2020	11/11
Stephen Jones	Chief Corporate Affairs Officer	01 April 2019 - 30 March 2020	11/11
Suzanne Marsello*3	Chief Strategy Officer	01 April 2019 - 30 March 2020	11/12
Ellis Pullinger*2	Chief Operating Officer	01 April 2019 - 30 March 2020	8/11

*1 Jacqueline Totterdell, Chief Executive Officer, took sick leave between January-February 2020. During this period, Andrew Grimshaw, Chief Financial Officer/Deputy Chief Executive undertook the role of Acting Chief Executive and his deputy, Tom Shearer undertook the role of Acting Chief Financial Officer. In March 2020 Jacqueline Totterdell returned to work on a phased basis and was required to self-isolate in response to the Covid-19 pandemic. Andrew Grimshaw substantively carried out the role of Deputy Chief Executive.

*2 The substantive Chief Operating Officer, Ellis Pullinger resigned in February 2020. Avey Bhatia undertook the role of Interim Chief Operating Officer and her deputy, Robert Bleasdale was appointed to the role of Acting Chief Nurse/Director of Infection Prevention and Control.

*3 On one occasion during the period these Board members were required to attend a system meeting and whilst they could not attend the public Board meeting were present at the private meeting.

The NHS Foundation Trust Code of Governance requires the Trust's Annual Report to set out each Non-Executive Director it considers to be independent. The Board must determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. The Board is required to state its reasons if it determines that a Director is independent despite the existence of relationships or circumstances which may appear relevant to its determination. The Board considers the following Non-Executives to be independent: Ann Beasley, Stephen Collier, Professor Dame Parveen Kumar, Tim Wright and Dr Pui-Ling Li. Gillian Norton and Elizabeth Bishop both serve on the Board of Epsom and St Helier University Hospitals NHS Trust. The Board has authorised the existence of a conflict of interest in both cases but they are not considered independent for the purposes of this declaration. Ann Beasley chairs the Board of South West London and St George's Mental Health NHS Trust, however this relationship is not considered to impact on her independence as the two Trusts operate independently and are different types of NHS provider.

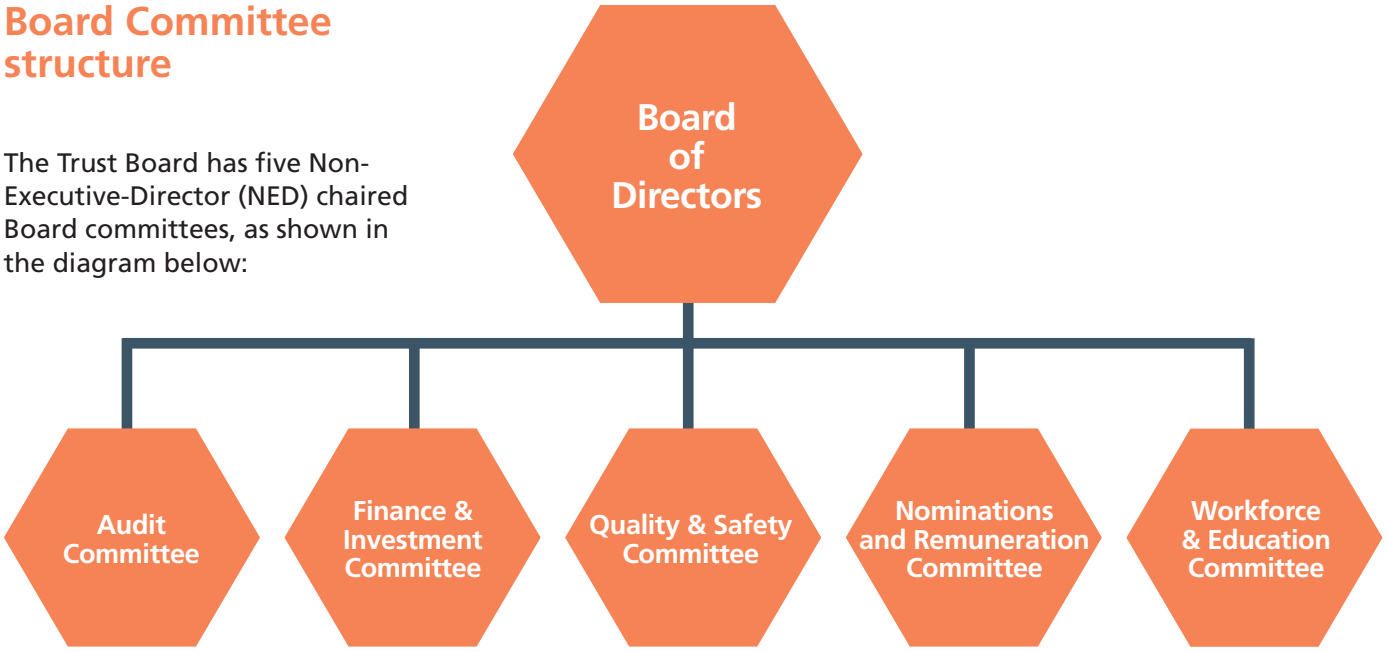
Non-Executive Directors are appointed for terms of office of three years. In the case of the Associate Non-Executive Director, the term of office is two years. The terms of office of our current Non-Executive Directors are set out in the table below:

NAME	CURRENT TERM OF OFFICE	TERM LENGTH	PREVIOUS TERM OF OFFICE (IF RELEVANT)
Gillian Norton	1 April 2020 – 31 March 2023	3 years	1 April 2017 – 31 March 2020
Ann Beasley	13 October 2019 – 12 October 2022	3 years	13 October 2016 – 12 October 2019
Elizabeth Bishop	1 February 2020 – 31 January 2023	3 years	N/A
Stephen Collier	13 October 2019 – 12 October 2022	3 years	13 October 2016 – 12 October 2019
Jenny Higham	1 January 2016 (open ended)*	3 years	N/A
Parveen Kumar	13 January 2020 – 12 January 2023	3 years	N/A
Pui-Ling Li	13 January 2020 – 12 January 2022	2 years	N/A
Tim Wright	26 September 2017 – 25 September 2020	3 years	N/A

* Professor Jenny Higham serves on as a Non-Executive Director on the Trust Board of Directors for the duration of her term of office as Principal of St George's University of London.

Board Committee structure

The Trust Board has five Non-Executive-Director (NED) chaired Board committees, as shown in the diagram below:



The Audit and Workforce and Education committees meet five and six times each year respectively, while the Finance and Investment, and Quality and Safety Committees meet monthly. In April 2019, the Board agreed that the Finance and Investment Committee should establish a sub-group of the Committee to on estates and facilities issues and assurance across the Trust. This group met each month since April 2019 and held its last meeting in March 2020 when the group was dissolved and was reintegrated into the main Finance and Investment Committee meetings in light of the significant assurance that the Trust had sufficient grip and control on estates and facilities issues.

The committees produce reports for the monthly Trust's public Board following each meeting summarising the key areas of assurance and risk considered by each forum. The committees also conduct an annual effectiveness review to assess its performance and produce annual reports including proposed revisions to their terms of reference for the Board to consider each year.

Audit Committee

The Audit Committee has been established to ensure that that the Trust has effective mechanisms and systems of internal control. It provides the Board of Directors with an independent review of the Trust's financial, corporate governance and risk management processes. It utilises the functions of independent internal and external auditors to provide assurance that these systems are sound and being adhered to across all areas of the Trust.

The Committee comprises four independent Non-Executive Director members. The Chief Corporate Affairs Officer and Chief Financial Officer, as the relevant executive leads, attended each meeting of the Committee and the Trust Chairman and Chief Executive Officer periodically attended meetings of Audit Committee but are not members.

During 2019/20 the Committee held five meetings and attendance is recorded below.

MEMBERS/ATTENDEES		MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Sarah Wilton (Committee Chair)	Non-Executive Director	5/5
Ann Beasley	Non-Executive Director	5/5
Sir Norman Williams	Non-Executive Director	2/3
Tim Wright	Non-Executive Director	5/5

During the period, the Committee:

- reviewed the 2018/19 draft Annual Report and Accounts, including the Quality Account, and recommended that the Board approve and adopt these reports as a true and fair record
- monitored the programme of internal audit based on which the Trust received a reasonable assurance rating of its systems and internal controls
- monitored the mechanisms and systems for staff to raise concerns about clinical, financial, quality, patient safety and other concerns through regular reports from the counter fraud team and Freedom to Speak Up Guardian
- conducted a substantive review of the Trust's standing orders and scheme of delegation, and recommended that the Board of Directors adopt the revised documents
- received regular reports on the Trust Board Assurance Framework and plans to conduct a substantive review on the Trust's Risk Management Policy following receipt of the report on the internal audit review of risk management across the Trust in July 2020
- considered and approved the 2019/20 review of compliance and any changes to key documents such as the Trust's managing conflicts of interest policy
- considered the Trust's compliance with its Constitution and with the NHS Foundation Trust Code of Governance

Each year the Committee conducts a review of the effectiveness of the internal and external audit functions. In 2019/20 the Committee, on behalf of the Board, undertook a competitive procurement process for the internal audit function which resulted in TIAA being re-appointed as the Trust's internal Auditors for a period of three years from April 2020 to March 2023.

Finance and Investment Committee

The Committee assists the Trust to maximise its healthcare provision subject to its financial constraints, while considering patient safety. It achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensure that detailed consideration is given to the Trust's financial, investment and associated performance issues, and 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.

During the period, the Committee:

- considered and recommended the Board approve the annual plan and budgets for 2019/20, and kept key risks under close scrutiny
- closely monitored performance against emergency flow activity levels, and the transformation programme for outpatients
- reviewed and recommended that the Board approve the digital and outpatients supporting strategies during the year.

In April 2019, following concerns regarding assurance on water safety and estates issues more broadly, the Board decided to establish a new sub-group of the Committee. Known as the Finance and Investment Committee (Estates), the group focused on scrutinising assurances around estates issues including water safety, estates infrastructure and soft facilities management systems across the Trust. The group met monthly and worked to provide assurance to the Board that there was clarity around the key assurances on estates and effective management of key risks. The group approved the commissioning of an external review of estates governance and has actively overseen its implementation. In March 2020, the Board decided that while estates challenges remained the group had succeeded in establishing greater grip and control on estates, such that the Board decided to reintegrate scrutiny of estates within the core Finance and Investment Committee.

The Committee membership comprises Non-Executive and Executive Directors. The Chief Corporate Affairs Officer, Chief Operating Officer Chief Strategy Officer, Chief Transformation Officer and Chief People Officer regularly attended the meetings of the Committee.

During 2019/20 the Committee held 12 meetings and attendance is recorded below.

MEMBERS		MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Ann Beasley (Committee Chair)	Non-Executive Director	11/12
Gillian Norton (Ex-Officio Member)	Trust Chairman	9/12
Sarah Wilton	Non-Executive Director	8/11
Tim Wright	Non-Executive Director	11/12
Stephen Collier	Non-Executive Director	9/12
Elizabeth Bishop	Non-Executive Director	1/1
Jacqueline Totterdell	Chief Executive	4/12
Avey Bhatia	Chief Nurse/Director of Infection & Prevention Control*	8/10
Andrew Grimshaw	Chief Financial Officer/Acting Chief Executive/Deputy Chief Executive	11/12
Dr Richard Jennings	Chief Medical Officer	6/12
Tom Shearer	Acting Chief Financial Officer	3/3
Robert Bleasdale	Acting Chief Nurse/Director of Infection & Prevention Control	2/2

* Continued to attend the Committee as Chief Operating Officer from February 2020

Quality and Safety Committee

The Quality and Safety 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 requirements are being met.

As part of its annual work programme, the Committee:

- held regular deep dives across a range of quality and safety issues within its remit where it considered further assurance was necessary. During 2019/20, the Committee conducted a total of eight deep dive reviews
- monitored the four strategic risks on the Board Assurance Framework for which it is responsible for providing assurance to the Board
- monitored Serious Incidents and Never Events
- monitored, sought assurances, and supported mitigation of risks related to water safety, cardiac catheter laboratories, compliance with NICE guidance assessments, implementation of the seven day standards, and impact of delays in the national procurement on cervical screening
- monitored of the Trust's completion of the outstanding actions from the 2016 Care Quality Commission Inspection
- received monthly reports on cardiac surgery and received regular updates on the progress of the independent external mortality review commissioned by NHS Improvement in December 2018.
- received updates on progress in implementing the findings of the first two phases of an independent external clinical governance review.
- focused on safeguarding, medicines management, mortality monitoring, infection control and prevention, learning disabilities services and improving the clinical governance infrastructure of the Trust.
- reviewed and recommended that the Board approve the Quality and Safety and Research supporting strategies during the year.

The Committee membership comprises Non-Executive and Executive Directors. The Trust Chairman, Chief Executive and Chief Corporate Affairs Officer regularly attended the meetings of the Committee.

During 2019/20 the Committee held 12 meetings and attendance is recorded below.

MEMBERS		MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Professor Dame Parveen Kumar (Current Committee Chair)	Non-Executive Director	3/3
Professor Jenny Higham	Non-Executive Director	10/12
Elizabeth Bishop (February – March 2020)	Non-Executive Director	2/2
Dr Pui-Ling Li (January– March 2020)	Non-Executive Director	2/3
Avey Bhatia	Chief Nurse/Director of Infection & Prevention Control/	8/10
	Chief Operating Officer	1/2
Dr Richard Jennings	Chief Medical Officer	10/12
Robert Bleasdale*	Acting Chief Nurse/Director of Infection & Prevention Control	2/2
Ellis Pullinger (April – February 2020)	Chief Operating Officer	9/11
Sarah Wilton (April 2019 – February 2020)	Non-Executive Director	7/9
Sir Norman Williams (Committee Chair – April-September 2019)	Non-Executive Director	5/5
Tim Wright (Interim Chair – October–December 2019)	Non-Executive Director	9/10

Workforce and Education Committee

In August 2019, the Committee revised its terms of reference and membership, but its key purpose remained which is to consider the development and delivery of workforce and education strategies, oversee and monitor workforce planning and performance and delivery of the Trust's strategic aims in relation to workforce, plus monitor staff wellbeing and development and compliance with regulatory requirements in relation to workforce and culture.

During the year the Committee:

- considered, approved and monitored progress against the staff engagement plan, and diversity and inclusion plans
- received reports on results from the medical engagement survey and NHS staff surveys, and progress on the Trust's culture and organisational development work
- received reports on the Trust's Freedom to Speak Up Guardian and Guardian of Safe Working
- recommended that the Board approve the workforce and education supporting strategies during the year.

The Committee membership comprises Non-Executive and Executive Directors. The Trust Chairman, Chief Executive and Chief Corporate Affairs Officer regularly attended the meetings of the Committee.

During 2019/20 the Committee held six meetings and attendance is recorded below.

BOARD OF DIRECTORS		MEETINGS ATTENDED (ACTUAL/ELIGIBLE ATTENDANCE)
Stephen Collier (Committee Chair)	Non-Executive Director	6/6
Tim Wright	Non-Executive Director	6/6
Sarah Wilton	Non-Executive Director	4/6
Professor Dame Parveen Kumar	Non-Executive Director	0/1
Dr Pui-Ling Li (from January 2020)	Associate Non-Executive Director	0/1
Harbhajan Brar	Chief People Officer	6/6
Avey Bhatia (Until January 2020)	Chief Nurse & Director of Infection & Prevention Control	2/5
Robert Bleasdale (from February 2020)	Acting Chief Nurse & Director of Infection & Prevention Control	1/1
Dr Richard Jennings	Chief Medical Officer	2/6

Finance and use of resources

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

AREA	METRIC	2019/20 SCORES				2018/19 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	[3]	[1]	[1]	[1]	[2]	[4]
	Agency spend	[1]	[1]	[1]	[1]	[1]	[1]
OVERALL SCORING	[4]	[4]	[4]	[4]	[4]	[4]	

Better Payment Practice Code

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.

NON NHS PAYABLES	2019-20 NUMBER	2019-20 £000s	2018-19 NUMBER	2018-19 £000s
Total non-NHS trade invoices paid in the year	114,159	343,574	116,627	334,253
Total non-NHS trade invoices paid within target	36,610	170,743	41,683	173,129
PERCENTAGE OF NON-NHS TRADE INVOICES PAID WITHIN TARGET	**32.10%**	**49.70%**	**35.74%**	**51.80%**

NHS PAYABLES	2019-20 NUMBER	2019-20 £000s	2018-19 NUMBER	2018-19 £000s
Total NHS trade invoices paid in the year	5,028	74,581	4,445	84,657
Total NHS trade invoices paid within target	753	34,037	1,053	41,844
PERCENTAGE OF NHS TRADE INVOICES PAID WITHIN TARGET	**15.00%**	**45.60%**	**23.69%**	**49.43%**

Auditors

The Trust's appointed external auditors are Grant Thornton LLP. The auditors provide audit services including carrying out the statutory audit of the Trust's annual accounts and the use of resources work, as mandated by Monitor and the National Audit Office, and a review of the Quality Accounts (in 2019/20 due to the operational pressures of Covid-19, the review of the Quality Accounts is not required by NHS England and NHS Improvement). The Council of Governors is responsible for appointing our external auditors. The tender for external audit was last conducted in November 2017 with an appointment commencing in January 2018. During the period the Trust paid £104,100 for external auditor's fees.

The Trust has a rigorous internal audit function provided by TIAA. Each year the Audit Committee considers a programme of internal audit work to be carried out as well as a three-year internal audit strategy. This programme is devised from executive assessment of risks, the key matters enshrined in the Board Assurance Framework, and the independent assessment on the internal audit team of the external risks and internal profile of the Trust. Internal audit reports are considered by the Audit Committee and escalated to the relevant governance forums or responsible officers. Key areas reviewed by the internal auditors in 2019/20 included but were not limited to, consultant job planning; car parking; data security; patient engagement; the Board Assurance Framework; corporate governance; financial planning; safeguarding; infection prevention and control; estates and facilities; iClip implementation project; diagnostics testing and financial planning and budget setting. During the period the Trust paid internal audit fees of £140,000. During 2019/20, the Trust ran an open procurement for internal audit services for the period April 2020 to March 2023. The Committee approved the re-appointment of TIAA as the Trust's internal auditors in August 2019.

Auditors attend the meetings of the Audit Committee, and as part of the systems of internal control meet periodically with non-executive director members of the Committee to highlight any issues or challenges which need to be escalated for the attention of the Board.

A description of the Board Nominations and Remuneration Committee and the attendance register for the Committee is detailed in the Remuneration Report.

Disclosure of information to auditors

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

Income from the provision of goods and services

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

Impact of other (non-NHS) income on the Trust's provision of goods and services for the purposes of the health service in England.

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.

The Directors confirm that the Trust complies with the cost allocation and charging guidance issued by HM Treasury.

Jacqueline Totterdell
Chief Executive
25 June 2020

Remuneration Report

Remuneration Report

St George's University Hospitals NHS Foundation Trust's Remuneration Report describes how the Trust applies the principles of good corporate governance in relation to Directors' remuneration, as required by the Companies Act 2006, Regulation 11 and Schedule 8 of the Large and Medium Sized Companies and Groups (Accounts and Reports) Regulations 2008 and the NHS Foundation Trust Code of Governance.

The Remuneration Report comprises:

- annual statement of remuneration
- very senior managers' pay policy
- annual report on remuneration

Nominations and Remuneration Committee

The Trust has a Board Nominations and 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 respectively and give consideration to both performance and 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, each prepares a description of the role and capabilities required for appointment of Executive (Board) and Non-Executive Directors, including the Chairman (Council).

The Board Nominations and Remuneration Committee makes decisions regarding pay for Executive Directors. It is also responsible for determining, on behalf of the Board, the broad policy for remuneration of the Trust's very senior managers (VSMs).

The Council of Governors' Nominations and Remuneration Committee determines the remuneration of Non-Executive Directors. In 2019/20, the Committee considered the remuneration of the Non-Executive Directors, having taken the decision in 2018/19 to uplift NED remuneration from £12,000 per annum to £14,000 per annum. For 2019/20, the Committee decided to make no changes to NED remuneration, although it noted new guidance published by NHS England and NHS Improvement in November 2019 to introduce a new remuneration structure for NEDs in the coming years which will involve a flat remuneration rate of £13,000 per annum and, for a Trust the size of St George's, additional remuneration for up to three NEDs of £2,000 per annum for additional responsibilities such as chairing Board Committees. The Committee will consider the matter further during 2020/21.

Attendance at the Board Nominations and Remuneration Committee is set out below.

MEMBERS		MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Gillian Norton (Committee Chair)	Trust Chairman	7/7
Ann Beasley	Non-Executive Director (Vice Chair)	7/7
Tim Wright	Non-Executive Director	6/7
Stephen Collier	Non-Executive Director	5/7
Professor Jenny Higham	Non-Executive Director	3/7
Professor Dame Parveen Kumar (January– March 2020)	Non-Executive Director	2/2
Elizabeth Bishop (February – March 2020)	Non-Executive Director	2/2
Dr Pui-Ling Li (January– March 2020)	Associate Non-Executive Director	2/2
Sarah Wilton (April 2019 – February 2020)	Non-Executive Director	4/5
Sir Norman Williams (April-September 2019)	Non-Executive Director	3/3

*See also note in Table 1: Board of Directors and Meeting Attendance
Membership of the Council of Governors' Nominations and Remuneration Committee is set out in the Organisational Structure and Governance section of this report.

Senior managers' remuneration policy

During 2019/20, the Board Nomination and Remuneration Committee decided to award a flat rate uplift of £2,075 pa for the financial year 2018/19 to all VSMs who were appointed on either a substantive or fixed-term basis on or before the 1 April 2019. This was in line with guidance from NHS Improvement. The Committee also reviewed the remuneration arrangements of leadership team posts. The Trust as a policy on diversity and inclusion which applies to all staff and the decisions of the Committee are taken in line with this.

Very senior managers' pay principles

St George's is committed to the overarching principles of value for money and high performance. The Trust recognises that it must attract and retain a high-calibre senior management team and workforce in order to ensure it maintains its excellent standards of clinical outcomes and patient care, functions efficiently and is well positioned to deliver the business strategy.
As a Foundation Trust, the Remuneration Committee has the freedom to determine the appropriate remuneration level for very senior managers, however given that Trust is in special measures, it has sought NHSI approval for all Executive Director salaries. In reaching its decisions the Committee considers the responsibilities and requirements of the role, time in the role, marketability of the individual, benchmarking data from within the NHS or relevant sector, the external economic environment, NHS guidance and the performance of the Trust.

Differences between remuneration for Executive Directors and other employees

The key difference between the remuneration of Executive Directors and other employees is that the fixed salary of executive directors is inclusive of a high cost area supplement, whereas for other employees this is a separate part of their pay.

When setting remuneration levels for the Executive Directors, the committee considers the prevailing market conditions, the competitive environment (in particular through comparison with other NHS Trusts of similar size and complexity) and the positioning of pay and employment conditions across the broader Trust workforce.

Our workforce 2019/20 disclosures (audited)

MULTIPLE TABLE	2019/20	2018/19
Payroll costs (£000)	576,066	534,983
Whole time equivalent	9,790	9,589
Median (£000)	39.2	38.6
Highest paid director (£000)	228	223
Median will fit into highest	5.8	5.8

Range of staff remuneration for 2019/20

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 2019/20 was £228k (2018/19 £223k).

This was 5.8 times (2018/19, 5.8 times) the median remuneration of the workforce, which was £39.2k (2018/19 £38.6k). The highest paid Director was employed on a permanent basis.

The highest paid Director's remuneration did not change significantly compared to previous year and therefore median ratio remains the same.

In 2019/20 the lowest annualised salary was £100 (2018/19 £473). This is as per the payroll report and is distorted by bank staff and several variables. The lowest paid annualised band in the Trust is £22,053 (2018/19 £21,786 (Band 1). The highest paid was £382,551 (2018/19 £356,793).

Expenses

The aggregate amount of expenses paid to Directors, Non-Executive Directors and Governors was:

EXECUTIVE DIRECTORS	NON-EXECUTIVE DIRECTORS	GOVERNORS
£334	£0	£0

A statement on how pay and conditions of service are determined by the Remuneration and Nomination Committee is set out in the very senior managers' pay principles section of the Remuneration Report.

Remuneration Report (audited)

NAME	JOB TITLE	PERIOD	2019			
			Salary	Expense payments (taxable)	Performance pay and bonuses	
EXECUTIVE DIRECTORS			(bands of £5000) £000	Total to the nearest £100	(bands of £5000) £000	
Ms Jacqueline Totterdell	Chief Executive	from 1st May 2017	225-230	0	0	
Mr Andrew Grimshaw	Chief Financial Officer	from 19th June 2017	180-185	0	0	
Ms Avinderjit Bhatia	Acting Chief Operating Officer (as of March 2020)	Secondment (from Feb 17 to Nov 17, permanent from December 2017	160-165	0	0	
Mr Harbhajan Brar	Chief People Officer	from 2nd May 2017	165-170	300 *(Note 2)	0	
Mr James Friend	Chief Transformation Officer	from 28th April 2017	130-135	0	0	
Ms Suzanne Marsello	Chief Strategy Officer	from 2nd January 2018	120-125	0	0	
Mr Stephen Jones	Chief Corporate Affairs Officer	from 5th March 2018	115-120	0	0	
Dr Richard Jennings	Chief Medical Officer	from 19th November 2018	190-195	0	0	
Mr Robert Bleasdale	Acting Chief Nursing Officer and Director of Infection Prevention and Control	from 17th Feb 2020	5-10	0	0	
Leavers						
Mr Ellis Pullinger	Chief Operating Officer	from 12th June 2017 to 1st March 2020	140-145	0	0	
Mr Kevin Howell	Director of Estates, Facilities and Capital Projects	from 2nd January 2018 to 31st December 2019	110-115	0	0	
Dr Andrew Rhodes	Medical Director	from May 2016 - left the Board 31st December 2018	0	0	0	
Non-executive Directors						
Ms Gillian Norton	Chair (Chair Nominations and Remuneration Committee)	from July 2016	60-65	0	0	
Ms Ann Beasley	Non-Executive Director (Chair Finance and Investment Committee and Senior Independent Director)	from October 2016	10-15	0	0	
Mr Stephen Collier	Non-Executive Director (Chair Workforce and Education Committee)	from October 2016	10-15	0	0	
Mr Timothy Wright	Non-Executive Director	from 25th September 2017	10-15	0	0	
Dr Pui-Ling Li	Associate Non-Executive Director	from January 2020	0-5	0	0	
Ms Elizabeth Bishop	Non-Executive Director (Chair of Audit Committee)	from February 2020	0-5	0	0	
Professor Dame Parveen Kumar	Non-Executive Director(Chair of Quality & Safety Committee)	from January 2020	0-5	0	0	
Professor Jennifer Higham	Non-Executive Director	from 1st November 2015 (see note 1)	0	0	0	
Leavers						
Ms Sarah Wilton	Non-executive Director (Chair Audit Committee)	from September 2016 to January 2020	10-15	0	0	
Prof Sir Norman Williams	Non-executive Director (Chair Quality and Safety Committee)	from April 2016 to December 2019	5-10	0	0	

Note 1. Ms Jacqueline Totterdell – The valuation from NHS Pensions Agency resulted in a net reduction during the year which under the guidelines is reported as a zero value pension related benefit.
Note 2. Mr Harbhajan Brar is not in the NHS pension scheme and he recieved a taxable benefit payment towards his business miles.
Note 3. No comparative information in 2018/19 for Mr Robert Bleasdale as he joined the Trust on 17th February 2020
Note 4. No pension related benefit information received from NHS Pension Agency as Robert Mr Bleasdale joined the Board end of the year
Note 5. Mr Kevin Howell – The valuation from NHS Pensions Agency resulted in a net reduction during the year which under the guidelines is reported as a zero value pension related benefit.

/20				2018/19					
	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
	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	total to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
	0	0 *(Note 1)	225-300	220-225	0	0	0	7.5-10	230-235
	0	17.5-20	195-200	155-160	0	0	0	0 (*Note 8)	155-160
	0	1225-1227.5	1385-1390	130-135	0	0	0	0 (*Note 7)	130-135
	0	0 *(Note 2)	165-170	165-170	0	0	0	0 (*Note 2)	165-170
	0	30-32.5	165-170	130-135	0	0	0	25-27.5	155-160
	0	10-12.5	130-135	120-125	0	0	0	12.5-15	130-135
	0	25-27.5	140-145	110-115	0	0	0	25-27.5	140-145
	15-20	32.5-35	245-250	65-70	0	0	5-10	362.5-365	435-440
	0	0 *(Note 4)	5-10	0	0	0	0	0	0 *(Note 3)
	0	22.5-25	165-170	150-155	0	0	0	150-152.5	300-305
	0	0 *(Note 5)	110-115	140-145	0	0	0	227.5-230	365-370
	0	0	0	130-135	0	0	35-40	102.5-105	270-275
	0	0	60-65	60-65	0	0	0	0	60-65
	0	0	10-15	10-15	0	0	0	0	10-15
	0	0	10-15	10-15	0	0	0	0	10-15
	0	0	10-15	10-15	0	0	0	0	10-15
	0	0	0-5	0	0	0	0	0	0 *(Note 6)
	0	0	0-5	0	0	0	0	0	0 *(Note 6)
	0	0	0-5	0	0	0	0	0	0 *(Note 6)
	0	0	0 *(Note 9)	0	0	0	0	0	0 *(Note 9)
	0	0	10-15	10-15	0	0	0	0	10-15
	0	0	5-10	10-15	0	0	0	0	10-15

Note 6. No comparative information in 2018/19 for Dr Pui-Ling Li, Ms Elizabeth Bishop & Prof Dame Parveen Kumar as they joined the Trust in FY 2019/20
Note 7. Ms Avinderjit Bhatia – An error in 18/19 has resulted in her being taken out of the NHS pension scheme. This is now rectified in 19/20.
Note 8. Mr Andrew Grimshaw – For FY19-20 The valuation from NHS Pensions Agency resulted in a net reduction during the year which under the guidelines is reported as a zero value pension related benefit.
Note 9. Professor Jenny Higham is the St George's University of London Medical School representative on the Trust Board. She is not remunerated by the Trust for her role on the Board.

Pensions Report (audited)

		2019/20						
NAME AND JOB TITLE	PERIOD	Real increase in pension at pension age	Real increase in pension and related lump sum at pension age	"Total accrued pension at pension age at 31 March 2020"	"Lump sum at pension age related to accrued pension at 31 March 2020"	"Cash Equivalent Transfer Value at 01 April 2020"	"Real Increase in Cash Equivalent Transfer Value"	
		(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	
Ms Jacqueline Totterdell, Chief Executive	from 1st May 2017	(0-2.5)	(5-7.5)	95-100	260-265	2,075	16	
Mr Andrew Grimshaw, Chief Financial Officer	from 19th June 2017	0-2.5	0-2.5	50-55	120-125	1025	34	
Mr Harbhajan Brar, Chief People Officer	from 2nd May 2017	0	0	0	0	0	0	
Mr James Friend, Chief Transformation Officer	from 28th April 2017	2.5-5	0-2.5	5-10	0-5	107	11	
Ms Suzanne Marsello, Chief Strategy Officer	from 2nd January 2018	0-2.5	(0-2.5)	45-50	110-115	877	13	
Mr Stephen Jones, Chief Corporate Affairs Officer	from 5th March 2018	0-2.5	0-2.5	0-5	0-5	45	5	
Dr Richard Jennings, Chief Medical Officer	from 19th November 2018	0-2.5	2.5-5	60-65	180-185	1,396	57	
Ms Avinderjit Bhatia, Acting Chief Operating Officer (as of March 2020)	Secondment (from Feb 17 to Nov 17, permanent from December 2017	55-57.5	120-122.5	55-60	120-125	1032	1,006	
Mr Robert Bleasdale, (Acting Chief Nursing Officer & Director of Infection Prevention and Control	from 17th Feb 2020	0	0	0	0	0	0	
Leavers								
Mr Kevin Howell, Director of Estates, Facilties and Capital Projects	from 2nd January 2018 to 31st December 2019	(0-2.5)	(5-7.5)	55-60	165-170	1,304	0	
Mr Ellis Pullinger, Chief Operating Officer	from 12th June 2017 to 1st March 2020	0-2.5	(0-2.5)	30-35	65-70	560	12	
Andrew Rhodes, Medical Director	from May 2016 - left the Board 31st December 2018	0	0	0	0	0	0	

Note 10. NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Note 11. The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) Indexation on 08th August 2019. This will affect the calculation of the real increase in CETV and does not affect the real increase in pension benefits. This is more likely to affect the 1995 section and the 2008 section.

Note 12. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of non-executive directors.

Note 13. The above disclosures is audited by Trust's external auditor

Pension scheme

As Non-Executive Directors 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

			2018/19							
	"Cash Equivalent Transfer Value at 31 March 2019"	Employer's contribution to stakeholder pension	Real increase in pension at pension age	Real increase in pension and related lump sum at pension age	"Total accrued pension at pension age at 31 March 2019"	"Lump sum at pension age related to accrued pension at 31 March 2019"	"Cash Equivalent Transfer Value at 01 April 2019"	"Real Increase in Cash Equivalent Transfer Value"	"Cash Equivalent Transfer Value at 31 March 2018"	Employer's contribution to stakeholder pension
	£000	£000	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
	1,995	16	0-2.5	(5-7.5)	90-95	260-265	1,995	179	1,732	32
	961	6	0-2.5	(5-7.5)	50-55	115-120	961	71	842	23
	0	0	0	0	0	0	0	0	0	0
	74	19	0-2.5	0-2.5	5-10	0-5	74	13	40	19
	822	18	0-2.5	(0-2.5)	45-50	105-110	822	89	690	17
	23	17	0-2.5	0-2.5	0-5	0-5	23	5	1	16
	1,289	18	15-17.5	47.5-50	30-35	95-100	744	391	878	6
	0	19	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0
	1,312	2	10-12.5	27.5-30	55-60	170-175	1,312	318	947	19
	513	20	7.5-10	15-17.5	30-35	65-70	513	158	323	22
	0	0	5-7.5	7.5-10	50-55	130-135	1,058	179	1,103	19

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.

Jacqueline Totterdell
Chief Executive
25 June 2020

Andrew Grimshaw
Chief Finance Officer
25 June 2020

Staff Report

Staff Report

This year, we employed around 9,500 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.

Male and female (Full time equivalent basis)

STAFF GROUP	WTE		%	
	Female	Male	Female	Male
Directors	9	8	52.94%	47.06%
Senior manager (AFC 8c+)	78	53	59.54%	40.46%
All staff	6,810	2,588	72.46%	27.54%

Average number of employees (Full time equivalent basis) (audited)

TYPE	2019/20			2018/19
	PERMANENTLY EMPLOYED NUMBER	OTHER NUMBER	TOTAL NUMBER	TOTAL NUMBER
Medical and dental	1,909	68	1,977	1,919
Administration and estates	1,911	205	2,116	2,132
Healthcare assistants and other support staff	1,150	134	1,284	1290
Nursing, midwifery and health visiting staff	2,486	488	2,974	2,927
Scientific, therapeutic and technical staff	1,323	128	1,451	1,488
Total average numbers	8,779	1,023	9,802	9,756
Number of employees (WTE) engaged on capital projects	43	14	57	26

Sickness absence data for the financial year 2019/20 is published by NHS Digital and can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Disclosures required by Health and Social Care Act

Total employee expenses

COST	2019/20			2018/19
	Permanently employed £000	Other £000	Total £000	Total £000
Salaries and wages	436,512	0	436,512	424,434
Social security costs	47,251	0	47,251	42,896
Apprenticeship Levy	2,135	0	2,135	2,044
Employer's contributions to NHS pensions	49,623	0	49,623	48,416
Pension Cost – employer contribution paid by NHSE on provider's behalf (6.3%)	21,772	0	21,772	0
Pension cost – other	0	0	0	0
Other post-employement benefits	0	0	0	0
Other employement benefits	0	0	0	0
Temination benefits	271	0	271	122
Temporary staff	0	18,502	18,502	17,071
Total gross staff costs	557,564	18,502	576,066	534,983

Average number of employees (WTE basis)

TYPE	2019/20			2018/19
	PERMANENTLY EMPLOYED NUMBER	OTHER NUMBER	TOTAL NUMBER	TOTAL NUMBER
Medical and dental	1,909	68	1,977	1,919
Administration and estates	1,911	205	2,116	2,132
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Scientific, therapeutic and technical staff	1,323	128	1,451	1,488
Total average numbers	8,779	1,023	9,802	9,756
Number of employees (WTE) engaged on capital projects	43	14	57	26

Expenditure on consultancy

EXPENDITURE ON CONSULTANCY	2019/20	2018/19
Consultancy costs (£k)	2,361	7,420

During the year the Trust engaged consultancy services to improve recording of elective care treatment times and support operational and cost improvement projects across a range of services.

Staff exit packages (audited)

EXIT PACKAGE COST BAND	NUMBER OF COMPULSORY REDUNDANCIES	NUMBER OF OTHER DEPARTURES AGREED	TOTAL NUMBER OF EXIT PACKAGES BY COST BAND
<£10,000	0	3	3
£10,001 – £25,000	2	1	3
£25,001 – £50,000	1	1	2
£50,001 – £100,000	2	0	2
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	0	5	10
Total resource cost (£k)	£210	£61	£271

Exit packages: non-compulsory departure payments (audited)

OTHER (NON-COMPULSORY) DEPARTURE PAYMENT	AGREEMENTS NUMBER	TOTAL VALUE OF AGREEMENTS £0
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	6	61
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	6	61

Off-payroll engagements

Table 1: For all off-payroll engagements as of 31 March 2020 for more than £245 per day and that last longer than six months.

	2019/20 NUMBER OF ENGAGEMENTS	2018/19 NUMBER OF ENGAGEMENTS
Number of existing engagements as of 31 March 2019	11	13
Of which…		
No. that have existed for less than one year at time of reporting	6	8
No. that have existed for between one and two years at time of reporting	2	3
No. that have existed for between two and three years at time of reporting	0	0
No. that have existed for between three and four years at time of reporting	0	0
No. that have existed for more than four years at time of reporting	0	0

Table 2: For all new off-payment engagements, or those that reached six months duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months.

	2019/20 NUMBER OF ENGAGEMENTS	2018/19 NUMBER OF ENGAGEMENTS
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2018	17	26
Of which:		
Number assessed as within the scope of IR35	4	0
Number assessed as not within the scope of IR35	0	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0	0
Number of engagements reassessed for consistency/assurance purposes during the year	0	0
Number of engagements that saw a change to IR35 status following the consistency review	0	0

Table 3: For any off-payroll engagements of Board members, and/or senior officials with any significant responsibility, between 1 April 2019 and 31 March 2020.

	2019/20 NUMBER OF ENGAGEMENTS	2018/19 NUMBER OF ENGAGEMENTS
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	0	0

Table 4: All Foundation Trusts must disclose the number of individuals in the capacity of a Board member or senior manager having significant financial responsibility in the year. This includes both on-payroll and off-payroll engagements.

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

Staff Engagement

Our workforce is the most valuable asset we have. We understand the importance of engaging with our staff, because an engaged workforce delivers better patient care. In 2019/20, we published our new workforce and education strategies which aim to ensure that we develop an empowered and engaged workforce, which feels supported and safe in speaking up about concerns, and which values and embraces our diversity. We are committed to developing a modern and flexible workforce and make use of new and innovative roles to support the delivery of outstanding patient care. As part of this, we are stepping up the ways in which we recruit, retain, train, develop and educate our staff. Effective staff engagement underpins this.

Ways in which we engage with staff include:

- the annual NHS Staff Survey and the Friends and Family Test for staff – two ways we find out what it is like to work at St George's
- regular team briefings for all staff and for individual teams
- ensuring staff know how to raise concerns
- delivering our diversity and inclusion strategy
- recognising the achievements of our staff, through awards and other recognition events
- taking an in-depth look at the culture of our organisation.

In 2019/20, this work was monitored by our People Management Group – following its establishment in August 2019, and the Trust Executive Committee and, at Board level, by the Workforce and Education Committee.

Diwali was one of the cultural events we celebrated during the year

Diversity and inclusion

We serve a diverse range of communities across south west London and beyond, and understand the importance of making sure our processes are fair and open, and that we champion the diversity of our patients and 46% of our staff who are from Black, Asian and Minority Ethnic (BAME) backgrounds.

During 2019/20 we established a Diversity and Inclusion Steering Group, chaired by the Trust's Chairman. We also re-launched all four of our Executive-sponsored staff networks, and appointment Chairs for each. These are:

- Black, Asian and Minority Ethnic (BAME) staff network
- Disability and Wellbeing staff network
- LGBTQ+ staff network
- Women's staff network

During 2019/20 St George's also held events for Diwali, Chanukah, Chinese New Year, Black History Month and International Women's Day.

Although we have made some progress this year, this has not been at the pace and of the scale that we want – and need – to achieve. The Board is committed to driving real change in this area and this will be a key priority in 2020/21.

Career progression equality

Despite having a diverse workforce, this is not proportionally reflected across all of our staff grades. We are working to increase the number of BAME staff at senior positions within the Trust, and have made a commitment that all recruitment panels for roles at Band 8a and above should be ethnically representative. To this end, in February 2020, 40 BAME members of staff were trained to become representatives on these panels.

We have also developed a proforma that managers complete to record a career coaching conversation if a staff member from a BAME background is not successful at interview for a Band 8a or above role.

Our own data also tells us that we are more likely to start a disciplinary process involving our BAME members of staff. We have reviewed 25% of disciplinary cases from 2018/19 and as a result, a pre-disciplinary investigation checklist has been devised that human resources advisers must complete before initiating formal disciplinary processes.

We know there is more to do, and will continue to work with our staff networks to shape improvements, including understanding and challenging 'unconscious bias' within our hospitals.

Workforce Race and Equality Standard (WRES)

Since 2017, all healthcare providers are required to publish

WRES INDICATOR	2018	2019
Relative likelihood of white applicants being appointed from short listing across all posts compared to BAME applicants	1.59	1.57
Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	2.04	1.82
Relative likelihood of white staff accessing non mandatory training and CPD compared to BAME staff	1.1	0.94
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	28.4%	27.9%
Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	31%	31.4%
Percentage of BAME staff believing the Trust provides equal opportunities for career progression or promotion	63%	59.6%
Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	18%	19.1%
BAME Board membership	12.5%	12.5%

their Workforce Race Equality Standard data which reports on the experience and treatment of BAME staff. Our WRES report, published in August 2019, reports on data from the period April 2018 to March 2019, and uses data taken from our 2018 NHS Staff Survey results.

Equality and Human Rights

Although we are not yet mandated to report on our ethnicity pay gap we have chosen to do so. This not only ensures greater transparency but also complements both the gender pay gap reporting and the Trust's diversity and inclusion strategy. As with the gender pay gap report, the data is based on a snapshot date of 31 March 2019 and is available via the Trust's website: www.stgeorges.nhs.uk/about/living-our-values/equality-and-human-rights. More information can also be found on the Cabinet Office website: https://gender-pay-gap.service.gov.uk

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 support 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 while working at St George's.

In 2019, we also established a Disability and Wellbeing staff network where issues related to disability in the workforce can be discussed, and the Trust can respond by providing appropriate support.

Improving staff health and wellbeing

We want everyone who works at St George's to feel supported with their physical and mental health. In the NHS Staff Survey 2018, staff told us that we need to prioritise staff health and wellbeing more, and since then we have introduced a range of initiatives in this area.

Our health and wellbeing strategy outlines our ambition for St George's to become a health promoting Trust. Progress is overseen by the People Management Group, Trust Executive Committee and, at Board level, by the Workforce and Education Committee.

Health and wellbeing opportunities to all staff working across the Trust include:

- an occupational health service including physiotherapy support
- a staff support service (including staff counselling, trauma debriefing, mediation)
- smoking cessation support
- mental health awareness training
- an annual Health and Wellbeing Day
- wellbeing events including Time to Talk Day and the Step Challenge
- wellbeing classes including pilates, yoga, gardening, and art club
- annual free flu vaccination for staff
- a second edition of our Mind Your Health booklet which contains information and signposting for managing emotional distress
- access to staff health and wellbeing champions across the Trust
- our wellness action plan: a tool for staff to fill out with their line managers to identify what keeps us healthy at work.

We know there is still more for us to do, and this is echoed by staff responses in our 2019 NHS Staff Survey (see below). Improving scores in this area will be a focus throughout the coming year.

NHS Staff Survey 2019

The NHS Staff Survey is conducted annually and provides a highly valuable insight into what our staff feel about the organisation and how they are treated. The feedback we receive from the survey is carefully analysed and used to inform our staff engagement strategy and our developing work to improve the culture of the organisation. Staff Survey questionnaires were sent to 8,518 eligible members of staff with 4,923 staff returning their survey. This was a 59.5% response rate, which is higher than 54% last year, and higher than the average response rate of 47.5% for acute Trusts nationally. A high response rate is a positive sign – but the real importance is in finding out what staff think is working well; and what we need to do better. In this year's survey the results were grouped into eleven indicators. The scores are out of ten with the indicator score being the average of those.

The NHS Staff Survey provides valuable insight into how our staff feel

The eleven indicators are compared against other Trusts. We are below the NHS average on eight indicators, and equal or above the NHS average on three, but the target areas for improvement remain to:

- improve overall staff engagement
- address bullying and harassment
- improve support for equality, diversity and inclusion.

These are critical areas to address in the coming year and link fundamentally to our commitment to improving the culture of the organisation. We will never achieve our vision of providing outstanding care, every time if we fail to deliver significant improvements in each of these areas. We are committed to achieving this and it will be a key priority for the Board in 2020/21.

	2019/20		2018/19		2017/18	
	TRUST	BENCHMARKING GROUP	TRUST	BENCHMARKING GROUP	TRUST	BENCHMARKING GROUP
Equality, diversity and inclusion	8.5	9.0	8.4	9.1	8.4	9.1
Health and wellbeing	5.5	5.9	5.6	5.9	5.7	6.0
Immediate managers	6.5	6.8	6.4	6.7	6.5	6.7
Morale	5.7	6.1	5.6	6.1	n/a	n/a
Quality of appraisals	5.7	5.6	5.6	5.4	5.5	5.3
Quality of care	7.5	7.5	7.4	7.4	7.4	7.5
Safe environment – Bullying and Harassment	7.6	7.9	7.6	7.9	7.6	8.0
Safe environment - violence	9.4	9.4	9.4	9.4	9.4	9.4
Safety culture	6.5	6.7	6.4	6.6	6.5	6.6
Staff engagement	6.9	7.0	6.8	7.0	6.9	7.0
Team work	6.4	6.6	n/a	n/a	n/a	n/a

Future priorities and targets

Despite progress in some areas, it is very clear that the results show that we need to do a lot more to make St George's a truly outstanding place to work.

The results of the Staff Survey have been shared in full with our Trust Board which is committed to making substantial progress in changing the culture of the Trust, and we have already embarked on a number of projects – such as our culture champions initiative which you can read more about in the Performance Report, to help us address some of the longstanding challenges we face. Over the coming year, our Leadership Academy, and Quality Improvement Academy, and staff networks will focus on improving staff engagement, health and wellbeing of our staff, and promoting a safety culture for our patients.

Guardian of Safe Working

We have a Guardian of Safe Working to ensure our doctors are always working a safe number of hours. The Guardian receives reports, and monitors compliance against our doctors' 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. The Guardian produces a quarterly report to the Trust Board and this is also presented to the Workforce and Education Committee.

Freedom to Speak Up Guardian

Enabling staff to speak up and raise their concerns about patient care, quality or safety is integral to providing outstanding care every time. Our Freedom to Speak Up service is in place for staff to raise any issues, led by Our Freedom to Speak Up Guardian, Karyn Richards-Wright. The Guardian's role and details of how to get in touch are outlined to all new staff at our Trust induction. In 2019/20, the Executive lead for Freedom to Speak Up was the Chief People Officer and the Non-Executive lead was Stephen Collier.

The service has been closely aligned to our LIAiSE service which is a one-stop listening and signposting service for all staff, introduced as a direct result of feedback from staff about the support available to them.

In 2019/20, we undertook a number of actions to strengthen our Freedom to Speak Up function, revising the Trust policy, investing in a new software package to document, on a confidential basis, concerns that were raised. We also invited NHS England and NHS Improvement's Freedom to Speak Up team to work with us to review our Freedom to Speak Up function, as we know from the outcomes of the 2019 NHS Staff Survey that not all staff feel safe and supported in speaking up. We have made a number of changes in response to this advice to strengthen its independence and increase its resourcing. Looking ahead, in 2020/21 we will be developing a new Freedom to Speak Up vision and strategy, taking action to ensure full compliance with new guidance published by NHS England and NHS Improvement in July 2019, and taking steps to identify and embed learning from cases in which staff speak up. This will be a key priority in 2020/21 and will support our work in improving the culture of the organisation.

ACTIVITY	TIME OR COST
Number of trade union representatives	53
Total FTE of trade union representatives	49.85
Number who spend between 1 – 50% of their time on Trade Union activities	53
Number who spend 100% of their time on trade union activities	0
Total Trust pay bill	£543,000,000.00
Total cost of facility time	£15361.99
Percentage of total pay spent on facility time	0.003%
Hours spent on paid facility time	1842
Hours spent on paid trade union activities	1170
Percentage of total paid facility time hours spent on paid TU activities	63.52%

Trade union facility time

The following information is published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017. The relevant period is 1 April 2019 until 31 March 2020.

Some of our Freedom to Speak up champions

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.

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

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

In preparing the accounts and overseeing the use of public funds, I can confirm we comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- 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 and Social Care 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
- Confirm that 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 St George's University Hospitals NHS Foundation Trust's performance, business model and strategy, and
- Prepared the financial statements on a going concern basis and disclose any material uncertainties over going concern.

As Accounting Officer, I can confirm we keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to 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.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that St George's University Hospitals NHS Foundation Trust's auditors are aware of that information.

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

Jacqueline Totterdell
Chief Executive

25 June 2020

Annual Governance Statement

Annual Governance Statement Statement of Compliance with the NHS Foundation Trust Code of Governance

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.

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of St George's University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Chief Executive Jacqueline Totterdell with staff on our special care unit

Capacity to handle risk

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

There is an established governance framework, supported and maintained by a framework of committees. The Trust Board has overall responsibility for the effectiveness of the governance framework and as such requires that each of its committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness. The Board itself has standing orders, reservation and delegation of powers and standing financial instructions in place which are reviewed annually. As the Accountable Officer, I support the Chairman in ensuring the effective performance of the Board and its committees and achieve this in a number of ways, including:

- 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 members 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 Chief Corporate Affairs Officer who also acts as the Trust Secretary. Governance is embedded across the Trust's Directorates and clinical divisions and is led by a Divisional Chairman, therefore 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. The Trust undertakes regular reviews of its governance structures including reviewing the effectiveness of its committees and groups.

During 2019/20, the Trust took a number of steps to further strengthen its governance arrangements following the independent external review of governance considered by the Trust Board in February 2018 to ensure they continued to be fit for purpose and support the delivery of key activities. Building on this, the Trust commissioned two external reviews of clinical governance; to review the processes and systems supporting our mortality monitoring meetings and multi-disciplinary team meetings; and the capacity and resilience of clinical governance processes and systems across the Trust. Both reports

The Trust commissioned two external reviews of clinical governance

were received by the Trust Board together with a business case for investment which was fully endorsed by the Board. A detailed action plan is in place to drive the recommended improvements forward.

We have continued to review the effectiveness of our Board sub-committees, and made improvements where appropriate. We have also commissioned a third external review to look at quality and safety reporting to our Patient Safety and Quality Group up to the Quality and Safety Committee, a sub-committee of the Board. We expect the findings of this report in quarter two of 2020-21 and will take forward recommendations for improvement.

Staff receive training in risk management that is appropriate to their roles and duties. The Trust policy on risk management is made available to all staff in the organisation and this provides both the risk management framework and guidance to staff to handling and managing risk. Good practice in risk management is identified in discussions of risk through our governance framework and this captured both informally and formally through updates to our policy and guidance.

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 them 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 has an agreed scheme of delegation and standing orders, and monitors compliance with these and with Trust policies and procedures. Certain procurement matters are reserved for the Board in the scheme of delegation, and this oversight helps to ensure resources are used efficiently and effectively.

More information on how the Trust manages risk relating to data security; the organisation's major risks; how stakeholders are involved in managing risks that impact them; and the ways in which we ensure that our workforce strategies and staffing systems assure the Board that staffing processes are safe, sustainable and effective, can be found throughout the Annual Governance Statement.

St George's has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

St George's has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust is able to assure itself of the validity of its Corporate Governance Statement through reporting via the Trust's Audit Committee. The Committee scrutinises compliance with the Trust's Constitution and provider licence, the NHS Foundation Trust Code of Governance and with its Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Members of the security team at St George's Hospital

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 on-going challenge, and this plays out against a backdrop of significant changes in terms of integrated, cross-system working. This context is important in understanding both St George's risks, and some of the drivers of those risks, as well as the constraints on the mitigations that the Trust can necessarily call upon.

The Board agreed the major risks relating to the delivery of its strategy in April 2019. The following strategic risks are recorded in detail in the Board Assurance Framework as at May 2020. These are monitored monthly by the relevant Board Committees and by the Board on a quarterly basis, and are available in full via the Board papers on the Trust's website.

TRUST OBJECTIVE	RISK DESCRIPTION	MITIGATION
Treat the patient, treat the person	Our highest priority is to provide safe and high quality care to our patients. A key risk to this is that we do not create an environment and embed an approach to quality improvement which minimises the occurrence of harm to our patients. At the same time, there is also a risk that our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care.	In 2019/20, we have sought to mitigate this risk through a number of actions. We developed and agreed a new quality and safety strategy which provides clarity about how we will achieve outstanding care and minimise harm as well as develop an effective culture of quality improvement throughout the organisation. To improve our clinical governance, we commissioned two independent reviews to examine clinical governance the capacity at care group, divisional and corporate level, and we now have in place a clear programme of work to address the areas of improvement identified. To address the specific challenges around the quality of care in cardiac surgery identified in previous annual reports, we have put in place a clear action plan and are implementing the actions identified by the independent external mortality review and by the independent scrutiny panel, with the CQC having observed the improvements we are making to the safety, governance and culture of the service in its December 2019 inspection report.
Right care, right place, right time	Timely access to care is critical to both the quality of care our patients receive and to their experience of care. Delays in care therefore represent risks to the quality of care our patients received. Linked to this, there is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated. We also identified the risk that we fail to make progress in delivering our clinical services strategy. Linked to this, there is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities.	While our performance on a number of operational standards remains challenged, during 2019/20 we took a number of actions to improve our performance and minimise delays to care and treatment. In terms of emergency care performance, we put in place a Rapid Assessment Zone to assess and triage our patients in a quicker and more effective way. We invested in new MRI scanners, made changes to our patient pathways, and took action to reduce the number of patients waiting for care on our Patient Tracking List. We have also taken a significant number of steps to improve both the effectiveness and reliability of our IT, and to make it more usable for our staff to enhance patient care. We have improved our cyber security resilience and the resilience of our data centre. Alongside a number of steps to improve our data quality and Patient Tracking List, we have also agreed both a new IT strategy and a new outpatients strategy, supported by clear implementation plans which will help us to deliver improvements in the way we care for our patients and the settings in which we provide care. To ensure we make real progress in delivering our strategy, we have developed a suite of supporting strategies and implementation plans and have put in place arrangements to ensure robust oversight of the delivery of the strategy. To mitigate the risks around developments in the system, we have been an active partner in the South West London STP and in the SWL Acute Provider Collaborative. We have worked in partnership with neighbouring Trusts and have played an active role in developing system wide pathways to improve patient care.

TRUST OBJECTIVE	RISK DESCRIPTION	MITIGATION
Balance the books, invest in our future	There is a risk that we do not develop plans to achieve unsupported financial balance within three years. There is a risk that the Trust is unable to source sufficient capital funds to support investment in areas of material risk.	In 2019/20, we put in place new processes for overseeing grip and control of Trust finances. While we did not achieve our agreed deficit of £3m by the end of the year, we reduced the deficit compared with previous years and delivered the majority of our Cost Improvement Plans. During 2019/20, the Trust Executive Committee and Finance and Investment Committee maintained close oversight and scrutiny of the Trust's financial position. Capital continued to be a significant challenge, particularly in the context of the need for significant investment in our infrastructure. To mitigate this risk, our CFO is playing a central role in the South West London capital prioritisation programme, and capital bids were submitted to NHS England and NHS Improvement.
Build a better St George's	There is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy. There is also a risk that we do not improve our estate to provide a safe environment for our patients and staff.	The Board took action to address concerns about the level of assurance it could take on estates issues by creating a sub-group of the Finance and Investment Committee to scrutinise the governance of estates issues. This work continued during 2019/20 and concluded in March 2020 when the Board agreed that it had established much clearer assurance on the position of estates risks and mitigations. The Trust commissioned an external governance review of estates and is now implementing the recommendations of this review. All health and safety systems and processes have likewise been reviewed and an action plan was developed which is being implemented. Developing an estates strategy remains a challenge, particularly in the context of changes in the system as a result of Covid-19. However, work is underway and we plan to produce the strategy in the coming months.
Champion Team St George's	Our workforce is our biggest asset and it is critical that we put in place a culture that is inclusive and empowering and that we recruit and retain staff with the skills we need both now and in the future. We have identified a number of risks to this. There is a risk that we are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care. There is also a risk that we are not seen as a diverse and inclusive employer by our staff and that we are unable to sufficiently address issues of harassment and bullying. In addition, there is a risk that we are unable to recruit, train and sustain (retain) an engaged and effective workforce, and that we are unable to develop new and innovative roles/ways of work to deliver our Trust clinical strategy.	We continue to face a number of challenges in this area, particularly in terms of establishing the right culture, addressing bullying and harassment, and ensuring that all staff are treated with respect and feel able to raise concerns without fear of detriment. During 2019/20, we recognised the importance of the need for cultural change in the organisation and established a culture change programme and recruited a number of culture change champions. The early diagnostics phase of this work is well underway and this will feed into a programme of work to develop an inclusive and empowering culture across the organisation. We have put in place measures to strengthen staff engagement and the Go-Engage system will go live shortly. To assist in progressing our priorities on equality and diversity, we have established four new staff networks (BAME, LGBTQ+, Women's and Disability) each sponsored by two members of the Executive team. We have also updated our policy on raising concerns. Throughout the year we have focused on putting in place effective recruitment campaigns and the Trust won an award for nursing recruitment in October 2019. We continue to invest in our staff and we will shortly launch an upgrade of our Totara system to support staff with appraisals. To ensure we continue to make progress in addressing both our culture and wider workforce challenges, we have agreed a new workforce strategy and an education strategy, and this is being closely monitored by the Workforce and Education Committee.
Develop tomorrow's treatments today	There is a risk that we cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.	In 2019/20, the Board agreed a new research strategy in order to give focus to research and to realising the Trust's potential, including through its partnership with St George's University of London. This is focusing on securing new research funding and in the Trust playing a leading role in research. We have made progress in this area by significantly increasing the number of patients participating in clinical trials, and are now actively engaged in Covid-19 research.

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 Informatics Governance Group (IGG) oversees the completion of the Data Security and Protection Toolkit (DSPT) on an annual basis, as well as reviewing any information governance incidents and all other IG activities. In turn the IGG reports to the Trust Executive Committee.

The Chief Financial Officer acts as the Senior Information Risk Officer and an Associate Medical Director as Caldicott Guardian. The Trust also has a Chief Information Officer, Data Protection Officer, an Information Governance Manager and a range of policies, procedures and training to ensure that all staff are aware of information governance requirements. The achievement level assessed within the DSPT provides an overall compliance against the National Data Security Standards.

During 2019/20 there were no incidents reportable to the Information Commissioner's Office (ICO) as of 31 March 2020. Information Governance Team is working together with other teams in Informatics Directorate on National Data Opt-Out process to be compliant.

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 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, and the audit committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control by the Board and Audit Committee are set out below.

On behalf of the Board, our Board committees regularly review the Integrated Quality and Performance report (IQPR) from the perspective of their remit. The Board also reviews this monthly. The monthly IQPR report details national priority and regulatory indicators including safety, clinical effectiveness and patient experience. The report is supplemented by more detailed briefings on any areas of adverse performance. In addition to this, our divisional directorates hold monthly performance review meetings with their care groups and individual services, and hold regular performance meetings with the executive team.

The Audit Committee provides the Board of Directors with an objective review of financial and corporate governance and internal control within the Trust, thereby providing independent assurance on them to the Board. In addition, it reviews and independently scrutinises 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. It also reviews the integrity of financial statements prepared by the Trust.

Internal audit reports are 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 our 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 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 the Board 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; and 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.

Conclusion

The head of internal audit has provided reasonable assurance that no significant internal control issues have been identified. The opinion is that overall reasonable assurance could be provided, and that the controls are generally sound and operating effectively. 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 £13.3m, which is greater than planned for the start of the year, and that we remain in financial special measures.

Additional disclosures

Emergency Preparedness, Resilience & Response (EPRR) assurance process 2019/20

This year has been an extremely busy time for EPRR with Brexit being a key issue during 2019/20 (and good resilience planning underway) and late 2019/2020 with the response to Covid-19 pandemic.

In terms of general assurance, and the plan for, responding to and recovery from emergencies, the Trust was assessed in the autumn 2019 against 64 core standards for EPRR and we are pleased to report we increased our assurance level from partially compliant to substantially compliant. At the end of this assurance process, NHS England felt that 'overall, the Trust demonstrated its commitment to EPRR' and did not find any aspects of our arrangements to be non-compliant.

The Trust has agreed with NHS England to an overall rating of substantially compliant and has an action plan in place for those areas requiring improvement.

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

Performance is monitored monthly, via the monthly quality and performance framework, by the Finance and Investment Committee and the Board. Our performance is reported through a number of key performance indicators (KPIs) through the appropriate regulatory framework. At the end of this reporting period, March 2020, the Trust was performing positively against a large number of key indicators. However there remain challenges including the ED four-hour standard, and returning to financial balance.

The Trust's financial stability rating has been under review during the reporting year and currently holds an NHS Oversight Framework Segmentation rating of 4 – Special Measures reflecting the financial and quality challenges the Trust faces.

Jacqueline Totterdell
Chief Executive

25 June 2020

Quality Report (Account) 2019/20

Part 1

Statement on quality from the Chief Executive

I am pleased to write this introduction to the Quality Report, particularly as I believe we have made real progress over the last twelve months.

Since joining the organisation as Chief Executive in May 2017, I've talked about the need for St George's to become an organisation that is constantly looking to improve, day in, day out, and the last year gives us real hope that this is now becoming part of the cultural norm.

In December 2019, we were commended by the Care Quality Commission for delivering 'significant improvements' to the services we provide. Our services for children and young people were rated outstanding overall, and three of our core services improved to Good for being safe.

Crucially, the CQC also recommended the Trust be removed from the special measures regime for quality of services, and this was officially confirmed by NHS Improvement in March 2020.

Of course, we still have a long way to go to deliver our vision of providing outstanding care, every time, but exiting special measures was a big step forward for the organisation, and staff morale.

In March 2020, NHS Improvement published the findings of an external, independent review of cardiac surgery at St George's Hospital. The report concluded that there were failings in the care provided to 102 patients between 2013 and 2018. We fully accepted the panel's findings, and apologised unreservedly to the patients' families that the care we provided fell way short of the high standards they deserved.

The heart surgery service at St George's is now safe, and the current service is very different to the one we took urgent steps to improve in 2017. These improvements were confirmed by the Care Quality Commission in their December 2019 inspection report.

We have completed the recommendations put forward by the panel in their review. There is still more work to do, but heart surgery patients should now be confident they will receive safe and effective care at St George's.

Quality and safety continues to be central to how we plan and deliver care for patients. During 2019/20, the Trust Board approved a new quality and safety strategy for the next five years (2019-24), and our teams continue to participate in a wide range of national and local clinical audits; which helps ensure we remain in step with care trends across key specialties.

Reducing harm to our patients means creating a culture where staff feel supported to raise concerns about any aspect of patient care. Over the past year, we have taken proactive steps to make it easier for staff to do this by creating a network of Freedom to Speak Up Champions, and raising awareness about how to report incidents from the moment staff join the Trust at their induction.

Over the past twelve months, we have also worked on giving staff access to the information and tools they need to deliver joined up care. This includes the extension of iClip – our electronic patient record – to Queen Mary's Hospital in Roehampton, making it much easier for staff across our different hospital sites to access and update information about our patients.

In many areas, we are setting the standard for others to follow. For example, as part of our commitment to research, we doubled the number of patients taking part in clinical research during 2019/20; and the partnership we have with St George's, University of London is a key part of this success.

This year, we also established a Medical Examiners' Office on the St George's Hospital site. The team, led by Dr Nigel Kennea, one of our consultants, provides independent scrutiny of deaths, guidance in death certification and helps to support bereaved families; the important role they play has been particularly evident since the start of the Covid-19 pandemic.

To the best of my knowledge, the information contained in this report is accurate and reflects our view of the quality of the health services we provide.

Finally, I would like to thank our dedicated staff who work tirelessly every day to provide safe and compassionate care to the communities we serve.

Jacqueline Totterdell
Chief Executive

25 June 2020

Part 2

2.0 Priorities for improvement and statements of assurance from the board

2.1 Our quality priorities for 2020/21

Context

Our vision is to provide outstanding care, every time for our patients, staff and the communities that we serve as described in the Trust's clinical strategy 2019/2024.

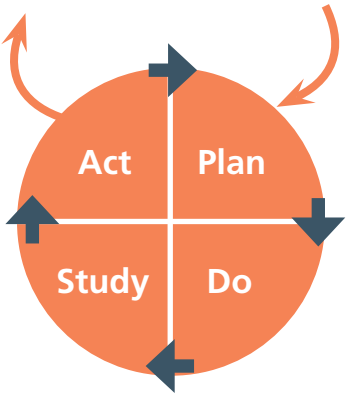
Throughout 2019/20 a series of underpinning strategies were developed to support the delivery of the Trust clinical strategy; one of which is our quality and safety strategy 2019/2024.

To support the delivery of our quality and safety strategy we have further developed our approach to quality improvement to help teams solve problems at their own level and to embed a culture of quality, safety and learning. Our experience is that we will best achieve this by continuing to use a simple yet effective improvement model to bring about positive change: Plan, Do, Study, Act (PDSA).

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Staff undertaking service improvement initiatives will continue to be able to draw upon support from our Quality Improvement Academy with particular emphasis on culture, leadership support, accountability, reliability and sustainability.

In 2019/20 we also refocused our quality improvement plan (QIP) by reviewing the progress we had made against the previous year's QIP and external assessments: care Quality Commission (CQC) inspections; national surveys; and local and national audit. We were also keen to move away from a plethora of action plans and have one plan so the refocused QIP was integrated with the Trust's Annual Plan 2019/20 and aligned to the Trust's Corporate Objectives 2019/20.

Our quality priorities 2020/21 and why we chose them

The quality priorities for 2020/21 were informed by:

- themes highlighted from our ward and departmental accreditation scheme
- progress against our QIP 2019/20
- local and national audit
- national priorities for sepsis, safe staffing, falls, and infection prevention and control
- actions from the 2018 CQC inspection which we implemented during 2018/19.

The key priorities for quality improvement have also been identified through analysis of serious incidents, moderate and low harm incidents and feedback from national and local surveys and Healthwatch 'Enter and View' visits.

As part of the development of our quality and safety strategy 2019/24 we also met and listened to the views of our patients and staff.

Our priorities for 2020/21 are aligned with year one of our quality and safety strategy and set out our programme of work for the year to come so that we continue to make improvements to safety and the quality of care for our patients and their families.

Each quality priority comes under one of three quality themes:

Priority 1 – Improve 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

Priority 2 – Improve patient experience: meeting our patients' emotional as well as physical needs

Priority 3 – Improve effectiveness and outcomes: providing the highest quality care, with world class outcomes whilst also being efficient and cost effective

Patients are safer when there

Priority 1 – Improve patient safety

is a safety culture that is fully embedded in everyday business. We believe that all our staff have responsibility to take all necessary steps to avoid harm to our patients, to learn from best practice, deliver the best possible outcomes and reduce unwarranted variation.

In 2020/21 the patient safety priorities we will focus on are interlinked with the full implementation of our new critical care outreach service which we established at the end of 2019/20. The critical care outreach service will have a significant impact on supporting our staff to manage deteriorating patients promptly and effectively.

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Timely escalation and response to deteriorating patients	Ensure all non-elective adult inpatients have a treatment escalation plan (TEP) in place within 24 hours of admission	Reduction in avoidable harm and death associated with missed opportunities when compared with 2019/20 Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 All adult inpatients will have a TEP Reduction in the number of cardiac arrests compared with 2019/20
Patients who lack mental capacity will have proper protection and care	Demonstrate through audit of healthcare records that patients who lack mental capacity are identified promptly, and have proper protection and care	Achieve compliance with our training targets for Mental Capacity Act (MCA) training and target specific areas based on analysis of notes audit
Consent for treatment	All patients will be supported to give consent for treatment	All adult inpatients will have a TEP Audit of consent demonstrates an improved position when compared with 2019/20
Learn from deaths	Embed medical examiner service and learning from deaths processes	Maintain Summary Hospital Level Mortality Indicator (SHIMI) within confidence intervals

Priority 2 – Improve patient experience

We want to provide the fundamentals of care that matter to our patients: communication; privacy; dignity; safety; nutrition and hydration; comfort; and warmth, in order to meet both their emotional and physical needs. We will listen to our patients and their carers and use patient feedback to focus on continuous improvement

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Learn from deaths	Embed medical examiner service and learning from deaths processes	Maintain Summary Hospital Level Mortality Indicator (SHIMI) within confidence intervals

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Learn from complaints to provide patients with an excellent experience	Undertake thematic analysis of our complaints to identify recurrent themes and share the findings	Reduction in the number of complaints when compared with the 2019/20 baseline
Provide an equitable experience for patients from vulnerable groups	Undertake self-assessment against the National Learning Disability Standards	Improvement in our self-assessment when compared to baseline
Improve patient flow particularly with reference to improved discharge processes	Continue with our clinically led long length of stay meeting with local authority input to support patients with complex discharge needs. Progress further the implementation of Red to Green in iClip to highlight the issues that delay discharge Continue to survey our patients on discharge and respond to what they tell us to ensure our patients are equipped with the information they need to manage their health and know how to access appropriate support Continue to improve our process for discharge summaries and enable our patients to leave our care with a follow up appointment or investigation date if required	Reduction in the number of patients awaiting external assessment, repatriation or external care when compared with the 2019/20 baseline See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2019/20 Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2019/20 Improvement in the patients who were discharged from an inpatient setting with a follow up appointment or investigation date when compared with 2019/20

Priority 3 – Improve effectiveness and outcomes

We want to support continuous learning and improvement. We want to demonstrate measurable improvement in patient outcomes and reduce unwarranted variation as evidenced in the results of national audits and quality standards reviews.

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Develop and implement an integrated training and education framework	With SWL and St George's Mental Health Trust we develop an integrated education and training framework for our staff to support the care and treatment of mental health patients in an acute setting	We will have an integrated education and training framework
Embed a culture of quality, safety and learning	Implement the recommendations from the external reviews of our clinical governance processes to ensure they support the delivery of safe, high quality care	Improvements in related questions in the NHS Staff Survey
Patients will not wait too long for treatment	Deliver care in line with activity plans	Achievement of targets for: • Referral to Treatment (RTT) within 18 weeks • Diagnostics within six weeks • Four hour operating standard • Cancer standards

2.1.4 How progress to achieve these priorities will be reported

The progress against 'what will success look like' outlined against our quality priorities above will be reported and monitored by monthly progress reports to the Patient Safety Quality Group and quarterly progress reports to the Quality and Safety Committee, a sub-committee of the Trust Board.

2.1.5 Progress against priorities for 2019/20 [See part 3]

Queen Mary's Hospital in Roehampton

2.2 Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by St George's University Hospitals NHS Foundation Trust. These are common to all quality reports and can be used to compare our Trust with other organisations.

St George's University Hospitals NHS Foundation Trust is the largest healthcare provider in south west London, and one of the largest healthcare providers in the country. The Trust 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 our main site, St George's Hospital in Tooting, but we also provide services from Queen Mary's Hospital in Roehampton and from health centres in Wandsworth. We also provided healthcare services for residents of HMP Wandsworth until August 2019 when the service was transferred to another provider.

We also 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 this includes family human immunodeficiency virus (HIV) services and bone marrow transplantation for non-cancer diseases.

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.

2.2.1 During 2019/20 the Trust provided and/or subcontracted 64 relevant health services. A detailed list is available in the Statement of Purpose on our website www.stgeorges.nhs.uk/about

2.2.1.1 The Trust has reviewed all the data available to us on the quality of care in 64 of these relevant health services through our performance management framework and our assurance processes.

2.2.1.2 The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by St George's University Hospitals NHS Foundation Trust for 2019/20.

2.2.2 Participation in clinical audit and National Confidential Enquiries

During 2019/20, 67 national clinical audits and four national confidential enquiries covered relevant health services that St George's University Hospitals NHS Foundation Trust provides.

2.2.2.1 During that period St George's University Hospitals NHS Foundation Trust participated in 99% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2.2.2 The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust was eligible to participate in during 2019/20 are as follows:

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		RELEVANT	PARTICIPATING
Assessing Cognitive Impairment in Older People / Care in Emergency Departments		✓	✓
British Association of Urological Surgeons (BAUS) Data & Audit Programme	Cystectomy	✓	✓
	Female Stress Urinary Incontinence	X	X
	Nephrectomy	✓	✓
	Percutaneous Nephrolithotomy	✓	✓
	Radical Prostatectomy	✓	✓
Care of Children in Emergency Departments		✓	✓
Case Mix Programme (CMP)	Neurology Intensive Care Unit	✓	✓
	General Adult Intensive Care	✓	✓
	Cardiothoracic Intensive Care Unit	✓	✓
Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Long Term Ventilation	✓	✓
Elective Surgery – National Patient Reported Outcome Measures (PROMs) Programme		✓	X
Endocrine and Thyroid National Audit		✓	✓
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	✓	✓
	National Audit of Inpatient Falls (NAIF)	✓	✓
	National Hip Fracture Database (NHFD)	✓	✓
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit		✓	✓
Major Trauma Audit (TARN)		✓	✓
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection		✓	✓
Maternal, Newborn and Infant Clinical Outcome Review Programme	Confidential Enquiry into Maternal Deaths	✓	✓
	Perinatal Mortality Surveillance	✓	✓
	Perinatal Mortality and Morbidity Confidential Enquiries	✓	✓
Medical and Surgical Clinical Outcome Review Programme	Acute Bowel Obstruction	✓	✓
	Out of Hospital Cardiac Arrests (OHCA)	✓	✓
	Dysphagia in Parkinson's Disease	✓	✓
Mental Health - Care in Emergency Departments		✓	✓

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		RELEVANT	PARTICIPATING
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community Support		X	X
Mental Health Clinical Outcome Review Programme		X	X
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Chronic Obstructive Pulmonary Disease (COPD)	✓	✓
(NACAP)	Adult Asthma	✓	✓
	Paediatric Asthma	✓	✓
	Pulmonary Rehabilitation	✓	✓
National Audit of Breast Cancer in Older People (NABCOP)		✓	✓
National Audit of Cardiac Rehabilitation (NACR)		✓	✓
National Audit of Care at the End of Life (NACEL)		✓	✓
National Audit of Dementia (Care in general hospitals)		✓	✓
National Audit of Pulmonary Hypertension (NAPH)		X	X
National Audit of Seizure Management in Hospitals (NASH3)		✓	✓
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)		✓	✓
National Bariatric Surgery Registry (NBSR)		✓	✓
National Cardiac Arrest Audit (NCAA)		✓	✓
National Cardiac Audit Programme (NCAP)	Adult Cardiac Surgery	✓	✓
	Adult Percutaneous Coronary Interventions	✓	✓
	Cardiac Rhythm Management (Arrhythmia Audit)	✓	✓
	Congenital Heart Disease in Children and Adults	X	X
	Heart Failure Audit	✓	✓
	Myocardial Ischaemia National Audit Programme (MINAP)	✓	✓
National Clinical Audit of Anxiety and Depression		X	X
National Clinical Audit of Psychosis		X	X
National Diabetes Audit (NDA)	Adults: Core Audit	✓	✓
	Adults: Inpatient Audit (NaDIA)	✓	✓
	Adults: Foot Care Audit	✓	✓
	Adults: National Pregnancy in Diabetes (NPID)	✓	✓
National Early Inflammatory Arthritis Audit (NEIAA)		✓	✓
National Emergency Laparotomy Audit (NELA)		✓	✓
National Gastro-intestinal Cancer Programme		✓	✓
National Joint Registry (NJR)		✓	✓
National Lung Cancer Audit (NLCA)		✓	✓
National Maternity and Perinatal Audit (NMPA)		✓	✓
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)		✓	✓
National Ophthalmology Audit (NOD)		X	X
National Paediatric Diabetes Audit (NPDA)		✓	✓
National Prostate Cancer Audit		✓	✓

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		RELEVANT	PARTICIPATING
National Smoking Cessation Audit		✓	✓
National Vascular Registry		✓	✓
Neurosurgical National Audit Programme		✓	✓
Paediatric Intensive Care Audit Network (PICANet)		✓	✓
Perioperative Quality Improvement Programme (PQIP)		✓	✓
Prescribing Observatory for Mental Health (POMH-UK)		X	X
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Antibiotic Consumption	✓	✓
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Antimicrobial Stewardship	✓	✓
Sentinel Stroke National Audit programme (SSNAP)		✓	✓
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		✓	✓
Society for Acute Medicine's Benchmarking Audit (SAMBA)		✓	✓
Surgical Site Infection Surveillance Service		✓	✓
UK Cystic Fibrosis Registry		X	X
UK Parkinson's Audit		✓	✓

2.2.2.3 The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust participated in during 2019/20 are as follows:

NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)	
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	
British Association of Urological Surgeons (BAUS) Data & Audit Programme	Cystectomy
	Nephrectomy
	Percutaneous Nephrolithotomy
	Radical Prostatectomy
Care of Children in Emergency Departments	
Case Mix Programme (CMP)	Neurology Intensive Care Unit
	General Adult Intensive Care
	Cardiothoracic Intensive Care Unit
Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Long Term Ventilation
Elective Surgery – National Patient Reported Outcome Measures (PROMs) Programme	
Endocrine and Thyroid National Audit	
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)
	National Audit of Inpatient Falls (NAIF)
	National Hip Fracture Database (NHFD)
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	
Major Trauma Audit (TARN)	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	
Maternal, Newborn and Infant Clinical Outcome Review Programme	Confidential Enquiry into Maternal Deaths
	Perinatal Mortality Surveillance
	Perinatal Mortality and Morbidity Confidential Enquiries
Medical and Surgical Clinical Outcome Review Programme	Acute Bowel Obstruction
	Out of Hospital Cardiac Arrests (OHCA)
	Dysphagia in Parkinson's Disease
Mental Health – Care in Emergency Departments	

NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)	
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	COPD
	Adult Asthma
	Paediatric Asthma
	Pulmonary Rehabilitation
National Audit of Breast Cancer in Older People (NABCOP)	
National Audit of Cardiac Rehabilitation (NACR)	
National Audit of Care at the End of Life (NACEL)	
National Audit of Dementia (Care in general hospitals)	
National Audit of Seizure Management in Hospitals (NASH3)	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	
National Bariatric Surgery Registry (NBSR)	
National Cardiac Arrest Audit (NCAA)	
National Cardiac Audit Programme (NCAP)	Adult Cardiac Surgery
	Adult Percutaneous Coronary Interventions
	Cardiac Rhythm Management (Arrhythmia Audit)
	Heart Failure Audit
	Myocardial Ischaemia National Audit Programme (MINAP)
National Diabetes Audit (NDA)	Adults: Core Audit
	Adults: Inpatient Audit (NaDIA)
	Adults: Foot Care Audit
	Adults: National Pregnancy in Diabetes (NPID)
National Early Inflammatory Arthritis Audit (NEIAA)	
National Emergency Laparotomy Audit (NELA)	
National Gastro-intestinal Cancer Programme	
National Joint Registry (NJR)	
National Lung Cancer Audit (NLCA)	
National Maternity and Perinatal Audit (NMPA)	
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	
National Paediatric Diabetes Audit (NPDA)	
National Prostate Cancer Audit	
National Smoking Cessation Audit	
National Vascular Registry	
Neurosurgical National Audit Programme	
Paediatric Intensive Care Audit Network (PICANet)	
Perioperative Quality Improvement Programme (PQIP)	
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Antibiotic Consumption
	Antimicrobial Stewardship
Sentinel Stroke National Audit programme (SSNAP)	
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	
Society for Acute Medicine's Benchmarking Audit (SAMBA)	
Surgical Site Infection Surveillance Service	
UK Parkinson's Audit	

2.2.2.4 The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		SUBMISSION RATE (%)
Assessing Cognitive Impairment in Older People / Care in Emergency Departments		100%
British Association of Urological Surgeons (BAUS) Data & Audit Programme	Cystectomy	100%
	Nephrectomy	100%
	Percutaneous Nephrolithotomy	On-going
	Radical Prostatectomy	74%
Care of Children in Emergency Departments		100%
Case Mix Programme (CMP)	Neurology Intensive Care Unit	100%
	General Adult Intensive Care	100%
	Cardiothoracic Intensive Care Unit	100%
Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Long Term Ventilation	100%
Elective Surgery - National PROMs Programme		0%
Endocrine and Thyroid National Audit		On-going
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	On-going
	National Audit of Inpatient Falls (NAIF)	100%
	National Hip Fracture Database (NHFD)	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit		On-going
Major Trauma Audit (TARN)		100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection		100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Confidential Enquiry into Maternal Deaths	Submitted on case by case basis
	Perinatal Mortality Surveillance	100%
	Perinatal Mortality and Morbidity Confidential Enquiries	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Bowel Obstruction	66.7%
	Out of Hospital Cardiac Arrests (OHCA)	100%
	Dysphagia in Parkinson's Disease	100%
Mental Health - Care in Emergency Departments		100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease (COPD)	On-going
	Adult Asthma	On-going
	Paediatric Asthma	100%
	Pulmonary Rehabilitation	On-going
National Audit of Breast Cancer in Older People (NABCOP)		100%
National Audit of Cardiac Rehabilitation (NACR)		On-going
National Audit of Care at the End of Life (NACEL)		95%
National Audit of Dementia (Care in general hospitals)		100%
National Audit of Seizure Management in Hospitals (NASH3)		100%

NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		SUBMISSION RATE (%)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)		100%
National Bariatric Surgery Registry (NBSR)		On-going
National Cardiac Arrest Audit (NCAA)		100%
National Cardiac Audit Programme (NCAP)	Adult Cardiac Surgery	On-going
	Adult Percutaneous Coronary Interventions	On-going
	Cardiac Rhythm Management (Arrhythmia Audit)	On-going
	Heart Failure Audit	On-going
	Myocardial Ischaemia National Audit Programme (MINAP)	On-going
National Diabetes Audit (NDA)	Adults: Core Audit	On-going
	Adults: Inpatient Audit (NaDIA)	100%
	Adults: Foot Care Audit	On-going
	Adults: National Pregnancy in Diabetes (NPID)	On-going
National Early Inflammatory Arthritis Audit (NEIAA)		On-going
National Emergency Laparotomy Audit (NELA)		97.9%
National Gastro-intestinal Cancer Programme		100%
National Joint Registry (NJR)		100%
National Lung Cancer Audit (NLCA)		100%
National Maternity and Perinatal Audit (NMPA)		N/A
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)		On-going
National Paediatric Diabetes Audit (NPDA)		On-going
National Prostate Cancer Audit		100%
National Smoking Cessation Audit		100%
National Vascular Registry		On-going
Neurosurgical National Audit Programme		On-going
Paediatric Intensive Care Audit Network (PICANet)		On-going
Perioperative Quality Improvement Programme (PQIP)		On-going
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Antibiotic Consumption	100%
	Antimicrobial Stewardship	100%
Sentinel Stroke National Audit programme (SSNAP)		On-going
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)		100%
Surgical Site Infection Surveillance Service		On-going
UK Parkinson's Audit		100%

2.2.2.5 National clinical audits – action taken

The reports of 32 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
British Association of Urological Surgeons (BAUS) Urology Audit: Percutaneous Nephrolithotomy	The Trust is performing in line with national averages on all aspects of this audit. As the department is performing well on this audit, the clinical lead plans to continue working towards a high level of compliance, meeting the targets set by BAUS.
British Association of Urological Surgeons (BAUS) Urology Audit: Radical Prostatectomy	The report showed favourable performance against the national average with regards to average length of stay (both are measured at 3 days per patient). The Trust also provides treatment for a larger number of high risk patients than average. For example, the percentage of patients with Gleason 3+3 (low grade cancer) that are treated is 11.75%, against the national average of 13.49%. However, the Trust fell short of submission targets, with only 74% of the expected cases submitted for this audit. As the department is performing well on this audit the service is working on improving data quality levels and continuing working towards a high level of compliance, meeting the targets set by BAUS.
British Association of Urological Surgeons (BAUS) Urology Audit: Cystectomy	The Trust submitted 106% of the expected cases for this audit, showing good reporting from the department. The Trust is at 0% for both of 30-day and 90-day mortality rates, below the national average of 1.14% and 1.95% respectively. This is despite performing surgery on more high risk patients (≥75yo, with a BMI outside of healthy parameters, and with kidney function below normal) than national. As the department is performing well on this audit, the project lead plans to continue working towards a high level of compliance, meeting the targets set by BAUS.
British Association of Urological Surgeons (BAUS) Urology Audit: Nephrectomy	The Trust submitted 125% of the expected cases for this audit, showing good data quality. 2.02% of cases at the Trust involved a complication; lower than the national average of 2.51%. The measured mortality rate is 0% on this procedure, below the national average of 0.36%. As the department is performing well on this audit, the clinical lead plans to continue working towards a high level of compliance, meeting the targets set by BAUS.
Fracture Liaison Service Database (FLS-DB)	Results from the last audit report show the Trusts submission rate is low for the year. This has led to the Trust currently in the below average for 9 key metrics. The service has responded by entering data regularly onto the FLS database rather than storing it locally for bulk upload. This has already led to an increased number of submissions and the audit lead is hopeful the next report will reflect this.
Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme (CMP)	The audit lead stated that the Trust performed as expected for the three 3 streams of cardiothoracic intensive care, general adult critical care and neuroscience critical care. The action plan for this year is to work to improve mortality and morbidity meetings for all three streams.
Major Trauma Audit (TARN)	This project looks at survival rates of patients undergoing treatment for injuries. The Trust had a 98% case ascertainment rate between January 2018 and July 2019; this is significantly higher than the expected rate of 80%. The report shows number of survivors broken down by their survival chance pre-operatively. The Trust was found to have over performed on patients with a lower chance of survival (between 0%-45%), with 44 expected survivors against 56 actual survivors. Due to this good performance, the department plans to keep working towards the same standards they have set, while monitoring to make sure compliance stays high.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma	The service reports that there have been issues with spirometry recording carried out in primary care. Due to vacancies within the respiratory CNS team, the Trust was unable to participate in the previous audit round, but this team is now back to full establishment and data collection recommenced at the start of 2019/20. Work is underway to improve the rate of patients receiving: • Specialist input to their care within 24 hours of admission • A discharge bundle before discharge

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): COPD	The service has steadily improved submission rates throughout the year in response to The Royal College of Physicians stating that the audit may move to being linked to best practice tariff. The audit lead has been working with the Trust IT team in order to arrange for all relevant patient data to be automatically extracted, which will allow the service to collect a sample every month, reduce the workload for clinical staff and further improve submission rates.
National Audit of Breast Cancer in Older People (NABCOP)	The latest audit report indicated a 100% submission rate for the Trust. Performance is generally in line with the national average except for Triple Diagnostic (clinical assessment, imaging and tissue biopsy). An action plan is in place to improve this performance moving forward.
National Audit of Percutaneous Coronary Interventions (PCI)	The audit report indicates that radial rate is stable and continues to be in line with the national average. The service plans to review NSTEMI data after making changes to data collection which will involve bringing this work under the remit of a clinical audit lead for Cardiology and tasking them with data submission, review and feedback to clinical teams.
National Cardiac Audit Programme (NCAP): National Heart Failure Audit	The Trust performed well for patients that are discharged from hospital on either angiotensin receptor blockers or beta blockers. Areas for improvement have been identified to look at the number of patients seen by a specialist, where the Trust was lower than national average for this measure and the number of patients referred to cardiac rehabilitation with confirmed heart failure.
National Cardiac Rhythm Management	The service reports that data collection is now collated for submission via PaceNet, an electronic record system. Results being uploaded once a month which has seen a large improvement in data quality and turnaround time which it is hoped will be reflected in the next audit round. Moving forward, this work will be brought under the remit of a clinical audit lead for Cardiology, who will be responsible for overseeing data submission, review and feedback to clinical teams.
National Diabetes Audit (NDA) - Adults: Pregnancy in Diabetes	The latest report indicates that the Trust were above the national average for managing HbA1c levels in the first and third trimesters. However, the Trust was below average for the number of women taking folic acid prior to pregnancy; the number of pregnancies where the first contact with the antenatal diabetes team was at less than 10 weeks gestation; and the percentage of babies born at or after 37 weeks who were admitted to a neonatal unit. The audit lead has recognised these issues and an action plan is under development.
National Diabetes Core Audit (NDA)	The service measures well against its peers in the latest report. However, it has been identified that the service are not capturing all eligible cases. Due to the low submission numbers the service lead and the clinical audit team are working with the Trust IT team in order to develop a system to automatically capture the 8 main criteria for the audit. This system will provide data that can be collated with the intent of monitoring improvements in patient results.
National Diabetes Footcare Audit (NDFA)	The Trust performs well against the national average for outcomes in the latest report results, and was in the minority of Trusts that all 6 care structures provided. The service is prioritising the following areas in the coming year: • Providing training sessions for ward staff and community teams on diabetic foot examination • Developing dedicated referral pathway into diabetic foot care and referral forms on primary care systems in the community for direct e-referral and assessment within 1 working day of referral. A pathway for A&E referrals and ward referrals to the service also exists • Integrated foot protection pathway covering community and acute settings from Tier 1 to Tier 4 • Integrated step-down pathway for patients returning to community foot protection. Promoting shared care with community podiatry and district nursing teams.
National Early Inflammatory Arthritis Audit (NEIAA)	The audit report highlighted the low numbers of submission from the Trust. The service have recognised this as due to a lack of patient pathway for eligible patients, and are in the process of modifying the pathway so all patients are seen and treated within the 6 week specified period. A new GP pro forma is being developed to assist GPs in identifying appropriate patients.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Gastrointestinal Cancer Programme: National Bowel Cancer Audit (NBoCA)	The Trust submitted 143 cases for this audit period, which was RAG rated green by NBoCA. The report highlighted that 42% of patients having major resections were classed as urgent or emergency cases. The national average is 15%. The audit lead believes this is largely due to incorrect coding by support staff. The service is working on raising awareness and implementing training around this topic to address this. Also only 7% of the Trust's patients were reported as being seen by a CNS, against a national average of 87% - this is an error in reporting, as the pathway exists that that a CNS attend every appointment. Historic data available shows that Trust compliance on this measure has never been below 95% and has always been above national average. A plan is in place to correct data entry.
National Gastrointestinal Cancer Programme: National Oesophago-Gastric Cancer Audit (NOGCA)	The Trust submitted 131 records during the audit period, within the expected parameters based on HES. 20.7% of patients with oesophago-gastric cancer at the Trust were diagnosed after an emergency admission. This figure is 13% nationally. The audit lead believes that this rate is not truly accurate, as those reviewed in the acute ambulatory area will have been coded as an emergency, when in fact they were a GP referral. Awareness and education has been implemented to rectify this issue. The national target on referral to start of treatment is 62 days. The Trust reports patients have their treatment started after, on average, 69 days for curative treatment, and 78 days for non-curative treatment. Actions to address this include setting up a new telephone triage clinic, faster reporting times of CTs and a new nurse appointment for identified patients.
National Joint Registry (NJR)	The Trust submitted 100% of eligible cases with data quality also being either as expected or above the national standard. On both hip and knee replacements, the Trust performed 'as expected' on the three KPIs – 90 Day Mortality, Revision Rate Operations Aug 14-Aug 19 and Revision Rate: Operations Aug 14-Aug 19. As the service performed well, the project lead plans to continue working to the same standards, and hopes to keep the same high quality of results for the next audit round.
National Lung Cancer Audit (NLCA)	The Trust had a 100% submission rate. However, data completeness was below the national average. The audit lead has attributed this to Infoflex, the data collection tool, being incompatible with the Trust's IT infrastructure. System upgrades are due to be implemented this year and it is hoped to see an improvement in the next audit round.
National Maternity and Perinatal Audit (NMPA)	The service is performing well against the national average for key metrics in this project, including the number of babies given breast milk and the proportion of late preterm babies admitted to NNU. Actions for the coming year include embedding a new bariatric pathway for women with high BMI with a specific obstetric consultant and midwifery team, and monitoring the induction of labour rates for changes due to reduced fetal movements' guidance and 36-40 week scans.
National Paediatric Diabetes Audit (NPDA)	The audit lead confirmed that the service are working towards the following: • Increasing insulin pump usage by offering access to more modern insulin pumps and continuous glucose monitoring systems. A business case has been submitted to obtain funding for this equipment • Routinely offering families a separate appointment primarily for structured diabetes education and psychological support. • To improve the completion of all 7 cre processes, we have investigated the issues and have discovered shortfalls in receiving and reporting of the samples. An action plan is in place to address this.
Paediatric Intensive Care Audit Network (PICANet)	The latest audit report indicates that the rate of unplanned extubation was higher in 2018 compared to 2017 and was reflected nationally. The Trust performed well against the relative rate of emergency readmissions within 48 hours of discharge. The audit lead recognised these findings and an action plan is in place.
Perioperative Quality Improvement Programme (PQIP)	The Trust is performing above national average with regards to patients eating and drinking within 24 hours. The department reports to be continuing to strive towards a high level of compliance.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Antibiotic Consumption	The Trust increased its compliance against lowering UTIs during the year, but has identified further education and quality improvement work to be done within the elderly care department, whilst a new UTI pathway is introduced to the emergency department. Compliance improved for colorectal surgery over the year, meeting target in Q3. The project lead is working with the clinical coding department to improve timely identification of patients. The results for Q4 were unavailable and will be reviewed and responded to in due course.
Royal College of Emergency Medicine (RCEM): Feverish child audit 2019	The Trust was fully compliant in the audit submitting 120 cases. The Trust were below the national average for assessing risk of sepsis, assessing source of infections as per NICE guidance, timely reviews by seniors and an appropriate 'safety net' for discharged children. The results were fed back to staff during the departmental audit meeting and it was accepted that there is room for improvement. An action plan has been developed to address the main issue of documentation issue which will be rectified by using electronic record systems over the next 12 months with co-ordination from the clinical audit team.
Royal College of Emergency Medicine (RCEM): VTE risk in Lower Limb immobilisation 2019	The Trust was fully compliant in submitting 123 cases. The national report summarised the results into 3 key standards and we were above the national average for all of these measures showing a positive outcome. Results were fed back to staff during the service audit meeting by the project lead. A re-audit is planned for this year.
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	The project lead has identified that wrong blood in tube remains an on-going issue, along with avoidable transfusion reaction. There have been a low number of transfusion associated circulatory overload cases, which is a risk common in vulnerable patients. The following actions have been outlined for the coming year: • Continue to raise awareness and educate regarding common issues around the transfusion practice, including fluid balance and danger of transfusion associated circulatory overload cases • Currently auditing all sampling practice across the Trust, and putting together a business case for blood transfusion management software • Investigations into each case of transfusion reactions and share learning.
Surgical Site Infection Surveillance Services	The Trust was below the national average for the percentage of SSI cases for inpatients. Actions for the service in the coming year include: • Revising and adapting the RCA tool to expand the situations where it can be used • Reviewing the type of sutures used • Feeding back the findings of reports to wider range of stakeholders.
The National Audit of Cardiac Rehabilitation (NCAR) 2019	The Trust met all 7 of the key metrics of the audit. The service reports to be concentrating their efforts on the following areas in the coming year: • Continuing to maintain full certification of the standards required • Examining heart failure referrals into the Trust, as local figures suggest that there are potentially more patients who could be referred into the service, which could then pose a risk to capacity • Investigating the ratio of male to female referrals across all conditions/treatment groups, as the figures from the past 3 years suggest an imbalance. The service will update the departmental website with patient testimonials from a diverse set of patients to encourage attendance to the service.
UK Parkinson's Audit	The Trust performed well against 8 of the 9 key metrics and reported 100% submission rate. The report showed that the Trust performed below national average for patients feeling they were given suitable levels of information at diagnosis or when prescribed new medication. These finds have seen the following actions: • The service has implemented a 'newly diagnosed' session which provides patients with substantially more information than before • Working with clinicians to improve patient led decision making when new medications are prescribed.

2.2.2.6 Local clinical audits – actions taken

The reports of eight local clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided.

LOCAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
Controlled Drugs Check & Stock Audit	This audit is conducted quarterly and ensures that controlled drugs are correctly stored and secured and that an adequate record is kept which complies with controlled drug guidance. Performance over the year has been largely positive, including a new standard related to Enfit bottle adaptors. Following the introduction of Enfit bottle adaptors the proportion of incorrect balance incidents involving liquid discrepancies has decreased Actions noted for the year ahead include: • Ward pharmacists have identified the need for enhancing the ward training package, to include how to order, how to enter into registers and calculate the amount of medication required • Implement brief training sessions on controlled drugs directly to ward nurses.
Early Warning Score Audit	This audit measures the graded response strategy used by the Trust for patients identified as being at risk of clinical deterioration as per NICE guidelines. The lead for this project reported an action plan for the next audit round: • Investigate the deterioration of the previous baseline for 'appropriate response' of 75% to a plateau of 60%. • Ensure ID card sized aide memoirs for escalation are available for staff.
Emergency Department Mental Health Documentation Audit	This audit was implemented in response to Care Quality Commission recommendations. The audit is conducted quarterly and has been in place since 2018, the last audit round indicated a need for improvement in nursing documentation. The following actions are planned for the upcoming year: • Teaching sessions – both at staff induction and on-going sessions. • Undertake review of any related research • Increase the sample size audit with assistance from medical students • Modify the audit tool to reflect new paper-light process in the department.
IV to Oral Switch Compliance Audit	This project aims to ascertain the number of patients who are prescribed IV antibiotics and those that are eligible to switch to oral antibiotics. Data is sampled from across different specialities. The average percentage of patients on IV antibiotics was measured higher than previous years due to assessing a select number of wards with the highest usage across the different specialities. All cases that were eligible for IV to oral switch were carried out within 24 hours, which is an improvement over previous audit rounds.
Local Safety Standards for Invasive Procedures (LocSSIPs): Theatre Areas	This audit project looks at reviewing the Trusts use of LocSSIPs for all invasive procedures. In Q4 19/20, 14 of the 17 reporting specialties were 100% compliant on all aspects of the LocSSIPs audit. Action plan for the coming year is to review all LocSSIPs tools to make sure that they are fit for purpose, as well as ensuring that all eligible procedures are audited.
Mechanical Thrombophylaxis Audit	An audit on medical thrombophlaxis was conducted to understand compliance behaviour at the Trust, following introduction of electronic prescribing, and to assess performance against guidance. The project lead confirmed the following actions in light of the findings: • Nurses, midwifes and healthcare assistants to be continuously trained on measuring, fitting and monitoring of anti-embolism stockings • Ensure information leaflets are available on all wards on VTE prevention • VTE champions to highlight importance of VTE prevention • Increase the focus on prescribing and nursing documentation by providing regular training sessions to doctors and nursing staff.

LOCAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
Nasogastric Tube Audit	This audit was introduced as a response to investigate the care and maintenance of nasogastric tubes. The results showed that there is shortfall in the information recorded with respect to the insertion of and positioning of tubes prior to administering food, drink or medication. In response improvement actions were as follows: • Update the Trust policy to reflect changes to intensive care department guidance • Modify aspirate restrictions on wards, which contributes to more x-rays and delays in feeds or medication • Work at organisational level to send clear guidance to improve and standardise documentation on electronic record system • Electronic record system champions to offer training across all wards • Re-audit in 2020.
Safety Thermometer	The Trust has continued to submit data for this project, which focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs. The average harm free care over the previous 13 months is 96%, which is both higher than the national average and the national standard of 95%.

2.2.3 Our participation in clinical research

Research is core to the purpose of St George's. Through research, we play our part in developing the treatments of tomorrow, give our patients access to new treatments and improve our clinical care. We lead and undertake research across our clinical specialities, supported by our diverse research nursing teams and Clinical Research Facility.

St George's recently launched its 2019/24 research strategy, with plans built on our strong research base and invest more in our staff to support their research ambitions, invest in our IT research infrastructure and gain core National Institute for Health Research (NIHR) funding for our Clinical Research Facility.

Crucial to our research is our partnership with St George's, University of London. We have set up four Clinical Academic Groups in specific areas where both institutions have expertise and critical mass, in which clinicians, clinical academics and scientists can collaborate to improve research activity. As part of our new research strategy, we are establishing the St George's Institute of Clinical Research, a joint NHS-University structure to increase collaboration and further our research.

A key way to develop and offer new treatments is through participation in clinical research studies that are approved by the NIHR, which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. In 2019/20 St George's recruited 10,710 patients onto the NIHR portfolio adopted studies, which is double the number of three years ago.

The number of patients receiving relevant health services provided or subcontracted by St George's University Hospitals NHS Foundation Trust in 2019/20 that were recruited during that

The team behind our record increase in clinical trials

reporting period to participate in research approved by a research ethics committee was 10,928.

2.2.4 Our Commissioning for Quality and Innovation (CQUIN) performance

A proportion of St George's University Hospitals NHS Foundation Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between St George's and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at NHS England » 2019/20 CQUIN

In 2019/20 £8.3 million of our income is conditional on achieving quality improvement and innovation goals. In 2019/20 the percentage value for CQUIN dropped from 2.5% to 1.25% (1.55% for NHS England) of total contract income (excluding drugs and devices); hence the reduction.

2.2.5 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".

In 2019 we were named Innovative Trust of the Year by the Health Innovation Network (HIN)

The CQC has not taken any enforcement action against St George's University Hospitals NHS Foundation Trust during 2019/20.

A group of core services were inspected by the CQC in July 2019; the report was published in December 2019 and our rating was confirmed as 'Requires Improvement'. We were pleased to see significant improvement in our ratings across the key lines of enquiry for core services when compared with the 'Requires Improvement' position of the previous year.

Services for children and young people were rated as 'Outstanding' overall and there were services that were rated as 'good' overall. In the caring domain we were also pleased to receive a rating of 'Outstanding' for services for children and young people and 'Good' for all other services. The table overleaf shows the ratings for our core services and our overall rating.

The CQC made a recommendation to NHS England and Improvement (NHSE/I) for the Trust to be removed from Quality Special Measures. In February 2020 NHSE/I confirmed that the Trust was removed from Quality Special Measures, a significant step forward and one that recognises the improvements in quality and safety for our patients, their families and our staff.

Ratings for St George's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement ↔ Dec 2019	Good ↑ Dec 2019	Good ↔ Dec 2019	Requires Improvement ↔ Dec 2019	Good ↑ Dec 2019	Requires Improvement ↔ Dec 2019
Medical care (including older people's care)	Requires Improvement ↔ Dec 2019	Requires Improvement ↔ Dec 2019	Good ↔ Dec 2019	Requires Improvement ↓ Dec 2019	Requires Improvement ↓ Dec 2019	Requires Improvement ↔ Dec 2019
Surgery	Good ↑ Dec 2019	Good ↑ Dec 2019	Good ↔ Dec 2019	Requires Improvement ↔ Dec 2019	Good ↔ Dec 2019	Good ↑ Dec 2019
Critical care	Requires Improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Maternity	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Services for children and young people	Good ↑ Dec 2019	Good ↔ Dec 2019	Outstanding ↑ Dec 2019	Outstanding ↑ Dec 2019	Good ↑ Dec 2019	Outstanding ↑↑ Dec 2019
End of life care	Requires Improvement Nov 2016	Requires Improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires Improvement Nov 2016	Requires Improvement Nov 2016
Outpatients	Good ↑ Dec 2019	Not rated	Good ↔ Dec 2019	Requires Improvement ↔ Dec 2019	Requires Improvement ↑ Dec 2019	Requires Improvement ↔ Dec 2019
Overall*	Requires Improvement ↔ Dec 2019	Requires Improvement ↔ Dec 2019	Good ↔ Dec 2019	Requires Improvement ↔ Dec 2019	Requires Improvement ↔ Dec 2019	Requires Improvement ↔ Dec 2019

*Overall ratings for the Trust are identified by the CQC by combining the ratings for the services. The CQC decisions on overall ratings take into account the relative size of services. The CQC uses their professional judgement to reach fair and balanced ratings.

Throughout 2019/20 the Trust continued to take proactive steps to deliver improvements within our cardiac surgery service and continues to provide a safe cardiac surgery service, confirmed by the Care Quality Commission (CQC) following an inspection of the service in August 2018. The CQC carried out a further inspection of our cardiac surgery service in July and September 2019 and the report, published on 18 December 2019, recognised the improvements made to the service and that the CQC were assured that there was credible and effective leadership in the cardiac surgery service. The CQC also noted the further improvements in governance, particularly in relation to mortality and morbidity meetings.

A separate panel of independent experts reviewed all patient deaths that occurred following cardiac surgery between April 2013 and December 2018. The panel examined the safety and quality of care that patients received during this period. The report was published in March 2020.

External oversight of the service is being maintained by NHSE/I and a package of support measures is in place to ensure there is continued progress and improvement.

2.2.7 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 carried out of services provided by St George's University Hospitals NHS Foundation Trust are available on the CQC website www.cqc.org.uk

2.2.8 Our data quality

St George's University Hospitals NHS Foundation Trust submitted records during 2019/20 for inclusion in the Hospital Episode Statistics which are included in the latest published data.

2.2.8.1 The percentage of records in the published data which included the patient's valid NHS number was:

- 98.86% for admitted care
- 99.60% for outpatient care
- 94.98% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

- 99.96% for admitted care
- 99.92% for outpatient care
- 99.95% for accident and emergency care

2.2.9 Our Information Governance Assessment Report

The Trust planned to be compliant with all the mandatory requirements of the NHS Data Security and Protection Toolkit (DSPT) by 31 March 2020. Due to Covid-19 outbreak, NHS Digital allowed all NHS organisations to postpone the toolkit submission until 30 September 2020. They also extended Mandatory Information Governance Training Requirement and National Data Opt-OUT Compliance until 30 September 2020. The Trust's Information Governance Manager together with the Informatics Services continues to work on the toolkit submission under the leadership of the Chief Information Officer while tackling emergent challenges due to the impact of Covid-19. The Trust will submit the toolkit with all the mandatory requirements by "Satisfactory Standard Met Status" by 30 September 2020.

2.2.10 Payment by Results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20.

2.2.11 Learning from deaths

During 2019/20 1,660 of St George's University Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of this reporting period:

- 406 in the first quarter
- 370 in the second quarter
- 426 in the third quarter
- 458 in the fourth quarter

By 31 March 2020, 1063 case record reviews have been carried out in relation to 64% of the deaths included.

In 1063 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record or an investigation was carried out was:

- 384 in the first quarter
- 349 in the second quarter
- 312 in the third quarter
- 18 in the fourth quarter

Five (representing 0.3%) 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:

- Three representing 0.74% of the number of deaths which occurred in the first quarter
- Zero representing 0% of the number of deaths which occurred in the second quarter
- Two representing 0.47% of the number of deaths which occurred in the third quarter
- Zero representing 0% of the number of deaths which occurred in the fourth quarter

These numbers have been estimated using the locally developed online screening tool and structured review, which is based on the Royal College of Physicians (RCP) tool. Any death that is judged to be more than likely avoidable (more than 50:50) is included in this figure.

What we have learnt and action taken

Summary

Through timely review of a significant proportion of the deaths that occur within the Trust it is inevitable that opportunities for learning and reflection will be found. For any death where the central Mortality Review Team feel there is significant concern, the case is escalated immediately to the Risk Team to consider if a serious incident, or other, investigation is required. Any significant problem of care, whether or not it affected outcome, is highlighted to the clinical team for discussion and local learning.

During the course of the year a number of issues have been highlighted for local reflection and learning, including instances where excellent practice has been observed. These issues include documentation and communication, management of end of life care, early consideration of treatment escalation plans, responsiveness of medical teams and frequency of senior review. A selection of brief examples of issues raised and actions taken during the year are given below:

- There were a small number of cases where potential issues of care related to a lack of senior review at weekends. These were raised directly with the Chief Medical Officer for his consideration and were used to inform existing work-streams

looking at the configuration of care out of hours.

- Potential learning in relation to the discussion and documentation of decisions not to attempt resuscitation have been identified in a small number of cases. Reflections from clinical teams and discussion at local Morbidity and Mortality meetings identified the need to improve the transfer of information between teams and to ensure that documentation of decisions is not deferred.
- Improvements in communication related to patients transferred from Queen Mary's Hospital to St George's Hospital were realised through the deployment of our electronic patient system (iClip) to Queen Mary's, significantly improving information sharing and reducing the risk of communication difficulties in the future.
- Liaison with specialist teams continues to bring benefits. Mortality reviews for all patients that had venous thrombus embolisms in the Trust are now considered by the Hospital Thrombosis Group, in particular to consider whether they might influence any current clinical guidelines and practice. The Palliative Care Team have been consulted for their assessment of care in a number of cases and this has resulted in the team being invited to specialty meetings to provide training.

Action taken in 2019/20 and plans for 2020/21

For the first three quarters of the year our independent team of trained mortality reviewers ensured the timely review of over 90% of deaths in line with the Learning from Deaths framework. All patients where a care issue may have contributed to death were escalated to the risk team and included in our serious incident decision meeting (SIDM) discussions. Any death where review suggested it may have been potentially avoidable was escalated to the risk team to consider detailed investigation and rapid response through our serious incident process. Any significant problem of care, whether or not it affected outcome, was brought to the attention of the clinical team for discussion and learning at the local morbidity and mortality meeting.

In the final quarter of the year we introduced the Medical Examiner service. The Medical Examiner scrutinises non-coronial deaths and alerts the Trust's team of trained mortality reviewers to any death that requires completion of a structured judgement review, in line with Learning from Deaths. To support robust clinical governance processes the Medical Examiner will alert clinical teams to any deaths where potential learning has been identified.

The implementation of the treatment escalation plan (TEP) process was one of three clinical priorities for the Trust this year. Our mortality reviews suggest that an increasing proportion of patients are benefitting from having a TEP in place and continuing to embed this will help to address a number of issues that have been identified through our Learning from Deaths process. Common themes for improvement include documentation, particularly of discussions between teams and with families and carers; management of end of life care; and the involvement of senior team members at key points in the patients' care. The TEP process and associated documentation supports improved practice across these elements of care.

In addition to promoting reflection and learning by highlighting to governance and clinical teams where care or treatment could potentially have been better, the mortality review team has also sought to achieve this aim through acknowledging excellent practice.

This year an extensive review of mortality governance has been completed and the action plan arising from this has been endorsed by the Board. The aim of this work is to strengthen existing processes to ensure that we maximise the opportunities for learning identified by mortality reviews, and to support the design and delivery of appropriate action plans.

During 2019/20 the Trust has established a Medical Examiner Office to further support the bereaved. Medical Examiners began scrutinising deaths in January 2020 and have been expanding the coverage of the service during the final quarter of the year with the intention of performing full scrutiny of all non-coronial in-hospital deaths by April 2020, in line with the expectations of the National Medical Examiner. In 2020/21 the focus will be on refinement of the Medical Examiner service and planning the extension of scrutiny to deaths that occur outside of hospital.

There were no (0) case record reviews and no (0) investigations completed after 30 April 2019 which related to deaths which took place before the start of the reporting period.

Five representing 0.3% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the locally developed online screening tool and structured review, which is based on the Royal College of Physicians (RCP) tool.

Five representing 0.3% of patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.2.12 Standards for Seven day Services

The Trust is compliant with standards five, six and eight for seven day services and has improved compliance with standard two (all emergency admissions must be seen by a consultant within 14 hours of admission). Throughout 2019/20 a series of improvement actions were taken by the Trust however the Trust was unable to deliver full compliance by April 2020.

Due to the impact of Covid-19 the Board assurance statement has been deferred until September 2020 and will be reflected in the Quality Account 2020/21.

2.2.13 How our staff can speak up

Staff are encouraged and supported to speak up and have various ways of doing so. Staff are encouraged in the first instance to raise issues with their line manager, often concerns can be resolved at this level. However, it is recognised that some staff may not feel comfortable in taking this route, especially if the concern being raised pertains to their line manager.

Staff can raise concerns with:

- Any manager/ leader within their department
- Freedom to Speak up Guardian/ Champion
- Their Human Resource Adviser/ Manager
- Executive and Non – Executive leads for Freedom to Speak Up
- Chief Corporate Affairs Officer
- Chairman

Staff can raise concerns in different ways such as:

- Face to Face (verbally)
- In writing (letter/ email)
- Telephone contact

Staff are also advised of external reporting routes if they are unhappy with using any of the internal reporting routes or if they indicate that after raising a concern they do not feel the concern was investigated in line with Trust procedures, for example Care Quality Commission, and recognised professional or union body.

Staff who speak up are advised to report incidents where they feel due to speaking up they have come to a detriment. If it is found that this is the case, the Trust will take appropriate action to mitigate the risk to the staff member concerned and if necessary appropriate action taken under the Trusts disciplinary procedure. Staff are also regularly referred for additional support after raising concerns to our staff support team and or Occupational Health by agreement with the staff member.

Once an outcome is received the feedback is given to the person raising the concern either in writing or verbally dependent upon the issue raised, how it was resolved i.e. formally or informally and the preference of the person raising the concern. Clearly, anonymous concerns cannot be fed back however the outcome is logged by the Trust.

2.2.14 Guardian of Safe Working

We have a Guardian of Safe Working Hours who ensures our doctors are always working a safe number of hours and comply with the Terms and Conditions for Doctors and Dentists in Training (NHS England, update 2019). The Guardian acts as the champion of safe working hours and receives reports and monitors compliance. 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. A health roster system is now available to all medical staff.

In 2019/20 throughout the year the rota gap ran at an average of 10%. A total of 348 exceptions (rota gaps) were reported which is a significant reduction from 2018/19 (369 exception reports). Ten were highlighted as an immediate safety concern, compared with fifteen immediate safety concerns raised in 2018/19. Each safety concern was addressed immediately and no patients came to harm. Improvement plans were developed which saw targeted recruitment to support rota cover, a full work schedule review in one case, communication on how to escalate clinical concerns (also included in junior doctor induction), IT training and provision of laptops to support different ways of working and specific support for trainees in difficulty.

Gaps in rotas remain a nationwide problem and despite active recruitment, posts can stand unfilled for substantial periods of

time. The Trust workforce strategy 2019-24 focusses on recruitment and retention of all staff which will benefit doctors in training.

2.3 Reporting against Core Indicators 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.

2.3.1 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 1, a score below 1 denotes a lower than average mortality rate. 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.

SUMMARY HOSPITAL LEVEL MORTALITY INDICATOR (SHMI)	Apr 18 – Mar 19	May 18 – Apr 19	Jun 18 – May 19	Jul 18 – Jun 19	Aug 18 – Jul 19	Sep 18 – Aug 19	Oct 18 – Sep 19	Nov 18 – Oct 19	Dec 18 – Nov 19	Jan 19 – Dec 19
SHMI	0.82	0.82	0.81	0.83	0.83	0.83	0.85	0.85	0.85	0.86
Banding	Lower than expected	Lower than expected	Lower than 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	51	51	50	49	49	50	49	49	48	47

Source: NHS Digital

2.3.1.1 The Trust considers that this data is as described 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.

2.3.1.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- We have fully implemented the Learning from Deaths Framework and commenced implementation of the Medical Examiner System. We undertook a review of our mortality monitoring process. We plan to continue to strengthen this and review all deaths to ensure we identify and share every opportunity to learn and improve the care our patients receive.

2.3.2 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 two clinical procedures, which are hip replacement or knee replacement.

Percentage of patients reporting an increase in health following surgery		2013-14		2014-15		2015-16		2016-17		2017-18		2018-19*	
		SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average
Hip replacement	EQ-5D™	86	82.7	90	88.2	100	88.4	77	89.1	71	90	66.7	90.2
	EQ-VAS	65	64.2	80	65.1	58	65.6	75	67.2	43	68.3	66.7	69.6
	Specific	81	96	100	96.4	94	96.5	71	96.7	75	97.2	100	97.2
Knee replacement	EQ-5D™	60	80.3	60	80.5	69	80.7	100	81.1	0	82.6	No data	82.7
	EQ-VAS	50	54.6	50	55.3	33	56.4	40	57.5	33	59.7	No data	59
	Specific	80	93	82	93.2	85	93.6	100	93.8	33	94.6	No data	94.7

Source: NHS Digital9https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/hip-and-knee-replacement-procedures---april-2018-to-march-2019

* The 2019/20 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2020/21.

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. 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 and we consider it likely that this explains our variance from the national average score. For example, we had three patients with total hip replacements and no patients for total knee replacement in 2019/20 (although this data has not been published at the time of writing this report).

2.3.2.1 The Trust considers that this data is as described 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 a minimum of three 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.

2.3.2.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to offer patients the opportunity to participate in PROMs and contact the patient at the three month intervals to prompt a further response.

2.3.3 Readmission within 28 days of discharge

Emergency readmission occurs when a patient has an unplanned re-admission to hospital within 28 days of previous discharge.

READMISSIONS	2016-17			2017-18			2018-19			2019-20		
	0-15	16 and over	Total	0-15	16 and over	Total	0-15	16 and over	Total	0-15	16 and over	Total
Discharges	14102	46946	61048	14201	47572	61773	13975	48206	62181	13022	47103	60125
28 day readmissions	659	4236	4895	651	4428	5079	751	4006	4757	932	4218	5150
28 day readmissions rate	4.67%	9.02%	8.02%	4.58%	9.31%	8.22%	5.37%	8.31%	7.65%	7.16%	8.95%	8.57%

2.3.3.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.3.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- By committing to reducing re-admission for all patients irrespective of whether that care is planned or unplanned, 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.

2.3.4 Patient experience

In the national inpatient survey five questions are asked focussing on the responsiveness and personal care of patients. Our scores are consistent with the national average shown below. The data below shows the average, highest and lowest performers and our previous performance.

PATIENT EXPERIENCE	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19*
St George's University Hospitals	66.6	68.8	68.6	67.9	66	65	67.2
National average	68.1	68.7	68.9	69.6	68.1	68.6	67.2
Highest (best)	84.4	84.2	86.1	86.2	85.2	85	85
Lowest	57.4	54.4	59.1	58.9	60	60.5	58.9

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

* The 2019/20 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2020/21.

2.3.4.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.4.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to maintain and improve performance, by continually engaging with patients, family, friends and carers
- Respond to the findings of our ward and department accreditation programme
- Take improvement action in line with our Quality and Safety Strategy 2019/24.

2.3.5 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 NHS National Staff Survey; it is collected and submitted annually to the Staff Survey Co-ordination Centre. The data for 2019/20 shows that we achieved above average scores for staff who would be happy with the standard of care that would be provided to a friend or a relative who needed treatment by this organisation.

STAFF RECOMMENDATION	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
St George's University Hospitals	67%	73%	71%	70%	73%	69%	72%
Average for Acute	66%	68%	70%	68%	69%	70%	71%
Highest Acute Trust	94%	93%	93%	95%	86%	87%	87%
Lowest Acute Trust	40%	36%	46%	48%	47%	41%	40%

http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RJ7_full.pdf

2.3.5.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.5.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Focus on staff engagement and quality improvement, listening to staff and addressing their concerns.

2.3.6 Patient recommendations to friends and family

Our patients are very positive about our services and in 2019/20, 96.5% of our Inpatients and 82.4% of those visiting our A&E department said they would recommend our services to their friends and family.

FRIENDS AND FAMILY TEST	2016-17		2017-18		2018-19		2019-20	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	23.10%	30.76%	20.19%	25.50%	26.20%	26.40%	15.27%	34.38%
% would recommended	83.80%	95.81%	84.26%	96.24%	87.00%	97.00%	82.41%	96.5%
% would not recommend	10.51%	1.29%	10.39%	1.08%	8.50%	1.00%	12.36%	1.14%
National comparison as at March 2020 response rate	12.9%	26.1%	12.8%	23.2%	12.3%	24.6%	12.1%	24.4%
National comparison as at March 2020 % would recommend	87%	96%	84%	96%	86%	96%	85%	96%
National comparison as at March 2020 % would not recommend	7%	1%	9%	2%	8%	2%	9%	2%

..\Performance Visibility Team\Performance Board & Quality Monthly Reports\Archive\FFT 2017.xlsx

2.3.6.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.6.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to improve the quality of its services, by listening to patients and addressing their concerns.

2.3.7 Venous thromboembolism

Venous thromboembolism (VTE) occurs when a deep vein thrombosis (blood clot in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) causes substantial long term health problems or death. Risk assessments for VTE ensures that we intervene with preventative measures at the earliest possible time

2.3.7.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.7.2 The Trust plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to working to achieve higher VTE risk assessment rates
- Optimisation of iClip.

VTE ASSESSMENTS	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
St George's University Hospitals	95.89%	96.77%	96.64%	95.90%	96.0%	93.9%
National Average	96.10%	95.76%	95.61%	95.80%	95.6%	95.5%
Best performing Trust*	100%	100%	100%	100%	100%	100%
Worst performing Trust*	79%	78.1%	63%	72%	74.4%	71.7%

https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-q2-201920/

2.3.8 Infection control

We are committed to improving safety by avoiding or reducing Clostridium Difficile which results in shorter length of stay and improved patient experience.

CLOSTRIDIUM DIFFICILE	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
St George's University Hospitals						
Trust apportioned cases *Change in reporting: denotes those Cases confirmed due to lapses in care	38	29	36	16	31	*8
Trust bed-days as at 20/2/20	254,213	273,493	287,962	296,981	282,339	285,321
Rate per 100,000 bed days	14.9	10.6	12.5	5.4	11.0	2.8
National average	33.7	33.7	30.2	31.2	33	3
Worst performing trust	121	139	116	113	177	15
Best performing trust	0	0	0	0	0	0

http://stg1tableau01/#/site/L/views/BedOccupancy_1/OccupiedBedDaysbyAdmissionMethod?:iid=4

2.3.8.1 The Trust considers that this data is as described for the following reasons:

- We have a process in place for collating data on Clostridium Difficile cases. The data is collated internally and submitted to Public Health England. The CCG reviews the root cause analysis undertaken and provides validation as to whether Clostridium Difficile acquisition was due to a lapse in our care.

2.3.8.2 The Trust plans to take the following actions to improve this indicator and so the quality of our services:

- 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 improved environmental hygiene and antibiotic stewardship supported by continuous staff engagement and education.

2.3.9 Patient safety incidents

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 18	Oct 18- Mar 19	Apr 19- Sep 19	Oct 19 – Mar 20
St George's University Hospitals									
Total reported incidents	5,188	5,353	5,453	5,964	5,928	5,548	5934	6268	Not published
Rate per 1000 bed days	34.1	33.2	32.8	36.5	37.6	34.2	39.5	45.3	Not published
*National average (acute non-specialist)	37.1	39.3	39.6	40.8	41.1	42.8	46.1	Not	Not published
*Highest reporting rate	82.2	74.7	75.9	71.8	69	111.7	95.9	Not published	Not published
*Lowest reporting rate	3.6	18.1	14.8	21.1	23.1	23.5	16.9	Not published	Not published

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 18	Oct 18- Mar 19	Apr 19- Sep 19	Oct 19 – Mar 20
St George's University Hospitals									
Incidents causing Severe Harm or death	16	23	20	15	13	14	23	10	Not published
% incidents causing Severe Harm or death	0.31%	0.43%	0.37%	0.25%	0.22%	0.25%	0.15%	0.12%	Not published
*National average (acute non-specialist)	0.50%	0.43%	0.79	0.38%	0.37%	0.35%	0.36%	Not published	Not published
*Highest reporting rate	5.10%	1.96%	1.33%	1.38%	1.09%	1.23%	0.49	Not published	Not published
*Lowest reporting rate	0.05%	0.09%	0%	0.02%	0.03%	0.02%	0.01%	Not published	Not published

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-5-treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5-6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5-4

2.3.9.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.9.2 The Trust has taken the following actions to improve this indicator and so the quality of our services:

- Continue to work towards enhancing existing mechanisms throughout 2020/21. These include: risk management input into training programmes, increased frequency of root cause analysis (RCA) training, increased involvement from medical staff in following up incidents, a monthly governance newsletter and a quarterly analysis report and thematic learning.

Part 3

3.1 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 can be seen in the table below.

Key performance indicators

		TARGET	ANNUAL PERFORMANCE 2018-19	ANNUAL PERFORMANCE 2019-20
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on a complete pathway		N/A (Not reporting)	84.2%
ED access	95% of patient wait less than 4 hours	>=95%	88.4%	83.2%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	>=85%	86.9%	85.2%
	% patients treated within 62 days from screening referral	>=90%	86%	88.8%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	99%	99%	95.7%

3.2 Our performance against our Quality priorities in 2019-20

The progress we have made in delivering our quality priorities for last year is set out in the table below and where able, compared with performance for the previous year, 2018/19.

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. In addition, all qualitative measures of success have been assured through the relevant Trust governance frameworks.

PATIENT SAFETY			
OUR QUALITY PRIORITIES	WHAT WILL SUCCESS LOOK LIKE?	HOW DID WE DO IN 2019/20?	HOW OUR PERFORMANCE COMPARED WITH 2018/19
Emergency adult patients will have treatment escalation plans (TEP)	We will ensure that all non-elective adult inpatients have a treatment escalation plan (TEP) in place within 24 hours of admission	We partially achieved this We implemented TEP in paper format whilst we built an electronic TEP in the test domain of iClip. We rolled out the electronic TEP Trustwide in March 2020 in response to Covid-19. We will take this quality priority forward in to 2020/21 and develop an electronic mechanism to monitor the number of TEPs in place for adults within 24 hours of admission	In 2018/19 we established an improvement project and started developed the TEP (paper)
Identification, protection and care of patients who lack mental capacity to make certain decisions	We will demonstrate through audit of healthcare records that patients who lack mental capacity are identified promptly, and have proper protection and care. We will achieve compliance with our training targets for Mental Capacity Act (MCA) training	We partially achieved this Revisions to iClip have been made in the test domain to standardise recording and enable efficient audit processes. The electronic forms will be implemented in 2020/21. Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 training performance has achieved the target of 90% or above Level 2 training performance is 76.4% against a target of 85%	In 2018/19 we established an improvement project and developed level 1 and 2 training modules

PATIENT SAFETY			
OUR QUALITY PRIORITIES	**WHAT WILL SUCCESS LOOK LIKE?**	**HOW DID WE DO IN 2019/20?**	**HOW OUR PERFORMANCE COMPARED WITH 2018/19**
We will ensure that inpatients that deteriorate are recognised and treated promptly; consistently identifying the deteriorating patient so that we can intervene promptly and improve outcomes for patients	We will identify deteriorating patients early and so reduce the number of cardiac arrests compared with the 2018-19 baseline. We will improve the outcomes in our audits on appropriate response to the National Early Warning Score (NEWS2)	We partially achieved this We have successfully launched the Critical care Outreach team who operate on the wards in response to calls and also pro-actively seek out patients with high NEWS2 scores NEWS2 audits showed 94.1% in March 2020 The number of cardiac arrests in 2019/20 showed a reduction of 12% when compared with 2018/19. (From 177 in 2018/19 to 151 in 2019/20)	The number of cardiac arrests in 2018-19 showed a slight increase reduction of 2.3% when compared with 2017/18. (From 173 in 2017/18 to 177 in 2018/19). NEWS2 audits showed 89.6 % in March 2019
We will provide a responsive, high quality complaints service	We will achieve our targets for responding to complaints by the end of September 2019	We achieved this From August 2019 to March 2020 we achieved the complaints response performance targets across all 3 complaint response categories	The performance targets were not met in 2018/19: • 68% against 85% target for 25 day responses • 55% against 90% target for 40 day responses • 62% against 100% target for 60 day responses
We will build a patient partnership structure to enable patients to be involved in improvement work from the earliest stage	We will deliver year one of the strategy and develop the strategy for the next three years	We achieved this We delivered the objectives as set out in the one year Patient Partnership and Experience Strategy 2019/20. The strategy for Patient Partnership and Experience is included as a priority focus area within the Quality and Safety Strategy 2019/24	In 2018/19 twelve patient partners were recruited to the Patient Experience and Partnership Group. A service level patient user group was established in dermatology, urology and at Queen Mary's Hospital
We will improve immediate feedback from patients through the Friends and Family Test (FFT) by increasing response rates for both inpatient and outpatient services	We will achieve a response rate of at least 20% by the end of 2019-20 for both inpatient and outpatient services and the emergency department	We did not achieve this Our response rate for inpatient, outpatient and the emergency department was 34.5%, 5.6% and 15.3% respectively Changes in FFT guidance will be implemented in April 2020. The guidance encourages patients to provide feedback throughout their care episode. In preparation for this and in line with guidance, the wording of the questions and changes to the Trust systems have been developed for launch when appropriate to do so in 2020 (responding to the impact of Covid-19)	In 2018/19 the improvements that were expected to enable the Trust to achieve this target were put in place in Q4; these include FFT being made available on our public website and by launching text messaging

CLINICAL EFFECTIVENESS AND OUTCOMES			
OUR QUALITY PRIORITIES	**WHAT WILL SUCCESS LOOK LIKE?**	**HOW DID WE DO IN 2019/20?**	**HOW OUR PERFORMANCE COMPARED WITH 2018/19**
We will improve services for people with mental health needs who are in an acute healthcare setting	We will demonstrate through audit of healthcare records that patients' mental health needs have been met when they are receiving care from our acute services	We achieved this We have met our CQUIN goal and achieved our objective for 2019/20	In 2018/19 we met our CQUIN goal and achieved this objective through the delivery of a joint project with SW London Mental Health NHS Trust to improve physical and mental health care for those in crisis
We will improve the effectiveness of our discharge process by ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support	We will see an improvement in the response to these questions on our local patient surveys and in the national patient survey 2019	We partially achieved this Work with Healthwatch tells us that discharge continues to be an area where our patients and our local community want to see us improve. This priority is being carried forward into 2020/21	We did not see an improvement in the response to these questions on our local patient surveys and in the national patient survey
We will review and improve our clinical governance	We will carry out a review of our clinical governance processes throughout the trust to ensure they support the delivery of safe, high quality care	We achieved this We carried out two external reviews: Review 1 Mortality Meetings and MDT review meetings; Review 2 Clinical Governance Resilience and Capacity. Improvement plans have been developed and will be implemented throughout 2020/21 together with a third external review that will look at the quality and safety reporting and monitoring within the divisions up to the sub-committees of the Board	Not applicable

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

A1.1 Statement from Wandsworth Clinical Commissioning Group (Now SWL CCG)

Wandsworth Clinical Commissioning Group (CCG) was the host commissioner for St George's University Hospitals NHS Foundation Trust (SGUH) during 2019/20 and was responsible for the commissioning of high-quality health services from the Trust on behalf of the population of Wandsworth and surrounding boroughs. On 1 April 2020, Wandsworth CCG became part of the new South West London (SWL) CCG. The reference made in this statement to 'The CCG' therefore refers to the previous Wandsworth CCG.

The SGUH leadership team has engaged fully with Wandsworth CCG during 2019/20 and has provided a good level assurance in relation to these commissioned services, obtained mainly through the monthly Clinical Quality Review Group (CQRG) meetings. The CQRG meetings bring together stakeholders, including GPs, senior clinicians, and managers from both SGUH and Wandsworth CCG, Commissioners from local CCGs, NHS England/ Improvement. Assurance is also gained through undertaking

quality assurance visits in SGUH, and intelligence gained from other sources including the patient feedback directly to the CCG.

SGUH has been proactive in addressing quality issues identified through the CCG's well-established Quality Alert system (Make a Difference). This system allows general practitioners and other healthcare professionals to raise quality issues relating to a provider to the CCG. The provider is then required to address the issues and respond to the alert. SGUH have successfully addressed a number of quality issues identified through this system, and the CCG is pleased to note that some of these issues, including addressing the long wait for treatment and improving patient flow in relation to discharges, have been included in the priorities for 2020/21.

The CCG has worked closely with the Trust throughout 2019/20 on their implementation of the CQC action plan, which has been monitored monthly at the CQRG. The CCG commends the Trust on the significant progress made by the Trust in delivering on the CQC action plan. This was reflected in the outcome of the CQC inspection in 2019, reported in December 2019, which recommended that the Trust should be removed from quality special measures. We will continue to monitor the CQC action plan from the inspection throughout 2020/21.

The CCG welcomes the opportunity to provide a statement for SGUH's Quality Account for 2019/20. We confirm that we have reviewed the information contained within the draft Quality Account and agree with the Trust's assessment of the delivery of the 2019/20 priorities. We are pleased to note the significant progress made in delivering our quality priorities for last year, particularly the launch of the critical care outreach team as well as the achievement of the complaints response performance targets. We are pleased to note that the focus for the next year will be to undertake thematic analysis of complaints to identify themes and share findings. In addition, the CCG would like to see the Trust focus on the triangulation of these findings with themes from other sources, like incidents and serious incidents to achieve integrated learning.

The CCG was disappointed to note that only little progress was made in improving effectiveness of discharge processes in 2019/20. Work with Healthwatch and quality alerts received by the CCG during the year suggest that discharge continues to be an area where our patients and our local community want to see improvements. We are encouraged to note that this priority is being carried forward into 2020/21.

The CCG welcomes the continued focus on patient safety, clinical effectiveness and patient experience. We have taken particular account of the identified quality priorities for 2020/21 and are pleased to note that these priorities are in line with those agreed at the CQRG. We are also pleased with the continued priorities on managing the deteriorating patient and outpatient follow up appointments.

We would urge SGUH to also consider a focus on improving outcomes for non-cohorted heart failure patients, and the implementation of the maternity continuity of care targets for 2020/21.

In addition, we would like to have seen an overview of some of the quality challenges in 2019/20 in relation to the cardiac surgery services and emphasis of some of the quality improvement work that has already taken place in the services. We were pleased to note that the actions from the two clinical and mortality governance reviews will continue to be implemented in 2020/21. It is important for the Trust to continue to focus on improvements to the clinical and quality governance systems and processes across the organisation.

Overall comments

Overall, the Quality Report provides an encouraging account of quality within the Trust and reflects the work that the senior team has invested in improving quality over the year.

The CCG is committed to working collaboratively to support the Trust in delivering the priorities identified in the quality report for 2019/20.

Dr Nicola Jones MBE
MBChB DRCOG MRCGP MBA
Chair, Wandsworth Clinical Commissioning Group (Now SWL CCG)

05 June 2020

A1.2 Statement from Healthwatch Wandsworth

Thank you for the opportunity to view and provide comments on this year's Quality Account. We have continued to have been kept informed and involved in the monitoring of quality improvement throughout the year at the monthly Quality and Safety Committee, the Clinical Quality Review Group and the Patient Partnership Engagement Group. We also take part in other areas of governance through our Healthwatch appointed Governor.

Although at times, it can be challenging for our small team of staff and volunteers to keep pace with the fast pace of arrangements for meetings and the preparation involved, we are grateful for the welcome our input and presence receives and for the opportunity to comment on the annual quality account.

We witness a great deal of time and energy spent on quality improvement plans, processes and assurance. Staff at all levels can be congratulated for the achievements made to move the Trust forward from CQC Quality Special Measures and a number of ratings of 'Outstanding'. As the quality account alludes to, there are still areas of challenge and need for further improvement. We hope that it will not be long before the Trust is able to progress from 'Requires Improvement' as they develop an organisation wide culture of continuous improvement.

Discharge

We were pleased that discharge was a focus for quality improvement during the year based on our feedback. In 2019-20 we conducted Enter and View activity at the hospital's discharge lounge. Many patients were positive about their experience, but we were able to highlight areas the Trust can focus on for further development and we are pleased to see discharge as a quality improvement priority for the next year.

In 2019, Healthwatch Wandsworth conducted a 'Enter and View' in our departure lounge (pictured).

Consent

Consent has appeared as an area for improvement, particularly in relation to cardiac surgery. We think this is a crucial part of managing quality because it is essential to the patient experience and as assurance that the patient has made an informed choice about their own care.

Cardiac surgery

We welcome the independent review of cardiac deaths, and the Trust's commitment to implement all the recommendations. We look forward to monitoring the action plan. Within the Quality Account we think it could be more meaningful to include some more detail about this, specifically the finding that out of 202 deaths between 2013 and 2018 examined by the independent panel, 'there were failings in the care provided to 102 patients at St George's during this period, and that for 67 patients these care failings either definitely, more likely or probably contributed to their deaths.'

Patient experience data

The Trust has improved its response times in the complaints process over the year, which had previously appeared a significant challenge. Over the next year we shall see if we begin to hear more positive experiences of the process. We hope that use of insight from complaints continues to develop and provide learning and improvement opportunities,

and that patients are involved in any further development of the complaints and feedback mechanisms as well as their individual cases.

Response rates for the 'Family and Friends Test' have room to be improved. Could the Trust explore other ways of obtaining direct feedback that can inform quality improvement monitoring systems?

We would welcome more of a sense about the feedback from patients on the quality priorities as mentioned in the introduction, and how patients' feedback influences quality improvement.

Experience for patients who lack mental capacity

This is an essential area for the Trust to focus on. We suggest that patient and carer experiences could offer an informative and insightful contribution to develop something that works for them, as well as enhancing staff understanding of care needs. There are many community-based support organisations where experience could be gathered.

Provide an equitable experience for patients from vulnerable groups

The focus this year is on patients with learning disabilities which is very important. We would like to see some mention of other protected characteristic groups.

Waits for treatment

We support the priority targets for waiting for treatment and commend progress made in improving processes to monitor and improve waiting times. However, it would be useful to see how the achievability of targets have been tempered by the impact of Covid-19.

We recognise that the Covid-19 pandemic only struck towards the end of the reporting year. Nevertheless, its impact on patients and communities has been so great that we feel it merits greater attention in this Account. We would welcome explicit assurance that, as services continue to change in response to the pandemic, quality will remain at the forefront of the new plans, and that, while recognising the need at times for pace, patients will remain engaged and consulted throughout.

Finally, St George's Hospital is a valued and central service within our Wandsworth Community. The Covid-19 pandemic has demonstrated how the service and staff are needed and appreciated by our community. Stronger frameworks for collaborative working are now being established within Wandsworth and a wider region, such as that of the new South West London CCG and ICS, and closer links with Epsom and St Helier through a shared chairperson. Covid-19 has already encouraged closer alignment with community, primary and social services on key areas such as discharge management. It would be fitting for the Account to refer explicitly to these strategic opportunities to raise quality and standards of care through improved collaboration.

Stephen Hickey
Chair, Healthwatch Wandsworth

09 June 2020

A1.3 Statement from Wandsworth Adult Care and Health Overview Scrutiny Committee

[Not provided due to Covid-19 pandemic]

A1.4 2018/19 limited assurance report on the content of the Quality Reports and mandated performance indicators

[Not provided due to Covid-19 pandemic]

A1.5 Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

[Not provided due to Covid-19 pandemic]

Annex 2: A2.1 Statement of Directors' responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

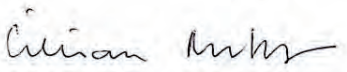
NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the Quality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

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

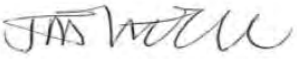
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2019 to 25 June 2020
  - papers relating to quality reported to the board over the period April 2019 to June 2020
  - feedback from commissioners dated 5 June 2020
  - feedback from governors dated 5 June 2020 [Governors invited to comment]
  - feedback from local Healthwatch organisations dated 9 June 2020
  - feedback from overview and scrutiny committee dated [Not provided due to Covid-19 pandemic]
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 6 December 2019
  - the latest national patient survey Inpatient, June 2019; Urgent and Emergency Care, October 2019; Children and Young People, November 2019; and Maternity, January 2020
  - the latest national staff survey dated March 2020
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated [Not provided due to Covid-19 pandemic]
  - the CQC inspection reports dated 18 December 2019
- the Quality Report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality 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
Chairman
25 June 2020



Jacqueline Totterdell
Chief Executive
25 June 2020

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

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 2020 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Health Service Act 2006, the NHS foundation trust annual reporting manual 2019/20 and the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; 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.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accounting Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates that the Trust incurred a deficit of £13.1 million during the year ended 31 March 2020 and borrowed £32.3 million under interim revenue support facilities provided by the NHS Independent Trust Financing Facility.

As stated in Note 1.2 the 2020/21 plan is for a breakeven financial position, having taken account of the underlying financial position going into 2020/21 and the Block contract arrangements in place in relation to the Covid-19 pandemic.

From a cash perspective there is not expected to be any risk to the financial plan for the first two months of 2020/21, but as the financial year progresses this risk may increase due to the funding gap which currently exists.

These events or conditions, along with the other matters as set forth in note 1.2, 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.

In concluding that there is a material uncertainty, our audit work included but was not restricted to:

- We reviewed management's going concern assessment and considered the reasonableness of the key assumptions expressed.
- we assessed the completeness and accuracy of the disclosures in the going concern note.
- we assessed whether the Trust had updated its cash flow forecast to reflect the impact of Covid-19.

Overview of our audit approach

Financial statements audit

- Overall materiality: £13,000,000, which represents 1.48% of the Trust's gross operating costs (consisting of operating expenses);
- Key audit matters were identified as:
  - Revenue recognition
  - Valuation of land and buildings
  - Going Concern
  - Covid-19
- The inclusion of Covid-19 is the only key change in the scope of the audit from the prior year.

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

- We identified two significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (see Report on other legal and regulatory requirements section).

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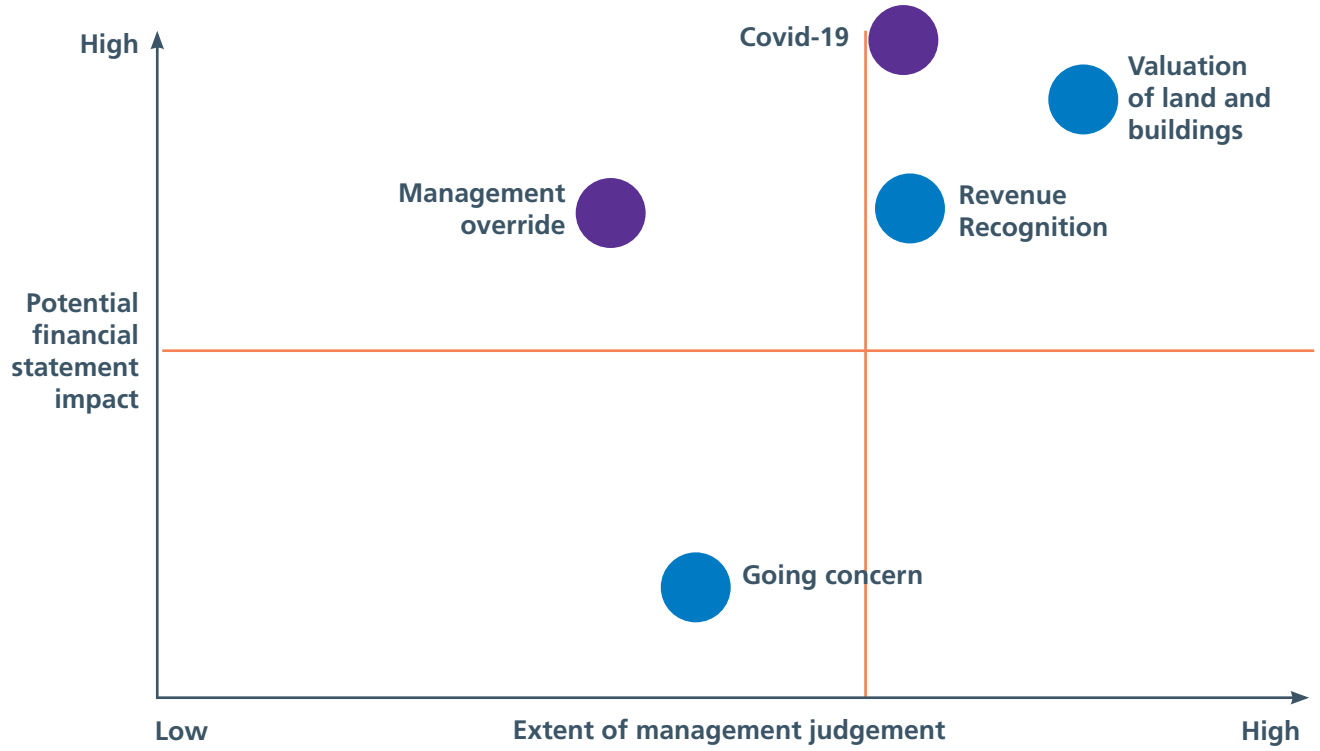
Key audit matters

The graph below depicts the financial statement 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 matters 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
Risk 1 Valuation of land and buildings	
The Trust revalues its land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statements date. This valuation represents a significant estimate by management in the financial statements. Management have engaged the services of a valuer to estimate the current value as at 31 March 2020. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. The effects of the Covid-19 virus will affect the work carried out by the Trust's valuer in a variety of ways. Inspecting properties could prove difficult and access to evidential data, such as values of comparable assets may be less freely available. RICS Regulated Members have therefore been considering whether a material uncertainty declaration is now appropriate in their reports. Its purpose is to ensure that any client relying upon the valuation report understands that it has been prepared under extraordinary circumstances. In their 2019/20 valuation report the Trust's valuer included a material uncertainty and this was disclosed in note 1.25 to the financial statements. We therefore identified valuation of land and buildings, particularly 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: • evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work. This included considering if the impact of Covid-19 had been considered for impact on valuations. • evaluating the competence, capabilities and objectivity of the valuation expert • writing to the valuer to confirm the basis on which the valuations were carried out • challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding • engaging our own valuer to assess the instructions to the Trust's valuer, the Authority's valuer's report and the assumptions that underpin the valuation • testing, on a sample basis, revaluations made during the year to ensure they have been input correctly into the Trust's asset register The Trust's accounting policy on property, plant and equipment, including land and buildings is shown in note 1.9 to the financial statements and related disclosures are included in note 14. As, disclosed in note 1.25 to the financial statements, the outbreak of Covid-19 has caused uncertainties in markets. As a result, the Trust's valuer has declared a 'material valuation uncertainty' in their valuation report which was carried out with a valuation date of 31 March 2020. The values in the valuation report have been used to inform the measurement of property assets at valuation in the financial statements. The Trust has disclosed the estimation uncertainty related to the year-end valuations of land and buildings in note 1.25 to the financial statements. The Trust's valuer prepared their valuations in accordance with the RICS Valuation – Global Standards using the information that was available to them at the valuation date in deriving their estimates **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. • We would emphasise the importance of the material uncertainty disclosure reference in note 1.25

Key Audit Matter	How the matter was addressed in the audit
Risk 2 Revenue recognition	
Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. In this environment, we considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue. We rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We determined these to be income from: • Block contract income element of patient care revenues We did not deem it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue. We therefore identified the occurrence and accuracy of these income streams of the Trust and the existence of associated receivable balances 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: • evaluating the Trust's accounting policy for recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2019/20 • updating our understanding of the Trust's system for accounting for income from patient care and other operating revenue, and evaluate the design of the associated controls • For patient care income, agreeing, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners and evaluating the Trust's estimates and the judgments made by management with regard to corroborating evidence in order to arrive at the total income from contract variations recorded in the financial statements. • For other operating revenue, agreeing, on a sample basis, income and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence • Agreeing PSF income to supporting evidence The Trust's accounting policy on recognition of income is shown in note 1.4 to the financial statements and related disclosures are included in notes 3 and 4. **Key observations** We obtained sufficient audit assurance to conclude that: • the Trust's accounting policy for recognition of income from patient care activities and other operating revenues complies with the DHSC Group Accounting Manual 2019/20 and has been properly applied; and • income from patient care activities and other operating revenues and the associated receivable balances are not materially misstated.

Key Audit Matter	How the matter was addressed in the audit
Risk 3 Covid-19	
The global outbreak of the Covid-19 virus pandemic has led to unprecedented uncertainty for all organisations, requiring urgent business continuity arrangements to be implemented. We expect current circumstances will have an impact on the production and audit of the financial statements for the year ended 31 March 2020, including, and not limited to: • Remote working arrangements and redeployment of staff to critical front line duties may impact on the quality and timing of the production of the financial statements, and the evidence we can obtain through physical observation • Volatility of financial and property markets will increase the uncertainty of assumptions applied by management to asset valuation and receivable recovery estimates, and the reliability of evidence we can obtain to corroborate management estimates • Financial uncertainty will require management to reconsider financial forecasts supporting their going concern assessment and whether material uncertainties have arisen; and • Disclosures within the financial statements will require significant revision to reflect the unprecedented situation and its impact on the preparation of the financial statements as at 31 March 2020 in accordance with IAS1. We therefore identified Covid-19 as a significant risk, which was one of the most significant assessed risks of material misstatement.	We worked with management to understand the implications the response to the Covid-19 pandemic has on the organisation's ability to prepare the financial statements and update financial forecasts and assessed the implications for our materiality calculations We liaised with other audit suppliers, regulators and government departments to co-ordinate practical cross sector responses to issues as and when they arise. Our audit work has: • Evaluated the adequacy of the disclosures in the financial statements that arose in light of the Covid-19 pandemic. • Evaluated whether sufficient audit evidence can be obtained in the absence of physical verification of assets through remote technology • Evaluated whether sufficient audit evidence can be obtained to corroborate significant management estimates such as asset valuations and recovery of receivable balances • Evaluated management's assumptions that underpin the revised financial forecasts and the impact on management's going concern assessment • Discussed with management any potential implications for our audit report if we have been unable to obtain sufficient audit evidence **Key observations** We obtained sufficient audit assurance to conclude that: • The Trust's disclosures are in line with the DHSC guidance relating to the impact of the Covid-19 pandemic • Financial forecasts and the cashflow analysis of the Trust supports the ability for the Trust to prepare the accounts on a going concern basis • The inclusion of a material uncertainty disclosure regarding the valuation of the Trust's property, plant and equipment has been emphasized in a Key Audit Matter as detailed in risk 1 above.

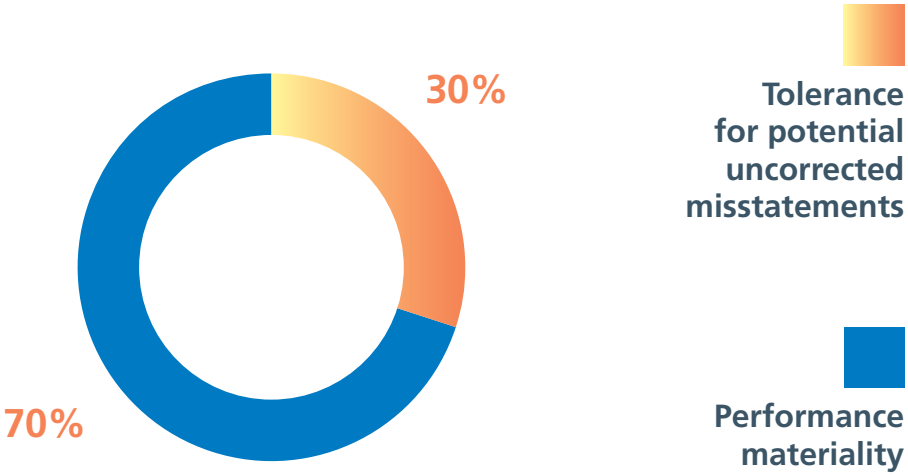
Our application of materiality

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	£13,000,0000 which is 1.48% 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 the Trust has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs, allowing for rounding, as we determined for the year ended 31 March 2019 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	70% of financial statement materiality
Specific materiality	Remuneration repot and related party disclosures have a lower materiality of £100,000 due to the increased sensitivity of these areas due to stakeholder interest.
Communication of misstatements to the Audit Committee	£300,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

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

Overall materiality – Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and in particular 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;
- obtaining supporting evidence, on a sample basis, for the Trust's operating expenses and finance costs;
- obtaining supporting evidence, on a sample basis, for property plant and equipment and the Trust's other assets and liabilities.

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 obtained in the audit 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 the 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 2019/20 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

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 2019/20 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 issue a report 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 refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take 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 the Chief Executive's responsibilities as the Accounting Officer set out on pages 103 to 104, 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 2019/20, 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 Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, except for the effects of the matters described in the basis for qualified conclusion section of our report we are 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 2020.

Basis for qualified conclusion

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

- NHS Improvement placed the Trust into financial special measures on 22 March 2017 and the Trust remained in financial special measures throughout 2019/20. The Trust delivered a deficit of £13.1 million in 2019/20, which represents an overspend compared to its original budgeted deficit of £3 million, however this is a significant improvement on the reported deficit in 2018/19 of £45.4million against a budgeted deficit of £29 million.
- The Trust originally set a budget for 2020/21 with the intention of achieving a break even position however this will be subject to the ongoing impact of Covid-19 expenditure and the level of support being provided by Government. A key area of risk highlighted by the Trust within the financial plan approved for 2020/21 is around achieving the plan and being in receipt of the expected funding streams and the identification and delivery of Cost Improvement Programmes (CIPs). The resolution of these issues will have a significant bearing on whether the Trust is able to achieve its forecast.

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.

This matter identifies weaknesses in proper arrangements for:

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

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks not forming part of our qualified conclusion	How the matter was addressed in the audit
Risk 1 Financial outturn and financial sustainability The Trust's audited financial statements for the year ended 31 March 2019 reported a deficit of £45 million. The Trust agreed a budgeted deficit in 2019/20 of £3 million with NHS Improvement. This was a challenging target. As a result of the Trust's poor financial performance, in March 2017 NHS Improvement placed the Trust into Financial Special Measures and this remains the case in 2019/20.	Our audit work included, but was not restricted to: The current scale of the deficit will not be sustainable in the longer term and as such there is a risk that the Trust does not have sufficient arrangements in place to ensure medium term financial stability. • review the Trust's arrangements for putting together and agreeing its budget, including identification of savings plans; and its arrangements for monitoring and managing delivery of its budget and savings plans for 2019/20 and 2020/21, including the impact on service delivery • meeting with key officers to discuss and review planned arrangements for returning the Trust to a position of financial stability. **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis for qualified conclusion section of the report.

Significant risks not forming part of our qualified conclusion	How the matter was addressed in the audit
Risk 1 Care Quality Commission (CQC) inspection An inspection by the Care Quality Commission in June 2016 rated the Trust as requiring significant improvement. Follow-up CQC inspections in May 2017 and March - April 2018 identified that progress had been made in addressing their findings but that areas for improvement remained. The rating was changed from 'inadequate' to 'requires improvement' in July 2018. A further inspection was undertaken in July to September 2019 which reported in December 2019 and retained the rating of 'requires improvement'. The Trust currently remained in quality special measures in 2019/20 however we have been informed that the Trust has now been removed from quality special measures. There is a risk that the Trust will not be able to adequately respond to areas identified by the CQC as requiring improvement during 2019/20.	Our audit work included, but was not restricted to: • assessing how the Trust is implementing and monitoring delivery of its agreed action plan which was designed to address the findings of the CQC inspection. • Evaluating CQC reports issuing following inspection visits during 2019/20. **Key findings** The Trust has responded to the issues raised in the CQC report including producing a detailed action plan based on the issues raised by CQC.

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 April 2020, 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 2020, 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.

Use of our report

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.

Paul Dossett, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London
25 June 2020

Annual Financial Accounts

Foreword to the accounts

St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2020, 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.

The accounts are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Signed

Name Jacqueline Totterdell
Job title Chief Executive
Date 25 June 2020

Statement of Comprehensive Income

		2019/20	2018/19
	Note	£000	£000
Operating income from patient care activities	3	717,397	686,114
Other operating income	4	189,229	158,019
Operating expenses	6, 7	(908,076)	(879,058)
Operating surplus/(deficit) from continuing operations		(1,449)	(34,925)
Finance income	10	237	88
Finance expenses	11	(11,937)	(10,776)
Net finance costs		(11,700)	(10,688)
Other gains/(losses)	12	-	175
Surplus/(deficit) for the year from continuing operations		(13,149)	(45,438)
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		-	-
Surplus/(deficit) for the year		(13,149)	(45,438)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6.4	(9,653)	-
Revaluations	16	12,604	12,945
Total comprehensive income/(expense) for the period		(10,198)	(32,493)

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	13	37,658	19,509
Property, plant and equipment	14	389,272	370,963
Receivables	19	13,104	11,901
Other assets	20	11	11
Total non-current assets		440,045	402,384
Current assets			
Inventories	18	11,871	7,763
Receivables	19	80,567	90,325
Cash and cash equivalents	21	3,425	3,232
Total current assets		95,863	101,320
Current liabilities			
Trade and other payables	22	(114,067)	(124,215)
Borrowings	24	(323,085)	(73,805)
Provisions	26	(270)	(545)
Other liabilities	23	(2,480)	(2,484)
Total current liabilities		(439,902)	(201,049)
Total assets less current liabilities		96,006	302,655
Non-current liabilities			
Borrowings	24	(69,335)	(269,589)
Provisions	26	(2,463)	(1,037)
Total non-current liabilities		(71,798)	(270,626)
Total assets employed		24,208	32,029
Financed by			
Public dividend capital		135,735	133,358
Revaluation reserve		113,841	110,890
Other reserves		1,150	1,150
Income and expenditure reserve		(226,518)	(213,369)
Total taxpayers' equity		24,208	32,029

The notes on pages 188 to 227 form part of these accounts.

Signed 

Name Jacqueline Totterdell
Job title Chief Executive
Date 25 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 – brought forward	133,358	110,890	1,150	(213,369)	32,029
Surplus/(deficit) for the year	-	-	-	(13,149)	(13,149)
Impairments	-	(9,653)	-	-	(9,653)
Revaluations	-	12,604	-	-	12,604
Public dividend capital received	2,377	-	-	-	2,377
Taxpayers' and others' equity at 31 March 2020	135,735	113,841	1,150	(226,518)	24,208

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	133,153	97,945	1,150	(167,931)	64,317
Surplus/(deficit) for the year	-	-	-	(45,438)	(45,438)
Revaluations	-	12,945	-	-	12,945
Public dividend capital received	205	-	-	-	205
Taxpayers' and others' equity at 31 March 2019	133,358	110,890	1,150	(213,369)	32,029

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 organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the 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.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserves

This reserve of £1.15m was created in March 2003 to recognise the portion of land at St George's Grove that had been omitted from the land valuation used to establish the St George's opening PDC capital balance when it became a NHS Trust on 1 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 Trust.

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(1,449)	(34,925)
Non-cash income and expense:			
Depreciation and amortisation	6.1	23,341	23,836
Income recognised in respect of capital donations	4	(545)	(524)
(Increase) / decrease in receivables and other assets		7,756	8,878
(Increase) / decrease in inventories		(4,108)	(1,319)
Increase / (decrease) in payables and other liabilities		(28,161)	3,968
Increase / (decrease) in provisions		1,151	435
Other movements in operating cash flows		(190)	(189)
Net cash flows from / (used in) operating activities		(2,205)	160
Cash flows from investing activities			
Interest received		237	88
Purchase of intangible assets		(10,138)	(1,533)
Purchase of PPE and investment property		(25,125)	(33,355)
Sales of PPE and investment property		-	175
Receipt of cash donations to purchase assets		545	524
Net cash flows from / (used in) investing activities		(34,481)	(34,101)
Cash flows from financing activities			
Public dividend capital received		2,377	205
Movement on loans from DHSC		51,135	47,722
Movement on other loans		(1,478)	(1,478)
Capital element of finance lease rental payments		(2,881)	(2,523)
Capital element of PFI, LIFT and other service concession payments		(1,136)	(1,062)
Interest on loans		(9,001)	(7,379)
Other interest		(5)	(1)
Interest paid on finance lease liabilities		(227)	(204)
Interest paid on PFI, LIFT and other service concession obligations		(2,704)	(2,779)
PDC dividend (paid) / refunded		799	1,131
Net cash flows from / (used in) financing activities		36,879	33,632
Increase / (decrease) in cash and cash equivalents		193	(309)
Cash and cash equivalents at 1 April - brought forward		3,232	3,541
Cash and cash equivalents at 1 April - restated		3,232	3,541
Cash and cash equivalents transferred under absorption accounting		-	-
Cash and cash equivalents at 31 March	21	3,425	3,232

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These 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.

Note 1.2 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 £13.1m for the year ended 31 March 2020 (after adjusting for donated capital income and donated depreciation). During the year the Trust borrowed £32.3m under interim revenue support facilities provided by the NHS Independent Trust Financing Facility.

The Trust has received notification that loans will be converted to PDC from April 2020, and the Trust is not expecting to borrow any further interim revenue support loans in 2020/21.

The 2020/21 plan is for a breakeven financial position, having taken account of the underlying financial position going into 2020/21 and the Block contract arrangements in place in relation to the COVID-19 pandemic. Currently the Trust is exploring the methodology used to calculate the appropriate funding allocated, as at present a gap exists that would cause a material risk to delivery of this plan.

From a Cash perspective, there is not expected to be any risk to the financial plan in the early months as two months of block payment have been received in April 2020. As the financial year progresses this risk may increase again depending on progress with the gap mentioned above.

After making enquiries, although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the directors, 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 2019/20, 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.

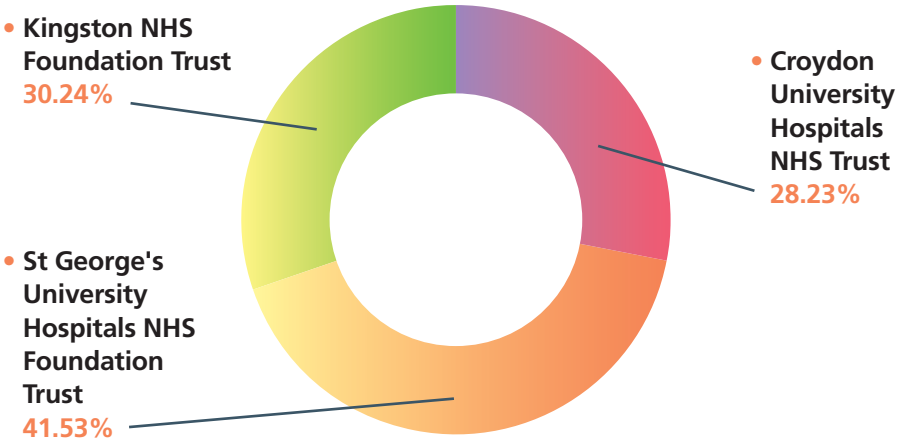
The Trust has received notification that loans will be converted to PDC from April 2020. The Trust is not expecting to borrow any revenue support loans in 2020/21. Total loan value converted to PDC is Capital £51.6m and Working Capital Loan £263.4m, a total of £315m. This will attract the PDC charge of 3.5%, an impact of £11m p.a. The DHSC Loan interest saving from this is £9.2m, Capital 0.6m and Working capital loan of £8.6m.

Note 1.3 Interests in other entities

From 1 April 2015, the Trust has participated in South West London Pathology, a partnership with Kingston NHS Foundation Trust and Croydon University Hospitals NHS Trust to provide pathology services for all three organisations.

The partnership is hosted by St George's and accountable through a consortia agreement to the SWL Acute Provider Collaborative.

Ownership is divided based on full year activity:



South West London Pathology is not a separate vehicle for the three trusts, making this a joint operation as defined by IFRS11. As a joint operation the Trust accounts for its share of the income and expenditure for South West London Pathology.

Note 1.4 Revenue from contracts with customers

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The majority of income received by the Trust is via NHS commissioning organisations and is paid in the month that the activity is undertaken as per the SLA. Variances to commissioner plan are dealt with through over and under performance invoices and credit notes which are finalised following agreement with commissioners on 'Freeze' performance. Typically this is 2-3 months after the end of the period that the contractual obligation is undertaken.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. Income recognised at year end is also consistent with the year end settlement agreement from the Trust's main commissioners – these cover approximately 85% of the NHS Commissioning income of the Trust.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

In reviewing income recognised in the annual accounts in accordance with IFRS15, the Trust has reviewed contractual challenges and penalties, CQUIN delivery and education and training income as

all are material elements of the Trust's income performance.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

The Trust receives income from Health Education England for Education and training of medical and non medical trainees. Revenue is in respect of training provided and is recognised when performance obligations are satisfied when training has been performed. All performance obligation are undertaken within the financial year and is as agreed and invoiced to HEE.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust's accounting treatment of the income is on an accruals basis, rather than a defrayals basis. The accrual is based on historic data, for which the Trust has received notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. This income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or 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. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Trust
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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.

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 changed the basis of the valuation of the land to an alternative site basis in 2015/16.

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.

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 80 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 expenditure.

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 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 expenditure 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 disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and 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) and Local Improvement Finance Trust (LIFT) 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.

PFI asset

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

PFI liability

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

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

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

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance

with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the statement of comprehensive income.

Lifecycle replacement

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

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

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

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

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's statement of financial position.

Other assets contributed by the NHS trust to the operator

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

Note 1.9 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 where it meets the requirements set out in IAS 38.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	3	80
Dwellings	3	80
Plant & machinery	1	25
Transport equipment	-	-
Information technology	5	10
Furniture & fittings	3	15

Finance-leased assets (including land) are depreciated over the shorter of the useful 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.

Software

Software which is integral to the operation of hardware, e.g. 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, e.g. 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. Where intangible assets, which are held for operational use, have short useful economic lives, or are of low value (or both), then these are held at depreciated historic cost, as this is not considered to be materially different from current value in existing use. 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	10	12
Software licences	5	7

Note 1.10 Inventories

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

Note 1.11 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables including contract receivables, other receivables loans receivable, cash and other simple debt instruments. After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument. The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.13 Leases

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

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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 charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

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 a lessor

Finance leases

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

Operating 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 as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The 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 HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following

		Inflation rate
Short-term	Year 1	1.90%
Medium-term	Year 2	2.00%
Long-term	Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 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 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the 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 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 and grant 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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

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

Note 1.18 Corporation tax

St George's University Hospitals NHS Foundation Trust has no corporation tax liability because under the relevant extant legislation Foundation Trusts are not subject to corporation tax.

Note 1.19 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in note 21.1 to the accounts in accordance with the requirements of HM Treasury's FReM .

Note 1.21 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.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 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.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised

equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable.

However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation

The effective date of IFRS 17 Insurance Contracts to annual reporting periods beginning on or after 1 January 2023, and interpreted and adapted by the FReM effective from 1 April 2023.

Note 1.25 Critical judgements in applying accounting policies

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

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.

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 2020.

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 2018/19. 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 modern equivalent replacement of 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.

Gerald Eve LLP have valued the existing buildings as they stand using Gross Internal Floor areas provided by the Trust by reference to the cost of providing a modern equivalent asset capable of delivering the required service provision. In instances where buildings or parts of buildings would not form part of the MEA, then this has been reflected in the valuation.

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.

Note 1.26 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

As a result of the impact of the novel coronavirus (Covid-19), which was declared a global pandemic on 11 March 2020, on market activity, the external valuers have included a 'material valuation uncertainty' statement in their report. The clause states that: "As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to Covid-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement. Our valuation is therefore reported as being subject to 'material valuation uncertainty' as set out in VPS 3 and VPGA 10 of the RICS Valuation – Global Standards. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that Covid-19 might have on the real estate market, we recommend that you keep the valuation under frequent review.

For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. Rather, the declaration has been included to ensure transparency of the fact that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case. The material uncertainty clause is to serve as a precaution and does not invalidate the valuation."

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.

Note 2 Operating Segments

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

Income from CCGs account for 44% (2018/19: 44%) of the Trust revenue with a further 34% (2018/19: 34%) from NHS England. No customer external to the NHS accounts for more than 10% of the Trust's revenue hence there are no other segments.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	2019/20 £000	2018/19 £000
Elective income	117,307	114,398
Non elective income	169,156	164,409
First outpatient income	47,858	44,741
Follow up outpatient income	50,712	50,287
A & E income	26,072	22,740
High cost drugs income from commissioners (excluding pass-through costs)	42,212	39,556
Other NHS clinical income	204,619	201,379
Community services		
Community services income from CCGs and NHS England	28,600	34,558
Income from other sources (e.g. local authorities)	75	738
All services		
Private patient income	3,429	3,120
Agenda for Change pay award central funding*		6,617
Additional pension contribution central funding**	21,772	
Other clinical income	5,585	3,571
Total income from activities	717,397	686,114

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.
**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	325,726	292,584
Clinical commissioning groups	377,590	370,201
Department of Health and Social Care	-	6,621
Other NHS providers	3,474	1,032
NHS other	1,464	1,491
Local authorities	129	741
Non-NHS: private patients	3,429	3,120
Non-NHS: overseas patients (chargeable to patient)	2,133	3,571
Injury cost recovery scheme	3,153	6,569
Non NHS: other	299	184
Total income from activities	717,397	686,114
Of which:		
Related to continuing operations	717,397	686,114

Note 3.3
Overseas visitors (relating to patients charged directly by the provider)

	2019/20 £000	2018/19 £000
Income recognised this year	2,133	3,571
Cash payments received in-year	24	460
Amounts added to provision for impairment of receivables	(3,795)	(541)

Note 4 Other operating income

	2018/19			2019/20		
	Contract income £000	Non-contract £000	Total income £000	Contract income £000	Non-contract income £000	Total £000
Research and development	5,270	-	5,270	5,121	-	5,121
Education and training	36,363	-	36,363	35,264	-	35,264
Non-patient care services to other bodies	66,960		66,960	65,210		65,210
Provider sustainability fund (PSF)	9,133		9,133	6,904		6,904
Financial recovery fund (FRF)	19,454		19,454			
Marginal rate emergency tariff funding (MRET)	6,637		6,637			
Income in respect of employee benefits accounted on a gross basis	39,948		39,948	40,618		40,618
Receipt of capital grants and donations		545	545		524	524
Charitable and other contributions to expenditure		59	59		374	374
Other income	4,860	-	4,860	4,004	-	4,004
Total other operating income	188,625	604	189,229	157,121	898	158,019
Of which:						
Related to continuing operations			189,229			158,019

Note 5.1
Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,484	2,049

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.2
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 licence 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:

	2019/20 £000	2018/19 £000
Income from services designated as commissioner requested services	686,611	685,733
Income from services not designated as commissioner requested services	198,227	153,390
Total	884,838	839,123

Note 6.1 Operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	5,134	6,105
Purchase of healthcare from non-NHS and non-DHSC bodies	1,711	1,931
Staff and executive directors costs	576,066	534,983
Remuneration of non-executive directors	138	137
Supplies and services - clinical (excluding drugs costs)	103,913	96,720
Supplies and services - general	21,718	20,831
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	81,427	82,925
Consultancy costs	2,361	7,420
Establishment	5,264	5,026
Premises	26,444	30,038
Transport (including patient travel)	9,111	7,944
Depreciation on property, plant and equipment	19,949	19,428
Amortisation on intangible assets	3,392	4,408
Movement in credit loss allowance: contract receivables / contract assets	569	2,713
Increase/(decrease) in other provisions	(13)	598
Audit fees payable to the external auditor		
audit services- statutory audit	94	84
other auditor remuneration (external auditor only)	10	10
Internal audit costs	140	140
Clinical negligence	23,295	24,795
Legal fees	895	1,050
Insurance	54	62
Research and development	-	49
Education and training	2,866	3,471
Rentals under operating leases	16,484	18,119
Redundancy	210	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	6,297	6,358
Car parking & security	419	12
Losses, ex gratia & special payments	-	18
Other	129	3,684
Total	**908,076**	**879,058**
Of which:		
Related to continuing operations	908,076	879,058
Related to discontinued operations	-	-

Note 6.2
Other auditor remuneration

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	10	10
Total	10	10

Note 6.3
Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 6.4
Impairment of assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Total net impairments charged to operating surplus / deficit	-	-
Impairments charged to the revaluation reserve	9,653	-
Total net impairments	9,653	-

Land revaluation impairment in 19/20

Note 7
Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	436,512	424,434
Social security costs	47,251	42,896
Apprenticeship levy	2,135	2,044
Employer's contributions to NHS pensions	71,395	48,416
Termination benefits	271	122
Temporary staff (including agency)	18,502	17,071
Total gross staff costs	576,066	534,983
Recoveries in respect of seconded staff	-	-
Total staff costs	576,066	534,983
Of which		
Costs capitalised as part of assets	-	-

Note 7.1 Retirements due to ill-health

During 2019/20 there was one early retirement from the Trust agreed on the grounds of ill-health (two in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £24k (£182k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 8 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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up

some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

d) National Employment Savings Scheme (NEST)

The Trust offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), for those members of staff who do not qualify for the NHS pension scheme.

Note 9 Operating leases

Note 9.1
St George's University Hospitals NHS Foundation Trust as a 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.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	16,484	18,119
Total	16,484	18,119

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	16,483	17,993
- later than one year and not later than five years;	65,935	71,973
- later than five years.	16,483	17,993
Total	98,901	107,959

	2019/20 £000	2018/19 £000
Category of Lease		
Building	95,272	103,548
Other	3,629	4,411
Total	98,901	107,959

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2019/20 £000	2018/19 £000
Interest on bank accounts	237	88
Total finance income	237	88

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health and Social Care	8,873	7,629
Other loans	133	161
Finance leases	227	203
Interest on late payment of commercial debt	5	1
Main finance costs on PFI and LIFT schemes obligations	2,704	2,779
Total interest expense	11,942	10,773
Unwinding of discount on provisions	(5)	3
Other finance costs	-	-
Total finance costs	11,937	10,776

Note 11.2 The late payment of commercial debts (interest) Act 1998/Public Contract Regulations 2015

	2019/20 £000	2018/19 £000
Amounts included within interest payable arising from claims made under this legislation	5	1

Note 12 Other gains / (losses)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	-	175
Total gains/(losses) on disposal of assets	-	175

2019/20

In 2019/20 and 18/19 the Trust disposed of old plant and equipment with a net book value of £0k.

Note 13.1 Intangible assets – 2019/20

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	2,879	35,792	38,671
Additions	51	10,087	10,138
Reclassifications	-	11,403	11,403
Valuation / gross cost at 31 March 2020	2,930	57,282	60,212
Amortisation at 1 April 2019 - brought forward	1,924	17,238	19,162
Provided during the year	291	3,101	3,392
Amortisation at 31 March 2020	2,215	20,339	22,554
Net book value at 31 March 2020	715	36,943	37,658
Net book value at 1 April 2019	955	18,554	19,509

Note 13.2 Intangible assets - 2018/19

	Software licences £000	Internally generated information technology £000	Total £000
Valuation/gross cost at 1 April 2018 – as previously stated	2,164	34,974	37,138
Valuation/gross cost at 1 April 2018 – restated	2,164	34,974	37,138
Transfers by absorption	-	-	-
Additions	679	854	1,533
Reclassifications	36	(36)	-
Valuation/gross cost at 31 March 2019	2,879	35,792	38,671
Amortisation at 1 April 2018 – as previously stated	1,553	13,201	14,754
Amortisation at 1 April 2018 – restated	1,553	13,201	14,754
Provided during the year	371	4,037	4,408
Amortisation at 31 March 2019	1,924	17,238	19,162
Net book value at 31 March 2019	955	18,554	19,509
Net book value at 1 April 2018	611	21,773	22,384

Note 14.1 Property, plant and equipment – 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2019 - brought forward	55,929	225,285	113	38,640	83,408	24,373	10,743	438,490
Additions	-	9,097	-	26,026	8,975	2,581	31	46,710
Impairments	(9,653)	-	-	-	-	-	-	(9,653)
Revaluations	-	4,477	-	-	-	-	-	4,477
Reclassifications	-	10,344	-	(23,503)	12	1,424	320	(11,403)
Valuation/gross cost at 31 March 2020	46,276	249,203	113	41,163	92,395	28,378	11,094	468,621
Accumulated depreciation at 1 April 2019 - brought forward	-	(0)	10	-	46,353	14,235	6,928	67,527
Provided during the year	-	8,127	5	-	7,833	3,331	653	19,949
Revaluations	-	(8,127)	-	-	-	-	-	(8,127)
Accumulated depreciation at 31 March 2020	-	(0)	15	-	54,186	17,566	7,581	79,349
Net book value at 31 March 2020	46,276	249,203	98	41,163	38,208	10,812	3,513	389,272
Net book value at 1 April 2019	55,929	225,285	103	38,640	37,054	10,138	3,815	370,963

Note 14.2 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 – as previously stated	46,144	221,784	113	35,327	77,874	20,361	10,073	411,676
Valuation/gross cost at 1 April 2018 – restated	46,144	221,784	113	35,327	77,874	20,361	10,073	411,676
Additions	-	6,501	-	4,898	6,767	4,012	427	22,605
Revaluations	9,785	(4,343)	-	-	-	-	-	5,442
Reclassifications	-	1,343	-	(1,585)	-	-	243	-
Disposals / derecognition	-	-	-	-	(1,233)	-	-	(1,233)
Valuation/gross cost at 31 March 2019	55,929	225,285	113	38,640	83,408	24,373	10,743	438,490
Accumulated depreciation at 1 April 2018 – as previously stated	-	-	5	-	39,791	10,794	6,245	56,835
Accumulated depreciation at 1 April 2018 – restated	-	-	5	-	39,791	10,794	6,245	56,835
Provided during the year	-	7,503	5	-	7,795	3,441	683	19,428
Revaluations	-	(7,503)	-	-	-	-	-	(7,503)
Disposals / derecognition	-	-	-	-	(1,233)	-	-	(1,233)
Accumulated depreciation at 31 March 2019	-	(0)	10	-	46,353	14,235	6,928	67,527
Net book value at 31 March 2019	55,929	225,285	103	38,640	37,054	10,138	3,815	370,963
Net book value at 1 April 2018	46,144	221,784	108	35,327	38,083	9,567	3,828	354,841

Note 14.3 Property, plant and equipment financing – 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2020								
Owned - purchased	45,261	180,725	98	41,163	29,104	10,795	3,376	310,521
Finance leased	-	-	-	-	7,915	-	-	7,915
On-SoFP PFI contracts and other service concession arrangements	-	54,362	-	-	-	-	-	54,362
Owned - government granted	-	2,131	-	-	-	-	9	2,140
Owned - donated	1,015	11,985	-	-	1,189	17	128	14,334
NBV total at 31 March 2020	46,276	249,203	98	41,163	38,208	10,812	3,513	389,272

Note 14.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019								
Owned - purchased	54,914	161,314	103	38,640	28,702	10,108	3,638	297,418
Finance leased	-	-	-	-	7,167	-	-	7,167
On-SoFP PFI contracts and other service concession arrangements	-	51,585	-	-	-	-	-	51,585
Owned - government granted	-	2,181	-	-	5	-	13	2,199
Owned - donated	1,015	10,205	-	-	1,180	30	164	12,594
NBV total at 31 March 2019	55,929	225,285	103	38,640	37,054	10,138	3,815	370,963

Note 15 Donations of property, plant and equipment

The Trust has recognised capital donations receivable towards the cost of various items of medical equipment. These donations are receivable from the St George's Hospital Charity and other various charitable organisations.

Note 16 Revaluations of property, plant and equipment

In 2019/20 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 2020 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 2016/17 the Trust 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 80 years.

Plant and machinery asset lives range from 1 year to 25 years.

Transport equipment asset lives range from 5 years to 7 years.

Information technology assets range from 5 years to 10 years.

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

Note 17 Disclosure of interests in other entities

The Trust does not have any subsidiaries and is not part of a joint venture

Note 18 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	3,851	2,678
Consumables	8,020	5,085
Total inventories	11,871	7,763
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £83,261k (2018/19: £81,514k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

Note 19.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	78,242	82,168
Allowance for impaired contract receivables / assets	(9,211)	(8,642)
Prepayments (non-PFI)	4,134	4,782
PDC dividend receivable	-	799
VAT receivable	1,504	4,362
Other receivables	5,898	6,856
Total current receivables	80,567	90,325
Non-current		
Contract receivables	11,097	11,901
Other receivables	2,007	-
Total non-current receivables	13,104	11,901
Of which receivable from NHS and DHSC group bodies:		
Current	48,553	47,652
Non-current	2,007	-

Note 19.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	8,642	-	-	8,347
Allowances as at 1 April - restated	8,642	-	-	8,347
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			8,347	(8,347)
New allowances arising	569	-	2,713	-
Utilisation of allowances (write offs)	-	-	(2,418)	-
Allowances as at 31 Mar 2020	9,211	-	8,642	-

The Trust determines the provision for impairment of receivables on the bases of the age of the debt and the risk of non- collection.

Note 19.3 Exposure to credit risk

The Trust has carried out a review of 19/20 receivables and there is no material exposure to credit risks.

Note 20 Other assets

	31 March 2020	31 March 2019
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	11	11
Total other non-current assets	11	11

Note 21 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.

	2019/20 £000	2018/19 £000
At 1 April	3,232	3,541
At 1 April (restated)	3,232	3,541
Net change in year	193	(309)
At 31 March	3,425	3,232
Broken down into:		
Cash at commercial banks and in hand	50	56
Cash with the Government Banking Service	3,375	3,176
Total cash and cash equivalents as in SoFP	3,425	3,232
Total cash and cash equivalents as in SoCF	3,425	3,232

Note 21.1 Third party assets held by the Trust

St George's University Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020 £000	31 March 2019 £000
Monies on deposit	5	6
Total third party assets	5	6

Note 22.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	64,731	95,721
Capital payables	22,499	4,270
Accruals	14,401	4,043
Social security costs	6,679	13,702
Other taxes payable	5,189	5,475
Other payables	568	1,003
Total current trade and other payables	114,067	124,215

Of which payables from NHS and DHSC group bodies:		
Current	14,758	17,107
Non-current	-	-

Note 23 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	2,480	2,484
Total other current liabilities	2,480	2,484
Total other non-current liabilities	-	-

Note 24.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	317,998	69,157
Other loans	1,478	1,478
Obligations under finance leases	2,394	2,034
Obligations under PFI, LIFT or other service concession contracts	1,215	1,136
Total current borrowings	323,085	73,805
Non-current		
Loans from DHSC	20,448	217,932
Other loans	5,173	6,652
Obligations under finance leases	3,461	3,536
Obligations under PFI, LIFT or other service concession contracts	40,253	41,469
Total non-current borrowings	69,335	269,589

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 2019/20. As at 31/03/20 the balance owed by the Trust on this loan is £12.0m.

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 31/03/20 the balance owed by the Trust on this loan is £11.3m.

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 31/03/20 the balance owed by the Trust on this loan is £8m.

4. The Trust drew down a capital loan of £27.2m between the periods May-19 to March-20. The capital loan is repayable over 25 years at a fixed interest rate of 1.55%. The Trust repaid £0.4m in 2019/2020 and the balance owed by the Trust on this loan is £26.8m.

5. The Trust drew down a capital loan of £5.4m in March 2020. This capital loan is repayable over 10 years at a fixed interest rate of 0.45%. As at 31/03/2020 the balance owed by the Trust on this loan is £5.4m.

DH working capital loans and working capital facilities

6. 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 2019/20. As at 31/03/20 the balance owed by the Trust on this loan is £10m.

7. 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 2019 however before the end of the 2018/19 financial year the Department of Health deferred the repayment of the facility to March 2020. In 2019/20 DH again deferred the payment to March 2021 and so the repayment of this facility is classified as a current liability for the fourth successive year in 2019/20. The interest rate is fixed at 1.5% and the full amount borrowed of £48.7m is repayable in March 2020. As at 31/03/20 the balance owed by the Trust on this facility is £48.7m.

8. 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 31/03/20 the balance owed by the Trust on this facility is £64.3m.

9. 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 was originally repayable in March 2020 however DH deferred to March 21. As at 31/03/20 the balance owed by the Trust on this facility is £15.1m.

10. 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. The Trust repaid £9.6m of £11m loan in 2019/20.These loans are repayable in full in the period July 2020 to October 2020 inclusive. As at 31/03/20 the balance owed by the Trust on these loans is £24.9m.

11. The Trust borrowed £25.8m interim working capital facility loans in the period November 2018 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 31/03/20 the balance owed by the Trust on these loans is £25.8m.

12. The Trust borrowed £51.9m interim working capital facility loans in the period April 2018 to March 2019. The interest rate is 3.5% for all borrowings under these loan agreements. These loans are repayable in full in the period April 2021 to March 2022 inclusive. As at 31/03/20 the balance owed by the Trust on these loans is £51.9m.

13. The Trust borrowed £32.7m interim working capital facility loans in the period April 2019 to March 2020. The interest rate is 3.5% for all borrowings under these loan agreements. These loans are repayable in full in the period April 2022 to March 2023 inclusive. As at 31/03/20 the balance owed by the Trust on these loans is £32.7m.

DHSC Loan conversion to PDC in 2020/21

14. Total outstanding capital loan of £51.8m as of 2019/20 will be converted to PDC in 2020/21. This excludes two loans a total of £14.7m. These are repayable over 25 years. All converted loans will attract a PDC charge of 3.5%.

15. Total outstanding working capital loan of £263m as of 2019/20 will be converted to PDC in 2020/21. This excludes £15m which will be repayable over 15 years. All converted loans will attract a PDC charge of 3.5%.

Borrowings from other bodies

London Energy Efficiency Fund

16. 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 2019/20. As at 31/03/20 the balance owed by the Trust on this loan is £6.7m.

Note 24.2
Reconciliation of liabilities arising from financing activities – 2019/20

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	287,089	8,130	5,570	42,605	343,394
Cash movements:					
Financing cash flows - payments and receipts of principal	51,135	(1,478)	(2,881)	(1,136)	45,640
Financing cash flows - payments of interest	(8,651)	(350)	(227)	(2,705)	(11,933)
Non-cash movements:					
Additions	-	-	3,166	-	3,166
Application of effective interest rate	8,873	133	227	2,704	11,937
Change in effective interest rate	-	216	-	-	216
Carrying value at 31 March 2020	338,446	6,651	5,855	41,468	392,420

Note 24.3
Reconciliation of liabilities arising from financing activities – 2018/19

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	238,204	9,608	7,896	43,667	299,375
Carrying value at 1 April 2018 - restated	238,204	9,608	7,896	43,667	299,375
Cash movements:					
Financing cash flows - payments and receipts of principal	47,722	(1,478)	(2,523)	(1,062)	42,659
Financing cash flows - payments of interest	(7,379)	-	(204)	(2,779)	(10,362)
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	712	67	-	-	779
Application of effective interest rate	7,629	161	203	2,779	10,772
Change in effective interest rate	-	(228)	198	-	(30)
Other changes	201	-	-	-	201
Carrying value at 31 March 2019	287,089	8,130	5,570	42,605	343,394

Note 25
Finance leases

Note 25.1 St George's University Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	6,611	6,120
of which liabilities are due:		
- not later than one year;	2,730	2,233
- later than one year and not later than five years;	3,373	3,743
- later than five years.	508	144
Finance charges allocated to future periods	(756)	(550)
Net lease liabilities	5,855	5,570
of which payable:		
- not later than one year;	2,394	2,034
- later than one year and not later than five years;	3,030	3,406
- later than five years.	431	130
	5,855	5,570

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.

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2019	1,037	424	121	1,582
Arising during the year	121	137	2,019	2,277
Utilised during the year	(697)	(141)	-	(838)
Reversed unused	-	(283)	-	(283)
Unwinding of discount	(5)	-	-	(5)
At 31 March 2020	456	137	2,140	2,733
Expected timing of cash flows:				
- not later than one year;	-	137	133	270
- later than one year and not later than five years;	456	-	2,007	2,463
- later than five years.	(0)	-	-	(0)
Total	456	137	2,140	2,733

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.

Note 26.2 Clinical negligence liabilities

At 31 March 2020, £361,965k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2019: £354,931k).

Note 27 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(62)	(101)
Gross value of contingent liabilities	(62)	(101)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(62)	(101)
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.

Note 28 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	5,580	1,215
Intangible assets	-	-
Total	5,580	1,215

The capital commitments total of £5.580m as at 31/03/20 relates to increased capital funding and Covid capital related spend

Note 29 On-SoFP PFI, LIFT or other service concession arrangements

Note 29.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	70,493	74,335
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.	51,289	55,131
Finance charges allocated to future periods	(29,025)	(31,730)
Net PFI, LIFT or other service concession arrangement obligation	41,468	42,605
- not later than one year;	1,215	1,136
- later than one year and not later than five years;	5,777	5,399
- later than five years.	34,476	36,070

The Trust signed a private finance initiative (PFI) contract in March 2000 for the exclusive use of the new Atkinson Morley wing on the St George's Hospital site. The new wing was commissioned in August 2003 and the 35 year lease for the wing started from this date. At the end of the 35 year term the Trust has the right to exercise the option to acquire the building at a nominal cost. The contract is with Blackshaw Healthcare Services Ltd, a special purpose vehicle company which is responsible for the maintenance of the building and the availability of the facilities within the building. On the adoption of International Financial Reporting Standards (IFRS) in 2008/09 the Trust accounted for the scheme as an on-statement of financial position PFI scheme and therefore the £50m original capital value of the facility was included within property plant and equipment and the associated finance lease creditor within borrowings. The building is depreciated and revalued on a consistent basis with purchased buildings.

Note 29.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	243,529	246,021
Of which payments are due:		
- not later than one year;	10,662	10,126
- later than one year and not later than five years;	44,824	42,567
- later than five years.	188,043	193,328

Note 29.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	10,137	10,199
Consisting of:		
- Interest charge	2,704	2,779
- Repayment of balance sheet obligation	1,136	1,062
- Service element and other charges to operating expenditure	6,297	6,358
Total amount paid to service concession operator	10,137	10,199

Note 30 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 2018/19 or 2019/20.

Note 31 Financial instruments

Note 31.1 Financial risk management

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.

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 2020 are in receivables from customers, as disclosed in the trade and other receivables note. The Trust does not have any substantiated basis to conclude that the impact of Covid 19 will result in a credit risk.

Liquidity risk

The Trust's operating costs are incurred primarily under contracts with clinical commissioning groups which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks in terms of the timing of payments for most of its receivables. The Trust has incurred operating deficits since 2014/15 and this has necessitated borrowing from government to maintain liquidity.

Note 31.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	76,936	-	-	76,936
Cash and cash equivalents	3,425	-	-	3,425
Total at 31 March 2020	80,361	-	-	80,361

Financial assets as per Statement of Financial Position	£000
Trade and other receivables excluding non financial assets	76,936
RTA	11,097
Prepayments	4,134
VAT	1,504
Total at 31 March 2020	93,671
Statement of Financial Position	
Non Current Receivables	80,567
Current Receivables	13,104
Total at 31 March 2020	93,671

Carrying values of financial assets as at 31 March 2019	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	89,717	-	-	89,717
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	3,232	-	-	3,232
Total at 31 March 2019	92,949	-	-	92,949

Financial assets as per Statement of Financial Position	£000
Trade and other receivables excluding non financial assets	89,717
RTA	2,566
Prepayments	4,782
PDC	799
VAT	4,362
Total at 31 March 2019	102,226

Statement of Financial Position	
Non Current Receivables	11,901
Current Receivables	90,325
Total at 31 March 2019	102,226

Note 31.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	338,446	-	338,446
Obligations under finance leases	5,855	-	5,855
Obligations under PFI, LIFT and other service concession contracts	41,468	-	41,468
Other borrowings	6,651	-	6,651
Trade and other payables excluding non financial liabilities	81,298	-	81,298
Total at 31 March 2020	473,718	-	473,718

The Financial Liabilities as per Statement of Financial Position	
Borrowing	£000
Loans from the Department of Health and Social Care	338,446
Obligations under finance leases	5,855
Obligations under PFI, LIFT and other service concession contracts	41,468
Other borrowings	6,651
Total at 31 March 2020	392,420

Statement of Financial Position	
Current Borrowings	323,085
Non Current Borrowings	69,335
Total at 31 March 2020	392,420

Trade and other payables	£000
Trade and other payables excluding non financial liabilities	81,298
Social Security cost	13,179
Other Taxes	5,189
Accruals	14,401
Total at 31 March 2020	114,067

Statement of Financial Position	
Current Trade and other payables	114,067
Total at 31 March 2020	114,067

Carrying values of financial liabilities as at 31 March 2020	
Borrowing	392,420
Trade and other payables	95,699
	488,119

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	287,089	-	287,089
Obligations under finance leases	5,570	-	5,570
Obligations under PFI, LIFT and other service concession contracts	42,605	-	42,605
Other borrowings	8,130	-	8,130
Trade and other payables excluding non financial liabilities	98,511	-	98,511
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2019	441,905	-	441,905

The Financial Liabilities as per Statement of Financial Position Borrowing	
	£000
Loans from the Department of Health and Social Care	287,089
Obligations under finance leases	5,570
Obligations under PFI, LIFT and other service concession contracts	42,605
Other borrowings	8,130
Total at 31 March 2019	343,394

Statement of Financial Position	
Current Borrowings	73,805
Non Current Borrowings	269,589
Total at 31 March 2019	343,394

Trade and other payables	
	£000
Trade and other payables excluding non financial liabilities	98,511
Social Security cost	13,702
Other Taxes	5,475
Accruals	6,527
Total at 31 March 2019	124,215

Statement of Financial Position	
Current Trade and other payables	124,215
Total at 31 March 2019	124,215

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	
Borrowing	343,394
Trade and other payables	98,511
Total at 31 March 2019	441,905

Note 31.4
Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	404,384	157,243
In more than one year but not more than two years	5,921	23,942
In more than two years but not more than five years	14,463	198,550
In more than five years	48,950	62,170
Total	473,718	441,905

Note 31.5 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 2020 Book Value £000	31 March 2020 Fair Value £000	31 March 2019 Book Value £000	31 March 2019 Fair Value £000
Carrying values of financial assets as at 31 March 2020 under IFRS 9				
Trade and other receivables excluding non financial assets	76,936	76,936	89,717	89,717
Cash and cash equivalents at bank and in hand	3,425	3,425	3,232	3,232
Total at 31 March 2020	80,361	80,361	92,949	92,949

	31 March 2020 Book Value £000	31 March 2020 Fair Value £000	31 March 2019 Book Value £000	31 March 2019 Fair Value £000
Carrying values of financial liabilities as at 31 March 2020 under IFRS 9				
Loans from the Department of Health and Social Care	338,446	338,446	287,089	287,089
Obligations under finance leases	5,855	5,855	5,570	5,570
Obligations under PFI, LIFT and other service concession contracts	41,468	41,468	42,605	42,605
Other borrowings	6,651	6,651	8,130	8,130
Trade and other payables excluding non financial liabilities	81,298	81,298	98,511	98,511
Total at 31 March 2020	473,718	473,718	441,905	441,905

Note 32 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	-	-
Total losses	-	-	-	-
Special payments				
Ex-gratia payments	79	420	70	68
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	79	420	70	68
Total losses and special payments	79	420	70	68
Compensation payments received		-		-

There are two exceptional payments total of £392k within the Medicine and Cardiovascular area.

Note 33 Gifts

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Gifts made	-	-	-	-

Note 34 Related parties

St George's University Hospitals NHS Foundation Trust is a Foundation Trust within the the Department of Health and Social Care. During the year, St George's University Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department, 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	
	2019/20 £000	2018/19 £000	2019/20 £000	2018/19 £000
Non - NHS Related party transactions				
St George's University of London	5,805	1,540	4,252	3,207
St George's Hospital Charity	457	455	1	-
Total	6,262	1,995	4,253	3,207

	Receipts from Related Party		Payments to Related party	
	2019/20 £000	2018/19 £000	2019/20 £000	2018/19 £000
Non - NHS Related party transactions				
St George's University of London	7,200	4,087	4,747	3,154
St George's Hospital Charity	1,454	1,369	107	46
Total	8,654	5,456	4,854	3,200

2019/20 Related parties

There are no related parties for Directors in 2018/2019 and 2019/2020.

Note 35 Events after the reporting date

The additional cost incurred by the Trust due to the impact of Covid-19 will reimbursed in 20/21.

The Trust has received notification that loans will be converted to PDC from April 2020. Total loan value conversion will attract PDC charge of 3.5%. The DHSC Loan interest payable will cease.The Trust is not expecting to borrow any revenue support loans in 2020/21.

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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 4522
Email: giving@stgeorges.nhs.uk
Web: www.stgeorgeshospitalcharity.org.uk

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