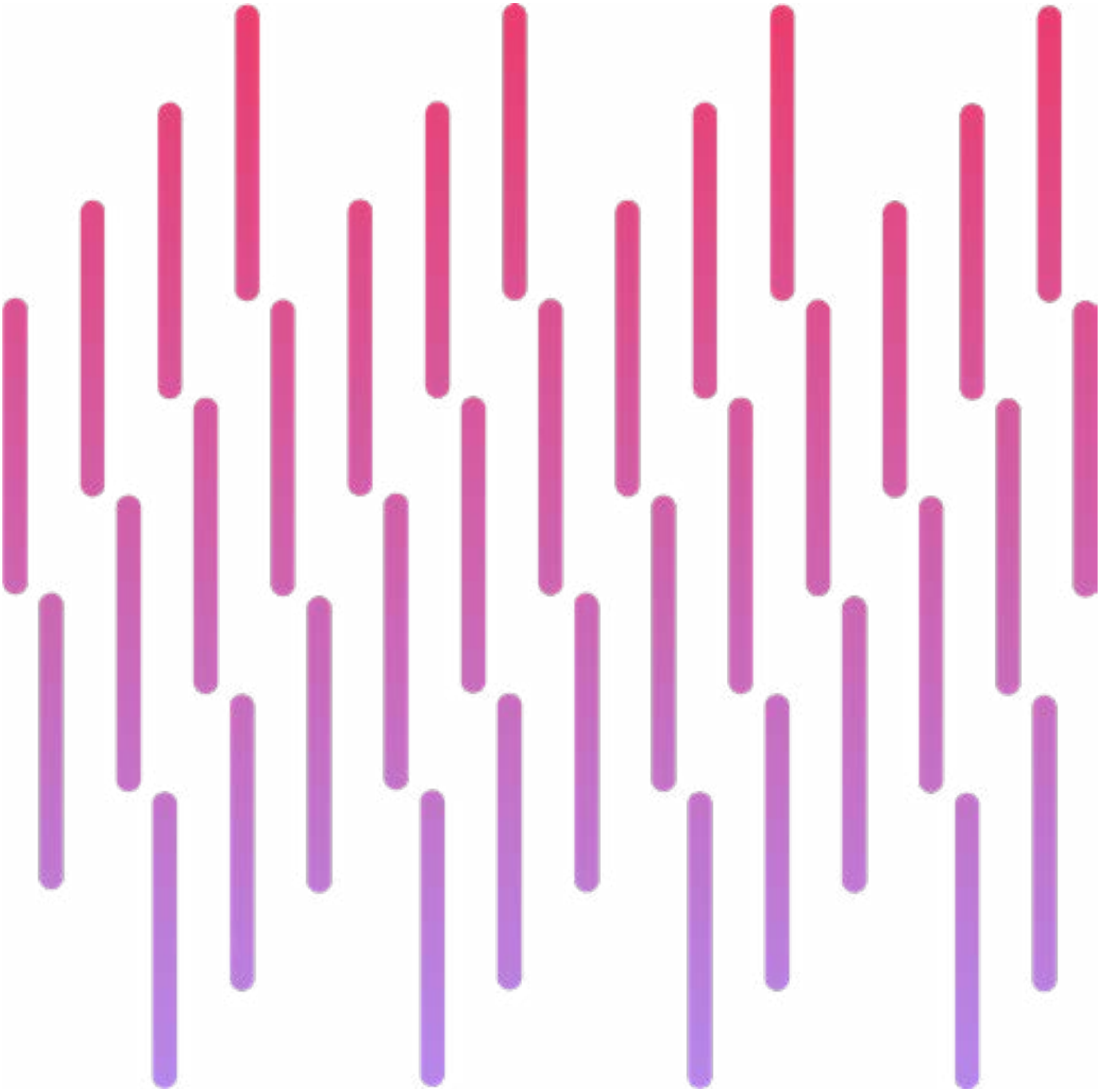
# Quality Report (Account) 2020/21



# Part 1

## Statement on quality from the Chief Executive

Since my introduction to last year's Quality Account, Covid-19 has had a profound impact across the NHS, with services under very significant pressure. Here at St George's, staff have worked through a period of extreme challenge, but have continued to put quality – and the safety of our patients – at the forefront of everything we do.

I am pleased at the progress we have made in a number of areas – and this is down to the efforts of staff across the organisation, in a wide variety of roles. Of course, there have also been challenges, some significant, which are rightly detailed in this report.

In March 2020 we exited the special measures regime for quality of services which was a big step forward for the organisation and staff morale. In December 2020 we were also removed from financial special measures – an achievement which means regulators have confidence in our leadership, and we can focus on the quality of care we provide.

Our performance metrics are starting to evidence the shift in culture to one of an organisation constantly looking to improve. This is shown by consistent achievement of lower than expected SHMI (Summary hospital level mortality indicator); the increase of VTE (venous thromboembolism) assessments to 96.18%; and the reduction by 50% of C.difficile cases due to lapses in care.

Due to the pandemic, national quality surveillance was paused – however we continued to monitor our services internally, which this report demonstrates. This includes our delivery of the clinical audit programme where the Trust performed above the national average on a number of important quality and safety indicators.

The shift in culture was also reflected in this year's Staff Survey results, where we saw an increase in how satisfied staff are with the quality of care they give to patients, and an improvement in how staff perceive the culture of safety at the Trust. These scores are encouraging, but we are focussed on continuing to make progress in these areas.

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 steps to make it easier for staff to do this, including launching our Freedom to Speak Up strategy, and raising awareness about how to report incidents from when new staff join the Trust to regular awareness raising on our all staff communications.

We continue to focus on delivering improvements within our cardiac surgery service at St George's. 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.

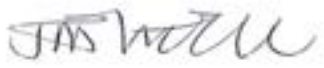
We have introduced positive changes to the department in recent months, and data from the National Institute for Cardiovascular Research (NICOR) continues to demonstrate that the service is safe, and no longer an outlier for mortality which means the service is no longer subject to external scrutiny. The Trust Board continues to review the service's mortality data on a regular basis.

Strengthening our own governance processes has been integral to our quality priorities since the cardiac surgery review, and this year we completed our third external governance review, looking at ward to Board reporting and monitoring of quality and safety. One of the outcomes has been the appointment of three deputy chief medical officers, with responsibility for safety, quality, effectiveness and quality improvement. These appointments are an important step in strengthening our corporate medical directorate and wider clinical governance.

We continue to respond to the effects of the pandemic, despite the small numbers of patients with the virus in our hospitals at the time of writing. As a result of pausing non-urgent treatment during the second Covid-19 wave, we are tackling our elective backlogs that have grown in certain specialities. Reducing our waiting lists will take time, but we are working with other hospitals in south west London – as we have throughout the pandemic – to ensure patients get the care they need as quickly as possible.

Despite the many challenges brought by Covid-19, some areas of development have been accelerated as a direct result of the pandemic. For example, we have been at the forefront of clinical research and together with St George's, University of London, have extended our research portfolio, focussing on trials relating to the Covid-19 virus. We are also now running the majority of our outpatient appointments virtually where assessed safe to do so, and we have improved our IT infrastructure to enable our teams to do this.

To the best of my knowledge the information contained in this document is accurate and reflects our view of the quality of the health services we provide. I would like to thank our staff who have worked so hard to deliver outstanding care, every time for our patients in a truly unprecedented year – they are a credit to the organisation.



**Jacqueline Totterdell**
**Chief Executive**
**24 June 2021**

# Part 2

## 2.0 Priorities for improvement and statements of assurance from the board
## 2.1 Our quality priorities for 2021/22

### 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.

In September 2020 the Trust Board agreed a refresh of our corporate objectives, setting out our priorities for rest of the year (October 2020 – March 2021). This does not change our vision or our five year strategy.

Our new corporate objectives drive everything we do, and help us focus our efforts on what matters most. They are not designed to be an exhaustive list of everything we are doing, but to help us prioritise and guide decision-making, at a Trust, managerial and staff level.

For each of our three new objectives of Care, Culture and Collaboration, a series of priorities underpin them, and these are set out below.

Throughout 2020/21 the Trust continued to implement the quality priorities set out in 2020/21 which were aligned to the seven priority areas in our Quality and Safety Strategy:

1. We will minimise avoidable harm across our organisation, utilising the developments in technology and embedding further, robust quality assurance and learning processes

2. We will improve outcomes for patients through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our patients

3. We will provide patients with an excellent experience through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients

4. We will improve staff experience, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology

5. We will provide patients with an equitable experience by proactively reaching out with system partners to our communities and our vulnerable groups

6. We will embed a culture in which quality, safety and learning is embraced across the organisation, and is supported by robust systems of safety governance

7. We will be at the forefront of providing and developing pioneering and leading edge treatments for today and for the future

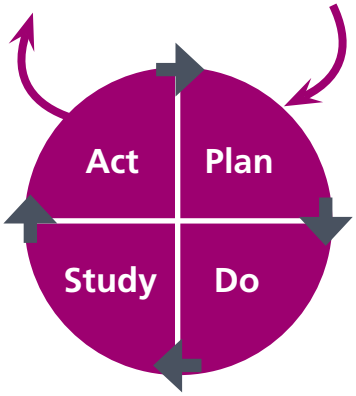
| CARE | CULTURE | COLLABORATION |
|---|---|---|
| **We will keep staff safe, and invest in their health and wellbeing**<br>**We will share the findings of our culture discovery project, so we understand how staff feel about working at St George's**<br><br>**We will work more closely with local hospitals and partner organisations in south west London** | **We will make sure we are prepared to meet the demands of Covid-19, flu and winter**<br><br>**We will develop a plan with staff to improve our culture, and measure the impact it is having**<br><br>**We will overcome challenges together, rather than as individual organisations** | **We will provide routine and planned care, and keep patients safe during their stay**<br><br>**We will celebrate diversity, and support our leaders to be more inclusive**<br><br>**We will work with St George's, University of London to build our training and research expertise** |

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 2020/21 we developed the year 1 implementation plan to support the delivery of our five year Quality and Safety Strategy. Although, the objectives of the implementation plan were not fully met due to the impact of the pandemic, progress was made across all areas.

## Our quality priorities 2021/22 and why we chose them

The quality priorities for 2021/22 were informed by:

- Our progress against the Quality Priorities for 2020/21 which was impacted by the Covid-19 pandemic
- Themes highlighted from our ward and departmental accreditation scheme
- Actions from the 2019 CQC inspection which we implemented during 2020-21
- Analysis of our complaints and PALs enquiries
- Analysis of our serious incidents, moderate and low harm incidents
- Previous feedback from Healthwatch 'Enter and View' visits
- Local and national audit
- National priorities for sepsis, safe staffing, falls, and infection prevention and control

We have not held specific listening events in the last year

### 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

## Priority 1 – Improve patient safety

Patients are safer when there 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 2021/22 due to the impact of the pandemic on our progress we want to continue to focus on the patient safety priorities identified in 2020/21 together with the inclusion of one new quality priority. The additional quality priority will focus our learning from both a local and South West London perspective on Nosocomial Covid-19 infection with a view to amending our infection prevention and control procedures as appropriate.

| WHAT | HOW | WHAT WILL SUCCESS LOOK LIKE |
|---|---|---|
| **Reduce the risk of Nosocomial Covid-19 infection for in-patients** | **Review Nosocomial Covid-19 infection at a local and system level and revise infection prevention and control procedures** | **Reduction in the level of Nosocomial Covid-19 infection when compared with 2020/21** |
| **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 and 2020/21**<br><br>**Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 and 2020/21**<br><br>**80% of adult inpatients will have a TEP (compared with 33% in April 2021)**<br><br>**Reduction in the number of cardiac arrests compared with 2019/20 and 2020/21** |
| **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** | **80% of adult inpatients will have a TEP (compared with 33% in April 2021)**<br><br>**Audit of consent demonstrates an improved position when compared with 2020/21** |
| **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.

| 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 (complaint numbers impacted in 2020/21 due to the pandemic)** |
| **Provide an equitable experience for patients from vulnerable groups** | **Undertake NHS benchmark assessment against the National Learning Disability Standards having had the opportunity to make service improvements following the self-assessment in 2020** | **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.**<br><br>**Progress further the implementation of Red to Green in iClip to highlight the issues that delay discharge**<br><br>**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**<br><br>**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 2020/21 baseline (fast track process implemented due to pandemic in 2020/21)**<br><br>**See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2019/20 and 2020/21**<br><br>**Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2020/21**<br><br>**Improvement in the patients who were discharged from an inpatient setting with a follow up appointment or investigation date when compared with 2019/20 and 2020/21** |

## 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 [revised to reflect the impact of the pandemic] | Achievement of targets for:<br>• Four hour operating standard<br>• Cancer standards<br>Achievement of agreed trajectories for target recovery due to the impact of the pandemic for:<br>• Referral to Treatment (RTT) within 18 weeks<br>• Diagnostics within six weeks |

## 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 progress reports to the Patient Safety Quality Group and the Quality and Safety Committee, a sub-committee of the Trust Board.

## 2.1.5 Progress against priorities for 2020/21 [See part 3]

## 2.2 Statements of assurance from the Board of Directors

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

St Georges 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 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.

During the year our anaesthetic team at St George's were re-accredited under the Royal College of Anaesthetists (RCoA) Anaesthesia Clinical Services Accreditation (ACSA) scheme. This is a significant achievement, as to receive accreditation, departments are expected to demonstrate high standards in areas such as patient experience, patient safety and clinical leadership.

In July 2020 St George's was named the world's first Twins Trust Centre for Research and Clinical Excellence, so demonstrating our position as one of the best providers of care for multiple pregnancies. Our fetal medicine team has also created the first ever registry of cases of TTTS (twin to twin transfusion syndrome) and employed a specialist TTTS/ Multiple Pregnancy research study coordinator, who looks after the registry and liaises with parents.

In March 2021, the brain tumour centre provided jointly by St George's, the Royal Marsden Hospital and Royal Surrey County Hospital was awarded designation as a Tessa Jowell Centre of Excellence. This reflects many years of collaborative working across South West London and Surrey, striving to get the very best diagnostics, surgery, oncological treatment and holistic care for patients with brain tumours.

**2.2.1** During 2020/21 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 2020/21 represents 100% of the total income generated from the provision of relevant health services by St George's University Hospitals NHS Foundation Trust for 2020/21.

## 2.2.2 Participation in clinical audit and National Confidential Enquiries

During 2020/21, 69 national clinical audits and 1 national confidential enquiry 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 2020/21 are as follows:

**Key:**
**N/A** – Audit postponed due to the impact of COVID-19
**X** – Unable to participate due to the lack of a data collection tool. This position will be rectified in 2021/22

| NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE) | | RELEVANT | PARTICIPATING |
|---|---|---|---|
| Antenatal and newborn national audit protocol 2019 to 2021 | | ✓ | ✓ |
| British Association of Urological Surgeons (BAUS) Audits | Cystectomy | ✓ | ✓ |
| | Female Stress Urinary Incontinence | X | N/A |
| | Nephrectomy | ✓ | ✓ |
| | Percutaneous Nephrolithotomy | ✓ | ✓ |
| | Radical Prostatectomy | ✓ | ✓ |
| | Bladder Outflow Obstruction Snapshot Audit | ✓ | ✓ |
| | Renal Colic Snapshot Audit | ✓ | ✓ |
| | Management of the Lower Ureter in Nephroureterectomy Audit | ✓ | ✓ |
| British Spine Registry | | ✓ | ✓ |
| Case Mix Programme (CMP) | Neurology Intensive Care Unit | ✓ | ✓ |
| | General Adult Intensive Care | ✓ | ✓ |
| | Cardiothoracic Intensive Care Unit | ✓ | ✓ |
| Child Health Clinical Outcome Review Programme | Transition from Child to Adult Health Services | N/A | N/A |
| Cleft Registry and Audit Network (CRANE) | | X | N/A |
| Elective Surgery (National PROMs Programme) | | ✓ | X |
| Emergency Medicine QIPs | Fractured Neck of Femur | ✓ | ✓ |
| | Pain in Children | ✓ | ✓ |
| | Infection Control | ✓ | ✓ |
| Falls and Fragility Fracture Audit Programme (FFFAP) | Fracture Liaison Service Database (FLS-DB) | ✓ | ✓ |
| | National Audit of Inpatient Falls (NAIF) | ✓ | ✓ |
| | National Hip Fracture Database (NHFD) | ✓ | ✓ |
| Inflammatory Bowel Disease (IBD) Audit | | ✓ | ✓ |
| Learning Disabilities Mortality Review Programme (LeDeR) | | ✓ | ✓ |
| Mandatory Surveillance of HCAI | | ✓ | ✓ |
| Maternal and Newborn Infant Clinical Outcome Review Programme | Maternal mortality surveillance and confidential enquiries | ✓ | ✓ |
| | Perinatal Mortality Surveillance | ✓ | ✓ |
| | Perinatal confidential enquiries | ✓ | ✓ |
| Medical and Surgical Clinical Outcome Review Programme – Physical Health in Mental Health Hospitals | | ✓ | ✓ |
| Mental Health Clinical Outcome Review Programme | | X | N/A |

| NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE) | | RELEVANT | PARTICIPATING |
|---|---|---|---|
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) | Adult Asthma | ✓ | ✓ |
| | COPD | ✓ | ✓ |
| | Paediatric Asthma | ✓ | ✓ |
| | Pulmonary Rehabilitation | ✓ | ✓ |
| National Audit of Breast Cancer in Older Patients (NABCOP) | | ✓ | ✓ |
| National Audit of Cardiac Rehabilitation | | ✓ | ✓ |
| National Audit of Care at the End of Life (NACEL) | | ✓ | N/A |
| National Audit of Dementia (NAD) | | ✓ | N/A |
| National Audit of Pulmonary Hypertension | | X | N/A |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) | | ✓ | ✓ |
| National Bariatric Surgery Register | | ✓ | ✓ |
| 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 | N/A |
| | Heart Failure Audit | ✓ | ✓ |
| | Myocardial Ischaemia National Audit Programme (MINAP) | ✓ | ✓ |
| National Clinical Audit of Anxiety & Depression (NCAAD) | | X | N/A |
| National Clinical Audit of Psychosis (NCAP) | | X | N/A |
| National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia | | ✓ | ✓ |
| National Diabetes Audit – Adults | Core Audit | ✓ | ✓ |
| | Foot Care Audit | ✓ | ✓ |
| | Inpatient Audit - Harms (NaDIA) | ✓ | ✓ |
| | Inpatient Audit (NaDIA) | N/A | N/A |
| | Pregnancy in Diabetes 2020/21 | ✓ | ✓ |
| National Early Inflammatory Arthritis Audit (NEIAA) | | ✓ | ✓ |
| National Emergency Laparotomy Audit (NELA) | | ✓ | ✓ |
| National Gastro-intestinal Cancer Programme | National Bowel Cancer Audit (NBoCA) | ✓ | ✓ |
| | National Oesophago-Gastric Cancer Audit (NOGCA) | ✓ | ✓ |
| National Joint Registry | | ✓ | ✓ |
| National Lung Cancer Audit (NLCA) | | ✓ | ✓ |
| National Maternity and Perinatal Audit (NMPA) | | ✓ | ✓ |
| National Neonatal Audit Programme (NNAP) | | ✓ | ✓ |
| National Ophthalmology Database Audit | | X | X |
| National Paediatric Diabetes Audit (NPDA) | | ✓ | ✓ |
| National Prostate Cancer Audit (NPCA) | | ✓ | ✓ |
| National Vascular Registry | | ✓ | ✓ |
| Neurosurgical National Audit Programme | | ✓ | ✓ |
| NHS provider interventions with suspected/confirmed carbapenemase producing Gram negative colonisations/infections. | | ✓ | N/A |

| NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE) | RELEVANT | PARTICIPATING |
|---|---|---|
| Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry | N/A | N/A |
| Paediatric Intensive Care Audit (PICANet) | ✓ | ✓ |
| Perioperative Quality Improvement Programme (PQIP) | ✓ | ✓ |
| Prescribing Observatory for Mental Health UK (POMH-UK) | X | N/A |
| Sentinel Stroke National Audit Programme (SSNAP) | ✓ | ✓ |
| Serious Hazards of Transfusion Scheme (SHOT) | ✓ | ✓ |
| Society for Acute Medicine Benchmarking Audit | ✓ | ✓ |
| Surgical Site Infection Surveillance | ✓ | ✓ |
| The Trauma Audit & Research Network (TARN) | ✓ | ✓ |
| UK Cystic Fibrosis Registry | X | N/A |
| UK Registry of Endocrine and Thyroid Surgery | ✓ | ✓ |
| UK Renal Registry National Acute Kidney Injury programme | ✓ | ✓ |

**2.2.2.3** The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust participated in during 2020/21 are as follows:

| NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE) | |
|---|---|
| Antenatal and newborn national audit protocol 2019 to 2022 | |
| British Association of Urological Surgeons (BAUS) Audits | Cystectomy |
| | Nephrectomy |
| | Percutaneous Nephrolithotomy |
| | Radical Prostatectomy |
| | Bladder Outflow Obstruction Snapshot Audit |
| | Renal Colic Snapshot Audit |
| | Management of the Lower Ureter in Nephroureterectomy Audit |
| British Spine Registry | |
| Case Mix Programme (CMP) | Neurology Intensive Care Unit |
| | General Adult Intensive Care |
| | Cardiothoracic Intensive Care Unit |
| Elective Surgery (National PROMs Programme) | |
| Emergency Medicine QIPs | Fractured Neck of Femur |
| | Pain in Children |
| | Infection Control |
| Falls and Fragility Fracture Audit Programme (FFFAP) | Fracture Liaison Service Database (FLS-DB) |
| | National Audit of Inpatient Falls (NAIF) |
| | National Hip Fracture Database (NHFD) |
| Inflammatory Bowel Disease (IBD) Audit | |
| Learning Disabilities Mortality Review Programme (LeDeR) | |
| Mandatory Surveillance of HCAI | |
| Maternal and Newborn Infant Clinical Outcome Review Programme | Maternal mortality surveillance and confidential enquiries |
| | Perinatal Mortality Surveillance |
| | Perinatal Confidential Enquiries |
| Medical and Surgical Clinical Outcome Review Programme | |

| NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE) | |
|---|---|
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) | Adult Asthma |
| | COPD |
| | Paediatric Asthma |
| | Pulmonary Rehabilitation |
| National Audit of Breast Cancer in Older Patients (NABCOP) | |
| National Audit of Cardiac Rehabilitation | |
| National Audit of Care at the End of Life (NACEL) | |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) | |
| National Bariatric Surgery Register | |
| 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 – Adults | Core Audit |
| | Foot Care Audit |
| | Inpatient Audit - Harms (NaDIA) |
| | Inpatient Audit (NaDIA) |
| | Pregnancy in Diabetes |
| National Early Inflammatory Arthritis Audit (NEIAA) | |
| National Emergency Laparotomy Audit (NELA) | |
| National Gastro-intestinal Cancer Programme | National Bowel Cancer Audit (NBoCA) |
| | National Oesophago-Gastric Cancer Audit (NOGCA) |
| National Joint Registry | |
| National Lung Cancer Audit (NLCA) | |
| National Maternity and Perinatal Audit (NMPA) | |
| National Neonatal Audit Programme (NNAP) | |
| National Paediatric Diabetes Audit (NPDA) | |
| National Prostate Cancer Audit (NPCA) | |
| National Vascular Registry | |
| Neurosurgical National Audit Programme | |
| Paediatric Intensive Care Audit (PICANet) | |
| Perioperative Quality Improvement Programme (PQIP) | |
| Sentinel Stroke National Audit Programme (SSNAP) | |
| Serious Hazards of Transfusion Scheme (SHOT) | |
| Society for Acute Medicine Benchmarking Audit | |
| Surgical Site Infection Surveillance | |
| The Trauma Audit & Research Network (TARN) | |
| UK Registry of Endocrine and Thyroid Surgery | |
| UK Renal Registry National Acute Kidney Injury programme | |

**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 2020/21, 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 (%) |
|---|---|---|
| Antenatal and newborn national audit protocol 2019 to 2022 | | 100% |
| British Association of Urological Surgeons (BAUS) Audits | Cystectomy | 100% |
| | Nephrectomy | 100% |
| | Percutaneous Nephrolithotomy | 100% |
| | Radical Prostatectomy | 80.2% |
| | Bladder Outflow Obstruction Snapshot Audit | On-going |
| | Renal Colic Snapshot Audit | On-going |
| | Management of the Lower Ureter in Nephroureterectomy Audit | On-going |
| British Spine Registry | | On-going |
| Case Mix Programme (CMP) | Neurology Intensive Care Unit | 100% |
| | General Adult Intensive Care | 100% |
| | Cardiothoracic Intensive Care Unit | 100% |
| Elective Surgery (National PROMs Programme) | | *0% |
| Emergency Medicine QIPs | Fractured Neck of Femur | 100% |
| | Pain in Children | 100% |
| | Infection Control | On-going |
| Falls and Fragility Fracture Audit Programme (FFFAP) | Fracture Liaison Service Database (FLS-DB) | On-going |
| | National Audit of Inpatient Falls (NAIF) | 100% |
| | National Hip Fracture Database (NHFD) | 89.9% |
| Inflammatory Bowel Disease (IBD) Audit | | On-going |
| Learning Disabilities Mortality Review Programme (LeDeR) | | On-going |
| Mandatory Surveillance of HCAI | | 100% |
| Maternal and Newborn Infant Clinical Outcome Review Programme | Maternal mortality surveillance and confidential enquiries | 100% |
| | Perinatal Mortality Surveillance | 100% |
| | Perinatal Confidential Enquiries | 100% |
| Medical and Surgical Clinical Outcome Review Programme | | 100% |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) | Adult Asthma | On-going |
| | COPD | On-going |
| | Paediatric Asthma | 100% |
| | Pulmonary Rehabilitation | On-going |
| National Audit of Breast Cancer in Older Patients (NABCOP) | | 100% |
| National Audit of Cardiac Rehabilitation | | On-going |
| National Audit of Care at the End of Life (NACEL) | | On-going |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) | | 100% |
| National Bariatric Surgery Register | | On-going |
| National Cardiac Arrest Audit (NCAA) | | 100% |

| NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE) | | SUBMISSION RATE (%) |
|---|---|---|
| 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 – Adults | Core Audit | On-going |
| | Foot Care Audit | On-going |
| | Inpatient Audit - Harms (NaDIA) | 100% |
| | Inpatient Audit (NaDIA) | N/A |
| | Pregnancy in Diabetes | 100% |
| National Early Inflammatory Arthritis Audit (NEIAA) | | *0% |
| National Emergency Laparotomy Audit (NELA) | | On-going |
| National Gastro-intestinal Cancer Programme | National Bowel Cancer Audit (NBoCA) | 100% |
| | National Oesophago-Gastric Cancer Audit (NOGCA) | 100% |
| National Joint Registry | | 100% |
| National Lung Cancer Audit (NLCA) | | 100% |
| National Maternity and Perinatal Audit (NMPA) | | 100% |
| National Neonatal Audit Programme (NNAP) | | 100% |
| National Paediatric Diabetes Audit (NPDA) | | On-going |
| National Prostate Cancer Audit (NPCA) | | 100% |
| National Vascular Registry | | On-going |
| Neurosurgical National Audit Programme | | 100% |
| Paediatric Intensive Care Audit (PICANet) | | On-going |
| Perioperative Quality Improvement Programme (PQIP) | | On-going |
| Sentinel Stroke National Audit Programme (SSNAP) | | On-going |
| Serious Hazards of Transfusion Scheme (SHOT) | | 100% |
| Society for Acute Medicine Benchmarking Audit | | 100% |
| Surgical Site Infection Surveillance | | 100% |
| The Trauma Audit & Research Network (TARN) | | 86% |
| UK Registry of Endocrine and Thyroid Surgery | | 100% |
| UK Renal Registry National Acute Kidney Injury programme | | On-going |

* The Trust was unable to participate in the National PROMs Programme and NEIAA audit due to the lack of a data collection tool. This position will be rectified in 2021/22.

## 2.2.2.5 National clinical audits - action taken

The reports of 34 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2020/21 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) Audit: Nephrectomy | The service stated that the complication rate in procedures at the Trust was 1.31%, which was below the national average of 2.45% and a mortality rate of 0% which was also below the national average of 0.39% despite our patients having a higher risk profile than average. The service lead is looking forward to continuing these positive results this coming year |
| British Association of Urological Surgeons (BAUS) Audit: Percutaneous Nephrolithotomy | The project lead stated that transfusion rate is slightly below national average (1.22% compared to 1.76% nationally). The Trust is generally in line with the national average patient risk profile (stone complexity, stone dimensions, and presence of Spina Bifida/ Spinal Injury). An action plan is in place to address these areas |
| British Association of Urological Surgeons (BAUS) Audit: Radical Prostatectomy | The service has been working on the data quality rate, although below 100%, has improved since the last audit round. The complication rate in procedures was 1.10%, which was below the national average of 1.41%. All other measures including patient risk profile are in line with national average |
| Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database (NHFD) | The Trust was performing above the national average on all key performance indicators from this audit: Prompt orthogeriatric review, prompt surgery, NICE compliant surgery, prompt mobilisation, not delirious post-operative, and return to original residence. The service reports to be striving towards continuing this high level of compliance |
| ICNARC (Intensive Care National Audit and Research Centre) Case Mix Programme (CMP) | The audit lead confirmed submission data also included COVID-19 ITU surge areas. The Trust had also submitted data to ICNARC on a weekly basis with respect to COVID admissions. Further data was provided internally on a daily basis regarding ventilation support of patients admitted to ICU with COVID |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): National Report Pulmonary Rehabilitation | The audit report showed 75% of patients were seen within 90 days of referral, while this is above the national average of 58%, it is below the target of 85%. The Trust also performed above the national average on the measure of patients undertaking a practice exercise test (91% against 41.8% nationally) but still below the target of 100%.<br><br>The service provided an action plan based on the findings of the audit and has commenced work with the SWL partnership in order to secure funding from NHSE for additional resources to address increased patient wait times:<br><br>• The service is working to change how they inform people of the audit and is setting steps in place to improve data completeness<br><br>• Work is underway to adjust the data collection method with mandatory information required to improve data availability to clinicians<br><br>• Nomination of an audit lead to monitor progress, troubleshoot issues as they arise and drive action plans<br><br>• Working group assembled to ensure all patients have written discharge plans |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Asthma | The Trust performed well against 3 of the 6 key performance indicators. The project lead confirmed that staffing levels are at full strength. Due to pressures from COVID-19 respiratory nurses were required to work on the wards full time, and data collection was impacted. This has now recovered, with the clinical audit team having worked with the service to ensure adequate data collection. |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma | The project lead reported that overall outcomes were above average. Action planning was focussed on patients receiving steroids within one hour of admission, with examination of supporting documentation |
| National Audit of Breast Cancer in Older Patients (NABCOP) | The Trust is performing largely in line with national averages on all key performance indicators. The project lead reported that improvements had been made on triple diagnostic assessment after action planning from the previous audit round |

| NATIONAL CLINICAL AUDIT | ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION |
|---|---|
| National Audit of Percutaneous Coronary Interventions (PCI) | The report showed the Trust was below many of the expected measures for this audit, such as use of Drug Eluting Stents (DES) during PCI procedures in specific syndromes which was used 81% of the time, against the recommended standard of 90%. However, the reported DES use was impacted by a new DES in use at the Trust not appearing as an option on the national audit portal. The data completion at source by operators was also suboptimal, leading to large amounts of data cleansing by clinically capable individuals. There was also a catheter lab upgrade underway which will include new software to improve data completion rates at source. |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) | The report showed that the Trust performed well against all national averages. The audit lead commented that the service now offered a specialist service 7 days a week with specialist advice available the next working day. The Trust remained a best practice clinic and was one of few in the country that had clinical psychology and neuropsychology input |
| National Cardiac Audit Programme (NCAP): Cardiac Rhythm Management (Arrhythmia Audit) | The report showed good performance with compliance rate, data quality and submission rates. The service lead stated that work on data quality was a priority in the coming year with a new software system replacing paper notes, and training being rolled out to ensure that all staff utilise the system to its full potential. The catheter lab upgrade also provides opportunities for expanding patient capacity |
| National Cardiac Audit Programme: Heart Failure Audit | The Trust performed well in 12 of 15 key measures of the audit with a participation rate of 93% compared to 90% nationally. Prescription of key disease-modifying medicines for patients with heart failure was very good; this included beta blockers (95%) and mineralocorticoid antagonists (69%) treatments that are life-saving and inexpensive. Both figures were significantly higher than the national average. During hospital admission, 96% of patients received an echocardiogram, a key diagnostic test; the national average for this measure was 87%. Action planning for the coming year centres around improving specialist input, all patients receiving a plan, and ACE inhibitors on discharge |
| National Cardiac Surgery Audit | The report showed the Trust's risk adjusted in-hospital survival rate between 2016 and 2019 was 97%. This demonstrated that the unit was performing as expected and that there was no statistically significant difference between units in that category. The audit lead confirmed performance was closely monitored and reported on a monthly basis |
| National Diabetes Audit – Adults: Pregnancy in Diabetes | The report was released every two years since 2017, with the most recent report in October 2019. This allowed for comparison of two years' worth of data. The next report is expected to be released later in 2021/22.<br><br>In the absence of recent national findings, the project lead stated that the next round of audit will expand parameters to include continuous glucose monitoring, and all women with Type 1 diabetes will be eligible. Work is underway to ensure that all patient data are accurately captured. Locally, the Maternal medicine team performed an audit investigating diagnostics for gestational diabetes, which had been altered due to COVID-19 and had reverted to use of glucose intolerance testing – this work was published in the British Journal for Obstetrics and Gynaecology |
| National Diabetes Audit: Core Audit | The Trust had historically submitted limited numbers of cases for this project. The results show the Trust was performing quite well and was either as expected or higher than expected for 8 of 9 key measures for patients with type 1 diabetes and was in line with all 9 metrics for patients with type 2 diabetes.<br><br>The low submission rates led the service and the clinical audit team to collaborate with the Trust ICT team and develop an electronic data collection tool to routinely capture the 8 main performance indicators of the audit. Early analysis indicated that submission rates were greatly improved and provided a more accurate reflection of the care provided in the diabetic unit |

| NATIONAL CLINICAL AUDIT | ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION |
|---|---|
| National Diabetes Audit: Inpatient Audit | The last snapshot audit captured 144 in-patients with diabetes, equating to 17.6% of inpatients that day which was in line with nationally recorded data.<br><br>Overall, patient satisfaction was reported at 72% which was 11% less than the 83% recorded nationally. The national report breaks the results down into 10 key metrics and improvement areas for the Trust were; a higher proportion of patients with severe hypoglycaemic episodes during their last 7 days of hospital; average time a nursing specialist and consultant spent with each patient; and proportion of patients receiving a foot assessment within 24 hours.<br><br>The service lead developed the following actions in place for the coming year, based on the recommendations from the report:<br><br>• Audit the perioperative pathways, utilising the results from GIRFT to aid this process<br><br>• Create an electronic alert on patient database system to help assist identifying all eligible patients on admission<br><br>• Expand weekend services in line with standards for Seven Day Services<br><br>• Promote mandatory staff training, after the initial training package implemented<br><br>• Develop a diabetes safety board to promote excellence in patient care and ensure learning from incidents is shared |
| National Diabetes Audit: Inpatient Harms | The NaDIA Harms audit results are not broken down to Trust level data. However, the report showed the Trust had submitted data every month since the audit began, 1 of only 28 hospitals to achieve this out of 120 participating sites. The project lead plans to continue current working practices to maintain the same high standards |
| National Early Inflammatory Arthritis Audit (NEIAA) | The Trust had historically struggled to complete data entry and meet key process measures for this project. The Trust submitted a low number of incomplete cases during this period and did not meet the 6 key performance indicators and was unable to meet the best practise tariff requirement.<br><br>Actions for the year ahead:<br><br>• Recruit to the funded new consultant post to lead the service<br><br>• Recruit more staff into the audit process, including Physicians Associates to assist with data entry onto the audit platform to reduce the burden on consultants and increase compliance<br><br>• Construct an electronic data collection tool on the patient record system to streamline data collection |
| National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBoCA) | The report showed data completeness in submitted cases was 95% for the Trust which was significantly higher than the national average of 83%. 99% of patients were seen by a Clinical Nurse Specialist, higher than the national average of 86%. The project lead looks forward to continuing the high quality work in the coming year, and is closely monitoring results with supplementary local level audits |
| National Gastro-intestinal Cancer Programme: National Oesophago-Gastric Cancer Audit (NOGCA) | A key metric from the report examined the percentage of patients diagnosed with oesophago-gastric cancer after an emergency admission. Previously the Trust has performed below national average, but the latest results were 14.6%, which is now better than the national average of 20.7%. The second key measure was from referral to treatment time, with 62 days being the expected timeframe, the Trust had outperformed this standard with an average time of 60 days. Actions for this year will work on consolidating these gains, and continuing to work to high standards |
| National Joint Registry (NJR) | The Trust performed in line with the expected rate with regard to 90-day mortality rates on knee and hip procedures, as well as revision rates operations. Data quality was 100% on all measures, higher than the expected standard |

| NATIONAL CLINICAL AUDIT | ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION |
|---|---|
| National Lung Cancer Audit (NLCA) | The report showed the Trust performed above national (38.7%) and regional average (45.6%) for survival rate with a rate of 49.2%. This marked the department out as a positive outlier. The project is looking forward to continuing the positive performance in the coming year |
| National Maternity and Perinatal Audit (NMPA) | The latest report was released in August 2020 examining 2016-2017 data, and showed Trust outcomes are broadly in line with national averages. A key metric where the Trust performed above the average was in babies receiving mechanical ventilation. The report was shared with the service and an action plan is in place |
| National Neonatal Audit Programme | The latest report showed the Trust performed above the national average on several key measures including ensuring that babies born at least than 32 weeks had their temperature taken in a timely manner and was at expected levels (81.5% compared to 70.3% nationally). The Trust also performed well on parents having consultations with a senior member of the team within 24 hours (99% against 96.7% nationally).<br><br>The Trust complied with national standards on staffing levels in 57.9% of shifts, below the national average of 69%.<br><br>An action plan was developed in line with the report recommendations |
| National Paediatric Diabetes Audit (NPDA) | The project lead reported that The Trust's mean HbA1c level was continually improving, health check completion rate (7 checks) had also improved due to a diligent team approach, and a new electronic database had allowed for increased data accuracy and easier data management. Actions for the year ahead centre around:<br><br>• Patient education in annual health check habits<br><br>• Ensuring all samples reach the laboratory<br><br>• Increasing the uptake of diabetes technology, which is currently below the national average<br><br>• Providing more support and information to patients transitioning from child to adult services. The service is involved in improvement work within the regional network in relation to address this |
| National Prostate Cancer Audit (NPCA) | The Trust has performed within the expected range on all key measures - 90-day readmission, patients experiencing at least one genitourinary complication requiring procedural/surgical intervention within 2 years, mean sexual function score, and mean urinary incontinence score.<br><br>The project lead was satisfied with the progress made and the action plan for the year ahead will focus on embedding current best practice |
| National Vascular Registry | The report was released in November 2020. Benchmarking of the 5 key measures shows the Trust was either meeting the standard or within the expected range for 4 of these. Action planning for this year will focus on the last metric, which is case ascertainment |
| Paediatric Intensive Care (PICANet) | The report was published in January 2021 and showed that the Trust had a 96% case ascertainment within 3 months of discharge, as required and was in the lower limits for Emergency Readmissions within 48 hours and Standardised Risk Adjusted Mortality Ratio which is positive. The number of WTE nurses to one bed reflected the national picture and the Trust ensured staff numbers met the needs of patients on ICU |
| Royal College for Emergency Medicine (RCEM): Assessing for Cognitive Impairment in Older People. | The Trust submitted 501 cases, significantly higher than the recommended target of 120. The latest report showed that the Trust performed better than the national average for all key performance indicators. The project lead is looking forward to continuing working at these high standards |
| Royal College for Emergency Medicine (RCEM): Pain in Children | The report was published in January 2021 and showed room for improvement. One area that was significantly lower than the expected range and the national average, was for senior clinician reviewing notes once a patient leaves or is removed from the department without being seen. The project lead presented these findings and an action plan was put in place |

| NATIONAL CLINICAL AUDIT | ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION |
|---|---|
| Serious Hazards of Transfusion (SHOT): UK National Haemovigilance | The latest audit findings showed the Trust was able to record no instances of Serious Adverse Reactions, and Near Miss – Other. This was below both the area average of 3.45 and 3.32 respectively, and below the average of Trusts of a similar size (6.47 and 7.53).<br><br>The project lead is working on the following action plan:<br><br>• Continue to investigate transfusion reactions as they arise, currently there are no specific actions due to the reaction of an individual donor and is unlikely to reoccur<br><br>• Deliver the business case for a new electronic tagging system to eliminate wrong blood in tube incidences |
| Surgical Site Infection Surveillance | The latest report focused on reduction of long bone fractures. Nationally a surgical site infection (SSI) occurred in 0.9% of cases whereas it was slightly higher at 1.1% of cases at the Trust (inpatient and readmission). However, for inpatient cases alone, the Trust performed better (0.3%) that the national average (0.6%).<br><br>The following actions have been put forward by the project lead:<br><br>• Revise and adapt a SSI root cause analysis tool in collaboration with clinical teams to ascertain any lessons for future clinical practice with feedback to clinicians and Divisional Governance Teams<br><br>• Continue to monitor compliance with standard NICE guidance regarding theatre procedures including sutures<br><br>• Continue with feedback to surgical teams and other relevant stakeholders regarding infections, rates of SSIs and PHE reports<br><br>• Continue Infection Prevention and Control walkabouts in theatres<br><br>• Establish closer links with the Trauma and Orthopaedic clinic |
| The National Audit of Cardiac Rehabilitation (NCAR) | The Cardiac Rehabilitation service has adapted throughout COVID-19 restrictions via telephone/email/text and using a variety of resources, including exercise manuals and DVDs.<br><br>The latest audit report published in 2020 showed the Trust met all 7 key performance metrics. The audit lead provided actions for the recommendations highlighted in the report. The aim going forward was to maintain the standards set and to resume a face-to-face service, in conjunction with the now remote service giving patients more flexibility and to improve outcomes over previous levels. The service will be requesting feedback from patients that attended Cardiac Rehabilitation over the pandemic period to improve the remote style service. |

## 2.2.2.6 Local clinical audits – actions taken

The reports of 5 local clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2020/21 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 |
|---|---|
| Consent Audit | This audit examined the consent process across the Trust, and consisted of two separate components to provide additional assurance. The first component of the audit was a retrospective self-directed examination of consent forms from across all clinical specialities and the second component was a deep dive investigation of a random sample taken from the first component, these cases were then scrutinised by subject matter experts to ensure that both the letter and spirit of the consent process had been adhered to. The findings showed that documentation of discussions around alternative treatments and questions the patients may have raised could be improved. In addition, patients deemed to be lacking capacity often either lacked documented evidence of decision specific capacity assessments or a checklist of best interest. An action plan was developed to embed the consent form on the electronic patient record system with the interim plan to ensure all paper consent forms were scanned to prevent issues of loose filing; to re-audit within the next 6 months; to develop a flow chart to assist in clinical decision making and improve equity and quality of care provided |
| Controlled Drugs Check and Stock Audit | This audit was carried out on a quarterly basis to ensure controlled drugs are correctly stored and secured and that an adequate record was kept which complied with controlled drug guidance. The project lead confirmed that performance in this quarterly project has been largely positive, despite wider disruptions due to COVID-19. Compliance was recorded at or above 90% for 17 or more of the 22 standards each quarter. Actions for the year ahead include expanded training outreach to ensure learning points are embedded |
| Local Safety Standards for Invasive Procedures (LocSSIPs) Audit | This audit project looked at reviewing the Trust's use of LocSSIPs for all invasive procedures, and was split into a theatre and non-theatre version. The most recent data was quarter 4 2020/21 and the Trust achieved 100% for all Theatre areas combined. Action plan for the coming year: The clinical audit team have been working closely with project lead and Theatres staff to revise the audit tool. This involved implementing aspects of the Theatre Accountable Items audit, streamlining the questions included. This is now being used as of quarter 1 2021/22 and the team are optimistic that this will deliver a more accurate portrayal of specialties compliance in the audit |
| Paediatric Intrathecal Audit | The audit examined the process and procedures around intrathecal injections as part of a paediatric chemotherapy regimen. Data for appointments and drugs administered for these patients was collected via the chemotherapy prescribing system which allowed for easier collation. The audit lead confirmed that this was a biannual audit of Oncology and Haematology intrathecal prescription services for Children and Young People, with data submitted as evidence for part of a peer review process. Work remains around the arrangements for paediatric oncology, considerations and will include which e-prescribing system to use and where chemotherapy is prepared. If intrathecal chemotherapy is to be administered at the Trust it would need to be prescribed on Chemocare, checked, made up, collected and administered by staff on the Trust register. Actions to respond to this involve developing a common training programme and a patient assessment tool |
| Protected Mealtimes and Nutritional Screening Audit | This audit was carried out quarterly across the Trust and was made up of two elements, firstly the audit examined the principals of avoiding non-clinically urgent mealtime interruptions for inpatients, along with if appropriate assistance was provided; the nursing team carried out this part of the audit. The nutritional screening component examined if appropriate measurements were taken of patients, and if nutritional assessments were carried out; dieticians carried out this element of the audit. Results for protected mealtimes showed good adherence to most standards of the audit, however some work remains around adequately preparing all vulnerable patients for their meals. Actions for the coming year centre on targeted training. Results of the nutritional screening audit found that standards were missed for weighing patients, completion of nutritional screening tool within 24hours of admission, and body mass index recording. The project lead suspects that staff redeployments may have impacted results this year, a re-audit is scheduled to ensure standards have now recovered |

## 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 for 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 2019/24 Research Strategy sets out plans to build 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. In 2020, we established the St George's Translational and Clinical Research Institute (TACRI), 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, and we doubled the number of patients recruited between 2017 and 2020. Since the pandemic began, in line with NIHR guidance we have prioritised Covid-19 clinical research. We have recruited over 6,000 patients to 40 clinical research studies, we led the Novavax Covid vaccine trial in the UK, and we are amongst the top NHS Trusts in the country for the number of urgent public health Covid studies.

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 reporting period to participate in research approved by a research ethics committee was 7,549. (This number was lower than the published number for 2019/20 of 10,928 due to the NIHR requirement to prioritise Covid-19 research).

## 2.2.4 Our Commissioning for Quality and Innovation (CQUIN) performance

In 2020/21 the percentage value for CQUIN was 1.25% for both CCGs and NHSE of total contract income.

As a result of the COVID-19 pandemic, the operation of CQUIN (both CCG and specialised) was suspended for all providers until 31 March 2021 and the Trust was not required to implement CQUIN requirements, carry out CQUIN audits or submit CQUIN performance data in order to be eligible for payment of the funding allocated for CQUIN.

However, the 1.25% allowance for CQUIN included in the nationally set block payments and CQUIN payments were paid to the Trust in full at the applicable rate.

## 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".

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

The last formal CQC inspection of a group of core services was in July 2019; the report was published in December 2019 and our rating was confirmed as 'Requires Improvement'.

At that time 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 in the 2018 CQC inspection. 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 published ratings for our core services and our overall rating.

In December 2019 the CQC also made a recommendation to NHS England and Improvement (NHSE/I) for the Trust to be removed from Quality Special Measures. In March 2020 NHSE/I confirmed the removal of the Trust 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.

In April 2021 the Trust was also removed from Financial Special Measures.

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.

During the pandemic CQC inspection visits were suspended and over the last year the Trust has met with the CQC on a three monthly basis to discuss service and Trust wide issues of quality and safety.

During the last year the CQC has explored and tested new ways of working (which were not an inspection and Trust services were not rated) including the provision of an Emergency Support Framework and a Transitional Regulatory Approach which both included enhanced monitoring and gathering of evidence against a set of structured questions. The structured assessments looked at Infection Prevention and Control practice in the Trust in July 2020, provision of care and treatment in Urgent and Emergency Care in October 2020.

No concerns were highlighted by the CQC; if concerns had been identified an on-site inspection would have taken place.

We continue to focus on delivering improvements within our cardiac surgery service at St George's. 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 have introduced positive changes to the department in recent months, and data from the National Institute for Cardiovascular Research (NICOR) continues to demonstrate that the service is safe, and no longer an outlier for mortality which means the service is no longer subject to external scrutiny. The Trust Board continues to review the service's mortality data on a regular basis.

**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 at www.cqc.org.uk

## 2.2.8 Our data quality

St George's University Hospitals NHS Foundation Trust submitted records during 2020/21 for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:
- 99.5% for admitted patient care
- 99.8% for outpatient care
- 98.0% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice code was:
- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

## 2.2.9 Our Information Governance Assessment Report

The Trust was compliant with all the mandatory requirements of the NHS Data Security and Protection Toolkit (DSPT) for 2019/20 and planned compliance for 2020/21 by 31 March 2021. However, due to COVID-19 outbreak, NHS Digital allowed all NHS organisations to postpone the Toolkit submission until 30 June 2021. They also extended National Data Opt-Out Compliance until 30 September 2021. The Trust's Information Governance Manager together with the Informatics Services continued 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 aims to submit the Toolkit with all the mandatory requirements by "Satisfactory Standard Met Status" by 30 June 2021.

## 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 2020/21.

## 2.2.11 Learning from deaths

During 2020/21 1,744 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:

- 429 in the first quarter
- 287 in the second quarter
- 420 in the third quarter
- 608 in the fourth quarter

By 31 March 2021, 111 case record reviews have been carried out in relation to 6.4% of the deaths included.

The number of deaths in each quarter for which a case record or an investigation was carried out was:

- 18 in the first quarter
- 22 in the second quarter
- 31 in the third quarter
- 40 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:

- 2 representing 0.47% of the number of deaths which occurred in the first quarter
- 1 representing 0.35% of the number of deaths which occurred in the second quarter
- 1 representing 0.24% of the number of deaths which occurred in the third quarter
- 1 representing 0.16% of the number of deaths which occurred in the fourth quarter

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

## What we have learnt and action taken

During the year a number of investigations were conducted. As part of these investigations issues were highlighted for local reflection and learning, including instances where excellent practice was observed, for example:

- The Trust has continued to demonstrate full compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Action One, as evidenced by the quarterly Perinatal Mortality Review Tool reports. In addition to summarising compliance with the standards each report also detailed potential areas for learning and improvement. Over the year these included improving clinical record templates to prompt carbon monoxide monitoring, incorporating learning from deaths in mandatory training, and introducing a new placental histology form

- Investigation of mortality related to sepsis was conducted by the Trust Sepsis Lead. This work contributed to a number of improvement initiatives, including the design of an infographic to guide accurate diagnosis, recording and subsequent coding of sepsis. A risk stratification tool was implemented in the Emergency Department and a new sepsis tool launched across wards through our electronic patient record system, iClip

- A review of mortality following hip fracture was completed which led to improvements to clinical documentation and governance processes. Clinical documentation templates were updated across specialties to support consistent and accessible documentation of pre-anaesthesia medical comorbidities. Governance was strengthened through the discussion of all breaches of key national standards at multi-disciplinary best-practice tariff meetings and the prioritisation of local mortality review. Improvements to data quality and completeness was also achieved through a programme of regular review and quarterly audit

Summary of action taken in 2020/21 and plans for 2021/22
A new clinical lead for Learning from Deaths was appointed in April 2020 and the spent last year developing the strategic approach to Learning from Deaths and defining the processes to support improved implementation of the national Learning from Deaths framework.

Progress against the action plan arising from the external governance review of mortality conducted in 2019, has been prioritised. The aim of this work was to strengthen existing processes and develop new approaches within specialties to ensure that we maximise the opportunities for learning identified by mortality reviews, and to support the design and delivery of robust action plans.

The Trust invested in six new posts to create a team of Mortality and Morbidity coordinators to support care groups and this year ended with the successful recruitment of the Team Leader and work was initiated to develop a standardised approach to Mortality and Morbidity meetings. The full team will be in place by June 2021 and will provide practical support to clinical teams and facilitate the improved flow of information and learning related to mortality across the Trust.

As part of the improvement plan implemented following the external governance review of mortality a comprehensive review of the Trust's Learning from Deaths policy was carried out. The updated policy was modelled on the national template, published by NHS Improvement.

The Learning from Deaths Lead also undertook training to complete mortality reviews using the Royal College of Physicians structured judgement review, and supported by another trained consultant, completed independent mortality reviews for deaths that met the criteria defined within the Learning from Deaths policy. These included:

- Deaths where bereaved families, or staff, had raised a significant concern
- Deaths of inpatients with learning disabilities
- Deaths of inpatients with severe mental illness
- Deaths in a speciality where the Mortality Monitoring Committee agreed that enhanced oversight was required or that learning would inform the Trust's quality improvement work
- Deaths where the patient was not expected to die including all deaths following elective admission

For any death where the central Mortality Review Team felt there was significant concern, the case was escalated immediately to the Risk Team to consider if a serious incident, or other, investigation was required. Any significant problem of care, whether or not it affected the outcome, was highlighted to the clinical team for discussion and local learning. In addition to promoting reflection and learning by highlighting to governance and clinical teams where care or treatment could potentially have been better, the Learning from Deaths Lead also highlighted excellent practice.

During the year the Medical Examiner (ME) service was embedded further within the Trust building on the developments in 2019/20 and scrutinised all non-coronial deaths in addition to those referred to the Coroner. The service continued to support accurate and consistent certification of death and to support the bereaved. Where the ME identified potential governance issues that need to be further explored they have continued to refer these either to the Lead for Learning from Deaths, to the Risk Team or to the clinical team involved with the patient's care.

In line with national expectations, it is anticipated that during 2021/22 the service will begin to scrutinise deaths that occur within defined areas of the community. Recruitment of two Medical Examiner Officers is planned and will be essential to the expansion of the ME service.

The Trust identified an Associate Non-Executive Director as the nominated individual with Non-Executive responsibility for Learning from Deaths.

There were no (0) case record reviews and no (0) investigations completed after 30 April 2021 which related to deaths which took place before the start of the reporting period.

5 representing 0.29% 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 structured judgement review, which is based on the Royal College of Physicians (RCP) tool.

## 2.2.12 Standards for Seven Day Services

The Trust undertook a risk based review of its compliance against the clinical standards for seven day services and identified that the Trust was unable to deliver full compliance during the last year.

However, the Trust had further improved its compliance with standard 2 in that more than 90% of patients received a consultant review within 14 hours of admission.

The Trust was not compliant with Standards 5, 6 and 8 and the planned improvement actions were delayed due to the pandemic.

The Board assurance statement was deferred until September 2021 and will be reflected in the Quality Account 2021/22.

## 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. Anonymous concerns cannot be fed back however the outcome is logged by the Trust.

## 2.2.14 Guardian of safe working

The year 2020/2021 was dominated by the Covid-19 pandemic. During the first wave (April to June 2020) the Doctors in training were redeployed and worked willingly in acute areas. The result was a flexible workforce supported by senior colleagues; but who have had to compromise on many training opportunities despite the accommodation of speciality colleges and examination boards. Annual leave catch up was completed by the end of March 2021. The second wave (November 2020 to March 2021) saw a different approach with doctors working shorter periods and rotating back to their specialities as soon as possible.

The Trust had provided wellbeing support with psychologists visiting the wards, wellbeing hubs and a mentoring scheme was offered. The impact on exception reporting was a dramatic drop to (210 compared with 458) more than half the previous year reflecting that trainees were so committed to their work they did not want to claim extra money but also the increased vigilance of consultants made sure that the shift work ran smoothly and trainees could get home on time. Rota gaps were then not analysed in the same way as direct comparisons could not be made as the rotas were rewritten to support the Covid-19 response.

From the wellbeing fund, £27,397 was spent on rest facilities and new bathroom facilities for the Doctor's mess; £32896 remains to be spent. No fines were issued in the last year.

In the next year, emphasis will be on recruiting doctors to represent their specialties in the Junior Doctors Forum, looking into support for the Medcard division where 83 of the exception reports arose and completing the spending plans for the wellbeing monies in the Mess.

## 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 | Jan 20 – Dec 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| SHMI | 0.82 | 0.82 | 0.81 | 0.83 | 0.83 | 0.83 | 0.85 | 0.85 | 0.85 | 0.86 | 0.84 |
| 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 | Lower than expected |
| % Deaths with palliative care coding | 51 | 51 | 50 | 49 | 49 | 50 | 49 | 49 | 48 | 47 | 49 |

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 embedded the implementation of the Medical Examiner System. We undertook a review of our mortality monitoring process. We have recruited an addition 6.0 wte posts to strengthen the administrative support to the monitoring process. We 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 | | 2015-16 | | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | | 2020-21* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | SGH | National average | SGH | National average | SGH | National average | SGH | National average | SGH | National average | SGH | National average |
| Hip replacement | EQ-5DTM | 100 | 88.4 | 77 | 89.1 | 71 | 90 | 66.7 | 90.2 | No Data | 90.1 | | |
| | EQ-VAS | 58 | 65.6 | 75 | 67.2 | 43 | 68.3 | 66.7 | 69.6 | No Data | 69.8 | | |
| | Specific | 94 | 96.5 | 71 | 96.7 | 75 | 97.2 | 100 | 97.2 | No Data | 97.3 | | |
| Knee replacement | EQ-5DTM | 69 | 80.7 | 100 | 81.1 | 0 | 82.6 | No data | 82.7 | 50.0 | 83.2 | | |
| | EQ-VAS | 33 | 56.4 | 40 | 57.5 | 33 | 59.7 | No data | 59 | No Data | 60.1 | | |
| | Specific | 85 | 93.6 | 100 | 93.8 | 33 | 94.6 | No data | 94.7 | 100 | 94.7 | | |

Source: NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/
*The 2020/21 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2021/22.

For both hip and knee replacement 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 coupled with the current lack of data collection tool this explains our variance from the national average score for these measures. A new data collection provider will be in place in 2021/22 however the Trust's participation will still be with reference to small patient numbers.

**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 | 2017-18 | | | 2018-19 | | | 2019-20 | | | 2020-21 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 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 | 14201 | 47572 | 61773 | 13975 | 48206 | 62181 | 13022 | 47103 | 60125 | 8,522 | 34,886 | 43,408 |
| 28 day readmissions | 651 | 4428 | 5079 | 751 | 4006 | 4757 | 932 | 4218 | 5150 | 524 | 3,638 | 4,162 |
| 28 day readmissions rate | 4.58% | 9.31% | 8.22% | 5.37% | 8.31% | 7.65% | 7.16% | 8.95% | 8.57% | 6.15% | 10.43% | 9.59% |

**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 better than 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 | 2019-20 | 2020-21* |
|---|---|---|---|---|---|---|---|---|---|
| St George's University Hospitals | 66.6 | 68.8 | 68.6 | 67.9 | 66 | 65 | 67.2 | 67.1 | |
| National average | 68.1 | 68.7 | 68.9 | 69.6 | 68.1 | 68.6 | 67.2 | 64.2 | |
| Highest (best) | 84.4 | 84.2 | 86.1 | 86.2 | 85.2 | 85 | 85 | 84.2 | |
| Lowest | 57.4 | 54.4 | 59.1 | 58.9 | 60 | 60.5 | 58.9 | 59.5 | |

https://digital.nhs.uk/data

* The 2020/21 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2021/22.

**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 2020/21 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 | 2020-21 |
|---|---|---|---|---|---|---|---|---|
| St George's University Hospitals | 67% | 73% | 71% | 70% | 73% | 69% | 72% | 76% |
| Average for Acute | 66% | 68% | 70% | 68% | 69% | 70% | 71% | 74% |
| Highest Acute Trust | 94% | 93% | 93% | 95% | 86% | 87% | 87% | 92% |
| Lowest Acute Trust | 40% | 36% | 46% | 48% | 47% | 41% | 40% | 48% |

http://www.nhsstaffsurveyresults.com/wpcontent/uploads/2021/02/NHS_staff_survey_2020_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 2020/21, 97.5% of our Inpatients and 89.3% 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 | | 2020-21 | |
|---|---|---|---|---|---|---|---|---|---|---|
| St George's University Hospitals | A&E | Inpatient | 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% | 18.97% | 28.74% |
| % would recommended | 83.80% | 95.81% | 84.26% | 96.24% | 87.00% | 97.00% | 82.41% | 96.5% | 89.83% | 97.5% |
| % would not recommend | 10.51% | 1.29% | 10.39% | 1.08% | 8.50% | 1.00% | 12.36% | 1.14% | 6.52% | 0.75% |
| National comparison as at March 2020 response rate | 12.9% | 26.1% | 12.8% | 23.2% | 12.3% | 24.6% | 12.1% | 24.4% | N/A* | N/A* |
| National comparison as at March 2020 % would recommend | 87% | 96% | 84% | 96% | 86% | 96% | 85% | 96% | N/A* | N/A* |
| National comparison as at March 2020 % would not recommend | 7% | 1% | 9% | 2% | 8% | 2% | 9% | 2% | N/A* | N/A* |

..\Performance Visibility Team\Performance Board & Quality Monthly Reports\Archive

* FFT data collection was suspended in March 2020 and was re-started in December 2020 due to Covid-19. No national data has been published since national collection restarted.

**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. Our scores are better than the national average shown below and were an improvement on the previous year. The data below shows the average, highest and lowest performers and our previous performance.

**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

| VTE Assessments | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|---|---|
| St George's University Hospitals | 95.89% | 96.77% | 96.64% | 95.90% | 96.0% | 93.9% | 96.18% |
| National Average | 96.10% | 95.76% | 95.61% | 95.80% | 95.6% | 95.5% | 95.33% |
| Best performing Trust* | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Worst performing Trust* | 79% | 78.1% | 63% | 72% | 74.4% | 71.7% | 77.16% |

https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-q2-202021/

**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

## 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 | 2020-21 |
|---|---|---|---|---|---|---|---|
| St George's University Hospitals | | | | | | | |
| Trust apportioned cases<br>*Change in reporting: denotes those Cases confirmed due to lapses in care | 38 | 29 | 36 | 16 | 31 | *8 | *4 |
| Trust bed-days | 254,213 | 273,493 | 287,962 | 296,981 | 282,339 | 285,321 | 225,244 |
| Rate per 100,000 bed days | 14.9 | 10.6 | 12.5 | 5.4 | 11.0 | 2.8 | 1.75 |
| National average | 33.7 | 33.7 | 30.2 | 31.2 | 33 | 3 | N/A |
| Worst performing trust | 121 | 139 | 116 | 113 | 177 | 15 | N/A |
| Best performing trust | 0 | 0 | 0 | 0 | 0 | 0 | N/A |

https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure
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 - Sept 16 | Oct 16 - Mar 17 | Apr 17 - Sep 18 | Oct 18 - Mar 19 | Apr 19 - Sep 19 | Oct 19 – Mar 20 | Apr 20- Sep 20 |
|---|---|---|---|---|---|---|---|---|---|---|
| St George's University Hospitals | | | | | | | | | | |
| Total reported incidents | 5,188 | 5,353 | 5,453 | 5,964 | 5,928 | 5,548 | 5934 | 6268 | 6697 | Not published |
| Rate per 1000 bed days | 34.1 | 33.2 | 32.8 | 36.5 | 37.6 | 34.2 | 39.5 | 45.3 | 45.4 | Not published |
| *National average (acute non-specialist) | 37.1 | 39.3 | 39.6 | 40.8 | 41.1 | 42.8 | 46.1 | | | |
| *Highest reporting rate | 82.2 | 74.7 | 75.9 | 71.8 | 69 | 111.7 | 95.9 | | | |
| *Lowest reporting rate | 3.6 | 18.1 | 14.8 | 21.1 | 23.1 | 23.5 | 16.9 | | | |
| Incidents causing Severe Harm or death | 16 | 23 | 20 | 15 | 13 | 14 | 23 | 10 | 9 | Not published |
| % incidents causing Severe Harm or death | 0.31% | 0.43% | 0.37% | 0.25% | 0.22% | 0.25% | 0.38% | 0.16% | 0.13% | Not published |
| *National average (acute non-specialist) | 0.50% | 0.43% | 0.79 | 0.38% | 0.37% | 0.35% | 0.36% | | | |
| *Highest reporting rate | 5.10% | 1.96% | 1.33% | 1.38% | 1.09% | 1.23% | 0.49 | | | |
| *Lowest reporting rate | 0.05% | 0.09% | 0% | 0.02% | 0.03% | 0.02% | 0.01% | | | |

https://digital.nhs.uk/data-and-information/

*As of April 2019 NHS Digital no longer publishes data on the national averages for patient safety incidents

**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 2021/22. 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

| Key performance Indicator | Indicator Description | Target | Annual performance 2018-19 | Annual performance 2019-20 | Annual performance 2020-21 |
|---|---|---|---|---|---|
| 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% | No data |
| ED access | 95% of patient wait less than 4 hours | >=95% | 88.4% | 83.2% | No data |
| Cancer access | % cancer patients treated within 62 days of urgent GP referral | >=85% | 86.9% | 85.2% | No data |
| | % patients treated within 62 days from screening referral | >=90% | 86% | 88.8% | No data |
| Diagnostic waits | Maximum 6 week wait for diagnostic procedures | 99% | 99% | 95.7% | No data |

Due to the Covid-19 pandemic and the uneven flow of patient activity throughout the year the Trust is unable to supply the annual performance for 2020-21 due to the mis-leading nature of the data.

The table below presents the average monthly performance for the year, together with the year-end exit position for March 2021 compared against the exit position for March 2020.

| Key performance Indicator | Indicator Description | Target | Average Monthly Performance (Apr 20 - Mar 21) | March 2021 Performance (Year End Exit) | March 2020 Performance (Comparison) |
|---|---|---|---|---|---|
| Referral to treatment times | Number of 52 week breaches | 0 | N/A | 2,644 | 32 |
| Referral to treatment times | % of patients treated within 18 weeks of referral | >=92% | 65.2% | 69.3% | 79.3% |
| Cancer access | % of cancer patients treated within 62 days of urgent GP referral | >=85% | 70.4% | 77.1% | 82.6% |
| | % of patients treated within 62 days from screening referral | >=90% | 66.2% | 80.8% | 77% |
| Diagnostic waits | % of patients receiving a diagnostic test within 6 weeks of referral | 99% | 71.4% | 89.8% | 81.5% |
| 4 Hour Operating Standard | % of patients discharged, admitted or transferred within 4 hours of arrival | 95% | 92.8% (actual) | 94.8% | 79.1% |

## 3.2 Our performance against our Quality priorities in 2020-21

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, 2019/20. 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 2020/21?** | **How our performance compared with 2019/20** |
| We will ensure timely escalation and response to deteriorating patients | All adult inpatients will have a TEP<br><br>Reduction in avoidable harm and death associated with missed opportunities when compared with 2019/20 and 2020/21<br><br>Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 and 2020/21<br><br>Reduction in the number of cardiac arrests compared with 2019/20 and 2020/21 | **We partially achieved this**<br><br>We developed an electronic mechanism to monitor the number of TEPs in place for adults within 24 hours of admission<br><br>We monitor TEP performance on a monthly basis in the Integrated Quality and Performance Report<br><br>In April 2020 45% of adults had a TEP in place within 24 hours of admission, performance in March 2021 was 33.8%<br><br>The number of cardiac arrests in 2020/21 was 108; 2.3/1000 inpatient admissions<br><br>NEWS2 audits showed an appropriate response performance of 89% in March 2021 which was a reduction in appropriate response performance from 94.1% in March 2020 | In 2018/19 we established an improvement project and developed the TEP (paper) and in 2019 we implemented TEP in paper format whilst we built an electronic TEP in the test domain of iClip<br><br>We rolled out the electronic TEP Trust wide in March 2020 in response to Covid-19<br><br>The number of cardiac arrests in 2019-20 was 153; 2.3/1000 inpatient admissions<br><br>NEWS2 audits showed an appropriate response performance of 89.6 % in March 2019 and an appropriate response performance of 94.1% in March 2020 |
| 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.<br><br>We will achieve compliance with our training targets for Mental Capacity Act (MCA) training | **We partially achieved this**<br><br>The electronic forms to standardise recording were implemented<br><br>A Trust wide audit of Consent was undertaken in December 2020<br><br>Mental Capacity Act and Deprivation of Liberties (MCA/ DoLs) Training – Level 1 training performance had achieved the target of 90% or above since 2019<br><br>Level 2 training performance was 79% in March 2021 against the target of 85% | Revisions to iClip were made in the test domain to standardise recording and enable efficient audit processes.<br><br>Mental Capacity Act and Deprivation of Liberties (MCA/ DoLs) Training – Level 1 training performance had achieved the target of 90% or above<br><br>Level 2 training performance was 76.4% against a target of 85% |

| Patient Safety | | | |
|---|---|---|---|
| **Our quality priorities** | **What will success look like?** | **How did we do in 2020/21?** | **How our performance compared with 2019/20** |
| All patients will be supported to give consent for treatment | All non-elective adult inpatients will have a treatment escalation plan (TEP) in place within 24 hours of admission | **We did not achieve this**<br><br>In April 2020 45% of adults had a TEP in place within 24 hours of admission, performance in March 2021 was 33.8% | No data available |
| Embed medical examiner service and learning from deaths processes | Maintain Summary Hospital Level Mortality Indicator (SHMI) within confidence intervals | **We achieved this**<br><br>Mortality as measured by the summary hospital-level mortality indicator (SHMI) was lower than expected for the 12 months from January 2020 to December 2020 at 0.84 | Mortality as measured by the summary hospital-level mortality indicator (SHMI) was lower than expected for the 12 months from January 2019 to December 2020 at 0.86 |
| **Patient experience** | | | |
| **Our quality priorities** | **What will success look like?** | **How did we do in 2020/21?** | **How our performance compared with 2019/20** |
| 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 | **We achieved this**<br><br>2020/21: 752<br>(However, the impact of Covid-19 on the number of complaints received should be noted) | 2019/20: 956<br>(2018/19: 1101) |
| 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 partially achieved this**<br><br>The group was suspended earlier this year due to Covid-19 and meetings were re-established later in the year<br><br>The group focused on finalising the Toolkit for User Groups resource and reviewed the PPEG web pages during this time<br><br>Engagement of Patient Partners in the development of the Emergency Department works<br><br>A number of other projects and developments requiring input from Patients Partners were put on hold this last year<br><br>A successful recruitment campaign brought 10 new patient partners on board | In 2018/19 twelve patient partners were recruited to the Patient Experience and Partnership Group<br><br>A service level patient user group was established in dermatology, urology and at Queen Mary's Hospital<br><br>We delivered the objectives as set out in the one-year Patient Partnership and Experience Strategy 2019/20.<br><br>The strategy for Patient Partnership and Experience is included as a priority focus area within the Quality and Safety Strategy 2019/24 |

| Patient experience | | | |
|---|---|---|---|
| **Our quality priorities** | **What will success look like?** | **How did we do in 2020/21?** | **How our performance compared with 2019/20** |
| Undertake a second self-assessment against the National Learning Disability Standards having had the opportunity to make service improvements following the first self-assessment in 2020 | Improvement in our self-assessment when compared to baseline | **We partially achieved this**<br><br>Due to exceptional demands on the service implementation of the improvement plan following the 2018/19 self-assessment was slower than expected<br><br>The second self-assessment was completed against national standards for Learning Disability patients for 2019/20<br><br>The 2019/20 self-assessment was against 107 questions, 79 of which were considered as measurable for benchmark purposes.<br><br>For 61% (48/79) the Trust was in line with other Trusts, however although it was recognised the Trust was not an outlier in these areas, improvement actions are to be developed for delivery in 2021/22.<br><br>For the remaining standards:<br>• 25% (20/79) were above the national standard<br><br>• 14% (11/79) were below the national standard | The NHS benchmark assessment was completed against national standards for Learning Disability patients |

| Patient experience | | | |
|---|---|---|---|
| **Our quality priorities** | **What will success look like?** | **How did we do in 2020/21?** | **How our performance compared with 2019/20** |
| Improve patient flow particularly with reference to improved discharge processes | Reduction in the number of patients awaiting external assessment, repatriation or external care when compared with the 2019/20 baseline<br><br>See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2019/20<br><br>Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2019/20<br><br>Improvement in the patients who were discharged from an inpatient setting with a follow up appointment or investigation date when compared with 2019/20 | **We partially achieved this**<br>Discharge hub implemented and aligned to the site team to enable increased oversight of expected discharges<br><br>Implemented South West London system approach of agreed discharge to assess process<br><br>Created a monitoring process<br><br>The number of patients awaiting external assessment, repatriation or external care increased to 1108 in 2020/21 compared with 991 in 2019/20. This position was impacted by Covid-19<br><br>87.5% of patients reported feeling involved in the discharge planning process compared with 87.8% in 2019/20<br><br>In 2019/20 discharge summaries were sent to GP practices within 24 hours for 46.4% of our discharged patients. The data for 2020/21 is available in iClip, however a revised interface with the Trust's data warehouse in currently being developed and the 2020/21 data was not available at the time of publishing this report | Review of patient experience of discharge through the departure lounge by Healthwatch<br><br>The number of patients who were discharged from an elective inpatient setting with a follow up appointment or investigation date deteriorated by 57% from 2348 in 2019/20 to 1347 in 2020/21. This was impacted by Covid-19 as there was less elective activity in 2020-21<br><br>Established 'long length of stay' meetings to help facilitate the discharge of complex patients<br><br>Incorporated Red to Green reporting on iClip (a process to identify the internal delays for discharge associated with waiting for investigations to take place and/ or obtaining the results)<br><br>991 patients awaited external assessment, repatriation or external care<br><br>88% of patients reported feeling involved in the discharge planning process<br><br>Discharge summaries were sent to GP practices within 24 hours for 46.4% of our discharged patients<br><br>2348 patients were discharged from an inpatient setting with a follow up appointment or investigation date |

| Clinical effectiveness and outcomes | | | |
|---|---|---|---|
| **Our quality priorities** | **What will success look like?** | **How did we do in 2020/21?** | **How our performance compared with 2019/20** |
| With SWL and St George's Mental Health Trust we will 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 | **We did not achieve this**<br>The new post of Head of Nursing for Mental Health was recruited to and the post holder commenced in December 2020<br><br>The development of the integrated training and education framework did not commence as expected due to delayed recruitment | This was not included as a quality priority in 2019/20 |
| We will embed a culture of quality, safety and learning by implementing 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 2020 | **We partially achieved this**<br>Quality of Care: 7.6<br>(average trust score 7.5)<br><br>Safety Culture: 6.6<br>(average trust score 6.8) | NHS Staff Survey 2019<br>Quality of Care: 7.5<br>(average trust score 7.5)<br><br>Safety Culture: 6.5<br>(average trust score 6.7) |
| Deliver care in line with activity plans | Achievement of targets for:<br>• Referral to Treatment (RTT) within 18 weeks<br><br>• Diagnostics within six weeks<br><br>• Four hour operating standard<br><br>• Cancer standards | **We did not achieve this**<br>Activity plans and associated performance targets were not delivered due to the impact of the pandemic | As reported in section 3.1, page 33 |

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

## A1.1 Statement from South West London Clinical Commissioning Group

South West London Clinical Commissioning Group (SWL CCG - Wandsworth Borough) is the host commissioner for St George's University Hospitals NHS Foundation Trust (SGUH) and is responsible for the commissioning of high-quality health services from the Trust on behalf of the population of Wandsworth and surrounding boroughs.

SWL CCG and the SGUH leadership team have worked collaboratively throughout 2020/21 to provide a good level of assurance in relation to the quality of services provided to the local population. The CCG has continued to attend the Trust internal patient safety and quality group meetings, and quarterly quality partnership meetings have been maintained to address externally generated quality issues not covered at the internal meetings. The Quality Partnership meetings bring together stakeholders including GPs, senior clinicians, managers from both SGUH and SWL CCG, commissioners from other local CCGs, and Healthwatch. Intelligence is also gained from other sources including patient feedback received directly by the CCG.

SGUH has been proactive in addressing quality issues identified through the CCG's well-established Quality Alert system (Make a Difference), where quality issues relating to a provider are raised with to the CCG. 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 waits for treatment and improving patient flow in relation to discharges, have been included in the priorities for 2021/22.

The CCG acknowledges that 2020/21 has been a challenging year with the pressure and impact of the COVID-19 pandemic. The Trust is to be commended for continuing to maintain a focus on patient safety and quality throughout the pandemic.

The Trust has made significant progress in implementation of the CQC action plan from December 2019 with 40 of the 46 improvement actions completed during the year. Good progress has also been made against the actions from two clinical governance reviews during 2020/21. The report from the third governance review has just been received by the Trust. The CCG will continue to monitor and support the Trust with implementation of the actions from this review during 2021/22.

The CCG welcomes the opportunity to provide a statement for SGUH's Quality Account for 2020/21. 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 2020/21 priorities. We are pleased to note the progress made in delivering the quality priorities for last year, particularly the implementation of the medical examiner service and learning from deaths framework. We are also pleased to note the progress made with undertaking thematic analysis of complaints to identify themes and share learning. The CCG would like to see the Trust focus on the triangulation of these findings with themes from other sources, like incidents, serious incidents, and quality alerts, to achieve integrated learning.

The CCG was disappointed to note that improving patient flow with reference to improved discharge processes was partially achieved in 2020/21. As with previous years, discharge related issues at the Trust continued to be a top theme from quality alerts received by the CCG during the year. We are encouraged to note that this priority is being carried forward into 2021/22 and would urge the Trust to continue to develop the launch of the discharge forum where stakeholders could work collaboratively with the Trust to address these issues. This includes maintaining a focus on improving communication and shared care arrangements in relation to the pathway for DOACs.

The CCG has taken account of the identified quality priorities for 2021/22 and are pleased to note that these priorities include prevention of Nosocomial COVID-19 infection for in-patients. The CCG would like a focus on the recovery from COVID-19 in relation to ensuring a robust system is in place to track patients whose care was paused or stopped during the COVID-19 pandemic. We are also pleased with the continued priorities on managing the deteriorating patient and hope that the re-

launch of the outreach team will help to support this work.

In addition to the priority to improve patients discharged from an inpatient setting with a follow-up appointment or investigation, the CCG suggests that the Trust also includes patients discharged from ED in this work. We urge SGUH to also consider a focus on improving outcomes for non-cohorted heart failure patients, and to continue the work on achieving the NICE guidance for cholecystitis in 2021/22.

## 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 2020/21.

The CCG is committed to working collaboratively to support the Trust in delivering the priorities identified in the quality report for 2021/22.

**Dr Nicola Jones MBE**
**MBChB DRCOG MRCGP MBA**
**Place Lead for Wandsworth**
**(On behalf of SWL CCG)**
**1 June 2021**

**Dr Gloria Rowland MBE**
**SWL Chief of Nurse &**
**Executive Director for Quality**
**(ICS) NHS SWL CCG**
**3 June 2021**

## A1.2 Statement from Healthwatch Wandsworth

We are pleased to have the opportunity once more to comment on the Quality Account for St George's Hospital. Despite the challenging climate of the pandemic and related restrictions, 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 Quality Partnership meeting (previously 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.

These comments have been written at the beginning of June 2021, as the Covid-19 pandemic in the UK is still present and as the effects of over a year of coping with waves of Covid related patients and safety measures continue to impact what the system can achieve and where it has to focus quality and infection prevention. The tremendous effort of staff across the hospital teams is very much appreciated in the community and we would like to recognise the challenges faced and the achievement accomplished to maintain of quality of provision through this period. Staff have made enormous and swift changes made in wave one and two in particular, learning from wave one, such as making changes to the Emergency Department, ensuring the decrease in nosocomial infections, making rapid changes to capacity in Intensive Care Units and more. Planning has taken place across hospitals in the area, the hospital has been involved in research and delivery of the vaccine programme and at the same time there have been rapid changes to the hospital's physical estate.

**Outpatients:** we welcome changes to more online appointments. Many people have told us that they really can be useful. However, for certain consultations that may be more sensitive or complex or for particular sections of the community face-to-face consultations or other special arrangements are needed. We would like to see quality monitoring and scrutiny that ensures clinical effectiveness, safety and quality as well as accessibility in access. For example, monitoring online appointment bookings and monitoring missed calls and the reasons for them to ensure continuity of communications.

**Cardiac services:** we note the improvements in the issues raised in the CQC report and that these have been achieved alongside the major disruption due to the pandemic. We welcome the clear articulation of the final areas for continued improvement in future plans.

**Waiting lists:** one of the major impacts of the pandemic has been the growth of waiting lists, including 52+ weeks. Tackling this needs to be a top priority and should include ensuring that those waiting are regularly reviewed to ensure they are at right level of clinical risk and kept informed about their wait. The management of pain and other condition related issues whilst waiting will also be an important part of this process.

**Communication:** We have seen during the pandemic how patients can be reluctant to seek care if they perceive services to be busy or if they are worried about entering services and coming in to contact with Covid. It is important that communications and information about measures to ensure patient safety are promoted widely and that people are encouraged to contact support to help them manage their health.

During the last year we did receive reports from the public about difficulties with communications as appointments were cancelled or re-arranged and hope that communications into the next year will not have such issues.

Building on learning from the previous Covid challenges for supportive communication between clinical teams and families is important and the hospital website must be kept fully up-to-date on what patient and family expectations should be in fraught circumstances because this will be the main source of guidance for many.

**Screening services:** ensuring progress on screening services should be prioritised.

**Discharge procedures:** We are pleased to see a focus on discharge. We hope to see that patients and carers are involved in continued improvements in the discharge processes, including via the new Discharge Forum. We hope that there will be a focus on ensuring carers are well informed and take part in discharge planning and continued care where appropriate.

**Patient experience and involvement:** involvement and consideration of patient experience in designing and improving services will be particularly important in the coming year. More specific information in future accounts about how patients have been involved in improving the quality of services at the hospital, from the National Patient Survey to the contribution of patient partners on the Patient Partnership Engagement Group as well as patient feedback to individual departments would be welcome. We would also welcome if the account demonstrated how patients have been involved in setting the quality priorities for the following year.

**Co-ordination with other parts of the health and care system:** as a new ICS system will soon be developed it will be important to see how quality is monitored and improved across the system. We welcome the focus on infection prevention as part of work across South West London. It would be welcome to see further collaboration with South West London and St George's Mental Health Trust to improve care for people with a mental health condition in the acute setting.

Moreover, patients have told us that one of the most important things that would improve their health and care is how organisations co-ordinate their care and communicate with them as a system, they often would like a single access point for care and information.

We hope our comments will be helpful for the continued and improving focus on quality and safety at St George's Hospital. We hope to continue to encourage and be involved in how the hospital works with our community, particularly those who are in minority or disadvantaged groups, to ensure access to quality services to meet their needs.

**Stephen Hickey**
**Chair, Healthwatch Wandsworth**
**2 June 2021**

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

Whilst this statement is submitted on behalf of the Wandsworth Adult Care and Health Overview and Scrutiny Committee, the tight timescale for its submission means that any outstanding year end information that was not included in the original report sent has not been covered here. Also due to the timings allowed for its submission meant that it has not been possible to agree it at a Committee meeting and the below comments have been prepared in consultation with its leading members.

Due to the COVID-19 pandemic starting in 2020, the Local Authority's Public Health Service has not had capacity to contribute to this Quality Account, noting that the majority of Public Health service provision was halted with focus re-directed to pandemic related services.

### We are providing comment according to the Trust's three Priorities:

### 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

### Noting within these Priorities are seven qualities from the Trust's Quality and Safety Strategy:

**1.** We will minimise avoidable harm across our organisation, utilising the developments in technology and embedding further, robust quality assurance and learning processes

**2.** We will improve outcomes for patients through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our patients

**3.** We will provide patients with an excellent experience through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients

**4.** We will improve staff experience, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology

**5.** We will provide patients with an equitable experience by proactively reaching out with system partners to our communities and our vulnerable groups

**6.** We will embed a culture in which quality, safety and learning is embraced across the organisation, and is supported by robust systems of safety governance

**7.** We will be at the forefront of providing and developing pioneering and leading edge treatments for today and for the future

## Priority 1 – Improve patient safety

| 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 and 2020/21**<br><br>**Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 and 2020/21**<br><br>**80% of adult inpatients will have a TEP (compared with 33% in April 2021)**<br><br>**Reduction in the number of cardiac arrests compared with 2019/20 and 2020/21** |
| **Learn from deaths** | **Embed medical examiner service and learning from deaths processes** | **Maintain Summary Hospital Level Mortality Indicator (SHIMI) within confidence intervals** |

We would like to understand more as to ways in which the Adult Health Overview and Scrutiny Committee can receive periodical reporting measuring the Timely escalation and response to deteriorating patients and Learning from deaths. Is there an opportunity to share this information with key Adult Social Care staff, particularly those who work alongside Acute Hospital staff supporting the needs of these patients? Sharing learnings and practices will support the professional development of health and care staff within and externally to St George's Hospital.

## Priority 2 - Improve patient experience

| WHAT | HOW | WHAT WILL SUCCESS LOOK LIKE |
|---|---|---|
| **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.**<br><br>**Progress further the implementation of Red to Green in iClip to highlight the issues that delay discharge**<br><br>**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**<br><br>**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 2020/21 baseline (fast track process implemented due to pandemic in 2020/21)**<br><br>**See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2019/20 and 2020/21**<br><br>**Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2020/21**<br><br>**Improvement in the patients who were discharged from an inpatient setting with a follow up appointment or investigation date when compared with 2019/20 and 2020/21** |

We would like to ask for Hospital discharge reporting information as described in 'Priority 2 – Improve patient experience' to be shared with Adult Social Care Senior Management and periodically presented to the Adult Health OSC. We would like to understand the process set out for Acute Hospital staff, Social Workers and other partners when considering discharging patients from hospital and ensuring their Continuing Health Care needs are recognised and addressed before discharge takes place.

Within the Discharge to Assess procedures and processes, we would be interested to hear from the Trust describing the current whole pathways of care delivered and examples of proactively reaching out to system partners, local communities and vulnerable groups. We are seeking examples from Discharge to Assess (D2A) services as to how the Trust embeds a culture in which quality, safety and learning is embraced and the robust systems of safety governance in place. We welcome opportunity to work with Trust and systems partners to agree an operating model for the Discharge Hub and D2A process.

We would welcome hearing of the learnings from the past year which can be shared across health and social care partners.

For future Quality Account comments, we would like to be allowed 30 working days to collate and submit comments to the Trust and would welcome ways to receive periodical updates throughout the year reflecting the Priorities and Qualities.

Finally, we would like to thank the Trust for enabling the Wandsworth health Overview and Scrutiny Committee to provide comment on its Quality Account.

**Cllr Adrian Flook**
**Chairman**
**Wandsworth Council Adult Care and Health Overview and Scrutiny Committee**
**4 June 2021**

## 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 2020/21 and supporting guidance Detailed requirements for quality reports 2010/21

- 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 2020 to 25 June 2021

- papers relating to quality reported to the board over the period April 2020 to June 2021

- feedback from commissioners dated 3 June 2021

- feedback from governors [Governors invited to comment]

- feedback from local Healthwatch organisations dated 3 June 2021

- feedback from overview and scrutiny committee dated 4 June 2021

- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 April 2019 – 31 March 2020

- 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 2021

- 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

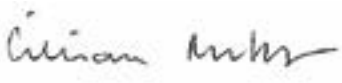
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

- 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

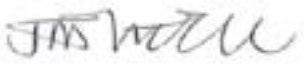
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporate the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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**
**24 June 2021**



**Jacqueline Totterdell**
**Chief Executive**
**24 June 2021**

# 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 on financial statements

We have audited the financial statements of St George's University Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2021, 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 accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

### In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; 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, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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.

### Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to

public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

## 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.

## 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 in April 2020 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 comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2020/21 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.

## Opinion on other matters required by the Code of Audit Practice

## In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 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, 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 an officer of the Trust, is

about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, 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 111 to 112, 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 2020/21, 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 its 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.

## Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).

- We enquired of management and the Audit Committee concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the Audit Committee whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, fraudulent revenue recognition and fraudulent expenditure recognition.

- Our audit procedures involved:

– evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;

– journal entry testing, with a focus on unusual journals made during the year and the accounts production stage for appropriateness and corroboration;

– challenging assumptions and judgements made by management in its significant accounting estimates in respect of property, plant and equipment valuations; and

– assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

– understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;

– knowledge of the health sector and economy in which the Trust operates; and

– understanding of the legal and regulatory requirements specific to the Trust including:

– the provisions of the applicable legislation;

– NHS Improvement's rules and related guidance; and

– the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:

– the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.

– the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

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

## Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work

does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

## Responsibilities of the Accounting Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust set out on pages 111 to 112, the Chief Executive, as Accountable 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. 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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

## Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

## 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**

**Paul Dossett,**
**Key Audit Partner**
**for and on behalf of**
**Grant Thornton UK LLP,**
**Local Auditor London**
**25 June 2021**

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

In our auditor's report issued on 25 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had:

Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have now completed this work, and the results of our work are set out below.

## Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 25 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

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

## Responsibilities of the Accounting Officer

The Chief Executive, as 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. 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

## Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2021 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

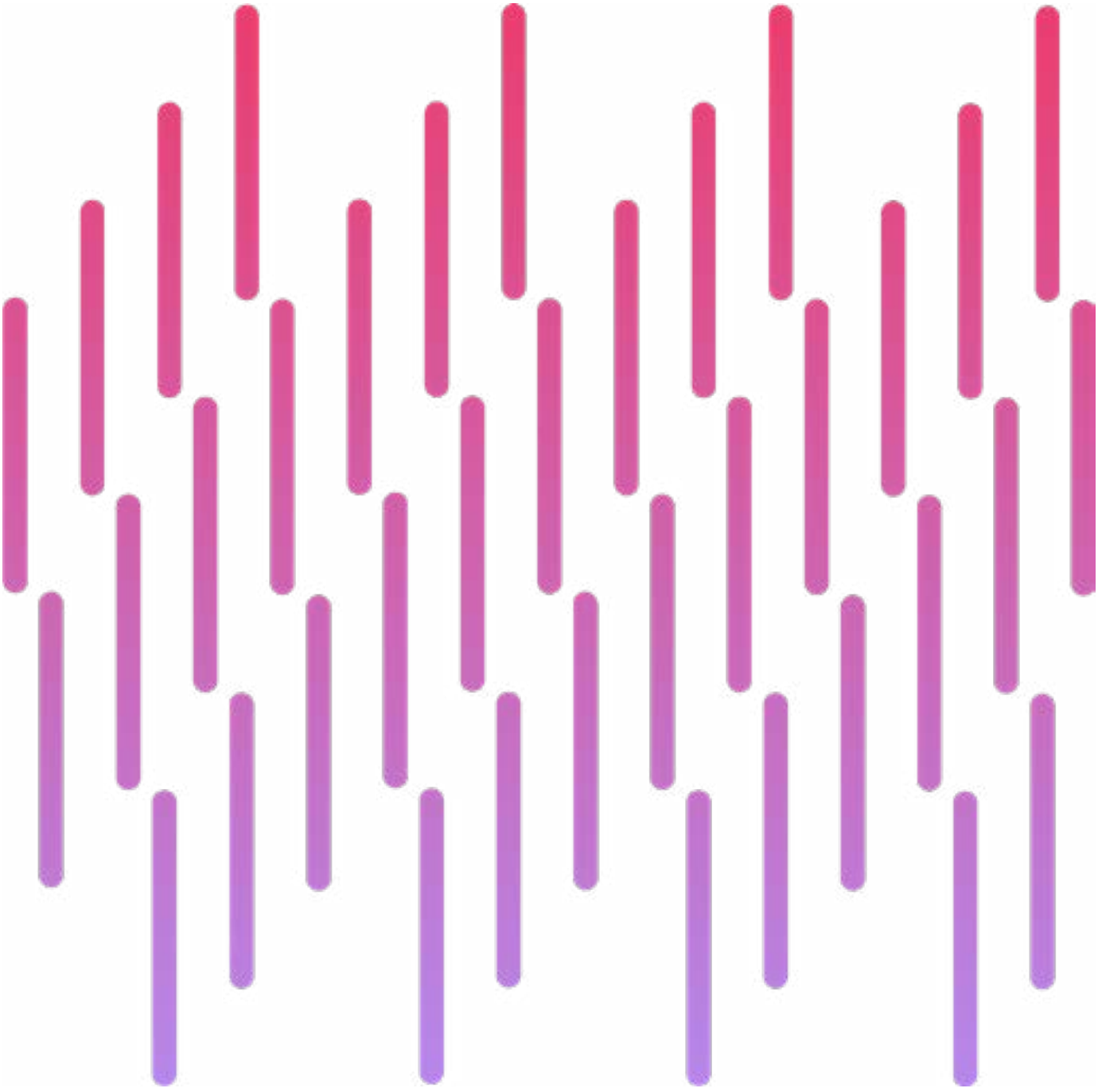
This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's 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**

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

**London**
**1 September 2021**

# Annual Financial Accounts

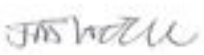


# Foreword to the accounts

# St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by St George's University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

**Signed**



**Name** Jacqueline Totterdell
**Job title** Chief Executive
**Date** 24 June 2021

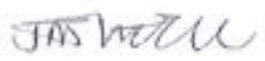
# Statement of Comprehensive Income

| | Note | 2020/21 £000 | 2019/20 £000 |
|---|---|---|---|
| Operating income from patient care activities | 3 | 802,318 | 686,114 |
| Other operating income | 4 | 239,825 | 158,019 |
| Operating expenses | 6, 8 | (908,076) | (879,058) |
| Operating surplus/(deficit) from continuing operations | | 13,923 | (1,449) |
| Finance income | 11 | 10 | 237 |
| Finance expenses | 12 | (3,470) | (11,937) |
| PDC dividends payable | | (9,182) | - |
| Net finance costs | | (12,642) | (11,700) |
| Other gains/(losses) | 13 | 0 | - |
| Surplus/(deficit) for the year from continuing operations | | 1,282 | (13,149) |
| Surplus/(deficit) for the year | | 1,282 | (13,149) |
| Other comprehensive income/expense | | | |
| that will not be reclassified to income and expenditure: | | | |
| Impairments | 7 | (31,475) | (9,653) |
| Revaluations | 16 | - | 12,604 |
| Total comprehensive income/(expense) for the period | | (30,193) | (10,198) |

# Statement of Financial Position

| | Note | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 13 | 42,782 | 37,658 |
| Property, plant and equipment | 14 | 427,912 | 389,272 |
| Receivables | 19 | 10,929 | 13,104 |
| Other assets | 20 | 11 | 11 |
| **Total non-current assets** | | 481,634 | 440,045 |
| **Current assets** | | | |
| Inventories | 18 | 13,215 | 11,871 |
| Receivables | 19 | 72,351 | 80,567 |
| Cash and cash equivalents | 21 | 36,561 | 3,425 |
| **Total current assets** | | 122,127 | 95,863 |
| **Current liabilities** | | | |
| Trade and other payables | 22 | (139,158) | (114,067) |
| Borrowings | 24 | (5,589) | (323,085) |
| Provisions | 26 | (882) | (270) |
| Other liabilities | 23 | (7,648) | (2,480) |
| **Total current liabilities** | | (153,277) | (439,902) |
| **Total assets less current liabilities** | | 450,484 | 96,006 |
| **Non-current liabilities** | | | |
| Borrowings | 24 | (57,045) | (69,335) |
| Provisions | 26 | (3,253) | (2,463) |
| **Total non-current liabilities** | | (60,298) | (71,798) |
| **Total assets employed** | | 390,186 | 24,208 |
| **Financed by** | | | |
| Public dividend capital | | 531,906 | 135,735 |
| Revaluation reserve | | 82,366 | 113,841 |
| Other reserves | | 1,150 | 1,150 |
| Income and expenditure reserve | | (225,237) | (226,518) |
| **Total taxpayers' equity** | | 390,186 | 24,208 |

The notes on pages 9 to 57 form part of these accounts.

**Signed** 

**Name** Jacqueline Totterdell
**Job title** Chief Executive
**Date** 24 June 2021

# Statement of Changes in Equity for the year ended 31 March 2021

| | Public dividend capital £000 | Revaluation reserve £000 | Other reserves £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|---|
| Taxpayers' and others' equity at 1 April 2020 - brought forward | 135,735 | 113,841 | 1,150 | (226,518) | 24,208 |
| Surplus/(deficit) for the year | - | - | - | 1,282 | 1,282 |
| Impairments | - | (31,475) | - | - | (31,475) |
| Public dividend capital received | 396,171 | - | - | - | 396,171 |
| Public dividend capital repaid | - | - | - | - | - |
| Taxpayers' and others' equity at 31 March 2021 | 531,906 | 82,366 | 1,150 | (225,237) | 390,186 |

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

| | Public dividend capital £000 | Revaluation reserve £000 | Other reserves £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|---|
| Taxpayers' and others' equity at 1 April 2019 - brought forward | 133,358 | 110,890 | 1,150 | (213,369) | 32,029 |
| Taxpayers' and others' equity at 1 April 2019 - restated | 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 |

# 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.

## Other reserves

This reserve of £1.15m was created in March 2003 to recognise the portion of land at St George's Grove that had been omitted from the land valuation used to establish the St George's opening PDC capital balance when it became a NHS Trust on 1st April 1993. The associated land has since been sold but this reserve remains as an adjustment to the originating PDC Capital balance.

## Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

# Statement of Cash Flows

| | Note | 2020/21 £000 | 2019/20 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus / (deficit) | | 13,923 | (1,449) |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 6.1 | 28,732 | 23,341 |
| Net impairments | 7 | 12 | - |
| Income recognised in respect of capital donations | 4 | (5,451) | (545) |
| (Increase) / decrease in receivables and other assets | | 10,753 | 7,756 |
| (Increase) / decrease in inventories | | (1,344) | (4,108) |
| Increase / (decrease) in payables and other liabilities | | 16,785 | (28,161) |
| Increase / (decrease) in provisions | | 1,402 | 1,151 |
| Other movements in operating cash flows | | (199) | (190) |
| Net cash flows from / (used in) operating activities | | 64,613 | (2,205) |
| **Cash flows from investing activities** | | | |
| Interest received | | 10 | 237 |
| Purchase of intangible assets | | (5,031) | (10,138) |
| Purchase of PPE and investment property | | (77,161) | (25,125) |
| Receipt of cash donations to purchase assets | | 244 | 545 |
| Net cash flows from / (used in) investing activities | | (81,938) | (34,481) |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 396,171 | 2,377 |
| Movement on loans from DHSC | | (325,620) | 51,135 |
| Movement on other loans | | (1,478) | (1,478) |
| Capital element of finance lease rental payments | | (3,056) | (2,881) |
| Capital element of PFI, LIFT and other service concession payments | | (1,216) | (1,136) |
| Interest on loans | | (1,663) | (9,001) |
| Other interest | | (27) | (5) |
| Interest paid on finance lease liabilities | | (482) | (227) |
| Interest paid on PFI, LIFT and other service concession obligations | | (2,625) | (2,704) |
| PDC dividend (paid) / refunded | | (9,544) | 799 |
| Net cash flows from / (used in) financing activities | | 50,460 | 36,879 |
| Increase / (decrease) in cash and cash equivalents | | 33,135 | 193 |
| Cash and cash equivalents at 1 April - brought forward | | 3,425 | 3,232 |
| Cash and cash equivalents at 31 March | 21.1 | 36,561 | 3,425 |

# 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 2020/21 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 £1.2m for the year ended 31 March 2021 (after adjusting for donated capital income and donated depreciation).

The Trust  loans of £325m was converted to PDC 20/21, and the Trust is not expecting to borrow any further interim revenue support loans in 2021/22."

The 2021/22 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 funding streams confirmed for the new financial year, in order to decide if any risk exist to this position exists

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 2021. 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 2020/21, 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.

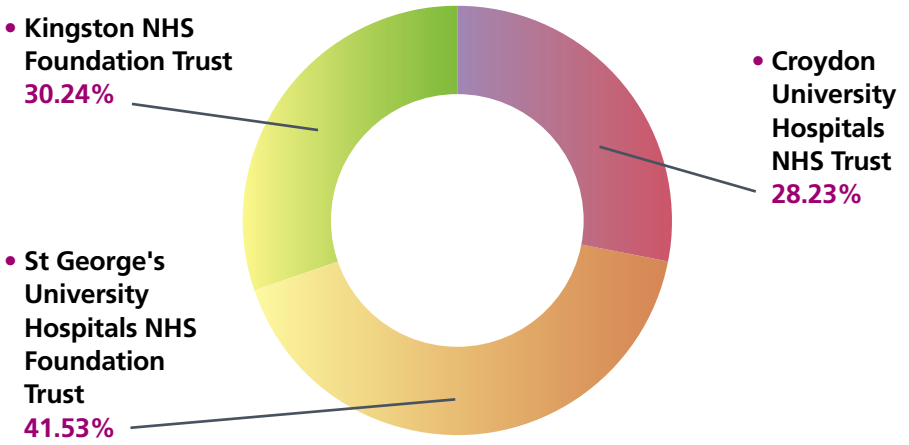
## Note 1.3 Interests in other entities

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.

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.

**Ownership is divided based on full year activity:**




## 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. In the financial year 2020/21, the Trust received the vast majority of income through Block contracts with its main commissioners. This is in recognition of the impact of the COVID-19 pandemic, simplifying financial arrangements to support front line care. In April 2020, the Trust received a cash payment of two months' block contract value, in order to further support healthcare delivery (this was the M1 and M2 block value, the latter received in advance, continuing through the year, with the final M12 block payment received in advance in M11). In contrast to previous years, variances to commissioner plan for activity differences are negated by the Block contract, so over and under performance invoices and credit notes, normally finalised following agreement with commissioners on 'Freeze' performance, are not required. The Trust has however been funded on a 'cost and volume' basis for areas such High Cost Drugs and Devices, COVID testing income and COVID vaccination income.

## Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. As noted above, this occurred through block contracts in 2020/21. 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. In contrast with previous years, at the year end, the Trust does not accrue income relating to activity delivered in that year, where a patient care spell is incomplete. Income recognised at year end is consistent with the block contract values agreed with the Trust's main commissioners

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 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 arrangements noted in the 2019/20 accounts were suspended in the 2020/21 financial regime, owing to COVID-19. The M1-6 financial performance was brought to breakeven by the COVID retrospective top-up. In the M7-12 financial regime, the Trust was awarded a Block COVID top-up value allocated by local commissioners.

## 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 be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

or

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 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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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.

The FReM suggests that appropriate approaches to valuation might include a five year valuation supplemented by either annual indexation or regular desktop valuation update. A desktop valuation was carried out in 20/21 and the last full revaluation was completed in 2019/20.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

## Depreciation

Items of property, plant and equipment are depreciated over their remaining useful 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 has 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 the criteria in IFRS 5 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

## 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 |
| **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, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

## Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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. The cost of inventories is measured 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.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

## 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.

## 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 2021:

| | | Nominal rate |
|---|---|---|
| Short-term | Up to 5 years | -0.02% |
| Medium-term | After 5 years up to 10 years | 0.18% |
| 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 rates are set by HM Treasury, effective 31 March 2020:

| | | Inflation rate |
|---|---|---|
| Short-term | Year 1 | 1.20% |
| Medium-term | Year 2 | 1.60% |
| Long-term | Into perpetuity | 2.00% |

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% 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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

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 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

## Note 1.20 Foreign exchange

The functional and presentational currency of the trust is 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 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 1.21 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 a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

## Note 1.22 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 1.23 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 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

## Note 1.25 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 2022. 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 2022, 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 0.91% 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 2022 for existing finance leases.

For leases commencing in 2022/23, 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.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

## IFRS 17 Insurance

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.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

| | £000 |
|---|---|
| **Estimated impact on 1 April 2022 statement of financial position** | |
| **Additional right of use assets recognised for existing operating leases** | 168,845 |
| **Additional lease obligations recognised for existing operating leases** | - |
| Net impact on net assets on 1 April 2022 | 168,845 |

| | |
|---|---|
| **Estimated in-year impact in 2022/23** | |
| **Additional depreciation on right of use assets** | (12,601) |
| **Additional finance costs on lease liabilities** | (7,540) |
| Estimated impact on surplus/deficit in 2022/23 | (20,141) |

## Note 1.26 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:

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 2021.

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 1.27 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.

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. The value of the Trust's provision for impairment of receivables at the 31 March 2021 is £15m.

The Trust's external valuers, Gerald Eve LLP, provided a desktop valuation for land and buildings in 20/21. Market trends and forecasts are a prediction based on current data and historic trends and have the potential to change with consumer behaviour. The net book value of land and buildings at the 31 March 2021 is £301m.

Buildings have the potential to deteriorate or last longer than predicted and therefore the useful lives estimated may not be appropriate. These are reviewed each year and therefore ensure that any changes to condition, use etc. which affect this are picked up annually and at full valuation. Building asset lives range from 3 years to 80 years.

## Note 2 Operating Segments

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

Income from CCGs account for 44% (2019/20 44%) of the Trust revenue with a further 33% (2019/20: 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)

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Block contract/system envelope income* | 732,759 | 585,086 |
| High cost drugs income from commissioners (excluding pass-through costs) | 6,186 | 42,212 |
| Other NHS clinical income | 38,371 | 30,638 |
| **Community services** | | |
| Block contract/system envelope income* | - | 28,600 |
| Income from other sources (e.g. local authorities) | - | 75 |
| **All services** | | |
| Private patient income | 1,383 | 3,429 |
| Additional pension contribution central funding** | 23,324 | 21,772 |
| Other clinical income | 296 | 5,585 |
| Total income from activities | 802,318 | 717,397 |

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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)

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| **Income from patient care activities received from:** | | |
| NHS England | 359,745 | 325,726 |
| Clinical commissioning groups | 439,358 | 377,590 |
| Department of Health and Social Care | 1 | - |
| Other NHS providers | 1,445 | 3,474 |
| NHS other | 90 | 1,464 |
| Local authorities | - | 129 |
| Non-NHS: private patients | 1,383 | 3,429 |
| Non-NHS: overseas patients (chargeable to patient) | 978 | 2,133 |
| Injury cost recovery scheme | (709) | 3,153 |
| Non NHS: other | 27 | 299 |
| **Total income from activities** | 802,318 | 717,397 |
| **Of which:** | | |
| Related to continuing operations | 802,318 | 717,397 |

## Note 3.3
## Overseas visitors (relating to patients charged directly by the provider)

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Income recognised this year | 978 | 2,133 |
| Cash payments received in-year | 530 | 24 |
| Amounts added to provision for impairment of receivables | (1,591) | (3,795) |
| Amounts written off in-year | - | - |

## Note 4 Other operating income

| | 2020/21 | | | 2019/20 | | |
|---|---|---|---|---|---|---|
| | Contract income £000 | Non-contract income £000 | Total £000 | Contract income £000 | Non-contract income £000 | Total £000 |
| Research and development | 8,476 | - | 8,476 | 5,270 | - | 5,270 |
| Education and training | 36,934 | - | 36,934 | 36,363 | - | 36,363 |
| Non-patient care services to other bodies | 61,598 | | 61,598 | 66,960 | | 66,960 |
| Provider sustainability fund (2019/20 only) | | | - | 9,133 | | 9,133 |
| Financial recovery fund (2019/20 only) | | | - | 19,454 | | 19,454 |
| Marginal rate emergency tariff funding (2019/20 only) | | | - | 6,637 | | 6,637 |
| Reimbursement and top up funding | 62,943 | | 62,943 | - | | - |
| Income in respect of employee benefits accounted on a gross basis | 42,665 | | 42,665 | 39,948 | | 39,948 |
| Receipt of capital grants and donations | | 5,451 | 5,451 | | 545 | 545 |
| Charitable and other contributions to expenditure | | 18,652 | 18,652 | | 59 | 59 |
| Other income | 3,106 | - | 3,106 | 4,860 | - | 4,860 |
| Total other operating income | 215,722 | 24,103 | 239,825 | 188,625 | 604 | 189,229 |
| Of which: | | | | | | |
| Related to continuing operations | | | 239,825 | | | 189,229 |
| Related to discontinued operations | | | - | | | - |

## Note 5.1
## Additional information on contract revenue (IFRS 15) recognised in the period

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods | - | 2,484 |

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:

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Income from services designated as commissioner requested services | 799,103 | 686,611 |
| Income from services not designated as commissioner requested services | 243,040 | 198,227 |
| Total | 1,042,143 | 884,838 |

## Note 6.1 Operating expenses

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Purchase of healthcare from NHS and DHSC bodies | 2,733 | 5,134 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 1,626 | 1,711 |
| Staff and executive directors costs | 638,409 | 576,066 |
| Remuneration of non-executive directors | 148 | 138 |
| Supplies and services - clinical (excluding drugs costs) | 114,834 | 103,913 |
| Supplies and services - general | 26,832 | 21,718 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 91,372 | 81,427 |
| Inventories written down | 237 | - |
| Consultancy costs | 1,176 | 2,361 |
| Establishment | 5,371 | 5,264 |
| Premises | 34,358 | 26,444 |
| Transport (including patient travel) | 13,709 | 9,111 |
| Depreciation on property, plant and equipment | 23,603 | 19,949 |
| Amortisation on intangible assets | 5,129 | 3,392 |
| Net impairments | 12 | - |
| Movement in credit loss allowance: contract receivables / contract assets | 5,489 | 569 |
| Increase/(decrease) in other provisions | 1,411 | (13) |
| Audit fees payable to the external auditor | | |
| audit services- statutory audit | 113 | 94 |
| other auditor remuneration (external auditor only) | - | 10 |
| Internal audit costs | 133 | 140 |
| Clinical negligence | 25,911 | 23,295 |
| Legal fees | 802 | 895 |
| Insurance | 49 | 54 |
| Research and development | 2 | - |
| Education and training | 2,215 | 2,866 |
| Rentals under operating leases | 17,813 | 16,484 |
| Redundancy | 160 | 210 |
| Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) | 6,563 | 6,297 |
| Car parking & security | 1,151 | 419 |
| Losses, ex gratia & special payments | 14 | - |
| Other | 6,845 | 129 |
| Total | 1,028,220 | 908,076 |
| Of which: | | |
| Related to continuing operations | 1,028,220 | 908,076 |
| Related to discontinued operations | - | - |
| Audit Fees | | |
| The fees reconciles to the Financial statement as follows | | |
| Statutory Audit Fee | 93,750 | |
| VAT | 18,750 | |
| Total per Note 6.1 | 112,500 | |

## Note 6.2 Other auditor remuneration

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| **Other auditor remuneration paid to the external auditor:** | | |
| Audit-related assurance services | - | 10 |
| Total | - | 10 |

## Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

## Note 7 Impairment of assets

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| **Net impairments charged to operating surplus/deficit resulting from:** | | |
| Total net impairments charged to operating surplus/deficit | 12 | - |
| Impairments charged to the revaluation reserve | 31,475 | 9,653 |
| Total net impairments | 31,487 | 9,653 |

## Note 8 Employee benefits

| | 2020/21 Total £000 | 2019/20 Total £000 |
|---|---|---|
| Salaries and wages | 491,801 | 436,512 |
| Social security costs | 51,852 | 47,251 |
| Apprenticeship levy | 2,332 | 2,135 |
| Employer's contributions to NHS pensions | 76,555 | 71,395 |
| Pension cost - other | 53 | - |
| Termination benefits | 272 | 271 |
| Temporary staff (including agency) | 15,544 | 18,502 |
| Total gross staff costs | 638,409 | 576,066 |
| Recoveries in respect of seconded staff | - | - |
| Total staff costs | 638,409 | 576,066 |
| **Of which** | | |
| Costs capitalised as part of assets | - | - |

## Note 8.1 Retirements due to ill-health

During 2020/21 there were 3 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £22k (£24k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

## Note 9 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

## a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 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 10 Operating leases

## Note 10.1 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.

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| **Operating lease expense** | | |
| Minimum lease payments | 17,813 | 16,484 |
| Total | 17,813 | 16,484 |

| | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| **Future minimum lease payments due:** | | |
| - not later than one year; | 17,813 | 17,993 |
| - later than one year and not later than five years; | 71,252 | 71,973 |
| - later than five years. | 17,813 | 17,993 |
| Total | 106,878 | 107,959 |
| Future minimum sublease payments to be received | - | - |

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| **Category of Lease** | | |
| Building | 102,072 | 95,272 |
| Other | 4,806 | 3,629 |
| Total | 106,878 | 98,901 |

## Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Interest on bank accounts | 10 | 237 |
| Total finance income | 10 | 237 |

## Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Interest expense: | | |
| Loans from the Department of Health and Social Care | 257 | 8,873 |
| Other loans | 107 | 133 |
| Finance leases | 482 | 227 |
| Interest on late payment of commercial debt | 6 | 5 |
| Main finance costs on PFI and LIFT schemes obligations | 2,625 | 2,704 |
| Total interest expense | 3,477 | 11,942 |
| Unwinding of discount on provisions | (8) | (5) |
| Other finance costs | 1 | - |
| Total finance costs | 3,470 | 11,937 |

## Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Amounts included within interest payable arising from claims made under this legislation | 6 | 5 |

## 2020/21

The Trust did not dispose of any old plant and equipment in 2020/21 and 2019/20.

## Note 13 Intangible assets – 2020/21

| | Software licences £000 | Internally generated information technology £000 | Total £000 |
|---|---|---|---|
| Valuation / gross cost at 1 April 2020 – brought forward | 2,930 | 57,282 | 60,212 |
| Additions | 552 | 4,479 | 5,031 |
| Reclassifications | - | 5,222 | 5,222 |
| Valuation / gross cost at 31 March 2021 | 3,482 | 66,983 | 70,465 |
| | | | |
| Amortisation at 1 April 2020 – brought forward | 2,215 | 20,339 | 22,554 |
| Provided during the year | 955 | 4,764 | 5,129 |
| Amortisation at 31 March 2021 | 2,580 | 25,103 | 27,683 |
| | | | |
| Net book value at 31 March 2021 | 902 | 41,880 | 42,782 |
| Net book value at 1 April 2020 | 715 | 36,943 | 37,658 |

## Note 13.1 Intangible assets – 2019/20

| | Software licences £000 | Internally generated information technology £000 | Total £000 |
|---|---|---|---|
| Valuation/gross cost at 1 April 2019 – as previously stated | 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 – as previously stated | 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 14.1 Property, plant and equipment – 2020/21

| | 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 2020 – brought forward | 46,276 | 249,203 | 113 | 41,163 | 92,395 | 28,378 | 11,094 | 468,621 |
| Additions | - | 30,982 | - | 31,083 | 26,867 | 8,880 | 1,140 | 98,952 |
| Impairments | 3,581 | (35,056) | - | - | - | - | - | (31,475) |
| Reclassifications | - | 14,890 | - | (21,745) | 584 | 956 | 93 | (5,222) |
| Disposals/ derecognition | - | - | - | - | (2,119) | - | - | (2,119) |
| Valuation/gross cost at 31 March 2021 | 49,857 | 260,019 | 113 | 50,501 | 117,727 | 38,214 | 12,327 | 528,757 |
| | | | | | | | | |
| Accumulated depreciation at 1 April 2020 – brought forward | - | (0) | 15 | - | 54,186 | 17,566 | 7,581 | 79,349 |
| Provided during the year | - | 9,032 | 5 | - | 10,024 | 3,993 | 549 | 23,603 |
| Impairments | - | 12 | - | - | - | - | - | 12 |
| Disposals/ derecognition | - | - | - | - | (2,119) | - | - | (2,119) |
| Accumulated depreciation at 31 March 2021 | - | 9,044 | 20 | - | 62,091 | 21,559 | 8,130 | 100,845 |
| Net book value at 31 March 2021 | 49,857 | 250,975 | 93 | 50,501 | 55,635 | 16,655 | 4,197 | 427,912 |
| Net book value at 1 April 2020 | 46,276 | 249,203 | 98 | 41,163 | 38,208 | 10,812 | 3,513 | 389,272 |

## Note 14.2 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 – as previously stated | 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 – as previously stated | - | (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 14.3 Property, plant and equipment financing – 2020/21

| | 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 2021 | | | | | | | | |
| Owned – purchased | 48,842 | 185,912 | 93 | 50,501 | 41,518 | 16,650 | 4,092 | 347,607 |
| Finance leased | - | - | - | - | 7,872 | - | - | 7,872 |
| On-SoFP PFI contracts and other service concession arrangements | - | 51,824 | - | - | - | - | - | 51,824 |
| Owned – donated/ granted | 1,015 | 13,239 | - | - | 6,245 | 5 | 105 | 20,609 |
| NBV total at 31 March 2021 | 49,857 | 250,975 | 93 | 50,501 | 55,635 | 16,655 | 4,197 | 427,912 |

## Note 14.4 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 – donated/ granted | 1,015 | 14,116 | - | - | 1,189 | 17 | 137 | 16,474 |
| NBV total at 31 March 2020 | 46,276 | 249,203 | 98 | 41,163 | 38,208 | 10,812 | 3,513 | 389,272 |

## 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 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Drugs | 4,461 | 3,851 |
| Consumables | 8,754 | 8,020 |
| Total inventories | 13,215 | 11,871 |
| of which: | | |
| Held at fair value less costs to sell | - | - |

Inventories recognised in expenses for the year were £105,403k (2019/20: £83,261k). Write-down of inventories recognised as expenses for the year were £237k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £18,033k of items purchased by DHSC.

The year-end balance of consumables provided by DHSC is immaterial, with receipt charged to expenditure and the gain of the same amount in income to offset.

## Note 19.1 Receivables

| | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Current | | |
| Contract receivables | 57,827 | 78,242 |
| Allowance for impaired contract receivables / assets | (14,700) | (9,211) |
| Prepayments (non-PFI) | 5,021 | 4,134 |
| PDC dividend receivable | 362 | - |
| VAT receivable | 7,598 | 1,504 |
| Other receivables | 5,898 | 5,898 |
| Total current receivables | 72,351 | 80,567 |
| Non-current | | |
| Contract receivables | 8,561 | 11,097 |
| Other receivables | 2,368 | 2,007 |
| Total non-current receivables | 10,929 | 13,104 |
| Of which receivable from NHS and DHSC group bodies: | | |
| Current | 33,606 | 48,553 |
| Non-current | 2,368 | 2,007 |

## Note 19.2 Allowances for credit losses

| | 2020/21 | 2019/20 |
|---|---|---|
| | Contract receivables and contract assets £000 | Contract receivables and contract assets £000 |
| Allowances as at 1 April - brought forward | 9,211 | 8,642 |
| New allowances arising | 5,489 | 569 |
| Allowances as at 31 Mar 2021 | 14,700 | 9,211 |

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 20/21 receivables and there is no material.

## Note 20 Other assets

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| Non-current | | |
| Net defined benefit pension scheme asset | - | - |
| Other assets | 11 | 11 |
| Total other non-current assets | 11 | 11 |

## Note 21.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| At 1 April | 3,425 | 3,232 |
| Net change in year | 33,136 | 193 |
| At 31 March | 36,561 | 3,425 |
| Broken down into: | | |
| Cash at commercial banks and in hand | 71 | 50 |
| Cash with the Government Banking Service | 36,490 | 3,375 |
| Total cash and cash equivalents as in SoFP | 36,561 | 3,425 |
| Total cash and cash equivalents as in SoCF | 36,561 | 3,425 |

## Note 21.2 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 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Monies on deposit | - | 5 |
| Total third party assets | - | 5 |

## Note 22.1 Trade and other payables

| | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Current | | |
| Trade payables | 35,924 | 64,731 |
| Capital payables | 36,033 | 22,499 |
| Accruals | 65,934 | 14,401 |
| Social security costs | 107 | 6,679 |
| Other taxes payable | - | 5,189 |
| PDC dividend payable | - | - |
| Other payables | 1,160 | 568 |
| Total current trade and other payables | 139,158 | 114,067 |
| Of which payables from NHS and DHSC group bodies: | | |
| Current | 13,604 | 14,758 |
| Non-current | - | - |

## Note 23 Other liabilities

| | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Current | | |
| Deferred income: contract liabilities | 7,648 | 2,480 |
| Total other current liabilities | 7,648 | 2,480 |

## Note 24.1 Borrowings

| | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| **Current** | | |
| Loans from DHSC | 694 | 317,998 |
| Other loans | 1,501 | 1,478 |
| Obligations under finance leases | 2,093 | 2,394 |
| Obligations under PFI, LIFT or other service concession contracts | 1,301 | 1,215 |
| Total current borrowings | 5,589 | 323,085 |
| | | |
| **Non-current** | | |
| Loans from DHSC | 10,840 | 20,448 |
| Other loans | 3,695 | 5,173 |
| Obligations under finance leases | 3,558 | 3,461 |
| Obligations under PFI, LIFT or other service concession contracts | 38,952 | 40,253 |
| Total non-current borrowings | 57,045 | 69,335 |

### 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 31/03/21 the balance owed by the Trust on this loan is £11.4m.
2. The Trust capital loan of £51.6m outstanding as of 31st March 2020, converted to PDC on September 2020

### DH working capital loans and working capital facilities

3. The Trust has a working capital loan of £263.4m and revolving working capital loan of £10m outstanding loan as of 31st March 2020, converted to PDC on 01st Spetmber 2020.

### Borrowings from other bodies

### London Energy Efficiency Fund

4. 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 2020/21. As at 31/03/21 the balance owed by the Trust on this loan is £5.2m.

## Note 24.2
## Reconciliation of liabilities arising from financing activities – 2020/21

| | Loans from DHSC £000 | Other loans £000 | Finance leases £000 | PFI and LIFT schemes £000 | Total £000 |
|---|---|---|---|---|---|
| Carrying value at 1 April 2020 | 338,446 | 6,651 | 5,855 | 41,468 | 392,420 |
| **Cash movements:** | | | | | |
| Financing cash flows - payments and receipts of principal | (325,620) | (1,478) | (3,056) | (1,216) | (331,370) |
| Financing cash flows - payments of interest | (1,549) | (114) | (482) | (2,625) | (4,770) |
| **Non-cash movements:** | | | | | |
| Additions | - | - | 2,853 | - | 2,853 |
| Application of effective interest rate | 257 | 107 | 482 | 2,625 | 3,471 |
| Other changes | - | 30 | (1) | 1 | 30 |
| Carrying value at 31 March 2021 | 11,534 | 5,196 | 5,651 | 40,253 | 62,634 |

## Note 24.3
## 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 |
| Prior period adjustment | - | - | - | - | - |
| Carrying value at 1 April 2018 - restated | 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 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 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Gross lease liabilities | 6,418 | 6,611 |
| of which liabilities are due: | | |
| - not later than one year; | 2,378 | 2,730 |
| - later than one year and not later than five years; | 3,158 | 3,373 |
| - later than five years. | 882 | 508 |
| Finance charges allocated to future periods | (767) | (756) |
| Net lease liabilities | 5,651 | 5,855 |
| of which payable: | | |
| - not later than one year; | 2,093 | 2,394 |
| - later than one year and not later than five years; | 2,781 | 3,030 |
| - later than five years. | 777 | 431 |
| | 5,651 | 5,855 |

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 2020 | 456 | 137 | 2,140 | 2,733 |
| Arising during the year | 648 | 763 | 361 | 1,772 |
| Utilised during the year | (211) | (137) | (14) | (362) |
| Unwinding of discount | (8) | - | - | (8) |
| At 31 March 2021 | 885 | 763 | 2,487 | 4,135 |
| Expected timing of cash flows: | | | | |
| - not later than one year; | - | 763 | 119 | 882 |
| - later than one year and not later than five years; | 885 | - | 2,368 | 3,253 |
| - later than five years. | (0) | - | - | (0) |
| Total | 885 | 763 | 2,487 | 4,135 |

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 2021, £434,848k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2020: £361,965k).

## Note 27 Contingent assets and liabilities

| | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| **Value of contingent liabilities** | | |
| NHS Resolution legal claims | (50) | (62) |
| Gross value of contingent liabilities | (50) | (62) |
| Amounts recoverable against liabilities | - | - |
| Net value of contingent liabilities | (50) | (62) |
| 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 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Property, plant and equipment | 7,305 | 5,580 |
| Total | 7,305 | 5,580 |

The capital commitments total of £7,305m as at 31/03/21 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 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Gross PFI, LIFT or other service concession liabilities | 66,653 | 70,493 |
| **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. | 47,449 | 51,289 |
| Finance charges allocated to future periods | (26,400) | (29,025) |
| Net PFI, LIFT or other service concession arrangement obligation | 40,253 | 41,468 |
| - not later than one year; | 1,301 | 1,215 |
| - later than one year and not later than five years; | 6,181 | 5,777 |
| - later than five years. | 32,771 | 34,476 |

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 2021 £000 | 31 March 2020 £000 |
|---|---|---|
| Total future payments committed in respect of the PFI, LIFT or other service concession arrangements | 226,255 | 243,529 |
| Of which payments are due: | | |
| - not later than one year; | 10,567 | 10,662 |
| - later than one year and not later than five years; | 44,422 | 44,824 |
| - later than five years. | 171,266 | 188,043 |

## 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:

| | 2020/21 £000 | 2019/20 £000 |
|---|---|---|
| Unitary payment payable to service concession operator | 10,404 | 10,137 |
| Consisting of: | | |
| - Interest charge | 2,625 | 2,704 |
| - Repayment of balance sheet obligation | 1,216 | 1,136 |
| - Service element and other charges to operating expenditure | 6,563 | 6,297 |
| Total amount paid to service concession operator | 10,404 | 10,137 |

## 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 2019/20 or 2020/21

## 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 2021 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 2021 | 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 | 70,299 | - | - | 70,299 |
| Other investments / financial assets | - | - | - | - |
| Cash and cash equivalents | 36,561 | - | - | 36,561 |
| Total at 31 March 2021 | 106,860 | - | - | 106,860 |

| Financial assets as per Statement of Financial Position | £000 |
|---|---|
| Trade and other receivables excluding non financial assets | |
| RTA | 83,280 |
| Prepayments | (5,021) |
| PDC | (362) |
| VAT | (7,598) |
| Total at 31 March 2021 | 70,299 |

| Statement of Financial Position | 31,670 |
|---|---|
| Non Current Receivables | 38,629 |
| Current Receivables | 70,299 |
| Total at 31 March 2021 | 108,928 |

| 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 |

## Note 31.3 Carrying values of financial liabilities

| Carrying values of financial liabilities as at 31 March 2021 | 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 | 11,534 | - | 11,534 |
| Obligations under finance leases | 5,651 | - | 5,651 |
| Obligations under PFI, LIFT and other service concession contracts | 40,253 | - | 40,253 |
| Other borrowings | 5,196 | - | 5,196 |
| Trade and other payables excluding non financial liabilities | 139,051 | - | 139,051 |
| Total at 31 March 2021 | 201,685 | - | 201,685 |

| The Financial Liabilities as per Statement of Financial Position | |
|---|---|
| Borrowing | £000 |
| Loans from the Department of Health and Social Care | 11,534 |
| Obligations under finance leases | 5,651 |
| Obligations under PFI, LIFT and other service concession contracts | 40,253 |
| Other borrowings | 5,196 |
| Total at 31 March 2021 | 62,634 |

| Statement of Financial Position | |
|---|---|
| Current Borrowings | 5,589 |
| Non Current Borrowings | 57,045 |
| Total at 31 March 2021 | 62,634 |

| Trade and other payables | £000 |
|---|---|
| Trade and other payables excluding non financial liabilities | |
| Social Security cost | 139,158 |
| Accruals | (107) |
| Total at 31 March 2021 | 139,051 |

| Statement of Financial Position | |
|---|---|
| Current Trade and other payables | 139,051 |
| Total at 31 March 2021 | 139,051 |

| 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 |
| Other financial liabilities | - | - | - |
| Provisions under contract | - | - | - |
| 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 |

## Note 31.4
## Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

| | 31 March 2021 £000 | 31 March 2020 restated* £000 |
|---|---|---|
| In one year or less | 147,673 | 407,453 |
| In more than one year but not more than five years | 25,550 | 30,477 |
| In more than five years | 58,042 | 65,842 |
| Total | 231,265 | 503,771 |

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

## 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 2021 Book Value £000 | 31 March 2021 Fair Value £000 | 31 March 2019 Book Value £000 | 31 March 2019 Fair Value £000 |
|---|---|---|---|---|
| Carrying values of financial assets as at 31 March 2021 under IFRS 9 | | | | |
| Trade and other receivables excluding non financial assets | 31,670 | 31,670 | 89,717 | 89,717 |
| Other investments / financial assets | 38,629 | 38,629 | - | - |
| Cash and cash equivalents at bank and in hand | 36,561 | 36,561 | 3,232 | 3,232 |
| Total at 31 March 2021 | 106,860 | 106,860 | 92,949 | 92,949 |

| | 31 March 2021 Book Value £000 | 31 March 2021 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 | 11,534 | 11,534 | 287,089 | 287,089 |
| Obligations under finance leases | 5,651 | 5,651 | 5,570 | 5,570 |
| Obligations under PFI, LIFT and other service concession contracts | 40,253 | 40,253 | 42,605 | 42,605 |
| Other borrowings | 5,196 | 5,196 | 8,130 | 8,130 |
| Trade and other payables excluding non financial liabilities | 13,383 | 13,383 | 98,511 | 98,511 |
| Other financial liabilities | 125,668 | 125,668 | - | - |
| Provisions under contract | - | - | - | - |
| Total at 31 March 2020 | 201,685 | 201,685 | 441,905 | 441,905 |

## Note 32 Losses and special payments

| | 2020/21 Total number of cases Number | Total value of cases £000 | 2019/20 Total number of cases Number | Total value of cases £000 |
|---|---|---|---|---|
| **Losses** | | | | |
| Cash losses | - | - | - | - |
| Total losses | - | - | - | - |
| Special payments | | | | |
| Ex-gratia payments | 25 | 14 | 79 | 420 |
| Total special payments | 25 | 14 | 79 | 420 |
| Total losses and special payments | 25 | 14 | 79 | 420 |
| Compensation payments received | | - | | - |

## Note 33 Related parties

St Georges University Hospitals is a Foundation Trust within the Department of Health and Social Care. The Department of Health and Social Care is regarded as a related party.

During the year, St George's University Hospitals has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department, as listed below:

## NHS Foundation Trusts

## NHS Trusts

## Department of Health and Social Care

## Public Health England

## Health Education England

## CCGs and NHS England

## Special Health Authorities

## Non – Department Public Bodies

## Other DH bodies

| | Amounts due from Related Party | | Amounts owed to Related Party | |
|---|---|---|---|---|
| | 2020/21 £000 | 2019/20 £000 | 2020/21 £000 | 2019/20 £000 |
| **Non – NHS Related party transactions** | | | | |
| St George's University of London | 7,509 | 5,805 | 7,273 | 4,252 |
| St George's Hospital Charity | 100 | 457 | - | 1 |
| Total | 7,609 | 6,262 | 7,273 | 4,253 |

| | Receipts from Related Party | | Payments to Related party | |
|---|---|---|---|---|
| | 2020/21 £000 | 2019/20 £000 | 2020/21 £000 | 2019/20 £000 |
| **Non – NHS Related party transactions** | | | | |
| St George's University of London | 3,809 | 7,200 | 2,565 | 4,747 |
| St George's Hospital Charity | 1,304 | 1,454 | - | 107 |
| Total | 5,113 | 8,654 | 2,565 | 4,854 |

## 2020/21 Related parties

There are no related parties for Directors in 2019/20 and 2020/21

## Note  Events after the reporting date

There are no known events after reporting date at present

excellent
kind
responsible
respectful

# Contact us

## Giving to George's

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

Telephone: 020 8725 4522
Email: giving@stgeorges.nhs.uk
Web: www.stgeorgeshospitalcharity.org.uk

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