Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust

Annual Report and Accounts 2020/21

St George's University Hospitals NHS Foundation Trust

Annual Report and Accounts 2020/21 Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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Chairman's introduction

I am pleased to write this introduction to the Trust's Annual Report and Accounts for 2020/21, a year like no other in the 73-year history of the health service.

In my introduction last year, I anticipated that Covid-19 would be an ever-present reality for the Trust over the coming year and, unfortunately, this has proved to be the case.

Like many organisations, St George's has spent the past 12 months dealing with the effects of the Covid-19 virus – it has changed the way we work in so many ways, from the way we see and treat patients to where and how our staff go about their jobs.

We have lost colleagues to the virus, and while more than 2,600 people with Covid-19 have been treated successfully in our hospitals, more than 750 with the virus have sadly died. This has been devastating for relatives – who in many cases have been unable to see their loved ones in their final days.

It has also been incredibly difficult for our staff, who have – time and again – gone above and beyond over the past year to care for patients and keep our services running. We have worked hard to support them – and looking after their mental and physical wellbeing has been an absolute priority for the organisation, and will continue to be.

Staff have adapted rapidly to changing circumstances; for example, a large proportion of outpatient appointments are now delivered virtually, which would have been unthinkable even 12 months ago. Many staff are also working from home, which is a new experience for them, but the response has been fantastic.

I am also incredibly grateful to our patients and local communities for their support over the past year. Our relationship with local people has always been strong, but the pandemic has seen us form an even closer bond.

The kindness and generosity local communities have shown has well and truly kept our staff going – from donations of food through to letters and drawings sent in by local school children. It is something we will always remember, and a special film we launched on St George's Day this year was our small way of saying thank you for all the support we've had.

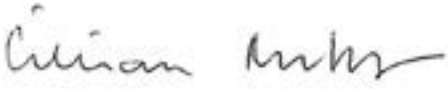
I would also like to thank the many charities and volunteers that have supported staff and patients, including in particular St George's Hospital Charity, whose Covid-19 appeal raised hundreds of thousands of pounds, which has helped fund everything from iPads on the wards (for video calls between patients and relatives) to care bags for staff to keep them going at the most challenging time in their careers.

The Charity's fundraising team has also provided on the ground support, as have many other generous people and volunteer action groups, all of whom have been a central part of our response to the pandemic.

As Chairman-in-Common for both St George's and Epsom and St Helier University Hospitals NHS Trust, I have also been struck by the positive way in which local hospitals, and other healthcare organisations, have worked so collaboratively during the pandemic, and Covid-19 has fast-tracked closer working across south west London, which is better for patients and staff. The benefits are clear, and I am keen we build on this over the coming months and years.

Finally, I would like to thank the Trust Board and our Governors for the commitment they continue to bring to their roles, and the organisation as a whole. But most of all, I would like to thank our local communities, and our staff, without whom the past year would have been even more challenging than it proved to be.

> "A large proportion of outpatient appointments are now delivered virtually, which would have been unthinkable even 12 months ago."



Gillian Norton
Chairman
24 June 2021

Our hospitals

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

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

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

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

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

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

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

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

St George's in numbers:

We have 1,083 beds; 995 at St George's Hospital and 88 at Queen Mary's Hospital

The beds at St George's Hospital comprise 871 general and acute, 67 maternity and 57 critical care*

The beds at Queen Mary's Hospital comprise 46 for people with limb amputations who require neurorehabilitation, and 42 for sub-acute care, treatment and rehabilitation of older people.

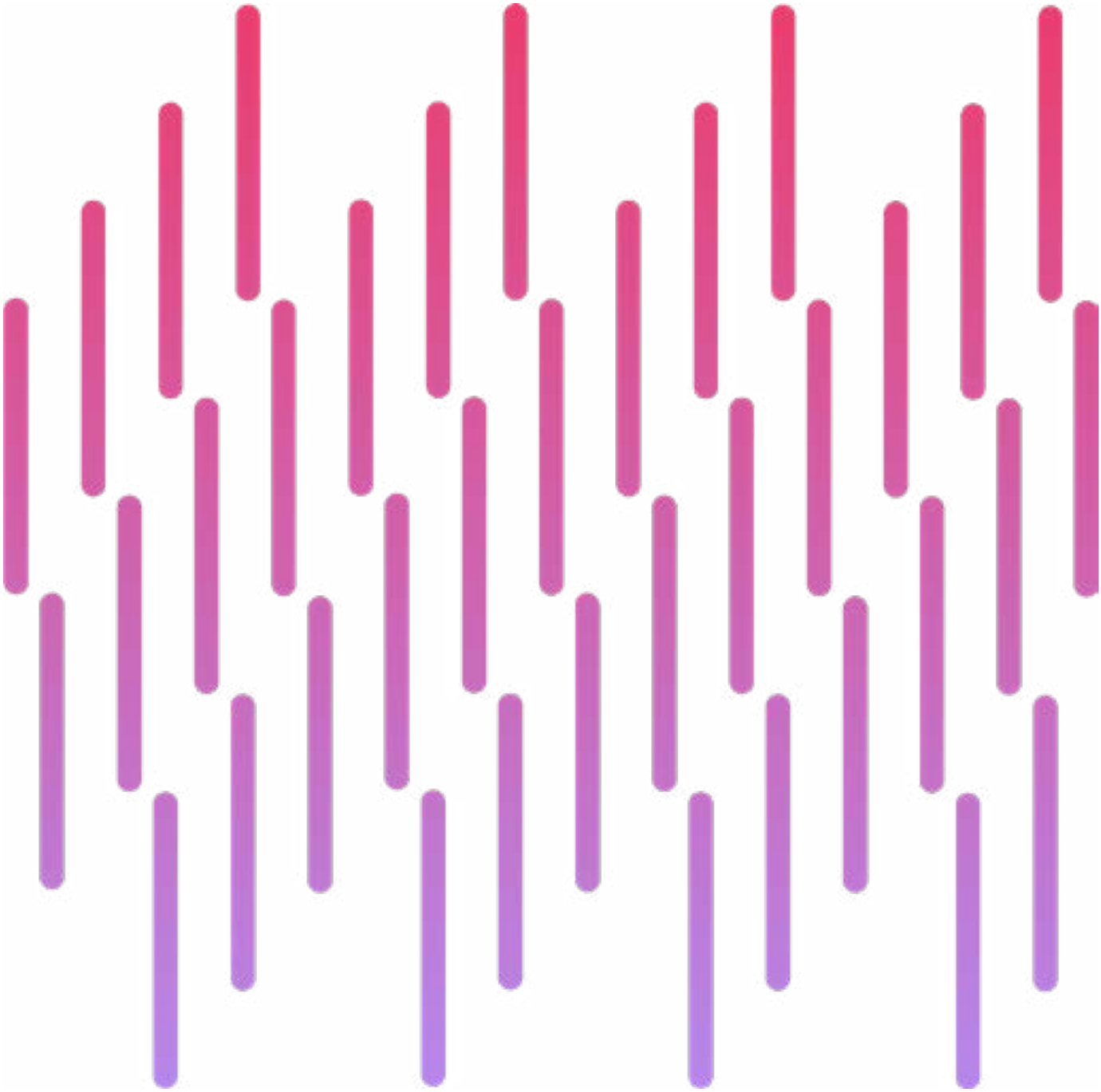
Many of our services are also part of established clinical networks, which bring together clinicians and support staff from a range of healthcare providers to improve the quality of services for patients.

*In late March and April 2020, and in December and January 2021, in response to the developing Covid-19 pandemic, the Trust took a number of steps to increase temporarily its critical care capacity in order to meet the demand for ICU beds from patients requiring ventilation. As part of the Trust's Covid-19, flu and winter plan 2020/21, the Trust increased its ability to convert areas for use as intensive care facilities.

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

Performance report

In this statement and the following performance section of the annual report, we set out a short, high-level summary of our vision and strategy as an organisation, our objectives and how we have met them, and where there is work still to do. Also covered is our purpose, the key risks we face to the achievement of our objectives, how we have performed during the year, and a summary of how we are embedding equality within the organisation and in our decision-making processes.



Performance report: Overview

Annual performance statement from the Chief Executive

I have always been proud to say that I am Chief Executive of St George's University Hospitals NHS Foundation Trust – but never more so than this year.

The past year has been arguably the most challenging St George's – and the wider NHS – has ever faced. The Covid-19 pandemic has tested our staff and local communities to an unprecedented degree – and the response has been phenomenal.

> "The Covid-19 pandemic has tested our staff and local communities to an unprecedented degree – and the response has been phenomenal."

I have been Chief Executive of the Trust for just over four years. The organisation is more resilient than it was back in 2017 – but, despite this, the past 12 months have been incredibly difficult for everyone in the NHS.

Covid-19 has dominated our lives since early 2020 – and our Annual Report and Accounts describes in more detail the impact this has had on our organisation.

The pandemic has also meant we've had to pause a number of key projects and initiatives – however, I am still pleased with the progress we have made, given the enormous challenges our teams have faced.

Crucially, we exited the special measures regime for management of our finances, which is the first time the Trust has been in neither financial or quality special measures since November 2016. A big and positive step forward.

Covid-19 – a phenomenal response

The impact of Covid-19 on our services and staff cannot be underestimated.

To date, I am pleased to say that we have successfully treated over 2,600 hospital patients who tested positive for Covid-19. Our teams quickly adapted to new ways of working as soon as the scale of the pandemic became clear; for example, during the first Covid-19 peak in March/April 2020, our teams created a 37 bedded intensive care unit in under seven hours, a previously unthinkable idea, let alone one we would have thought feasible.

Sadly, we have also treated 753 patients who tested positive for Covid-19 and died whilst under our care. This includes three of our staff and contractor colleagues and, for some staff, family and friends. Our staff worked hard to support relatives, who were unable to visit their loved ones – with virtual visits organised, including for those patients at the end of their lives.

Staff learned to take on new and different roles, often at extremely short notice. For example, members of our breast screening team moved rapidly to form a family liaison service for patients in ITU. Staff based in the Minor Injuries Unit at Queen Mary's Hospital transferred to St George's Hospital to support our Emergency Department. And some of our managers provided hands on support to clinical staff on the wards.

In December 2020, we created one of the world's first Covid-19 vaccination centres at St George's Hospital – and to date, more than 50,000 patients and staff have passed through the clinic. The clinic was set up in record time, and involved a truly multi-disciplinary effort from teams across the Trust. The vaccine offers hope for the future and a route out of lockdown, and I am

immensely proud that we were one of the first hospitals anywhere to offer this vital service.

Throughout the past year, I have been overwhelmed by the generosity and kindness of the communities we serve in south west London – and of the wider public support for the NHS across the country. The public and local organisations have donated food, supplies, electronic devices, and their time to help us respond to the pandemic and provide care for our patients – as well as wonderful messages of support, which made a huge difference to our staff at a very difficult time. I am also incredibly grateful to St George's Hospital Charity, who in addition to raising hundreds of thousands of pounds have provided practical support where it was most needed – including everything from iPads on the wards to care bags for patients and staff. The Trust owes the Charity a huge debt of gratitude for the incredible help and support is has provided. That support has enabled some of our most acutely unwell Covid-19 patients to have a final opportunity to speak to loved ones on tablet devices provided through the Charity. It has also provided much needed respite for our staff through the creation of rest areas and the provision of meals. On behalf of the Board, thank you to everyone for your support.

Planned care

At the start of the pandemic, we made clear that we would continue to provide life-saving and life-preserving care for everyone who needed it. This included patients requiring urgent cancer care.

We delivered on this promise, and adapted our services accordingly but – like all NHS Trusts – we had to postpone a large number of operations for people awaiting routine, non-urgent care. This was regrettable and unavoidable – and we are aware of the distress and upset it has caused.

In February 2020, only 11 patients were waiting more than 52 weeks for routine surgery at St George's. As a direct result of the pandemic, over 2,644 patients were waiting more than a year for their routine operation just over a year later at the end of March 2021.

We are not alone in this regard, and our focus over the coming year is on tackling our waiting lists, and the long backlog that has grown in certain specialities. Our teams are already putting solutions in place. For example, we have established four new modular operating theatres at Queen Mary's Hospital, which open in June 2021; and we have also now re-opened all 29 of our operating theatres on the St George's Hospital site.

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.

The grid below shows our cancer, RTT and diagnostic performance for the past year:

Indicator	Indicator description	Target	Average monthly performance (Apr 20 - Mar 21)	Mar 21 Performance (year end exit)	Mar 20 performance (comparison)
Referral to treatment times	% of patients treated within 18 weeks of referral	>=92%	65.20%	69.30%	79.30%
Cancer access	% of cancer patients treated within 62 days of urgent GP referral	>=85%	69.7% (Apr 20 - Feb 21)	68.5% (Feb 2021)	82.60%
	% of patients treated within 62 days from screening referral	>=90%	64.8% (Apr 20 - Feb 21)	70.0% (Feb 2021)	77%
Diagnostic waits	% of patients receiving a diagnostic test within 6 weeks of referral	99%	71.40%	89.80%	81.50%

Emergency care

I am pleased that we have continued to deliver urgent and emergency care to a consistently high standard over the past year.

Our Emergency Department (ED) at St George's has remained open at all times, and despite the challenges presented by Covid-19, performance has improved, with 92.8% of patients seen, treated and either admitted or discharged within four hours.

This is a significant achievement, and makes St George's one of the best performing Trusts in London for emergency care performance. I am particularly pleased as the department has undergone some significant estates works over the past six months, which are designed to improve the experience of patients coming to the department, and make the department Covid-secure.

Our ED team are innovating all the time, and a new initiative whereby patients can virtually 'check-in' to the department and share their medical history securely is just one example of how we are working differently as a result of the pandemic.

We also continued to provide heart attack, stroke and trauma services throughout the pandemic, although we did see a reduction in the number of patients presenting, which was a trend seen across the NHS. However, numbers have now returned to the normal levels our teams would expect.

Modernising our hospitals

Despite the challenges presented by Covid-19, we have also managed to progress our ambitious plans to improve our hospital estate, and information technology (IT) infrastructure.

> "Our clinical teams have continued to innovate, and I am really proud to say that patients continue to receive world class care here..."

We have refurbished existing wards – this includes McEntee ward at St George's, one of our clinical infectious diseases wards. As mentioned above, we have modernised our Emergency Department at St George's this year, and we are currently mid-way through a multi-million pound project to upgrade our cardiac catheter labs, which will improve the care we provide for patients undergoing heart procedures.

We are currently finalising our new estates strategy, which will help ensure we make the very best use of our hospital and community sites and plan for the future. Ahead of this, we have demolished many of the old, disused buildings on the St George's Hospital site during the past year, which will put us in a much better position to maximise the use of our Tooting site, for the benefits of patients and staff.

We have invested significantly in our IT infrastructure over recent years, and the roll out of iClip – our electronic patient record – to all inpatient and outpatient areas is now complete. We are now running the vast majority of outpatient appointments virtually, as a direct result of the pandemic – and have improved our IT infrastructure to enable our teams to deliver this. The vast majority of internal and external meetings are also now held virtually.

Innovation and research

Our clinical teams have continued to innovate, and I am really proud to say that patients continue to receive world class care here at St George's. Together with St George's, University of London, we have also extended our research portfolio, with a particular focus on Covid-19. There have been a number of notable achievements over the past 12 months, and too many to name here.

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.

St George's was also 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 recent months, cardiologists at St George's have implanted the world's smallest pacemaker, known as the Micra Transcatheter Pacing System, in a first for the Trust. The device is 93% smaller than traditional devices and, unlike standard pacemakers that are placed in the patient's chest with wires running to the heart, the device is implanted directly into the heart where it delivers electrical impulses from an electrode.

Our stroke team became the first to launch a new international trial called SWIFT-Direct, which is investigating whether patients experiencing a stroke caused by a blockage in one of the major arteries in the brain can be treated with thrombectomy (a surgical procedure) alone, compared to those also receiving the 'clot-busting' treatment thrombolysis.

Together with St George's, University of London, our clinical and academic colleagues have led a number of important trials in the fight against Covid-19. These include research into immunity and reinfection, whether the virus can be passed from pregnant women onto their babies, and assessing the efficacy of the Novovax vaccine.

The NHS staff survey results published in March 2021 demonstrate that we have made progress. The headlines:

67% of staff said they would recommend the Trust as a place to work – up from 61% in 2019.

76% of staff said they would be happy for your friend or relative to receive care at the Trust – an increase of 4% compared to last year's results (72%)

79% of staff said care of patients/service users is our top priority – up 2% on 2019 (77%)

Supporting our staff

Finally, I would like to talk again about our staff, and the importance we place on making sure staff stay physically and mentally well.

Overall, the results represent a positive step forward for the organisation. Equally, there is still a lot more to do – and our staff told us they are worried about bullying and harassment, violence in the workplace, as well as the Trust's approach to diversity, equality and inclusion.

Diversity and inclusion is an issue we have discussed at length as an organisation over the past 12 months – due in large part to the disproportionate impact Covid-19 has had on BAME staff and communities.

We have appointed a new diversity and inclusion lead, and taken significant steps to become a more inclusive organisation – for example, there is now a requirement for a trained BAME representative to sit on all recruitment panels for senior posts. We are also offering diversity training to more and more staff. However, this is going to require a cultural shift, and will take time – and a concerted effort from everyone within the organisation.

Overall, it has been an incredibly challenging year, beyond anything we could have imagined, anticipated or prepared for. However, as well as being extremely difficult, I strongly believe that St George's is a better and stronger organisation as a result – we have learned a huge amount, and the response from staff, and the support from local communities, has been truly magnificent.

Our challenge now, going forward, is to support our staff, and to continue providing high quality care to our patients.

Jacqueline Totterdell
Chief Executive
24 June 2021

Performance report: Our objectives

9,000

Staff employed by the Trust across our sites

St George's became an NHS foundation trust in February 2015. As a foundation trust, our principal purpose is the provision of goods and services to the National Health Service. In practice, that means providing care and treatment for patients across south west London, Surrey, Sussex and beyond. St George's is the largest healthcare provider in south west London. Our two hospital sites at St George's Hospital and Queen Mary's Hospital in Roehampton serve a population of 1.3 million across south west London. As a provider of many tertiary services, such as neurosciences and paediatric medicine, we offer care for significant populations in Surrey and Sussex, totalling around 3.5 million people. St George's is one of the four major trauma centres for London, and home to hyper acute stroke and heart attack centres. It is a major centre for cancer services, one of London's largest children's hospitals with one of only four paediatric trauma units in London, and a major centre for neurosciences.

The Trust is led by the Board of Directors, which is accountable, through the Chairman, to NHS England and NHS Improvement and to our Council of Governors. The Trust is structured into three clinical divisions, each led by a Clinical Chair, supported by a Divisional Director of Operations and Divisional Director of Nursing and Governance: Medicines and Cardiovascular Division; Surgery, Neurosciences, Cancer and Theatres Division; and Children, Women's, Diagnostics and Therapies Division. Alongside these, the Corporate Division comprises key corporate services including estates and facilities, information communication and technology, finance, human resources, strategy, and corporate affairs. In total, the Trust employs more than 9,000 staff across our sites.

> "As a foundation trust, our principal purpose is the provision of goods and services to the National Health Service."

The Trust is part of the South West London Integrated Care System and the South West London Acute Provider Collaborative. Many of our services are also part of established clinical networks, which bring together clinicians and support staff from a range of healthcare providers to improve the quality of services for patients.

Further information about the Trust and its history are set out above in the section Our hospitals.

Our objectives

Responding to the Covid-19 pandemic by caring for patients and supporting our staff has been our collective focus during the last year. However, while Covid has had a profound impact on the Trust, and the NHS as a whole, we also remain committed to the clinical strategy we published in April 2019.

Called 'Delivering Outstanding Care, Every Time', the five-year strategy sets out how we plan to deliver our ambitions for patients, staff, and the communities we serve. It is founded on four key priorities; establishing strong foundations by getting the fundamentals in place; delivering excellent local services to the people of Wandsworth and Merton; closer collaboration with our partners to deliver joined-up services; and being a provider of leading specialist healthcare for the people of south west London and beyond. In the months following its launch we also published supporting strategies in a range of areas to help make our aims a reality. You can read more about these on our website at www.stgeorges.nhs.uk/about/our-strategy

> "The five-year strategy sets out how we plan to deliver our ambitions for patients, staff, and the communities we serve."

Refreshed corporate objectives

Despite our vision of 'outstanding care, every time' and our five-year strategy remaining unchanged, we felt it was right to reassess our day to day objectives in line with the impact that Covid-19 was having on our services and staff.

In September 2020, the Trust Board agreed a fresh set of corporate objectives for the rest of the year (October 2020 – March 2021).

Following engagement with staff and stakeholders, we agreed that they would be "Care", "Culture" and "Collaboration", with a series of priorities underpinning each one. These objectives were aligned and triangulated with our clinical and divisional strategies, as well as our Board Assurance Framework, and are set out below.

We have established ways of reporting on progress in delivering our objectives to the Board. We track our quality and operational performance against key performance indicators which are scrutinised at committee and Board meetings. Our integrated quality and performance report to the Board sets out the Trust's performance against a range of productivity measures and quality metrics. Likewise, we consider our performance against a range of workforce metrics which include staff turnover and sickness absence. You can read more about our organisational structure and governance in the Accountability Report section.

Our corporate objectives (October 2020-March 2021):

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

In the next section, we have expanded on each of our three objectives and corresponding priorities, and included a summary of what we have done over the period to make them a reality. More detail on many of the areas covered can be found elsewhere in this report, and references are provided where this is the case.

Objective 1: Care

This objective was developed to ensure we could prepare for the coming winter period knowing that – like all Trusts – we faced a number of distinct challenges: the usual increase in demand for healthcare during the colder months; the potential for a second Covid-19 surge; plus the health risks posed by influenza. It is also about ensuring patients and staff feel cared for when accessing and providing high quality, timely care at St George's, and how the Trust starts to recover from Covid-19.

Priority one: We will make sure we are prepared to meet the demands of Covid-19, flu, and winter

Our Winter Plan

One of the key milestones under our Care objective was the publication of our Winter Plan in September 2020, following approval by the Board. Its aim was to ensure we could continue to provide excellent care for all patients – both Covid-19 and non-Covid-19 – throughout the period. Developing the plan benefitted from a wide range of staff engagement and lessons learned from our response to the first wave of the Covid-19 pandemic (March to July 2020), which we incorporated into the plan.

Second Covid-19 surge

Our Winter Plan set out what services St George's could run during a subsequent Covid surge within the constraints of our physical capacity and staffing for up to 160 ITU beds, in line with national guidance, our Clinical Safety Strategy, and the plan for us to be the intensive care unit (ITU) centre for the local south west London system. Guided by these factors, we modelled three scenarios and responses ranging in projected demand.

These were:

- Plan A – Base case (66 ITU beds)
- Plan B – Intermediate case (116 ITU beds)
- Plan C – High case (140 increasing to 160 ITU beds)

We planned to move between the three responses over the period, potentially needing to flex up and down, pause and re-start, re-direct and re-provide services in a phased way.

This agile approach was needed by mid-December 2020, when it became clear how different wave two was from what had come before. The number of emergency admissions did not reduce as they did previously, and the demands for general and acute beds increased in excess of expectations for winter. The patients we were caring for in wave two were also sicker and younger compared with those in the first wave. Our workforce needed to respond to these challenges and adapted to different ways of working, and like much of the NHS we adjusted our usual patient-to-ITU-nurse ratios. We also converted some of our wards to provide additional ITU capacity.

The Christmas and New Year period was extremely difficult for our teams, with Covid-19 admissions increasing at a rapid rate; on 1 December 2020, we had 56 Covid-positive patients on our wards, and 13 in ITU. By 22 January 2021, we had 263 Covid-19 positive patients on our wards, and 91 on ITU. The peak of the second wave of Covid-19 was undoubtedly incredibly challenging, but thanks to our detailed preparations and the resilience and commitment of our staff, we were able to respond positively, adjusting our plans as needed.

In March 2021 we were able to start reducing the number of ITU beds we had open (from a high of 129 during the New Year peak). At the time of writing, ITU surge areas have been converted back into ward areas, but we expect to maintain a higher number of ITU beds going forward, and as part of business as usual.

Priority two: We will keep staff safe, and invest in their health and wellbeing

As referenced above, by the end of the second Covid wave, our staff had been working in a very difficult environment for almost a year, including some being redeployed to different clinical areas, and others continuing to run our emergency and many other retained services throughout the period.

In planning for winter 2020, we made the health and wellbeing of staff one of the priorities in our Care objective and held several events to gather views on the key lessons from the first wave of Covid-19 in relation to their wellbeing. One of the resulting major themes was a request to invest in additional counsellors as part of our staff support service. Other initiatives we put into place to prioritise the health and wellbeing of staff included increased recruitment, especially in our acute medicine and intensive care units; training and development to aid redeployment; continued operation of wellbeing hubs; and targeted campaigns for staff around staying well and accessing support. In January 2021, Tim Wright was appointed as our non-executive lead for health and wellbeing, a role set out on the NHS People Plan. You can read more detail about the Trust's provision for staff health and wellbeing in the Staff Report section.

As of March 2021, the Trust's Staff Support and Wellbeing Forum, in conjunction with our organisational development team, are building a Trust-wide recovery plan to ensure staff continue to be supported as the second Covid-19 surge eases and as they begin to decompress. This includes providing 1:1 counselling for all staff, providing tailored guidance to line managers on supporting their teams through recovery, and introducing initiatives to reward and thank staff for their contribution throughout the pandemic so far.

Health and wellbeing for Black, Asian, and Minority Ethnic (BAME) staff

During the first Covid-19 wave, one of the biggest challenges faced nationally and at St George's was the impact of Covid-19 on BAME groups and the injustice some BAME staff members experienced in the way they were treated by their colleagues, and the increased risk they faced in the workplace compared to other staff groups. In response, and at the peak of the first wave, we held a series of BAME listening events and, as a result, developed a new Diversity and Inclusion Action Plan. You can read about this in detail, plus the progress we are making, in the Staff Report section.

We are also encouraging our BAME staff to raise issues around racial discrimination by holding structured and facilitated discussions on race, providing several routes to raise concerns anonymously, including through our Freedom to Speak Up Guardian. We have been supporting our BAME network to hold regular meetings, so that we can agree our priorities for improvement together and become a Trust where everyone is treated equally, all of the time.

Covid-19 risk assessments

In June 2020, we implemented risk assessments for everyone working at St George's to ascertain the impact of Covid-19 on staff, which individuals are at greater risk or more vulnerable to infection, and what additional measures we may need to put in place to support people as a result. This has become embedded into the Trust, with assessments reviewed regularly and undertaken for new starters. It is an especially important tool to assist us in counteracting the risks of Covid-19 that some staff groups face.

As of the end of March 2021, more than 70% of Trust staff have attended the Covid-19 vaccination clinic at St George's for their first dose. This is in addition to us vaccinating 86% of our frontline staff against flu during the period. We have launched a campaign to encourage staff to get their Covid-19 vaccine, with targeted communications to engage our BAME staff, where take-up is lower – and encourage managers to talk to staff who are hesitant or unsure.

Priority three: We will provide routine and planned care, and keep patients safe during their stay

As well as introducing measures to help keep staff safe, we have worked hard to make sure patients are safe during their hospital stay, and get the care they need – and this forms the last of the priorities under our Care objective.

We have been focussed at all times on maintaining high infection prevention and control standards across our services. We know that the potential for nosocomial infections is high and have fully implemented the London Infection Prevention guidelines and national operating framework, including the screening of patients for Covid-19 on admission, day 3, and day 7 of admission. We also segmented our patient pathways as far as possible and colour coded our wards and areas to indicate risk status, ranging from super green (14 days shielded and Covid-19 negative) to blue (Covid-19 positive). You can read more about infection prevention and control in the Quality Report.

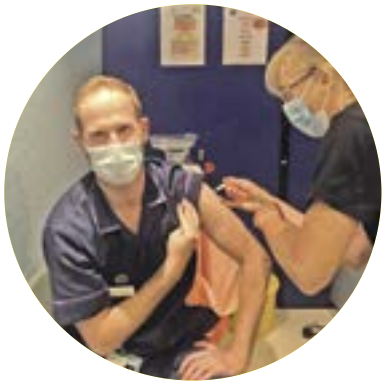
Accessing care safely

During the winter period we introduced some changes to the way we provide emergency care at both St George's and Queen Mary's hospitals. For example, our Emergency Department (ED) became a pilot site for 111 First, designed to help manage capacity in the department, and further prevent the spread of Covid-19 and flu.

In December 2020, a new Enhanced Primary Care Hub was opened at Queen Mary's Hospital with support from St George's, which provides urgent and routine appointments for local people. This is particularly important given the decision we made with our commissioners in March 2020 to temporarily close the Urgent Treatment Centre at Queen Mary's as the facility didn't provide enough space for staff to separate walk-in patients with Covid-19 from others using the service.

At the start of February 2021, our Emergency Department's new front of house triage entrance officially opened. The redesigned layout helps with patient flow, but also keeps staff and patients safe, and reduces the risk of Covid-19 infection. Improvements include a new covered entrance with space to maintain social distancing, a new check-in and streaming area, and enclosed bays and cubicles.

The improved resilience of the department and the hard work of our ED teams has led to instances of St George's being the top performing Trust in London for seeing patients within the four-hour target. Despite the challenges of Covid-19, we have been keen to stress that the department is always there for those who need urgent and emergency care.



86%

of staff have been vaccinated against flu

Public vaccination programme

A crucial tool in helping keep patients safe from Covid-19 is vaccination. St George's was one of the very first hospitals in the world to administer the Covid-19 vaccine on 8 December 2020, and our vaccination centre became operational in a very short space of time. At the time of writing, we have vaccinated more than 50,000 members of the public and staff in line with national guidance.

While this was a turning point in the pandemic, we have not become complacent when it comes to the spread of the virus and have continued to do everything we can to keep people safe. To this end, we ran campaigns throughout the year reminding patients, visitors, and staff of the importance of wearing masks, regular hand washing, and observing social distancing at all times.

Providing routine and planned care

Despite the hope that the Covid-19 vaccination brings, it is vital that patients – with or without the virus – are able to receive the care treatment they need.

During the first wave of Covid-19, the majority of elective procedures were suspended as we re-purposed St George's to meet the demands of the pandemic while continuing to provide unplanned and emergency care, as well as outpatient services which took place virtually and face-to-face.

Our Winter Plan set out how we would rise to the capacity challenges of a Covid-19 second wave while also making sure we continued to provide patients with routine care, including planned surgery – reducing or pausing planned care services only during significant surges in Covid-19 or unplanned care demand.

By early December 2020, it was clear that the peak of the second Covid-19 wave was imminent, and by the end of the month, we took the decision to pause the vast majority of non-urgent planned activity until the end of January 2021, with many of our operating theatres closed or re-purposed to allow nursing staff and anaesthetists to be redeployed to support the wards and ITU. As a result, the number of patients waiting more than 52 weeks for treatment has increased.

We continued with the highest priority procedures, and ran a range of retained services including trauma, maternity, neonatal, cancer, stroke, heart attack, paediatrics, imaging, pathology, outpatients, and diagnostics.

Elective recovery plan

As of March 2021, the combined effect of the vaccine rollout and the third national lockdown means we are treating fewer patients with Covid-19 and are restarting as much elective activity as we safely can. Our focus continues to be on treating the highest priority patients who are the most unwell, but some specialties are starting to treat less urgent patients as we open more theatres enabled by the return of staff from ITU redeployment. You can read more about our elective recovery plan further on in this section.

> "Our focus continues to be on treating the highest priority patients who are the most unwell, but some specialties are starting to treat less urgent patients as we open more theatres..."

Learning from Covid-19

Throughout the pandemic, we have sought to understand the impact of Covid-19 and respond in an agile way to ensure we learn from the experience and improve how we respond to future waves of the virus. The development of our winter plan was an example of how we learned from the first phase, as were the steps we put in place to support our staff with their health and wellbeing.

Given the amount that has happened in the last 12 months, however, we also want to ensure we take a systematic approach to learning from Covid-19 – to inform both immediate next steps in managing our response to the virus and our longer-term response to both this and potential future pandemics. Following the second Covid-19 wave, we initiated a detailed piece of work looking at how we can learn from the way we responded to Covid-19. This includes reviewing what has worked well, where we can improve for future waves, and how to use the learning from operational changes during our response to drive quality improvement and transform services.

We have structured this work into four workstreams:

- Resources and wellbeing, which looks at how we can learn the lessons of responding to the pandemic in relation to staff redeployment, staff health and wellbeing, homeworking, staff experience in the workplace.
- Systems and processes, which looks at how we can improve these in the context of greater virtual working and increasing use of electronic over paper-based systems.
- Team working and decision-making, which looks at how we have developed and implemented our operational plans, facilitated clinical leadership, improved rapid decision-making, and communications with staff.

- Infection prevention and control, which looks at how we have sought to minimise the risk of spread of Covid-19 on site, and point of care testing.

Once this work is completed, we will bring the findings to the Trust Board for consideration and engage with our staff to embed the lessons learnt.

Cardiac surgery

Beyond Covid-19, we continue to focus on delivering improvements within our cardiac surgery service at St George's as part of our objective of keeping patients safe during their stay.

In March 2020, NHS England and NHS Improvement published a report by an independent external mortality review chaired by Mr Mike Lewis. The review concluded that there were failings in the care provided to 102 cardiac surgery patients at St George's between April 2013 and December 2018, and that for 67 of these patients these care failings either definitely, most likely or probably contributed to their deaths. The Trust accepted the recommendations of the review at a meeting of the Board of Directors in March 2020, and those of a separate report from the independent scrutiny panel for cardiac surgery at St George's, chaired by Sir Andrew Cash.

Over the past 12 months, we have met many of the families affected, and we will continue to offer them support going forward. Over the past year, we have also focused on implementing the recommendations of the reviews and have made significant progress in doing so. Our work to improve the quality, clinical governance and culture of the service began following the Trust's receipt of the first mortality alert from the National Institute for Cardiovascular Outcomes Research (NICOR) in May 2017. The progress that we have made since then was documented in the Care Quality Commission's most recent inspection report, published in December 2019, which highlighted a number of areas in which the service had improved. We have continued to build on this over the past year, notwithstanding the suspension of cardiac surgery at the Trust during the first and second Covid-19 surges in Spring 2020 and winter 2020/21 in line with the London-wide cardiac surgery plans. The most recent data from NICOR continues to demonstrate that the service is safe, and no longer an outlier for mortality.

The Trust board continued to review cardiac surgery service mortality data on a regular basis throughout 2020/21, and received regular progress reports from the Trust's Chief Medical Officer. Looking ahead to 2021/22, the Board's Quality and Safety Committee will continue to closely monitor the Trust's work to improve the service, and will escalate any issues to the attention of the full Board.

Strengthening our clinical governance

During 2020/21, the Trust continued to implement the recommendations of two clinical governance reviews undertaken and reported to the Board during 2019/20. These reviews focused on mortality and morbidity meetings and multidisciplinary team meetings and the clinical governance capacity at a corporate level. The Quality and Safety Committee of the Board closely monitored the implementation of the recommendations which were agreed by the Board. In addition, in January 2020 the Board commissioned a third clinical governance review focused on the structures of ward to Board reporting on quality and safety. The review was led by Elizabeth Seale, an independent external reviewer who had no existing or previous connection to the Trust, and who also led the first and second clinical governance reviews.

Objective 2: Culture

This objective is about how we make St George's a truly inclusive place to work, where staff feel respected and empowered to deliver high quality care to our patients.

Priority one: We will share the findings of our culture discovery project, so we understand how staff feel about working at St George's

Although our focus in recent months has been on caring for patients and supporting staff through the second wave of the Covid-19 pandemic, we have continued to make progress with a strengthening culture project that we launched in January 2020, although we have adjusted the pace of the programme to ensure it will effectively deliver for the long-term. Its aim is to help us build a positive culture at St George's; one that enables our teams provide quality care, in an environment that challenges discrimination in all its forms and helps make the Trust an enjoyable place to work.

Below is a summary of the work, but you can read about it in more detail in the Staff Report section. The initial phase of this project involved a group of culture champions interviewing and surveying staff and using patient feedback to discover what our culture is at present. In November 2020, we published the detailed findings of this discovery stage, which were grouped into six themes for improvement, including clearer decision-making, investment in leadership, and a focus on innovation and teamwork. These themes will be used to identify opportunities and challenges that we need to address in future phases of the project, which you can read more about below.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

NOVEMBER 2020 – SUMMARY REPORT

Our Culture

What you told us, and how you can help

We recently embarked on an exciting new project to improve the culture of our organisation, so it becomes a better place to work, and to be treated.

Many of us love St George's, but we know our culture can sometimes make our working lives difficult; from how we treat each other, to challenges we face when trying to make changes or introducing improvements.

Over the past six months, our culture champions have taken time out of their busy day jobs at the Trust to meet, interview and survey staff, to discover what our culture is. The next stage is sharing these findings with you, and shaping jointly what we do next.

This month, we've published the detailed findings of our 'culture discovery' – and you can access this via our intranet. Go to '**Culture change programme – 2020**' tab on the right hand side of the intranet homepage.

However, we know how busy you are, so this document summarises what you and our patients told our culture champions. It also sets out what happens next, and how you can help.

Staff feel proud to work at St George's – but we know there is more we can do

Who we spoke to

- We held over 30 focus groups with staff
- Over 25 of our senior clinicians and managers were interviewed; including Trust Board members
- More than 500 staff completed an online survey
- We also used data from a range of other sources; including the NHS Staff survey.
- We also used feedback from patients; e.g. the NHS Friends and Family test.

What you told us

We are grateful to all staff for sharing such honest feedback, and for helping us understand our organisational culture better. Here, we have summarised the key findings, but please log onto our intranet homepage to access the full, detailed document if you wish to.

Staff on the helipad celebrating Clap for Carers

excellent
kind
responsible
respectful

Priority two: We will develop a plan with staff to improve our culture, and measure the impact it is having

The next stage of our culture improvement project is to clearly define the culture we want to create, and take steps to establish it. Staff were asked if they recognised the six themes that came out of the discovery phase, and if not, what we should focus on to make St George's a great organisation to work in and be associated with. We set out our priorities in a paper presented to the Board in May 2021, and progress will be monitored by our Culture, Diversity and Inclusion Programme Board which had an initial meeting in January 2021.

This culture work links closely to how we respond to the results of the latest annual NHS Staff Survey published in March 2021 where staff told us about their experience of working at the Trust. Overall, the results were positive, and show we are heading in the right direction, although there is more to do in order to make St George's an outstanding place to work. You can read more detail on our Staff Survey results in the Staff report section.

At the end of March 2021 we ran a series of virtual interactive sessions with staff to inform our 'big five' key priorities for improvement for the coming year in relation to the NHS staff survey results, and these, in turn, will feed into our wider culture improvement project. You can also read more about this in the Staff report section.

Priority three: We will celebrate diversity, and support our leaders to be more inclusive

We are working towards our aim of ensuring all staff have a great experience of working at St George's, with every opportunity to develop and thrive in their roles.

Diversity and Inclusion Action Plan

To this end, in July 2020 our Trust Board approved a Diversity and Inclusion Action Plan drafted in response to issues raised by staff – particularly staff from BAME backgrounds – through a variety of events and engagement sessions. The scope of the plan covers diversity and inclusion in the broadest since, and includes actions to ensure appropriate action is taken in relation to all protected characteristics. Many of the specific actions in the plan range from improving the career progression and development opportunities of BAME staff, to changing behaviours and building awareness and understanding. The plan's indicators also triangulate to the NHS Equality Delivery System (EDS2) and our public sector equality duties.

You can read more detail on progress with our Diversity and Inclusion Plan in the Staff Report section, but progress to date includes making our recruitment processes fairer with the requirement for all Band 8A roles and above to have a Recruitment Inclusion Specialist (RIS) on the interview panel, which we hope will support more inclusive recruitment across the organisation, particularly into leadership roles where diversity and representation is poor. We also created a training session tailored to St George's about challenging our unconscious biases which can influence decisions in recruitment and staff development, leading to a less diverse workforce. In August 2020, we launched a toolkit which encourages open and honest conversations among teams about matters of race and inclusion.

There is more to do to make St George's truly inclusive, but the Board is committed to driving change in this area, and this will continue to be a key priority in 2021/22. The Workforce Race Equality Standard (WRES) provides the Trust with a baseline to demonstrate progress against nine indicators of staff experience. You can read more about the WRES in the Staff report section.

Celebrating diversity

In parallel with the development of the Diversity and Inclusion Action Plan, we have continued to hold events to celebrate the diversity of our staff – albeit in different ways from usual given the restrictions Covid-19 has presented on events and gatherings. This year – with the help of our four staff networks (BAME; Disability and Wellbeing; LGBTQ+; and Women's) – we have marked Black History Month; International Day of People With Disabilities; Freedom to Speak Up Month; International Women's Day; Chanukah; and LGBTQ+ History Month.

You can read more detail about what we have done in the past year to promote and celebrate diversity and inclusion in the Staff report section.

Equality of service delivery to different groups

Alongside our efforts to make the Trust a more inclusive place to work for our staff, we have also continued to focus on equality of service delivery to different groups. In January 2020, the Trust Board approved our Quality and Safety Strategy for 2020 - 2024. One of the seven objectives of the strategy was to provide patients with equitable access and quality by proactively improving access and care for vulnerable groups. The Trust serves a diverse population and we want our patients and communities to have equal access to our services which, despite our best efforts, we do not always manage to achieve. As part of our strategy, we committed to improving our use of data to understand where issues with patient access exist and utilise this to optimise equitable provision. As part of this, we set as a goal increasing patient participation, including dedicated initiatives to engage with our seldom heard patient groups. A further goal was focusing on improving the experiences of care to our most vulnerable patients and their carers, including children, our homeless patients and those living with dementia, learning disabilities and mental health issues. To understand whether we were succeeding in our goals, we said that we would be successful in our task if we reduced incidents relating to patient access to care and reduce avoidable incidents in vulnerable patient groups. In 2020/21, we have undertaken benchmarking against national standards for patients with learning disabilities, and together with South West London and St George's Mental Health NHS Trust we have started to develop an integrated education and training framework for our staff to support the care and treatment of mental health patients in an acute setting. Our work to promote greater equality of access, however, was impacted by the operational demands of Covid-19, and progressing this important area will be a key focus in the coming year.

> "...we set as a goal increasing patient participation, including dedicated initiatives to engage with our seldom heard patient groups."

Objective 3: Collaboration

Only by working more closely together can the NHS best tackle the challenges we face and provide the best care for our patients. Responding to Covid-19 has demonstrated the importance of cross-system working with our partners, and this objective is about continuing to collaborate to shape a system that's better able to meet the needs of the communities we serve.

Priority one: We will work more closely with local hospitals and partner organisations in south west London

Working with our local partners

In April 2020, the South West London Health and Care Partnership – made up of NHS providers, local authorities, Healthwatch and voluntary organisations – was formally awarded Integrated Care System (ICS) status. This status recognises the strength of the partnership, the shared ambition for the six boroughs involved, and the progress it has made to deliver better outcomes for local people.

Throughout the year St George's has continued to work as a key partner within the system. You can read more about this and our other key partnerships in the Accountability Report section.

Integrating care

This model of care may soon become the norm. In February 2021, the Government published a White Paper called 'Innovation and integration: working together to improve health and social care for all'. It included proposals for NHS and social care reform, with a strong focus on collaboration between the NHS, local government, and delivery partners. This would mean legislating for every part of England to be covered by an ICS, changing current commissioning functions. This has implications for our local NHS, but given the way we have worked so collaboratively in recent months, the changes have the potential to benefit both local patients and staff.

An example of this joint working in action is the new South West London Procurement Partnership, launched on 1 April 2021. It is a new single procurement function for the four acute south west London Trusts – St George's, Croydon, Epsom and St Helier, and Kingston, with St George's as the host Trust. Bringing our teams together is a good way for us to provide the best service we can to the people of south west London, providing consistency across the system. This is a similar model to the award-winning South West London Recruitment Hub, which has been in operation since October 2020 and helps support the region's workforce needs.

Collaboration with Epsom and St Helier University Hospitals NHS Trust

On the theme of collaboration, we continue to work closely with our colleagues at Epsom and St Helier. Arlene Wellman, Chief Nurse and Director of Infection Prevention and Control for that Trust, agreed to work with us from October 2020 to begin to explore and develop the nursing, midwifery, and allied health professional contribution to this joint-working. There are real advantages and opportunities to further exploring collaboration with Epsom and St Helier, and this has been evident throughout the Covid-19 pandemic – but also in recent work we have started together on developing renal services across both organisations. Gillian Norton has been Chairman of both St George's and Epsom and St Helier since October 2019, and we already have many staff working in a number of services across both Trusts.

Priority two: We will overcome challenges together, rather than as individual organisations

Partnership working was strengthened during the first wave of Covid-19, and mutual aid and support continued to prove vital as we faced and dealt with the effects of wave two.

Intensive care capacity

An example of this was the designation of St George's as the intensive care unit (ITU) centre for the south west London system, being the first provider to scale up capacity for the most unwell, and the last to scale back down. This flexible and collaborative approach highlighted the benefits of removing the traditional barriers that exist between organisations for the benefit of local patients.

Long-term effects of Covid-19

Collaboration will also help the many patients in the region who are suffering the debilitating effects of 'long Covid'. St George's has been designated one of 40 sites nationally to host a Post Covid Specialist Assessment Clinic, to be operational from late spring 2021. This is in partnership with other providers in south west London who will play key roles in the service through local primary care, social prescribing, psychological therapies, and social care support.

Elective care challenge

Another example of partnership working is how have been delivering the elective activity

that we suspended as a result of Covid-19 – with a particular focus on reducing the number of patients waiting over 52 weeks for treatment. Our own teams are working hard on this elective recovery plan, but we are also working closely with other hospitals in south west London to ensure a co-ordinated response to this challenge – and many patients previously under our care have had their operations carried out at Croydon and Kingston hospitals in recent weeks.

Similarly, in February 2021 it was announced that four mobile day-surgery theatres will open on our Queen Mary's Hospital site from June 2021 to tackle the longer waiting times for routine operations and procedures due to Covid-19. These will be staffed and run by St George's, but will enable surgical teams – from St George's and other local Trusts – to carry out many extra operations.

As well as expertise, leadership from St George's will also play a part in the recovery of the local health care system.

> "St George's has been designated one of 40 sites nationally to host a Post Covid Specialist Assessment Clinic..."

In November 2020, our Chief Executive Jacqueline Totterdell was appointed Senior Responsible Officer for planned care, ITU, diagnostic and outpatient transformation programmes for south west London, and she is also regional lead for outpatient transformation across the whole of London. This work will involve building on the changes brought about at pace as a result of Covid-19, using innovations and new ways of working.

Objective three: We will work with St George's, University of London to build our research, training, and teaching expertise

This objective is about our key partnership with St George's, University of London, and how it enables us to work together on fundamental, translational, and clinical research for the benefit of our patients. As one of London's teaching hospitals, we also work together with the university to help train the clinicians of the future and offer innovative education.

Covid-19 studies and clinical trials

St George's has a proud history of being at the forefront of medical developments, and this has continued throughout the pandemic. Together with St George's, University of London, our teams are helping to further the knowledge of Covid-19 through ground-breaking research and clinical trials.

More than 50 Covid-19 studies have been approved at the Trust. These include the initial investigation of a possible vaccine, understanding whether pregnant women can pass Covid-19 onto their babies, research into immunity and reinfection, and assessing the efficacy of the Novovax vaccine. We were also one of eight sites in the UK to take part in a world-first vaccine trial that will examine the effectiveness of mixing different approved vaccines for the two doses.

Translational and Clinical Research Institute

Outside of Covid-19, in December 2020 we launched the Translational and Clinical Research Institute (TACRI).

The new virtual institute, with strong support from St George's, University of London, forms a key part of the Trust's five-year research strategy published in 2019. The institute was set up to provide a structure for clinical researchers (including nurses, midwives, doctors, and allied health professionals) to collaborate across Trust specialties and with the University.

TACRI will foster joint working and the development of research interests, skills, and careers, and break down barriers between the Trust and University. Investment in the institute includes a full-time manager who started in post in January 2021.

Building on our training and teaching expertise

St George's is globally renowned as a centre of excellence and one of the UK's largest teaching hospitals. Our staff are our most valuable asset, and as a learning organisation, we want to nurture talent and inspire our staff to reach for excellence.

We partner with St George's, University of London on a variety of courses and educational programmes, ranging from undergraduate to postgraduate training in many clinical specialities to less formal training opportunities. Due to our focus on responding to Covid-19 throughout the past year, most non-essential courses were suspended. However, at the time of writing this report, these are beginning to be re-started and we can continue collaborating to offer opportunities for education and research that support excellent patient care.

You can read about St George's has provided innovative training to help staff respond to the pandemic in the Staff report section.

Our objectives for 2021/22

In March 2021, NHS England published its priorities for the NHS for the coming year, and these included supporting the health and wellbeing of staff, building on what was learned during the pandemic to transform the delivery of services, and the continuation of working collaboratively across systems.

Despite the hope that any future waves of Covid-19 will be easier to manage, planning for the next year will be challenging. Our objectives have to take account of the need to restore services, meet new care demands, and reduce the care backlogs that are a direct consequence of the pandemic, while supporting staff recovery and taking further steps to address inequalities in patient access, experience and outcomes. We are working with staff to finalise our corporate objectives for 2021/22, aligning them with plans for the wider NHS and the aims set out in our five-year clinical strategy. In the meantime, we have carried over our updated objectives from 2020/21.

Major risks to Trust's objectives

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

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

In 2020/21, we undertook a major refresh of our Board Assurance Framework. We reviewed the key risks to the delivery of the Trust's strategic objectives and defined ten strategic risks facing the organisation. We aligned these both to our ongoing strategic objectives and to our newly defined corporate objectives. In the context of the Covid-19 pandemic, the Board considered whether to include on the BAF a specific Covid-19 risk, however on balance the Board considered that the pandemic had an impact across all of the current strategic risks and decided to monitor the impact of Covid-19 against each strategic risk. In addition, we reviewed our approach to the information contained within the BAF, to ensure it became an effective tool for providing assurance to the Board. This included setting out the key controls the Trust has in place to manage these risks, identifying the key sources of assurance already in place alongside the remaining gaps in control and assurance. We plotted the actions needed to address these gaps and ensured that our BAF linked to both the key performance monitored by the Board and to our work on horizon scanning to identify emerging risks to the Trust and plan mitigating actions.

> "In 2020/21, we undertook a major refresh of our Board Assurance Framework."

The ten strategic risks on the BAF in 2020/21, grouped by our 2020/21 corporate objectives, were:

1. Care:

- Our patients do not receive safe and effective care build around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation.
- We are unable to provide outstanding care as a result of weaknesses in our clinical governance.
- Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives.
- We are unable to provide a safe environment for our patients and staff, and to support the transformation of services, due to the poor condition of our estate.

2. Culture:

- We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best.
- We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain and modern and flexible workforce and build the leadership we need at all levels.

3. Collaboration:

- As part of our local Integrated Care System (ICS), we fail to deliver the fundamental changes necessary to transform and integrate services for patients in south west London.
- We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to release wider efficiency opportunities.
- We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds.
- Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.

Strategic risks on the Board Assurance Framework are assigned to Committees of the Board which provide oversight of the risks and actions being taken to mitigate them. The Committees report on their role in overseeing the risks assigned to them in their reports to the Board. In 2020/21 the Board directly oversaw one strategic risk – working as part of our ICS to transform care for patients across south west London. The Board received the full BAF at its public meetings on a quarterly basis throughout 2020/21.

Further information about the strategic and organisational risks, and the Trust's approach to managing and mitigating these are set out in the Annual Governance Statement.

Performance report: Financial analysis

During the financial year 2020/21, the Trust exited financial special measures following the endorsement of NHS Improvement (NHSI). This was owing to sustained improvement in financial performance, having achieved an adjusted financial performance of £13.3m deficit in 2019/20 and an expected breakeven position in 2020/21.

For 2020/21, the Trust developed a plan to reduce its deficit to breakeven, which was achieved, albeit with a control total adjustment for annual leave of £3.1m. Actual performance for the year was a deficit of £3.1m representing an improvement on 2019/20 of £10.2m. The financial plan shown in the tables is a deficit of £11.1m, which excluded a Non NHS income top-up of £13.0m, and block income reduction of £1.9m (hence an adjusted plan of breakeven).

St George's did not formally deliver a Cost Improvement Plan (CIP) owing to the demands of the Covid-19 pandemic in 2020/21, nor was one planned for following the adjusted financial regime agreed nationally by NHS England and NHS Improvement at the start of the financial year. Covid block contracts and top-ups

The Trust did not receive funding from PSF/FRF or MRET as per 2019/20 as the financial architecture changed owing to the pandemic. The Trust instead received block contract funding from its main commissioners in the financial year, and for M1-6, a retrospective top-up to breakeven the financial position. From M7 onwards this changed, as a Covid top-up was fixed at £24.7m and the Trust was able to deliver expenditure within this envelope (subject to the allowance for annual leave accrual of £3.1m). Performance against plan

Delivering the 2020/21 financial plan was achieved through regular monitoring of Covid and non-Covid expenditure as the Trust moved through the various waves of the pandemic. The security of having (largely) predetermined income allowed the Trust to focus efforts on cost control, while the suspension of portions of elective activity led to significant underspends in clinical consumables. The Trust did incur significant extra cost in socially distanced transport costs and more intense cleaning costs associated with Covid-19.

Capital expenditure

The Trust spent £98.6m of capital in 2020/21. This was funded from internally generated funds, Covid-19 funding and additional one-off funding. The capital funds available to us were used to support ongoing investment in IT, our estate and medical equipment. This level of funds meant that the Trust was able to address a full investment programme.

Finance leases

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

During 2020/21 we took out new finance leases with various leasing companies for equipment with a capital value of approximately £2.8m.

Cash flow

We began the financial year with £3.4m of cash and cash equivalents. During the year, cash balances increased to £36.6m. This significant increase in cash balance is due to the rise in capital creditors as we received funding from DHSC in the last quarter and these invoices will be paid in April 21/22.

Financial performance against plan

	2020/21 Actual £ millions	2020/21 Plan £ millions	Variance £ millions
Total income excluding capital & PSF	973.7	917.1	56.6
Expenditure excluding donated	-1,039.8	-973.5	-66.3
Adjusted financial performance	**-66.0**	**-56.3**	**-9.7**
Capital donations/depreciation	4.3	-0.7	5.0
PSF/FRF/MRET/top-up	62.9	45.2	17.7
Surplus deficit including PSF/FRF/MRET/top-up	**1.3**	**-11.8**	**13.1**
Adjusted financial performance incl PSF/FRF/MRET/top-up	**-3.1**	**-11.1**	**8.1**

Financial performance comparison

	2020/21 Actual £ millions	2019/20 Actual £ millions	Change £ millions
Total income excluding capital & PSF	973.7	871.0	102.7
Expenditure excluding donated	-1,039.8	-919.0	-120.8
Adjusted financial performance	**-66.0**	**-48.0**	**-18.0**
Capital donations/depreciation	4.3	0.2	4.1
PSF/FRF/MRET/top-up	62.9	34.7	28.2
Surplus deficit including PSF/FRF/MRET/top-up	**1.3**	**-13.1**	**14.4**
Adjusted financial performance incl PSF/FRF/MRET/top-up	**-3.1**	**-13.3**	**10.2**

Cash flow

	2020/21 £ million	2019/20 £ million
Operating surplus/deficit before finance and other costs	13.9	-1.4
Add back non-cash and expense	23.3	22.8
Increase/decrease in operating activities	27.6	-23.6
Net cash generated from operating activities	**64.8**	-2.2
Net cash generated from investing activities	-82.1	-34.4
Net cash generated from financing activities	50.4	36.8
Net increase / decrease in cash	33.1	0.2
Total Cash and equivalents at 31 March	36.5	3.4

Charitable funding

We received £0.3m from charitable sources during the year, principally from St George's Hospital Charity. However, the Trust also received £5.2m of donated equipment from the Department of Health due to Covid-19.

Private Finance Initiative

We entered into a Private Finance Initiative (PFI) contract in March 2000 for the exclusive use of Atkinson Morley Wing on the St George's Hospital site over a 35-year term. The capital value of the building is approximately £51.8m. All of these loans are included within borrowings in the statement of financial position within the accounts, included separately in this annual report.

Revaluation of land and buildings

As part of the preparation of the annual accounts, we are required to assess the value of our land and buildings. This exercise is carried out at the end of each financial year. The annual revaluation has led to a £31.5 million reduction in value of some buildings.

This is a reflection of changes in the basis of the valuation. The valuer has to assess operational properties by reference to the cost of providing a 'modern equivalent asset', this by definition creates a 'ceiling' value beyond which it would not be possible to go, no matter how much might be expended on an asset. This decrease was not included in the plan and represents a technical accounting adjustment.

External audit services

Grant Thornton received £112,500 in audit fees in relation to the statutory audit of the Trust to 31 March 2021.

Events since the end of the financial year

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

Contracts with commissioners

The financial performance regime for H1 (M1-6) 21/22 mirrors the guidance from H2 20/21. Guidance from NHS England and NHS Improvement (NHSE&I) is that Trusts will be funded through block contracts with cost and volume adjustments for items such as high cost drugs/devices and Covid-19 testing/vaccination. At the time of writing, the material risks for the Trust come from shortfalls in non-NHS Income as yet unconfirmed to be funded fully (in the same way as 2020/21) and additional post EBITDA costs from additional depreciation on new assets and additional PDC cost. Central funding provided is calculated so that sectors and Trusts can break even after the impact of inflation, with a small efficiency requirement based off Q3 20/21.

Processes to manage cash and working capital

The Trust has accurate and clear cash forecasting and collection processes, an achievable aged debt recovery plan, clear payments processes for creditors, and ensure we manage stock holdings to agreed levels.

Capital planning

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

- the urgent need for stabilising and upgrading IT infrastructure, estates infrastructure, and theatres
- increasing diagnostic capacity and upgrades
- maintaining our infrastructure to ensure we provide safe, compliant services
- the need to invest capital and revenue in service transformation that will drive change and more efficient ways of working both internally and with partners (e.g. as part of the South West London Health and Care Partnership)
- investment in digital transformation and analytical capacity.

Procurement

This year has been very different for procurement and the service it has needed to provide.

The focus of procurement in 2020/2021 has been split over the following main areas:

- **Personal protective equipment (PPE) and intensive care unit (ITU) consumables:** Ensuring that not only our staff, but also contractors and suppliers to the Trust have PPE of adequate quality and sufficient quantity. This also extended to hosting the consolidation centre for mutual aid PPE provision to all providers of care in partnership with the other acute Trusts in south west London. This included the central management of ITU consumable provision and any other supply disruption.

- **Commercial management and savings:** Ensuring the Trust was not adversely affected in its pricing by the reduction in activity within volume-based contracts and holding pricing, and this included working with the national supply chain teams where relevant. In addition, we conducted contract negotiations where needed, and maintained procurement activity where required.

- **Improving data quality and systems:** The Inventory Management System has continued to be rolled out across the Trust. This enables more efficient identification of cost improvement opportunities or for commercial advantage.

- **Collaboration:** Working with other acute Trusts across south west London, and strengthening collaborative and joint working, including shaping the future strategy and operating model of procurement across the sector. In addition, we have supported in shaping the national strategy with partners at NHS Supply Chain. A new single procurement function for the four acute south west London Trusts went live on 1 April 2021, hosted by St George's – merging the other teams into a single central service.

Cost Improvement Programme (CIP) 2021/22

CIPs are expected to be required in the 2021/22 financial year although this process will likely commence later in the financial year, assuming no further Covid-19 surge.

Political and charitable donations

We have not made any political or charitable donations during 2020/21.

Countering fraud and corruption

We have a counter fraud and corruption policy. Counter fraud arrangements are reviewed during the year by the Local Counter Fraud Specialist (LCFS). The LCFS undertakes an ongoing programme of work to raise the profile of counter fraud measures and carries out ad hoc audits and specific investigations of any reported alleged frauds. This includes the use of fraud awareness presentations and fraud awareness surveys. The Audit Committee receives and approves the Counter Fraud Annual Report, monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

Transactions with related parties

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

Remuneration of senior managers

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

Anti-bribery and fraud policies and issues

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

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

Statement of going concern

These accounts have been prepared on a going concern basis. IAS 1 has been adapted for the public sector in that accounts are prepared on going concern basis if services will continue. The Trust incurred a deficit of £3.1m for the year ended 31 March 2021 (after adjusting for donated capital income and donated depreciation.) The 2021/22 plan is for a £1.2m deficit financial deficit 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.

The Trust loans were converted to PDC in 20/21 Total loan value converted was £51.6m for Capital Loan and £273.4 million for Working Capital, a total of £325m. This will attract the PDC charge of 3.5%. The Trust is not expecting to borrow any interim revenue support loans in 2021/22.

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.

Performance report: Environmental analysis

In Autumn 2020, the NHS launched its commitment to delivering a 'net zero' health service, recognising that climate change has direct consequences for patients, the public, and the NHS as a whole.

St George's is committed to delivering our contribution to the net zero plan, and adopting the broader principles of sustainable development. In April 2021 we published our Green Plan which, in tandem with our new Estates Strategy, will help us identify carbon, financial, and waste savings as we look to grow and improve our estate. Key commitments and targets are set out below.

- To align to the NHS net zero carbon pledge and become net zero carbon by 2040.
- To align to the London Plan, in particular to its Circular Economy principles.
- To undertake audits of our green spaces and biodiversity, travel plans, digital infrastructure, and wellbeing strategies by 2025.
- Develop a Climate Change Adaptation Plan (CCAP).
- To switch our electricity to green energy providers by the end of 2021.

An annual progress review will be provided to Trust Board to ensure that implementation is on track.
Energy usage

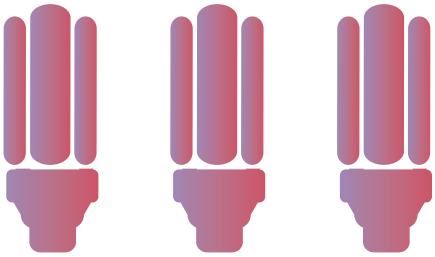
In 2020/21 the Trust's electricity and gas costs were £4.25m, which was a decrease of £746,000 in comparison to 2019/20. Across our sites, there was a drop in consumption of gas and electricity utilities by 17% this year. These financial savings come from optimised operation of the boiler house, and the Covid-19 pandemic has lowered consumptions of utilities by approximately 17.7 million kWh– even after increasing operations to six days-a-week.

The Trust produced more than 37 million kWh of electricity, 1.9 million kWh of which we exported back to the national grid, contributing towards the combined energy savings of £1m for the year. We are also on track to reduce our emissions to net zero by 2040 to meet national demands.

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

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

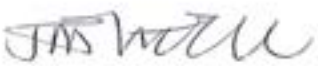
We are continuously developing and upgrading our facilities to suit growing demands. We have further improved our existing heating infrastructure by upgrading and replacing old and inefficient heat exchangers, and through a higher utilisation of the available low temperature hot water from the CHPs.



50% of our StGeorge's Hospital site has LED lighting installed so far

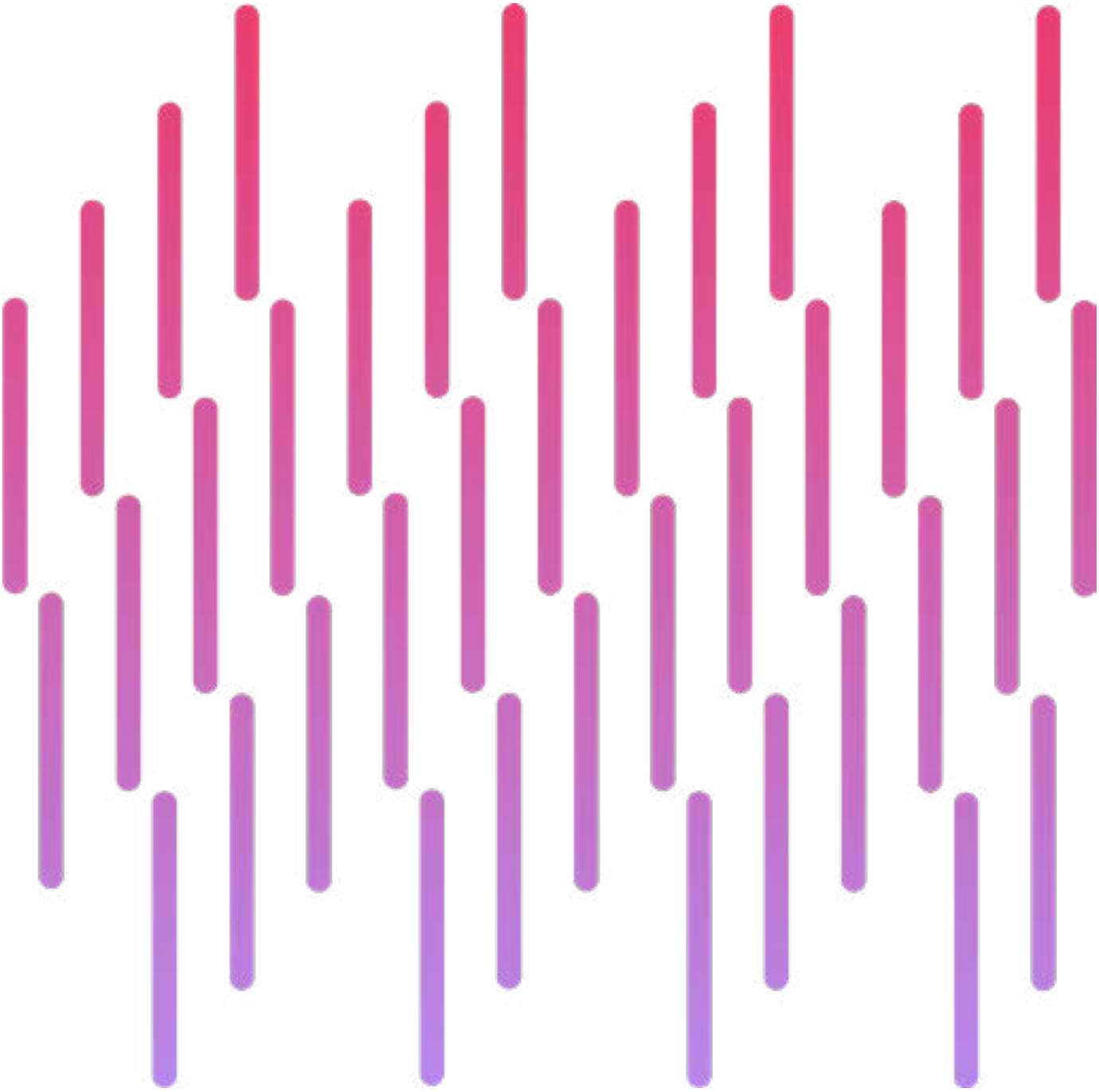
We are on course with the installation of LED lighting across the hospital, which to date covers approximately 50% of our St George's Hospital site. Our Green Plan will ensure all new projects are sustainable, and require input from the Trust's energy and sustainability manager. This should assist us in remaining on course towards our net zero target.

Finally, we are in the process of establishing sustainability champions across the Trust who will ensure suggestions to reduce our impact on the environment are captured and fed through to our wider sustainability team and up to our senior leaders.



Jacqueline Totterdell
Chief Executive
24 June 2021

Accountability report



Accountability report: Directors' report

Delivering outstanding care, every time

Our vision is to provide outstanding care, every time for our patients, staff, and the communities we serve. It reflects our commitment to continually improve the quality of care we provide, achieve financial sustainability, and ensure that care is delivered to our patients by an engaged, empowered and highly skilled workforce. While the past year has naturally been dominated by the Covid-19 pandemic, and by keeping our patients and staff safe, we remain committed to delivering on our strategic priorities.

As well as guiding the organisation in achieving this ambition, the Board ensures the Trust upholds the qualities that make the NHS what it is, while also adapting to a period of significant social, demographic and technological change. The NHS Long Term Plan re-set accepted norms in healthcare delivery, and the Trust's strategic priorities take account of this national agenda to give patients greater access to personalised care and treatment. At the same time, the Covid-19 pandemic has reinforced the importance of effective collaboration across local health care systems, and has created new opportunities for redesigning services for the benefit of patients and communities.

The most acute challenges facing the Trust in the short term stem from managing the impact of the Covid-19 pandemic on our patients and our staff; keeping our patients and staff safe, and ensuring we are able to care effectively for both Covid-19 and non-Covid patients. We are pleased that over the past year, the Trust has been removed from both quality and financial special measures, in March 2020 and December 2020 respectively. This highlights the hard work and dedication of staff across the organisation. At the same time, we know we have some way to go before we can realise our vision of delivering outstanding care, every time to our patients, staff and the communities we serve. We know we need to improve our operational performance, particularly in relation to the impact of the pandemic on elective care. We need to implement our plans to strengthen our clinical governance, invest more in improving our estates and IT infrastructure, and deliver the changes to strengthen our organisational culture.

Leadership through strategic direction

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

Our five-year strategy – Delivering outstanding care, every time – was published in April 2019. It is founded on four key priorities: providing strong foundations; delivering excellent local services; closer collaboration; and offering leading specialist healthcare. While our immediate priority over the past year has been on keeping our patients and staff safe and responding to the Covid-19 pandemic, these remain the overarching priorities that will drive the focus of the Board, and inform the key decisions we make.

During 2019/20, the Board agreed a number of supporting strategies to help us make these priorities a reality. These supporting strategies cover research; digital; workforce; education; quality and safety; and outpatients; with an estates strategy also being developed. During 2020/21, we have focused on implementing these supporting strategies. The pandemic has had conflicting impacts on this; in some areas impacting negatively on progress while in others, such as outpatients and digital, serving to escalate the pace of change radically.

At the same time, we recognise the challenges of turning both the NHS Long Term Plan and our own strategy into reality. Many of the long-standing issues we face – including our aging estate at St George's Hospital, and fragile information technology infrastructure cannot be solved

quickly; and the delivery of our supporting strategies will be dependent on our ability to target investment in key aspects of patient care.

The Trust Board is confident that all directors are appropriately qualified to discharge their functions effectively, including monitoring and managing performance, and ensuring management capacity and capability. Both the Board selection process and the Board Development Programme are in place to ensure that the Directors and Non-Executive Directors have the skills and experience necessary to deliver the Trust's vision and strategic objectives.

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

Our regulatory position

During 2020/21, the Care Quality Commission (CQC) has modified its approach to overseeing providers in recognition of the extraordinary challenges of responding to the Covid-19 pandemic. The Trust, like other provider organisations, has not received a CQC inspection during the past year, though we continue to work closely with the CQC to ensure safe and effective care for our patients.

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

The CQC found 'significant improvements' in many services across the Trust, in particular, services for children and young people which were rated Outstanding. Surgery at St George's improved its overall rating to Good. Our outpatient service – a key focus area for the organisation in recent years – improved its rating to Good for safety and Requires Improvement for well-led.

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

As well as areas of good practice, the CQC also identified some areas for improvement – including making sure patient records are stored securely, and that patient consent is effectively documented. The Trust developed responses to two requirement notices and submitted these to the CQC, as required, in January 2020.

A wider plan to address areas for improvement was developed and put into action, with close oversight from the Board's Quality and Safety Committee. During 2020/21 the Committee has overseen the implementation of the action plan and, as at May 2021, we are in a position where 40 of the 46 actions have been completed, with the remaining six incorporated into business as usual activity.

You can access the CQC's full report here: https://www.cqc.org.uk/location/RJ701#accordion-1

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

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

Since we reset our approach to patient involvement at St George's in 2018, our Patient Partnership and Experience Group has continued to help us focus on the principles and benefits of patients working as partners with the Trust. The past year, however, has been a challenging one in the context of the restrictions on social interaction as a result of the Covid-19 pandemic. Our Patient Partnership and Engagement Group paused its activity during the first Covid-19 surge and has since resumed its meetings virtually.

Examples of patient engagement during the year include:

- review of the questions in our complaints satisfaction survey, so that we are getting meaningful feedback from people who have raised concerns formally through the NHS complaints procedure
- feedback on the 'frequently asked questions' included in our guidance on patients wearing masks in the hospital
- providing views on proposals for a new 'emergency floor' at St George's to improve our emergency pathways
- review of forms from the Acute Frailty Network to assess suitability for patient needs
- providing patient views on the installation of a new MRI facility.

Children's and Young People's Council

In 2021, a Children's and Young People's Council was set up at St George's Hospital to enable young patients to support each other, and provide input into hospital decisions affecting them. It is made up of nine young people aged between 10 and 16, all of whom received or continue to receive care at the Trust. The creation of the Council is a way of providing a trusted forum within which children and young people can share their honest views about what is working well at the Trust, and what can be improved. It has met virtually three times so far, and the plan is for the group to meet every month going forward.

Our members

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

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

Our Quality Improvement Academy (QIA) was set up to address this, and despite the pandemic, has continued to make progress in embedding a quality improvement across the Trust, and not just for those holding formal leadership positions.

Examples of quality improvement projects implemented over the year are set out below.

Improving quality standards for sickle cell patients

The problem	**Sickle cell disorders are a group of illnesses which affect your red blood cells. Sickle Cell Disease (SCD) is a genetic condition. SCD can affect anyone, although it predominantly affects people from African and Caribbean backgrounds. It is both serious and lifelong, with sufferers experiencing episodes of extreme pain known as a sickle cell crisis. This often requires attendance at the Emergency Department (ED) and urgent provision of analgesia. Patients with SCD often feel stigmatised by healthcare staff due to a lack of understanding of the disease and historical issues of race and discrimination. There is a national standard when patients with SCD attend the ED, stating patients should receive analgesia within 30 minutes. An audit undertaken in 2018 demonstrated only 39% of patient were receiving analgesia within 30 minutes. In addition, a series of complaints were made by patients about the care they received.**
The solution	**A small project team was formed comprising staff within the ED and haematology teams. Carol Rose (Sickle Cell Clinical Nurse Specialist) and Terence Joe (Head of Patient Experience) organised a patient focus group to better understand our patient's needs and develop potential solutions in conjunction with the ED team led by Tori Cooper (Head of Nursing, Emergency Department) and Mark Haden (Emergency Department Consultant).** **Several early ideas helped improve staff understanding of the disease including: awareness sessions for ED staff, small group teaching and competency roll out using Carol's expertise and link champions in the ED team. However, this appeared to have minimal impact and patient experiences were still noted to be poor. The team are developing a bespoke intranet page for staff and internet page for patients. The team are also going to be launching a sickle cell alert card (an idea which arose from the focus group) and an e-learning package, created by the haematology team which will become a mandatory part of the new-starter induction process for staff joining the ED.** **The team have involved the patient group with the development of the ideas and will be facilitating an education awareness week where a patient will attend to help with the education and awareness training.**
The outcome	**Delivery of the 30-minute access to analgesia standard has improved from 41% to 68% over the course of a year. The team anticipate with the Introduction of a series of further improvement initiatives this percentage and patient experience within ED will continue to improve.**

Supporting maternity patients to access virtual advice and guidance

The problem	During Covid-19, antenatal classes had to be suspended. Women fed back that they did not feel they were able to get as much information as they wanted about their pregnancy and plans for birth, as well as information to address their concerns about how Covid-19 would impact their experience.
The solution	The solution was twofold. During the first wave of Covid-19, one of our midwives organised colleagues to produce antenatal education films and a virtual tour of the maternity unit, which are hosted on our website and on YouTube. During the second wave, we used Microsoft Teams to launch weekly on-line Question and Answer sessions with Consultant Midwives.
The outcome	To date, the virtual tour has been viewed over seven thousand times on YouTube. The online sessions have been attended by more than 40 families a month and the concept has now spread to other teams who have set up specialist sessions. Feedback from women has been very positive, with over 95% responding that they found the sessions very, or extremely useful, with many commenting that their anxiety had been reduced as a result of attending.

Maintaining urgent and complex surgery during Covid-19

The problem	It is well documented that Covid-19 severely limited the capacity of NHS hospitals to provide the full range of surgical services beyond the most urgent and complex cases. Many of our surgical wards and staff were re-designated to care for Covid-19 patients, but we still needed to ensure we could safely meet the urgent care needs of our most seriously ill patients. The problem was further complicated by the need to maintain effective boundaries between Covid-19 and non-Covid-19 patients under our care.
The solution	A small team, drawn largely form our anaesthetics and critical care teams quickly identified a solution to create a dedicated post anaesthetic care unit (PACU) which became operational in July 2020. The unit of up to six beds was established in a geographically separate area from the main ITU areas, enabling the flow of elective "green" (Covid-19 free) patients during the normal pressure of winter and peaks of the second surge. It also ensured ITU beds were only allocated to those requiring the highest levels of care, such as cancer. The project team also helped to train recovery nurses to safely manage the PACU patients and communicate with surgical teams to implement a process for identifying potential PACU patients before attending the hospital for surgery.
The outcome	In the first four months of operation the PACU helped treat 164 patients and saved the equivalent of 500 ITU bed nights in one year. Such savings helped maintain a flow of elective patients, particularly during the second Covid-19 surge. It also resulted in fewer minor or major complications in patients' care and similarly reduced the number of on the day cancellations. Given its clinical and financial successes, the team is now working on plans for a larger unit to become a permanent fixture of our elective care programme.

At a senior level, the work of the QIA has been strengthened through the appointment, in December 2020, of a new Deputy Chief Medical Officer with responsibility for quality improvement.

Closer collaboration and system leadership

Part of being a well-led organisation means being a proactive partner as well as a system leader in the wider health and care system. This closer collaboration is reflected as one of the four central themes in our five-year strategy, and as a one of our three corporate objectives.

One of the most striking lessons from responding to the Covid-19 pandemic has been the benefits of cross-system working, and the removal of traditional barriers that exist between organisations. We have seen collaboration across health and social care at a pace and scale unimaginable even a little over a year ago.

As the pressures brought by Covid-19 lessen, we aim to maintain these collaborative solutions to challenges across south west London.

Although the experience of the pandemic has undoubtedly cast a new light on the importance of collaboration, we were working more closely with our partners pre-pandemic to ensure patients get the care they need. Some of our most significant partnerships are outlined below.

South West London Integrated Care System

We continued our work this year as a key partner within the South West London Integrated Care System (previously the South West London Health and Care Partnership), which is where the NHS, local councils, and the voluntary sector come together to deliver better care for the people of the region.

At system level, the Trust has been fully involved in the partnership's Programme Board, and in its response to Covid-19, including work on tackling health inequalities in relation to the pandemic; improving vaccine uptake; the introduction of NHS 111 to reduce ED walk-ins across south west London; and the south west London-wide focus on elective care.

The partnership was awarded Integrated Care System (ICS) status on 1 April 2020, with the coming together of the six clinical commissioning groups (CCGs) in the region. In obtaining ICS status, NHS England and NHS Improvement has recognised the strength of the south west London partnership, and the shared ambitions for the six boroughs – Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. This model of integrated care is likely to become the norm as set out in the Department of Health and Social Care's February 2021 White Paper proposals.

The partnership's recovery work is underway, which will mean continuing to provide safe and equitable services while also managing the long-term effects from Covid-19 and preparing for potential future waves. At borough level, and through Local Transformation Boards, St George's will be involved in the partnership's review of its South West London Five Year Plan and plans for Wandsworth and Merton. These will be adapted to take account of the need to deliver services differently post-pandemic, while recognising the strategic ambitions set out in previous plans.

Our part in the Acute Provider Collaborative (APC) has seen us work together with other Trusts in the region where it makes clinical and financial sense to do so, turning the aims of joint working into real, tangible benefits for the four providers involved. We are continuing to see real progress in some areas. An example is South West London Pathology, set up by host Trust St George's, plus Kingston and Croydon hospitals, which this year has played a vital role in each Trust's response to Covid-19 through its testing facilities.

Similarly, the South West London Elective Orthopaedic Centre (SWLEOC) established by the four south west London acute Trusts and based at Epsom Hospital, is continuing to treat patients and has excellent outcomes, low complication rates and high patient satisfaction. In December 2020, planned procedures were stopped to increase capacity for Covid-19 patients at the hospital, but the centre resumed admitting patients for elective surgery in March 2021.

As well as clinical collaboration, the APC helps to tackle the region's workforce challenges with the South West London Recruitment Hub, and the South West London Procurement Partnership was recently launched across the Trusts to create a consistent service throughout the local system.

West London Cancer Alliance

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

South East Genomic Medicine Service Alliance

In December 2020, the South East Genomic Medicine Service Alliance (GMSA) was established as part of a network of seven GMSAs commissioned by NHSE/I to support the embedding of genomics into mainstream healthcare. Dr Frances Elmslie, consultant in genetics at St George's, has been appointed Clinical Director of the NHS South East GMSA. The alliance will work to deliver equitable and consistent access to genomic testing across south London, Kent, Surrey, and Sussex. St George's has a widely respected regional genetics service and we are looking forward to developing this collaboration for the benefit of the region's patients.

Operational Delivery Networks

We are continuing to collaborate with partner hospitals through Operational Delivery Networks (ODNs) which focus on coordinating patient pathways between providers to make sure patients have access to the specialist support and expertise they need. London ODNs we are part of include critical care, major trauma, renal, Hepatitis C, and neurosciences.

Clinical Research Network (CRN) South London

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

One of the Trust's priorities is to develop our strength in research, as outlined in our five-year strategy, and our corporate objectives.

St George's Hospital Charity

The support of St George's Hospital Charity throughout the Covid-19 pandemic has been indispensable. It harnessed the outpouring of appreciation from our communities to raise over £1 million in its Coronavirus Appeal. These funds allowed the charity to respond to the urgent needs of the hospital including setting up five dedicated staff wellbeing hubs, providing iPads for patients to connect with their loved ones, and funding comfort kits for those going through cancer treatment.

As the number of Covid-19 admissions decreased, the charity set up a Thank You Appeal, to continue to raise funds for staff as a way of showing gratitude to our staff. Money raised will go towards making improvements staff and patients, be that new medical equipment, bulbs for the surrounding gardens, or arts and music therapies. In addition, the Charity has been an active member of NHS Charities Together, working with other hospital charities across the Country to support the health service, and St George's has benefitted hugely from this, including receiving generous donations thanks to the inspirational fundraising by the late Captain Sir Tom Moore. Outside of Covid, the charity has continued with its Campaign for Renal, and has made available research funding, and new facilities including a new staff intranet which was launched in January 2021.

Health Overview and Scrutiny Committees

A representative from St George's has attended every quarterly Wandsworth Health Overview and Scrutiny Committee meeting since June 2017, and this continued virtually throughout the pandemic. Throughout the past year our updates to the Committee have focused on our response to Covid-19, but we have also provided assurances on other issues including our diversity and inclusion work, and staff flu vaccination rates.

Members of the Committee continue to receive our monthly stakeholder bulletin which provides an update on major programmes of work, and challenges facing the Trust. In addition to this, we proactively brief the Chair of the Committee in advance of any major announcements or adverse media stories being published. Our clinical service changes during this time have not required consultation or input from the Committee, but members have been made aware of them via the channels outlined above, and had the opportunity to get involved if required.

Organisational structure and governance

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

Our Council of Governors

Our Council of Governors forms an integral part of our governance framework and is led by the Trust Chairman. Our Council of Governors represents our membership body, and during the reporting period its activities helped to ensure that the Trust could continue to provide high quality services and care to its patients and that any decisions made by the Trust did not adversely impact on the experience of the patients. During the first wave of the Covid-19 pandemic in the period from April to June 2020, the Council paused its meetings as part of the efforts by the Trust, and the NHS nationally, to streamline governance and reporting to assist with the operational response to Covid-19. Having made new appointments to the Board in late 2019/20, during 2020/21 the Council reappointed one of the Non-Executive Directors to a second term of office and continued to help to ensure that the Board of Directors had the right balance of skills and knowledge to lead the Trust.

Members of the Council of Governors are elected from the Trust's membership body – which includes members of the public and our staff – and appointed local authority, university and Healthwatch stakeholder representatives. A total of 36 Governors served on the Council of Governors during the period. Governors were appointed from the constituencies set out in the Trust's Constitution, and the size of the Council was sufficient to enable governors to give effect to their key duties. The names and terms of the members of the Council of Governors can be found in table 1 below.

Table 1: Constituency and terms of Governors

GOVERNOR	CONSTITUENCY/OFFICE	TERM	ELECTED/RE-ELECTED/ APPOINTED	PERIOD IN OFFICE
Gillian Norton	Trust Chairman	N/A	N/A	N/A
ELECTED PUBLIC GOVERNORS				
Nasir Akhtar	Merton	First	01 February 2020	01 February 2020 - 31 January 2023
Adil Akram	Wandsworth	First	01 February 2021	01 February 2021 – 31 January 2024
Padraig Belton	Rest of England	First	01 February 2021	01 February 2021 – 31 January 2024
Hilary Harland	Merton	Third	01 February 2021	01 February 2021 - 31 January 2024
Nasir Javed Khan	Merton	First	01 February 2020	01 February 2020 - 31 January 2023
Afzal Ashraf	Wandsworth	First	01 February 2020	01 February 2020 - 31 January 2023
John Hallmark	Wandsworth	Second	01 February 2021	01 February 2021 - 31 January 2024
Basheer Khan	Wandsworth	First	01 February 2020	01 February 2020 - 31 January 2023
Ataul Qadir Tahir	Wandsworth	First	01 February 2020	01 February 2020 - 31 January 2023
Mia Bayles	Rest of England	Third	01 February 2021	01 February 2021 - 31 January 2024
Sandhya Drew	Rest of England	First	01 February 2020	01 February 2020 - 31 January 2023
Shalu Kanal	Wandsworth	First	01 February 2021	01 February 2021 – 31 January 2024
Khaled Simmons	Merton	Third	01 February 2021	01 February 2021 - 31 January 2024
Stephen Sambrook	Rest of England	Second	01 February 2020	01 February 2020 - 31 January 2023
Richard Mycroft	South West Lambeth (Lead Governor)	Second	01 February 2021	01 February 2021 - 31 January 2024
ELECTED STAFF GOVERNORS				
Jenni Doman	Non-Clinical	Third	01 February 2020	01 February 2020 - 31 January 2023
Marlene Johnson	Nursing & Midwifery	Second	01 February 2021	01 February 2021 - 31 January 2024
Alexander Quayle	Allied Health Professionals	First	01 February 2021	01 February 2021 - 31 January 2024
Tunde Odutoye	Clinical & Dental	First	01 February 2021	01 February 2021 - 31 January 2024
APPOINTED STAKEHOLDER GOVERNORS				
Alfredo Benedicto	Healthwatch Merton	Second	01 February 2021	01 February 2021 - 31 January 2024
Sarah Forrester	Wandsworth Healthwatch	First	01 February 2021	01 February 2021 - 31 January 2024
Sarah McDermott	Wandsworth Council	Second	01 February 2018	01 February 2018 – 31 January 2021
Sangeeta Patel	Merton/Wandsworth Clinical Commissioning Group	Second	01 February 2021	01 February 2021 - 31 January 2024
Prof. Kathy Curtis	Kingston University	First	21 April 2021	20 April 2024
Linda Kirby	Merton Council	First	17 February 2021	16 February 2024
PAST GOVERNORS – LEFT OFFICE IN 2020/21				
Anneke de Boer	Merton	Third	01 February 2020	01 February 2020 - 31 January 2021
Nick de Bellaigue	Wandsworth	First	20 July 2018	20 July 2018 - 31 January 2021
Doulla Manolas	Wandsworth	First	01 February 2018	01 February 2018 - 31 January 2021
Damien Quinn	Rest of England	First	01 February 2018	01 February 2018 - 31 January 2021
Val Collington	Kingston University	Second	01 February 2018	01 February 2018 - 31 January 2021
Frances Gibson	St George's University	Second	01 February 2018	01 February 2018 - 31 January 2021
Rebecca Lanning	Merton Council	First	01 February 2018	01 February 2018 - 31 January 2021
Donald Roy	Wandsworth Healthwatch	First	01 February 2018	01 February 2018 - 31 January 2021
Bassey Williams	Allied Health Professionals	First	01 February 2018	01 February 2018 - 31 January 2021
Anup Sharma	Clinical & Dental	First	01 February 2018	01 February 2018 - 31 January 2021

We held elections to the Council of Governors in November 2020, and in February 2021 six new Governors joined the Council and we welcomed back four of our long serving Governors who were re-elected (see table 2 below). The Trust will hold its next elections in November 2022.

In March 2021, we were saddened to learn that Nasir Javed Khan, Governor from the Merton Constituency, had sadly died. At its meeting in April 2021, the Council of Governors formally offered its condolences to Nasir's family and friends and recognised his contribution to the work of the Council since his election in January 2020.

Council of Governors: role and duties

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

These include:

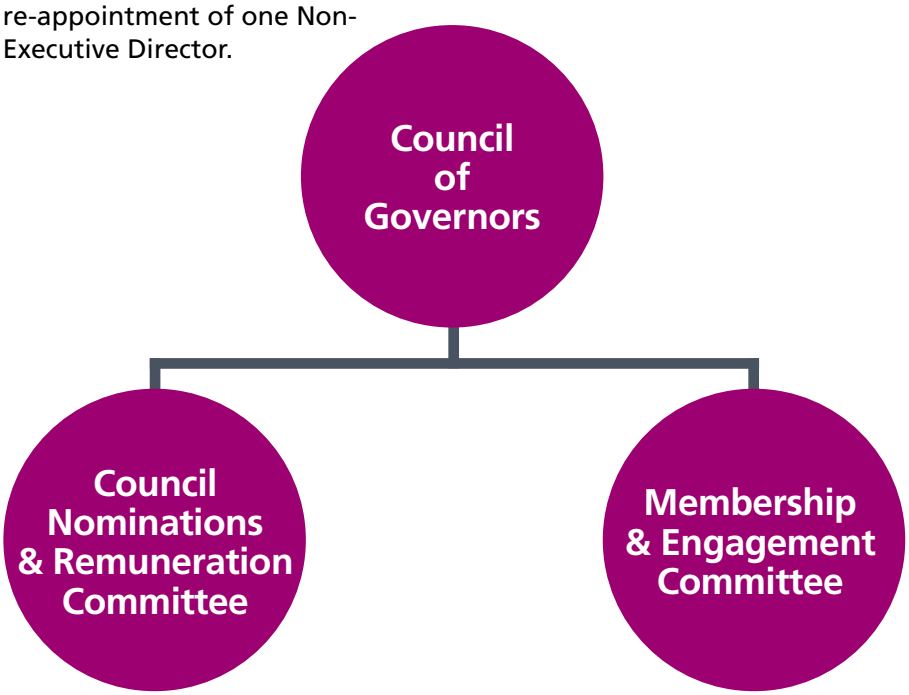
- appointment of Non-Executive Directors, setting their terms and conditions, and, where appropriate, removal of Non-Executive Directors
- appointment of the external auditors and setting their terms and conditions
- approving the appointment of the Chief Executive by the Non-Executive Directors
- any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

During 2020/21, the Council of Governors has exercised some of these functions, specifically the re-appointment of one Non-Executive Director.

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

The Council of Governors reviews its own collective effectiveness regularly. It undertook its most recent review in December 2019 but did not undertake such a review in 2020/21 in light of the unusual circumstances in which the Council had operated during 2020/21, including meeting remotely and avoiding attending the Trust in light of the pandemic response. The Council however continued to focus on implementing the actions agreed as part of its effectiveness review. As part of this, it undertook an enhanced programme of training and development in 2020/21.

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



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

- reappoint one Non-Executive Director for a further term of office
- receive and endorse the appraisal of the Chairman and other Non-Executive Directors.

The Committee is led by the Trust Chairman and the members are governors. During 2020/21 the following Governors were members of the Committee:

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

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

- the Membership Strategy 2019-2022:, year two implementation plan and progress updates
- a review of issues raised by members and the public
- plans for engagement events and activities including: Annual Members Meeting, constituency events, implementation of tiered membership. This included developing plans for an online constituency engagement event in Merton in March 2021.

The Committee is led by the Lead Governor and its members are governors. During 2020/21 the following Governors were members of the Committee:

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

Following guidance from NHS England and NHS Improvement, the Council of Governors suspended its meetings during the first wave of the pandemic. In May 2020, the Council held a briefing session on Covid-19 and the Trust's response. Starting from July 2020, the Council of Governors met four times during 2020/21. Attendance of individual Governors is set out in table 4 below.

Table 4: Council of Governors' attendance at meetings

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

Some of the key matters considered by the Council included:

09.07.20	10.09.20	10.12.20	16.02.21
CEO's Report and COVID-19 Update	CEO's Report and COVID-19 Update	CEO's Report and COVID-19 Update	CEO's Report and COVID-19 Update
Diversity & Inclusion	Trust Finance Update	Culture, Diversity and Inclusion Programme Update	Culture Programme Update
Council of Governors Work Programme and Engagement Activities Updates	Membership Engagement Committee Report and Terms of Reference	Care Quality Commission Actions Update	Quality Priorities: Review 2020/21 and Planning 2021/22
Nominations & Remuneration Committee Report	Overview from Non-Executive Director (Finance & Workforce Focus)	Membership Engagement Report	Finances: Where are we now & Forward Planning
External Auditors Report 2019-20	Renal Services and Epsom & St Helier	Governor Elections and Annual Member's Meeting Update	Council of Governors 2021/22 Meeting Schedule
Overview from Non-Executive Directors (Quality Focus)		Overview from Non-Executive Directors (Quality & Safety, Ethics & IT Focus)	
		Financial Forecast	
		Cardiac Surgery	
		Collaborations with Epsom and St Helier	

Governors also received a briefing in May 2020 which covered Covid-19, resuming elective and urgent care services, working across the NHS and in south west London to recover services and manage intensive care capacity, and general changes to governance and working arrangements for the Council of Governors.

There are clear processes and procedures for the Council to engage with the Trust Board to raise any issues, with the Senior Independent Director and Lead Governor acting as key conduits to ensure that these are appropriate and effective. During 2020/21, Senior Independent Director was Ann Beasley who also continued to serve as Vice Chair of the Trust.

The Council of Governors reviews and discusses the Trust's forward plan for the forthcoming year. In 2020/21, the Council reviewed the draft forward plan at its meeting in February 2021. The Council undertakes engagement events with members, which includes opportunities for Governors to seek the views of members on the plan. Governors are able to raise questions regarding the plan with the Board. Questions are posed to the Chairman and Non-Executive Directors at Council meetings, and Governors have the opportunity to attend Board meetings and ask questions. Due to the Covid-19 pandemic, in 2020/21 opportunities for Governors' engagement with members have been more constrained the usual in light of the restrictions on social gatherings and social distancing requirements. However, Governors have continued to seek the views of members through virtual meetings.

The Trust's Constitution sets out the procedures for resolving any disputes between the Board and Governors. Information on the constitution can be found on our website at : https://www.stgeorges.nhs.uk/about/living-our-values/nhs-constitution/

The Council of Governors did not need to make use of these procedures during 2020/21.

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

The following Directors attended the Council of Governors:

NAME	TITLE
Jacqueline Totterdell	Chief Executive Officer
Andrew Grimshaw	Chief Finance Officer
Avey Bhatia	Chief Operating Officer
Richard Jennings	Chief Medical Officer
Stephen Jones	Chief Corporate Affairs Officer
Humaira Ashraf	Acting Chief People Officer (Culture)

Governor development

Governors are afforded the opportunity to attend NHS Providers' training courses and networking events and we seek to match these opportunities to identified training needs of our Governors.

The Trust reviewed its arrangements for Governor training and development following the Council's effectiveness review in December 2019. Despite the Covid-19 pandemic, the Trust has continued to provide a range of training and development opportunities for Governors to support them in their roles throughout 2020/21. The Covid-19 pandemic has meant that Governors have not had their usual opportunities to attend the Trust for meetings or to participate in PLACE inspections, ward accreditation visits, and Meet Your Governor events. However, online meetings of the Council of Governors and its Committees, online development sessions, online Members Talks, and an online Governor constituency engagement event have all been held during 2020/21.

During 2020/21, the following training and development activities were provided to Governors:

- **May 2020:** The Trust held a briefing session for Governors focused on the Covid-19 pandemic and the Trust's response.
- **August 2020:** The Trust held a half-day Governor development session which was externally facilitated by NHS Providers. This provided an introduction to the NHS and the NHS landscape, an overview of NHS governance and the role of Foundation Trust Governors, and training in effective questioning and challenge. This was attended by 18 members of the Council of Governors.
- **September 2020:** The Trust provided Governors with a confidential briefing on closer collaboration with Epsom and St Helier University Hospitals NHS Trust and on the development of a joint renal service. This was attended by 18 members of the Council of Governors.
- **October 2020:** The Trust held a Council of Governors development seminar, supported internally by the Trust. The areas of focus included: strategy and NHS system working; the Trust's workforce, staff engagement and culture change programme; and training in risk management and the Board Assurance Framework. This session was attended by 20 members of the Council of Governors.
- **January 2021:** A further half-day development session for Governors supported by NHS Providers was delivered in January 2021, which focused on NHS finance and quality. This was attended by 19 members of the Council of Governors.
- **March 2021:** The Trust held a Governor development seminar focused on the Trust's estate and facilities management, digital and information technology, and closer collaboration with Epsom and St Helier University Hospitals. This was attended by 17 members of the Council of Governors.

In 2020/21, as part of the programme of formal Council meetings, Governors also had briefings on Covid-19 and the Trust's response, the Trust's financial position, patient partnership and engagement, the Trust's CQC action plan, and the Trust's cultural change programme, as well as confidential briefings on the Trust's cardiac surgery service and collaboration with Epsom and St Helier.

Our membership

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

We have a combined membership of around 22,000 members:

Membership constituency	2020/21	2019/2020
Total Public Members	**12,938**	**13,038**
Lambeth	**548**	**555**
Merton	**3,380**	**3,412**
Wandsworth	**4,113**	**4,130**
Rest of England	**4,897**	**4,941**
Total Staff Members	**9,171**	**9000**

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

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

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

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

We have already made progress in meeting the aims set out in the strategy – for example we have improved the way in which we engage with members by introducing a new monthly bulletin rounding up key news stories and ways to get involved with the Trust. In March 2020 we also held the first of a series of 'Question Time' events in community spaces where the public had the chance to meet their local Trust Governor, hear from a member of our Board, and ask questions about our services. In March 2021, we resumed these sessions in an online format.

To achieve the vision set out in our strategy, we know we have more to do, particularly following a year in which opportunities for direct engagement with members has been limited. Subject to the Covid-19 restrictions, we have a programme of membership engagement events planned for 2021/22, and while the social distancing requirements related to Covid-19 pose challenges, we will continue to improve the quality of our engagement with our members and deliver events virtually until face-to-face engagement can restart. As part of this, we also want to ensure that our membership is truly representative of our diverse communities.

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

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

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

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

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

The Trust Board of Directors

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

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

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

Trust Board membership

Gillian Norton,
Chairman

Gillian Norton was appointed Chairman in April 2017, having been a Non-Executive Director since June 2016. She spent her executive career in local government, serving as Chief Executive for a total of 23 years, the last 17 of which were in London Borough of Richmond. She has been Representative Deputy Lieutenant for Richmond since 2016, and in 2017 was awarded OBE for services to local government. In October 2019, Gillian also became Chairman of Epsom and St Helier University Hospitals NHS Trust. In May 2019, Gillian was reappointed as Chairman of St George's by the Trust's Council of Governors for a further three-year term of office from 1 April 2020.

Non-Executive Directors

Ann Beasley,
Non-Executive Director (Deputy Chair)

Ann Beasley joined St George's as a Non-Executive Director in October 2016. She has a background in finance, her most recent role being Director General for the Finance, Assurance and Commercial Group at the Ministry of Justice. Ann has also been Chair of Trustees for the Alzheimer's Society. Ann was awarded a CBE in 2010 and in September 2018 was appointed as Chair of South West London and St George's Mental Health NHS Trust. Ann is Vice Chair of the Trust and, since October 2019, has served as Senior Independent Director. From 1 June 2021, Ann will also serve as Non-Executive Director at Epsom and St Helier University Hospitals NHS Trust.

Non-Executive Directors (cont.)

Elizabeth Bishop, Non-Executive Director

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

Stephen Collier, Non-Executive Director

Stephen Collier is currently the Chair of NHS Professionals and recently served as a member of the independent inquiry panel into the issues raised by Ian Paterson. Stephen has worked extensively in the private health sector, including a period as Chair of the NHS Partners Network – the trade association for private providers to the NHS. He is a Trustee of ReSurge Africa, a Scottish medical charity working in Ghana and Sierra Leone. Stephen took up the role of Non-Executive Director in October 2016.

Professor Jenny Higham, Non-Executive Director

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

Professor Dame Parveen Kumar, Non-Executive Director

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

Dr Pui-Ling Li, Associate Non-Executive Director

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

Tim Wright, Non-Executive Director

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

Executive Directors (voting)

Jacqueline Totterdell,
Chief Executive

Jacqueline Totterdell joined St George's as Chief Executive in May 2017. Jacqueline is an experienced NHS leader, having previously been Chief Executive of West Middlesex University Hospital NHS Trust, where she helped steer the organisation through its merger with Chelsea and Westminster Hospital NHS Foundation Trust. She has also been Chief Executive of Southend University Hospital NHS Trust, where she spent five years. She has also been Chief Operating Officer at Barts Health and The Hillingdon Hospital NHS Trust. Since joining St George's, Jacqueline has also been appointed Chair of the South London NIHR Clinical Research Network. She is also Senior Responsible Officer for planned care, ITU, diagnostic and outpatient transformation across south west London; and also regional lead for outpatient transformation.

Andrew Grimshaw,
Chief Financial Officer/ Deputy Chief Executive

Andrew Grimshaw joined St George's as Chief Financial Officer in June 2017. Andrew was previously Director of Finance at London Ambulance Service (LAS), and was also Acting Chief Executive at LAS between January and June 2017. Prior to joining LAS, Andrew worked at a number of teaching, specialist and district general hospitals, having joined the NHS as a trainee accountant in 1989. Andrew was appointed Deputy Chief Executive in May 2019.

Dr Richard Jennings,
Chief Medical Officer

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

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

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

Non-voting Board members

Anne Brierley,
Chief Operating Officer

Anne Brierley joined the Trust as Chief Operating Officer in October 2020. Anne was previously Programme Director for the South West London Acute Provider Collaborative, a role she held for three years. Prior to this, Anne held a number of senior operational management roles across a range of NHS settings.

James Friend,
Chief Transformation Officer

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

Paul da Gama,
Chief People Officer

Paul da Gama joined St George's as our Chief People Officer in February 2021. Paul joined the Trust from West Hertfordshire Hospitals NHS Trust, where he had been Chief People Officer since 2014. Prior to joining West Herts, Paul was Director of Human Resources at Hinchingbrooke Hospital. Paul began his career as a teacher, working in Japan and Poland, before joining banking group, HSBC, where he worked for 10 years. He has also worked at Royal Mail Group, where he held a variety of different senior HR roles.

Stephen Jones,
Chief Corporate Affairs Officer

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

Suzanne Marsello,
Chief Strategy Officer

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

Other Directors who served on the Board during 2020/21

During 2020/21, two other Directors served on the Trust Board who have since left the Trust. There were also two Directors who had acting roles on the Board.

Avey Bhatia, Chief Operating Officer (until October 2020)

Avey Bhatia joined St George's as Chief Nurse in February 2017. Avey was previously Chief Nurse at Maidstone and Tunbridge Wells NHS Trust, before which she was Deputy Chief Nurse at South London Healthcare NHS Trust from 2010 to 2013. Prior to joining South London Healthcare, Avey held senior nursing and management positions at St George's. For much of 2019/20, Avey served as Chief Nurse and Director of Infection Prevention and Control. In February 2020, she became interim Chief Operating Officer.

Harbhajan Singh Brar, Chief People Officer (until May 2020)

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

Humaira Ashraf and Elizabeth Nyawade, Acting Joint Chief People Officers (May 2020 to February 2021)

From May 2020 to February 2021 Humaira Ashraf, Director of Education and Organisational Development, and Elizabeth Nyawade, Director of Workforce, provided interim cover as Acting Chief People Officer for Culture and Organisational Development, and Acting Chief People Officer for Workforce respectively while we recruited to the substantive role of Chief People Officer.

Trust Board Attendance Register 2020/21

BOARD OF DIRECTORS	APPOINTED ROLE	ELIGIBLE PERIOD	ACTUAL/ELIGIBLE ATTENDANCE
VOTING NON-EXECUTIVE DIRECTORS			
Gillian Norton	Chairman	01 April 2020 - 30 March 2021	8/8
Ann Beasley	Non-Executive Director	01 April 2020 - 30 March 2021	8/8
Elizabeth Bishop	Non-Executive Director	01 February 2020 - 30 March 2020	8/8
Stephen Collier	Non-Executive Director	01 April 2020 - 30 March 2021	8/8
Prof. Jenny Higham	Non-Executive Director	01 April 2020 - 30 March 2021	8/8
Dame Professor Parveen Kumar	Non-Executive Director	13 January 2020 - 30 March 2020	8/8
Pui-Ling Li	Associate Non-Executive Director	13 January 2020 - 30 March 2020	8/8
Tim Wright	Non-Executive Director	01 April 2020 - 30 March 2021	8/8
VOTING EXECUTIVE DIRECTORS			
Jacqueline Totterdell	Chief Executive	01 April 2020 - 30 March 2021	8/8
Andrew Grimshaw	Chief Financial Officer/Deputy Chief Executive	01 April 2020 - 30 March 2021	7/8
Avey Bhatia	Chief Operating Officer	01 April 2020 – 30 September 2020	5/5
Robert Bleasdale	Acting Chief Nurse/Director of Infection & Prevention Control	01 April 2020 - 30 March 2021	8/8
Dr Richard Jennings	Chief Medical Officer	01 April 2020 - 30 March 2021	8/8
NON-VOTING MEMBERS			
Harbhajan Brar	Chief People Officer	01 April 2020 - 30 May 2021	2/2
James Friend	Chief Transformation Officer	01 April 2020 - 30 March 2021	5/8
Stephen Jones	Chief Corporate Affairs Officer	01 April 2020 - 30 March 2021	8/8
Suzanne Marsello	Chief Strategy Officer	01 April 2020 - 30 March 2021	8/8
Anne Brierley*2	Chief Operating Officer	01 October 2020 - 30 March 2021	3/3
Elizabeth Nyawade	Acting Chief People Officer	22 May 2020 – 31 January 2021	5/5
Humaira Ashraf	Acting Chief People Officer	01 July 2020 – 31 January 2021	4/4
Paul Da Gama	Chief People Officer	01 March 2021	1/1

The NHS Foundation Trust Code of Governance requires the Trust's Annual Report set out each Non-Executive Director it considers to be independent. The Board must determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. The Board is required to state its reasons if it determines that a Director is independent despite the existence of relationships or circumstances which may appear relevant to its determination. The Board considers the following Non-Executives to have been independent for the year 2020/21: Ann Beasley, Stephen Collier, Parveen Kumar, Tim Wright and Pui-Ling Li. Gillian Norton and Elizabeth Bishop both served on the Board of Epsom and St Helier University Hospitals NHS Trust during 2020/21. The Board has authorised the existence of a conflict of interest in both cases but they are not considered independent for the purposes of this declaration. Ann Beasley chairs the Board of South West London and St George's Mental Health NHS Trust, however this relationship is not considered to impact on her independence as the two Trusts operate independently and are different types of NHS provider.

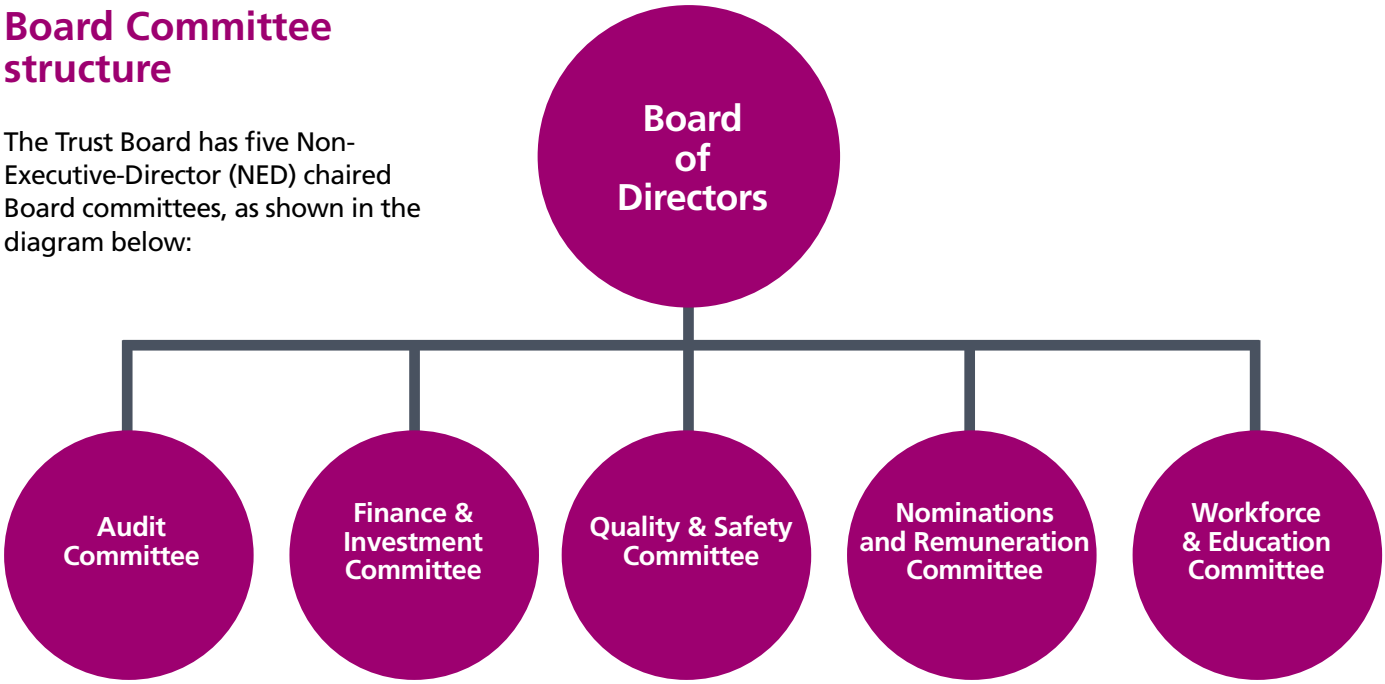
Non-Executive Directors are appointed for terms of office of three years. In the case of the Associate Non-Executive Director, the term of office is two years. The terms of office of our current Non-Executive Directors are set out in the table below:

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

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

Board Committee structure

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



The Audit Committee meets five times each year, while the Finance and Investment and Quality and Safety committees meet monthly. In July 2020, the Board decided that the Workforce and Education Committee would move from meeting six times a year to meeting monthly to provide additional oversight and assurance in relation to diversity, inclusion and culture.

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

Audit Committee

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

The Committee comprises four independent Non-Executive Director members (including one Associate Non-Executive Director). The Chief Corporate Affairs Officer and Chief Financial Officer, as the relevant executive leads, attended each meeting of the Committee.

During 2020/21 the Committee held five meetings and attendance is recorded below.

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Elizabeth Bishop	Non-Executive Director, Chair	5/5
Ann Beasley	Non-Executive Director	4/5
Tim Wright	Non-Executive Director	4/5
Pui-Ling Li	Non-Executive Director	4/5

During the period, the Committee:

- reviewed the 2019/20 draft Annual Report and Accounts, including the Quality Account, and recommended that the Board approve and adopt these as a true and fair record, and considered the plan for the 2020/21 Annual Report;
- monitored the programme of internal audit based on which the Trust received a reasonable assurance rating of its systems and internal controls;
- monitored the mechanisms and systems for staff to raise concerns about clinical, financial, quality, patient safety and other concerns through regular reports from the counter fraud team and Freedom to Speak Up Guardian;
- reviewed the Trust's standing orders and scheme of delegation, and recommended that the Board of Directors adopt the revised documents;
- received regular reports on the Trust Board Assurance Framework and plans to conduct a substantive review on the Trust's Risk Management Policy;
- considered and review compliance to key documents such as the Trust's managing conflicts of interest policy.

Finance and Investment Committee

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

Membership comprises Non-Executive and Executive Directors. The Chairman, Chief Executive Officer, Chief Corporate Affairs Officer, Chief Strategy Officer, Chief Transformation Officer and Chief People Officer attended the Committee meetings.

During 2020/21 the Committee held 12 meetings and attendance is recorded below:

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Ann Beasley (Committee Chair)	Non-Executive Director	12/12
Gillian Norton (Ex-Officio Member)	Trust Chairman	11/12
Tim Wright	Non-Executive Director	11/12
Stephen Collier	Non-Executive Director	11/12
Elizabeth Bishop	Non-Executive Director	12/12
Jacqueline Totterdell	Chief Executive	5/12
Avey Bhatia	Acting Chief Operating Officer	6/6
Andrew Grimshaw	Chief Financial Officer/ Deputy Chief Executive	10/12
Dr. Richard Jennings	Chief Medical Officer	6/12
Robert Bleasdale	Acting Chief Nurse/Director of Infection & Prevention Control	12/12
Anne Brierley	Interim Chief Financial Officer	6/6

During the period, the Committee:

- considered and kept key financial risks under close scrutiny especially in regard to the national changes to funding the NHS during the Covid-19 pandemic;
- closely monitored performance, including against emergency flow activity levels, and the transformation programme for outpatients;
- reviewed key risks and mitigations in relation to information technology;
- considered the Trust's capital position and reviewed business cases for investment in the Trust's services and infrastructure;
- reviewed the development of work to inform the development of the Trust's estates strategy.

Quality and Safety Committee

The Quality and Safety Committee is responsible for examining and providing assurances on the level of risk to which patients are exposed, and the extent to which clinical outcomes requirements are being met.

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

During 2020/21 the Committee held 12 meetings and attendance is recorded below:

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Dame Parveen Kumar	Non-Executive Director, Committee Chair	12/12
Prof. Jenny Higham	Non-Executive Director	12/12
Elizabeth Bishop	Non-Executive Director	12/12
Pui-Ling Li	Associate Non-Executive Director	12/12
Avey Bhatia*	Acting Chief Operating Officer	6/6
Anne Brierley	Chief Operating Officer (Interim Until March 2021)	6/6
Dr Richard Jennings	Chief Medical Officer	12/12
Robert Bleasdale	Acting Chief Nurse/Director of Infection Prevention & Control	12/12

As part of its annual work programme, the Committee:

- held regular deep dives across a range of quality and safety issues within its remit where it considered further assurance was necessary. During 2020/21, the Committee conducted a total of eight deep dive reviews;
- monitored the three strategic risks on the Board Assurance Framework for which it is responsible for providing assurance to the Board;
- monitored Serious Incidents and Never Events;
- monitored, sought assurances, and supported mitigation of risks related to, personal protective equipment, Covid-19 surge management, winter planning, infection prevention controls for Covid-19;
- monitored of the Trust's implementation of the outstanding actions from the 2019 Care Quality Commission Inspection;
- received regular reports on cardiac surgery;
- received updates on progress in implementing the findings of the first two phases of an independent external clinical governance review;
- focused on safeguarding, medicines management, mortality monitoring, infection control and prevention, learning disabilities services and improving the clinical governance infrastructure of the Trust.

Workforce and Education Committee

The Workforce and Education Committee considers the development and delivery of workforce and education strategies, oversees and monitors workforce planning and performance and delivery of the Trust's strategic aims in relation to workforce, plus monitors staff wellbeing and development and compliance with regulatory requirements in relation to workforce and culture. During 2020/21, the Committee's role in relation to providing assurance to the Board in relation to culture, diversity and inclusion was strengthened and the Committee increased the frequency of its meetings during the year from six meetings a year to monthly.

The Committee membership comprises Non-Executive and Executive Directors. The Trust Chairman, Chief Executive and Chief Corporate Affairs Officer regularly attended the meetings of the Committee. During 2020/21 the Committee held ten meetings and attendance is recorded below.

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Stephen Collier	Non-Executive Director	9/9
Tim Wright	Non-Executive Director	9/9
Prof Dame Parveen Kumar	Non-Executive Director	9/9
Pui-Ling Li	Associate Non-Executive Director	8/9
Paul Da Gama	Chief People Officer	2/2
Elizabeth Nyawade	Acting Chief People Officer* Director of Workforce	7/7 1/2
Humaira Ashraf	Acting Chief People Officer* Director of Education and Organisational Development)	7/7 2/2
Dr Richard Jennings	Chief Medical Officer	6/9
Robert Bleasdale	Acting Chief Nurse/Director of Infection Prevention & Control	8/9

*No longer members of the Committee/ change in status on the Committee

During the year the Committee:

- considered, approved and monitored progress against the culture change programme, staff engagement plan, and diversity and inclusion plans;
- received reports on results from the medical engagement survey and NHS staff surveys;
- received reports on the Trust's Freedom to Speak Up Guardian and Guardian of Safe Working;
- Reviewed the two Strategic Risks assigned to the Committee on the Board Assurance Framework;
- reviewed progress in implementing the Board approved workforce and education supporting strategies.

Declaration of interests

St George's is committed to openness, transparency and public accountability in its work and decision making. As part of that commitment, we maintain a register of interests declared (including gifts and hospitality) by members of the Board of Directors, Council of Governors and senior decision-making staff across the Trust. The Trust's declarations can be found on the Trust's website here: https://stgeorges.mydeclarations.co.uk/declarations

Performance evaluation of the Board

The Trust has in place established processes for undertaking performance evaluations of Board members, both Executive and Non-Executive. The Trust has in place a policy, which is agreed by the Council of Governors, which governs the appraisal process for the Chairman and other Non-Executive Directors. Annual objectives are agreed at the start of year; the Chairman's objectives are agreed with the Senior Independent Director, and the other Non-Executive Directors' objectives are agreed with the Chairman. These are reported to the Council of Governors' Nominations and Remuneration Committee for information. The annual appraisal of the Chairman and Non-Executive Directors involves seeking multi-source feedback from other Non-Executives, Executive Directors, and members of the Council of Governors as well as, in the case of the Chairman, feedback from a broad range of external stakeholders. This multi-source feedback is shared with the relevant Non-Executive Director on a non-attributable basis and informs the appraisal discussion.

As with the setting of objectives, the Chairman's appraisal is undertaken by the Senior Independent Director and the other Non-Executives' appraisals are undertaken by the Chairman. The outcomes of the appraisals are shared with the Council of Governors' Nominations and Remuneration Committee. The Council of Governors has the power to appoint Non-Executives and also has the authority, subject to the provisions of the Trust's Constitution and NHS Foundation Trust Code of Governance, to remove Non-Executives in certain circumstances. In April 2020, the Council of Governors Nominations and Remuneration Committee considered the outcomes of the appraisals of the Chairman and Non-Executive Directors in 2019/20 and, following this, the outcome of the appraisals was presented to the Council of Governors in private session. The Council completed a similar process for the 2020/21 appraisals in April 2021.

The process for the appraisal of Executive Directors is broadly similar and involves multi-source feedback from other Executives, their direct reports, and from Non-Executives. The appraisal process is undertaken every other year, and the outcomes are reported to the Board's Nominations and Remuneration Committee. Executive appraisals were undertaken in February and March 2020/21.

The Board of Directors considers that there is an appropriate balance of skills and experience on the Board, and that the Board is constituted in such a way as to meet appropriately the requirements of the Trust. The skills mix among the Non-Executives is reviewed by the Council of Governors' Nominations and Remuneration Committee and the skills mix among Executive Directors by the Board's Nominations and Remuneration Committee.

NHS Oversight Framework

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

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

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy.

Segmentation

St George's University Hospitals NHS Foundation Trust has been placed in segment 3 – Mandated and targeted support. This reflects the latest position as published on the NHS Improvement website at the time of writing this report.

You can view the current list of provider segmentation on NHS England's website here: http://www.england.nhs.uk/financial-accounting-and-reporting

Better Payment Practice Code

The Better Payment Practice Code (BPPC) requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

NON NHS PAYABLES	2020-21 NUMBER	2020-21 £000s	2019-20 NUMBER	2019-20 £000s
Total non-NHS trade invoices paid in the year	112,612	386,741	114,159	343,574
Total non-NHS trade invoices paid within target	69,532	266,140	36,610	170,743
PERCENTAGE OF NON-NHS TRADE INVOICES PAID WITHIN TARGET	**61.70%**	**68.80%**	**32.10%**	**49.70%**

NHS PAYABLES	2020-21 NUMBER	2020-21 £000s	2019-20 NUMBER	2019-20 £000s
Total NHS trade invoices paid in the year	4,649	83,879	5,028	74,581
Total NHS trade invoices paid within target	1,312	62,971	753	34,037
PERCENTAGE OF NHS TRADE INVOICES PAID WITHIN TARGET	**28.20%**	**75.10%**	**15.00%**	**45.60%**

Auditors

The Trust's appointed external auditors are Grant Thornton LLP. The auditors provide audit services including carrying out the statutory audit of the Trust's annual accounts and the use of resources work, as mandated by Monitor and the National Audit Office, and a review of the Quality Accounts (in 2020/21 due to the operational pressures of Covid-19, the review of the Quality Accounts is not required by NHS England and NHS Improvement). The Council of Governors is responsible for appointing our external auditors. The tender for external audit was last conducted in November 2017 with an appointment commencing in January 2018. During the period the Trust paid £112,500 for external auditors' fees.

The Trust's internal audit function is provided by TIAA. Each year the Audit Committee considers a programme of internal audit work to be carried out as well as a three-year internal audit strategy. This programme is devised from executive assessment of risks, the key matters enshrined in the Board Assurance Framework, and the independent assessment on the internal audit team of the external risks and internal profile of the Trust. Internal audit reports are considered by the Audit Committee and escalated to the relevant governance forums or responsible officers. Key areas reviewed by the internal auditors in 2020/21 included but were not limited to, Temporary Staffing Arrangements, Procurement, Facilities, Safeguarding Children, Disaster Recovery, Data Quality, Payroll, Bullying and Harassment, Cyber Security Planning, Core Financial Controls, Trust Wide Policies, Trust Wide Accreditation systems, Learning from Complaints, Recruitment to Band 8 Plus and Data Security Protection. During the period the Trust paid internal audit fees of £133,200. The Committee approved the re-appointment of TIAA as the Trust's internal auditors in August 2019.

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

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

Disclosure of information to auditors

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

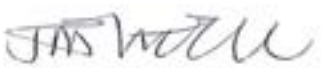
Income from the provision of goods and services

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

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

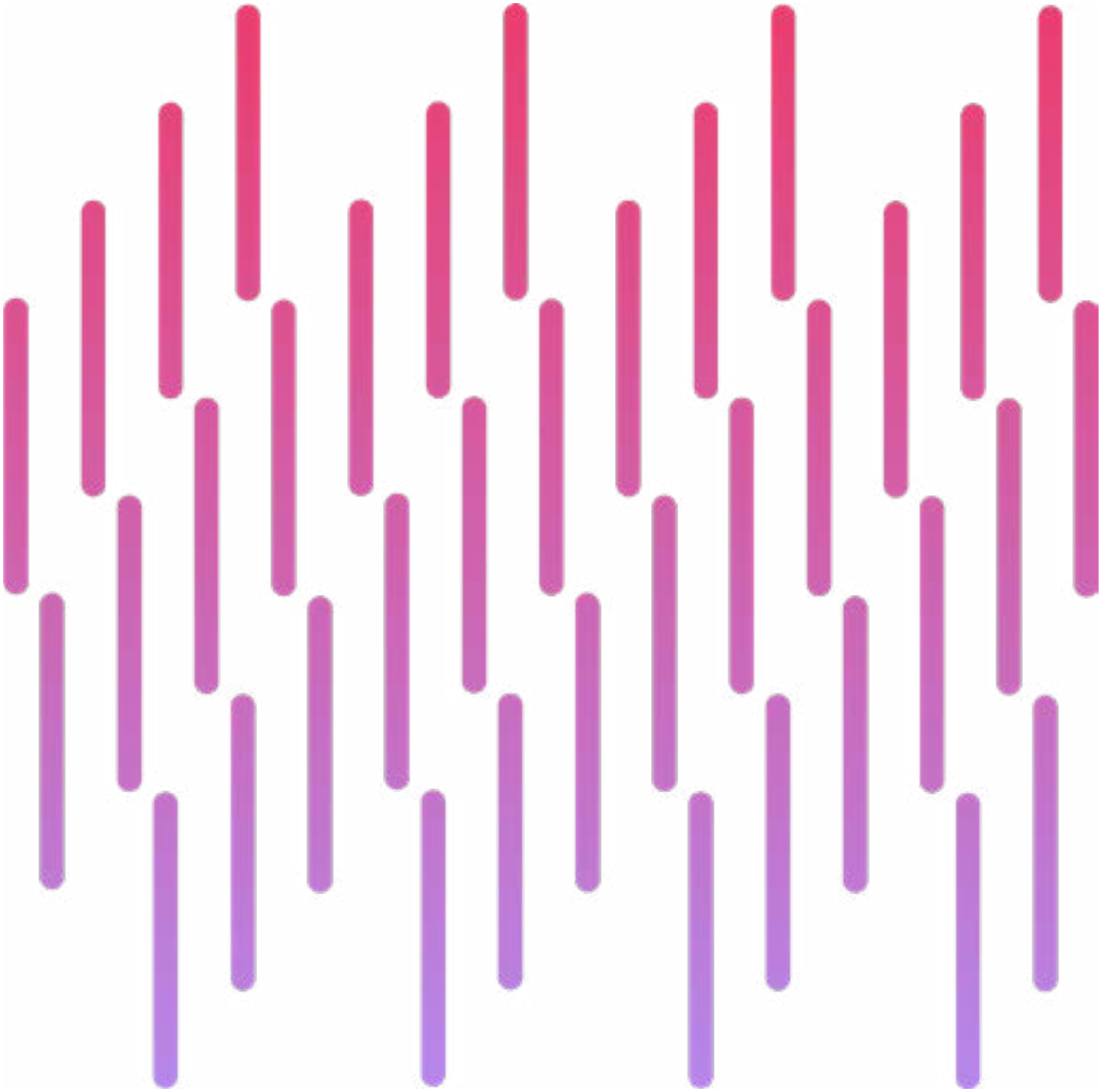
Surpluses from other income that the Trust has received have been used to support the provision of goods and services for the purposes of the health service in England.

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



Jacqueline Totterdell
Chief Executive
24 June 2021

Remuneration report



Remuneration report

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

The remuneration report comprises:

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

Nominations and Remuneration Committee

The Trust has a Board Nominations and Remuneration Committee and a Council of Governors Nominations and Remuneration Committee. Both work in tandem to ensure that there remains an appropriate balance of skills and experience on the Board. These Committees, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors respectively and give consideration to both performance and succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them.

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

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

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

MEMBERS	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Gillian Norton (Committee Chair)	Trust Chairman	6/6
Ann Beasley	Non-Executive Director (Vice Chair)	6/6
Tim Wright	Non-Executive Director	6/6
Stephen Collier	Non-Executive Director	6/6
Professor Jenny Higham	Non-Executive Director	6/6
Professor Dame Parveen Kumar	Non-Executive Director	6/6
Elizabeth Bishop	Non-Executive Director	6/6
Pui-Ling Li	Associate Non-Executive Director	6/6

The Council of Governors' Nominations and Remuneration Committee determines the remuneration of Non-Executive Directors. During 2020/21 the Committee made no changes to NED remuneration.

Senior managers' remuneration policy

The Committee reviews the remuneration arrangements of leadership team posts in line with NHS guidance. The Trust has a policy on diversity and inclusion which applies to all staff and the decisions of the Committee are taken in line with this.

Very Senior Managers' pay principles

St George's is committed to the overarching principles of value for money and high performance. The Trust recognises that it must attract and retain a high-calibre senior management team and workforce in order to ensure it maintains its excellent standards of clinical outcomes and patient care, functions efficiently and is well positioned to deliver the business strategy.

As a Foundation Trust, the Remuneration Committee has the freedom to determine the appropriate remuneration level for very senior managers. In reaching its decisions the Committee considers the responsibilities and requirements of the role, time in the role, marketability of the individual, benchmarking data from within the NHS or relevant sector, the external economic environment, NHS guidance and the performance of the Trust.

Differences between remuneration for Executive Directors and other employees

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

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

Our workforce 2020/2021 disclosures (audited)

MULTIPLE TABLE	2020/21	2019/20
Payroll costs (£000)	638,409	576,066
Whole time equivalent	9,937	9,790
Median (£000)	52.6	39.2
Highest paid director (£000)	263	228
Median will fit into highest	5.0	5.8

Range of staff remuneration for 2020/21

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

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

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

The banded remuneration of the highest paid Director in the financial year 2020-21 was £263k (2019-20 £228k).
This 5.0 times (2019-20, 5.8 times) the median remuneration of the workforce, which was 52.6k (2019-20 £39.2k). The highest paid Director was employed on a permanent basis.

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

In 2020/21, the lowest annualised salary was £7 (2019-20 £100). This is as per the payroll report and is distorted by bank staff and several variables. The lowest paid annualised band in the Trust is £22,478 (2019-20 £22,053 (Band 1). The highest paid was £386,169 (2019-20 £382,551).

Expenses

There were no taxable expenses for Board Directors, Non-Executive Directors, or Governors this financial year.

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

Remuneration Report (audited)

NAME	JOB TITLE	PERIOD	20			
			Salary	Expense payments (taxable)	Performance pay and bonuses	
EXECUTIVE DIRECTORS			(bands of £5000) £000	Total to the nearest £100	(bands of £5000) £000	
Ms Jacqueline Totterdell	Chief Executive	from 1st May 2017	260-265	0	0	
Mr Andrew Grimshaw	Chief Financial Officer	from 19th June 2017	210-215	0	0	
Mr Paul Da Gama	Chief People Officer	from 8th February 2021	20-25	0	0	
Mr James Friend	Chief Transformation Officer	from 28th April 2017	135-140	0	0	
Ms Suzanne Marsello	Chief Strategy Officer	from 2nd January 2018	120-125	0	0	
Mr Stephen Jones	Chief Corporate Affairs Officer	from 5th March 2018	115-120	0	0	
Dr Richard Jennings	Chief Medical Officer	from 19th November 2018	195-200	0	0	
Mr Robert Bleasdale	Acting Chief Nursing Officer and Director of Infection Prevention and Control	from 17th Feb 2020	130-135	0	0	
Anne Brierley	Chief Operating Officer	from 1st October 2020 (see note 6)	95-100	0	0	
LEAVERS						
Ms Avinderjit Bhatia	Chief Nurse and Director of Infection Prevention and Control	secondment from Feb 17 to Nov 17, permanent from Dec 2017 to 31st October 2020	90-95	0	0	
Ms Elizabeth Nyawade	Acting Chief People Officer	from 19th May 2020 to 07th Feb 2021	80-85	0	0	
Ms Humaira Ashraf	Acting Chief People Officer	from 19th May 2020 to 07th Feb 2021	80-85	0	0	
Mr Harbhajan Brar	Director of Human Resources and Organisational Development	from 2nd May 2017 to 31st May 2020	25-30	0	0	
Mr Ellis Pullinger	Chief Operating Officer	from 12th June 2017 to 1st March 2020	0	0	0	
Mr Kevin Howell	Director of Estates, Facilities and Capital Projects	from 2nd January 2018 to 31st December 2019	0	0	0	
NON-EXECUTIVE DIRECTORS						
Ms Gillian Norton	Chairman (Chair Nominations and Remuneration Committee)	from April 2017	55-60	0	0	
Ms Ann Beasley	Non-executive Director (Chair Finance and Investment Committee and Senior Independent Director)	from October 2016	10-15	0	0	
Mr Stephen Collier	Non-executive Director (Chair Workforce and Education Committee)	from October 2016	10-15	0	0	
Mr Timothy Wright	Non-executive Director	from 25th September 2017	10-15	0	0	
Dr Pui-Ling Li	Associate Non-executive Director	from January 2020	5-10	0	0	
Ms Elizabeth Bishop	Non-executive Director (Chair of Audit Committee)	from February 2020	10-15	0	0	
Professor Dame Parveen Kumar	Non-executive Director (Chair of Quality & Safety Committee)	from January 2020	10-15	0	0	
Professor Jennifer Higham	Non-executive Director	from 1st November 2015	0	0	0	

Note 1. Ms Jacqueline Totterdell & Mr Andrew Grimshaw- For FY19-20 the valuation from NHS Pensions Agency resulted in a net reduction during the year which under the guidelines is reported as a zero value pension related benefit as there is no pension contribution this year because they are over the Normal Pension Age (NPA)

Note 2. Mr Harbhajan Brar and Ms Elizabeth Nyawade are not on the NHS pension scheme.

Note 3. No comparative information in 2019/20 for Mr Paul Dagama, Ms Elizabeth Nyawade and Ms Humaira Ashraf as they joined the Trust this financial year.

20/21				2019/20					
	Long term performance pay and bonuses	All pension-related benefits	Total	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	total to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
	0	0-2.5 *(Note 1)	260-265	225-230	0	0	0	0	225-300
	0	0-2.5 *(Note 1)	210-215	180-185	0	0	0	17.5-20	195-200
	0	0-2.5 *(Note 4)	20-25	0 *(Note 3)	0	0	0	0	0
	0	32.5-35	165-170	130-135	0	0	0	30-32.5	165-170
	0	40-42.5	165-170	120-125	0	0	0	10-12.5	130-135
	0	27.5-30	145-150	115-120	0	0	0	25-27.5	140-145
	15-20	72.5-75	285-290	190-195	0	0	15-20	32.5-35	245-250
	0	127.5-130	260-265	5-10	0	0	0	0	5-10
	0	127.5-131 *(Note 6)	95-100	0* (Note 6)	0	0	0	0	0
	0	37.5-40	130-135	160-165	0	0	0	1225-1227.5	1385-1390
	0	0-2.5*(Note 2)	80-85	0 *(Note 3)	0	0	0	0	0
	0	232.5-235	315-320	0 *(Note 3)	0	0	0	0	0
	0	0-2.5 *(Note 2)	25-30	165-170	300	0	0	0	165-170
	0	0	0	140-145	0	0	0	22.5-25	165-170
	0	0	0	110-115	0	0	0	0	110-115
	0	0	55-60	60-65	0	0	0	0	60-65
	0	0	10-15	10-15	0	0	0	0	10-15
	0	0	10-15	10-15	0	0	0	0	10-15
	0	0	10-15	10-15	0	0	0	0	10-15
	0	0	5-10	0-5	0	0	0	0	0-5
	0	0	10-15	0-5	0	0	0	0	0-5
	0	0	10-15	0-5	0	0	0	0	0-5
	0	0*(Note 5)	0	0	0	0	0	0	0

Note 4. Mr Paul Da Gama - For the FY20-21 the valuation from NHS Pensions Agency resulted in a net reduction during the year which under the guidelines is reported as a zero value pension related benefit.

Note 5. Professor Jenny Higham is the St George's University of London Medical School representative on the Trust Board. She is not remunerated by the Trust for her role on the Board.

Note 6. Ms. Anne Brierley is on secondment and her salary has been recharged from Kingston Hospitals. She is on the payroll from 1st April 2021.

Pensions Report (audited)

		2020/21						
NAME AND JOB TITLE	PERIOD	Real increase in pension at pension age	Real increase in pension and related lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 01 April 2021	Real Increase in Cash Equivalent Transfer Value	
		(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	
Ms Jacqueline Totterdell, Chief Executive	from 1st May 2017	0-2.5	0-2.5	0-5	0-5	0	0	
Mr Andrew Grimshaw, Chief Financial Officer	from 19th June 2017	0-2.5	0-2.5	0-5	0-5	0	0	
Mr Paul Da Gama, Chief People Officer	from 8th February 2021	(0)-(2.5)	0-2.5	15-20	0-5	238	2	
Mr James Friend, Chief Transformation Officer	from 28th April 2017	2.5-5	0-2.5	10-15	0-5	142	14	
Ms Suzanne Marsello, Chief Strategy Officer	from 2nd January 2018	2.5-5	0-2.5	50-55	110-115	956	42	
Mr Stephen Jones, Chief Corporate Affairs Officer	from 5th March 2018	0-2.5	0-2.5	5-10	0-5	71	8	
Dr Richard Jennings, Chief Medical Officer	from 19th November 2018	2.5-5	2.5-5	65-70	185-190	1525	87	
Mr Robert Bleasdale, (Acting Chief Nursing Officer & Director of Infection Prevention and Control	from 17th Feb 2020	5-7.5	10-12.5	25-30	50-55	380	76	
LEAVERS								
Ms Avinderjit Bhatia, Acting Chief Operating Officer (as of March 2020)	from Feb-17 to 31st October 2020	0-2.5	12.5-15	60-65	145-150	1183	60	
Ms Elizabeth Nyawade, Chief People Officer	from 19th May 2020 to 07th Feb 2021	0-2.5	0-2.5	0-5	0-5	0	0	
Ms Humaira Ashraf, Chief People Officer	from 19th May 2020 to 07th Feb 2021	10-12.5	5-7.5	15-20	5-10	288	198	
Mr Harbhajan Brar, Chief People Officer	from 2nd May 2017 to 31st May 2020	0	0	0	0	0	0	
Mr Kevin Howell, Director of Estates, Facilties and Capital Projects	from 2nd January 2018 to 31st December 2019	0	0	0	0	0	0	
Mr Ellis Pullinger, Chief Operating Officer	from 12th June 2017 to 1st March 2020	0	0	0	0	0	0	

Note 6. McCloud judgement:The Court of Appeal ruling on 'protection', kown as the McCloud judgement. From 1st April 2022 all active members will be members of the reformed scheme. All legacy pension schemes will be closed, including the 1995/2008 NHS Pension Scheme

Note 7. The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) Indexation on 08th August 2019. This will affect the calculation of the real increase in CETV and does not affect the real increase in pension benefits. This is more likely to affect the 1995 section and the 2008 section.

Note 8. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of non-executive directors.

Note 9. The above disclosures is audited by Trust's external auditor

Pension scheme

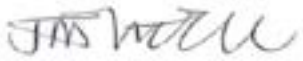
As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

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

			2019/20							
	Cash Equivalent Transfer Value at 31 March 2020	Employer's contribution to stakeholder pension	Real increase in pension at pension age	Real increase in pension and related lump sum at pension age	Total accrued pension at pension age at 31 March 2020	Lump sum at pension age related to accrued pension at 31 March 2020	Cash Equivalent Transfer Value at 01 April 2020	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
	£000	£000	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
	2075	0	(0-2.5)	(5-7.5)	95-100	260-265	2,075	16	1,995	16
	1025	0	0-2.5	0-2.5	50-55	120-125	1,025	34	961	6
	196	3	0	0	0	0	0	0	0	0
	107	19	2.5-5	0-2.5	5-10	0-5	107	11	74	19
	877	18	0-2.5	(0-2.5)	45-50	110-115	877	13	822	18
	45	17	0-2.5	0-2.5	0-5	0-5	45	5	23	17
	1396	18	0-2.5	2.5-5	60-65	180-185	1,396	57	1,289	18
	279	19	0	0	0	0	0	0	0	0
	1032	13	55-57.5	120-122.5	55-60	120-125	1,032	1,006	0	19
	0	0	0	0	0	0	0	0	0	0
	0	12	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0
	0	0	(0-2.5)	(5-7.5)	55-60	165-170	1,304	0	1,312	2
	0	0	0-2.5	(0-2.5)	30-35	65-70	560	12	513	20

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

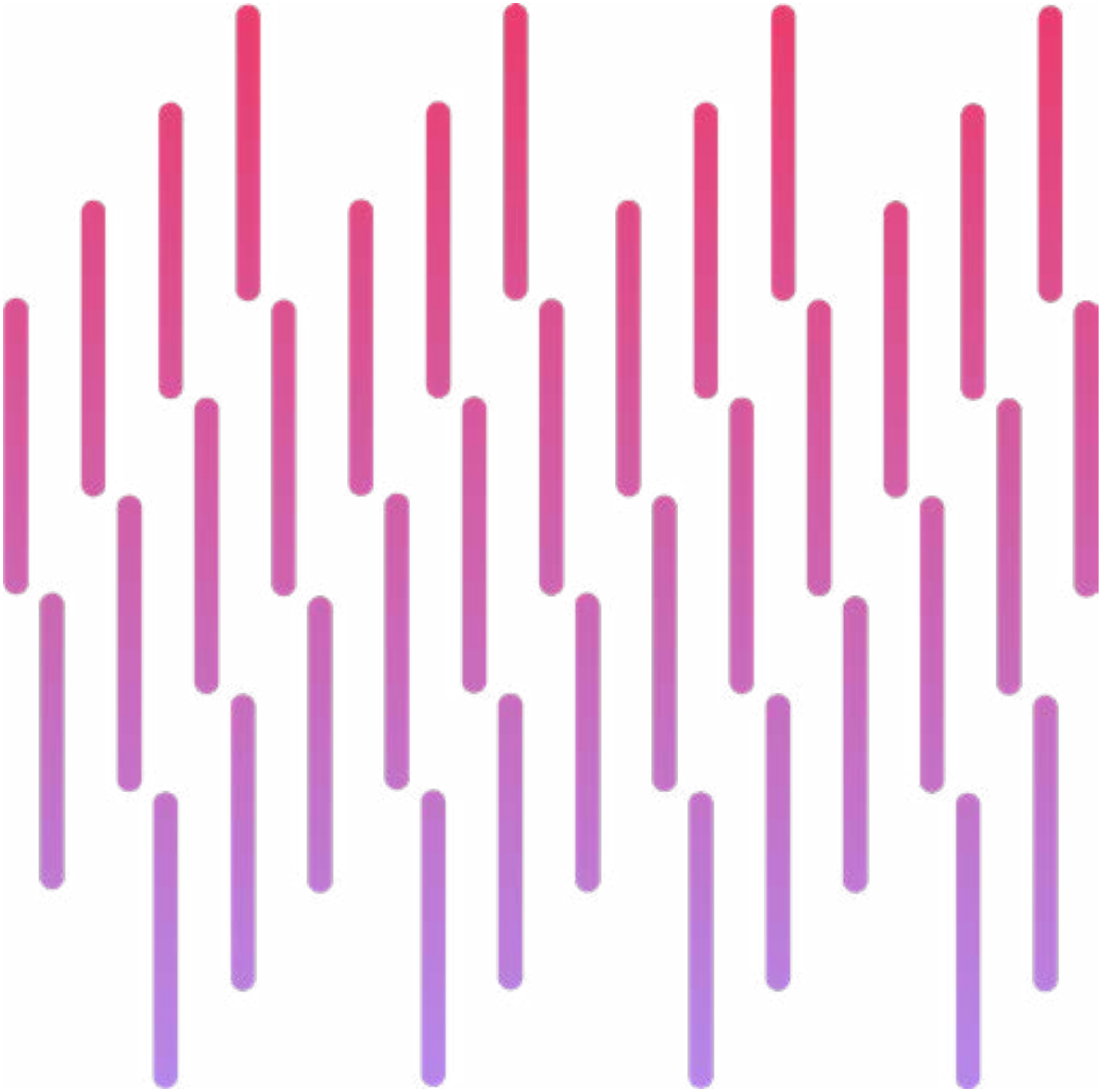
Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or an arrangement which the individual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



Jacqueline Totterdell
Chief Executive
24 June 2021

Andrew Grimshaw
Chief Finance Officer
24 June 2021

Staff report



Staff report

This year, we employed around 9,000 staff, clinical and non-clinical, all of whom contribute to providing quality patient care in our hospitals and in the local community. The majority of the Trust's staff are permanently employed clinical staff directly involved in delivering patient care. We also employ a significant number of scientific, technical, and administrative staff who provide vital expertise and support. The table below provides a breakdown of our workforce.

Male and female (Full time equivalent basis)

STAFF GROUP	WTE		%	
	Female	Male	Female	Male
Directors	9	8	52.94%	47.06%
Senior manager (AFC 8c+)	66	71	48.19%	51.81%
All staff	6,409	2,646	70.78%	29.22%

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

TYPE	2019/20			2018/19
	PERMANENTLY EMPLOYED NUMBER	OTHER NUMBER	TOTAL NUMBER	TOTAL NUMBER
Medical and dental	2,050	35	2,085	1,977
Administration and estates	1,943	177	2,120	2,116
Healthcare assistants and other support staff	1,187	121	1,308	1,284
Nursing, midwifery and health visiting staff	2,545	453	2,998	2,974
Scientific, therapeutic and technical staff	1,330	96	1,426	1,451
Total average numbers	9,055	883	9,937	9,802
Number of employees (WTE) engaged on capital projects	40	22	62	57

Sickness absence data

Sickness absence data for the financial year 2020/21 is published by NHS Digital and can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff turnover

Information of staff turnover for 2020/21 is published by NHS Digital, and can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Gender pay gap

Information on the gender pay gap can be found on the Cabinet Office website at: http://gender-pay-gap.service.gov.uk A copy of the Trust's most recent Gender Pay Gap report to the Trust Board, in May 2021, can be found at: https://www.stgeorges.nhs.uk/about/our-board/board-meetings/board-papers/

Disclosures required by Health and Social Care Act

Total employee expenses

COST	2020/21			2019/20
	Permanently employed £000	Other £000	Total £000	Total £000
Salaries and wages	446,997	44804	491,801	436,512
Social security costs	51,852	0	51,852	47,251
Apprenticeship Levy	2,332	0	2,332	2,135
Employer's contributions to NHS pensions	53,231	0	53,231	49,623
Pension Cost – employer contribution paid by NHSE on provider's behalf (6.3%)	23,324	0	23,324	21,772
Pension cost – other	53	0	53	0
Other post-employement benefits	0	0	0	0
Other employement benefits	0	0	0	0
Temination benefits	272	0	272	271
Temporary staff	0	15544	15,544	18,502
Total gross staff costs	578,061	60,348	638,409	576,066

Expenditure on consultancy

EXPENDITURE ON CONSULTANCY	2020/21	2019/20
Consultancy costs (£k)	1,176	2,361

Staff exit packages (audited)

EXIT PACKAGE COST BAND	NUMBER OF COMPULSORY REDUNDANCIES	NUMBER OF OTHER DEPARTURES AGREED	TOTAL NUMBER OF EXIT PACKAGES BY COST BAND
<£10,000	0	3	3
£10,001 – £25,000	0	2	2
£25,001 – £50,000	0	2	2
£50,001 – £100,000	0	0	0
£100,001 – £150,000	0	0	0
£150,001 – £200,000	1	0	1
Total number of exit packages by type	1	7	8
Total resource cost (£k)	£160	£112	£272

Exit packages: non-compulsory departure payments (audited)

OTHER (NON-COMPULSORY) DEPARTURE PAYMENT	AGREEMENTS NUMBER	TOTAL VALUE OF AGREEMENTS £0
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	7	112
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	7	112

Off-payroll engagements (audited)

Table 1: For all off-payroll engagements as of 31 March 2021 for more than £245 per day and that last longer than six months.

	2020/21 NUMBER OF ENGAGEMENTS	2019/20 NUMBER OF ENGAGEMENTS
Number of existing engagements as of 31 March 2019	28	11
Of which…		
No. that have existed for less than one year at time of reporting	17	6
No. that have existed for between one and two years at time of reporting	7	2
No. that have existed for between two and three years at time of reporting	2	0
No. that have existed for between three and four years at time of reporting	0	0
No. that have existed for more than four years at time of reporting	0	0

Table 2: For all new off-payment engagements, or those that reached six months duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last longer than six months.

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

Table 3: For any off-payroll engagements of Board members, and/or senior officials with any significant responsibility, between 1 April 2020 and 31 March 2021.

	2020/21 NUMBER OF ENGAGEMENTS	2019/20 NUMBER OF ENGAGEMENTS
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	0	0

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

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

Staff engagement

Our workforce is the most valuable asset we have. We understand the importance of engaging with our staff, because an engaged workforce delivers better patient care. We are committed to developing a modern and flexible workforce and make use of new and innovative roles to support the delivery of outstanding patient care. As part of this, we are stepping up the ways in which we recruit, retain, train, develop and educate our staff. Effective staff engagement underpins this.

Ways in which we engage with staff include:

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

In 2021/21, this work was monitored at Executive level by our People Management Group and Trust Management Group, and at Board level by the Workforce and Education Committee as well as by the Board itself.

Our culture improvement programme

In early 2020, we embarked on an exciting new project to strengthen the culture of St George's, so the Trust becomes a better place in which to work and to be treated.

We know the culture of our organisation can sometimes make our working lives difficult; from how we treat each other, to challenges we face when trying to make changes or introduce improvements.

To implement positive cultural changes, we are using the NHS Improvement's Culture and Leadership Programme framework, which has been applied in around 100 other NHS Trusts.

The first phase of the programme is known as the culture discovery phase and involved appointing a diverse group of culture champions from across the Trust to advocate for and deliver the work.

Our dedicated champions held more than 30 focus groups with junior staff across the Trust; interviewed 25 of our senior clinicians and managers (including Trust Board members); surveyed more than 500 staff members at band 7 and above; and used NHS staff survey and NHS Friends and Family Test data to better understand the culture of St George's.

Their findings were shared with all staff in November 2020 and six key themes for improvement were identified. They are:

- clearer decisions on the Trust's priorities, which balance the needs of the organisation, staff and patients;
- an environment where staff feel empowered to work together and improve services;
- investment in building strong leadership across all levels;
- an environment where people feel safe to share their views and learning;
- learning, innovation, and teamwork at the heart of how we do things;
- a commitment to long term improvement, supported by consistent processes and structures.

Once the findings and the six key themes were published, our staff were then asked to give their feedback. We wanted to know if they agreed with the areas of focus, and if not, tell us where they would like improvements to be made.

The feedback from staff, as well as the initial findings, fed directly into phase two of the programme, which is the agreement by the Board of the plan for strengthening culture which the Board reviewed in May 2021.

We know that change will not happen overnight, but our Trust Board is committed to improving our culture and the experience of our staff.

The third and final phase of the programme will be the delivery of our plan for change. This will again be a collaborative process, with staff kept informed and given the opportunity to share their views throughout.

The potential for cultural change in our organisation is enormous, and we are optimistic and excited for the future of St George's.

Diversity and inclusion

As with an engaged workforce, an inclusive culture at St George's not only improves the experience of our staff, but also offers benefits to our patients. Although we have made progress with our diversity and inclusion agenda over the past year, we are aware there is still more to do to reach our aim of every employee feeling that diversity, difference and uniqueness are truly valued.

St George's is the largest healthcare provider in south west London, and it is crucial that the diversity of our workforce reflects the diversity of the communities we serve.

Diversity and Inclusion Action Plan

In July 2020 our Trust Board approved our Diversity and Inclusion Action Plan, which was drafted in response to issues raised by staff – specifically from BAME backgrounds – through a variety of events and engagement sessions. The plan includes a number of short, medium, and long-term actions devised to address the challenge of achieving a real and sustainable difference in closing the gap in workplace inequalities that exist between BAME and white staff. Its indicators also link to the NHS Equality Delivery System (EDS2) and our public sector equality duties. The plan consists of a series of projects and initiatives under the following headings:

Key priority projects

- Improving the career progression of BAME staff.
- Improving development opportunities and ensuring equal access to development for staff.
- Listening and responding to concerns raised by BAME staff.

Changing behaviours and attitudes

- Leadership commitment.
- Building awareness and understanding.

Each workstream is led by an executive lead and supported by a professional lead and project manager, and success will be measured using the NHS Workforce Race Equality Standard (WRES) which provides a baseline to demonstrate progress against nine indicators of staff experience (see below). We have also developed targets and success measures for the other protested characteristics.

Progress with our action plan

Progress has been impacted by Covid-19 and the increased pressures on staff inside and outside of the Trust, however it has remained a key priority for St George's. With the successful appointment of a substantive Diversity and Inclusion Workforce Lead, and a Director of Education and Organisational Development, we have seen a number of initiatives introduced.

These include:

Recruitment Inclusion Specialists (RIS) Approximately 47% of our staff are from BAME backgrounds. The majority of these staff are in the lower banded grades, band 2 to band 5. The percentage of BAME staff in higher bands 8a and above, however, falls considerably.

To help tackle this, at St George's it is now a mandatory requirement for all medical recruitment and Agenda for Change (AfC) Bands 7 and above to include a trained Recruitment Inclusion Specialist (RIS) on the interview panel. This applies to all substantive, fixed term, secondments and acting up opportunities.

This process is currently being trialled for Band 6s with a view to mandating this in the coming months.

We have developed and delivered a bespoke training programme, training more than 100 members of staff to support and promote the RIS process.

Development and launch of 'Let's Talk about Race and Inclusion'
We developed a toolkit for leaders to begin conversations with their teams around race and inclusion. It was created in-house in consultation with our Black, Asian, and Minority Ethnic (BAME) network and other stakeholders. The toolkit includes suggested discussion questions and advice for facilitating inclusive dialogue.

Exploring our Bias and Building Inclusion workshop
This 2.5 hour online workshop is a refreshed take on 'unconscious bias' training. It has been piloted with a number of services and will be launching Trust-wide. Learning objectives include describing why tackling bias and discrimination are important priorities for St George's, and how we can challenge ourselves and others on our biases.

Leadership development training
Our leadership offerings have been updated to ensure inclusion runs through all programmes. This includes the commission of a five-module programme facilitated by the King's Fund, which includes one module on inclusive leadership within the NHS.

Continuous professional development (CPD) review panel
We have introduced a review panel to ensure equality of access for all CPD.

Diversity and inclusion intranet hub
We have developed a diversity and inclusion hub on our new staff intranet – a much needed central resource for all inclusion-related information. It includes news and events, a yearly diversity and inclusion calendar, ways to get involved, staff network pages, our action plans, and RIS guidance.

WRES expert programme
Following a successful application process, our Trust diversity and inclusion lead joined the London WRES Expert Programme. This course was developed in collaboration with NHSE/I and is designed to develop a generation of leaders dedicated to addressing and advocating for issues related to race inequality within the workplace.

Diversity and inclusion initiatives at a local level

As well as Trust-wide improvement programmes, throughout the year teams have been driving local initiatives in their areas. For example, staff in specialist medicine created an action plan to become a more inclusive directorate, based on hearing staff experiences at listening events. This includes a task and finish group on becoming anti-racist, and a virtual monthly book group to help deepen their knowledge.

Staff networks

Our four networks launched in late 2019 and have grown steadily over the last year under the direction of their nominated leadership committees. Our diversity and inclusion workforce lead has worked closely with each network and supported several events and initiatives, including the development of network action plans for three of the four networks. The current membership for each network is listed below:

- **Black, Asian, and Minority Ethnic (BAME) staff network** – current membership 125
- **Disability and Wellbeing staff network** – current membership 46
- **LGBTQ+ staff network** – current membership 106
- **Women's staff network** – current membership 37

Workforce Race and Equality Standard (WRES)

Since 2017, all healthcare providers have been required to publish their Workforce Race Equality Standard data which reports on the experience and treatment of Black, Asian, and Minority Ethnic staff. Our most recent WRES report, published in August 2020, uses data taken from our 2020 NHS Staff Survey results.

WRES INDICATOR	2019	2020
Relative likelihood of white applicants being appointed from short listing across all posts compared to BAME applicants	1.57	1.47
Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	1.82	2.54
Relative likelihood of white staff accessing non mandatory training and CPD compared to BAME staff	31%	35%
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27.4%	28%
Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	30.8%	30.1%
Percentage of BAME staff believing the Trust provides equal opportunities for career progression or promotion	63%	63%
Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	16.2%	18.0%
BAME Board membership	-32.1%	-25.9%

Workforce Disability Equality Standard (WDES)

The WDES was introduced in 2019 and is designed to improve the experiences of people with disabilities working in, or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its staff. These findings inform the organisation's WDES Action Plan, which aims to directly address inequalities faced by disabled members of staff. Our most recent WDES report, published in December 2020, reports on data from a snapshot date of 31 March 2019. You can view it on our website at: www.stgeorges.nhs.uk/about/living-our-values/equality-diversity-and-inclusion/wdes/

Our Sickness Absence Management policy and policy on the Employment of Disabled People have both been reviewed with input from our Staff Side representatives. The policy on the Employment of Disabled People sets out our commitment to support disabled people from the point at which they are recruited, through to circumstances where an employee becomes disabled during their employment. We are committed to making all reasonable adjustments and if necessary, finding alternative employment for staff who become disabled while working at St George's.

Improving staff health and wellbeing

We want everyone who works at St George's to feel supported with their physical and mental health. With Covid-19 placing enormous pressure on our staff, the Trust and NHS England have introduced a range of supportive measures. In 2020/21, health and wellbeing opportunities offered to staff included:

- new, accessible Wellbeing Hubs that offer free hot drinks, snacks, magazines, comfortable seating, and rest pods
- a staff counselling service offering up to six free sessions of confidential one-to-one support
- care packages that were delivered to all staff – in partnership with St George's Hospital Charity.
- a Health and Wellbeing Week, held in October 2020, which offered free online wellbeing talks, activities and classes
- free hot meals to all staff during the first wave of the Covid-19 pandemic, and ongoing free hot meals to staff working on Covid-19 wards
- free annual flu vaccination and Covid-19 vaccination
- Mind Your Health booklet, which contains information and signposting for managing emotional distress
- a wellness action plan for staff to fill out with line managers to identify what keeps us healthy at work
- group debrief and reflective sessions facilitated on wards
- a Covid-19 telephone and email support service
- fast-tracked physiotherapy through Occupational Health
- Schwartz Rounds, which promote open discussions and support staff wellbeing
- ongoing wellbeing training, including mental health awareness training
- smoking cessation support
- more counsellors within our staff counselling service.

To guide us out of the Covid-19 pandemic, we have produced a robust 'decompression' plan. This involves providing all staff with access to training to support their mental and physical wellbeing at work; increasing capacity within our staff counselling service; improving facilities for staff to stay healthy and well whilst at work (including investing in cycle storage, shower facilities and rest areas); and providing free or reduced cost staff wellbeing classes.

We were pleased to see our health and wellbeing scores on the 2020 NHS Staff Survey improved from the previous year (see below), but we know there is still more we can do. Staff health and wellbeing will remain a key focus in the year ahead as we continue our journey to make St George's a fully health promoting Trust.

NHS Staff Survey 2020

The NHS Staff Survey is conducted annually and provides a highly valuable insight into what our staff think about the Trust and how they are treated. The feedback we receive from the survey is carefully analysed and used to inform our staff engagement plans and our ongoing work to improve the culture at St George's.

In October 2020, Staff Survey questionnaires were sent to 8,602 eligible members of Trust staff and of those, 5,107 were returned. This was a 59.4% response rate, which is more than 10% higher than the average response rate for Acute and Acute & Community Trusts nationally (49%). A high response rate is extremely helpful as it helps us to understand what our staff think is working well, and areas for improvement. In this year's survey, the results were grouped into ten indicators. In the table below, our average scores (out of 10) are compared to the national average for each indicator and to our scores from 2019.

	2020/21		2019/20		2018/19	
	TRUST	BENCHMARKING GROUP	TRUST	BENCHMARKING GROUP	TRUST	BENCHMARKING GROUP
Equality, diversity and inclusion	8.4	9.1	8.5	9.0	8.4	9.1
Health and wellbeing	5.9	6.1	5.5	5.9	5.6	5.9
Immediate managers	6.6	6.8	6.5	6.8	6.4	6.7
Morale	6.0	6.2	5.7	6.1	5.6	6.1
Quality of appraisals	7.6	7.5	5.7	5.6	5.6	5.4
Quality of care	7.8	8.1	7.5	7.5	7.4	7.4
Safe environment – Bullying and Harassment	9.3	9.5	7.6	7.9	7.6	7.9
Safe environment - violence	6.6	6.8	9.4	9.4	9.4	9.4
Safety culture	7.0	7.0	6.5	6.7	6.4	6.6
Staff engagement	6.4	6.5	6.9	7.0	6.8	7.0
Team work	6.4	6.5	6.4	6.6	n/a	n/a

Comparing our results to last year, we are pleased to see we have improved in seven of the indicators, however we have stayed the same in one and worsened in two.

Positive takeaways from our results are that:

- 67% of staff said they would recommend the Trust as a place to work (a 6% increase from 61% in 2019)
- 76% of staff said they would be happy for their friend or relative to receive care at the Trust (an increase from 72% last year)
- 79% of staff said care of patients / service users is our top priority (up from 77% in 2019)

The ten indicators are compared against other Trusts nationally and show that we are below the NHS average on eight indicators, and equal or above the NHS average on two.

The results show that, despite progress in some areas, we still have more work to do to make St George's a truly outstanding place to work, and to be treated.

Future priorities and targets

The results of the Staff Survey have been shared in full with our Trust Board which is committed to making substantial progress in strengthening the culture of the Trust.

Over the coming year, we will focus on five key areas for improvement. These areas of focus will be known as our 'Big 5' priorities and they are:

1. Health and wellbeing
– looking after the physical and mental health of staff

2. Let's talk
– making it easier for staff to speak up, and raise concerns

3. Flexible working
– supporting flexible working for the benefit of staff and patients

4. Fair career progression
– building a culture where career progression is based on merit and hard work only

5. Creating a better workplace
– giving staff the tools and equipment they need to do their job effectively

Our efforts to deliver improvements do not start and end with our Big 5, but they do give our staff clarity about where we are focussing our energies. The Staff Survey results helped shine a light on many other areas for improvement, which we are already working hard to address.

Training and education: giving staff the skills they need

Although most of our non-essential training programmes had to pause during the second Covid-19 wave, we were committed to ensuring staff had the skills needed to carry out new aspects of their roles brought about by the pandemic. Education also played a part in preparing staff to the meet the changing clinical needs of the Trust. Some examples are outlined below.

- Our GAPS Simulation and Skills Centre developed and held some highly interactive and realistic sessions for staff in preparation for being deployed to medical wards during the second Covid-19 surge. This included critical care and ITU medical and nursing training, and covered adapting to different demands on team dynamics when managing Covid-19 patients, as well as specialised PPE requirements, and use of treatment escalation plans. The Centre also held similarly interactive palliative care communication training which focussed on managing Covid-19 inpatients receiving a ward-based ceiling of care, and communicating with their families.

- In partnership with the St George's, University of London, our nursing education team provided fast-track training for students and volunteers to become healthcare support workers (HCAs) and work in the Trust via Staff Bank. Initially the training programme was for ward areas, but as critical care capacity expanded, it was re-designed specifically for deployment to ITU areas.

- Our education centre became a hub for Nurse Refresher Training sessions which were provided to nursing staff in preparation for returning to frontline care and if being re-deployed.

- An enhanced induction was provided for Physician Associates so they could undertake their final placements in the Trust and graduate on schedule.

Guardian of Safe Working

We have a Guardian of Safe Working to ensure our doctors are always working a safe number of hours. The Guardian receives reports, and monitors compliance against our doctors' terms and conditions. Where necessary, the Guardian escalates issues to the relevant Executive Director for decision and action to reduce any risk to our patients' safety. The Guardian produces a quarterly report to the Trust Board and this is also presented to the Workforce and Education Committee.

Trade union facility time

The following information is published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations. The relevant period is 1 April 2020 to 31 March 2021.

ACTIVITY	TIME OR COST
Number of trade union representatives	53
Total FTE of trade union representatives	50.12
Number who spend between 1 – 50% of their time on Trade Union activities	53
Number who spend 100% of their time on trade union activities	0
Total Trust pay bill	£614,422,380
Total cost of facility time	19285.32
Percentage of total pay spent on facility time	0.003%
Hours spent on paid facility time	1337
Hours spent on paid trade union activities	1170
Percentage of total paid facility time hours spent on paid TU activities	87.51%

Freedom to Speak Up Guardian

The Trust has long experienced challenges in relation to staff feeling safe to raise concerns. We know that staff fear the consequences of speaking up and lack confidence that action will be taken in response to their concerns.

In late 2019/20, we asked NHS England and NHS Improvement to undertake a review of the Trust's arrangements in relation to Freedom to Speak Up. The report was received in March 2020 and set out a number of steps to strengthen the Trust's approach. In July 2020, following the departure of the Chief People Officer, the Chief Corporate Affairs Officer was appointed as Executive Lead for Freedom to Speak Up. In the same month, the Trust restructured the role of Freedom to Speak Up Guardian, bringing the role into line with the role description from the National Guardian's Office, focusing it full time on Freedom to Speak Up, and increasing the role's banding from a Band 6 to a Band 8a. Karyn Richards-Wright was appointed to this newly established role in July 2020. The Trust also developed its first vision and strategy for Freedom to Speak Up, with the Board approving this at its meeting in September 2020. The Trust is now implementing this strategy, the progress of which is being monitored closely by the Board and the Workforce and Education Committee.

We are undertaking an active programme to engage staff and strengthen our approach to Freedom to Speak Up, and have a number of initiatives planned during 2021/22.

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

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

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

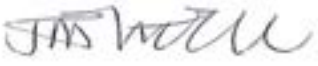
In preparing the accounts and overseeing the use of public funds, I can confirm we comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular:

- we have observed the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- we have made judgements and estimates on a reasonable basis
- we have met the applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) and have followed, disclosed and explained any material departures in the financial statements
- ensured that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess St George's University Hospitals NHS Foundation Trust's performance, business model and strategy, and
- prepared the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

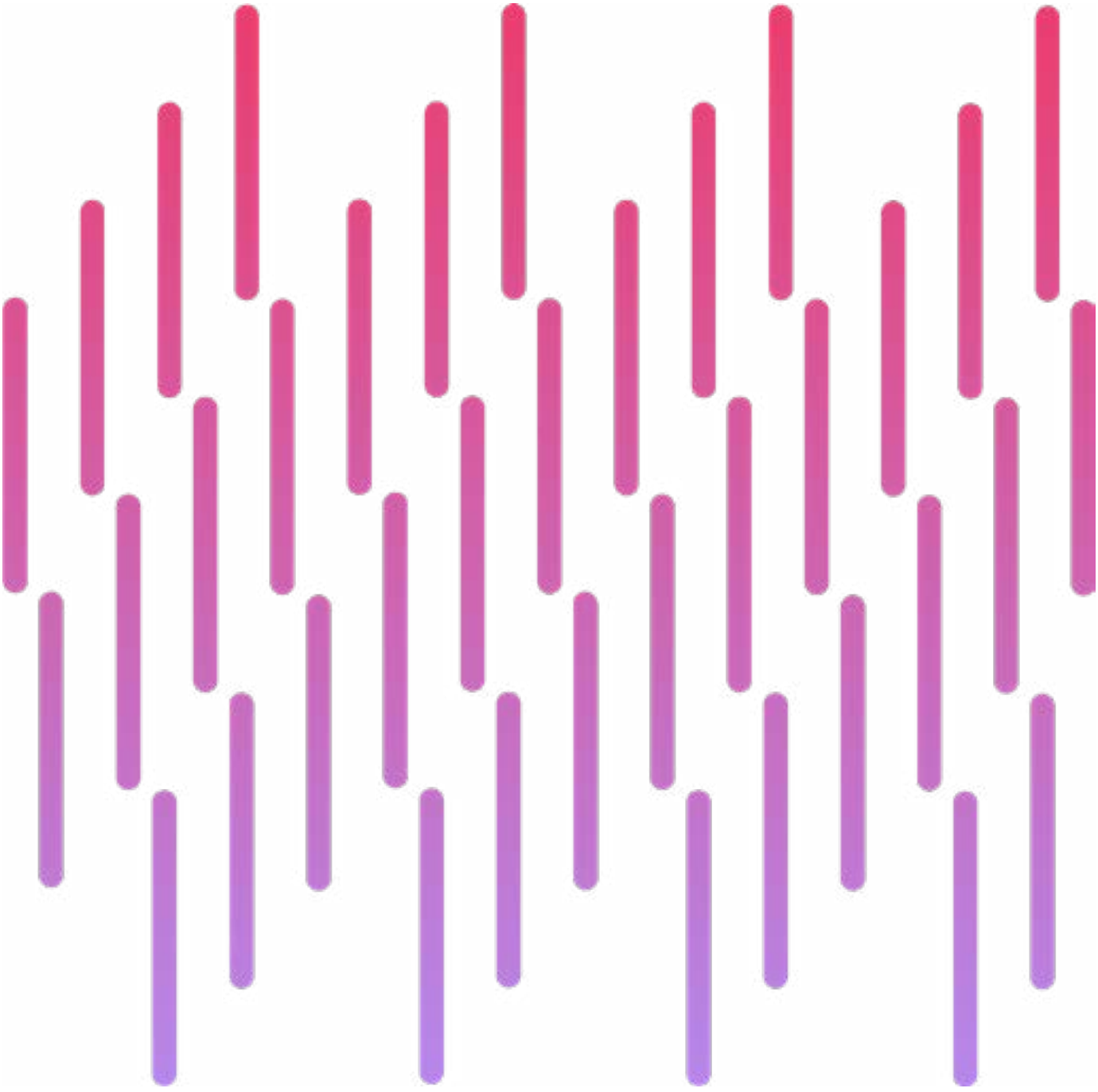
As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that St George's University Hospitals NHS Foundation Trust's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

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



Jacqueline Totterdell
Chief Executive
24 June 2021

Annual Governance Statement



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

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

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of St George's University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

The Board itself has standing orders, reservation and delegation

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

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

Senior leadership in corporate governance is provided by the Chief Corporate Affairs Officer who also acts as the Trust Secretary. Governance is embedded across the Trust's Directorates and the three clinical divisions are led by a Divisional Chair, ensuring clear responsibility and accountability across the Trust.

Each division has an established governance structure which reports into the Trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks. The Trust undertakes regular reviews of its governance structures including reviewing the effectiveness of its committees and groups.

During 2020/21, the Trust took a number of steps to further strengthen its governance arrangements to ensure they continued to be fit for purpose and support the delivery of key activities. In June 2020, the Trust introduced new executive governance structures, the design, development and implementation of which was led by the Chief Financial Officer. The Trust replaced its Trust Executive Committee, which had been in place since January 2018 as a formal Committee of the Board, with Trust Management Group which is accountable to the Board through the Chief Executive. Four sub-groups of the Trust Management Group were established to provider leadership and oversight of key areas: Patient Safety and Quality Group; Operations Management Group; People Management Group; and Risk and Assurance Group. Each of these groups reports into the Trust Management Group.

In addition, following the completion of two clinical governance reviews during 2019/20, the Trust appointed an external lead to undertake a third review, which focused on ward-to-board clinical governance structures and reporting. The report of this review was received during late 2020/21 and the recommendations and actions arising from this review were considered by the Quality and Safety Committee and the Trust Board in May 2020. At the same time, the Board, through the work of the Quality and Safety Committee, has continued to monitor the detailed action plan which was developed in response to the first two phases of the clinical governance review.

We have continued to review the effectiveness of our Board Committees in 2020/21, and made improvements where appropriate.

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

Risk and Control Framework

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

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

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

The Board Assurance Framework supports the process for monitoring ongoing compliance with the requirements for registration set by the Care Quality Commission (CQC), with mapping of the regulations to strategic priorities.

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

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

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

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

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

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

Risks to the Trust

As with all NHS organisations, balancing the need to deliver high quality care in the context of increasing demand and acuity, while increasing productivity, represents an on-going challenge, and this plays out against a backdrop of significant changes in terms of integrated, cross-system working. This context is important in understanding both St George's risks, and some of the drivers of those risks, as well as the constraints on the mitigations that the Trust can necessarily call upon.

The Board agreed the major risks relating to the delivery of its strategy in April 2019 and reviewed and updated these in May 2020. The strategic risks below are recorded in detail in the Board Assurance Framework as at May 2021. These are monitored monthly by the relevant Board Committees

and by the Board on a quarterly basis, and are available in full via the Board papers on the Trust's website. In May 2020, the Board considered whether to add a new strategic risk to the Board Assurance Framework in relation to the risks associated with the Covid-19 pandemic. Following careful consideration, the Board decided against adding a specific Covid-19 risk on the basis that the pandemic was, and would continue to, have an impact across all of the existing strategic risks on the BAF. As a result, the Board decided that the BAF should set out explicitly for each strategic risk the impact of Covid-19 so that the variegated impact of the pandemic could be understood and where possible managed and mitigated. The Corporate Risk Register contains specific risks associated with Covid-19.

Strategic Risks on the 2020/21 Board Assurance Framework (the impact of Covid-19 was mapped against each individual risk)

TRUST OBJECTIVE	RISK DESCRIPTION	MITIGATION
Care	**Our patients do not receive safe and effective care build around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation.** **We are unable to provide outstanding care as a result of weaknesses in our clinical governance.** **Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around patients' lives.** **We are unable to provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure.**	**In 2020/21, the impact of Covid-19 against all of our strategic risks related to patient care was significant. Specific risks around Covid-19 infection, transmission, the availability of personal protective equipment, and the impact on waiting times were added to the Corporate Risk Register. The ongoing impact of the pandemic, particularly during the first and second surges of Covid-19 in the spring and winter, were carefully monitored. Throughout, the priority for the Trust was to ensure the safety of our patients and our staff during a period of unprecedented challenge.** **In relation to the specific strategic risks set out on the BAF, we sought to mitigate these risks through a number of actions. We continued to implement our Quality and Safety Strategy, which the Board approved in January 2020, which provided clarity about how we would achieve outstanding care and minimise harm. In relation to Covid-19, we introduced new processes for separating clinical pathways, introduced testing for patients and staff, and made compulsory mask-wearing on wards. We invested in our emergency floor and increased the number of single room isolation facilities. We also continued to implement the recommendations of the first two clinical governance reviews to ensure identified weaknesses in our governance capacity and processes were improved. This involved making significant investment in strengthening our mortality and monitoring meetings, our multi-disciplinary team meetings, investment in our risk management and legal services teams, and the strengthening of our medical directorate through the appointment of three new Deputy Chief Medical Officers to lead on patient safety, quality improvement and workforce. At the same time, we continued to implement the recommendations of the independent mortality review and independent scrutiny panel to improve our cardiac surgery service.** **In terms of our operational performance, we have also taken steps to mitigate the risks of delays to treatment. During the year, we recorded improved compliance with the four-hour emergency operating standard. Within the constraints of responding to the Covid-19 pandemic, we continued to provide priority one and two cancer care and have sought to sustain elective work where it was safe to do so. We have also developed and are implementing plans to ensure that the backlog of elective care is addressed promptly.** **In terms of our estate, the Board has significantly increased its assurance regarding the management of the estate, and action has been taken to develop a new estates strategy which will be presented to the Board for approval in the coming months.**

TRUST OBJECTIVE	RISK DESCRIPTION	MITIGATION
Culture	We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best. We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels.	Improving our culture has been one of our key areas of focus in 2020/21. Covid-19 highlighted the differential risks facing patients and staff from Black, Asian and Minority Ethnic backgrounds and feedback from our staff highlighted the scale of the challenges we continue to face in building an inclusive culture within the organisation. To address the risks identified, we developed and the Board approved a new diversity and inclusion action plan and put in place new measures to improve the recruitment of staff from BAME backgrounds. We developed a new vision and strategy to support staff in raising concerns and speaking up, and have taken a number of steps to strengthen our Freedom to Speak Up capacity and processes. We also continued to focus on our programme of strengthening our culture. During the year, we completed the diagnostics phase of this work and developed an action plan, which was considered by the Board in May 2021, to improve our culture. We have also taken steps to improve how we manage employee relations cases and address bullying and harassment. In addition, we have restructured our Human Resources department to better support staff across the organisation.
Collaboration	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London. We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to release wider efficiency opportunities. We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds. Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	Covid-19 has meant working in new and innovative ways both within the Trust and across the system. In 2020/21, we have been actively involved with our partners across South West London and across the capital as a whole in responding to the pandemic. We are actively involved with our partner organisations in managing the impact of the pandemic on our elective patients, in expanding our intensive care bed base and providing mutual support. We also progressed with the creation of a new South West London Procurement Collaborative, which went live from 1 April 2021 as well as working to expand South West London Pathology to include Epsom and St Helier University Hospitals. At the same time, we have embarked on an important initiative to explore opportunities for closer collaboration with Epsom and St Helier University Hospitals, for the benefit of the patients and communities both Trusts serve. We have appointed a strategic committees-in-common, comprising a number of Board members drawn from both Trusts, to oversee and develop this exciting work. In terms of our financial risks, 2020/21 was a very usual year as a result of the Covid-19 pandemic. However, NHS England and NHS Improvement decided in December 2020 to take the Trust out of financial special measures, and we ended the year in breakeven position. While long-term access to sufficient capital remains uncertain, during the year we have also secured significant capital investment which we have used to improve our IT systems, our estate, and invest in critical care capacity. In relation to research, Covid-19 has had a dual effect; creating new and collaborative opportunities for ground-breaking Covid-19 research, while also hindering planned non-Covid research. We have been successful in undertaking significant Covid clinical research with over 6,000 patients recruited to 39 clinical trials. We have also had a high profile in Covid vaccine studies, with the trust being the UK lead for the Novavax vaccine study. In the longer term, we have also made steps to mitigate the risks around research through the launch of our new Translational and Clinical Research Institute.

Information governance

The Board is aware of the importance of maintaining high standards of information governance (IG), including protecting the confidentiality of patients' and staff information.

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

The Deputy Chief Executive and Chief Financial Officer is the Senior Information Risk Officer and the Deputy Chief Medical Officer (for Improvement and Innovation) is the Caldicott Guardian. The Trust also has an Information Governance Management Team consisting amongst others of the Chief Information Officer, the Data Protection Officer, and the Information Governance Manager. The Trust has a range of policies, procedures, and training to ensure that all staff are aware of information governance requirements. The achievement level assessed within the DSPT provides an overall indicator of compliance against the National Data Security Standards.

During the financial year 2020/21 there were no incidents reported to the Information Commissioner's Office (ICO). The Information Governance Team is working together with other teams in ICT on the National Data Opt-Out process to reach compliance later in the year.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and the Audit Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

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

Internal audit reports are issued to and followed-up with the responsible executive directors and the results are reported to the Audit Committee. Internal audit reports are also made available to our external auditors, who may rely on them in arriving at their annual opinion. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern.

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

The Board Assurance Framework provides the Board with evidence that the effectiveness of the controls used to manage the risks to the organisation in achieving its strategic objectives have been regularly reviewed. The Trust's committee structures ensure sound monitoring and review mechanisms to make certain that the systems of internal control are working effectively. Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports and mortality monitoring; and reports from external assessments. I am confident as to the effectiveness of the system described above and that conclusion is informed in a number of ways.

Conclusion

The Head of Internal Audit has provided reasonable assurance that no significant internal control issues have been identified. The opinion is that overall reasonable assurance could be provided, and that the controls are generally sound and operating effectively. Through review of these assurances, the Board has considered any issues that fall within the definition of 'significant issue' according to the requirements of this governance statement.

Additional disclosures

This year has been an extremely busy time for Emergency Preparedness Resilience and Response (EPRR) due to Covid-19, and the conclusion of the transition period in January 2021 of the UK's withdrawal from the European Union.

Like many NHS organisations, the past year saw the Trust having to respond rapidly to the Covid-19 pandemic, which had a significant impact on the range of services the Trust provides. Clinical and operational teams across the Trust made rapid changes to the way services were provided and delivered, so ensuring the Trust was able to provide emergency, urgent and cancer care at all times during the pandemic.

The Trust continued to provide key services, such as outpatient services, but in new and different ways – and as of February 2021, approximately 42% of outpatient appointments were run virtually, so reducing the impact of Covid-19 on routine and planned care services.

The Trust Board agreed a new winter plan in September 2020, which formalised the organisation's forward response to the expected pressures of winter, future Covid-19 surges, as well as influenza. This incorporated key learnings from the first Covid-19 surge in Spring 2020 – and a separate project is underway to examine other ways in which the Trust can learn from the events of the past year, and deliver improvements for patients and staff.

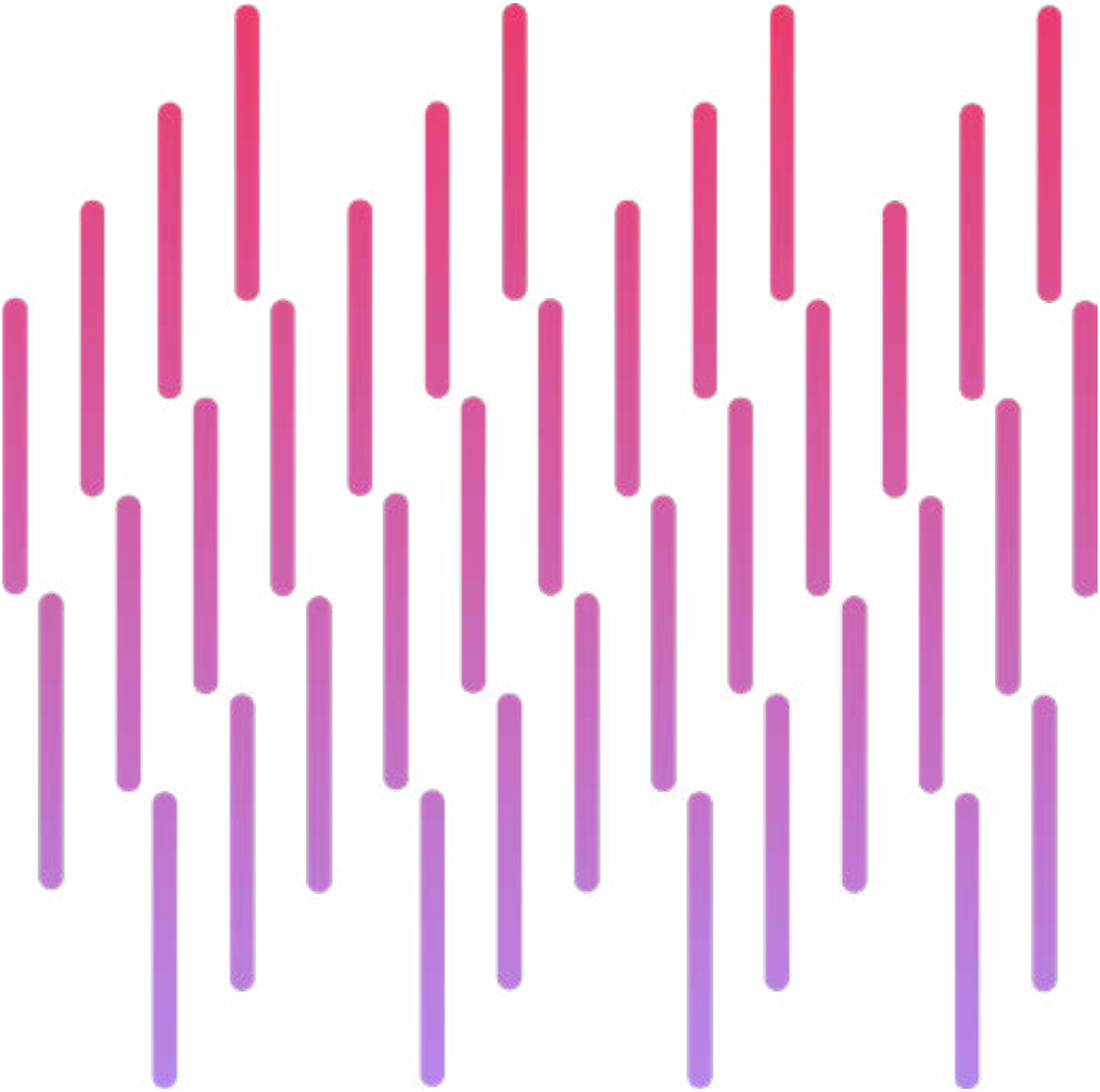
Separately, the Trust undertook detailed planning and preparation to support the conclusion of the transition period in January 2021 of the UK's withdrawal from the European Union. This helped ensure the Trust had plans in place to ensure key factors – such as staffing, and supplies – were not affected.

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

Performance is monitored monthly, via the monthly quality and performance framework, by the Finance and Investment Committee and the Board. Our performance is reported through a number of key performance indicators (KPIs) through the appropriate regulatory framework. At the end of this reporting period, March 2021, the Trust was performing positively against a large number of key indicators. However, there remain challenges in the wake of Covid-19 including our Referral to Treatment times (RTT), and need for a wider elective recovery plan.

Jacqueline Totterdell
Chief Executive
24 June 2021

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.

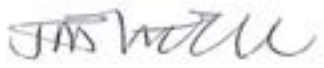
We have introduced positive changes to the department in recent months, and data from the National Institute for Cardiovascular Research (NICOR) continues to demonstrate that the service is safe, and no longer an outlier for mortality which means the service is no longer subject to external scrutiny.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

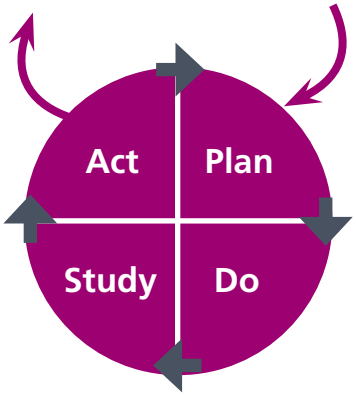
CARE	CULTURE	COLLABORATION
We will keep staff safe, and invest in their health and wellbeing **We will share the findings of our culture discovery project, so we understand how staff feel about working at St George's** **We will work more closely with local hospitals and partner organisations in south west London**	**We will make sure we are prepared to meet the demands of Covid-19, flu and winter** **We will develop a plan with staff to improve our culture, and measure the impact it is having** **We will overcome challenges together, rather than as individual organisations**	**We will provide routine and planned care, and keep patients safe during their stay** **We will celebrate diversity, and support our leaders to be more inclusive** **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** **Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 and 2020/21** **80% of adult inpatients will have a TEP (compared with 33% in April 2021)** **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)** **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.** **Progress further the implementation of Red to Green in iClip to highlight the issues that delay discharge** **Continue to survey our patients on discharge and respond to what they tell us to ensure our patients are equipped with the information they need to manage their health and know how to access appropriate support** **Continue to improve our process for discharge summaries and enable our patients to leave our care with a follow up appointment or investigation date if required**	**Reduction in the number of patients awaiting external assessment, repatriation or external care when compared with the 2020/21 baseline (fast track process implemented due to pandemic in 2020/21)** **See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2019/20 and 2020/21** **Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2020/21** **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: • Four hour operating standard • Cancer standards Achievement of agreed trajectories for target recovery due to the impact of the pandemic for: • Referral to Treatment (RTT) within 18 weeks • 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%. 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: • The service is working to change how they inform people of the audit and is setting steps in place to improve data completeness • Work is underway to adjust the data collection method with mandatory information required to improve data availability to clinicians • Nomination of an audit lead to monitor progress, troubleshoot issues as they arise and drive action plans • 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. 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. 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. 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. The service lead developed the following actions in place for the coming year, based on the recommendations from the report: • Audit the perioperative pathways, utilising the results from GIRFT to aid this process • Create an electronic alert on patient database system to help assist identifying all eligible patients on admission • Expand weekend services in line with standards for Seven Day Services • Promote mandatory staff training, after the initial training package implemented • 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. Actions for the year ahead: • Recruit to the funded new consultant post to lead the service • 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 • 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). The Trust complied with national standards on staffing levels in 57.9% of shifts, below the national average of 69%. 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: • Patient education in annual health check habits • Ensuring all samples reach the laboratory • Increasing the uptake of diabetes technology, which is currently below the national average • 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. 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). The project lead is working on the following action plan: • 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 • 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%). The following actions have been put forward by the project lead: • 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 • Continue to monitor compliance with standard NICE guidance regarding theatre procedures including sutures • Continue with feedback to surgical teams and other relevant stakeholders regarding infections, rates of SSIs and PHE reports • Continue Infection Prevention and Control walkabouts in theatres • 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. 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*

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* 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 *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 Reduction in avoidable harm and death associated with missed opportunities when compared with 2019/20 and 2020/21 Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 and 2020/21 Reduction in the number of cardiac arrests compared with 2019/20 and 2020/21	**We partially achieved this** We developed an electronic mechanism to monitor the number of TEPs in place for adults within 24 hours of admission We monitor TEP performance on a monthly basis in the Integrated Quality and Performance Report In April 2020 45% of adults had a TEP in place within 24 hours of admission, performance in March 2021 was 33.8% The number of cardiac arrests in 2020/21 was 108; 2.3/1000 inpatient admissions 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 We rolled out the electronic TEP Trust wide in March 2020 in response to Covid-19 The number of cardiac arrests in 2019-20 was 153; 2.3/1000 inpatient admissions 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. We will achieve compliance with our training targets for Mental Capacity Act (MCA) training	**We partially achieved this** The electronic forms to standardise recording were implemented A Trust wide audit of Consent was undertaken in December 2020 Mental Capacity Act and Deprivation of Liberties (MCA/ DoLs) Training – Level 1 training performance had achieved the target of 90% or above since 2019 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. Mental Capacity Act and Deprivation of Liberties (MCA/ DoLs) Training – Level 1 training performance had achieved the target of 90% or above 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** 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** 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** 2020/21: 752 (However, the impact of Covid-19 on the number of complaints received should be noted)	2019/20: 956 (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** The group was suspended earlier this year due to Covid-19 and meetings were re-established later in the year The group focused on finalising the Toolkit for User Groups resource and reviewed the PPEG web pages during this time Engagement of Patient Partners in the development of the Emergency Department works A number of other projects and developments requiring input from Patients Partners were put on hold this last year 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 A service level patient user group was established in dermatology, urology and at Queen Mary's Hospital We delivered the objectives as set out in the one-year Patient Partnership and Experience Strategy 2019/20. The strategy for Patient Partnership and Experience is included as a priority focus area within the Quality and Safety Strategy 2019/24

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** Due to exceptional demands on the service implementation of the improvement plan following the 2018/19 self-assessment was slower than expected The second self-assessment was completed against national standards for Learning Disability patients for 2019/20 The 2019/20 self-assessment was against 107 questions, 79 of which were considered as measurable for benchmark purposes. 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. For the remaining standards: • 25% (20/79) were above the national standard • 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 See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2019/20 Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2019/20 Improvement in the patients who were discharged from an inpatient setting with a follow up appointment or investigation date when compared with 2019/20	**We partially achieved this** Discharge hub implemented and aligned to the site team to enable increased oversight of expected discharges Implemented South West London system approach of agreed discharge to assess process Created a monitoring process 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 87.5% of patients reported feeling involved in the discharge planning process compared with 87.8% in 2019/20 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 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 Established 'long length of stay' meetings to help facilitate the discharge of complex patients 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) 991 patients awaited external assessment, repatriation or external care 88% of patients reported feeling involved in the discharge planning process Discharge summaries were sent to GP practices within 24 hours for 46.4% of our discharged patients 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** The new post of Head of Nursing for Mental Health was recruited to and the post holder commenced in December 2020 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** Quality of Care: 7.6 (average trust score 7.5) Safety Culture: 6.6 (average trust score 6.8)	NHS Staff Survey 2019 Quality of Care: 7.5 (average trust score 7.5) Safety Culture: 6.5 (average trust score 6.7)
Deliver care in line with activity plans	Achievement of targets for: • Referral to Treatment (RTT) within 18 weeks • Diagnostics within six weeks • Four hour operating standard • Cancer standards	**We did not achieve this** 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** **Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 and 2020/21** **80% of adult inpatients will have a TEP (compared with 33% in April 2021)** **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.** **Progress further the implementation of Red to Green in iClip to highlight the issues that delay discharge** **Continue to survey our patients on discharge and respond to what they tell us to ensure our patients are equipped with the information they need to manage their health and know how to access appropriate support** **Continue to improve our process for discharge summaries and enable our patients to leave our care with a follow up appointment or investigation date if required**	**Reduction in the number of patients awaiting external assessment, repatriation or external care when compared with the 2020/21 baseline (fast track process implemented due to pandemic in 2020/21)** **See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2019/20 and 2020/21** **Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2020/21** **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

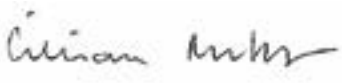
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

- 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

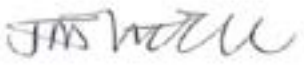
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporate the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

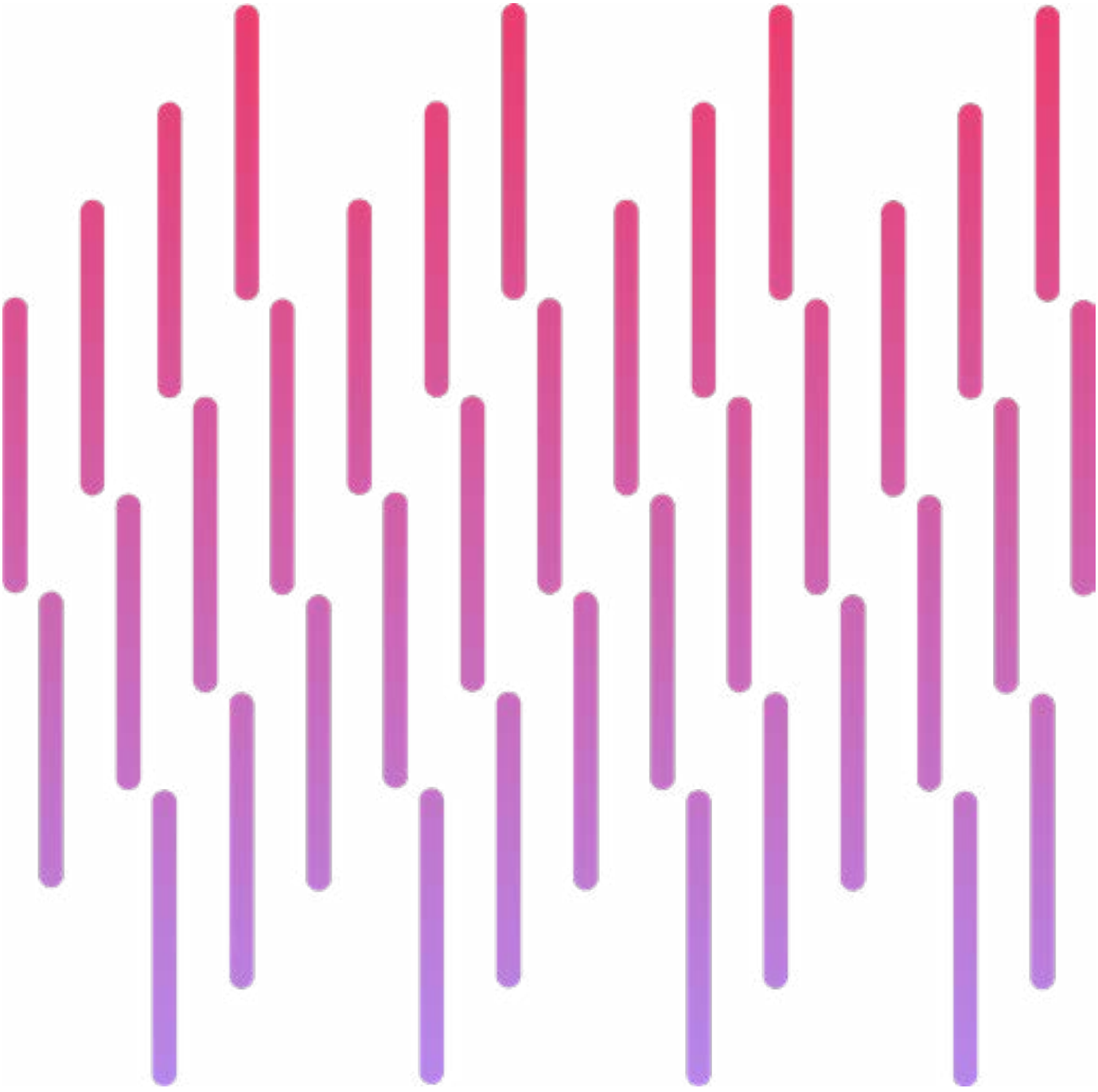
This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's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

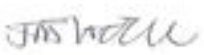


Foreword to the accounts

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

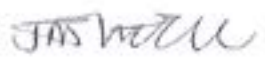
Statement of Comprehensive Income

	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.

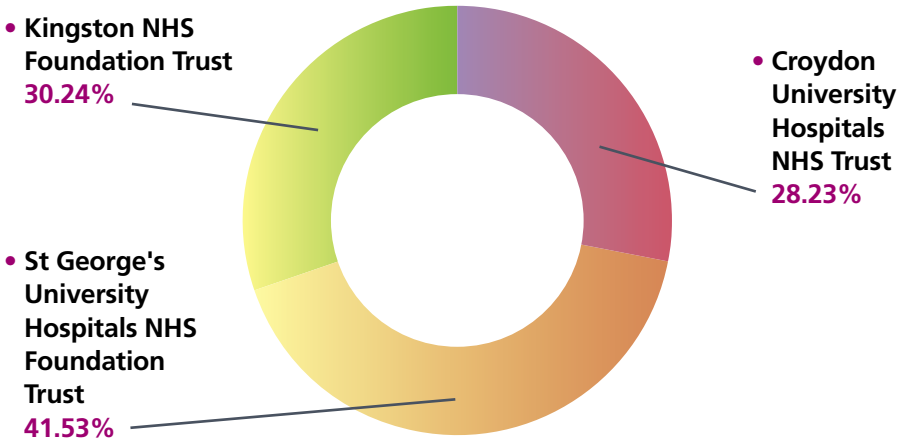
Note 1.3 Interests in other entities

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
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respectful

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Giving to George's

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

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

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