Annual Members' Meeting

Date and time: Monday 26 September 2022, 18:30 – 19:30

Venue: Monckton Lecture Theatre, St George's Hospital, Tooting

Reception event (17.45pm – 18.30pm)

- Meet and greet with refreshments
- Health testing – blood pressure and glucose
- Patient simulation team
- St George's Hospital Charity
- Musicians perform
- Flu jabs

WELCOME FROM OUR CHAIR, GILLIAN NORTON	
18:30	Gillian Norton, Chair
MINUTES OF MEETING HELD ON 16 SEPTEMBER 2021	
18.30	All
A REVIEW OF THE YEAR 2021 / 2022	
18:35	Jacqueline Totterdell, Group Chief Executive Officer This will include a short film followed by an update from Jacqueline.
TRUST FINANCE REVIEW & AUDITORS YEAR-END REPORT	
18:45	Andrew Grimshaw, Group Chief Finance Officer
PATIENT STORY - PATRICK MCCARTHY	
18:50	A young patient beats cancer for his birthday. His father will speak about his experience and staff who treated his son will also be present. Introduced by Jacqueline Totterdell, Group Chief Executive Officer
LEAD GOVERNOR UPDATE	
19:05	Richard Mycroft, Lead Governor
Q&A AND CLOSING COMMENTS	
19:10	Gillian Norton, Chairman, and Jacqueline Totterdell, Group Chief Executive, Kate Slemeck, Managing Director
CLOSE	
19:30	Gillian Norton, Chairman

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 2021/22

St George's University Hospitals NHS Foundation Trust

Annual Report and Accounts 2021/22

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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1. Chairman's introduction

I am pleased to introduce the Trust's Annual Report and Accounts for 2021/22 – our opportunity to reflect on the achievements and challenges of the past 12 months. In a year once again impacted by the Covid-19 pandemic, we have worked hard to deliver outstanding care for our patients, staff and the communities we serve, thanks in no small part to the extraordinary efforts of our colleagues across St George's.

Their commitment throughout the year, day in, day out, continued to make an enormous difference to our patients and the Trust Board is extremely grateful for the ongoing efforts of our staff across St George's.

Despite ongoing pressures, we have learnt a lot over the last 12 months and have continued to be innovative and agile as we respond to the challenges we face. By adapting and working in new ways with our partners, we have been able to continue to provide safe and timely care to our patients.

Last summer we took an important step in our journey to working more closely with Epsom and St Helier University Hospitals NHS Trust when the Boards of both Trusts agreed to form a hospital group. There are real advantages and opportunities to closer working between the two organisations – this has been evident throughout the Covid-19 pandemic, and more so in the recent proposals to bring together renal inpatient services from both Trusts into a brand new renal unit; and the establishment of coordinated electronic patient record systems for the two Trusts.

The resultant St George's, Epsom and St Helier University Hospitals and Health Group, which since February 2022 has been led by a single executive team, allows us to strengthen the professional networks we have already created, and helps ensure our two hospital Trusts continue to run efficiently and provide high quality services that will benefit our patients for years to come. Together, we are committed to the strong partnerships we have built with local health and care systems in Merton, Wandsworth, Sutton and Surrey, and wider strategic partnerships with Integrated Care Systems in south west London and Surrey Heartlands.

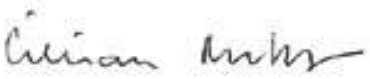
This report contains our annual accounts, and I am pleased that, overall, we have reported a balanced position for 2021/22. The accounts have been audited robustly and demonstrate effective accountability for how we use public money. We know, however, that the next financial year will be extremely challenging and the Trust Board will continue to bring rigorous scrutiny to our use of public money alongside its focus on quality and safety.

I remain grateful to the many charities and volunteers for their support, including in particular the St George's Hospital Charity. The Charity has funded schemes throughout the year that make a real difference to the experience of patients, families and staff, as well as projects within the community.

And finally, as ever, I would like to thank our active and engaged Trust Board and Governors for the commitment they bring to their roles at St George's.

> "Despite ongoing pressures, we have learnt a lot over the last 12 months and have continued to be innovative and agile as we respond to the challenges we face."

We are making great progress to becoming a more outward looking organisation and ensuring closer collaboration with our partners, as well as providing outstanding care to our patients and local communities.



Gillian Norton
Group Chairman
22 June 2022

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.

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, Sussex, Hampshire and beyond, 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: Our world-class children's cancer centre, twinned with the Royal Marsden, is one of the largest in the UK.

Our children's services are rated outstanding by the Care Quality Commission (CQC). We are one of London's largest children's hospitals, hosting the only paediatric intensive care unit, and the only paediatric major trauma centre in south west London. We are one of the top three centres for specialist paediatric surgery in London, and a centre of excellence in foetal medicine.

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

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

St George's in numbers:

We have over 1000 beds across St George's and Queen Mary's.

St George's Hospital and Queen Mary's Hospital in Roehampton serve a population of 1.3 million across south west London.

St George's Hospital sees around 450 Emergency Department attendances per day.

2. Performance report

Overview of performance

In this statement, and the following performance analysis 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 is monitored closely by the Trust Board and Executive against both the Trust's strategic priorities and the performance metrics set out in the NHS System Oversight Framework. The principal risks facing the Trust are set out in the performance analysis section.

Annual performance statement from the Chief Executive

Staff across our hospitals have, as ever, been superb over the past year, and I will always take every opportunity to pay tribute to them. Our teams have remained focussed on providing outstanding care to our patients, and the achievements outlined in this report are testament to their determination, resilience and compassion. We have made significant progress as an organisation during the last year – although I am equally aware that further improvements are required and of the scale of the challenges ahead.

Covid-19

I said in last year's annual report that the impact of Covid-19 on our services for patients and on our staff cannot be underestimated. That remains the case this year. While 2020/21 was dominated by successive Covid-19 surges and national lockdowns, the past year has posed different challenges – particularly in treating large numbers of patients whose care was delayed during the pandemic.

Keeping patients and staff safe has remained an enduring focus. From the early stages of the pandemic, we implemented robust infection prevention and control protocols, many of which remain in place to protect vulnerable patients and staff.

During December 2021, as we started to see the impact of the Omicron variant in our hospitals, we took a number of actions to help maximise clinical capacity such as creating additional space for trolleys and chairs in our emergency department, establishing a dedicated discharge team, and creating 'virtual frailty wards' to support patients at home who would otherwise be admitted or have longer lengths of stay whilst care packages are put in place. We were also supported by our system partners, particularly the primary care teams in both Wandsworth and Merton, who extended their evening clinic capacity which helped reduce the number of people attending our urgent treatment centre. We continued to work as a clinical network in south west London, providing critical care over the winter, and helping to manage clinical pressures across our intensive therapy units.

The continued importance of the vaccine as a tool in the fight against Covid cannot be overstated and in December 2021 our Covid-19 vaccine clinic at St George's increased capacity to support the nationwide booster campaign, at some points vaccinating around 1,000 people a day. Also in December 2021, St George's was one of the first hospitals in the country to open a Covid Medicines Delivery Unit (CMDU), meaning vulnerable patients could be treated with new antiviral drugs that offered protection against the virus. We were pleased to be able to host Sajid Javid, Secretary of State for Health and Social Care, for a visit to the Unit and show him the difference that antivirals can make for our patients.

Planned care

Despite significant increases in demand for our services, our staff have worked exceptionally hard to ensure patients receive the care and treatment they need and to address the backlog that has built up in planned care as a result of the pandemic. The scale of this challenge is huge – at the Trust, in south west London and across the country. Our year end position for those waiting more than 18 weeks for treatment is 72% against a national target of 92%. We have made real progress, but know we have more to do and have developed plans to address this. Caring for those patients who are waiting for their operations is a top priority, and we are working with partners across south west London on reducing the elective care backlog that has grown in some specialties. In February 2020, on the eve of the pandemic, only 11 patients were waiting more than

> "Our teams have remained focussed on providing outstanding care and the achievements outlined in this report are testament to their determination and compassion."

52 weeks for routine surgery at St George's. Just over a year later, in March 2021, this had risen to 2,644 patients. As part of our response to this, we opened our new Surgical Treatment Centre at Queen Mary's Hospital in June 2021. This innovative, newly built centre has meant we can offer day surgery to patients whose treatment had been delayed. Thanks to this and a real drive and focus across the Trust, the number of patients waiting longer than 52 weeks for routine treatment has fallen to 846 – still far too high, but a significant step forward. Likewise, the creation of additional diagnostic capacity has meant that routine diagnostic waits have come down, with over 98% of patients seen within six weeks of a referral at the time of writing. However, we have yet to see the consistent and sustained improvements in access performance that we need. Breast screening has been a particular challenge. This is an issue we are actively addressing, and we know the speed with which we see and treat our patients is key to the effectiveness of the services we provide and to the experience of our patients. You can read more about the steps we have taken on elective care recovery later in this report.

Emergency care

As with many NHS Trusts across the country, an area of challenge throughout the year has been reaching the emergency department access standard of seeing, treating, and either admitting or discharging patients within four hours. Our end of year position is 81% against a target of 95%.

As well as exceptionally large volumes of patients coming to our doors throughout the period, we have continued to see a significant number of high acuity patients, and people presenting at the department with complex needs which makes it even more challenging to find suitable follow-on care when they are ready to be discharged. Despite this, St George's has been the top performing Trust in London for emergency care performance at points throughout the year, and one of our teams was shortlisted for a Health Service Journal Award for their involvement in a project aiming to reduce waiting times for emergency patients needing a Covid PCR test. You can read about some of the actions we are taking to improve flow through our hospital in the performance analysis section of this report.

St George's, Epsom and St Helier University Hospitals and Health Group

In August 2021, after years of collaboration and creating closer working ties, we announced that the Boards of St George's and Epsom and St Helier agreed to form a hospital group, and I was proud to be appointed Group Chief Executive.

This is an important new chapter for both organisations – working together as a hospital group enables greater joined-up decision making for the benefit of local people, a larger and more resilient workforce, reduced variation in levels of care, and

Key performance indicators

KPI	Standard	Target	Annual performance 2018-19	Annual performance 2019-20	Annual performance 2020-21	Annual performance 2021-22
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	N/A (Not reporting)	84.2%	69.3%	72.3%
Referral to treatment times	Number of 52 week breaches	0	N/A (Not reporting)	32	2,644	846
ED access	95% of patient wait less than 4 hours	>=95%	88.4%	83.2%	92.8%	81.6%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	>=85%	86.9%	85.2%	77.1%	72.6%
	% patients treated within 62 days from screening referral	>=90%	86%	88.8%	80.8%	75.9%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	99%	99%	95.7%	89.8%	98.2%




greater access to a wider range of clinical services for the patients of both organisations. We will collaborate more closely on research, staff development, and education and training, which will continue to make a vital contribution to the quality and sustainability of clinical care into the future. The two Trusts remain separate legal entities but are now led by a single executive team and have put in place harmonised governance arrangements which enable and support closer collaborative working. By sharing skills, expertise and resources, we can ensure that both our organisations are better able to take on the challenge of growing demand on our services.

Integrated Care Boards

As always, we remained engaged with key discussions and developments at regional and national level. On 28 April 2022, the Health and Care Bill received Royal Assent – the biggest legislative reform to the NHS in a decade. The new Act provides a legislative framework for supporting collaboration and puts Integrated Care Systems (ICS) on a statutory basis, with ICSs taking on their new functions from July 2022. At St George's we are looking forward to engaging with the new South West London Integrated Care Board (ICB) and our partners on improving the health of our local populations. We are committed to working closely with the ICS to break down the traditional barriers that have prevented health services from making more joined-up decisions that will benefit communities across the region.

"By sharing skills, expertise and resources, both our organisations are better able to take on the challenge of growing demand on our services."

Supporting our staff

Finally, I would like to talk about our staff, and the importance we place on making sure they feel valued, included, and are physically and mentally well.

The results of our 2021 staff survey have identified some positive changes staff have seen but also a number of areas for improvement for us to focus on. It was encouraging to read that incidents of bullying and harassment have declined, and that Black, Asian and Minority Ethnic colleagues are reporting fewer instances of discrimination in the workplace. However, there has been a decrease in the number of staff that feel engaged at work, while many staff are reporting feeling worn out. We are committed to acting on what our staff have told us and making St George's a better place to work. Organisational culture has always been a key focus of mine, and the staff survey results demonstrate the importance of this, and point to the further improvements needed to make St George's an outstanding place to work.

The year ahead will bring change and challenge – not only for St George's but the NHS as a whole. I am pleased to say, however, that our excellent staff will respond magnificently, as they always do.

Jacqueline Totterdell
Group Chief Executive
22 June 2022

Highlights of 2021/22

April 2021	• Nurse Vicky Morrison and family featured in CBeebies show 'Our Family'. • New Children and Young People's Council set up to enable young patients to support each other and provide input into hospital decisions affecting them.
May 2021	• St George's opened an interventional radiology day case and recovery unit.
June 2021	• Queen Mary's Hospital opened new Surgery Treatment Centre. • Carbon cut from patient menu at St George's to help NHS net zero target.
July 2021	• St George's Twins Trust Centre celebrated its one-year anniversary. • Four St George's teams were shortlisted for the Nursing Times Awards.
August 2021	• St George's, Epsom and St Helier Hospital and Health Group model announced. • Innovative motor neurone disease trial opened at St George's.
September 2021	• Com-COV alternating vaccine schedule study for 12-to-16-year-olds launched. • Queen Mary's Surgery Treatment Centre hosted visit from Royal College of Surgeons President and Stephen Hammond MP. • St George's is one of the first Trusts to offer new life saving Covid antibody treatment.
October 2021	• Princess Michael of Kent visited to open new Maternity Memorial Garden. • We marked Black History Month with a range of events, including an interactive Workforce Race Equality Workshop for staff, and a talk from professor and historian David Olusoga.
November 2021	• 'Thank You George's' our season of gratitude to staff, opened with a free food festival funded by St George's Hospital Charity. • Launch of Homelessness service at St George's. • Newly refurbished cardiac catheter labs reopened.
December 2021	• St George's collaborated with TFL in campaign to encourage Londoners to wear face coverings to protect the NHS. • St George's, Epsom and St Helier University Hospitals and Health Group announced new executive team. • Sajid Javid, Secretary of State for Health and Social Care, visited St George's vaccine clinic and CMDU.
January 2022	• St George's won funding to deliver net zero emissions through 'Dora' system for cancer patients. • Jacqueline Totterdell opened new state of the art pathology lab at St Helier.
February 2022	• St George's Nurse Marlene Johnson selected as one of the BBC'S Top 100 Champions for the broadcaster's 100-year anniversary. • St George's, Epsom and St Helier Hospitals and Health Group establish a joint electronic patient records to deliver more streamlined patient care. • New St George's Major Trauma Network documentary aired for the first time. • St George's celebrated LGBT+ History Month.
March 2022	• St George's research found that pregnancy screening algorithm can reduce racial disparities in baby deaths. • St George's nurse Ediscyll Lorusso won Our Health Hero's Lifetime Achievement Award. • Group Chief Nurse Arlene Wellman received MBE in recognition for her contribution to nursing.

Performance analysis

As an NHS Foundation Trust, our principal purpose, defined in legislation, is the provision of goods and services for the purposes of the health service in England. In practice, that means providing care and treatment for patients across south west London, Surrey, Sussex and beyond.

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 in the last two years, during 2021/22 responding to the Covid-19 pandemic by caring for patients and supporting our staff has been our collective focus. However, while Covid has had a profound impact on the Trust, and the NHS as a whole, we have remained focused on implementing our clinical strategy which we published in April 2019, and the supporting strategies in a range of areas to help make our aims a reality. You can read more about our strategies on our website at www.stgeorges.nhs.uk/about/our-strategy.

> "Many of our services are part of clinical networks, bringing together clinicians and support staff from a range of healthcare providers to improve services."

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.

Our vision, priorities and objectives

Our vision is to provide outstanding care, every time for patients, staff and the communities we serve. We do this through 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.

Each year, we set corporate objectives for the organisation. For 2021/22, our objectives remained unchanged.

They were:

- **Care:** Patients and staff feel cared for when accessing and providing high quality timely care at St George's; in how the Trust starts to recovers from Covid-19 and in how we respond to any future wave.
- **Culture:** We will transform our culture to create an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in the delivery of high quality clinical care for our patients and service users.
- **Collaboration:** We will engender an ethos of collaborative working across our teams within St George's and with our system partners to achieve the best outcomes for patients, building on the spirit of collaboration developed internally and externally through Covid-19 response.

During the year, we reviewed our corporate objectives and agreed a common reporting methodology, streamlining the number of objectives in order to provide greater focus on our core priorities. We report on progress in delivering our objectives to the Board and 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, operational performance, quality and workforce metrics.

Objective 1: Care

Patients and staff feel cared for when accessing and providing high quality timely care at St George's; in how the Trust starts to recover from Covid-19 and in how we respond to any future wave.

Elective recovery

Alongside preparing for any future Covid-19 surges, our key priority – and biggest challenge – over the past year has been elective recovery. At St George's, we continued to carry out the most urgent and emergency operations and procedures, including for cancer, along with urgent outpatient and diagnostic appointments.

However, infection control guidance, redeployment of staff to care for Covid patients, and repurposing operating theatres have all contributed to the challenge of making sure patients get the treatment they need as safely and as quickly as possible.

We now have dedicated, ring-fenced surgical elective capacity reserved for the services with the greatest need. Other measures we have put in place throughout the year include operating a 23-hour Day Surgery Unit to free up ward beds for elective care, running extra outpatient sessions on Saturday mornings to speed up access to treatment, creating a new post anaesthetic care unit, and recruiting additional staff in a number of specialties.

Collaboration with our south west London partners has been key in our progress with elective recovery. A new NHS surgery treatment centre was constructed in less than four months on the Queen Mary's Hospital, Roehampton site (as set out above). The new centre has four dedicated operating theatres and a recovery area, enabling up to 120 procedures to be carried out per week, including plastic surgery for skin cancer, urological procedures, gynaecology, orthopaedic, vascular and general surgery, and maxillofacial specialties. This year also saw the opening of a Community Diagnostic Centre at Queen Mary's Hospital. It offers a range of tests and scans to increase capacity and speed up diagnosis.

Covid Medicines Delivery Unit

In December 2021, St George's became one of the first hospitals in the country to offer new antiviral treatments to people with Covid-19 who are at highest risk of going to hospital and becoming seriously ill. These treatments help manage the symptoms of the virus and reduce the risk of hospitalisation or death – thanks to successfully embedding research into everyday NHS practice and through the hard work of our research nurses, doctors and the commitment from our patients.

Emergency care and operational pressures

Throughout the year, and especially since summer 2021, we have faced significant operational pressures with increases in demand for services, particularly but not exclusively in emergency care. This was in line with trends seen across the NHS, with urgent and emergency care in London and nationally being under greater pressure due to unprecedented demand, which exceeded the levels of demand seen prior to the pandemic.

We also continue to see a significant number of high acuity patients and patients with complex needs. Staff have continued to innovate as they respond to these challenges. Our Same Day Emergency Care has helped to relieve some pressure in our emergency department, as well as services such as Hospital@Home teams which support patients to manage their condition while living independently. We are also working with London Ambulance Service to ensure pressures are better allocated between the four hospitals in south west London so we have fewer out of borough admissions, as well as working with community partners to ensure the timely discharge of patients to improve the flow of patients through the hospital.

Vaccination programme

Throughout the year St George's has played a key part in the national vaccination programme, offering the Covid-19 vaccination to patients and staff. As of April 2022 our clinic has administered 116,800 Covid-19 vaccines since opening in December 2020, and we continue our campaign to encourage take up of the vaccine.

Strengthening our clinical governance

During 2021/22, the Trust implemented a clinical governance improvement plan which incorporated the recommendations of a three-part independent clinical governance review undertaken between June 2019 and May 2021. This review focused on mortality and morbidity meetings and multidisciplinary team meetings, clinical governance capacity, and quality and safety reporting from ward to Board. The findings of the phase three review were reported to the Board in May 2021 and focused on the architecture of reporting, information flows from ward to Board, and the coverage of key quality issues by the Trust's Patient Safety and Quality Group and Quality and Safety Committee. It found that across 36 areas of ward to Board reporting considered by the review, 10 provided substantial assurance and 12 required minimal improvements to existing reporting lines to achieve effective assurance. There were 14 areas in which substantial improvements were required. Through an integrated clinical governance improvement plan implemented during the year, in March 2022 the Quality and Safety Committee was able to assure the Board that substantive progress had been made which enabled the Board to formally conclude the plan and reduce the risk score for clinical governance on the Board Assurance Framework in line with the year-end target.

Cardiac surgery

Last year, the annual report set out the steps the Trust was taking to deliver improvements within our cardiac surgery service following the publication in March 2020 of the reports of the Independent Mortality Review and the Independent Scrutiny Panel.

In 2021/22, the Trust has continued to embed these improvements and monitor performance within the service to provide continued assurance that the service is safe. Board level oversight of cardiac surgery outcomes is led by the Quality and Safety Committee, which has continued to review performance on a regular basis throughout the year. The most recent data from the National Institute for Cardiovascular Outcomes Research (NICOR) continues to demonstrate that the service is safe and outcomes are in line with similar centres across the country.

The restrictions introduced in September 2018 to give space for the service to make improvements were lifted in April 2021 by the Quality Surveillance Group chaired by NHS England. This reflected the progress made by the Trust in implementing the recommendations of the Independent Mortality Review. To support the service in moving towards full functioning while ensuring continued patient safety, the Quality Surveillance Group prescribed requirements for dual consultant operating, a pooling of referrals, sub- specialisation, and monitoring opportunities. To support a change in working relationships between cardiac surgery, cardiology, anaesthesia and intensive care, as recommended by the Review, the Trust engaged an independent human resources consultant to work with the service on team-working. A report by Health Education England following a visit to the service in July 2021 documented ongoing cultural challenges within the service and the Trust continues to work to address these to ensure a supportive learning environment for doctors in training.

Improvements to our estate

Our new estates strategy was agreed in July 2021 and sets out the steps we will take to have the right infrastructure to deliver outstanding care for patients, and modern, high-quality facilities for staff. This has been developed alongside our green plan, taking into account the importance of sustainability for both staff and patients.

Despite our focus on Covid-19 and recovery, we have continued to invest in improving our estate and upgrading clinical areas. In May 2021, a new facility to care for patients undergoing interventional radiology (IR) procedures opened at St George's Hospital. The new unit provides the Trust with a dedicated space for day case and inpatients before and after their IR procedures. The facility has six separate bays, and will improve care for the thousands of patients who undergo interventional radiology procedures at the Trust every year, both as day case and as inpatients. In November 2021 we completed refurbishment of two of our cardiac catheter labs with state of the art equipment and the very latest in x-ray imaging technology which allows teams to more rapidly and effectively treat heart conditions.

ICT improvements

Over the past year significant investments and improvements have been made in the Trust's information technology network and infrastructure. As our IT infrastructure affects all staff, ensuring our digital, data and infrastructure environments are reliable, secure, sustainable and resilient is fundamental to our digital maturity. We have taken steps to ensure we are meeting and surpassing best practice for information security and resilience, and in March 2022 we completed a programme of work to implement Microsoft Office 365 across the Trust. In March we also launched the My Care Patient Portal to provide patients with access to their appointment times, test results, and medical history.

In February 2022 St George's, Epsom and St Helier University Hospitals and Health Group signed contracts with Cerner to provide a shared electronic patient records system to deliver streamlined patient care. This is the first large scale digital project the two Trusts have launched since becoming a group in August 2021. While Cerner has been in use at St George's and Queen Mary's hospitals since 2013, the adoption of Cerner marks the single largest digital modernisation and transformation programme Epsom and St Helier has undertaken in recent years. It will replace the dated clinical and administrative systems currently in place, bringing welcome improvements for staff and patients.

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. Throughout the year we have continued to implement our quality priorities which were aligned to the seven priority areas in our Quality and Safety Strategy 2019/24.

One of the seven objectives of the strategy is to provide patients with equitable access and quality by proactively improving access and care for vulnerable groups. Success in this area was defined as an improvement in our self-assessment against the National Learning Disability Standards, having had the opportunity to make service improvements following the first self-assessment in 2020. In March 2021 we received the results of the NHS benchmark assessment that was completed against national standards for Learning Disability patients. There were 107 national benchmark Learning Disability Standards, of which 79 benchmark standards applied to St George's. 48/79 (61%) were in line with the national standard, 20/79 (25%) were above the national standard, 11/79 (14%) were below the national standard.

> "One of the seven objectives of the strategy is to provide patients with equitable access and quality by proactively improving access and care for vulnerable groups."

Another example of our progression in providing equality of service delivery to different groups was in November with the launch of a new team in our Emergency Department in collaboration with the homeless charity Pathway which helps homeless patients. The specialist team is made up of GP, nurse, care navigator and housing advisors.

Public Sector Equality Duty Report (PSED)

Due to the unprecedented impact of the Covid-19 pandemic on public bodies, the Equality and Human Rights Commission (EHRC) recognised that NHS organisations were under significant pressure and that it will take time for organisations to recover and to return to business as usual. St George's are not in a position to publish the full PSED report for 2021/22 at this time. We have, however, published and met our duties in relation to Workforce reporting for this period, these reports can be found on our website: www.stgeorges.nhs.uk/about/living-our-values/equality-diversity-and-inclusion/human-rights-and-equality/. You can read more about diversity and inclusion at St George's in our Staff report section.

Objective 2: Culture

We will invigorate our culture, helping ensure we are an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in the delivery of high-quality clinical care for our patients and service users.

Supporting our staff

We know that our staff are our most important asset so as we began to stand back up clinical services moving out of the pandemic, we continued to focus on the health and wellbeing of our staff.

physical health. We continued to provide staff with counselling and support services. We also supported staff who have been heavily involved in managing the Covid-19 operational priorities to take annual leave and reset as we resumed clinical services. We provided support to colleagues

> "During May 2021 we launched new initiatives designed to encourage more meaningful conversations between line managers and staff about their mental and physical health."

During May 2021 we launched a number of new initiatives – including our new Wellness Actions Plans, which are designed to encourage better, more meaningful conversations between line managers and staff about their mental and

to raise concerns, promoting awareness of how to speak up; and also focused on flexible working – urging staff and line managers to adopt a flexible by default approach. A hybrid model served us well during Covid and we want to continue to offer flexible working to staff wherever possible. To show our appreciation for everything staff have given throughout the pandemic, we started a three-month season of thanks in October 2021 – 'Thank You George's'. Every member of staff was given a gift voucher, and we also ran a week-long food festival where every member of staff was given a free meal. Most importantly, staff were given a chance to learn, reflect, and share their experiences of responding to Covid-19.

Wellbeing guardian

Following the publication of new guidance by NHS England and NHS Improvement in December 2021, we reviewed the non-executive director (NED) 'champion' roles at the Trust in order to appropriately embed NED responsibilities in the assurance work of Board committees. One of these existing champion roles is of the wellbeing guardian. This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the NHS People Plan. The role of the NED champion is to challenge the Trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

Continued focus on culture, equality, diversity and inclusion

At St George's we are committed to being an employer of choice, offering an excellent working and development environment. It is our ambition to have sustainable workforce which is empowered and dedicated to deliver outstanding care, every time. We recognise that the key quality and financial objectives can only be achieved through the contribution of a well-led, engaged and efficient workforce.

We launched a plan for addressing the key themes arising from last year's NHS Staff Survey. Between May and September, we focused on our "Big 5" priorities: in May we promoted mental health and wellbeing, helping staff to look after their physical and mental health; "let's talk" was our theme for June, which focused on speaking up and raising concerns; in July, we concentrated on flexible working, supporting flexible working for the benefit of patients and staff; in August, fairer career progression and building a culture where progression is based on merit and hard work was our focus; and in September we focused on creating a better workplace and providing our staff with the tools they need to do their job effectively. Of course, our efforts to deliver improvements do not start and end with our Big 5 – and the NHS Staff Survey results helped shine a light on many areas for improvement, which we are already working hard to address. But the Big 5 gave us a focus and gave our staff clarity about where we had been directing our energies.

We continued to make progress in strengthening our culture, and have developed a culture action plan, driven forward by our new culture, equity and inclusion (CEI) programme board, chaired by the Group Chief Executive. We have culture champions who meet on a regular basis, and we continue to develop the 'villages' concept to build a stronger sense of community, inclusion and belonging. The key pillars of our culture programme are: (i) creating an outstanding workplace for outstanding care, where we all consistently live our values; (ii) working together with compassion and inclusion; (iii) nurturing teamwork and collaboration; (iv) ensuring our systems, processes and workplace work for us; (v) supporting us to learn and innovate; (vi) ensuring clarity of priorities and accountability.

We developed plans for investing £1m in support of our culture programme, to develop inclusive and compassionate leadership, develop and deliver talent management, embed behaviours that support our values, develop effective multi- disciplinary teams and build our internal communications capability.

Objective 3: Collaboration

We will engender an ethos of collaborative working across our teams within St George's and with our system partners to achieve the best outcomes for patients, building on the spirit of collaboration developed internally and externally through Covid-19 response.

St George's, Epsom and St Helier University Hospitals and Health Group

As mentioned above, in August 2021, St George's and Epsom and St Helier agreed to form a hospital group. We are already starting to realise some of the expected benefits. In February 2022 we signed a contract with Cerner to provide a shared electronic patient records (EPR) system to deliver streamlined patient care across the group. The Group will support more effective engagement with the south west London and Surrey integrated care systems as well as better engagement at 'place'.

An example of the two Trusts working together for the benefit of local patients came in June 2021, when we announced that we secured funding for a new joint renal unit with Epsom and St Helier on the St George's Hospital site. The new unit will provide specialist care for the sickest renal patients across west London and Surrey in a new, state-of-the art building on the St George's site. It will support a range of improvements to patient care, such as better infection prevention, fewer inter- hospital transfers between St George's and Epsom and St Helier, and better access to surgery. The new unit will provide care for kidney patients on long-term dialysis who become ill and need to stay in hospital, and for patients who need more complex care such as a kidney transplant or surgery. It will also create exciting opportunities in research, co-locating what will be one of the largest renal centres in the country with St George's, University of London.

Development of the South West London Integrated Care System

St George's has shown throughout the pandemic that collaboration with our partners gives us the best outcomes for patients.

Throughout the year we continued to be involved closely with the development of the South West London Integrated Care System (SWL ICS) as it prepared for its transition to establishment on a statutory basis from July 2022. We have also developed our place-based relationships, and our new group arrangements will assist with this going forward.

Under the new Health and Care Act 2022, an Integrated Care Board (ICB) will be accountable for the NHS commissioning budget, with a membership drawn from across the local NHS; guided by an Integrated Care Partnership, drawing in a wider membership including councils and stakeholders such as the voluntary sector. A strengthened Acute Provider Collaborative, in which the St George's Chief Executive is the lead Chief Executive, will act as a core delivery vehicle; and a leadership team for each 'place' or borough in south west London, including representation from acute hospitals, with some of the NHS budget devolved to this level.

Research and innovation

We also welcomed the news that our partners, St George's, University of London, was ranked among the top universities for knowledge sharing, especially in the wake of our teams continued work to help further knowledge of Covid-19 through ground-breaking research and clinical trials.

"We also welcomed the news that our partners, St George's, University of London, was ranked among the top universities for knowledge sharing..."

Major risks to Trust's objectives

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

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 2021/22 to ensure our BAF continued to be an effective tool for providing assurance to the Board we set stretching but realistic target risk scores to achieve by March 2022. We also set out the key controls the Trust has in place to manage our risks. We identified key sources of assurance alongside the remaining gaps in control. We plotted the actions required to mitigate risks and ensured that our BAF linked to our work on horizon scanning to identify emerging risks to the Trust.

Grouped by corporate objectives, the ten strategic risks on the BAF in 2021/22 were:

St George's Board Assurance Framework 2021/22	
Corporate Objectives	**Strategic Risks (SR)**
Care	**SR1: 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.**
	SR2: We are unable to provide outstanding care as a result of weaknesses in our clinical governance.
	SR3: 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.
	SR7: 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.
Culture	**SR8: 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.**
	SR9: 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.
Collaboration	**SR4: 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.**
	SR5: We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to release wider efficiency opportunities.
	SR6: 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.
	SR10: 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 BAF 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 2021/22 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 2021/22.

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

Quality outcomes

Full details on our performance against quality priorities and indicators can be found on the Quality Account section of this report.

130,000

children treated by us every year.

Financial performance

The Trust continued to achieve financial balance in 2021/22 following the Trust's exit from financial special measures in 2020/21. The Trust is showing a £0.1m surplus in 2021/22 following breakeven financial performance in 2020/21 (after adjusting for the annual leave accrual of £3.1m). This is the adjusted financial performance (control total basis).

For 2021/22, the Trust developed a plan to reduce the deficit to breakeven, which was achieved following final confirmation of £5.0m additional funding in the second half of the year. Actual performance for the year was a £0.1m surplus, which was in line with the previous year's deficit (after adjusting for the annual leave accrual of £3.1m).[1]

St George's did not formally deliver a cost improvement plan (CIP) owing to the demands of the Covid-19 pandemic in 2021/22, although the Trust is planning to deliver a CIP of £58.2m in the financial year 2022/23.

Covid block contracts and top-ups

The Trust instead received block contract funding from its main commissioners in the financial year, in line with 2020/21. Top-up funding from SWL commissioners was fixed during the year, with the financial settlement split across two halves, H1 and H2. The difference included an adjustment for pay inflation, to reflect retrospective awards for Agenda for Change and Consultant staff.

Performance against plan

Delivering the 2021/22 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.

Capital expenditure

The Trust spent £66.0 million of capital in 2021/22. This was funded from internally generated funds, 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 2021/22 we took out new finance leases with various leasing companies for equipment with a capital value of approximately £5.3 million.

Cash flow

We began the financial year with £36.6 million of cash and cash equivalents. During the year, cash balances increased to £68.5m. 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 22/23.

1 The 2021/22 financial plan shown in the tables is a deficit of £5.0m, which excluded the additional funding outlined above.

Financial performance against plan

	2021/22 Actual £ millions	2021/22 Plan £ millions	Variance £ millions
Total income excl capital & PSF	1,067.1	1,001.4	65.7
Expenditure excluding donated	- 1,076.4	- 1,015.5	- 60.9
Adjusted financial performance	- 9.3	- 14.1	4.8
Capital donations/depreciation/AME impairment	7.3	0.2	7.1
PSF/FRF/MRET/top-up	9.4	9.1	0.3
Surplus deficit incl PSF/FRF/MRET/top-up	7.4	- 4.8	12.2
Adjusted financial performance incl PSF/FRF/MRET/top-up	0.1	- 5.0	5.1

Financial performance comparison

	2021/22 Actual £ millions	2020/21 Actual £ millions	Change £ millions
Total income excl capital & PSF	1,067.1	973.7	93.4
Expenditure excluding donated	- 1,076.4	- 1,039.8	- 36.6
Adjusted financial performance	- 9.3	- 66.0	56.7
Capital donations/depreciation/AME impairment	7.3	4.3	3.0
PSF/FRF/MRET/top-up	9.4	62.9	- 53.5
Surplus deficit incl PSF/FRF/MRET/top-up	7.4	1.3	6.1
Adjusted financial performance incl PSF/FRF/MRET/top-up	0.1	- 3.1	3.2

Cash flow

	2021/22 £ million	2020/21 £ million
Operating surplus/deficit before finance and other costs	6.9	13.9
Add back non-cash and expense	40.2	23.3
Increase/decrease in oeprating activities	35.3	27.6
Net cash generated from operating activities	82.4	64.8
Net cash generated from investing activities	- 63.3	- 82.1
Net cash generated from financing activities	12.8	50.4
Net increase/decrease in cash	31.9	33.1
Total Cash and equivalents at 31 March	68.5	36.6

Charitable funding

We received £0.7 million from charitable sources during the year, principally from St George's Hospital Charity. However, the Trust also received £50k of donated equipment from the Department of Health.

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 £50.5 million. All of these loans are included within borrowings in the statement of financial position within the accounts, included separately in this annual report.

Revaluation of land and buildings

As part of the preparation of the annual accounts, we are required to assess the value of our land and buildings. This exercise is carried out at the end of each financial year. The annual revaluation has led to a £15.3 million (£31.5 million 20/21) reduction in value of some buildings. This was an increase in value of land of £5.0m and a decrease in buildings of £20.3m. 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 2022.

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 2022-23 reflects a move away from the Covid arrangements of the previous two financial years. Guidance from NHS England and NHS Improvement (NHSE&I) is that Trusts will still be funded through block contracts with cost and volume adjustments for items such as high cost drugs/ devices and Covid testing/ vaccination. However, the Trust will lose a significant portion of non-recurrent income that relates to Covid which has been a major cause of the Trust declaring an unbalanced position for the new financial year.

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 ensuring we manage stock holdings to agreed levels.

Capital planning

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

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

Procurement

This year has been one of transformation within the procurement service. On 1 April 2021, South West London Procurement Partnership was launched, hosted by St George's, merging the teams of all four acute Trusts in south west London. The main focus and key achievements of procurement in 2021/22 have been split over the following main areas:

- We achieved Level 2 in the NHS Commercial and Procurement Standards, the first Trust in London to achieve this (along with the merged Trusts).

- We continued to provide personal protective equipment (PPE) and intensive care unit (ITU) consumables to the acute Trusts in south west London, ensuring that not only our staff but also contractors and suppliers to the Trust have PPE of adequate quality and sufficient quantity. This included the central management of ITU consumable provision and any other supply disruption.

- **Procurement Expertise:** Implementing category and contract management approaches to procurement to deliver and enhance value and maximise savings opportunities and ensuring the Trust was not adversely affected in its pricing by the reduction in activity within volume-based contracts and holding pricing. This included working with the national supply chain teams.

- **Systems:** Implementation of Scan4Safety across approximately 35 point of care areas (theatres and other settings) within St George's and a total of 86 areas across the four acute Trusts in south west London. Focus has also been on improving data quality and accessibility including contract registers. This enables more efficient identification of cost improvement opportunities or for commercial advantage and aids planning.

- **Collaboration:** Working with other Trusts across London, strengthening collaborative and joint working with appropriate partners - including shaping the future strategy and operating model of procurement across the sector. We continue to support the shaping of the national strategy with partners at NHS Supply Chain and regionally with the London Procurement Partnership (LPP) – with membership on the Steering Boards of both organisations.

- **People:** Board membership of the London Procurement Skills Development Network (PSDN). We are contributing to the future course development and framework to grow our current and future teams.

Cost Improvement Programme 2022/23

CIPs are expected to return to pre-pandemic arrangements, returning to the governance of Quality Impact Assessments signed off by the Chief Medical and Chief Nursing Officers for all schemes that deliver a financial improvement.

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 £0.1m surplus for the year ended 31 March 2022 (after adjusting for donated capital income and donated depreciation).

The 2022/23 plan is for a £50.8m deficit financial position, having taken account of the underlying financial position going into 2022/23 and the Block contract arrangements in place. Currently the Trust is exploring the external financial environment to see if any further improvement to the plan can be made.

From a Cash perspective, there is not expected to be any risk to the financial plan in the early months as there is a significant cash balance from year end in place.

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 2021/22, 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.

Environmental analysis

Estates strategy and our Green Plan

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 July 2021, we published our new Sustainability ('Green') Plan alongside our new estates strategy. Together these provide the framework to help us achieve our long-term vision. We want an estate that is efficient, sustainable, and flexible enough to meet the operational demands of St George's as well as the south west London healthcare system. In developing the strategy, we attended over 90 meetings with staff and external stakeholders to get their views on current issues, and future requirements and options. The benefits of our proposals include state-of-the art facilities to improve patient care, improvements to staff spaces to positively influence the way we work, and Green Plan principles which will further our commitment to delivering a net zero carbon health service. We have been clear about the need to improve our aging estate for some time. However, it has not been as clear how we will go about achieving it – and that is why our new strategy is so important for the Trust and our future.

"The benefits of our proposals include state-of-the art facilities to improve patient care, improvements to staff spaces to positively influence the way we work, and Green Plan principles which will further our commitment to delivering a net zero carbon health service."

At St George's we are not only passionate about patient care but also the environment and we continue to take steps to be more sustainable. We aim to be carbon neutral by 2040, so in tandem with developing our estates strategy we have developed a sustainable development plan which contains a clear action plan for the next 12-36 months which will further develop our plan and its associated governance, together with defining specific targets and objectives. Our Green Plan includes a roadmap which spans from 2021 to 2040. It covers audits of green spaces; travel plans and digital infrastructure; completing the shift from paper-based to efficient and effective electronic systems; switching our electricity to green energy providers; and re-introducing our Sustainability Champion Group.

We have already introduced a range of recycling, energy saving, and carbon reduction programmes – including

implementing a new programme to reduce emissions from anaesthetic gases; using recycled surgical instruments and items in operating theatres; a combined heat and power plant on the St George's site that provides excess renewable energy back to the National Grid. In addition to these initiatives, we are very pleased that we are the first Trust in England to introduce a carbon-neutral patient menu, sourced from ingredients with a low carbon footprint. Our new low carbon menu, which was introduced last summer to patients at St George's, will save up to 23 tonnes of CO2 a year – the equivalent of planting 30 acres of forests.

The Trust produced 36.5m kWh of electricity, of which we exported 2.1m kWh 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 by 80% of our 2017 records by 2032 and towards net zero by 2040 to meet national demands.

Our Energy Centre opened in June 2018 and its greater efficiency has helped us to achieve not only financial savings but also limit our carbon emissions. 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, a highly efficient chiller system and more energy efficient lighting and controls.

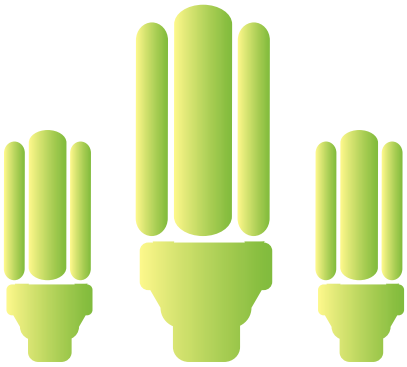
"Our new low carbon menu, which was introduced last summer to patients at St George's, will save up to 23 tonnes of CO2 a year – the equivalent of planting 30 acres of forests."

Energy usage analysis

In 2021/22 the Trust's electricity and gas costs were £4.62m, which was an increase of £590,000 when compared to the previous year. This 13% increase is a direct reflection of the rise in consumption of gas and electricity utilities. The last financial year has seen the Trust return to normal operations and even through continuous operation at 6-days-a-week there still remains a backlog of appointments. These factors have led to an increase in consumption of utilities by approximately 15.7 million kWh. The optimised operation of the boiler house during the course of the financial year has contributed towards financial savings.

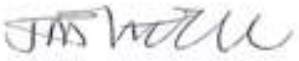
We are continuously developing and upgrading our facilities to keep up with the growing demands on our services. We have continued improvements to our existing infrastructure by upgrading and replacing old/inefficient heat exchangers and through a higher utilisation of the available low temperature hot water from the CHPs.

Reviewing current design and operations of BMI have further progressed the efficiencies of heating throughout the site.



LED lighting has been installed in 70% of the St George's Hospital site so far.

We are on course with the installation of LED lighting across the hospital covering approximately 70% site wide area to-date and expect to continue on for a few more years before completion. The Green Plan will ensure all new projects by the Trust will reflect sustainability decisions and require the energy and sustainability management sign-off which will ensure the Trust remains on course towards our net zero targets.



Jacqueline Totterdell
Group Chief Executive
22 June 2022

3. Accountability report

Accountability report: Directors' report
Delivering outstanding care, every time

Our vision is to provide outstanding care, every time for our patients, staff, and the communities we serve. It reflects our commitment to continually improve the quality of care we provide, achieve financial sustainability, and ensure that care is delivered to our patients by an engaged, empowered and highly skilled workforce. As well as guiding the organisation in achieving this ambition, the Board ensures the Trust upholds the qualities that make the NHS what it is, while also adapting to a period of significant social, demographic and technological change.

The most acute challenges facing the Trust in the short term relate to addressing the elective backlog which built up during the first year of the pandemic, ensuring effective flow through the hospital in the context of the pressures on emergency care, and responding to the financial pressures across the system as the supplementary financial support to the NHS introduced during the pandemic is scaled back. We have made progress on implementing our strategy despite the challenges of the pandemic, but at the same time we have some way to go to realise our vision of delivering outstanding care, every time to our patients, staff and the communities we serve – particularly in relation to improving operational performance on elective recovery and emergency care; improving our estates and IT infrastructure; strengthening our culture, all within a challenging financial outlook.

Leadership through strategic direction

Our five-year strategy was published in April 2019. While our priorities over the past two years have been on responding to the pandemic, these remain the overarching priorities that drive the focus of the Board, and inform the key decisions we make.

As set out above, in addition to the supporting strategies agreed by the Board in 2019/20 (which covered research; digital; workforce; education; quality and safety; and outpatients), in July 2021 the Board approved a new estates strategy and sustainability plan. During 2021/22, we have continued our focus 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.

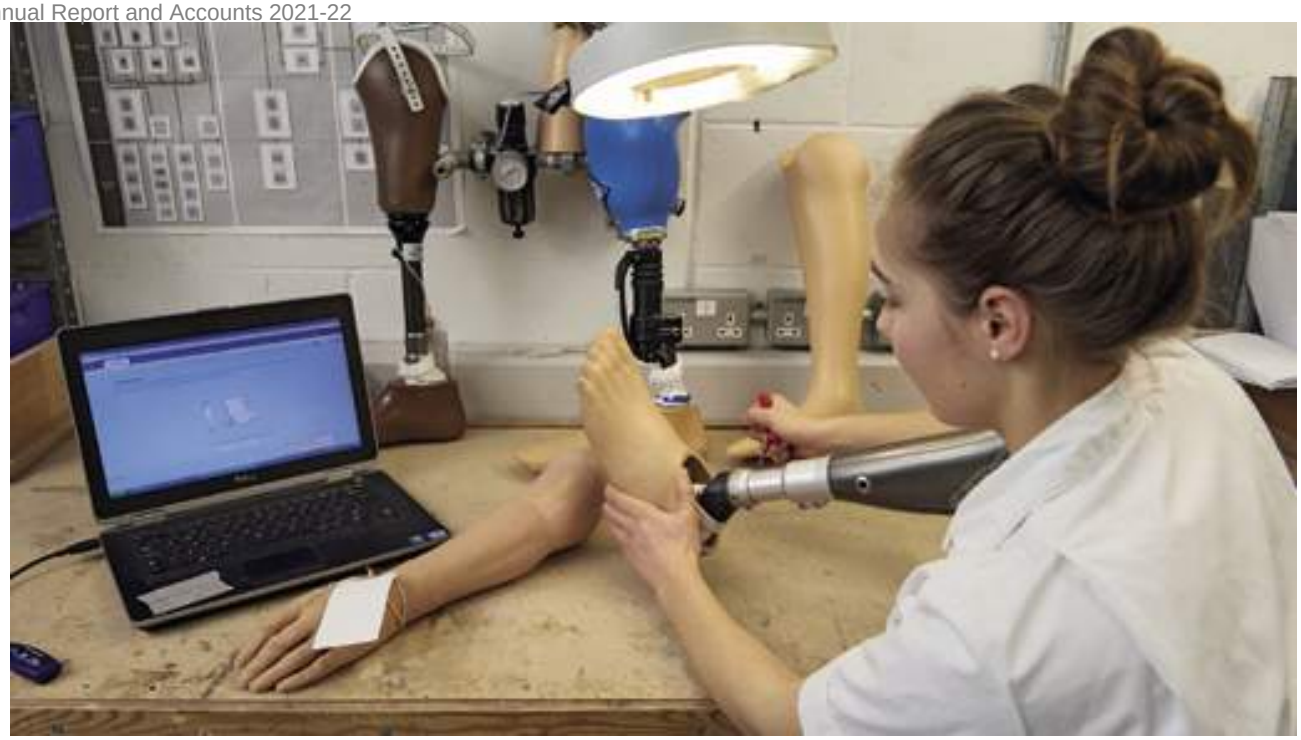
At the same time, we recognise the challenges of turning both the NHS Long Term Plan and our own strategy into reality. Many of the long-standing issues we face – including our aging estate at St George's Hospital, and fragile information technology infrastructure cannot be solved quickly; and the delivery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

The Trust did not receive a CQC inspection during 2021/22, though we continue to work closely with the CQC to ensure safe and effective care for our patients. The CQC published its



most recent inspection report for St George's on 18 December 2019 following its unannounced inspection in July 2019 and its well-led review in September 2019. In that inspection, the Trust maintained its CQC rating of Requires Improvement, but the CQC recommended that St George's be taken out of quality special measures, which was endorsed by NHS England and NHS Improvement in March 2020. The trust also exited financial special measures in December 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. 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 and was overseen by the Board's Quality and Safety Committee. During 2021/22 the Committee oversaw the implementation of the action plan. In May 2021, 40 of the 46 actions had been completed, with the remaining six incorporated into business as usual activity.

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

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. Examples of patient engagement during the year include:

- In summer 2021, patients were asked to have their say on the proposals to build a new specialist renal unit at St George's Hospital. This included writing directly to over 3,000 kidney patients, speaking to 750 kidney patients in local clinics, and two public events. Eight out of ten patients supported the proposal, and these findings were shared with decision making bodies
- Creation of a Patient Liver Forum, set up for patients to meet each other and the hepatology team and contribute to making improvements in the service
- Formation of the Queen Mary's Wheelchair Service User Group to help shape the wheelchair service and help with aspects of service delivery
- Our new Children and Young People's Council has been established, providing an important forum where young patients can share their honest views about what is working well at the Trust, and what can be improved.

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.

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 throughout 2021/22 has continued to make progress in embedding a quality improvement across the Trust, and not just for those holding formal leadership positions.

The St George's membership community includes more than

12,000

patients and members of the public.

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

Emergency Department Check-In (EDck.in)

Transformation has continued to support the Emergency Department team with the development of the EDck.in smart phone check-in system.

The problem	**Waiting to be seen is often a poor experience, particularly in busy environments like an Emergency Department.** **There are around 450 daily Emergency Department attendances at St George's, and every patient consultation involves collecting mostly standard information.** **Clinicians spend hours each day manually typing this information into the electronic record.**
The solution	**EDck.in is a smartphone check-in system developed by the ED team.** **Patients complete a brief questionnaire on their smartphone and information is sent immediately into the electronic patient record.** **This vastly reduces time spent by clinicians on note typing and improves the quality and standardisation of documentation.**
The outcome	**EDck.in automates much of the registration and assessment process and gives real time waiting information for patients, supporting both departmental efficiency and patient experience.** **The system launched in 2020 and with continued development has enabled more than 32,000 patients to check-in, saving thousands of hours in administration time.** **EDck.in was a finalist in three HSJ awards in 2021, was selected as an RCEM 2021 'Showcase of Good Practice' project and was recently announced as a 2022 DigitalHealth. London Launchpad product.**

Implementing the General Surgery Same Day Emergency Care (SDEC) Pathway

Transformation has supported the Nye Bevan Unit to design, develop and launch a General Surgery Same Day Emergency Care (SDEC) pathway, reducing unnecessary admissions and providing better patient experience.

The problem	Patients can often be admitted to wards for investigations and treatments when they are safe (and would prefer) to go home and return the following day. These unnecessary admissions increase bed occupancy and can reduce patient flow and efficiency in the hospital.
The solution	SDEC is the provision of same-day care for emergency patients who would otherwise be admitted to hospital. The Nye Bevan Unit team designed and implemented a General Surgery SDEC pathway. The pathway launched in December 2021 and enables appropriate General Surgery patients to be rapidly assessed, diagnosed, and treated without being admitted to a ward for a long inpatient episode.
The outcome	The SDEC pathway improves efficiency and flow by reducing length of stay and overnight admissions. It also provides better patient experience by avoiding unnecessary time in hospital. Since the SDEC pathway launch, overnight admissions per day for General Surgery have decreased by 25%.

Extending and improving telephone contact with maternity patients

The problem	During the Covid lockdown period the maternity service used mixed methods of telephone and virtual appointments to successfully maintain contact with patients who would normally have many face-to-face contacts. This enabled patients to continue to receive timely advice and guidance and supported collaboration between hospital and community staff. To continue this and improve accessibility/ call answering required funding and the setup of a more dedicated line with an organised process and aligned and dedicated staff.
The solution	A joint team made a successful bid for £30,000 to the Health Foundation Q community enabling setup of the service. A small project team, including maternity staff and patient representatives (through our Maternity voices partnership) designed and implemented the processes, procedures and staff support to run the helpline service.
The outcome	The maternity helpline launched successfully on 28th March, answering 170 calls in the first week. Further communications including banners & poster displays across community locations will drive up awareness and further call volumes over time – helping more patients.

Day Surgery Unit – model of service

The problem	**Elective recovery capacity in both inpatient and day surgery theatres needed to be maximised. The Day Surgery unit opening hours were a restriction on the types and number of procedures that could be carried out as day cases. Inpatient theatres were being used for many zero length of stay procedures.**
The solution	**The Day Surgery Unit hours of operation have been changed to accommodate extended recovery until 11pm and 23-hour beds. Additional staff have been recruited to manage the patients in the extended hours. Theatre lists have been moved from main theatres to the Day Surgery Unit to free up inpatient capacity.**
The outcome	**The new Day Surgery hours started on 31 January 2022 and the new theatre lists/cases are being incrementally introduced. The new lists are not dependent on ward bed availability. Initial patient feedback is very positive.**

Theatres Sustainability Programme

The problem	**Anaesthetic gases form a significant part of NHS greenhouse gas emissions.**
The solution	**St George's has worked alongside SW London sector trusts to reduce the use of one of the most polluting anaesthetic gases, desflurane. Alternative gases and the introduction of TIVA (totally intravenous anaesthesia) have been rolled out via an education programme.**
The outcome	**Desflurane use has reduced significantly and is now below the sector target of 5% anaesthetic usage.**

Theatres Sustainability Programme

The problem	**Single use theatre instruments produce a high volume of waste which is costly for the trust to dispose of and is environmentally unfriendly.**
The solution	**In partnership with Procurement, theatre teams have looked at their procedure sets with the aim of reducing the items in each set to include only the most frequently used items and replacing some single use items with reusable alternatives. They have also looked at the plastic content of each item and sought non-plastic or reduced plastic alternatives.**
The outcome	**Many sets, particularly in General Surgery, have been reduced to essential items only. This saves both purchasing costs and waste disposal costs. The Trust's procurement team is maintaining a savings dashboard to demonstrate the effect of the changes.**

At a senior level, the work of the QIA is overseen by a 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. Some of our most significant partnerships are outlined below.

South West London Integrated Care System

We continued our work as a key partner within the South West London Integrated Care System, 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.

At borough level, and through Local Transformation Boards, St George's is involved in the ICS's review of its South West London Five Year Plan and plans for Wandsworth and Merton. These are being 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. During 2021/22, Epsom and St Helier University Hospitals NHS Trust joined South West London Pathology, a further demonstration of our closer working across the providers in the area. 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 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, is the Clinical Director of the NHS South East GMSA. The alliance works 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 further 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.

We recruited over

7,500

patients to 50 clinical research studies during 21/22.

St George's Hospital Charity

During the height of the pandemic, the St George's Hospital Charity scaled up its operations and provided hugely generous support to the Trust, and as we come out of the pandemic that support remains indispensable. 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 has gone towards making improvements for 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, receiving £198,000 in April 2021. The funding will cover five projects across the hospital, focusing on addressing staff health and wellbeing, and includes new shower blocks, cycle storage, and garden areas. In Spring 2022 the charity launched a major new appeal – 'Time for a Change' – which aims to raise £5m to help transform children's services at St George's so that our facilities match our world class care.

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 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.

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 and is responsible for representing the views of members and the public and holds the non-executive directors to account for the performance of the Board.

Led by the Group 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 Group Chairman. Our Council of Governors represents our membership body, and during the reporting period its activities contributed to the Trust's work on providing high quality services and care to its patients.

In 2021/22, the Council appointed a new non-executive director as Audit Committee chair, extended the term of its associate non-executive director for a further year, and continued to help to ensure that the Board of Directors had the right balance of skills and knowledge to lead the Trust. In March 2021, the Council reviewed succession planning for the Board and, in the context of the extraordinary challenges presented by the pandemic, decided to extend the terms of office of the Chairman and three other Non-Executive Directors to ensure a progressive refreshing of the Board over the coming years.

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.– which includes members of the public and our staff – and appointed local authority, university and Healthwatch stakeholder representatives. 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	1 February 2020	1 February 2020 - 31 January 2023
Adil Akram	Wandsworth	First	1 February 2021	1 February 2021 - 1 January 2024
Afzal Ashraf	Wandsworth	First	1 February 2020	1 February 2020 - 31 January 2023
Mia Bayles	Rest of England	Third	1 February 2021	1 February 2021 - 31 January 2024
Padraig Belton	Rest of England	First	1 February 2021	1 February 2021 - 31 January 2024
Patrick Burns	Merton	First	21 April 2021	21 April 2021 - 31 January 2023
Sandhya Drew	Rest of England	First	1 February 2020	1 February 2020 - 31 January 2023
John Hallmark	Wandsworth	Second	1 February 2021	1 February 2021 - 31 January 2024
Hilary Harland	Merton	Third	1 February 2021	1 February 2021 - 31 January 2024
Shalu Kanal	Wandsworth	First	1 February 2021	1 February 2021 - 31 January 2024
Basheer Khan	Wandsworth	First	1 February 2020	1 February 2020 - 31 January 2023
Richard Mycroft (Lead Governor)	South West Lambeth	Second	1 February 2021	1 February 2021 - 31 January 2024
Ataul Qadir Tahir	Wandsworth	First	1 February 2020	1 February 2020 - 31 January 2023
Stephen Sambrook	Rest of England	Second	1 February 2020	1 February 2020 - 31 January 2023
Khaled Simmons	Merton	Third	1 February 2021	1 February 2021 - 31 January 2024
ELECTED STAFF GOVERNORS				
Jenni Doman	Non-Clinical	Third	1 February 2020	1 February 2020 - 31 January 2023
Marlene Johnson	Nursing & Midwifery	Second	1 February 2021	1 February 2021 - 31 January 2024
Alexander Quayle	Allied Health Professionals	First	1 February 2021	1 February 2021 - 31 January 2024
Tunde Odutoye	Clinical & Dental	First	1 February 2021	1 February 2021 - 31 January 2024
APPOINTED STAKEHOLDER GOVERNORS				
Alfredo Benedicto	Healthwatch Merton	Second	1 February 2021	1 February 2021 - 31 January 2024
Sarah Forrester	Wandsworth Healthwatch	First	1 February 2021	1 February 2021 - 31 January 2024
Sarah McDermott	Wandsworth Council	Second	1 February 2018	1 February 2018 - 5 May 2022
Sangeeta Patel	South West London CCG	Second	1 February 2021	1 February 2021 - 31 January 2024
Prof. Kathy Curtis	Kingston University	First	21 April 2021	14 April 2021 - 20 April 2024
Linda Kirby	Merton Council	First	17 February 2021	17 February 2021 - 16 February 2024

There were no elections to the Council of Governors during 2021/22 although Patrick Burns was appointed as public governor for Merton, following the sad death of Nasir Javed Khan in March 2021. Professor Kathy Curtis also joined the Council of Governors in April 2021 taking up the appointed governor post for Kingston University that had previously been vacant. Councillor Sarah McDermott resigned from the Council of Governors in May 2022 following her decision to step down as a Wandsworth councillor.

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.

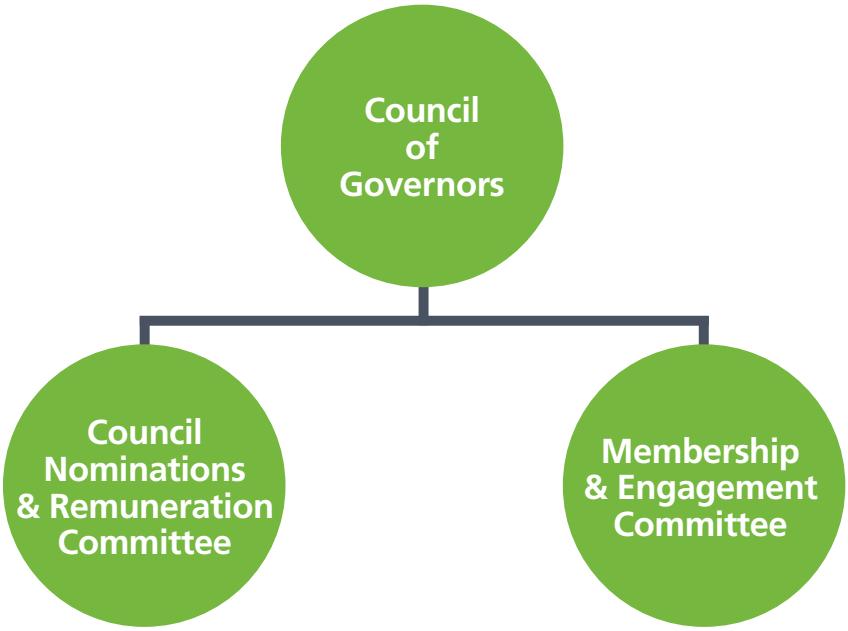
The Council of Governors has additional key decision-making responsibilities including;

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

During 2021/22, the Council of Governors exercised some of these functions, specifically: the re-appointment of the Chairman and a number of non-executive directors to further terms of office and approving the appointment of Jacqueline Totterdell as Group Chief Executive in August 2021. The Council also inputs into 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 but did not undertake such a review in 2021/22 in light of the unusual circumstances in which the Council had operated, including meeting remotely and avoiding attending the Trust in light of the pandemic response.

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 three times during the period. With the support of this Committee the Council was able to:

- reappoint the Chairman to a further term of office ending 31 March 2025
- reappoint three non-executive directors and the associate non-executive director for further terms of office
- receive the appraisal of the Chairman and other non-executive directors
- undertake the recruitment of a new non-executive director to succeed Elizabeth Bishop who stepped down from the Board in September 2021.

The Committee is led by the Group Chairman and the members are governors. During 2021/22 the following Governors were members of the Committee:

MEMBERS	TITLE
Gillian Norton	Trust Chairman (Committee Chair)
Adil Akram	Public Governor, Wandsworth
Mia Bayles	Public Governor, Rest of England
Alfredo Benedicto	Appointed Governor, Healthwatch Merton
Jenni Doman	Staff Governor, Non-Clinical
John Hallmark	Public Governor, Wandsworth
Hilary Harland	Public Governor, Merton
Marlene Johnson	Staff Governor, Nursing and Midwifery
Basheer Khan	Public Governor, Wandsworth
Richard Mycroft	Public Governor, South West Lambeth
Khaled Simmons	Public Governor, Merton

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

- the Membership Strategy 2019-2022, year three implementation plan and progress updates
- planning for a revision of the Membership Strategy in 2022
- 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.

During 2021/22 the following Governors were members of the Committee.

MEMBERS	TITLE
Richard Mycroft	Public Governor for South West Lambeth
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
Shalu Kanal	Public Governor for Wandsworth
Tunde Odutoye	Staff Governor, Medical and Dental
Stephen Sambrook	Public Governor for Rest of England

Due to the continuing Covid-19 pandemic, the Council of Governors met virtually during 2021/22 for all but its final meeting, in March 2022. In total there were five meetings of the Council and attendance of Governors is set out in table 2 below.

Table 2: Council of Governors' attendance at meetings

GOVERNOR	CONSTITUENCY/OFFICE	MEETINGS ATTENDED (ACTUAL/ELIGIBLE ATTENDANCE)
Gillian Norton	Group Chairman	5/5
ELECTED PUBLIC GOVERNORS		
Nasir Akhtar	Merton	5/5
Adil Akram	Wandsworth	4/5
Afzal Ashraf	Wandsworth	5/5
Mia Bayles	Rest of England	4/5
Padraig Belton	Rest of England	2/5
Patrick Burns	Merton	3/4
Sandhya Drew	Rest of England	3/5
John Hallmark	Wandsworth	4/5
Hilary Harland	Merton	5/5
Shalu Kanal	Wandsworth	4/5
Basheer Khan	Wandsworth	3/5
Richard Mycroft	South West Lambeth (Lead Governor)	5/5
Ataul Qadir Tahir	Wandsworth	4/5
Stephen Sambrook	Rest of England	5/5
Khaled Simmons	Merton	5/5
ELECTED STAFF GOVERNORS		
Jenni Doman	Non-Clinical	4/5
Marlene Johnson	Nursing & Midwifery	4/5
Tunde Odutoye	Medical & Dental	4/5
Alex Qualye	Allied Health Professionals	3/5
APPOINTED STAKEHOLDER GOVERNORS		
Alfredo Benedicto	Healthwatch Merton	3/5
Kathy Curtis	Kingston University	3/5
Sarah Forester	Healthwatch Wandsworth	2/5
Linda Kirby	Merton Council	2/5
Sarah McDermott	Wandsworth Council	4/4
Governor	Constituency/Office	Meetings Attended (Actual/Eligible Attendance)
Sangeeta Patel	Merton/Wandsworth Clinical Commissioning Group	2/5

As well as the regular report from the Chief Executive, updates from the Committees of the Council of Governors and regular questions to non-executive directors, some of the key matters considered by the Council included:

DATE	MATTERS CONSIDERED BY THE COUNCIL OF GOVERNORS
21 April 2021	Annual planning 2021/22 Council of Governors work programme and membership
14 July 2021	Governor training and development Estate strategy and green plan Culture programme Final Quality Account & Report 2020/21 External Auditors Report Integrated Quality & Performance Report (Outcomes, Performance and Productivity) Clinical and Supporting Strategies Integrated Care System Update Annual Members Meeting 2021 Plan Appointment of new Senior Independent Director Council of Governors meetings and site visits in 2021/22
16 September 2021	Integrated Care System Update Integrated Quality & Performance Report (Patient Safety) Patient Experience & Complaints Annual Review External Auditors Report – Value for Money Report
8 December 2021	Covid-19 and winter planning Learning from Covid-19: Workforce Finance and financial planning update Membership Engagement Committee update
10 March 2021	Quality priorities 2022/23 Workforce and culture update Annual planning and budget setting

Governors met in private in August 2021 to endorse the appointment of Jacqueline Totterdell as Group Chief Executive Officer to expand her remit to include Epsom and St Helier University Hospitals NHS Trust (ESTH). It also met in private in March 2021 to consider the extension of the non-executive appointments to the Board, and agreed to extend the terms of office of the Chairman and three non-executives.

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. The Senior Independent Director was changed in June 2021 from Ann Beasley to Stephen Collier. The Board made this appointment following consultation and engagement with the Council of Governors.

Governors are able to question the non-executive directors at Council meetings, and also have the opportunity to attend Board meetings and ask questions. Due to the Covid-19 pandemic, opportunities for Governors' engagement with members were 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 make use of these procedures during 2021/22.

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 non-executive directors understand the views of Governors. Executive directors are also invited to attend meetings of the Council on matters related to their portfolio.

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. 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. 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, meetings of the Council of Governors and its Committees and development sessions have been held online during 2021/22, with the March 2022 meeting of the Council being held in person. During 2021/22, as part of its development, the Council held a development session, led by the GovernWell Programme from NHS Providers.

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

Membership constituency	2020/21	2021/22
Total Public Members	**12,938**	**12,795**
Lambeth	**548**	**540**
Merton	**3,380**	**3,334**
Wandsworth	**4,113**	**4,061**
Rest of England	**4,897**	**4,860**
Total Staff Members	**9,171**	**9,526**

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.

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.

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 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.

During 2021/22 the pandemic again affected membership activities but there were online talks provided looking at topics such as the work of the St George's Hospital Charity, mental health issues and the Trust's diabetes and skin cancer services, and constituency engagement events led jointly by Governors and Board members. The Council of Governors is responsible for the delivery of the membership strategy, and through its Membership Engagement Committee it monitors the implementation and delivery of milestones in the membership strategy. The Council as a whole and the Committee receive regular reports on the extent to which the membership of the Trust is representative of the communities we serve. The membership strategy will be refreshed during 2022/23.

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 corporategovernance3@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, Board meetings held in public, 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. Executive members of the Trust Board are full time employees of the Trust, with a notice period of three 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,
OBE DL, Group Chairman

Gillian Norton OBE 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.

Non-Executive Directors

Ann Beasley,
Non-Executive Director (Deputy Chair)

Ann Beasley joined St George's in October 2016 and serves as Vice Chair. 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. From 1 June 2021, Ann has also been a non- executive director at Epsom and St Helier University Hospitals NHS Trust.

Non-Executive Directors (cont.)

Stephen Collier,
Non-Executive Director

Stephen Collier is currently the Chair of NHS Professionals. 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 and, since June 2021, has served as Senior Independent Director on the Board.

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.

Dr Peter Kane,
Non-Executive Director

Dr Peter Kane has a doctorate in economics from the London School of Economics and is a qualified accountant. Throughout his career he has worked in public services, including in the Treasury and Cabinet Office. His most recent role was the Chamberlain (or Chief Finance Officer) of the City of London Corporation. Peter brings a wealth of experience in finance, risk, performance. He is also a non-executive director of the Institute of Fiscal Studies and Historic England Audit Committee. Peter joined the St George's Board on 1 October 2021 and is Chair of the Audit Committee and holds a similar role at Epsom and St Helier.

Professor Dame Parveen Kumar DBE,
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. 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 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,
Group Chief Executive

Jacqueline was appointed the Group Chief Executive of the St George's and Epsom and St Helier University Hospitals and Health Group in August 2021, after joining St George's University Hospitals NHS Foundation Trust as Chief Executive in May 2017. Jacqueline is also the CEO Lead for the South West London Acute Provider Collaborative. A Paediatric Intensive Care Nurse by background, Jacqueline started her general management career at Leeds General Infirmary, moving on to Birmingham Children's Hospital, after which she spent two years working for the Modernisation Agency. After two Executive Director posts at Barnet & Chase Farm Hospitals NHS Trust, and then Hillingdon Hospitals NHS Foundation Trust, Jacqueline held Chief Executive positions at Southend University Hospital NHS Foundation Trust and West Middlesex University Hospital where she oversaw the merger of the Trust with Chelsea and Westminster NHS Foundation Trust. Before taking up her role at St George's, Jacqueline spent 18 months as part of the Executive Team supporting Barts Health NHS Trust out of Special Measures.

Andrew Grimshaw,
Group Chief Financial Officer

Andrew has over 30 years' experience in NHS finance and has worked in wide range of organisations from district general hospitals, tertiary, teaching and ambulance trusts. He joined St George's Hospitals as Chief Financial Officer in 2017 and also held the post of Deputy Chief Executive from 2019 until the formation of the St George's, Epsom and St Helier University Hospitals and Health Group.

Dr Richard Jennings,
Group 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.

Arlene Wellman MBE,
Group Chief Nursing Officer

Arlene qualified as a general registered nurse in Trinidad and migrated to the UK with the intention of training as a midwife. However she fell in love instantly with elderly care nursing and has more than 20 years' experience in this speciality. Arlene holds a first degree in Health and Social Care for Older People and a Master's degree in Clinical Healthcare Practice. She has held various senior nursing roles across acute trusts, including Matron, Senior Matron and Divisional Nurse at Oxford University Hospitals NHS Trust. Arlene was appointed as Chief Nurse at Epsom and St Helier University Hospitals NHS Trust in February 2018, a role she served in until her appointment as Group Chief Nursing Officer as part of the St George's, Epsom and St Helier University Hospitals and Health Group in February 2022.

Non-voting Board members

Dr James Marsh,
Group Deputy Chief Executive Officer

James has been at Epsom, Sutton and St Helier hospitals for more than 19 years, joining as a renal (kidney) consultant in 2003, before being made lead consultant for transplantation and, subsequently, clinical director for renal services. He was appointed as Deputy Medical Director in 2011. He graduated with first class honours from the University of Oxford in the mid-1980s, continuing his clinical training at Guy's Hospital where he earned a Distinction in pathology, surgery, pharmacology and therapeutics.

Dr Stephen Jones,
Group 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.

Paul da Gama,
Group 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.

Kate Slemeck,
Managing Director for St George's Hospital

Kate previously worked at Royal Free Hospital as Director of Operations in 2011 before being appointed as Chief Operating Officer in 2012 and then becoming Chief Executive of the Royal Free Hospital in 2018. Kate originally trained as an Occupational Therapist. Her previous roles also include Director of Operations and Chief Operating Officer and she has nearly 30 years' NHS management experience, mainly in acute Trusts (including Northwick Park Hospital and the Royal Hospital for Neurodisability).

Other Directors who served on the Board during 2021/22

During 2021/22, four other Directors served on the Trust Board who have since left the Trust or moved to site leadership roles.

Robert Bleasdale,
Acting Chief Nurse & and Director of Infection Prevention and Control (until March 2022)

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.

Suzanne Marsello,
Chief Strategy Officer (until January 2022)

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.

James Friend,
Chief Transformation Officer (until July 2021)

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.

Anne Brierley,
Chief Operating Officer (until January 2022)

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.

Trust Board Attendance Register 2021/22

BOARD OF DIRECTORS	APPOINTED ROLE	ELIGIBLE PERIOD	ACTUAL/ELIGIBLE ATTENDANCE
VOTING NON-EXECUTIVE DIRECTORS			
Gillian Norton	Chairman	1 April 2021 – 31 March 2022	6/6
Ann Beasley	Non-Executive Director	1 April 2021 – 31 March 2022	6/6
Elizabeth Bishop	Non-Executive Director	1 April 2021 – 30 Sept 2021	2/3
Peter Kane	Non-Executive Director	1 October 2021 – 31 March 2022	3/3
Stephen Collier	Non-Executive Director	1 April 2021 – 31 March 2022	6/6
Prof. Jenny Higham	Non-Executive Director	1 April 2021 – 31 March 2022	6/6
Dame Professor Parveen Kumar	Non-Executive Director	1 April 2021 - 31 March 2022	6/6
Tim Wright	Non-Executive Director	1 April 2021 - 31 March 2022	6/6
VOTING EXECUTIVE DIRECTORS			
Jacqueline Totterdell2	Group Chief Executive Officer	1 April 2021 – 31 March 2022	6/6
Andrew Grimshaw3	Group Chief Financial Officer	1 April 2021 – 31 March 2022	6/6
Robert Bleasdale	Acting Chief Nurse/Director of Infection & Prevention Control	1 April 2021 – 31 January 2022	5/5
Arlene Wellman	Group Chief Nursing Officer	1 February 2022 – 31 March 2022	1/1
Dr Richard Jennings2	Group Chief Medical Officer	1 April 2021 – 31 March 2022	6/6
NON-VOTING NON-EXECUTIVE DIRECTORS			
Pui-Ling Li	Associate Non-Executive Director	1 April 2021 – 31 March 2022	6/6
NON-VOTING EXECUTIVE DIRECTORS			
Stephen Jones[2]	Group Chief Corporate Affairs Officer	1 April 2021 – 31 March 2022	6/6
Suzanne Marsello* (on secondment since 31 Jan 2022)	Chief Strategy Officer	1 April 2021 – 31 January 2022	4/5
Anne Brierley	Chief Operating Officer	1 April 2021 – 31 January 2022	4/6
Paul Da Gama[2]	Chief People Officer	1 April 2021 – 31 March 2022	6/6
James Marsh	Deputy Group Chief Executive Office	1 February 2022 – 31 March 2022	1/1
Kate Slemeck	Managing Director	3 February 2022 – 31 March 2022	1/1

[2] Appointed Group Chief Executive from 1 August
[3] Appointed Group chief officer from 1 February 2022, prior to this held a Trust role

The NHS Foundation Trust Code of Governance requires the Trust's Annual Report to set out each non-executive director it considers to be independent. The Board must determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The Board is required to state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination.

The Board considers the following non-executives to have been independent for the purposes of this report for the year 2021/22: Stephen Collier, Parveen Kumar, Tim Wright and Pui-Ling Li. Gillian Norton, Ann Beasley, Elizabeth Bishop (until 30 September 2021) and Peter Kane (from 1 October 2022) served on the board of Epsom and St Helier University Hospitals NHS Trust during 2021/22. The Board has authorised the existence of a conflict of

interest in relation to posts across the St George's, Epsom and St Helier University Hospitals and Health Group. Ann Beasley also chairs the Board of South West London and St George's Mental Health NHS Trust.

Non-executive directors are appointed for terms of office of three years. In the case of the associate non-executive director, the term is two years (extended to three by the Council of Governors for the current incumbent in light of the impact of the pandemic). The terms of office of our current non-executive directors are set out below:

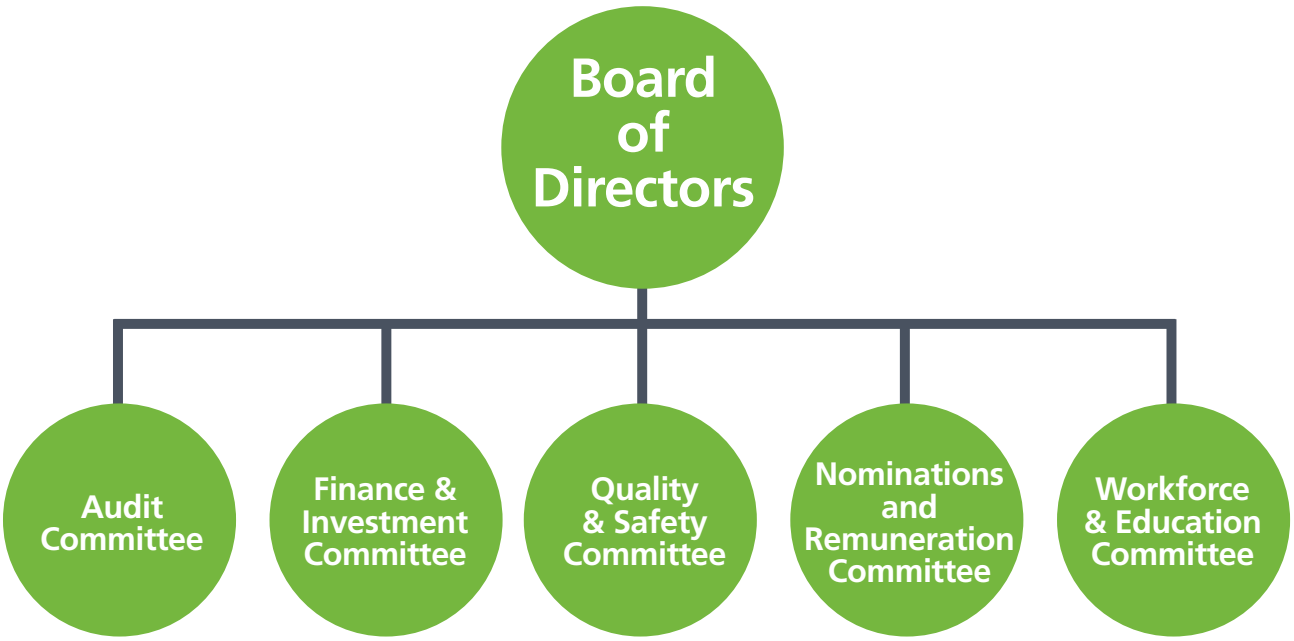
NAME	CURRENT TERM OF OFFICE	TERM LENGTH	PREVIOUS TERM OF OFFICE (IF RELEVANT)
Gillian Norton	1 April 2020 – 31 March 2023**	3 years	1 April 2017 – 31 March 2020
Ann Beasley	13 Oct 2019 – 12 Oct 2022**	3 years	13 Oct 2016 – 12 Oct 2019
Peter Kane	1 Oct 2021 – 30 Sept 2024	3 years	N/A
Stephen Collier	13 Oct 2019 – 12 Oct 2022**	3 years	13 Oct 2016 – 12 Oct 2019
Jenny Higham	1 January 2016 (open ended)*	3 years	N/A
Parveen Kumar	13 Jan 2020 – 12 Jan 2023	3 years	N/A
Pui-Ling Li	13 Jan 2022 – 12 Jan 2023	1 years	13 Jan 2020 – 12 Jan 2022
Tim Wright	26 Sept 2020 – 25 Sept 2023**	3 years	26 Sept 2017 – 25 Sept 2020

* Jenny Higham serves 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.

** In reviewing Board succession planning, and with a view to ensuring the progressive refreshing of the Board, the Council of Governors agreed in March 2022 to extend the terms of office of Gillian Norton by two years ending 31 March 2025, Ann Beasley by three years ending 12 October 2025, and Stephen Collier and Tim Wright by one year each ending 12 October 2023 and 25 September 2024 respectively.

Board Committee structure

The Trust Board changed its committee structure from1 April 2022, but during 2021/22 it had five Board committees, as shown in the diagram below:



The Audit Committee met seven times in the year 2021/22, while the Finance and Investment Committee, Quality and Safety Committees and Workforce and Education Committee met monthly.

The committees produce reports for the Trust's public Board following each meeting summarising the key areas of assurance and risk considered. 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 Group Chief Corporate Affairs Officer and Group Chief Finance Officer, as the relevant executive leads, attend each meeting of the Committee.

During 2021/22 the Committee held seven meetings and attendance is recorded below:

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Elizabeth Bishop (until 30 Sep 2022)	Non-Executive Director, Chair	5/5
Peter Kane (from 1 Oct 2022)	Non-Executive Director, Chair	2/2
Ann Beasley	Non-Executive Director	7/7
Tim Wright	Non-Executive Director	4/7
Pui-Ling Li	Non-Executive Director	4/7

During the period, the Committee:

- reviewed the 2020/21 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 2021/22 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;
- received regular reports on the Trust Board Assurance Framework and plans to conduct a substantive review on the Trust's Risk Management Policy;
- received regular updates from the Trust's counter-fraud specialist.

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 that the Trust uses public funds wisely. It also provides oversight and assurance in relation to operational performance, estates and information technology.

The Committee membership comprises non-executive and executive directors. The Trust Chairman, Group Chief Executive Officer, Group Chief Corporate Affairs Officer and Group Chief People Officer regularly attended the meetings of the Committee.

The Group Deputy Chief Executive Officer was appointed as a member of the Committee from May 2022. During 2021/22 the Committee held 12 meetings and attendance is recorded below:

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

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Ann Beasley	Non-Executive Director, Chair	11/11
Tim Wright	Non-Executive Director	10/11
Stephen Collier	Non-Executive Director	10/11
Elizabeth Bishop (until 30 Sep 2022)	Non-Executive Director	4/5
Peter Kane (from 1 Oct 2022)	Non-Executive Director	6/6
Anne Brierley (until 31 Jan 2022)	Chief Operating Officer	8/9
Andrew Grimshaw	Group Chief Finance Officer	10/12
Dr Richard Jennings	Group Chief Medical Officer	6/12
Robert Bleasdale (until 31 Jan 2022)	Acting Chief Nurse/Director of Infection & Prevention Control	10/10
Arlene Wellman (from 1 Feb 2022)	Group Chief Nursing Officer	2/2
Kate Slemeck (from 3 Feb 2022)	Managing Director	1/2

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 pandemic;
- closely monitored operational performance, including against emergency operating standard, elective performance, productivity and 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 and risks relating to estates issues.

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, Group Chief Executive and Group Chief Corporate Affairs Officer regularly attended the meetings of the Committee.

During 2021/22 the Quality and Safety Committee held 12 meetings and attendance is recorded below:

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Dame Parveen Kumar	Non-Executive Director, Chair	12/12
Prof. Jenny Higham	Non-Executive Director	11/12
Elizabeth Bishop (until 30 Sep 2022)	Non-Executive Director	4/6
Peter Kane (from 1 Oct 2022)	Non-Executive Director	6/6
Pui-Ling Li	Associate Non-Executive Director	9/12
Anne Brierley (until 31 Jan 2022)	Chief Operating Officer	7/10
Kate Slemeck (from 3 Feb 2022)	Managing Director	1/2
Dr Richard Jennings	Group Chief Medical Officer	12/12
Robert Bleasdale (until 31 Jan 2022)	Acting Chief Nurse/Director of Infection Prevention & Control	10/10
Arlene Wellman (from 1 Feb 2022)	Group Chief Nursing Officer	2/2

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 2021/22, 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 in order to provide 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;
- received regular reports on cardiac surgery;
- received updates on progress in implementing the findings 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, staff wellbeing, compliance with regulatory requirements in relation to workforce, and the Trust's culture, equality, diversity and inclusion programme.

The Workforce and Education Committee membership comprises non-executive and executive directors. The Group Chief Executive and Group Chief Corporate Affairs Officer regularly attend the meetings of the Committee. During 2021/22 the Committee held 12 meetings and attendance is recorded below:

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Stephen Collier	Non-Executive Director, Chair	12/12
Tim Wright	Non-Executive Director	12/12
Prof Dame Parveen Kumar	Non-Executive Director	12/12
Pui-Ling Li	Associate Non-Executive Director	9/12
Paul Da Gama	Group Chief People Officer	12/12
Dr Richard Jennings	Group Chief Medical Officer	6/12
Robert Bleasdale (until 31 Jan 2022)	Acting Chief Nurse/Director of Infection Prevention & Control	8/10
Arlene Wellman (from 1 Feb 2022)	Group Chief Nursing Officer	1/2

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 General Medical Council National Training survey and NHS staff surveys;
- received reports on the Trust's Freedom to Speak Up Guardian and Guardian of Safe Working;
- reviewed progress in implementing the Trust's culture programme and actions to improve equality, diversity and inclusion across the organisation;
- 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. 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 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.

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 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 May 2022, the Council of Governors Nominations and Remuneration Committee considered the outcomes of the appraisals of the Chairman and non-executive directors in 2021/22 and, following this, the outcome of the appraisals was presented to the Council of Governors in private session.

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-executive directors. The appraisal process is undertaken every other year, and the outcomes are reported to the Board's Nominations and Remuneration Committee. Executive appraisals were last 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 System Oversight Framework

NHS England and NHS Improvement recently consulted on the new NHS system oversight framework 2021/22, which introduced a new approach to provide focused assistance to organisations and systems. Following feedback from local leaders and others, the new system is now being implemented.

The framework looks at five national themes:

- quality of care, access and outcomes
- preventing ill health and reducing inequalities
- people
- finance and use of resources
- leadership and capability.

A segmentation decision indicates the scale and general nature of support needs from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). For systems and Trusts in segments 1 and 2, overall support needs will be formally reviewed on a quarterly basis by the relevant regional team (in the case of individual organisations this will happen in partnership with the integrated care system).

St George's University Hospitals NHS Foundation Trust has been placed in segment 2. This segmentation information is the Trust's position at the time of writing this report. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England and NHS Improvement website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

CQC Well-Led Framework

The Board is ultimately responsible for all aspects of leadership in the organisation and oversees the Trust's compliance with the CQC's well-led framework. A summary of the Trust's position in relation to the framework is set out below:

WELL-LED FRAMEWORK: SUMMARY OF TRUST POSITION	
KEY LINES OF ENQUIRY	**TRUST POSITION**
1. Is there leadership capacity and capability to deliver high quality, sustainable care	• The Board and Council of Governors' Nominations and Remuneration Committee regularly considers the skills mix on the Board of Directors. • The Trust has in place a substantive Executive team, and a newly appointed site leadership team, as well as clear Divisional leadership, led by a Clinical Chair. • Senior leaders are visible across the organisation and routinely undertake visits across the Trusts' sites and teams.
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver	• The Trust approved its five-year strategy in April 2019 which sets out the vision and strategic objectives for the organisation. • The clinical strategy is supplemented by a number of sub-strategies – quality and safety; workforce; IT; research; education; and estates. • Implementation of these strategies is overseen by the Committees of the Board and the Board itself on a quarterly basis.

WELL-LED FRAMEWORK: SUMMARY OF TRUST POSITION	
KEY LINES OF ENQUIRY	**TRUST POSITION**
3. Is there a culture of high quality, sustainable care?	• The Trust has put in place a programme to strengthen organisational culture, which is reviewed regularly by the Workforce and Education Committee and by the Board. • Culture is one of the organisation's three core corporate objectives, which are closely monitored by the Board and Executive team. • This is also driven by the Culture, Equity and Inclusion Programme Board which involves senior leaders from across the Trust.
4. Are there clear roles and systems of accountability to support good governance and management?	• There is a clear corporate governance structure at the Trust with clear lines of accountability. All Board committee's have Board-approved terms of reference and forward plans that are designed to meet the assurance requirements of the Board. • The Audit Committee oversees the systems of accountability, supported by external and internal audit.
5. Are there clear and effective processes for managing risks, issues and performance?	• The Trust has in place a risk management policy and processes. • The Board has agreed a Board Assurance Framework and is supported in reviewing this by its Committees. • The Corporate Risk register is overseen by Executive team via the Trust Management Group. • The Audit Committee oversees the organisation's approach to risk management, and this is also subject to annual internal audit.
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	• The Committees of the Board review the quality of information provided to them on an annual basis and the Board considers the quality of information at Board development sessions. • Board Committees and the Board offer robust challenge on all key operational, quality, people and financial performance metrics, as does the Executive.
7. Are the people who use services, the public, staff and external providers engaged and involved to support high quality sustainable services?	• The Trust has in place a range of measures for ensuring the engagement and involvement of staff, from a formal staff engagement programme, pulse surveys, listening events, and engagement on, for example, strategy development. • Patients and the public are engaged through a range of forums including the Patient Partnership and Engagement Group as well as through a number of other patient groups.
8. Are there robust systems and processes for learning, continuous improvement and innovation?	• The Trust has in place robust arrangements to ensure effective learning and continuous improvement. • A Quality Improvement Academy is in place to identify and spread good practice. • There is a structured approach to learning from incidents, deaths, complaints, and claims. • The Trust undertook a major programme of work to learn from the Covid-19 pandemic and identified and implemented a number of improvement measures.

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	2021-22 NUMBER	2021-22 £000s	2020-21 NUMBER	2020-21 £000s
Total non-NHS trade invoices paid in the year	114,294	390,672	112,612	386,741
Total non-NHS trade invoices paid within target	66,172	299,852	69,532	266,140
PERCENTAGE OF NON-NHS TRADE INVOICES PAID WITHIN TARGET	**57.90%**	**76.75%**	**61.70%**	**68.80%**

NHS PAYABLES	2021-22 NUMBER	2021-22 £000s	2020-21 NUMBER	2020-21 £000s
Total NHS trade invoices paid in the year	5,905	104,284	4,649	83,879
Total NHS trade invoices paid within target	2,178	86,401	1,312	62,971
PERCENTAGE OF NHS TRADE INVOICES PAID WITHIN TARGET	**36.88%**	**82.85%**	**28.20%**	**75.10%**

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 NHS Improvement and the National Audit Office, and a review of the Quality Accounts (in 2021/22 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 £113,000 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 2021/22 included but were not limited to: Clinical Audit and Governance, Estates, Patient Engagement, Data Quality (RTT), Homeworking, Infection Prevention and Control, Core Finance, Budget Setting and Financial Reporting, Staff Survey, Health and Safety, Diversity and Inclusion, Freedom to Speak Up, Board Assurance Framework, Consent, DSP Toolkit. During the period the Trust paid internal audit fees of £140,000. 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.

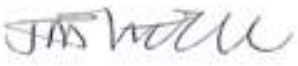
Income from the provision of goods and services

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,
Group Chief Executive
22 June 2022

4. 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 gives 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 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	Trust Chairman, Chair	3/3
Ann Beasley	Non-Executive Director (Vice Chair)	3/3
Elizabeth Bishop (until 30 Sep 2022)	Non-Executive Director	0/0
Stephen Collier	Non-Executive Director	2/3
Professor Jenny Higham	Non-Executive Director	2/3
Peter Kane (from 1 Oct 2022)	Non-Executive Director	2/3
Professor Dame Parveen Kumar	Non-Executive Director	2/3
Pui-Ling Li	Associate Non-Executive Director	1/3
Tim Wright	Non-Executive Director	3/3

The Council of Governors' Nominations and Remuneration Committee determines the remuneration of non-executive directors. During 2021/22 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 long and short-term strategic objectives, excellent standards of clinical outcomes and patient care, functions efficiently, and is well positioned to deliver its business strategy.

As a Foundation Trust, the Board Nominations and 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 other relevant sectors, 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 2021/22 disclosures

The banded remuneration of the highest paid director in the financial year 2021-22 was £198,000 (2020-21 £263,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Range of staff remuneration for 2021/22

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. This 4.5 times (2020-21, 5.0 times) the median remuneration of the workforce, which was 44.1 (2019-20 £52.6k). The highest paid director was employed on a permanent basis. From 1 February 2022, 50% of the salary of the following directors was recharged to Epsom and St Helier: Andrew Grimshaw, Richard Jennings, Paul da Gama, Stephen Jones. A 50% salary recharge to Epsom and St Helier was applied for Jacqueline Totterdell from 16 August 2021. From 1 February 2022, St George's has received 50% recharge from Epsom and St Helier for the following directors: James Marsh, Arlene Wellman.

In 2021/22 The lowest annualised salary was £80 (2020-21 £149). 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 £18,456 (2020-21 £22,478 (Band 1). The highest paid was £390,153 (2019-20 £386,169).

The aggregate amount of expenses paid to directors, non-executive directors and governors was:

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

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

Fair Pay Disclosures (audited)

Table 1: Percentage change in remuneration of the highest paid director.

	HIGHEST PAID DIRECTOR		AVERAGE EMPLOYEE PAY	
YEAR	SALARY AND ALLOWANCES £000	SALARY AND ALLOWANCES £000	SALARY AND ALLOWANCES £000	SALARY AND ALLOWANCES £000
FY 2021-22	198	0	576,066	39
FY 2020-21	263	0	9,790	14
% increase/decrease	-25%	0%	1%	181%

Notes:

1. In FY20-21 the highest-paid board member was the Chief Executive, in FY21-22, the Finance Director. There is a 25% decrease in the highest paid in FY21-22 compared to FY20-21 due to the group board members recharges between St George's University Hospital NHS FT and Epsom and St Helier University Hospitals NHS Trust (ESTH).
2. In FY21-22, 50% salary of the Chief Executive was recharged to ESTH from August -21 to March-22 compared to 50% of the salary of the Finance Director recharged to ESTH for the period between Feb- 22 and Mar-22 in FY21-22.
3. The highest-paid director received no performance pay and bonuses in FY20-21 and FY21-22.
4. There is a 1% increase in average pay for employees in FY21-22 compared to FY20-21. This excludes the highest-paid director.
5. An increase in performance pay and bonuses (Local Clinical Excellence Awards) is due to a one-off payment of £1.4m paid to consultants in FY21-22 for prior FY19-20 and FY20-21.

Table 2: Multiple table

MULTIPLE TABLE	2021/22	2020/21
Payroll costs (£000)	642,750	638,409
Whole time equivalent	9,983	9,937
25th percentile	30	29
Median (£000)	44	44
75th percentile	53	54
Highest paid director (£000)	198	263
25th percentile pay ratio	6.6	9.0
Median will fit into highest	4.5	5.9
75th percentile pay ratio	3.7	4.8

Table 3: Pay ratio disclosure

YEAR	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
FY 2021-22	6.6	4.5	3.7
FY 2020-21	9.0	5.9	4.8

Table 4: Pay ratio information table

FY 2021-22	25th percentile	Median	75th percentile
Total remuneration (£000)	30	44	53
Salary component of total remuneration (£000)	30	44	54
Pay ratio information	6.6	4.5	3.7

FY 2020-21	25th percentile	Median	75th percentile
Total remuneration (£000)	29	44	54
Salary component of total remuneration (£000)	29	44	54
Pay ratio information	9.0	5.9	4.8

Notes:

1. Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the 25th, 50th (median) and 75th percentile remuneration of the organisation's workforce.
2. The remuneration of the highest paid director compared to the lower quartile, median and upper quartile remuneration of the workforce.
3. Lower quartile, Median, and upper quartile – The median remuneration of the reporting entity's staff is the total remuneration of the staff member(s) lying in the middle of the linear distribution of the total staff, excluding the highest paid director. Similarly, lower quartile remuneration is the total remuneration of the staff members(s) on the 25th percentile of the linear distribution and the upper quartile on the 75th percentile of the linear distribution; for both, excluding the highest paid director. This is based on annualised, full-time equivalent remuneration as at the reporting period date 31st March 2022.
4. The calculation is based on full-time equivalent staff working for the Trust on 31 March 2022. Where staff are part time, their salaries have been annualised for the purposes of the pay ratio calculation and highest & lowest paid staff in the Trust.
5. The mid-point of banded remuneration of the highest paid Director within St George's University Hospitals NHS Foundation Trust in the financial year 2021/22 was £198k (2021/22: £263k). This was 4.5 times (2020/21: 5.9 times) the median remuneration of the workforce, which was £44k (2020/21: £44k). This was 6.6 times (2020/21: 9.0 times) the lower quartile remuneration of the workforce, which was £30k (2020/21: £29k). This was 3.7 times (2020/21: 4.8 times) the upper quartile remuneration of the workforce, which was £53k (2020/21: £54k).
6. There is no significant increase or decrease in Lower, Median and upper quartile between FY20-21 and FY21-22.
7. Total remuneration includes salary, benefits-in-kind, golden hellos and compensation for loss of office. It does not include employer pension contributions, termination payments and the cash equivalent transfer value of pensions.
8. The above disclosure is audited by the Trust's external auditors, Grant Thornton UK LLP.

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	Salary (bands of £5000) £000	Expense payments (taxable) Total to the nearest £100	Performance pay and bonuses (bands of £5000) £000	
EXECUTIVE DIRECTORS						
Ms Jacqueline Totterdell	Group Chief Executive	from 1st May 2017	180-185 *(Note 6)	0	0	
Mr Andrew Grimshaw	Chief Financial Officer and Deputy Chief Executive	(CFO) from 19th June 2017 and (Deputy CEO) from 25th April 2019 to 31st Jan 2022.	195-200 *(Note 6)	0	0	
Mr Paul Da Gama	Chief People Officer	from 8th February 2021	125-130 *(Note 6)	0	0	
Mr Stephen Jones	Chief Corporate Affairs Officer	from 5th March 2018	105-110 *(Note 6)	0	0	
Dr Richard Jennings	Chief Medical Officer	from 19th November 2018	175-180 *(Note 6)	0	0	
Kate Slemeck *(Note 3)	Managing Director – St George's	from 3rd February 2022	30-35	0	0	
Arlene Wellman *(Note 3)	Group Chief Nursing Officer	from 1st February 2022	15-20	0	0	
James Marsh *(Note 3)	Group Deputy Chief Executive Officer	from 1st February 2022	20-25	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	0	0	0	
Ms Elizabeth Nyawade	Acting Chief People Officer	from 19th May 2020 to 07th Feb 2021	0	0	0	
Ms Humaira Ashraf	Acting Chief People Officer	from 19th May 2020 to 07th Feb 2021	0	0	0	
Mr Harbhajan Brar	Director of Human Resources and Organisational Development	from 2nd May 2017 to 31st May 2020	0	0	0	
Mr James Friend	Chief Transformation Officer	from 28th April 2017 to 31st March 2021	0	0	0	
Ms Suzanne Marsello	Chief Strategy Officer	from 2nd January 2018 to 31st January 2022	125-130	0	0	
Mr Robert Bleasdale	Chief Nurse & Director of Infection, Prevention and Control	from 17th Feb 2020 to 31st January 2022	130-135	0	0	
Anne Brierley *(Note 8)	Chief Operating Officer	from 1st October 2020 to 31st January 2022	160-165	0	0	
NON-EXECUTIVE DIRECTORS						
Ms Gillian Norton	Group Chairman (Chair Board/ Council and Nominations and Remuneration Committee, Trust Board and Council of Governors)	from 1st April 2017	55-60	0	0	
Ms Ann Beasley	Non-executive Director (Chair of Finance and Investment Committee and Senior Independent Director).	NED from 13th October 2016. Senior Independent Director from 1st April 2021 to 31st May 2021	10-15	0	0	
Mr Stephen Collier	Non-executive Director (Chair Workforce and Education Committee)	NED from 13th October 2016. Senior Independent Director from 1st June 2021 to 31st March 2022	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 13th January 2020	5-10	0	0	
Ms Elizabeth Bishop	Non-executive Director (Chair of Audit Committee)	from 1st February 2020	5-10	0	0	
Professor Dame Parveen Kumar	Non-executive Director (Chair of Quality & Safety Committee)	from 13th January 2020	10-15	0	0	
Peter Kane *(Note 9)	Non-Executive Director	from 1st October 2021	5-10	0	0	
Professor Jennifer Higham *(Note 4)	Non-executive Director	from 1st November 2015 (see note 1)	0	0	0	
LEAVERS						
Ms Elizabeth Bishop	Non-executive Director (Chair of Audit Committee)	from 1st February 2020	5-10	0	0	

2021/22				2020/21					
	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2500) £000	Total (bands of £5000) £000	Salary (bands of £5000) £000	Expense payments (taxable) total to the nearest £100	Performance pay and bonuses (bands of £5000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2500) £000	Total (bands of £5000) £000
	0	0 *(Note 1)	180-185	260-265	0	0	0	0 *(Note 1)	260-265
	0	0 *(Note 1)	195-200	210-215	0	0	0	0 *(Note 1)	210-215
	0	50-52.5	180-185	20-25	0	0	0	0 *(Note 7)	20-25
	0	27.5-30	130-135	115-120	0	0	0	27.5-30	145-150
	15-20	20-22.5	215-220	195-200	0	0	15-20	72.5-75	285-290
	0	7.5-10	40-45	0	0	0	0	0	0
	0	0 *(Note 5)	15-20	0	0	0	0	0	0
	0	0 *(Note 5)	20-25	0	0	0	0	0	0
	0	0	0	90-95	0	0	0	37.5-40	130-135
	0	0	0	80-85	0	0	0	0-2.5 *(Note 2)	80-85
	0	0	0	80-85	0	0	0	232.5-235	315-320
	0	0	0	25-30	0	0	0	0-2.5 *(Note 2)	25-30
	0	0	0	135-140	0	0	0	32.5-35	165-170
	0	15-17.5	140-145	120-125	0	0	0	40-42.5	165-170
	0	22.5-25	150-155	130-135	0	0	0	127.5-130	260-265
	0	645-647.5	810-815	95-100	0	0	0	0 *(Note 8)	95-100
	0	0	55-60	55-60	0	0	0	0	55-60
	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	5-10	0	0	0	0	5-10
	0	0	5-10	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	0	0	0	0	0
	0	0	0	0	0	0	0	0	0
	0	0	5-10	10-15	0	0	0	0	10-15

Pensions Report (audited)

NAME AND JOB TITLE	PERIOD	2021/22						
		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension and related lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 01 April 2022 £000	Real Increase in Cash Equivalent Transfer Value £000	
Ms Jacqueline Totterdell, Group Chief Executive	from 1st May 2017	0	0	0	0	0	0	
Mr Andrew Grimshaw, Chief Financial Officer and Deputy Chief Executive	from 19th June 2017 and from 25th April 2019	0	0	0	0	0	0	
Mr Paul Da Gama, Chief People Officer	from 8th February 2021	2.5-5	0	20-25	0	289	29	
Mr Stephen Jones, Chief Corporate Affairs Officer	from 5th March 2018	0-2.5	0	5-10	0	98	9	
Dr Richard Jennings, Chief Medical Officer	from 19th November 2018	0-2.5	0	65-70	185-190	1600	49	
Kate Slemeck	from 3rd February 2022	0-2.5	0-2.5	55-60	105-110	1110	9	
LEAVERS								
Ms Avinderjit Bhatia, Acting Chief Operating Officer (as of March 2020)	from Feb-17 to 31st October 2020	0	0	0	0	0	0	
Ms Elizabeth Nyawade, Chief People Officer	from 19th May 2020 to 07th Feb 2021	0	0	0	0	0	0	
Ms Humaira Ashraf, Chief People Officer	from 19th May 2020 to 07th Feb 2021	0	0	0	0	0	0	
Ms Suzanne Marsello, Chief Strategy Officer	from 2nd January 2018	0-2.5	0	50-55	110-115	1006	28	
Mr Robert Bleasdale, (Acting Chief Nursing Officer & Director of Infection Prevention and Control	from 17th Feb 2020	0-2.5	0	30-35	50-55	413	8	
Anne Brierley	from 1st October 2020 To 31st January 2022 (see note 6)	30-32.5	52.5-55	35-40	60-65	576	460	

			2020/21							
	Cash Equivalent Transfer Value at 31 March 2021 £000	Employer's contribution to stakeholder pension £000	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension and related lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash Equivalent Transfer Value at 01 April 2021 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Employer's contribution to stakeholder pension £000
	0	0	0-2.5	0-2.5	0-5	0-5	0	0	2,075	0
	0	0	0-2.5	0-2.5	0-5	0-5	0	0	1,025	0
	238	0	(0)-(2.5)	0-2.5	15-20	0-5	238	2	196	0
	71	0	0-2.5	0-2.5	5-10	0-5	71	8	45	0
	1525	0	2.5-5	2.5-5	65-70	185-190	1,525	87	1,396	0
	1019	0	0	0	0	0	0	0	0	0
	0	0	0-2.5	12.5-15	60-65	145-150	1,183	60	1,032	0
	0	0	0-2.5	0-2.5	0-5	0-5	0	0	0	0
	0	0	10-12.5	5-7.5	15-20	5-10	288	198	0	0
	956	0	2.5-5	0-2.5	50-55	110-115	956	42	877	0
	380	0	5-7.5	10-12.5	25-30	50-55	380	76	279	0
	0	0	0	0	0	0	0	0	0	0

Note 1.	Ms Jacqueline Totterdell & Mr Andrew Grimshaw- For FY21-22 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 2021/22 for Kate Slemeck, Arlene Wellman, James Marsh and Peter Kane as they joined the Trust this financial year.
Note 4.	Professor Jenny Higham is the St George's University of London representative on the Trust Board. She is not remunerated by the Trust for her role on the Board.
Note 5.	Arlene Wellman and James Marsh has been recharged from Epsom and St Helier Hospital NHS Trust from 1st February 2022 as part of group management. Also their pension related benefit will be disclosed by Epsom and St Helier Hospital NHS Trust.
Note 6.	50% of salary recharged to Epsom and St Helier for Andrew Grimshaw, Richard Jennings, Paul da Gama, Stephen Jones for Feb-22 and Mar-22. 50% salary recharge to Epsom and St Helier for Jacqueline Totterdell from Aug-21 to Mar-22.
Note 7.	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 8.	In FY20-21 Ms. Anne Brierley is on secondment and her salary has been recharged from Kingston Hospitals. Her pension related benefits will be disclosed by Kingston Hospital for the FY20-21. She is on St George's payroll from 1st April 2021.
Note 9.	Peter Kane joined the Trust from October 2021 and he is the chair of audit committee
Note 10.	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 11.	The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) Indexation on 08th August 2019. This will affect the calculation of the real increase in CETV and does not affect the real increase in pension benefits. This is more likely to affect the 1995 section and the 2008 section.
Note 12.	As non-executive directors do not receive pensionable remuneration, there are no entries in respect of non-executive directors.
Note 13.	The above disclosures is audited by Trust's external auditor.

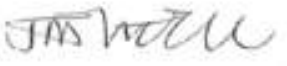
Pension scheme

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a result of their total membership of the pension scheme, not just their service in a senior capacity to which the 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
Group Chief Executive
22 June 2022

Andrew Grimshaw
Group Chief Finance Officer
22 June 2022

5. 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	8	7	53.33%	46.67%
Senior manager (AFC 8c+)	79	84	48.66%	51.34%
All staff	6,575	2,708	70.83%	29.17%

Average number of employees (audited)

TYPE	2021/22			2020/21
	PERMANENTLY EMPLOYED NUMBER	OTHER NUMBER	TOTAL NUMBER	TOTAL NUMBER
Medical and dental	1,518	70	1,588	2,085
Administration and estates	2,071	220	2,291	2,120
Healthcare assistants and other support staff	1,300	103	1,403	1,308
Nursing, midwifery and health visiting staff	2,606	468	3,074	2,998
Scientific, therapeutic and technical staff	1,417	209	1,626	1,426
Total average numbers	8,912	1,070	9,982	9,937
Number of employees (WTE) engaged on capital projects	26	26	52	62

Sickness absence data

Sickness absence data for the financial year 2021/22 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 2021/22 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 om the Cabinet Office website at: http://gender-pay-gap.service.gov.uk A copy of the Trust's most recent Gender Pay Gap report can be found at: Gender and Ethnicity Pay Gap – St George's University Hospitals NHS Foundation Trust

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	474,111	12,151	486,262	491,801
Social security costs	53,759	0	53,759	51,852
Apprenticeship Levy	2,178	0	2,178	2,332
Employer's contributions to NHS pensions	78,229	0	78,229	53,231
Pension Cost – employer contribution paid by NHSE on provider's behalf (6.3%)	23,793	0	23,793	23,324
Pension cost – other	49	0	49	53
Other post-employement benefits	0	0	0	0
Other employement benefits	0	0	0	0
Temination benefits	84	0	84	272
Temporary staff	0	22,189	22,189	15,544
Total gross staff costs	632,203	34,340	666,543	638,409

Expenditure on consultancy

EXPENDITURE ON CONSULTANCY	2021/22	2020/21
Consultancy costs (£k)	626	1,176

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	1	2	3
£10,001 – £25,000	0	0	0
£25,001 – £50,000	1	1	2
£50,001 – £100,000	0	0	0
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	2	3	5
Total resource cost (£k)	£49	£35	£84

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	3	35
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	3	35

EARLY RETIREMENT DUE TO ILL HEALTH	2021/22		2021/22	
	NUMBER	£0	NUMBER	£0
No of early retirements on the grounds of ill-health	2	0	3	
Value of early retirements on the grounds of ill-health		210		22

Off-payroll engagements

Table 1: For all off-payroll engagements as of 31 March 2022 for more than £245 per day and that last longer than six months.

	2021/22 NUMBER OF ENGAGEMENTS	2020/21 NUMBER OF ENGAGEMENTS
Number of existing engagements as of 31 March 2021	16	28
Of which…		
No. that have existed for less than one year at time of reporting	15	17
No. that have existed for between one and two years at time of reporting	1	7
No. that have existed for between two and three years at time of reporting	0	2
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 2021 and 31 March 2022, for more than £245 per day and that last longer than six months.

	2021/22 NUMBER OF ENGAGEMENTS	2020/21 NUMBER OF ENGAGEMENTS
Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	16	17
Of which:		
Number assessed as within the scope of IR35	0	0
Number assessed as not within the scope of IR35	0	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0	0
Number of engagements reassessed for consistency/assurance purposes during the year	0	0
Number of engagements that saw a change to IR35 status following the consistency review	0	0

Table 3: For any off-payroll engagements of Board members, and/or senior officials with any significant responsibility, between 1 April 2021 and 31 March 2022.

	2021/22 NUMBER OF ENGAGEMENTS	2020/21 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, and we know that 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 quarterly NHS People Pulse survey for staff – enabling us to understand views on working at St George's
- Our Big 5 campaign – an ongoing demonstration to staff that the organisation acts as a result of their feedback
- Staff Recognition programmes – recognising the achievements and contribution of our staff through awards and recognition events
- Delivery of our Diversity and Inclusion Programme – including actions regarding debiasing recruitment and building awareness
- Delivery of our Culture & Leadership Programme – taking an in-depth look at the culture of our organisation
- Delivery of the Living our Values project – as part of our wider culture programme. You can read more about this below.

Our culture improvement programme

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

In 2021/22, staff engagement work was monitored at Executive level by our People Management Group and Culture, Equity, and Inclusion Programme Board, and at Board level by the Workforce and Education Committee, as well as by the Board itself.

Living our Values

The past few years have shown us that now more than ever, it is important that 'living our values' is a critical part of how we do things at the Trust. Living our values is a project in which we identify the behaviours that underpin each of our values and are clear on the consequences when a colleague does not live by these values. It is also a means by which we can celebrate staff when they do live our values. Staff told us during the discovery phase of the culture improvement programme that, most importantly, everyone regardless of their position or banding, need to live by our values. This project will run in three phases:

- **Compiling and shaping**
  – we reviewed the culture 'Discovery' findings from 2020 and discussed these with a selection of staff and leaders to bring into our reality

- **Testing and development**
  – we launched an online survey to all staff to invite reactions and input as to what our values mean to them, and what they would like to see in a behaviour's framework. 493 staff members responded in this survey

- **Embedding and reinforcing**
  – this will see the launch of the values and behaviours framework and supporting policy; training workshops for staff and managers on our values; embedding into our staff processes such as inductions, recruitment, appraisals, and recognition programmes; and video content on our values.

This continues to be a collaborative process with staff in which we utilise our Culture Champions, Staff Networks, and other means to keep staff informed and give them opportunities to share their views.

We are also working in close partnership with Change Corp, a culture change consultancy with substantial NHS and public sector experience, to support the delivery of this project.

The potential for cultural change in our organisation is enormous, and we are optimistic and excited for the future of St George's. We are already beginning to see improvements in questions regarding behaviours in our latest staff survey results.

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 24 months, we are aware there is still much more to do to reach our aim of every employee feeling they can bring their whole selves to work. 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

Since publication in October 2020 our Diversity and Inclusion Action Plan has remained central to our vision and commitment to deliver much need change at the organisation. Our Action Plan was divided into several key workstreams, each with clear objectives and milestones to monitor progress. The plan includes several short, medium, and long-term actions, split into key workstreams, that were devised to address the challenge of achieving a real and sustainable difference in closing the gap in workplace inequalities. These workstreams also link to the NHS Equality Delivery System (EDS2) and our public sector equality duties. Whilst the fundamental elements of the plan remain unchanged, it is important to acknowledge that this plan was developed as a 'living document' and as such it has undergone changes since it was produced in 2020. This is to ensure that the actions remain relevant, and our targets and measures are adjusted accordingly. Each change has followed a close governance process and programme of change approach. The plan consists of a series of projects and initiatives, overseen by newly established Culture, Equity and Inclusion Programme Board, under the following headings:

Diversity & Inclusion Programme 2022/23
(Overseen by the CEI Programme Board)

WS1: Debiasing Recruitment and Career Progression		WS2: Speaking Up, Listening and Reporting Concerns		
Improved representation and inclusive practices within recruitment and selection	Equal Access to training and development opportunities for all staff	Improve freedom to speak up (FTSU) awareness	Improve organisational response to D&I and OF related concerns	Active bystander project

WS3: Leadership Commitment			WS4: Building Awarenss and Understanding				
Staff network development (members in leadership)	Implement a communication approach regarding D&I developments	Inclusion in all leadership & management development	Workplace adjustments	eLearning content project	Calibre leadership project	Recognise and celebrate workforce diversity	Improve access to D&I resources

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.

Culture, Equity and Inclusion (CEI) Programme Board

We introduced a Culture, Equity and Inclusion Programme Board in 2021 to oversee our culture & leadership programme and the diversity & inclusion programme. This Board holds us to account to ensure delivery of workstreams in these areas and keep us on track with progress against our agreed programme metrics. The board meets monthly and is chaired by our Group CEO, Jacqueline Totterdell. It also includes representatives from each of our staff networks, our culture champions and divisional representation, to make sure that we have a range of views and voices from across the organisation on these matters.

Recruitment Inclusion Specialists (RIS) Scheme

Recruitment Inclusion Specialists are members of staff from a Black, Asian or Minority Ethnic background who has been trained to provide a neutral perspective of the recruitment process, and support panels in reaching an unbiased recruitment decision. The RIS's objective is to ensure fair process and that the best person for the role gets the job. They bring an impartial view as their decision on a candidate's suitability for the role will be based solely on a candidates application form and performance at interview.

Our RIS scheme was introduced in late 2020 and is a mandatory requirement for all AFC Band 7 and above roles, as well as Medical Recruitment. This applies to all substantive, fixed term, secondments and acting up opportunities. Since its introduction, we have trained over 100 specialists that have gone on to support nearly

400 interview panels. Whilst this is a positive achievement it is only 60% of interview which means 40% went ahead without a RIS present. Our D&I have been working with the SWL Recruitment Hub and our managers to drive compliance and identify gaps. We have recently completed an annual review of the scheme and whilst there are some areas for improvement, overall, the experience of our RIS's has been positive with 100% of responders rating their experience on panels as satisfactory- very good. 89% of responders were happy with the outcome of the interviews they supported. 10% indicated they were 'not happy' with the outcome; however this was not necessarily due to diversity or inclusion.

Leadership Development Training

Our leadership offerings have been updated to ensure inclusion runs through all programmes. This includes all internal and external leadership and management development programmes i.e. Band 7 and 8 Clinical Leadership Programmes, Management Fundamentals Toolkit. We will ensure inclusion is a golden thread that runs through all stages of employment starting with recruitment and onboarding.

WRES expert programme

Following a successful application process, our Trust Diversity and Inclusion lead and one of our Heads of Nursing have successfully completed and graduated from 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.

Staff networks

Our four networks launched in late 2019 and have grown steadily over the last 2 years under the direction of their elected leadership committees. Our diversity and inclusion workforce team have 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)** –196 members
- **Disability and Wellbeing (DaWN)** – 64 members
- **LGBTQ+** – 122 members
- **Women's** – 70 members

For 21/22, across the staff networks, our diversity and inclusion team have completed training needs analysis for our network leadership teams to ascertain their thoughts on their training and development/ support needs both in their roles for the networks and on an individual level.

By doing so we hope to equip staff network leads and members to feel empowered to advocate for themselves and their respective communities in arenas like the culture, equity and inclusion board meetings but also for this support to form part of the long-term cultural change and inclusion projects that are ongoing in the Trust.

Staff members with a disability or long-term health condition who are part of the DaWN network are working closely with Diversity and Inclusion to improve awareness of Deaf Inclusion with the recording of a British Sign Language video and planned workshops. This is in addition to a being vocal members of a working group around requesting Workplace Adjustments by providing insights and observation based on their lived experiences. This has supported the development of two new mandatory elearning modules – Disability Awareness for all staff and Workplace Adjustments for Line Managers.

For some DaWN members these experiences as well as enthusiasm for change have been boosted by their involvement in the Calibre Leadership Development Programme. This 5-module programme was developed by Dr Ossie Stuart in partnership with Imperials EDI Centre and was funded by NHS England.

As part of our commitment to raising awareness and understanding of all disabilities, both hidden and visible, we launched the Hidden Disabilities Sunflower Lanyard scheme, as well as offering the sunflower badges to allies of these communities.

The Women's staff network have been a key voice in the initiatives geared at the reduction of violence and aggression towards staff and in particular women both inside and outside of work. D&I have worked with the network leads to facilitate practical and theoretical skills in this area as well as other key initiatives like the development of the Gender Pay Gap Action Plan, the launch of a new Breastfeeding Room for staff returning from maternity leave. This breastfeeding facility was kindly supported by our colleagues in the Charity.

Working with our D&I Team, the Black, Asian and Minority Ethnic (BAME) staff network have revised their network meetings to focus on single item agendas to explore important issues such as Recruitment and Progression, Disciplinary and Grievance as well as raised awareness of the significance of key cultural events like Ramadan, Chinese New Year and Black History Month.

The LGBTQ+ network has been supported to deliver virtual and face-face events to mark LGBTQ+ History Month and Transgender Visibility Day which involved getting to know the new network leads and which saw significant engagement from staff members with an increase in membership. Sponsored by our St George's Charity, we procured pronoun badges which are available to all staff across the organisation via our D&I Team.

With the input of the networks, D&I have launched a Diversity and Inclusion Calendar which details the important cultural and religious dates that will be celebrated throughout the year. As part of this calendar, staff members are provided with tips on how to be better Allies to marginalised communities and given advice on how to access key areas of support in the Trust such as the staff networks and Freedom to Speak Up Guardian.

Workforce Race and Equality Standard (WRES)

Since 2017, all healthcare providers have been required to publish their workforce data regarding ethnicity. This data helps organisations to understand and respond to the experience of Black, Asian, and Minority Ethnic staff. Our full WRES report for 2021/22 is currently in development and will be published in late August 2022.

The data below is a snapshot of data from 31st March 2021 and our 2021 NHS Staff Survey results.

WRES INDICATOR	2019	2020	2021
Relative likelihood of white applicants being appointed from short listing across all posts compared to BAME applicants	1.59	1.47	1.47
Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	1.95	2.54	1.82
Relative likelihood of white staff accessing non mandatory training and CPD compared to BAME staff	0.97	1.05	1.03
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27.4%	27.3%	23.3%
Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	30.8%	30.1%	25.9%
Percentage of BAME staff believing the Trust provides equal opportunities for career progression or promotion	40.4%	41.1%	42.1%
Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	16.2%	18.0%	16.6%
BAME Board membership	-32.1%	-25.9%	-33.1%

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 WDES report for 2021/22 is currently in development and in line with requirements will be published in late 2022.

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 has introduced a range of supportive measures:

- A Wellbeing Hubs that offer free hot drinks, snacks, magazines, comfortable seating in Hyde Park Room
- Staff counselling service offering up to six free sessions of confidential one-to- one support
- Thank you George's event, where all staff received a £40 voucher and free food was offered to staff working during Christmas and New Year
- Free annual flu vaccination and Covid-19 vaccination
- Mind Your Health booklet, which contains information and signposting for managing emotional distress
- 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
- 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 and sessions on menopause
- Menopause café sessions
- 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.

NHS Staff Survey 2021

The national 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 is carefully analysed and is used to inform our staff engagement plans and our ongoing work to improve the culture at St George's.

In October 2021, staff survey questionnaires were sent to 9,146 eligible members of Trust staff and of those, 5,036 were returned. This was a 55.1% response rate, which is 3.1% higher than the average response rate for Acute and Acute & Community Trusts nationally (52%). A high response rate ensures we can be more confident in understanding what our staff think is working well, and areas for improvement.

This year's survey saw significant changes to the reporting; in line with the commitment in the 2020/21 People Plan, the questionnaire and reporting was redeveloped to align with the People Promise. Results are now grouped into the seven People Promises for the first time this year. Staff Engagement and Morale continue to be reported on as previously, and are the only two themes we are able to show trend data for. In the table below, our average scores (out of 10) are compared to the national average for each indicator and for Staff Engagement and Morale, we have also compared these to our scores from previous years.

	2021/22		2020/21		2019/20	
	TRUST	BENCHMARKING GROUP	TRUST	BENCHMARKING GROUP	TRUST	BENCHMARKING GROUP
Morale	5.5	5.7	5.9	6.0	5.6	5.9
Staff engagement	6.8	6.8	7.0	7.0	6.9	7.0

We do have these figures for the full ten themes for the two previous years, which can be found in the table below.

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

Results are now grouped into the seven People Promises for the first time this year:

	2020/21	
	TRUST	BENCHMARKING GROUP
Promise 1: We are compassionate and inclusive	7.1	7.2
Promise 2: We are recognised and rewarded	5.7	5.8
Promise 3: We each have a voice that counts	6.5	6.7
Promise 4: We are safe and healthy	5.8	5.9
Promise 5: We are always learning	5.2	5.2
Promise 6: We work flexibly	5.7	5.9
Promise 7: We are a team	6.5	6.6

Comparing our results to benchmark average, we can see that we are slightly below the average in most indicators, with the exception of one, where we are in line.

However, positive takeaways from our results are that:

- We have improved in questions that are linked to values and behaviours
- Experiences of bullying and harassment from colleagues has improved by 3% since 2020
- Experiences of bullying and harassment from managers has improved by 2% since 2020
- Experiences of bullying and harassment from the service users/the public has improved by 2% since 2020
- Furthermore 71% of respondents would recommend us as a place for treatment or care.

However, the decline in some results show that, despite progress in some areas, we still have more work to do to make St George's a truly outstanding place for staff to work, and for patients to be treated at.

Performance against priority areas, monitoring arrangements, and how future priorities will be measured

We analysed data to comply a long list of themes, to which we consulted with our Site Executive Team, CEI programme board and the Divisions to agree a top five. This includes areas we areas we are improving in and require momentum, as well as areas we most need to improve:

1. Tackling violence and aggression
– whilst results in the survey have shown some improvements, anecdotal evidence suggests increase in abuse from relatives.

2. Staff Recovery and Wellbeing
– we are consistently below averages for questions with regards to health and wellbeing, sometimes by 3+%. Results have dropped a little further from our performance last year.

3. Speaking Up, Speaking Out
– our results are similar to last year in these questions are behind the National and London acute benchmark averages. Evidence from the Freedom to Speak Up service also suggests there are an increase in concerns around speaking up.

4. Living our Values
– in questions with regards to behaviours (including bullying and harassment) we have actually improved from last year, however we are still a little behind National and London acute benchmark averages on such questions.

5. Developing Line Managers
– questions on line managers scores consistent below the benchmark averages.

We have set objectives and staff survey measures against each of our Big 5 items and will monitor these through our People Management Group and CEI Programme Board for governance:

THEME	ANGLE/FOCUS	OBJECTIVE	STAFF SURVEY MEASURES
Tackling violence and aggression	Having empathy and understanding for each other, backed up by zero tolerance for reckless behaviours	• Recognise this is a complex subject, with increasing amounts of aggression between staff • Help staff recognise and diffuse difficult situations • Enforce a zero tolerance approach to reckless behaviour	• Q13a – In the last 12 months how many times have you personally experienced physical violence at work from patients/ service users, their relatives or other members of the public? • Q13b – In the last 12 months how many times have you personally experienced physical violence at work from managers? • Q13c – In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?
Staff recovery and wellbeing	As the nature of Covid changes, what can we do to care for ourselves and each other and overcomes the risk/reality of burnout which many of us are facing.	• Demonstrate to staff that the Trust acknowledges it's been difficult and that we recognise the continuous efforts and work during this challenging time. • Listening to staff to understand where the issues are for them and also providing space for them to share experiences and views on what will make life better for them. • Promotion of existing wellbeing tools, materials and avenues of support for staff to access. • Providing support for managers in regards to their own wellbeing and also looking after their teams wellbeing.	• Q11a – My organisation takes positive action on health and well-being • Q12b – How often, if at all, do you feel burnt out because of your work? • Q12e – How often, if at all, do you feel worn out at the end of your working day/shift? • Q11c – During the last 12 months have you felt unwell as a result of work related stress?
Speaking Up, Speaking Out	Enabling and encouraging people to speak up and raise concerns, especially when it comes to patient safety concerns. Speaking up is better for our staff and patients and enables us to deliver excellent patient care.	• Highlighting existing processes and routes to speak up (such as the F2SU process, incident reporting, etc.) • Supporting teams to locally deal with concerns.	• Q17a – I would feel secure raising concerns about unsafe clinical practice • Q21e – I feel safe to speak up about anything that concerns me in this organisation • Q21f – If I spoke up about something that concerned me I am confident my organisation would address my concern

THEME	ANGLE/FOCUS	OBJECTIVE	STAFF SURVEY MEASURES
Living our values	Building on our progress around behaviour towards colleagues. Being kind and respectful, including work on civility and inclusion/anti-discrimination.	• Improve the experience of our staff as evidenced by their feedback in the Staff Survey to 'selected' questions • Improve our engagement score "would recommend SGUH as a place to work" from 6.8 (avg) to over 7 • Managing Director to commit to personal leadership of the Values and Behaviours Policy and launch • All staff to participate in a 'learning' experience • Site Executive Team complete individual and team level workshop of Values and Behaviours Framework	• Q21c – I would recommend my organisation as a place to work • Q18 – I think that my organisation respects individual differences(e.g. cultures, working styles, backgrounds, ideas, etc). • Q8b – The people I work with are understanding and kind to one another • Q8c – The people I work with are polite and treat each other with respect • Q14b – In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers? • Q14c – In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?
Developing Line Managers	Supporting line managers with clarity on their role (emphasising elements of staff wellbeing and development), and training to build line manager capability at all levels	• Improvements in staff survey questions with regards to perceptions of line managers	• Q9a – Immediate manager encourages me at work • Q9b – Immediate manager gives clear feedback on my work • Q9c – Immediate manager asks for my opinion before making decisions that affect my work • Q9d – Immediate manager takes a positive interest in my health & well-being • Q9e – Immediate manager values my work • Q9f – Immediate manager works with me to understand problems • Q9g – Immediate manager listens to challenges I face • Q9h – Immediate manager cares about my concerns • Q9i – Immediate manager helps me with problems I face

Guardian of Safe Working

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

Freedom to Speak Up Guardian

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 September 2020, the Trust Board agreed a new Freedom to Speak Up Vision and Strategy. The Trust has continued to take steps to implement this strategy, the progress of which is being monitored closely by the Board and the Workforce and Education Committee. In June 2021, as part of the "Big 5" programme of activities to respond to key themes from the NHS Staff Survey, the Trust held a "Let's Talk" month, the purpose of which was to highlight the importance of staff raising concerns and how to speak up when they were concerned something may be going wrong. As part of this, the Trust's Freedom to Speak Up Guardian held a series of events with staff, supported by the Executive Lead for FTSU.

One of the key themes that emerges from the NHS Staff Survey is that staff do not always know how to raise concerns, who to speak to about them, and what to expect when they raise concerns or have concerns raised about them. In 2021/22, we focused on the importance of education and training of our staff at all levels in Freedom to Speak Up. In late 2021, we incorporated raising concerns training as part of the Trust's Mandatory and Statutory Training (MAST) programme, initially offering the training to new starters before expanding this to existing staff. At the time of writing, over 1,500 staff have completed the training to date.

We also took steps to refresh our network of FTSU Champions. We published a new role description for Champions, and successfully recruited 18 new Champions from a range of different professional backgrounds who are now supporting staff across the Trust to raise concerns. Looking ahead, a key priority is to establish a new Freedom to Speak Up Group. Through this new group, we plan to bring together information, on an anonymised basis, to help us triangulate emerging areas of concern and where teams and services may be encountering problems so that we can address these at an early stage. Building on our work in 2021/22, we also plan to hold a further FTSU month in August 2022 to highlight the importance of raising concerns.

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 2021 to 31 March 2022.

ACTIVITY	TIME OR COST
Number of trade union representatives	44
Total FTE of trade union representatives	39.95
Number who spend between 1 – 50% of their time on Trade Union activities	44
Number who spend 100% of their time on trade union activities	0
Total Trust pay bill	£642,898,629.00
Total cost of facility time	19370.78
Percentage of total pay spent on facility time	0.003%
Hours spent on paid facility time	1380
Hours spent on paid trade union activities	1170
Percentage of total paid facility time hours spent on paid TU activities	84.78%

6. Statement of Accounting Officer's responsibilities

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.

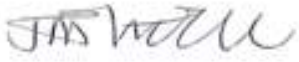
In preparing the accounts and overseeing the use of public funds, I can confirm we comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular:

- 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
- 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,
Group Chief Executive
22 June 2022

7. 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 2022 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 processes, 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 regularly. 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 Group Chief Corporate Affairs Officer who also acts as the Trust Secretary. Governance is embedded across the Trust's three clinical divisions which are each 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.

The Trust has robust governance arrangements to support the delivery of key activities. The Trust Management Group and Group Executive are accountable to the Board through the Chief Executive. The Group Executive comprises the Chief Executive and Group Directors, including the Managing Directors for St George's and is the most senior management group within the Trust. The Trust Management Group escalates issues to the Group Executive as required. There are four sub-groups of the Trust Management Group to provide 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 2021. 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. At its meeting of 24 March 2022, the Committee considered that the implementation of this review was now sufficiently embedded such that separate progress reports were no longer needed. In light of the progress achieved, the Board agreed that the risk on the Board Assurance Framework relating to clinical governance could be reduced.

Board committees have been reviewed during 2021/22 as part of the implementation of Group arrangements and from April 2022, the quality, finance and people committees will be run

as committees-in common with Epsom and St Helier University Hospitals NHS Trust (ESTH). The Trust's Audit Committee will continue to meet at a Trust level only to provide assurance to the Board in relation to governance, risk and internal control as the group model is embedded.

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.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

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 reviews these in May 2020 and agreed to carry these risks forward to 2021/22. The strategic risks below are recorded in the Board Assurance Framework. 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.

Strategic Risks on the 2021/22 Board Assurance Framework (the impact of Covid-19 was mapped against each individual risk)

TRUST OBJECTIVE	RISK DESCRIPTION	MITIGATION
Care	**Strategic Risk 1:** **Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation.** **Strategic Risk 2:** **We are unable to provide outstanding care as a result of weaknesses in our clinical governance.** **Strategic Risk 3:** **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 2021/22, the impact of Covid-19 against all of our strategic risks related to patient care continued to be significant. Specific risks around Covid-19 infection, transmission, the availability of personal protective equipment, and the impact on waiting times are included on the Corporate Risk Register. The ongoing impact of the pandemic and elective recovery, 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 continued to flex our capacity to ensure that there were separate clinical pathways, continued testing for patients and staff, and the compulsory mask-wearing in the Trust. 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, although compliance with the four-hour emergency operating standard has been a challenge during 2021/22. 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 improve the infrastructure, including much needed improvements to water safety.**

Strategic Risks on the 2021/22 Board Assurance Framework (the impact of Covid-19 was mapped against each individual risk)

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 continued to be one of our key areas of focus in 2021/22. 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 and both the Workforce and Education Committee and the Board received regular updates on progress with implementation. 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 Strategic Risks on the 2021/22 Board Assurance Framework 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 202/22, 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. We have developed a Group model with Epsom and St Helier University Hospitals, for the benefit of the patients and communities both Trusts serve. We have appointed joint executive directors to cover both trusts and from April 2022 implemented joint committees-in-common to provide assurance to both boards. In terms of our financial risks, 2021/22 was similar to 2020/21, in that they were largely mitigated by NHS England and NHS Improvement decided in December 2020. There has been a great deal of focus on 2022/23 and beyond which promise to be very challenging as Covid-specific funding is withdrawn whilst many of the underlying costs remain. 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 Informatics Governance Group (IGG) oversees the completion of the Data Security and Protection Toolkit (DSPT) on an annual basis, as well as reviewing information governance incidents and all other IG activities. In turn the IGG reports to the Trust Board via the Risk and Assurance Group. The Group Chief Financial Officer is the Senior Information Risk Officer (SIRO) 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 2021-22, there was an incident reported to the Information Commissioner's Office (ICO). However, the ICO confirmed that no further action will be taken against the Trust. The IG team is working together with other teams on the National Data Opt-Out process to meet compliance 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 the Trust Management Group provides oversight of Divisional performance.

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

Emergency preparedness, resilience and response (EPRR) assurance process 2021/22

The Civil Contingencies Act of 2004 requires the Trust to work in partnership with other NHS organisations and key partners to develop clear and co-ordinated strategic, tactical and organisational response plans for major and serious incidents.

As a result, each year, all NHS funded organisations are subject to an Emergency Preparedness, Resilience and Response (EPRR) assurance process carried out by NHS England and NHS Improvement (NHSE/I), to assess performance in relation to EPRR core standards. Each of the core standards are given a Red, Amber, Green (RAG) rating and the Trust receives an overall rating based on the total percentage of amber and red ratings. There is also a more detailed deep dive inspection every year which looks into a specific area of the organisation.

Nationally, the core standards have been amended to reflect the ongoing challenges of the Covid response and the simultaneous recovery and restoration work.

Regionally, the reviews have focused on operational effectiveness and the safety of patients and staff.

St George's University Hospitals NHS Foundation Trust achieved a rating of **Substantially Compliant** in the 2020/21 assurance process. The review panel noted the comprehensive suite of incident management and business continuity plans evidenced by us and some specific areas of good practice were highlighted.

We received an amber rating for the EPRR Resource core standard, which means one of our key priorities is to recruit to the vacant EPRR post. Despite the impacts of Covid, we continued to maintain an appropriate level of preparedness, and were commended by the review panel on the excellent work in this area by our previous EPRR manager, for providing a solid foundation for the future.

At the time of writing, we are recruiting a substantive post holder to enable us to continue to embed and champion contingency planning throughout the organisation, and will play a vital role in helping us maintain our current level of preparedness. Our other key priorities for the year ahead include reviewing and consolidation of the Major Incident Plan and developing a director on-call rota.

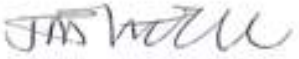
Modern Slavery and Human Trafficking Act 2015

Like all public sector organisations, we are committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015. We take very seriously our commitment towards ensuring that no modern slavery or human trafficking takes place in our supply chains or in any part of our organisations, or across the many services we run out of St George's, Queen Mary's, as well as in the community. Our internal policies reflect our commitment to acting ethically and with integrity in all our interactions – with staff, patients and suppliers of goods and services.

We have also developed a Modern Slavery and Human Trafficking Statement in line with the Modern Slavery Act 2015. This statement outlines our due diligence on modern slavery in respect of our supply chain; details of relevant policies and processes in place to ensure we are conducting our business in an ethical and transparent manner; details of the relevant training which facilitates staff awareness of the signs of modern slavery and the process for raising a safeguarding concerns; and assurance in respect of our pre-employment checks. This statement can be found on the Trust's website here https://www.stgeorges.nhs.uk/about/st-georges-and-the-modern-slavery-act, and is reviewed, updated and approved by the Board of Directors on an annual basis.

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 2022, the Trust was performing positively against a large number of key indicators. However, there remain particular challenges in the wake of Covid-19 including our Referral to Treatment times (RTT), breast screening, and diagnostic treatment, as well as in relation to emergency care performance, reflecting the broader challenges across the health service.



Jacqueline Totterdell,
Group Chief Executive
22 June 2022


PLAY
SPECIALIST

8. Quality report (account) 2021/22

Part 1

Statement on quality from the Chief Executive

I am pleased to introduce our quality report which outlines the progress we have made in advancing the quality of services for our patients. This document summarises our commitment to continually improve and put patients at the forefront of everything we do. Of course, we still have a way to go to deliver our vision of providing outstanding care every time, and the challenges we have faced are also detailed in this report.

However, it's been inspiring to see how much our teams at St George's have been able to achieve during periods of high operational pressure, while supporting the safety of our patients. Staff have had to react very quickly to changing rules, restrictions and guidance, with many going above and beyond to give patients the best experience of care – I am very grateful for their hard work and dedication. Some key achievements from the year are outlined below, as well as some of our challenges.

Although we continue to respond to the effects of the pandemic, we have worked hard to reach national access measures and ensure patients get the planned and emergency care they need.

The impact of Covid on our waiting lists has been significant, but part of our recovery efforts have involved working collaboratively with Epsom and St Helier, Croydon and Kingston hospitals and partners in the region – for example the opening of the Surgical Treatment Centre at Queen Mary's Hospital in June 2022 created four new operating theatres. We have also increased elective and diagnostics capacity overall which has led to improved performance in these areas.

At the end of 2020/21, there were 2,644 patients waiting more than 52 weeks for routine surgery at St George's as a direct result of the pandemic. In January 2022 this number had reduced to 887. While this is a significant improvement, our focus over the coming months will be to reduce this number to an absolute minimum.

Over the past year we have committed significant time and resource to tackling the backlog and responding to an increase in operational pressures, however we recognise that we have more to do to make sure all our patients have timely access to the care and treatment they need. Improving our performance in cancer access is one of the areas where we will focus our attentions, as well as ensuring more people visiting our emergency department are seen, treated, and either admitted or discharged within four hours.

the ongoing assurance processes for the Ockenden review. St George's is one of only six NHS Trusts in London demonstrating 100% compliance, validated by external review – despite the staffing challenges we faced over the year. As well as this, we have achieved Baby Friendly Gold Status, launched a maternity helpline for pregnant women, and introduced a new Maternity Support Worker Development Programme to upskill our staff – all ensuring we provide a safe and compassionate service for women who have their babies at St George's.

As well as improvements in care, we have also made progress with upgrading the environments that patients are treated in – for example the modernisation of our emergency department, upgrading cardiac catheter labs, and expanding MRI capacity. Patients as well as our staff have benefitted from these new environments.

> "Over the past year we have committed significant time and resource to tackling the backlog and responding to an increase in operational pressures..."

We continue to review nosocomial infections at a local and system level and have revised infection prevention and control procedures as and when necessary. I am pleased to say that the steps we have taken to keep patients, staff and visitors safe has resulted in a reduction in nosocomial infections when compared to last year.

I am pleased to report on our progress with compliance against the eight 'immediate and essential actions' as part of

We sustained our significant research portfolio and recruited over 7,500 patients to 50 clinical research studies. We are among the top NHS Trusts in the country for the number of urgent public health Covid studies, and we are leading a major Vaccine Task Force funded clinical trial on Covid vaccines in pregnancy – due to collaborative working with St George's, University of London.

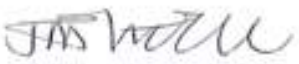
Our performance metrics continue to evidence the shift in culture to one of an organisation constantly looking to improve, consistent achievement of SHMI (Summary hospital level mortality indicator) at lower than expected, VTE (venous thromboembolism) assessments have increased to 96.4%, a further reduction in C.difficile cases due to lapses in care. We also delivered a clinical audit programme where the Trust performed above the national average on a number of important quality and safety indicators.

Strengthening our own governance processes has been integral to our quality priorities. We completed the third external governance review last year and this year focussed on delivering its recommendations which have all been successfully completed giving the Trust increased confidence in this area.

The formation of the St George's, Epsom and St Helier University Hospitals and Health Group this year builds on our existing, long-standing relationship with Epsom and St Helier University Hospitals NHS Trust. As a group, we will continue to run efficient and high-quality services for the benefit of the health and wellbeing of our local people and communities.

The partnership continues to bring benefits to patient care, for example in February we signed a joint contract with Cerner to share electronic patient records. This new, shared system will allow clinical teams to access patient information and records, irrespective of where care is provided across the group.

To the best of my knowledge the information contained in this document is an accurate and true account of the quality of the health services we provide. I would like once again to thank our staff for continuing to deliver compassionate and outstanding care for our patients during another challenging year.



Jacqueline Totterdell,
Group Chief Executive
22 June 2022

Part 2

2.0 Priorities for improvement and statements of assurance from the board
2.1 Our quality priorities for 2022/23 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 did not change our vision or our five-year strategy and the new corporate objectives continued into 2021/22.

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 2021/22 the Trust continued to implement the quality priorities set out in 2021/22 which were aligned to the seven priority areas in our Quality and Safety Strategy 2019/24:

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

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

In 2021/22 we developed the year 2 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. The progress we made was reported on a quarterly basis to our Quality and Safety Committee, which is a sub-committee of the Trust Board.

Our quality priorities 2021/22 and why we chose them

Our quality priorities 2022/23 and why we chose them

The quality priorities for 2022/23 were informed by:

- Our progress against the Quality Priorities for 2021/22 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 2022/23 due to the impact of the pandemic on our progress we want to continue to focus on nosocomial infection, Treatment Escalation Plans and consent, which were identified in 2021/22.

In order to address these patient safety priorities, we will work collaboratively across the new St George's and Epsom and St Helier University Hospitals Health Group. For the purposes of the quality account the measures for success will reflect St George's University Hospitals NHS Foundation Trust performance only.

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Prevent Nosocomial Covid-19 infection for in-patients	**Review Nosocomial Covid-19 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 2021/22**
Emergency patients will have Treatment Escalation Plans (TEP)	**Ensure non-elective adult inpatients have a TEP in place within 24 hours of admission**	**60% of all adult inpatients will have a TEP in place by March 2023 (compared with 33% in April 2021 and 43% in March 2022)** **Reduction in the number of cardiac arrests compared with 2021/22**
Consent for treatment	**All patients will be supported to give consent for treatment**	**60% of adult inpatients will have a TEP (compared with 33% in April 2021 and 43% in March 2022)** **Audit of consent demonstrates an improved position when compared with 2021/22**

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.

In 2022/23 due to the impact of the pandemic on our progress we want to continue to focus on patient feedback, equitable experience and discharge, which were identified in 2021/22.

In order to address these patient experience priorities, we will work collaboratively across the new St George's and Epsom and St Helier University Hospitals Health Group. For the purposes of the quality account the measures for success will reflect St George's University Hospitals NHS Foundation Trust performance only.

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Learn from complaints to provide patients with an excellent experience	**Monitor and review feedback to ensure continual improvement so we provide patients with an excellent experience through their journey**	**Reduction in the number of complaints when compared with the 2021/22 baseline**
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 2021**	**Improvement in our self- assessment when compared to baseline**
Improve patient flow particularly with reference to improved discharge processes	**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**	**See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2021/22** **Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2021/22** **Improvement in the patients who were discharged from an inpatient setting with a follow up appointment or investigation date when compared with 2021/22**

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.

In 2022/23 due to the impact of the pandemic on our progress we want to continue to focus on the quality, safety and learning culture, learning from cardiac surgery and waiting times for treatment, which were identified in 2021/22.

In order to improve effectiveness and outcomes for patients, we will work collaboratively across the new St George's and Epsom and St Helier University Hospitals Health Group. For the purposes of the quality account the measures for success will reflect St George's University Hospitals NHS Foundation Trust performance only.

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 national patient safety training syllabus across the Trust** **Launch the new Patient Safety Incident Reporting Framework** **Establish Patient Safety Partners** **Share learning via the bi- monthly Patient Safety Bulletin**	**Improvements in related questions in the NHS Staff Survey** **Level 1 and level training launched and 85% training performance target met by March 2023** **Patient Safety Incident Reporting Framework in place** **Patient Safety Partners in place and active participants in place**
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 2021/22 [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.

In May 2021 we opened a new facility to care for patients undergoing interventional radiology (IR), which involves radiologists using minimally invasive imaging procedures to diagnose and treat a wide range of diseases. The new facility provides a dedicated space for day case and inpatients before and after their IR procedures.

In June 2021 we started treating patients in our new NHS surgery treatment centre on the Queen Mary's site. The new centre was set up in direct response to the pandemic to address the longer waiting times for patients for routine operations and procedures.

Procedures that will be carried out include plastic surgery procedures for skin cancer, as well diagnostic urology procedures (e.g. cystoscopies), gynaecological, vascular, general surgery and maxillofacial procedures. We run the treatment centre but it is also used by surgical teams from Kingston Hospital NHS Foundation Trust, and over time, it will be available for use by patients from across south west London requiring day surgery procedures.

In June 2021 we reopened two newly refurbished cardiac catheter labs containing state of the art equipment and the very latest in x-ray imaging technology. The cath labs contain specialist imaging equipment to allow for the diagnosis and treatment of cardiovascular diseases and conditions like heart attacks, palpitations, and thickened heart valves. The refurbishment of the first two labs was an essential upgrade to improve both the environment that patients are treated in, and the areas where staff work. The new labs bring the necessary x-ray imaging up to modern standards, which allows the team to more rapidly and effectively treat heart conditions.

In February 2022 the new St George's and Epsom and St Helier University Hospitals Health Group was formed which will provide further opportunities for collaboration across the new hospital group for the benefits of patients. Together with Epsom and St Helier University Hospitals NHS Trust we have signed complimentary contracts with Cerner to provide a shared electronic patient records system to deliver streamlined patient care. Due the complete in 2024, the shared system means that our clinical teams will in future be able to access patient hospital information and records, irrespective of where care is provided across the group. It also enables more effective working with health and care partners including neighbouring hospitals, with the potential for benefits to be scaled across the south west London Integrated Care System (ICS).

In March 2022 our Midwifery Services were awarded the London CapitalMidwife Quality Kite Mark Award for our Preceptorship Midwife Programme. CapitalMidwife is a regional programme across London which aims to ensure that midwives are supported to develop and grow throughout their career and which ultimately improves the quality of the support and training we offer to our newly registered midwives.

Also in March 2022 after a successful pilot period we launched MyCare St George's which now means that every time a new or follow up appointment is made our patients will receive a text message inviting them to register for MyCare St George's. Once registered, they can access MyCare StGeorge's from any computer or mobile device. MyCare St George's provides the ability for the patient to:

- View upcoming appointments and appointment letters, receive messages directly from your consultant or care lead
- Complete questionnaires prior to attending hospital, such as pre-op questionnaires
- View hospital letters and documentation
- View test results
- View known allergies
- Access links to useful healthcare information

In 2021-22 we also saw the start of Baby Surgeons: Delivering Miracles, a brand new Channel 4 documentary filmed at St George's. The documentary was a fascinating look at the work of our fetal medicine, neonatal and maternity units, showcasing some of the pioneering procedures they carry out on our tiniest patients.

Finally, this year we established the St George's Children and Young People's Council. The council serves as a platform for our younger patients to give us feedback on our services and suggest ways for us to improve. The council is an important voice for children and will help our teams to further improve the care we provide.

2.2.1 During 2021/22 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 2021/22 represents 100% of the total income generated from the provision of relevant health services by St George's University Hospitals NHS Foundation Trust for 2021/22.

2.2.2 Participation in clinical audit and National Confidential Enquiries

During 2021/22, 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 2021/22 are as listed in Table 1:

Table 1 Key:
N/A – Audit postponed due to the impact of COVID-19

TITLE		RELEVANT	PARTICIPATING
Case Mix Programme	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	✓	✓
Chronic Kidney Disease registry		✓	✓
Cleft Registry and Audit Network Database		X	X
Elective Surgery (National PROMs Programme)		✓	X
Emergency Medicine QIPs	Pain in Children (care in Emergency Departments)	✓	✓
	Infection Prevention and Control	✓	✓
Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	✓	✓
	National Audit of Inpatient Falls	✓	✓
	National Hip Fracture Database	✓	✓
Inflammatory Bowel Disease Audit		✓	✓
Learning Disabilities Mortality Review Programme		✓	✓
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	Epilepsy	✓	✓
	Physical Health in Mental Health	X	X
Mental Health Clinical Outcome Review Programme		X	N/A
National Adult Diabetes Audit	National Diabetes Core Audit	✓	✓
	National Pregnancy in Diabetes Audit	✓	✓
	National Diabetes Footcare Audit	✓	✓
	National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	✓	✓

TITLE		RELEVANT	PARTICIPATING
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Paediatric Asthma Secondary Care	✓	✓
	Adult Asthma Secondary Care	✓	✓
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓
	Pulmonary Rehabilitation-Organisational and Clinical Audit	✓	✓
National Audit of Breast Cancer in Older Patients		✓	✓
National Audit of Cardiac Rehabilitation		✓	✓
National Audit of Cardiovascular Disease Prevention		X	N/A
National Audit of Care at the End of Life		✓	✓
National Audit of Dementia		✓	✓
National Audit of Pulmonary Hypertension		X	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		✓	✓
National Cardiac Arrest Audit		✓	✓
National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management	✓	✓
	Myocardial Ischaemia National Audit Project	✓	✓
	National Adult Cardiac Surgery Audit	✓	✓
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	✓	✓
	National Heart Failure Audit	✓	✓
	National Congenital Heart Disease	X	N/A
National Child Mortality Database		✓	✓
National Clinical Audit of Psychosis		X	N/A
National Comparative Audit of Blood Transfusion	Audit of Patient Blood Management & NICE Guidelines	✓	✓
	Audit of the perioperative management of anaemia in children undergoing elective surgery	✓	✓
National Early Inflammatory Arthritis Audit		✓	✓
National Emergency Laparotomy Audit		✓	✓
National Gastro-intestinal Cancer Programme	National Oesophago-Gastric Cancer	✓	✓
	National Bowel Cancer Audit	✓	✓
National Joint Registry		✓	✓
National Lung Cancer Audit		✓	✓
National Maternity and Perinatal Audit		✓	✓
National Neonatal Audit Programme		✓	✓
National Paediatric Diabetes Audit		✓	✓
National Perinatal Mortality Review Tool		✓	✓
National Prostate Cancer Audit		✓	✓
National Vascular Registry		✓	✓
Neurosurgical National Audit Programme		✓	✓
Out-of-Hospital Cardiac Arrest Outcomes Registry		X	N/A
Paediatric Intensive Care Audit		✓	✓
Prescribing Observatory for Mental Health	Prescribing for depression in adult mental health services	X	N/A
	Prescribing for substance misuse: alcohol detoxification	X	N/A

TITLE		RELEVANT	PARTICIPATING
Respiratory Audits - National Outpatient Management of Pulmonary Embolism		✓	✓
Sentinel Stroke National Audit Programme		✓	✓
Serious Hazards of Transfusion		✓	✓
Society for Acute Medicine Benchmarking Audit		✓	✓
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment		✓	✓
Trauma Audit & Research Network		✓	✓
UK Cystic Fibrosis Registry		X	N/A
Urology Audits	Cytoreductive Radical Nephrectomy Audit	✓	✓
	Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	✓	✓

Table 2:

2.2.2.3 The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust participated in during 2021/22 (n=60) are listed in table 2 below:

TITLE		RELEVANT	PARTICIPATING
Case Mix Programme	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	✓	✓
Chronic Kidney Disease registry		✓	✓
Emergency Medicine QIPs	Pain in Children (care in Emergency Departments)	✓	✓
	Infection Prevention and Control	✓	✓
Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	✓	✓
	National Audit of Inpatient Falls	✓	✓
	National Hip Fracture Database	✓	✓
Inflammatory Bowel Disease Audit		✓	✓
Learning Disabilities Mortality Review Programme		✓	✓
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	Epilepsy	✓	✓
National Adult Diabetes Audit	National Diabetes Core Audit	✓	✓
	National Pregnancy in Diabetes Audit	✓	✓
	National Diabetes Footcare Audit	✓	✓
	National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	✓	✓

TITLE		RELEVANT	PARTICIPATING
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Paediatric Asthma Secondary Care	✓	✓
	Adult Asthma Secondary Care	✓	✓
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓
	Pulmonary Rehabilitation-Organisational and Clinical Audit	✓	✓
National Audit of Breast Cancer in Older Patients		✓	✓
National Audit of Cardiac Rehabilitation		✓	✓
National Audit of Care at the End of Life		✓	✓
National Audit of Dementia		✓	✓
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		✓	✓
National Cardiac Arrest Audit		✓	✓
National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management	✓	✓
	Myocardial Ischaemia National Audit Project	✓	✓
	National Adult Cardiac Surgery Audit	✓	✓
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	✓	✓
	National Heart Failure Audit	✓	✓
National Child Mortality Database		✓	✓
National Comparative Audit of Blood Transfusion	Audit of Patient Blood Management & NICE Guidelines	✓	✓
	Audit of the perioperative management of anaemia in children undergoing elective surgery	✓	✓
National Early Inflammatory Arthritis Audit		✓	✓
National Emergency Laparotomy Audit		✓	✓
National Gastro-intestinal Cancer Programme	National Oesophago-Gastric Cancer	✓	✓
	National Bowel Cancer Audit	✓	✓
National Joint Registry		✓	✓
National Lung Cancer Audit		✓	✓
National Maternity and Perinatal Audit		✓	✓
National Neonatal Audit Programme		✓	✓
National Paediatric Diabetes Audit		✓	✓
National Perinatal Mortality Review Tool		✓	✓
National Prostate Cancer Audit		✓	✓
National Vascular Registry		✓	✓
Neurosurgical National Audit Programme		✓	✓
Paediatric Intensive Care Audit		✓	✓
Respiratory Audits - National Outpatient Management of Pulmonary Embolism		✓	✓
Sentinel Stroke National Audit Programme		✓	✓
Serious Hazards of Transfusion		✓	✓
Society for Acute Medicine Benchmarking Audit		✓	✓
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment		✓	✓
Trauma Audit & Research Network		✓	✓
Urology Audits	Cytoreductive Radical Nephrectomy Audit	✓	✓
	Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	✓	✓

2.2.2.4 The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2021/22, 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.

TITLE		SUBMISSION RATE (%)
Case Mix Programme	Neurology Intensive Care Unit	Ongoing
	General Adult Intensive Care	Ongoing
	Cardiothoracic Intensive Care Unit	Ongoing
Child Health Clinical Outcome Review Programme	Transition from Child to Adult Health Services	Ongoing
Chronic Kidney Disease registry		Ongoing
Elective Surgery (National PROMs Programme)		0%
Emergency Medicine QIPs	Pain in Children (care in Emergency Departments)	Ongoing
	Infection Prevention and Control	Ongoing
Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	Ongoing
	National Audit of Inpatient Falls	100%
	National Hip Fracture Database	105.8%
Inflammatory Bowel Disease Audit		100%
Learning Disabilities Mortality Review Programme		Ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiries	Ongoing
	Perinatal Mortality Surveillance	Ongoing
	Perinatal confidential enquiries	Ongoing
Medical and Surgical Clinical Outcome Review Programme		100%
National Adult Diabetes Audit	National Diabetes Core Audit	Ongoing
	National Pregnancy in Diabetes Audit	Ongoing
	National Diabetes Footcare Audit	Ongoing
	National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Paediatric Asthma Secondary Care	100%
	Adult Asthma Secondary Care	Ongoing
	Chronic Obstructive Pulmonary Disease Secondary Care	Ongoing
	Pulmonary Rehabilitation-Organisational and Clinical Audit	Ongoing
National Audit of Breast Cancer in Older Patients		100%
National Audit of Cardiac Rehabilitation		100%
National Audit of Care at the End of Life		100%
National Audit of Dementia		Data collection paused due to COVID-19 pandemic
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		Ongoing – submission deadline 31st March
National Cardiac Arrest Audit		100%

TITLE		SUBMISSION RATE (%)
National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management	Ongoing
	Myocardial Ischaemia National Audit Project	Ongoing
	National Adult Cardiac Surgery Audit	Ongoing
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Ongoing
	National Heart Failure Audit	Ongoing
National Child Mortality Database		100%
National Comparative Audit of Blood Transfusion	Audit of Patient Blood Management & NICE Guidelines	100%
	Audit of the perioperative management of anaemia in children undergoing elective surgery	100%
National Early Inflammatory Arthritis Audit		Ongoing
National Emergency Laparotomy Audit		Ongoing
National Gastro-intestinal Cancer Programme	National Oesophago-Gastric Cancer	100%
	National Bowel Cancer Audit	Ongoing
National Joint Registry		96.2%
National Lung Cancer Audit		100%
National Maternity and Perinatal Audit		100%
National Neonatal Audit Programme		100%
National Paediatric Diabetes Audit		Ongoing
National Perinatal Mortality Review Tool		Ongoing
National Prostate Cancer Audit		100%
National Vascular Registry		Ongoing
Neurosurgical National Audit Programme		100%
Paediatric Intensive Care Audit		100%
Respiratory Audits - National Outpatient Management of Pulmonary Embolism		100%
Sentinel Stroke National Audit Programme		Ongoing
Serious Hazards of Transfusion		100%
Society for Acute Medicine Benchmarking Audit		100%
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment		Ongoing
Trauma Audit & Research Network		87%
Urology Audits	Cytoreductive Radical Nephrectomy Audit	100%
	Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	100%

2.2.2.5 National clinical audits - action taken

The reports of 31 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2021/22 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
Falls and Fragility Fracture Audit Programme – Fracture Liaison Service (FLS) Database	The Fracture Liaison Service (FLS) audit report was released in October 2021. The results showed Trust performance to be above or in line with 4 of 11 key performance metrics but there was room for improvement in a number of areas. The clinical audit project lead provided an update on actions for the upcoming year: • Medical and nursing position vacancies continue to impact the ability to improve services. • New staff have been recruited and are currently undergoing training. The service is targeting independent working by summer 2022. FLS nurse clinic has been successfully implemented and has seen referral waiting times decrease.
Falls and Fragility Fracture Audit Programme – National Hip Fracture Database	The latest report was released in November 2021 examining data from 2020. 30-day mortality was recorded as 8.3% locally and nationally, with St George's performance improving despite the COVID-19 pandemic. The Trust was in the top quartile in cases that met the best practice criteria, as well as in surgery being supervised by a consultant surgeon and anaesthetist. Areas for improvement that the clinical lead is focussed on in the coming year are admittance to an orthopaedic ward within 4 hours, and the overall length of stay for patients.
Maternal and Newborn Infant Clinical Outcome Review Programme: Maternal mortality surveillance and confidential enquiries	The latest report was published in November 2021 and examined lessons learned in order to inform maternity care. The key findings based on national data show a non-significant decrease in overall maternal deaths, which indicates the need for continued focus on recommendations to work towards and achieve a reduction in deaths. There remain disparities in maternal mortality rates amongst women from black, Asian and white ethnic backgrounds. Cardiac disease remains the leading cause of direct maternal deaths, while neurological causes are the second most common cause. Thrombosis and thromboembolism continue to be the leading cause of deaths during or up to 6 weeks' post-partum and maternal suicide is still a leading cause of death within a year post-partum. The report has been shared with the service and actions for the following year will be based on the recommendations.
National Adult Diabetes Audit – National Inpatient Diabetes Audit, including National Diabetes In-patient Audit (NaDIA) Harms	The national report was published in July 2021. Although the report does not provide site level data, it does show that St George's were a key contributor to national data. St George's also continue to be compliant with all the key recommendations for NaDIA Harms. The clinical lead reports that the service has received additional funding to appoint a specialist diabetes nurse, and a project manager to support inpatient diabetes work.
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme – Chronic Obstructive Pulmonary Disease Secondary Care	The latest report was published in June 21 for results in 2019/20. The Trust fell below the national average for 3 key quality improvement priorities. The project lead reports that the issues highlighted are the ability to identify smokers in a timely fashion, and then once identified, offering behavioural change intervention and/or a prescription. In response to these findings the service are planning a series of grand round teaching sessions, coupled with a drive to add a mandatory training module for all staff.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme – Pulmonary Rehabilitation- Organisational and Clinical Audit	The 2021 data indicates good performance with patients starting pulmonary rehab within 90 days of referral, and average wait times from referral at 34 days. The service has been running virtual clinics alongside face-to-face sessions with standard operating procedures in place, which is a key recommendation. The clinical lead reports that a service allowing all patients to complete a walk test has been implemented, along with a remote excursive test. In the coming year the service is looking towards: • Starting initiatives to improve completion rates of patients enrolled on pulmonary rehabilitation programmes. • Complete discharge assessments with the non-completers, despite them having chosen not to continue with the course.
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme – Adult Asthma Secondary Care	The latest report was released in January 2021. The data showed that St George's performed well against 3 of the 6 key performance indicators. The service lead reports that workforce pressures continue, and that an action plan is being developed in line with the latest report recommendations.
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Paediatric Asthma Secondary Care	The latest report shows the Trust performed well in a number of key metrics: recording of exposure to second-hand smoke; outcome measures – community follow-up requested within 48 hours, and referral to asthma clinic requested within 4 weeks. The Trust fell below the national average for the following metrics: patients reviewed by MDT member; administration of systemic steroids. The clinical lead has received the report and is working to draw up a comprehensive action plan.
National Audit of Breast Cancer in Older Patients	Most recent data shows that the service is generally in line with national averages. Performance with regards to risk-adjusted rates of reoperation (percentage of patients experiencing this are lower across all three age ranges – 50-69, 70-79, 80+) is good. The project lead is looking forward to continuing the positive performance in the coming year.
National Audit of Cardiac Rehabilitation	The latest national report showed that St George's obtained full certification for achieving green in the 7 key performance metrics. The clinical project lead reports that key recommendations have been responded to. The service is offering face-to-face clinics in conjunction with remote services for greater patient choice and improved outcomes. A goal for the service is to increase staffing numbers and obtain funding to explore the feasibility of additional group exercise and education sessions in a local leisure centre.
National Audit of inpatient Falls (NAIF)	The latest national audit report was published in November 2021 and examines data from 2020 and 2021 facilities data. Six recommendations were published in this report. An action plan has been completed by the project lead with all relevant recommendations being addressed: • Conducting a baseline retrospective audit of 50 inpatient falls across the organisation to identify, clarify, and gain greater clarity on the issues exposed and the changes that are required. • Commissioning local ward level audits across all sites of the Trust. Develop structured clinical pro-forma based on best practice tariff for hip fracture as a mechanism for reviewing femoral fracture management in inpatient settings.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	The national report looks at data from December 2018 to November 2019. The Trust continues to be a best practice clinic for this audit, with 100% of data submitted with data completeness at 96% compared to 82% nationally. The clinical lead has reviewed the findings and provided a response to the findings. St George's performed well for the 12 key performance measures and comprehensive care planning for patients. One area for improvement is children diagnosed with epilepsy being seen within 2 weeks of referral by a paediatrician with expertise in epilepsy. The project lead believes this highlights a need for more paediatricians with expertise in epilepsy.
National Cardiac Audit Programme – Myocardial Ischaemia National Audit Project	The latest report was published in October 2021 and examines data from 2019/20. The clinical lead has received and acknowledged findings. The service is formulating an action plan in conjunction with the central clinical audit team.
National Cardiac Audit Programme – National Adult Cardiac Surgery Audit	The latest report was published in October 2021 and examines data from 2019/20. The clinical audit project lead is continuing to drive high standards across the service, with performance being closely monitored and reported on.
National Cardiac Audit Programme – National Audit of Cardiac Rhythm Management	The national report was published in October 2021 with data from 2019/20. The audit lead is pleased with the overall performance with the report results reflecting this. One metric examining the re-intervention rates within a year of implanting some pacemaker models were high, but within control limits. The service is investigating whether this is due to a duplication of data issues are at fault. The clinical lead is to contact the audit provider and investigate the issue further.
National Cardiac Audit Programme – National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	The latest national report was released in October 2021 and examines data from 2019/20. Several key findings were highlighted in the report: • 58% of STEMI patients were treated within 60 minutes of arrival at the organisation. This is below the national average, but has improved by 9% compared to last year's publication. • 92% of PCI procedures were performed using radial access at the Trust which is above the national average, and shows significant improvement compared to previous results. The use of drug-eluting stents (DES) during PCI procedures in specific syndromes (2008- 2020) was recorded at 80%, which is below the national average. The clinical lead believes this is a result of the age of the software system being used The database system has recently been updated, and it is hoped that future national results will provide a more accurate reflection of performance.
National Cardiac Audit Programme – National Heart Failure Audit	The latest report was published in October 2021. The results showed the organisation was above the national average for 12 of the 15 key measures. The clinical lead has highlighted the following areas for improvement over the next year: • Hospitals should ensure that high-risk cardiac patients have access to cardiology wards. Heart failure patients are often the highest risk. Our most recent data shows we only achieved this for 38% of patients in 20/21. Hospitals should review their pathways for referral to cardiac rehabilitation to allow greater access and uptake for heart failure patients. Our referral rate to cardiac rehabilitation is 12% which is below the national average of 15%.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Diabetes Core Audit	The results of the latest report showed that St George's care processes and treatment targets were good for patients with Type 1 Diabetes. With the Trust being either in line or above for 8 of the 9 key metrics. However, the results showed St George's were below the national average for the metrics of patients with Type 2 Diabetes. An action plan is being compiled by the service to address these areas.
National Early Inflammatory Arthritis Audit	The Trust has historically struggled to participate in this project. However, this year the service has resumed participation in the audit. The clinical lead has highlighted the following actions for the coming year: • Recruiting a new consultant post in order to lead on an early inflammatory arthritis pathway. Recruiting 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.
National Emergency Laparotomy Audit	The national report was released in November 2021 and covered data from December 2019 to November 2020. The report shows that: • Adjusted mortality rate nationally was 8.7%, with STG performance at a near identical rate (8.8%). • Final case ascertainment in this audit round was 86.3% (RAG rated green), and significantly higher than the national average of 78.8%. • Trust patients arriving in theatre in a timescale appropriate to their urgency was 82.9%, slightly better than the national average (80.9%). • St George's also performed favourably (either in line with or above) national average on all measures relating to consultant surgeon and anaesthetist's input. • Finally, SGH performed better than the national average in terms of proportion of patients returning to theatre after an emergency laparotomy (3.4% against 4.8%). The service lead is producing an action plan in line with the latest report recommendations.
National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit	The latest report is structured in two parts. The first part is based on patients diagnosed with bowel cancer in England and Wales between 1 April 2019 and 31 March 2020. Key findings include: • 90-day mortality improved from 3.5% in the 2015/16 audit period to 2.6% in the 2019/20 audit period • Patients presenting via screening programmes were more likely to have earlier stage disease and to undergo curative treatment (9 in 10 likely to be cured) • 61% of patients undergoing major resection for stage III colon cancer received adjuvant chemotherapy • Two-year all-cause mortality for all patients remained stable at 33% The second part of the report focuses on the recovery of bowel cancer services from the COVID-19 pandemic, and found that early in the COVID-19 pandemic there was a large impact on the diagnosis and treatment of bowel cancer patients, however service provision has largely recovered since then. The clinical lead is focussing on the quality of data collection in the coming year.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Gastro-intestinal Cancer Programme – National Oesophago-Gastric Cancer	The latest report was December 2021 and examined data from April 2018 to March 2020. The report recommends that all patients with oesophageal cancer undergo a PET-CT scan when being considered for curative treatment. St George's measured 61.1% of cases against 67.6% nationally. One area of possible concern is patients with clinical stage 0-3 disease who have a treatment plan. 60.8% of patients nationwide fit these criteria but only 28.1% of patients at St George's do. However, there are many reasons that could contribute to these figures. The clinical lead is investigating this further and is working to assemble an action plan for the coming year.
National Joint Registry	The latest report shows that the Trust meets achieved a Quality Data Provider Certificate for the year. With an expected compliance was 95% and which the Trust exceeded with 96.15%. The project lead is satisfied with the progress made. An action plan for the year ahead will focus on embedding current best practice.
National Lung Cancer Audit	The latest annual report was released in January 2022. The report data from January 2019 and December 2019 in Wales and Guernsey, and between January 2019 and December 2020 in England. The key findings include the 1-year survival of patients in England and Wales; curative treatment rates of non-small-cell lung cancer (NSCLC) patients with stage I/II and good performance status; lung cancer patient's diagnosis in England. The clinical lead reports that the Trust is working to expand its data quality and completeness.
National Maternity and Perinatal Audit	Two national reports were published in 2021 examining different aspects of care. The first report examined care for women with BMI 30+. The report makes core recommendations based on the likelihood of adverse outcomes for these women in pregnancy and birth. Ensuring accurate records of their care and that they are given information tailored to their circumstances. The clinical lead compiled an action plan with many of these are tracked through the Clinical Negligence Scheme for Trusts. The second report was a sprint audit report examining at ethnic and socio-economic inequalities in NHS maternity and perinatal care for women and their babies. The report key findings show that: There are differences in outcomes for women and their babies living in the most deprived areas, compared with those in the least deprived areas, and between minority ethnic groups compared to white ethnic groups. The report recommends improving access to information for women based on their individual circumstances and to help address the wider social determinants of health; for each Trust to understand backgrounds of women who access their services and use this to improve care and reduce inequality; improving and establishing facilities to support avoiding term admissions to neonatal units; review training around diversity and equality for staff and better recording around ethnicity. The clinical lead is working to compile an action plan for the upcoming year.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Paediatric Diabetes Audit	Two national reports were published in 2021 examining different aspects of care. The audit core report was published in June 2021. The Trust is performing in line with or above national average for key health checks. The report shows that St George's completion of all health checks since 2015/16 have improved year on year. The clinical lead has implemented all the recommendations made by the report. The second report examined young people with type 2 diabetes in England. The report recommends that services implement care plans for this group, and to ensure easy access to and usage of weight management programmes. These recommendations have been discussed within the service and are due to be implemented in the upcoming year.
National Prostate Cancer Audit	The latest report was released in January 2022. Based on data between April 2019 and March 2020, the report assessed the care provided and outcomes in addition to the impact of COVID-19. St George's compares favourably to the national average in both available measures. This report has been shared with the clinical leads who look forward to continuing the high quality work in the coming year, and closely monitoring results with supplementary local level audits.
National Vascular Registry	The national report was published in November 2021 for data collected in 2020. Benchmarking of the 5 key measures shows that St George's are either meeting the standard or within the expected range for 4 of these. The metric where the organisation fell slightly below the national average was for case ascertainment. The clinical lead has responded to these findings and is working towards addressing them in in the coming year.
Paediatric Intensive Care Audit	The 2021 annual report Focuses on 5 key metrics: case ascertainment, retrieval mobilisation times, number of qualified nurses per bed, emergency readmissions within 48 hours of discharge, and mortality. • The St George's site achieved 100% case ascertainment rate • The Trust were lower than the Paediatric Intensive Care Society (PICS) standards of a minimum number of 7.01 WTE qualified nurses to staff one level 3 critical care bed, with the Trust's level being just over 6 • Emergency readmission rates were lower at St George's than the national average • The risk-adjusted mortality rate for the Trust's paediatric intensive care unit fell below the 'expected' level and is therefore a positive result for the service. The clinical lead is working to compile an action plan based on the findings.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
Sentinel Stroke National Audit Programme	The national report shows that the Trust is performing above or in line with national averages on all key indicators. Case ascertainment was down slightly this year (at 70-79% which is amber RAG rated), COVID could have played a part in this as generally ascertainment is green RAG rating. The audit lead has acknowledged this report and working to high standards across the service.
Society for Acute Medicine Benchmarking Audit	The service participated fully in this audit round, with the national audit report published in October 2021. The report is highlights 3 key quality indicators. St George's are in-line or above the national average for 2 of the 3 measures. The metric for improvement was for patients that had an early warning score recorded within 30 minutes of arrival, which was recorded at 67% at St George's compared to 77% nationally. The clinical lead has presented these findings and is working to improve this metric in the upcoming year.

2.2.2.6 Local clinical audits – actions taken

The reports of 7 local clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2021/22 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
Audit of Patient Group Direction (PGD)	An annual audit and review of every PGD in practice must be undertaken as per Trust Clinical Audit Policy (Org 2.23) and Trust PGD Policy. The Patient Directions Authorisation Group (PAG) are responsible for providing assurances and compliance is maintained as per Trust PGD policy. The 2021/22 audit took place in June 2021 and 125 PGDs were audited across the Trust over a 2-week period. PGD's were audited against 14 standards and greater than 80% compliance was achieved in all 14 standards. Action is taken through issuing of red, amber, or green letters which respond to compliance levels with standards in each of the specialities audited.
Children and Young People's Patient Safety Thermometer	This is a monthly audit which takes place on all Paediatric wards, Paediatric Intensive Care and the Paediatric Assessment Unit within the Emergency Department. It aims to measure commonly occurring harms in CYP patients who access these services. Between April 2021 and Feb 2022, the harm free rate has been above 90% for all months except one. 100% harm free rate was achieved for 3 of the 12 months. Actions are taken every month by the relevant wards to understand why the harms occurred and how to learn from them going forward.
Controlled Drug and Stock Check Audit	This audit is carried out quarterly and ensures that controlled drugs are correctly stored and secured and that an adequate record is kept which complies with controlled drug guidance. The project lead confirmed that performance in this quarterly project, that ensures storage and security of controlled drugs has been largely positive, despite wider disruptions due to COVID-19. Compliance was recorded at or above 90% for 15 or more of the 22 standards each quarter. Actions for the year ahead include expanded training outreach to ensure learning points are embedded across the organisation.

LOCAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
Early Warning Score Audit	**This audit measures the graded response strategy used by the Trust for patients identified as being at risk of clinical deterioration as per NICE guidelines, the project is carried out bi- annually. The 4 key measures for the audit are: frequency of observations consistent with triggers; complete set of observations recorded; NEWS scored correctly; and where NEWS has triggered a score, an appropriate response has been documented. The compliance target is 100% for each of these.** **The lead for this project laid out actions for the next audit round:** **• Ensuring that the audit results are shared further in the organisation** **• Working with ward managers to target below compliance areas to examine the causes.** **• Appoint NEWS compliance champions on each ward** **• Ensuring familiarity with Trust and local policies** **Working with the internal training department to continue to develop nursing staff.**
Local Safety Standards for Invasive Procedures (LocSSIPs) Audit	**This audit project examines the use of LocSSIPs for all invasive procedures across the entire organisation. It is made up of a theatre and non-theatre versions, and the project runs quarterly.** **The latest round of Theatre audit makes use of a redesigned audit tool and has led to a significant change in results, with departments no longer reporting 100% across all areas. This speaks to the efficiency of the new tool, and with results improving quarter on quarter, an effort from relevant teams to improve their performances.** **The clinical lead is satisfied with the performance so far and is working to compile an action plan.**
Protected Mealtimes and Nutritional Screening	**This audit is carried out quarterly across the Trust and is made up of two elements, firstly the audit examines the principals of avoiding non-clinically urgent mealtime interruptions for inpatients, along with if appropriate assistance was provided - the nursing team carry out this part of the audit. The nutritional screening component examines if appropriate measurements are taken of patients, and if nutritional assessments were carried out – dieticians carry 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. Action for the coming year centre around targeted training in poorer performing areas.** **Results of the nutritional screening audit found that standards around weighing patients and if nutritional screening tool were completed within 24hours of admission, also if body mass index being recorded were missed.**
Smoking Cessation Audit	**The organisations smoking cessation team conducted a local review of data based on the metrics laid out in the national audit.** **The findings indicate a fall in the prevalence of inpatients who are current smokers, however the clinical lead cautions that smoking status is not recorded in all cases. Another finding was that only 35% of inpatient smokers were offered medication to support abstinence and reduce nicotine withdrawal symptoms during their stay, and only 25% were offered very brief advice and asked if they would like support to quit.** **The clinical lead is working towards the following goals in the upcoming year:** **• Smoking status to be documented in all patient notes.** **• Non-cigarette smoking to be documented in all patient notes.** **• All patients asked if they would like to stop smoking.** **Current smokers should be routinely offered nicotine replacement products to help them abstain from tobacco as well as referral to tailored smoking cessation support.**

*Based on information available at the time of publication

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, including investing more in our staff to support their research ambitions and developing our IT research infrastructure. Another key part of our research strategy is to gain core National Institute for Health Research (NIHR) funding, which we have achieved through a successful application for NIHR Clinical Research Facility designation which will commence in September 2022.

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. Recently, much of our focus has been on, Covid-19 clinical research. We have recruited over 7,800 patients to 53 clinical research studies and we are amongst the top NHS Trusts in the country for the number of urgent public health Covid studies. We are leading a major Vaccine Task Force funded clinical trial on Covid vaccines in pregnancy.

The number of patients receiving relevant health services provided or subcontracted by St George's University Hospitals NHS Foundation Trust in 2021/22 that were recruited during that reporting period to participate in research approved by a research ethics committee was 7,955.

2.2.4 Our Commissioning for Quality and Innovation (CQUIN) performance

No CQUIN schemes were published in 2021/22 for either CCG or specialised Commissioning (NHSE) due to ongoing COVID 19 pandemic. The CQUIN schemes were not applicable contractually and were brought within the scope of The NTPS. Block payments to NHS providers are deemed to include CQUIN financial values. Accordingly, the Trust received full CQUIN finding through its block allocation.

CQUINs have been reintroduced for the 2022/23 contract at the rate of 1.25% of the API contract value.

Ratings for St George's Hospital						
Division	Sale	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.

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 2021/22.

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.

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 continued to explore and test 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 the 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. There were no structured assessments using this format in 2021/22. The Trust and the CQC continued to meet on a regular basis in 2021/22.

Throughout 2021/22 the quality and safety standards were maintained within the cardiac surgery service which is supported by the data from the National Institute for Cardiovascular Research (NICOR). The Trust Board continues to review the service's mortality 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 2021/22 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:

- 99.6% for admitted patient care (against 99.7% national average)
- 99.8% for outpatient care (against 99.8% national average)
- 98.7% for accident and emergency care (against 98.9% national average)

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

- 99.1% for admitted patient care (against 99.7% national average)
- 99.1% for outpatient care (against 99.6% national average)
- 99.3% for accident and emergency care (against 99.5% national average)

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 2020/21 and planned compliance for 2021/22 by 31 March 2022. The Trust's Information Governance Manager together with the Informatics, Digital and Technology 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 2022.

The Data Security and Protection Toolkit managed by NHS Digital is available at https://www.dsptoolkit.nhs.uk/ together with facilities to view organisation compliance status.

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 2021/22.

2.2.11 Learning from deaths

During 2021/22 1,487 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:

- 298 in the first quarter
- 358 in the second quarter
- 433 in the third quarter
- 398 in the fourth quarter

By 31 March 2021, 145 case record reviews have been carried out in relation to 9.8% of the deaths included.

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

- 36 in the first quarter
- 26 in the second quarter
- 40 in the third quarter
- 43 in the fourth quarter

4 representing 0.27% 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:

- 1 representing 0.34% of the number of deaths which occurred in the first quarter
- 0 representing 0% of the number of deaths which occurred in the second quarter
- 3 representing 0.69% of the number of deaths which occurred in the third quarter
- 0 representing 0% 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 safety standards each report also detailed potential areas for learning and improvement. Over the year these included enhancements to bereavement care through recruitment to a specialist bereavement midwife role and review of the bereavement pathway to ensure compliance with national standards. Improvements to the documentation and support provided to parents following loss, and provision of staff education and training has further strengthened this service.

- A review of mortality following major trauma has progressed significantly, leading to changes designed to improve clinical documentation, governance, and clinical pathways. Enhancements to our electronic patient record to enable improved documentation of immediate major trauma care have been designed to support efficient delivery of best practice care and accurate data collection. Clinical pathways that have been amended following the mortality review include those for patients admitted medically and those who have experienced pelvic trauma. The Trust is continuing to seek opportunities for improvement which will be further informed through a strengthened prospective mortality review process.

Summary of action taken in 2021/22 and plans for 2022/23

This year we have made significant progress against the action plan arising from the external governance review of mortality conducted in 2019. The aim of this work is to maximise the learning identified through review and investigation of mortality and to support implementation of improvements as a result. This year we have introduced a team of six Mortality and Morbidity Coordinators to support clinical teams and to facilitate enhanced governance across the Trust.

Each clinical team has an allocated coordinator who is facilitating Mortality and Morbidity meetings. The team are working with governance leads to develop and implement consistent approaches to mortality governance. This includes defining a core, but adaptable, range of data that will be examined for each death reviewed, alongside guidelines and protocols for the operation of the meeting and sharing of findings. Pilots are underway which will inform the agreed approach to be implemented in the coming year. The coordinators are beginning to support shared learning through facilitating liaison between teams where discussion identifies that consideration of the case is required within another service. A strengthened link with the learning from deaths review process has also been established.

This year our clinical lead for Learning from Deaths recruited two additional consultants to the Mortality Review Team. This team of four consultants working on a sessional basis support independent mortality reviews using the structured judgement review developed by the Royal College of Physicians. Through this increased team we have been able to support a larger number of timely reviews of deaths that meet the criteria defined within our Learning from Deaths policy. These include:

- Deaths where the Medical Examiner has identified a potential concern
- Deaths where bereaved families, or staff, had raised a significant concern
- Deaths of inpatients with learning disabilities
- Deaths of inpatients with a clinical diagnosis of autism
- Deaths of inpatients with severe mental illness
- Deaths in a speciality where the Mortality Monitoring Group 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 Mortality Review Team felt there was significant concern, the case was escalated immediately to the Patient Safety Team to consider if a serious incident, or other, investigation was required. Significant problems of care, whether or not it affected the outcome, were highlighted to the clinical team for discussion and local learning in their Mortality and Morbidity meetings. 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 continued to scrutinise 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 these have been referred either to the Lead for Learning from Deaths, to the Patient Safety Team, or to the clinical team involved with the patient's care.

This year the service has prepared for the expansion of the service to encompass the scrutiny of all deaths that occur within Merton and Wandsworth. Through collaboration with colleagues in primary care the service have agreed a pilot in several practices prior to the introduction of the statutory system. Three Medical Examiner Officers have been appointed to the team and recruitment of two Medical Examiners from non-acute services is underway. These enhancements to the team are essential to the successful expansion of the ME service.

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.

0 representing 0% 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

In 2021/22 having undertaken a further risk-based review the Trust remained non-compliant with standard 2 (consultant review within 14 hours of admission), standard 5 (access to diagnostics – MRI at weekends) and standard 8 (regular consultant review of high dependency patients).

In 2021/22 there was no requirement to make an assurance statement to the Board. However, quarterly progress reports were reported to the Trusts Quality and Safety Committee, a sub- committee of the Trust Board. The quarterly reports demonstrated that progress was made to achieve 7-day equitable access to MRI scanning and reporting, on care group recruitment to improve weekend access to consultant review and on the establishment of a divisional review process to facilitate divisional oversight and ownership of seven-day service compliance.

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 2021/2022 continued to be dominated by the Covid-19 pandemic. During the first wave (April to June 2020) the Doctors in training were redeployed into 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 third wave (April 2021 to date) saw a more restricted redeployment into the Omicron variant wave and saw a fatigued junior doctor workforce with concerns raised with acute medicine about the inability to take breaks and the extra work generated by staff shortages. The Trust had provided wellbeing support with psychologists visiting the wards, wellbeing hubs and a mentoring scheme was offered although the take up suggests that junior doctors find it difficult to seek support, which is a national finding.

Unfortunately, exception reporting dropped from 210 compared with 458 in the previous year, which may in part be reflecting that trainees were committed to their work during the pandemic and they did not want to log their overtime. This may also be in part due to the increased vigilance consultants made to ensure that the shift work ran smoothly and trainees could get home on time where possible. Exception reporting is encouraged to help identify patient safety needs as well as supporting junior doctors to have their correct pay, training and rest. Rota gaps were not analysed in the same way as direct comparisons could not be made as the rotas were rewritten to support the Covid-19 response. Exception reporting has increased in the months of January-February 2022.

The majority of exception reports arise from the acute medical teams and early 2022 is seeing strategic meeting with the JDF to find solutions for staff shortages, delayed locum pay and non-taking of breaks working with medcard clinical leads, the deputy chief medical officer and Trust wellbeing lead.

Development for 2021/2022 included improving attendance to the Junior Doctors forum (JDF) which has already begun with the appointment of the new JDF chair who is the Chief Registrar, and three vice chairs, who will be encouraging speciality representatives to attend again after the pandemic has receded.

By April 2022 the BMA wellbeing fund will need to be spent and so junior doctor mess development plans have been finalised. The pilot for the mirror exception reporting scheme for fellow and trust doctors was delayed by the pandemic but is projected to be in effect by the beginning of quarter 1 2022/23 with the expected improvement of patient safety and junior doctor wellbeing in a section of the workforce who have lacked a voice. Further engagement with educational supervisors to support doctors to exception report will be supported through post graduate medical education and training into 2022/23.

From the wellbeing fund in 2021/22, £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.

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)	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	Dec 20-Nov 21	Jan 21-Dec 21
SHMI	0.81	0.83	0.83	0.83	0.85	0.85	0.85	0.86	0.84	0.90	0.91
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	As expected	As expected
% Deaths with palliative care coding	50	49	49	50	49	49	48	47	49	54	54

Source: NHS Digital – https://app.powerbi.com/view?r=eyJrIjoiMjAyMmRjMzItYWZlZC00MWU4LWFjYTQtNzRkODYyNmFmOTYxIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

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 additional 6.0 wte posts to strengthen the administrative support to the monitoring process and additional Medical Examiner Officers to support the reviews. 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		2017-18		2018-19		2019-20		2020-21		2021-22*	
		SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average
Hip replacement	EQ-5DTM	71	90	66.7	90.2	No Data	90.1	No Data No questionnaires returned			
	EQ-VAS	43	68.3	66.7	69.6	No Data	69.8				
	Specific	75	97.2	100	97.2	No Data	97.3				
Knee replacement	EQ-5DTM	0	82.6	No data	82.7	50.0	83.2				
	EQ-VAS	33	59.7	No data	59	No data	60.1				
	Specific	33	94.6	No data	94.7	100	94.7				

Source: NHS Digital 9 https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/
*2021/22 – No data submitted

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 was expected to be in place for 2021/22 however, this was not in place until March 2022 which meant that the Trust could not participate in this audit.

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

- The Trust was unable to participate in this audit in 2021/22 due to the absence of a data collection provider

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:

- From March 2022 when the new data provider was in place, 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	2018-19			2019-20			2020-21			2021-22		
	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	13975	48206	62181	13022	47103	60125	8,522	34,886	43,408	9,945	35, 549	45, 494
28 day readmissions	751	4006	4757	932	4218	5150	524	3,638	4,162	672	3,233	3,905
28 day readmissions rate	5.37%	8.31%	7.65%	7.16%	8.95%	8.57%	6.15%	10.43%	9.59%	6.76%	9.09%	8.58%

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 generally in line with the national average shown below. The data below shows the average, highest and lowest performers and our previous performance.

Patient Experience	2017-18	2018-19	2019-20	2020-21	2021-22*
St George's University Hospitals	65	67.2	67.1	65	
National average	68.6	67.2	64.2	67.1	
Highest (best)	85	85	84.2	84.4	
Lowest	60.5	58.9	59.5	54.4	

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework
* The 2021/22 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2022/23.

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 waction 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 2021/22 shows a 4.8% reduction in staff who would recommend St George's to their friends and families.

Staff recommendation	2017-18	2018-19	2019-20	2020-21	2021-22
St George's University Hospitals	73%	69%	72%	76%	71.2%
Average for Acute	69%	70%	71%	74%	66.9%
Highest Acute Trust	86%	87%	87%	92%	89.5%
Lowest Acute Trust	47%	41%	40%	49%	43.6%

https://www.nhsstaffsurveyresults.com/wpcontent/uploads/2021/02/NHS_staff_survey_2020_RJ7_full.pdf
https://public.tableau.com/app/profile/piescc/viz/ST20localdashboards/Aboutthesurvey

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 inpatient services in 2021/22 with 97.7% of our Inpatients saying they would recommend our services to their friends and family.

Unfortunately, due to the significant demand for A&E services and the associated waiting times 78.8% of those visiting our A&E department said they would recommend our services to their friends and family.

Friends and Family Test	2018-19		2019-20		2020-21- Dec21		2021-22- Mar 22	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	26.20%	26.40%	15.27%	34.38%	18.97%	28.74%	12.82%	32.71%
% would recommend	87.00%	97.00%	82.41%	96.5%	89.83%	97.5%	77.86%	97.70%
% would not recommend	8.50%	1.00%	12.36%	1.14%	6.52%	0.75%	12.82%	0.60%
National comparison positive response rate	12.3%	24.6%	12.1%	24.4%	80%	94%	81%	94%
National comparison as at March 2020 % would recommend	86%	96%	85%	96%	N/A*	N/A*	N/A*	N/A*
National comparison as at March 2020 % would not recommend	8%	2%	9%	2%	13%	3%	12%	3%

https://www.england.nhs.uk/publication/friends-and-family-test-data-january-2022/

* 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	2017-18	2018-19	2019-20	2020-21	2021-22
St George's University Hospitals	95.90%	96.0%	93.9%	96.18%	96.8%
National Average	95.80%	95.6%	95.5%	95.33%	N/A
Best performing Trust*	100%	100%	100%	100%	N/A
Worst performing Trust*	72%	74.4%	71.7%	77.16%	N/A

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	2017-18	2018-19	2019-20	2020-21	2021-22
St George's University Hospitals *Data is from April 21 to Mar 22					
Trust apportioned cases *Change in reporting: denotes those Cases confirmed due to lapses in care	16	31	8	34	33
Trust bed-days	296,981	282,339	285,321	225,244	278,832
Rate per 100,000 bed days	5.4	11.0	2.8	15.09	11.8
National average	31.2	33	3	21.52	28.47
					99.74
Worst performing trust	113	177	15	90	0
Best performing trust	0	0	0	0	0

NHSI HCAI Dashboard: Trust Overview – Tableau Server (england.nhs.uk) Bed Occupancy: Acute Bed Occupancy – Tableau Server
C. difficile infection: monthly data by prior trust exposure – GOV.UK (www.gov.uk)
Data showing National, Worst and Best performing Trust included all CDIff data. Does not separate Hospital and Community Onset.

NOTE: Hospital capacity has had to be organised in new ways as a result of the pandemic to treat Covid-19 and non-Covid-19 patients separately and safely in meeting the enhanced Infection Prevention Control measures. This results in beds and staff being deployed differently from in previous years in both emergency and elective settings within the hospital. As a result, caution should be exercised in comparing overall occupancy rates between this year and previous years. In general, hospitals will experience capacity pressures at lower overall occupancy rates than would previously have been the case.

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-Mar 21	Apr 21-Mar 22
St George's University Hospitals											
Total reported incidents	5,188	5,353	5,453	5,964	5,928	5,548	5934	6268	6697	12352	Data not yet published
Rate per 1000 bed days	34.1	33.2	32.8	36.5	37.6	34.2	39.5	45.3	45.4	51.2	
*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				

Patient Safety Incidents	Oct 14-Mar 15	Apr 15-Sep 15	Oct 15-Mar 16	Apr 16-Sept 17	Oct 16-Mar 17	Apr 17-Sep 18	Oct 18-Mar 19	Apr 19-Sep 19	Oct 19-Mar 20	Apr 20-Mar 21	Apr 21-Mar 22
St George's University Hospitals											
Incidents causing Severe Harm or death	16	23	20	15	13	14	23	10	9	21	Data not yet 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%	0.17%	
*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/publications/clinical-indicators/nhs-outcomes-framework/current/domain-5-treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5-6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5-4

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

The data submitted to the National Reporting and Learning System (NRLS) was previously published every six months. This has now changed to use annual timeframes, rather than six- monthly, and from 2020/21 the data will now be published on an annual basis.

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 2022/23. 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 bi-monthly patient safety 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	Annual performance 2021-22
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	N/A (Not reporting)	84.2%	69.3%	72.3%
Referral to treatment times	Number of 52 week breaches	0	N/A (Not reporting)	32	2,644	846
ED access	95% of patient wait less than 4 hours	>=95%	88.4%	83.2%	92.8%	81.6%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	>=85%	86.9%	85.2%	77.1%	72.6%
	% patients treated within 62 days from screening referral	>=90%	86%	88.8%	80.8%	75.9%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	99%	99%	95.7%	89.8%	98.2%

3.2 Our performance against our Quality priorities in 2021-22

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, 2020/21. 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 2021/22?**	**How our performance compared with 2020/21**
We will review Nosocomial Covid-19 infection for in- patients 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 the previous year	We did not achieve this Between April 2021 and March 2022 the Trust had reported 227 cases of HOHA (hospital onset, hospital acquired) nosocomial hospital onset healthcare associated >14 days after admission Between April 2021 and March 2022 the Trust had reported 137 cases of HOPA (hospital onset, probable acquired) nosocomial hospital onset healthcare associated 8-14 days after admission	Important note: National definitions for HOHA and HOPA were not confirmed until June 2020. In 2020/21 we reported 180 cases of HOHA nosocomial hospital onset healthcare associated >14 days after admission In 2020/21 we reported 199 cases of HOPA nosocomial hospital onset healthcare associated 8-14 days after admission
We will ensure timely escalation and response to deteriorating patients	All adult inpatients will have a Treatment Escalation Plan (TEP) Reduction in avoidable harm and death associated with missed opportunities when compared with the previous year Improved response to the National Early Warning Score (NEWS2) when compared with the previous year Reduction in the number of cardiac arrests compared with the previous year	We did not achieve this We monitored TEP performance on a monthly basis in the Integrated Quality and Performance Report We developed an electronic mechanism to monitor the number of TEPs in place for adults within 24 hours of admission In March 2022 37.4% of adults had a TEP in place within 24 hours of admission The number of cardiac arrests in March 2022 was 7.7/1000 inpatient admissions	In 2020/21 we established an improvemen t project and built an electronic TEP in the test domain of iClip In March 2021 33.8% of adults had a TEP in place within 24 hours of admission. NEWS2 audits showed an appropriate response performance of 90.8% in March 2022 The number of cardiac arrests in 2020/21 was 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

Patient Safety			
Our quality priorities	**What will success look like?**	**How did we do in 2021/22?**	**How our performance compared with 2020/21**
We will ensure the 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 did not achieve this Mental Capacity Act and Deprivation of Liberties (MCA/ DoLs) Training – Level 1 training performance was 85.9% in March 2022 against the target of 85% Level 2 training performance was 69.7% in March 2022 against the target of 85% Important note: In 2021/22 the Trust was awaiting the release of the guidance for the implementation of the new framework for MCA/DoLS – the Liberty Protection Safeguards. The revision of the Level 2 training module was paused whilst the new framework was awaited which impacted on training performance	The electronic forms to standardise recording were implemente d on iClip 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%
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 2021 35% of adults had a TEP in place within 24 hours of admission, performance in March 2022 was 37.4% At the time of writing this report consent audit data has not been published	In April 2020 45% of adults had a TEP in place within 24 hours of admission, performanc e in March 2021 was 33.8% No consent audit data was available in 2020/21
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) remained as or lower than expected	Mortality as measured by the summary hospital-level (SHMI) was lower than expected

Patient Experience			
Our quality priorities	**What will success look like?**	**How did we do in 2021/22?**	**How our performance compared with 2020/21**
We will undertake thematic analysis of our complaints to identify recurrent themes and share their findings	Reduction in the number of complaints when compared with the 2019/20 baseline (complaint numbers impacted in 2020/21 and 2021/22 due to the pandemic)	We partially achieved this We undertook thematic analysis on a quarterly basis which identified recurrent themes: care and treatment; communication; and staff attitude When compared with 2019/20 and 2018/19, the total number of complaints was 1,044	The number of complaints received in previous years was as follows: • 2020/2 1: 708* • 2019/2 0: 956 • 2018/1 9: 1101 *Impacted by Covid-19
Provide an equitable experience for patients from vulnerable groups	Improvement in our self-assessment against the National Learning Disability Standards having had the opportunity to make service improvements following the first self-assessment in 2020	We partially achieved this The second self-assessment was completed against national standards for Learning Disability patients and at the time of writing we are awaiting the results The action plan to address improvements identified against 11/ 79 national standards did not progress as expected due to significant staffing shortages in the team	In March 2021 we received the results of the NHS benchmark assessment that was completed against national standards for Learning Disability patients. There were 107 national benchmark Learning Disability Standards, of which 79 benchmark standards applied to SGH. 48/79 (61%) were in line with the national standard 20/79 (25%) were above the national standard 11/79 (14%) were below the national standard
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	We achieved this Collaboration continues across SW London and in discussion with local authority partners with reference to Discharge to Assess The multi-agency Discharge Forum has continued The discharge summary for in- patients in iClip has been extended to include a multidisciplinary section for the inclusion of nursing and social care needs	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 multi-agency Discharge Forum

Clinical effectivness and outcomes			
Our quality priorities	**What will success look like?**	**How did we do in 2021/22?**	**How our performance compared with 2020/21**
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	An integrated training and education framework will be in place with SWL and St George's Mental Health Trust	We did not achieve this Progress was impacted by Covid-19 and although this remains an objective of the SWLSTG-SGUH Mental Health reference group, further development work is now needed across the integrated care system in order to drive the work forward	The integrated training and education framework was not developed due to the new post of Head of Nursing commencing in post December 2020
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 2021	IMPORTANT NOTE: In 2021 the NHS Staff Survey altered its methodology to focus on 6 People Promises together with Staff Engagement and Morale. https://cms.nhsstaffsurveys.com/app/reports/2021/RJ7-benchmark-2021.pdf Therefore, it has not been possible to make a direct comparison with 2020 scores as set out in the column to the right. We are compassionate and inclusive: Trust score 7.1 (average trust score 7.2) We each have a voice that counts: Trust score 6.5 (average trust score 6.7)	NHS Staff Survey 2020 Quality of Care: 7.6 (average trust score 7.5) Safety Culture: 6.6 (average trust score 6.8)
Deliver care in line with our revised activity plans to ensure our patients do not wait too long for treatment	Achievement of targets for: • Referral to Treatmen t (RTT) within 18 weeks • Diagnostics within six weeks • Four-hour operating standard • Cancer standards	We did not achieve this As reported in section 3.1, page 37 RTT: We delivered against the revised trajectories for 78 week waits other than for General Surgery and Cardiology. As required, we maintained the end of September 2021 position for the 52-week trajectory Diagnostics: We did not meet our diagnostics within 6-weeks standards Cancer: We did not meet our cancer access standards Four-hour target: We did not deliver against the four-hour operating standard	The Trust was unable to supply annual performance for 2020-21 due to the impact of Covid-19 on data reporting and data flows

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

A1.1 Statement from South West London Clinical Commissioning Group

Thank you for sharing the Trust's 2021/2022 Quality Account with South West London Clinical Commissioning Group (SWL CCG). Having reviewed the Quality Account, we are pleased to see the progress made by the Trust in maintaining high quality care standards despite the challenges of the Covid-19 pandemic.

SWL CCG congratulates the Trust on achieving the majority of the priorities set for 2020/2021 and identifying areas where work will continue into 2022/23. We acknowledge the trusts progress with compliance against the eight 'immediate and essential actions' as part of the ongoing assurance processes for the Ockenden review and being one of only six NHS Trusts in London demonstrating 100% compliance. We recognise the significant work the Trust is undertaking to reduce the routine surgery backlog, which is a key priority. We welcome the continued strengthening of your governance processes across the Trust. The Trust's commitment to partnership working and providing integrated care is evidenced through the new hospital group leadership model between St George's and Epsom and St Helier University Hospitals.

For 2022/2023 the Trust has identified three quality priorities:

- **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
- **Improve patient experience:** meeting our patients' emotional as well as physical needs
- **Improve effectiveness and outcomes:** providing the highest quality care, with world class outcomes whilst also being efficient and cost effective

St Georges Hospital is a partner of the newly formed Integrated Care System for SWL, this partnership will bring about increased collaboration and new ways of working. The ICS will focus on the following quality priorities from July 2022:

- The launch of a new System Quality Strategy. The ICS has been active in developing a quality strategy that will enable greater collaboration to improve quality and tackle inequalities across the system
- Our continuous goal is to improve patient safety, experience and outcomes across health and care.
- The SWL ICS is working in collaboration with all system partners to reduce health inequalities and has adopted Core20PLUS5 as a framework to address systemic inequities and discrimination
- As we establish SWL System Quality and Oversight Committee, we will work collaboratively with all system partners to agree and deliver on our shared system quality priorities.

We look forward to continued work with the Trust under the new arrangements and strengthening our collaborative approach to system quality improvement.

Kind regards,
Dr Gloria Rowland MBE SWL Chief Nurse and Allied Health Professional Officer

A1.2 Statement from Healthwatch Wandsworth

Healthwatch Wandsworth (HWW) welcomes the opportunity to comment on the Quality Account 2021-22 for St George's University Hospital Foundation Trust. We respond with some general comments about the context of the quality performance described in the Account before looking more closely at some of the priorities it identifies. (Please note that our comments are based on a draft copy of the Account which does not contain all the information that will appear in the final version.)

First, we would like to put on record our congratulations and thanks to staff across the Trust for dealing with the extreme demands and pressures of the Covid-19 pandemic. These pressures may be partially responsible for the recent high turnover rates for medical and nursing staff, which create further challenges to the Trust in maintaining high standards of care. It is encouraging that the Trust is intent on improving the job satisfaction and overall well-being of its staff.

The year 2021-22 was dominated by managing the continuing impact of the pandemic. This involved not only dealing with the disease itself, but also meeting the challenge of supporting patients who were experiencing long waits for their appointments and treatment. We were kept informed of formidable systems of investigation into hospital- acquired COVID infections and were also kept abreast of the concerted effort and improvements made to tackle the backlog of patients in broad terms (with some exceptions, including referrals for breast cancer services). We are pleased that, despite many contextual difficulties, the Trust has successfully implemented the recommendations of an independent panel to improve the outcomes of cardiac surgery.

The disruption caused by the pandemic makes it difficult for HWW to make comparisons with the Trust's performance and expectations in previous years. In addition, we have experienced a reduction in our involvement in monitoring the Trust's quality improvement agenda. There have been fewer meetings of the kind that we would usually attend to perform a role in quality monitoring and ensuring that patients can inform service improvements. We continue to be involved through our Healthwatch-nominated Governor, who attends the Patient Safety and Quality subcommittee of the Trust Board; involvement in the Patient Partnership Engagement Group; and attendance at recently established, monthly 'touch base' meetings between the Trust and local Clinical Commissioning Groups. The latter is informative and valuable, but we understand that it is a transitional arrangement only before the South West London Integrated Care System is fully established. We had to suspend Enter & View visits, which are an invaluable way of getting direct feedback from patients and carers about their experiences. We have tried to compensate by organising a series of online and telephone surveys of service users.

The current restructuring of the health and care system, plus the recent joint -staffing arrangement with Epsom and St Helier University Hospitals Trust will bring significant changes to the organisation and governance of the Trust. These are likely to have an impact on our own involvement and opportunities to champion the voice of patients. We would welcome clarity and assurance that any new governance arrangements for assuring quality and safety will be appropriately robust and detailed, and that capacity for monitoring quality within the Trust will not be compromised. We hope over the coming year get to know new staff in key posts and also that there will be more clarity on how HWW and patients will be involved both at Trust level and at the level of the 'provider collaboratives' at the South West London Integrated Care System level.

With reference to the Quality Account process itself, we wish to draw attention to two unfortunate aspects influenced largely by the requirements of Government regulations. One is the rigidity of the Quality Account's content lending to detailed and formulaic statements required by the regulations that convey limited useful information and reduce the readability. The other is the rigidity of the imposed timetable. While stakeholders are invited to comment on the draft Account, the tight publication deadline results in little if any account being taken of those comments in the published version. We have some hope that the system may soon be changed following a review conducted by NHSE with the input of national and local

Healthwatch, including HWW, in 2021. We hope that individual Trusts will have freedom to devise a more rational Quality Account in consultation with their local stakeholders. But, for now we submit our comments under the existing system.

Improving collaboration

We are particularly pleased to see that one of the Trust's priorities next year is to work more closely with local hospitals and partner organisations in South West London. We commented on the importance of this in our submission on the last Quality Account. We hope that the Trust will devote the resources necessary to negotiate and agree cross-boundary pathways in the interests of assuring safe and seamless care between services. There is need for complete clarity about processes such as urgent referrals from general practice and transfers back to community health care and social services.

Hospital discharges

The discharge process is one of HWW's priority areas over the coming year, and we look forward to our future involvement in the Trust's refreshed Discharge Forum. We know that the Trust is already making great efforts to improve its discharge procedures. We have recently interviewed informal carers about their experiences of hospital discharge: respondents highlighted some important issues they thought were needed to improve the experience and outcomes for both patients and carers. We have presented our initial findings to members of hospital staff, and we plan to continue to work with the Trust, NHS England and other key organisations involved in the discharge process. We encourage the Trust to persist in its aim to give patients follow-up appointment dates before they leave hospital. This is one way of ensuring attendance at Outpatient clinics and - in extreme cases – of avoiding being lost to follow-up. The reported number of emergency readmissions for adults within 28 days of discharge from the Trust seem high, and in some cases is directly attributable to 'failed' discharges.

Maternity and perinatal mental health

We congratulate the Trust on the positive news that the midwifery service was found to be 100% compliant with the standards recommended by the Ockenden Review. Continuity of care has become a clear priority for ensuring good outcomes and good care in maternity, as was highlighted when we spoke to local people about perinatal mental health. We hope to be kept informed about progress in achieving continuity of care targets and the other recommendations made in our report.

Investigating mortality and morbidity

We welcome the progress that has been made to improve the Trust's capacity to investigate and report on mortality and morbidity which will provide important learning and help with quality improvement.

Communications

People regularly tell us they would like better communication between the Trust and patients to support co-ordination of their care. We are pleased that patients now have access to electronic records of their care via the new patient portal, MyCareStGeorge's. However, it is not clear at this stage if this will improve patient experience, communication and empowerment and we would like to hear about plans for evaluating this is effective.

We would like the Trust to do more to improve its direct communication with patients (for example, when sending out reminders and appointment information) by using email and landline calls as an alternative to text messaging where this is the patient's preference.

Patient experience and involvement (including Healthwatch Wandsworth)

We would like to hear more about how patients have been involved in quality improvements over the year 2021-22.

It is encouraging that the Trust will make it a priority next year to 'Improve patient experience: meeting our patients' emotional as well as physical needs' and 'to continue to focus on patient feedback, equitable experience and discharge' and plans 'to provide patients with an equitable experience by proactively reaching out with system partners to our communities and our vulnerable groups'. We would like more specific detail about what will happen.

We would have liked to see greater prominence given in the Quality Account to addressing inequalities throughout the reporting, including analysis and stratification of data to demonstrate if there are differences between demographics and to identify patterns of inequality do that the Quality Account can include information about actions to overcome them. One example that highlights the need for additional efforts to understand local health inequalities and capture the needs of a range of patients is that the national patient surveys for both adult and paediatric services were dominated by 'White British' respondents.

We have mentioned above how changes to local structures are having an impact on our own involvement and ability to champion the voice of patients. We would like assurance that there will be a commitment by staff at all levels to listening to the patient voice in quality improvement initiatives and projects, so that the Trust provides care that is tailored to individual needs.

Moving into 2022-3

Finally, HWW looks forward to continuing its engagement with Trust staff at a variety of levels about projects relating to our own priorities around discharge, dementia, hospital discharge, virtual wards and hospital at home.

Healthwatch Wandsworth
6 June 2022

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

[Not provided due to Covid-19 pandemic]

A1.4 2021/22 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:

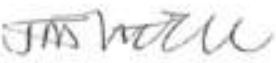
- board minutes and papers for the period April 2020 to 24 June 2022
- papers relating to quality reported to the board over the period April 2021 to June 2022
- feedback from commissioners dated 31 May 2022
- feedback from governors dated 30 May 2022 [Governors invited to comment at Council of Governors meeting]
- feedback from local Healthwatch organisations dated 6 June 2022
- feedback from overview and scrutiny committee dated [Not provided due to Covid-19 pandemic]
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 [not available at the time of writing]
- 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 2022
- 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
Group Chairman
22 June 2022



Jacqueline Totterdell
Group Chief Executive
22 June 2022

9. St George's University Hospitals NHS Foundation Trust

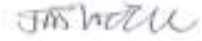
Annual accounts for the year ended 31 March 2022

Foreword to the accounts

St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2022, 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 Totterdale
Job title Group Chief Executive
Date 22 June 2022

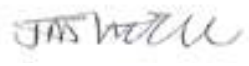
Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	934,053	802,318
Other operating income	4	143,284	239,825
Operating expenses	6, 8	(1,070,481)	(1,028,220)
Operating surplus/(deficit) from continuing operations		6,856	13,923
Finance income	11	34	10
Finance expenses	12	(3,242)	(3,470)
PDC dividends payable		(10,866)	(9,182)
Net finance costs		(14,074)	(12,642)
Surplus/(deficit) for the year from continuing operations		(7,218)	1,282
Surplus/(deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	-	-
Surplus/(deficit) for the year		(7,218)	1,282
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(8,726)	(31,475)
Total comprehensive income / (expense) for the period		(15,944)	(30,193)

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	13	43,507	42,782
Property, plant and equipment	14	443,776	427,912
Receivables	19	8,592	10,929
Other assets	20	-	11
Total non-current assets		495,875	481,634
Current assets			
Inventories	18	15,058	13,215
Receivables	19	75,306	72,351
Cash and cash equivalents	21	68,545	36,561
Total current assets		158,909	122,127
Current liabilities			
Trade and other payables	22	(170,694)	(139,158)
Borrowings	24	(5,783)	(5,589)
Provisions	26	(636)	(882)
Other liabilities	23	(11,965)	(7,648)
Total current liabilities		(189,078)	(153,277)
Total assets less current liabilities		465,706	450,484
Non-current liabilities			
Borrowings	24	(55,402)	(57,045)
Provisions	26	(2,128)	(3,253)
Total non-current liabilities		(57,530)	(60,298)
Total assets employed		408,176	390,186
Financed by			
Public dividend capital		565,840	531,906
Revaluation reserve		73,640	82,366
Other reserves		1,150	1,150
Income and expenditure reserve		(232,454)	(225,237)
Total taxpayers' equity		408,176	390,186

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

Signed 

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

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	531,906	82,366	1,150	(225,237)	390,186
Surplus/(deficit) for the year	-	-	-	(7,218)	(7,218)
Impairments	-	(8,726)	-	-	(8,726)
Revaluations	-	-	-	-	-
Public dividend capital received	33,934	-	-	-	33,934
Taxpayers' and others' equity at 31 March 2022	565,840	73,640	1,150	(232,454)	408,176

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
Taxpayers' and others' equity at 31 March 2021	531,906	82,366	1,150	(225,237)	390,186

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	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		6,856	13,923
Non-cash income and expense:			
Depreciation and amortisation	6.1	34,414	28,732
Net impairments	7	6,586	12
Income recognised in respect of capital donations	4	(795)	(5,451)
(Increase) / decrease in receivables and other assets		(571)	10,753
(Increase) / decrease in inventories		(1,843)	(1,344)
Increase / (decrease) in payables and other liabilities		39,334	16,785
Increase / (decrease) in provisions		(1,361)	1,402
Other movements in operating cash flows		(271)	(199)
Net cash flows from / (used in) operating activities		82,349	64,613
Cash flows from investing activities			
Interest received		34	10
Purchase of intangible assets		(5,404)	(5,031)
Purchase of PPE and investment property		(58,737)	(77,161)
Receipt of cash donations to purchase assets		795	244
Net cash flows from / (used in) investing activities		(63,312)	(81,938)
Cash flows from financing activities			
Public dividend capital received		33,934	396,171
Movement on loans from DHSC		(602)	(325,620)
Movement on other loans		(1,478)	(1,478)
Capital element of finance lease rental payments		(3,425)	(3,056)
Capital element of PFI, LIFT and other service concession payments		(1,301)	(1,216)
Interest on loans		(335)	(1,663)
Other interest		(17)	(27)
Interest paid on finance lease liabilities		(387)	(482)
Interest paid on PFI, LIFT and other service concession obligations		(2,540)	(2,625)
PDC dividend (paid) / refunded		(10,902)	(9,544)
Net cash flows from / (used in) financing activities		12,947	50,460
Increase / (decrease) in cash and cash equivalents		31,984	33,135
Cash and cash equivalents at 1 April - brought forward		36,561	3,425
Cash and cash equivalents at 31 March	21.1	68,545	36,561

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 2021/22 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. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust incurred a breakeven financial position for the year ended 31 March 2022 (after adjusting for excluded items against the control total).

The final financial plan for 22/23 remains to be finalised, with the Trust aspiring to achieve a break-even position, having taken account of the underlying financial position going into 2021/22 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

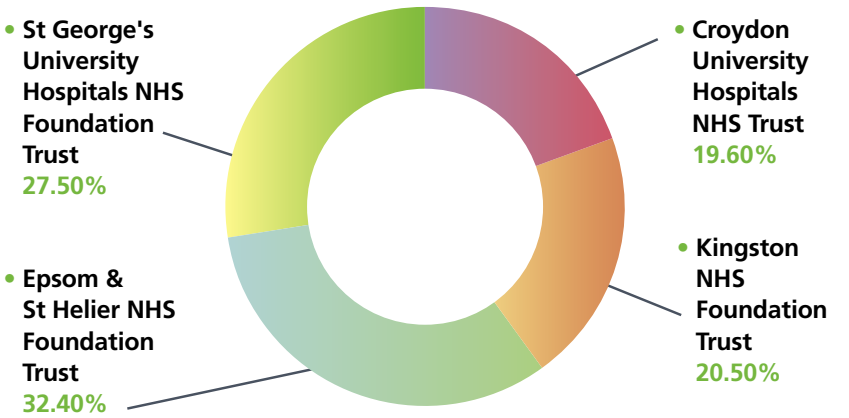
After making enquiries, although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the directors, have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the 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.

Ownership is divided based on full year activity:



South West London Pathology is not a separate vehicle for the three trusts, making this a joint operation as defined by IFRS11. As a joint operation the Trust accounts for its share of the income and expenditure for South West London Pathology.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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 2021/22, 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 2021, 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. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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 recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives 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. The 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.

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.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful 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 (ie 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 and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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.

This includes assets donated to the trust by the Department of Health and Social Care or NHS England 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 HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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.

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	100
Dwellings	3	80
Plant & machinery	1	25
Information technology	3	16
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.

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.

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 historical cost 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. Trust consider amortised historic cost as a proxy measure of current value in existing use. The balance is made up of low value items and any impact from this is will not be material.

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 and 2021/22, 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

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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 of financial assets

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.

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	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 from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

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 1.16 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.

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 2021/22.

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 without restatement and 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. For 2022, this rate is 0.95%. 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 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	156,745
Additional lease obligations recognised for existing operating leases	(156,745)
Net impact on net assets on 1 April 2022	-

Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(13,426)
Additional finance costs on lease liabilities	(1,425)
Lease rentals no longer charged to operating expenditure	14,176
Estimated impact on surplus / deficit in 2022/23	(675)
Estimated increase in capital additions for new leases commencing in 2022/23	4,923

Where the Trust has material PFI or LIFT liabilities with payments linked to a price index From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations 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.

Note 1.26 Critical judgements in applying accounting policies

There were no critical judgements, apart from those involving estimations (see below) that management made in the process of applying the trust accounting policies in the 2021/22 financial statements.

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.

Property, Plant and Equipment valuation including PFI infrastructure assets; estimation of the valuation of Property and Land is based upon professional valuer methodologies for applying modern equivalent asset concepts to the estimation of depreciated replacement cost. This methodology assumes a modern asset equivalent (MEA) approach to valuation of Trust's specialised assets, with replacement buildings being of the same service potential. Inherent within the MEA valuation approach, using the depreciated replacement cost, is the Build Cost Information Service Indices (BCIS) input. The carrying value of assets valued under DRC approach was £243m (part of the £254m land and buildings disclosed in note 14). The valuer uses the latest BCIS information closest to the date of valuation in valuing the Trust's specialised assets. Significant changes in the BCIS indices used valuations would result in a significantly lower or higher carrying value of building assets held by the Trust. For example a 10% +- percentage change in the building assets would result in a decrease or increase in asset values by £8.4m over the next financial year with an estimated decrease/increase to depreciation of £0.3m

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 55% (2020/21 44%) of the Trust revenue with a further 30% (2020/21: 33%) 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)

	2021/22 £000	2020/21 £000
Block contract / system envelope income	851,526	732,759
High cost drugs income from commissioners (excluding pass-through costs)	7,439	6,186
Other NHS clinical income	16,847	38,371
Private patient income	1,419	1,383
Elective recovery fund	26,573	-
Additional pension contribution central funding*	23,793	23,324
Other clinical income	6,455	296
Total income from activities	934,053	802,318

*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)

	2021/22 £000	2020/21 £000
Income from patient care activities received from:		
NHS England	327,959	359,745
Clinical commissioning groups	597,644	439,358
Department of Health and Social Care	-	1
Other NHS providers	1,097	1,445
NHS other	28	90
Non-NHS: private patients	1,419	1,383
Non-NHS: overseas patients (chargeable to patient)	1,803	978
Injury cost recovery scheme	3,991	(709)
Non NHS: other	112	27
Total income from activities	934,053	802,318
Of which:		
Related to continuing operations	934,053	802,318

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

	2021/22 £000	2020/21 £000
Income recognised this year	1,803	978
Cash payments received in-year	323	530
Amounts added to provision for impairment of receivables	977	(1,591)

Note 4 Other operating income

	2021/22			2020/21		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	8,059	-	8,059	8,476	-	8,476
Education and training	38,241	-	38,241	36,934	-	36,934
Non-patient care services to other bodies	70,859		70,859	61,598		61,598
Reimbursement and top up funding	9,420		9,420	62,943		62,943
Income in respect of employee benefits accounted on a gross basis	8,830		8,830	42,665		42,665
Receipt of capital grants and donations		795	795		5,451	5,451
Charitable and other contributions to expenditure		3,565	3,565		18,652	18,652
Other income	3,515	-	3,515	3,106	-	3,106
Total other operating income	138,924	4,360	143,284	215,722	24,103	239,825
Of which:						
Related to continuing operations			143,284			239,825

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

	2021/22 £000	2020/21 £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:

	2021/22 £000	2020/21 £000
Income from services designated as commissioner requested services	934,053	799,103
Income from services not designated as commissioner requested services	143,284	243,040
Total	1,077,337	1,042,143

Note 6.1
Operating expenses

	2021/22 £000	2020/21 £000
Purchase of healthcare from NHS and DHSC bodies	3,420	2,733
Purchase of healthcare from non-NHS and non-DHSC bodies	3,863	1,626
Staff and executive directors costs	642,750	638,409
Remuneration of non-executive directors	149	148
Supplies and services - clinical (excluding drugs costs)	125,793	114,834
Supplies and services - general	32,708	26,832
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	90,363	91,372
Inventories written down	32	237
Consultancy costs	728	1,176
Establishment	6,048	5,371
Premises	38,666	34,358
Transport (including patient travel)	17,970	13,709
Depreciation on property, plant and equipment	28,415	23,603
Amortisation on intangible assets	5,999	5,129
Net impairments	6,586	12
Movement in credit loss allowance: contract receivables / contract assets	(333)	5,489
Increase/(decrease) in other provisions	33	1,411
audit services- statutory audit	113	113
Internal audit costs	140	133
Clinical negligence	26,114	25,911
Legal fees	1,116	802
Insurance	66	49
Research and development	488	2
Education and training	2,991	2,215
Rentals under operating leases	17,560	17,813
Redundancy	49	160
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	7,751	6,563
Car parking & security	985	1,151
Losses, ex gratia & special payments	12	14
Other	9,904	6,845
Total	1,070,481	1,028,220
Of which:		
Related to continuing operations	1,070,481	1,028,220
Audit Fees		
The fees reconciles to the Financial statement as follows		
Statutory Audit Fee	93,750	93,750
VAT	18,750	18,750
Total per Note 6.1	112,500	112,500

Note 6.2 Other auditor remuneration

	2021/22 £000	2020/21 £000
Other auditor remuneration paid to the external auditor:		
1. Audit-related assurance services	-	-
Total	-	-

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

	2021/22 £000	2020/21 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	6,586	12
Total net impairments charged to operating surplus/deficit	6,586	12
Impairments charged to the revaluation reserve	8,726	31,475
Total net impairments	15,312	31,487

Note 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	486,262	491,801
Social security costs	53,759	51,852
Apprenticeship levy	2,178	2,332
Employer's contributions to NHS pensions	78,229	76,555
Pension cost - other	49	53
Termination benefits	84	272
Temporary staff (including agency)	22,189	15,544
Total gross staff costs	642,750	638,409
Recoveries in respect of seconded staff	-	-
Total staff costs	642,750	638,409
Of which		
Costs capitalised as part of assets	-	-

Note 8.1 Retirements due to ill-health

During 2021/22 there were 2 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £210k (£22k in 2020/21).

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 for Health and Social Care 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

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.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	17,560	17,813
Total	17,560	17,813

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	17,560	17,813
- later than one year and not later than five years;	70,239	71,252
- later than five years.	127,113	17,813
Total	214,912	106,878
Future minimum sublease payments to be received	-	-

	2021/22 £000	2020/21 £000
Category of Lease		
Building	210,353	102,072
Other	4,559	4,806
Total	214,912	106,878

Note 11 Finance income

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

	2021/22 £000	2020/21 £000
Interest on bank accounts	34	10
Total finance income	34	10

Note 12.1 Finance expenditure

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

	2021/22 £000	2020/21 £000
Interest expense:		
Loans from the Department of Health and Social Care	243	257
Other loans	80	107
Finance leases	387	482
Interest on late payment of commercial debt	2	6
Main finance costs on PFI and LIFT schemes obligations	2,540	2,625
Total interest expense	3,252	3,477
Unwinding of discount on provisions	(10)	(8)
Other finance costs	-	1
Total finance costs	3,242	3,470

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

	2021/22 £000	2020/21 £000
Amounts included within interest payable arising from claims made under this legislation	2	6

2021/22

The Trust did not dispose of any old plant and equipment in 2021/22 and 2020/21. There were expired leases of £5m in 21/22 with 0 net book value.

Note 13 Intangible assets – 2021/22

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2021 - brought forward	3,482	66,983	70,465
Additions	641	4,763	5,404
Reclassifications	-	1,320	1,320
Disposals / derecognition	(1,926)	(10,470)	(12,396)
Valuation / gross cost at 31 March 2022	2,197	62,596	64,793
Amortisation at 1 April 2021 - brought forward	2,580	25,103	27,683
Provided during the year	382	5,617	5,999
Disposals / derecognition	(1,926)	(10,470)	(12,396)
Amortisation at 31 March 2022	1,036	20,250	21,286
Net book value at 31 March 2022	1,161	42,346	43,507
Net book value at 1 April 2021	902	41,880	42,782

Note 13.1 Intangible assets – 2020/21

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2020 - as previously stated	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 - as previously stated	2,215	20,339	22,554
Provided during the year	365	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 14.1 Property, plant and equipment – 2021/22

	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 2021 – brought forward	49,857	260,007	113	50,501	117,727	38,214	12,327	528,745
Additions	-	9,152	-	30,716	16,865	4,021	157	60,911
Impairments	4,959	(20,271)	-	-	-	-	-	(15,312)
Revaluations	-	(18,725)	-	-	-	-	-	(18,725)
Reclassifications	332	23,869	-	(26,995)	-	1,417	57	(1,320)
Disposals/derecognition	-	-	-	-	(42,752)	(13,466)	(5,150)	(61,368)
Valuation/gross cost at 31 March 2022	55,148	254,032	113	54,222	91,840	30,186	7,391	492,931
Accumulated depreciation at 1 April 2021 – brought forward	-	9,032	20	-	62,091	21,559	8,130	100,833
Provided during the year	-	9,693	4	-	12,311	5,765	642	28,415
Impairments	-	-	-	-	-	-	-	-
Disposals/derecognition	-	-	-	-	(42,752)	(13,466)	(5,150)	(61,368)
Accumulated depreciation at 31 March 2022	-	(0)	24	-	31,650	13,858	3,622	49,155
Net book value at 31 March 2022	55,148	254,032	89	54,222	60,189	16,328	3,769	443,776
Net book value at 1 April 2021	49,857	250,975	93	50,501	55,635	16,655	4,197	427,912

Note 14.2 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 – as previously stated	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	(35,068)	-	-	-	-	-	(31,487)
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	260,007	113	50,501	117,727	38,214	12,327	528,745
Accumulated depreciation at 1 April 2020 – as previously stated	-	(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	-	-	-	-	-	-	-	-
Disposals/ derecognition	-	-	-	-	(2,119)	-	-	(2,119)
Accumulated depreciation at 31 March 2021	-	9,032	20	-	62,091	21,559	8,130	100,833
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 14.3 Property, plant and equipment financing – 2021/22

	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 2022								
Owned – purchased	54,133	190,708	89	54,222	44,541	16,328	3,693	363,713
Finance leased	-	-	-	-	10,097	-	-	10,097
On-SoFP PFI contracts and other service concession arrangements	-	50,536	-	-	-	-	-	50,536
Owned – donated/ granted	1,015	12,788	-	-	5,551	-	76	19,430
NBV total at 31 March 2022	55,148	254,032	89	54,222	60,189	16,328	3,769	443,776

Note 14.4 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 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.

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.

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 100 years.

Plant and machinery asset lives range from 1 year to 25 years Transport equipment asset lives range from 5 years to 7 years. Information technology assets range from 5 years to 16 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.

The Trust's external valuers, Gerald Eve LLP, provided a desktop valuation for land and buildings in 21/22. 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 2022 is £309m (2021 £301m).

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 2022 £000	31 March 2021 £000
Drugs	**4,506**	**4,461**
Consumables	**10,552**	**8,754**
Total inventories	**15,058**	**13,215**
of which:		
Held at fair value less costs to sell	**-**	**-**

Inventories recognised in expenses for the year were £104,252k (2020/21: £105,403k). Write-down of inventories recognised as expenses for the year were £32k (2020/21: £237k).

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 2021/22 the Trust received £3,346k of items purchased by DHSC (2020/21: £18,033k).

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 2022 £000	31 March 2021 £000
Current		
Contract receivables	63,234	57,827
Allowance for impaired contract receivables / assets	(11,881)	(14,700)
Prepayments (non-PFI)	6,816	5,021
PDC dividend receivable	398	362
VAT receivable	5,078	7,598
Other receivables	11,661	16,243
Total current receivables	75,306	72,351
Non-current		
Contract receivables	7,244	8,561
Other receivables	1,348	2,368
Total non-current receivables	8,592	10,929
Of which receivable from NHS and DHSC group bodies:		
Current	37,759	33,606
Non-current	1,348	2,368

Note 19.2 Allowances for credit losses

	2021/22 Contract receivables and contract assets £000	2020/21 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	14,700	9,211
New allowances arising	-	5,489
Changes in existing allowances	(329)	-
Reversals of allowances	(4)	-
Utilisation of allowances (write offs)	(2,486)	-
Allowances as at 31 Mar 2022	11,881	14,700

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 21/22 receivables and there is no material exposure to credit risks.

Note 20 Other assets

	31 March 2022 £000	31 March 2021 £000
Current		
Non-current		
Other assets	-	11
Total other non-current assets	-	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.

	2021/22 £000	2020/21 £000
At 1 April	36,561	3,425
Net change in year	31,984	33,136
At 31 March	68,545	36,561
Broken down into:		
Cash at commercial banks and in hand	52	71
Cash with the Government Banking Service	68,493	36,490
Total cash and cash equivalents as in SoFP	68,545	36,561
Total cash and cash equivalents as in SoCF	68,545	36,561

Note 22.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	35,095	35,924
Capital payables	32,552	36,033
Accruals	92,994	65,934
Social security costs	625	107
Other taxes payable	1,066	-
Other payables	8,362	1,160
Total current trade and other payables	170,694	139,158

Of which payables from NHS and DHSC group bodies:		
Current	10,830	13,604
Non-current	-	-

Note 22.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2022 £000	31 March 2022 Number	31 March 2021 £000	31 March 2021 Number
To buy out the liability for early retirements over 5 years	-	-	-	-
Number of cases involved	-	-	-	-

Note 23 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	11,965	7,648
Total other current liabilities	11,965	7,648

Note 24.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	689	694
Other loans	1,478	1,501
Obligations under finance leases	2,224	2,093
Obligations under PFI, LIFT or other service concession contracts	1,392	1,301
Total current borrowings	5,783	5,589

Non-current		
Loans from DHSC	10,238	10,840
Other loans	2,217	3,695
Obligations under finance leases	5,388	3,558
Obligations under PFI, LIFT or other service concession contracts	37,559	38,952
Total non-current borrowings	55,402	57,045

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 31/03/22 the balance owed by the Trust on this loan is £10.84m.

London Energy Efficiency Fund

2. 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 £1.48m of this loan in 2021/2. As at 31/03/22 the balance owed by the Trust on this loan is £3.69m.

Note 24.2
Reconciliation of liabilities arising from financing activities – 2021/22

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2021	11,534	5,196	5,651	40,253	62,634
Cash movements:					
Financing cash flows - payments and receipts of principal	(602)	(1,478)	(3,425)	(1,301)	(6,806)
Financing cash flows - payments of interest	(248)	(87)	(387)	(2,541)	(3,263)
Non-cash movements:					
Additions	-	-	5,386	-	5,386
Application of effective interest rate	243	80	387	2,540	3,250
Other changes	-	(16)	-	-	(16)
Carrying value at 31 March 2022	10,927	3,695	7,612	38,951	61,185

Note 24.3
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 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 2022 £000	31 March 2021 £000
Gross lease liabilities	8,635	6,418
of which liabilities are due:		
- not later than one year;	2,523	2,378
- later than one year and not later than five years;	4,566	3,158
- later than five years.	1,546	882
Finance charges allocated to future periods	(1,023)	(767)
Net lease liabilities	7,612	5,651
of which payable:		
- not later than one year;	2,224	2,093
- later than one year and not later than five years;	4,025	2,781
- later than five years.	1,363	777
	7,612	5,651

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 2021	885	763	2,487	4,135
Arising during the year	24	-	9	33
Utilised during the year	(119)	(291)	(984)	(1,394)
Unwinding of discount	(10)	-	-	(10)
At 31 March 2022	780	472	1,512	2,764
Expected timing of cash flows:				
- not later than one year;	-	472	164	636
- later than one year and not later than five years;	780	-	53	833
- later than five years.	(0)	-	1,295	1,295
Total	780	472	1,512	2,764

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 2022, £608,770k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2021: £434,848k).

Note 27 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(45)	(50)
Gross value of contingent liabilities	(45)	(50)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(45)	(50)
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 2022 £000	31 March 2021 £000
Property, plant and equipment	4,123	7,305
Intangible assets	-	-
Total	4,123	7,305

Note 29 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 2022 £000	31 March 2021 £000
Gross PFI, LIFT or other service concession liabilities	62,812	66,653
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.	43,608	47,449
Finance charges allocated to future periods	(23,861)	(26,400)
Net PFI, LIFT or other service concession arrangement obligation	38,951	40,253
- not later than one year;	1,392	1,301
- later than one year and not later than five years;	6,614	6,181
- later than five years.	30,946	32,771

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 29.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	223,395	226,255
Of which payments are due:		
- not later than one year;	11,163	10,567
- later than one year and not later than five years;	46,930	44,422
- later than five years.	165,302	171,266

Note 29.2 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2021/22 £000	2020/21 £000
Unitary payment payable to service concession operator	11,592	10,404
Consisting of:		
- Interest charge	2,540	2,625
- Repayment of balance sheet obligation	1,301	1,216
- Service element and other charges to operating expenditure	7,751	6,563
Total amount paid to service concession operator	11,592	10,404

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 2020/21 or 2021/22.

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 in previous years, The Trust has not borrowed funds in 20/21 and 21/22

Note 31.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	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	71,606	-	-	71,606
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	68,545	-	-	68,545
Total at 31 March 2022	140,151	-	-	140,151

Financial assets as per Statement of Financial Position	£000
Trade and other receivables excluding non financial assets	83,898
RTA	(5,078)
Prepayments	(398)
PDC	(6,816)
Total at 31 March 2022	71,606

Statement of Financial Position	
Non Current Receivables	8,592
Current Receivables	63,014
Total at 31 March 2022	71,606

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
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	83,280
RTA	(5,021)
Prepayments	(362)
PDC	(7,598)
Total at 31 March 2021	70,299

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

Note 31.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	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	10,927	-	10,927
Obligations under finance leases	7,612	-	7,612
Obligations under PFI, LIFT and other service concession contracts	38,951	-	38,951
Other borrowings	3,695	-	3,695
Trade and other payables excluding non financial liabilities	169,003	-	169,003
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2022	230,188	-	230,188

Borrowing	£000
Loans from the Department of Health and Social Care	10,927
Obligations under finance leases	7,612
Obligations under PFI, LIFT and other service concession contracts	38,951
Other borrowings	3,695
Total at 31 March 2022	61,185

Statement of Financial Position	
Current Borrowings	5,783
Non Current Borrowings	55,402
Total at 31 March 2022	61,185

Trade and other payables	£000
Trade and other payables excluding non financial liabilities	170,694
Social Security cost	(625)
Other Taxes	(1,066)
Accruals	
Total at 31 March 2022	169,003

Statement of Financial Position	
Current Trade and other payables	169,003
Total at 31 March 2022	169,003

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
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
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	139,158
Social Security cost	(107)
Other Taxes	-
Accruals	
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

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 2022 £000	31 March 2021 £000
In one year or less	177,731	147,673
In more than one year but not more than five years	25,373	25,550
In more than five years	54,086	58,042
Total	257,190	231,265

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.

	2022 Book Value £000	2022 Fair Value £000	2021 Book Value £000	2021 Fair Value £000
Carrying values of financial assets as at 31 March 2022 under IFRS 9				
Trade and other receivables excluding non financial assets	71,606	71,606	70,299	70,299
Other investments / financial assets	-	-		-
Cash and cash equivalents at bank and in hand	68,545	68,545	36,561	36,561
Total at 31 March 2022	140,151	140,151	106,860	106,860

	2022 Book Value £000	2022 Fair Value £000	2021 Book Value £000	2021 Fair Value £000
Carrying values of financial liabilities as at 31 March 2022 under IFRS 9				
Loans from the Department of Health and Social Care	10,927	10,927	11,534	11,534
Obligations under finance leases	7,612	7,612	5,651	5,651
Obligations under PFI, LIFT and other service concession contracts	38,951	38,951	40,253	40,253
Other borrowings	3,695	3,695	5,196	5,196
Trade and other payables excluding non financial liabilities	10,684	10,684	13,383	13,383
Other financial liabilities	158,319	158,319	125,668	125,668
Total at 31 March 2021	230,188	230,188	201,685	201,685

Note 32
Losses and special payments

	2021/22		2020/21	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Special payments				
Ex-gratia payments	39	24	26	354
Total special payments	39	24	26	354
Total losses and special payments	39	24	26	354
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	
	2021/22 £000	2020/21 £000	2021/22 £000	2020/21 £000
Non - NHS Related party transactions				
St George's University of London	4,027	7,509	4,718	7,273
St George's Hospital Charity	564	100	1	-
Epsom	4,134	-	4,396	
Total	8,725	7,609	9,115	7,273

	Receipts from Related Party		Payments to Related party	
	2021/22 £000	2020/21 £000	2021/22 £000	2020/21 £000
Non - NHS Related party transactions				
St George's University of London	1,915	3,809	10,434	2,565
St George's Hospital Charity	1,924	1,304	153	-
Epsom	20,025	-	5,739	0
Total	23,864	5,113	16,326	2,565

2021/22 Related parties

There are no related parties for Directors in 20/21 and 2021/22.

Note 34 Events after the reporting date

There are no known events after reporting date at present.

10. 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 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the 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 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 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 2021 to 2022; 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 2021 to 2022 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 this 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 2021/22 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, 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 2021/22, 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 2021 to 2022).

- 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, 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. We determined that the principal risks were in relation to:

– journal entries which met a range of criteria defined as part of our risk assessment;

– revenue recognition for material streams of non-Block contract/system envelope income and other operating revenue; 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 journals meeting a range of criteria defined as part of our risk assessment;

– evaluating the assumptions and judgments made by management in its recognition of revenue and expenditure at year-end; 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. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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.

- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to the valuation of land and buildings.

- Our 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 England's rules and related guidance

– 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 2022.

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 December 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 – Certificate

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

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

John Paul Cuttle
John Paul Cuttle, Key Audit Partner for and on behalf of Grant Thornton UK LLP, Local Auditor London 23 June 2022


WE
ARE
EXCELLENT
KIND
RESPONSIBLE
RESPECTFUL

Contact us

Giving to George's

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

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

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Grant Thornton

Auditor's Annual Report on St George's University Hospitals NHS Foundation Trust

2021/22

June 2022

Contents

We are required under Schedule 10 paragraph 1(d) of the National Health Service Act 2006 to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the National Audit Office (NAO) requires us to report to you our commentary relating to proper arrangements.

We report if significant matters have come to our attention. 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.

The contents of this report relate only to the matters which have come to our attention, which we believe need to be reported to you. It is not a comprehensive record of all the relevant matters, which may be subject to change, and in particular we cannot be held responsible to you for reporting all of the risks which may affect the Trust or all weaknesses in your internal controls. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

Executive summary

Value for money arrangements and key recommendation(s)

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to consider whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. The auditor is no longer required to give a binary qualified / unqualified VFM conclusion. Instead, auditors report in more detail on the Trust's overall arrangements, as well as key recommendations on any significant weaknesses in arrangements identified during the audit.

Auditors are required to report their commentary on the Trust's arrangements under specified criteria. As part of our work, we considered whether there were any risks of significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Our consideration of this is included within each the three themes noted. Our conclusions are summarised in the table below.

Criteria	Risk Assessment	Conclusion
Financial sustainability	At the planning stage of our audit we did not identify a significant weakness because planning guidance had not been issued and it was unclear what the financial arrangements would be for 2022/23. We updated our assessment based on the release of planning guidance and the submissions the Trust has made in relation to its 2022/23 plans. We concluded there was a potential risk of significant weakness in relation to the Trust's arrangements to adhere to the financial architecture for 2022/23 and plan for longer-term financial sustainability.	We concluded there are no significant weaknesses in arrangements but improvement recommendations have been made and we note the challenges the Trust faces in the next 12 months in terms of delivering a deficit budget with unidentified CIPs schemes and pressure on cash balances. Management are aware of the challenges and are reporting the position to the Board and engaging with NHSI/E on potential actions but are in a difficult position when there is such uncertainty in sector. A further iteration of the plan is now required by NHSEI from systems and providers and is due by 20 June 2022, it is anticipated that there will be a focus on all systems coming back into balance for the June submission and therefore improvement to the existing planned position is expected. We will review the Trust's financial performance arrangements at month six of 2022/23 year focusing in particularly on whether a fully identified CIP programme is in place and reported against and that there is no adverse position on cash balances that could lead to the Trust running out of working capital. Not all prior year recommendations have been fully implemented and will be followed up in 2022/23.
Governance	No risks of significant weakness identified	No significant weaknesses in arrangements but improvement recommendations made. We note one recommendation from the prior year have not been fully implemented and will be followed up in 2022/23.
Improving economy, effectiveness and efficiency	No risks of significant weakness identified	No significant weaknesses in arrangement or improvement recommendations made. We note two recommendations from the prior year have not been fully implemented and will be followed up in 2022/23.

Commentary on the Foundation Trust's arrangements

All Foundation Trusts are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. The Trust's responsibilities are set out in Appendix A.

Foundation Trusts report on their arrangements, and the effectiveness of these arrangements as part of their annual governance statement.

Under Schedule 10 of the National Health Service Act 2006, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The National Audit Office's Auditor Guidance Note (AGN) 3, requires us to assess arrangements under three areas:

Financial Sustainability

Arrangements for ensuring the Trust can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years).

Governance

Arrangements for ensuring that the Trust makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, and ensuring the Foundation Trust makes decisions based on appropriate information.

Improving economy, efficiency and effectiveness

Arrangements for improving the way the Trust delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

Our commentary on each of these three is set out on pages 5 to 15. Further detail on how we approached our work is included in the Executive Summary.

Financial sustainability

We considered how the Foundation Trust:

- identifies all the significant financial pressures it is facing and builds these into its plans
- plans to bridge its funding gaps and identify achievable savings
- plans its finances to support the sustainable delivery of services in accordance with strategic and statutory priorities
- ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning
- identifies and manages risk to financial resilience, such as unplanned changes in demand and assumptions underlying its plans.

Overview

2021/22 has continued to be an exceptional year in terms of financial planning and performance with funding being received to aid trusts to work towards breakeven positions allowing them to focus on COVID-19. Funding arrangements have changed looking forwards and as such financial sustainability is once again a priority for the sector.

Overall, the Trust has performed ahead of its financial target for the year as a result of the funding arrangements in place, however an underlying pre-pandemic deficit and ongoing cost pressures continue to be a challenge for the Trust. The 2022/23 plan has been developed and submitted to NHSI/E proposes a deficit position planned for the year. Although the proposed deficit has decreased in each iteration of the draft achievement is reliant on a significant level of savings. The Trust does not have sufficient cash reserves, based on current plans, to provide sufficient contingency for any slippage or risk to the plan. The Trust is currently in discussions with NHSI/E in order to find a solution to this issue and therefore arrangements are ongoing. At the time of reporting, there is insufficient evidence to determine whether there is a weakness in arrangements around the 2022/23 financial plan given it is early in the year. Therefore, we plan to review arrangements in six months when there is evidence to support the progress against the 2022/23 plan.

2021/22 Performance

In 2021/22, the majority of the Trust's income was received from its commissioners in the form of block contract arrangements, the funding envelopes which determined the level of funding received by each Trust were agreed by the South West London Integrated Care System (SWL ICS). The Trust has also received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services through the pandemic. The aim of this funding regime was to allow the sector to focus on the response to the pandemic and be funded to a breakeven position to support this aim.

At year end the Trust has reported a £7.2m deficit per the accounts, however once the impact of accounting adjustments are removed the outturn position as reported to Board is a surplus position of £118k. The Trust was set a target for the year of £5m deficit, however the overall expectation within the sector is that Trusts should breakeven as a result of the funding mechanisms in place. As such the Trust has performed in line with expectation and under the COVID-19 funding regime has demonstrated that it has sufficient income to cover its expenditure. Although it should be noted additional financial support from the system was required to enable the Trust to breakeven, in addition to the national funding regime.

Performance of a Trust is also reflected by the NHS Single Oversight Framework (SOF). NHS England and NHS Improvement (NHSEI) have allocated trusts and ICSs to one of four 'segments. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). The Trust has been included in segment 2 which provides positive assurance that they are deemed to require a lower level of support. The segmentation decision includes factors such as governance arrangements, financial performance and quality of services and therefore confirms that the Trust has appropriate arrangements across these areas for 21/22 since the segmentation decision was implemented in July 21. This demonstrates that the Trust has continually improved up until this point in relation to these areas following the historic inclusion in the Financial Special Measures regime, from which it was removed in 2019.

Financial sustainability

2022/23 Financial Plan

As per the 2022/23 planning guidance the Trust was required to submit, via the ICS, a draft financial plan 17th March 22 and a final plan 28th April 22, these deadlines were appropriately complied with and there was a strong level of liaison with the ICS throughout to ensure that assumptions were aligned and plans submitted as required. The Trust submitted an initial draft plan of a deficit of £81m which contributed to a system level deficit of £189m. Both were considered to be significant when compared to other trusts and systems in the London region. Following ongoing discussion, additional efficiencies committed to and updated assumptions on income and expenditure the Trust was able to submit a final plan of £50.8m which has contributed to a reduction on the ICS level deficit, now sitting at £145m. A further iteration of the plan is now required by NHSEI from systems and providers and is due on the 20th June 2022. This is expected to include notification of additional inflation funding, which will further reduce the current plan deficit, but the value of the inflation funding is not yet confirmed to systems. It is anticipated that there will also be a focus on all systems coming back into balance for the June submission.

The underlying recurrent financial position, removing all one-off funding sources, was £57m pre-pandemic. This has increased to £132.8m at the end of 2021/22 prior to any mitigations identified by the Trust and assumptions in relation to 2022/23 funding were accounted for. As such the 2022/23 planned deficit is an improvement on the underlying position. However, there is no evidence of a sustained and embedded plan to reduce the deficit further over time as there has been limited progress on medium term financial planning beyond 22/23. The 22/23 plan finalised in April 22 is a key building block in developing this medium term view, the planning guidance has only been released for one year and completed in early 22/23. As such the Trust has complied with the guidance in producing its business plan and has taken steps to fully understand its underlying deficit, the Trust therefore has the information available and has undertaken the work necessary to produce a medium term plan but there are inherent risks to both the income and expenditure position that could increase the gap if materialised. Therefore, the Trust is planning to revisit the medium term plan in early 2022/23 in order to benefit from reduced uncertainty in assumptions. This is a similar situation across the sector, as such the Trust is not an outlier.

The Trust has identified several risks which could impact the ability to achieve the proposed financial position. There are uncertainties which are commonplace within the sector that we would expect the Trust to have identified and these include inability to reduce COVID-19 costs as planned, delivery of planned savings less than expected, inability to achieve the level of activity required to achieve Elective Recovery Funding (ERF) and inflation on costs exceeding inflation included in national funding. We reviewed the risks and have noted there there is limited consideration at this point in the planning process regarding actions to deliver against the unidentified savings targets, and therefore the risk associated with this. In addition ,although appropriate risks have been identified, there is limited evidence of the impact of these being estimated in monetary terms. As such we would recommend that the Trust revisits risks to the plan in full on an ongoing basis to ensure they are complete, undertake work to estimate the impact and develop clear mitigations for each. This will improve transparency of the risks and ability to monitor progress against the risk throughout the year. (Recommendation A)

All other assumptions in the plan have also been agreed as appropriate and in line with the planning guidance, the environment the Trust faces and local discussions with the ICS. As such there has been no further risk, over and above that identified by the Trust (and our points made on potential omissions), to the plan identified in our work.

Consideration has been given to the reserves the Trust holds as a contingency to support the deficit. The Trust undertake regular monitoring of the cash position and report this monthly via the finance report. The Trust will enter 2022/23 with £68m at the start of April 22, however in order to support the £50.8m deficit plan the Trust is anticipating cash reserves reducing to £3m at the end of March 23. Cashflow forecasting suggests that there is an average of £5.5m monthly outflow (although this is variable each month) which would result in the Trust not having sufficient cash to support the Trust beyond March 23. In addition, the Trust has identified several risks to the plan and although there is limited information on the estimated value of these, any additional risk or under delivery on planned savings could not be supported by the cash reserves held. We are aware that the Trust has initiated discussions with the local health system and NHSE/I in order to identify a solution and therefore arrangements remain ongoing at year end. It is vital that a solution to the Trust's cashflow is identified in order for the Trust to remain financially viable beyond 2022/23. Therefore we will re-review whether there is a weakness in the Trust's arrangements in six months time. At that stage, if cashflow is progressing below expectation, the Trust is performing behind its planned financial position, or any risks to the plan are materialising and unmitigated (such as CIPs remaining unidentified or not delivering as planned), then there could be evidence to suggest a weakness exists.

Financial sustainability

Each iteration of the financial plan has been presented to the Finance and Investment Committee and there is evidence of a good level of discussion at each meeting. The documentation presented to the Committee is detailed with several appendices which clearly identifies issues driving the deficit position, changes since the last iteration and input from discussion via the ICS. The Committee has also been updated on how the Trust's position feeds into the overall ICS proposed plan. As noted in our governance work the reporting structure is robust and as such the oversight of the plan has been comprehensive.

Cost Improvement Plans (CIPs)

COVID-19 has meant the Trust has received additional funding in 2020/21 and 2021/22 to deliver a balanced budget and as such has not been required by NHS guidance to develop and track performance against a Cost Improvement Programme (CIP) as it would have been prior to the pandemic. In 2019/20 the Trust delivered £42.8m of savings via CIPs which was £3m below the £45.8m target set by the Trust, as such it achieved 94% of its original target. Although this is a contributor to the pre-pandemic underlying deficit, a driver in the planned 2022/23 deficit position, the under delivery was relatively small compared to the underlying deficit and level expenditure in that year. Given that the Trust now faces different operational pressures than in 2019/20, as COVID-19 pressures will need to be managed on a continual basis, prior years are not a reliable source of evidence on savings performance.

The 2022/23 planning guidance expects that Trust will need to make cost savings by developing CIPs in 22/23. The Trust's 2022/23 plan therefore includes £58.2m of CIPs which need to be made for achievement of the £50.8m deficit position. The level of CIPs has increased with each iteration of the plan and discussion with the ICS has led to stretching targets for all providers in the system. The target for the Trust represents 5.5% of total expenditure (4.5% of operating expenditure) and is greater than the total deficit position proposed. As such the target is deemed to be a significant challenge.

Upon submission of the final 2022/23 plan the Trust has assumed that 73% of the CIPs will be delivered recurrently, this is positive in terms of financial sustainability as this means the benefits of the efficiencies will impact more than one financial year, therefore reducing pressures to find additional savings in future years. Of the £58.2m of CIPs the Trust has been able to identify £45.5m at a high level, however there is limited evidence of individual projects plans in place for these identified schemes at the start of 2022/23 and as such there is limited assurance as to reliability of savings plans. Information provided suggests that the Trust is profiling the development of unidentified savings schemes into the latter part of the financial year. From our experience one of the most common causes of not meeting a CIP target by year end is the fact that schemes are unidentified at the start of the year. A high level of unidentified schemes in the first quarter means the Trust has a shorter time frame with which to take the necessary actions to achieve the savings required. It will be important there is no slippage in the savings plan to minimise the risk in the financial plan, as we have noted the Trust does not have sufficient reserves to respond to the risk. Therefore, we recommend that the Trust maximises the probability of the full savings target included in the 2022/23 financial plan by prioritising identification of £12.7m of unidentified savings early in the financial year, as well as ensuring that detailed project plans are in place for already identified savings. (Recommendation B)

The financial management culture at the Trust ensures that divisions are actively engaged in the process of developing and delivering savings. Divisional teams are encouraged and expected to develop their own CIPs and then work to deliver them autonomously. Divisions are supported in developing their CIPs by the Director of Financial Improvement using reliable sources of information, such as get It Right First Time (GIRFT) metrics and Model Hospital, on potential productivity and efficiency opportunities to allow CIPs to focus in the areas where the most benefit may be achieved. Under regular circumstances savings monitoring is undertaken through a fortnightly divisional review meeting between the Director of Finance and the divisional leads. Formal monitoring of CIPs by the decision makers at the Trust is usually undertaken via the finance report taken to Executive, Finance and Investment Committee and Board. For 2021/22 as there has been limited evidence of reporting and CIP development due to there not being a requirement to have schemes in place to meet the financial target. However, prior to the pandemic, the established process for monitoring savings was deemed to be comprehensive. The CIP target for 2022/23 is substantial and has some associated risk, therefore it will be paramount that performance continue to be monitored by the established process and finance reports are updated to ensure that there is sufficient oversight at the top tier of the organisation. It is important tracking is undertaken at individual project level or division level so that underachieving schemes can easily be identified and actions taken in a timely manner. It is our understanding that the rigour previously observed in monitoring savings is expected to be re-instated in 2022/23 and therefore will be assessed in our 2022/23 audit.

Financial sustainability

Capital

The Trust reported on its capital programme throughout 2021/22 via the monthly finance report, the same level of detail was reported to both Finance and Investment Committee and Board. This ensures that decision makers have information on capital by categories of spend, and scheme level where projects benefit the system. Year to date performance, full year budget and expected year end position are clear in the reporting and therefore decision makers have sufficient information to identify and take action on variances easily. The Trust has a capital plan for the 2021/22 financial year of £67m, of which it spent £65.8m. The variance of £1.2m is due to one specific diagnostics project that has under delivered and therefore is not a pervasive issue suggestive of weaknesses in the capital management process. 1.7% slippage on a £67m plan not deemed to be a significant pressure on future years. The Trust had an initial plan of £56m however updated its reporting over the year to account for additional investments made possible as a result of Target Investment Funding (TIF) and additional Public Dividend Capital (PDC) outside of its initial capital allocation. This demonstrates effective capital planning, as although £1.2m of the plan has not been achieved the Trust has quickly mobilised additional schemes to take advantage of additional funding and undertaken more work for the benefit of service users.

The Trust takes a risk based approach to capital planning and for 2022/23 has submitted a capital programme of £69.4m from known capital allocation, internal funds and external funding. The Trust has produced a plan in line with the capital allocation agreed with the ICS for 2022/23 with a further £41m of unfunded schemes, and £3m of other requests that are incomplete schemes. Unfunded schemes are risk based, i.e. if there is any slippage or additional funding available the completion of these schemes is prioritised according to need and impact This prioritisation process is commonplace amongst large acute Trusts and seen as effective capital management, it avoids the need to postpone or cancel inflight schemes which would be a bigger risk to finances (due to loss of sunk costs or penalty clauses in contracts for example) and service.

Governance

We considered how the Foundation Trust:

- monitors and assesses risk and gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud
- approaches and carries out its annual budget setting process
- ensures effectiveness processes and systems are in place to ensure budgetary control
- ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency
- monitors and ensures appropriate standards.

Overview

Governance is the system by which the organisation is controlled and monitored to ensure that decisions can be made effectively and the relevant people within the organization held to account.

Our work in the prior year established the Trust had an appropriate governance framework, policies and procedures in place. For 2021/22, the risk management process and strategy remains largely consistent with the prior year and arrangements in terms of committee structure, reporting via those structures, policies and procedures and assurance processes remain the same. The key change in governance arrangements for 2021/22 relates to the implementation of a shared management structure, which now includes the Trust Chair, Chief Executive and Senior Executive, with Epson St Helier University Hospital NHS Trust (ESH).

Overall we have not identified any weaknesses in governance arrangements for 21/22, however we have identified some potential improvements that could be made in order to ensure the Trust is demonstrating best practice in this area.

Risk Management

The Trust's risk management arrangements are set out clearly in the Risk Management Policy which was last updated and approved by Audit Committee in March 2021. The Trust continues to manage strategic risk effectively via the Board Assurance Framework (BAF), operational risk via the corporate risk register and specific departmental risks via the divisional risk register. The number of risks continues to be manageable and within expectation, there is a clear distinction between operational and strategic risks between the registers and we have not noted any obvious risks omitted based on the Trust activities or operating environment.

The reporting of risks via the Trust Board, Board sub-committee structure and Executive remains consistent with the prior year and continues to ensure risks are reviewed sufficiently frequently. Risks generate a good level of discussion at Board and its sub-committees, with input observed from a variety of corporate and clinically focused individuals as well as a range of Non-Executive Directors (NEDs). The discussion is well documented which provides transparency to Trust stakeholders on not only the risks the Trust faces, but actions being taken and who is accountable for the success or failure of those actions.

The format of the BAF has remained consistent and is presented in three different formats including a simplified list, executive summary and in depth reporting per individual risk. The Trust effectively balances providing decision makers with the detailed information it needs to make informed decisions around risk, whilst also ensuring it is not overwhelmed by information and, as such, is able to focus on key issues at each meeting.

We made a recommendation in the prior year that there was a possibility that corporate risk (and to a lesser extent BAF risk) scores were either not being appropriately adjusted, or that controls in place were doing little to impact the scoring outcome. Within the BAF all risks scores have reduced from July 2020 when initially identified and unmitigated, however most scores have remained stable during the year with the exception of Strategic Risk 9 relating to workforce (this is reflective of the challenges noted in the Trust's workforce reporting and Integrated Quality and Performance Report (IQRP) around agency staffing in particular. There is evidence that deep dives and discussions on scoring do take place by the Board and sub-committee throughout the year in relation to each risk and as such are satisfied there is an effective mechanism in place for adjusting risks should that be required.

Governance

Previously the Corporate Affairs Officer was responsible for updating and facilitating discussion on the BAF and Chief Nurse was responsible for the corporate risk register. For 2021/22 onwards the Group Corporate Affairs Officer will be responsible for both registers to ensure a consistent approach to scoring is in place, therefore upholding the integrity of both aspects of risk management whilst ensuring a clear distinction between operational and strategic risks continues. From the 1 February 2022, the Trust has established a group shared management structure with ESH and there is now a joint Trust Chair, Chief Executive and executive Management Team. The Trust has reviewed the BAF and corporate risk register as part of establishing the group model and will be regularly updated until the aim of having a single in common policy for risk management across both Trusts and commonality of risk scoring, templates and reporting is achieved. Currently risk associated with the close working arrangements with ESH are included in Strategic Risk 4 and therefore have sufficient oversight via this route.

Budget Setting Process

For 2020/21 and 2021/22 the Trust, like the rest of the sector, has been funded to a breakeven position with pre-agreed funding and top up income received from central government to allow a focus on responding to the pandemic, as opposed to financial performance and activity targets. However, the planning guidance for 2022/23 was released in December 2021 confirming the sector would no revert to funding arrangements similar to pre-COVID-19.

The Trust's budget setting process is a combination of a top-down approach, where initial modelling undertaken by finance is shared with divisions, and a bottom-up approach where finance work with divisions to understand operational pressures, risks and opportunities and incorporate these into the budget. This ensures that the budget, at each stage of its development, is realistic in its assumptions from a financial and operational perspective. There is a substantial level of engagement between finance and the divisions throughout the process demonstrated by fortnightly meetings and detailed presentations between the two disciplines which increases the commitment of teams to the plans developed. The Finance and Investment Committee have received several iterations of the budget as it has been developed which demonstrates a good level of scrutiny and transparency before final approval by Board. This is an effective process.

Reporting in relation to the budget, provided to Finance and Investment Committee, is appropriately detailed, explains the 2021/22 underlying position, 2022/23 assumptions, identified and unidentified mitigations and additional risks and opportunities. The information is presented in multiple formats (narrative, tables and graphs) and therefore it is accessible and easily understood.

By virtue of the NHSEI planning guidance, the Trust is expected to develop its financial plan in liaison with the local health system and there is extensive evidence to confirm this has taken place with the South West London Integrated Care System (SWL ICS). The Trust has developed its own financial, activity and workforce plans and has liaised with the ICS via fortnightly Director of Finance meetings with other ICS members to align assumptions and include these within each iteration of Trust plans. In addition, each time the plan is presented internally there is inclusion of the SWL position split by Trust to ensure the Board have a full picture of the region and can understand the Trust position within it. This is effective reporting, and coupled with quarterly reporting of the SWL financial position and the narrative detail in the planning documents explaining local assumptions, the Trust have effectively responded to the prior year recommendation in relation to greater clarity between ICS and Trust assumptions within the lines of the budget.

As noted, the Trust has a shared management team and is developing longer term governance arrangements with ESH. Given the governance arrangements were still in development at year end, the two Trust's are responsible for their own performance per the NHS guidance and are funded as separate organisations. Evidence confirms that the Trust plans incorporate only St George's activity, costs and funding, although ICS level information is included which includes ESH. The presentation of the plan has been amended slightly during its various iterations so that formatting is aligned with ESH and allows management o easily compare the two Trusts. As such, the planning process reflects the structure in place at the end of 2021/22.

The Trust is limited in the medium term forecasting it has undertaken as a result of the planning guidance only being released for a one year time frame by NHS England and NHS Improvement (NHSEI). The Trust has therefore complied with the guidance in producing its business plan for this period and has plans to revisit it medium term planning in Q1 of 22/23.

Financial Reporting

As per sector practice, the Trust monitors and reports on its finances on a monthly basis. Information is collated by the Finance Team with input from the divisions and is effectively reported through the governance structure for scrutiny by the Trust Executive Team, Finance and Investment Committee and Board. Each forum receives information in a timely manner which means that decision making is based on up to date information, there is no more than a one-month lag in information.

Governance

Throughout the year the Trust has focused on presenting actual vs budgeted position at Trust level and broken down by income, pay expenditure, non-pay expenditure and other factors such as ERF, capital, cash and COVID-19 costs. Given the Trust will be committing to a deficit position for 2022/23 per its plan (see Financial Sustainability), it may be of benefit to present financial performance in more detail at at divisional level to the Finance and Investment Committee and summarised to Board. The existing arrangements are appropriate given the current funding and financial outturn but the Trust may benefit from reporting in a greater level of detail in 2022/23 when it will be dealing a more financially challenging position. We note that the Trust reports a greater volume of information in the existing finance report to the Finance and Investment Committee than Board to reflect the decision making hierarchy in place at the Trust, as such to ensure this distinction continues to be made divisional reporting would be most beneficial to the Committee rather than Board (Recommendation C)

The Trust's financial reporting does include a forecast, as well as a comparison of actual to budget, however this element of the budget monitoring process only came into effect in the finance report after month 8 of 2021/22. Given that there is more uncertainty and less COVID-19 funding expected for 2022/23 we would expect that the impact of in year variances on the year end position is included and monitored from an earlier stage in the financial year so the Finance and Investment Committees are aware as early as possible if the Trust looks to be deviating from planned outturn and can take action accordingly. Given that the newly approved plan is likely to still be embedding during the first quarter of the financial year reporting performance against forecast would be of most benefit from month 4 onwards. (Recommendation D).

Engagement

We have confirmed that decision making at the top levels of the organisation is effective and underpinned by a strong, open and supportive culture at the Trust which has been achieved by:

- Effective monitoring of the risk of not creating an open and inclusive culture via the BAF, good progress and control assurances are reported across all related actions
- The 'Freedom to speak up Guardian (FTSU)' is now prevalent across most NHS Trusts including, St George's. The Board receives a quarterly update from the FTSU Guardian which positively reinforces an appropriate tone set by those at the top tier of the organisation. This is supported by a clear FTSU Vision and Strategy which was approved by Board in Sept 2020 and is well embedded.
- A Workforce and Education Committee, which meets monthly, committed to improving specific workforce issues and empowering staff through specific projects
- The most senior members of the Trust, including the Chief Executive and Chief Medical Officer, are regular attendees at Board and at Board sub-committees. This sets the tone from the top demonstrating accountability to scrutiny across all aspects of the Trust
- Reporting throughout the Trust is open and factual and does not avoid the difficult conversations or seem to ignore adverse results.

An area of good practice in terms of decision making is the involvement of key stakeholder within those decisions, whether that be internal or external to the Trust, to ensure that decisions are as effective as possible and encompass a range of ideas. The Trust evidences its commitment to gaining this additional level of insight via regular staff/patient case study stories taken to Board meetings and gaining service user feedback.

The Trust reports on complaints as part of its IQPR. Trust performance is in line with the prior year and therefore shows that despite a challenging year some other patient experience metrics, such as wait times, the Trust has been able to uphold a consistent level of service. The Trust's website clearly identifies how patients can make complaints and compliments and therefore clearly welcomes feedback of this nature. Ac a complimentary measure the Trust reports the Friends and Family Test results, both response rate and recommendation rate, monthly as part of its IQPR also. Overall the Trust scores highly across most points of delivery in this area which demonstrates both a strong level of engagement and service quality.

Governance

Compliance

The Trust 'Managing Conflicts of Interests Policy' provides effective guidance on how and who should make declarations on interests at the Trust, decision makers are required to make these at least annually. Results are published on the Trust website for transparency. There is a standing item in place at the beginning of all board or committee meetings for members to make declarations related to that meeting. Review of meetings shows that interests are regularly declared.

We made a recommendation in the prior year in this area in that the Trust had poor performance in terms of the percentage of decision makers making declarations, it was accepted that many would be nil returns and that these should be encouraged in order to increase compliance. The Trust has taken several steps in 21/22 to improve compliance and these have included:

- Monthly check-ins with decision makers to obtain returns, as opposed to the previous year-end exercise
- Targeted communications to specific groups - namely nil returns and decision making staff
- Proactive communications of gifts and hospitality returns at key points in the year such as Christmas
- Messaging from Chief Executive to staff on the issue to ensure the importance is stressed
- Trust-wide communication of the policy and need to make declarations via the intranet

The Trust uses the Declare system for staff to make declarations which does make declarations easy to complete and returns standardised. The Declare system confirms that 51% of decision makers have made a declaration for 2021/22, indicating that whilst improvements have been made the Trust needs to continue encouraging declarations to be made to support compliance in this area.

As the Trust now operates under a group model with ESH, key decision makers hold decision making positions at both Trusts. In line with the Trust constitution and Trust policies these individuals would need to declare interests and potentially remove themselves from Board and Committee meetings where decisions are made in relation to the interests they hold. The aim of the new structure is to collaborate and make consistent decisions for the benefit of patients at both Trusts. This aim would be difficult to achieve with a lack of transparency in the information being shared between the two Trusts. The Trust Board have therefore taken the decision to authorise allowable conflicts of interest as the collaboration of the Trusts is a benefit to patients. The decision was appropriately authorised via the Trust Board and Committee structure and having reviewed the decision we have confirmed that it is acceptable in line with the Trust's Constitution.

Improving economy, efficiency and effectiveness

We considered how the Foundation Trust:

- uses financial and performance information to assess performance to identify areas for improvement
- evaluates the services it provides to assess performance and identify areas for improvement
- ensures it delivers its role within significant partnerships, engages with stakeholders, monitors performance against expectations and ensures action is taken where necessary to improve
- ensures that it commissions or procures services in accordance with relevant legislation, professional standards and internal policies, and assesses whether it is realising the expected benefits.

Overview

Ensuring the Trust achieves economy, effectiveness and efficiency involves ensuring arrangements are in place to use the available resources to achieve the overall objectives (effectiveness), achieving the maximum service levels with the available resources (efficiency) and balancing revenue and costs effectively in the process (economy).

Performance Reporting

The process of review and scrutiny of non-financial performance is well established and embedded at the Trust and remains in consistent with the prior year. Non-financial performance is presented via the Integrated Quality and Performance Report (IQPR), is sufficiently detailed, has metrics which effectively represent the Trust's activities, operating environment and nationally expected standards and with no obvious omissions. In 2020/21 we recommended the Trust consider including the performance of other trusts in its performance reporting with the purpose of explaining certain ICS independencies but also comparison with similar organisations. Actions taken against existing metrics in the IQPR do reference collaborative activities with the ICS therefore Board members do have appropriate information to understand how working with the local health system impacts performance. However the Trust does not present comparative performance of other Trust's performance when reporting its own KPIs. Without this context it is difficult for stakeholders to understand the relative performance of the Trust and the trade-offs made between Trusts in the ICS. The Trust has this information available as reporting to NHSE for the ICS comprises system and individual Trust performance, with detail on mutual aid and the impact of speciality hubs reported in the quarterly 'deep dives' with NHSE on SWL elective recovery performance.

The Trust undertakes regular benchmarking using Model Hospital and Get It Right First Time (GIRFT) tools. Although the results of these exercises are not included within the IQPR, or a regular benchmarking report to Board, there is evidence that the tools have been used for specific reports or investigations in year where relevant.

The format of the IQPR allows for effective scrutiny as it presents information in an accessible way with a combination of numerical metrics, graphical representation and narrative clearly explaining actions to be taken. There is only a one-month lag between the performance being observed and presented, allowing for decisions to be made on relevant and timely information.

A key factor in whether at Trust can achieve economy, effectiveness and efficiency in its performance is its ability to effectively monitor and realise the benefits and savings it plans at the start of the financial year. Ordinarily savings and benefits would be reported monthly via the finance report, which included performance against the Cost Improvement Programme (CIPs). Whilst the requirement for formally delivering CIPs was not required in 2021/22 due to COVID-19 the Trust did set an internal savings target although we note it significantly underdelivered.

Prior to COVID-19, the progress of savings were monitored through a tracker maintained by Finance, and management has confirmed this process will be re-instated in 2022/23. have confirmed that they plan to reinstate this in 2022/23.

Improving economy, efficiency and effectiveness

Benchmarking

Via our own internal benchmarking tool we investigated several areas where the Trust was performing below the national average based on publicly available. The Trust was able to provide up to data to demonstrate performance had improved or actions are in place to respond as appropriate. The areas highlighted by our work were performance in relation to costs of delivering care, revenue per activity unit, staff stability and friends and family test for outpatients specifically. We found that the Trust had ongoing arrangements in place to fully understand the cost pressures facing the Trust via the planning cycle and support from the local health system clinical networks to ensure an appropriate distribution of activity by complexity across providers – these actions are key in responding to the financial metric findings. Staff turnover is sector wide issue through the pandemic however the Trust has taken steps to understand the underlying cause and take targeted action. The Trust is performing in line with its own target in relation to the friends and family test and therefore no issues were identified.

Quality Performance

The Trust identifies service failings via its rating by the care Quality Commission (CQC) across its key domains and via its own internal performance reporting. The Trust IQPR rates performance via a balanced scorecard where red rated performance is suggestive of performance issues that are either a sign of significant decline or sustained poor performance. The IQPR for 2021/22 identifies challenging performance in emergency flow, cancer waits and on the day cancellations. Referral to treatment (RTT) and diagnostics waits are two areas of performance concern across acute providers at the moment although St George's performance is showing improvement and stabilisation during the period. Improving performance is in part due to a mature ICS relationship and well-developed collaboration allowing the Trust to benefit from mutual aid transferring patients within the ICS, shared Patient Tracking Lists (PTL) within the ICS, a weekly Elective Care SWL Network and support from SWL wide clinical networks. Further elective recovery is planned for next year as four new theatres have also been added to the Trust estate to further improve the Trust and ICS's elective capacity.

To improve the Emergency Department performance the Trust has taken extensive actions which include a capital plan to expand Same Day Emergency Care (SDEC) and Medical Ambulatory capacity, working with London Ambulance Service to reduce out of borough arrivals and worked with Merton and Wandsworth and community providers to increase overall bed capacity. We made a recommendation around A&E plans needing to be kept under review last year and the actions identified are evidence this has taken place. The challenging performance observed is reflective of the sector demand and not a lack of response by the Trust. The A&E 4-hour target is set at the national expected level of 95%, a target unchanged since pre-COVID-19 yet attendances have nearly doubled since the start of the pandemic at the Trust. As such, a target based on pre-pandemic trends seems unrealistic and therefore performing below the target is not evidence of service failure. The Trust can demonstrate it is continually monitoring and reacting to Emergency Department flow and pathway positively and as such we are satisfied that the actions taken are robust and respond to our recommendation from prior year.

The Cancer service reports extensively across numerous metrics in the IQPR including on the 2 week wait which is the general focus in the sector. This metric has seen a decline during the year and Trust understands the underling cause is an increased number of referrals since pre-COVID-19 and the suspension of breast screening at various points during the pandemic which has increased the backlog. A comprehensive range of actions have been taken which are clearly reported including mutual aid from the Royal Marsden, increasing the number of triple assessment clinics and a further recovery plan to divert referrals to other ICS providers. We are satisfied that whilst clearing the backlog will be a challenge there is evidence of continued action by the Trust and collaboration with the ICS.

On the day cancellations reporting clearly shows that the performance is due to bed and capacity issues and the Trust is aware of which specialty and department each cancellation relates to as performance is well tracked. The actions in the IQPR are extensive and include new policies, awareness of existing policies to staff and further review. These are positive actions and the performance in January 2022, which saw a decline, is specifically linked to the Omicron outbreak which increased beds required for COVID-19.

The last CQC inspection was 2019 and the Trust was rated 'Requires Improvement'. The Trust has a comprehensive action plan in place to respond to all of the recommendations from the inspection, the Executive are regularly updated on progress and determine whether actions can be closed when they are satisfied they have been completed. In addition, the Trust has regularly liaised with the Trust Patient Safety & Quality Group and the Quality Governance Committee throughout the year to update them on progress on specific actions. By May 2021 the Trust had completed 40 of the 46 improvement actions with robust supporting evidence. The remaining improvement actions were incorporated into business-as-usual plans with exception reports presented as required. The Executive have confirmed all actions as closed and the effectiveness of the actions will be assessed upon reinspection by the CQC for which there has been no plan communicated.

Improving economy, efficiency and effectiveness

Partnerships

The partnership with the local health system is well established, supported by a SWL system-wide governance framework which includes a comprehensive allocation of responsibilities through the Trust, provider collaborative and ICS to ensure appropriate governance is directed at each level of the organisations. The framework enables a collective model of responsibility and decision-making however there is a sufficient framework in place to ensure decisions are not being taken in the ICS which do not meet the interests and aims of the Trust and vice versa. Our work confirms that the Trust is well engaged with the ICS via various role specific forums such as the Directors of Finance Group, Chief Operating Officers Group, Chief Executive Group and more formally the SWL Steering Group and the Partnership Board. Decisions made at ICS level are effectively communicated to the Trust Board and sub-committees via the Chief Executive updates and specific reports such as the quarterly finance report on the ICS. Despite the group shared management positions structure with ESH both Trusts remain answerable to their own Boards and sub-committees. The key mechanism by which the Trust Board are informed of work with ESH is via the Chief Executives Report at each meeting which notes specific work together. In year this included making joint clinical appointments and sharing electronic patient records across the group. Given the joint role of the Chief Executive across both Trusts this is an appropriate method of communication of decisions between the two Trusts.

Improvement recommendations

Financial sustainability

A Recommendation	The Trust's 2022/23 plan will again require updating and resubmitting by 20 June 2022. Once the new iteration of the plan is agreed the Trust will quickly need to revise its budgets and reporting to ensure revisions in income and expenditure assumptions are captured. We recommend the Trust prioritises re-assessing the assumptions to the risks and uncertainties built into the revised plan and identifies the impact of these in monetary terms.
Why/impact	The NHS 2022/23 plan guidance was issued later than in previous years and there is still uncertainty within the sector reflected by the fact a further iteration of plans require submission by June 2022. The Trust will therefore have for more limited time than in previous years to work towards delivering their financial plans. This includes revisiting saving plans and reviewing assumptions regarding the risks and uncertainties to the achievement of the financial plan.
Auditor judgement	There are various uncertainties and risks built into the existing iteration of the Trust's 2022/23 plan. The risks include inability to reduce COVID-19 costs as planned, delivery of planned savings less than expected, inability to achieve the level of activity required to achieve Elective Recovery Funding (ERF) and inflation on costs exceeding inflation included in national funding. A revision to the plan by 20 June 2022 means these need to be revisited as previous assessments will be out of date.
Management comment	The Trusts accepts this recommendation and will implement following the plan submission on 20 June 2022.

Financial sustainability

B Recommendation	Should the Trust's CIP target of £58.2m remain unchanged as part of the next submission of the 2022/23 plans the Trust will need to ensure it has a clear process in place for how it is going to promptly identify the £12.7m of unidentified savings identified.
Why/impact	Detailed scheme level project plans are vital to ensure that the Trust is able to maximise the time period in which the clinical groups can work towards achievement of those plans. In addition reliance on non-recurrent schemes places pressure on identification of savings in future years as they only have a one year benefit to the Trust.
Auditor judgement	Of the £58.2m of savings the Trust has included in the current iteration of the 2022/23 plan, £45.5m have been identified at a high level. However there is limited evidence of individual projects plans in place for these identified schemes at the start of 2022/23 and as such there is limited assurance as to reliability of savings plans. Information provided suggests the Trust are profiling the development of unidentified savings schemes into the latter part of the financial year which is understandable given timings but is therefore more risky. One of the most common causes of not meeting a CIP target by year end is the fact schemes are unidentified at the start of the year. A high level of unidentified schemes in the first quarter means the Trust have a shorter time frame with which to take the necessary actions to achieve the savings required.
Management comment	The Trust accepts that it must endeavour to have clear delivery plans for the full value of CIPs required in the plan.

Improvement recommendations

Governance

C Recommendation	We recommend the Trust considers including service level financial performance within its monthly reporting to the Finance and Investment Committee to ensure decision makers have a full suite of information with which to make financial decisions.
Why/impact	The 2022/23 financial landscape is expected to be more challenging across the sector than the prior year. The Trust will be committing to a deficit position for 2022/23 per their plan (see Financial Sustainability), as such decision makers of the Trust will require a full suite of information, including financial performance of individual services, with which to make effective financial decisions.
Auditor judgement	This Trust financial reporting is comprehensive but does not include the actual performance against budget of individual services within the Trust. The detail of 2021/22 reporting was appropriate given the funding and forecast outturn for the year. Given the 2022/23 financial position will be more challenging to deliver it would be more appropriate to include greater detail in the finance report presented to the Finance and Investment Committee.
Management comment	The Trust accepts this recommendation and will include some service level information of financial performance in FIC reports from Q2

Governance

D Recommendation	We recommend that the Trust include forecast outturn position within their financial reporting earlier in the financial year.
Why/impact	Presenting the forecast outturn position, alongside actual vs budget performance, allows decision makers to identify, in a timely manner, issue which may impact the year end position and take action to improve the position prior to the year end
Auditor judgement	The Trust financial reporting includes a forecast, as well as a comparison of actual to budget, however this element of the budget monitoring process only came into effect in the finance report after month 8 of 2021/22. Given that there is more uncertainty and less COVID-19 funding expected for 2022/23 the Trust should consider reporting against the forecast earlier than in prior years so there is more time available should remedial actions be required to be implemented.
Management comment	The Trust accepts this recommendation and will include information of financial forecasts from M6 onwards.

Follow-up of previous recommendations

Recommendation	Progress to date	Addressed?	Further action and management response
Governance - review scoring of risks in the BAF and corporate risk register to understand stagnation and consider whether the prioritisation of actions is appropriate.	There has been limited changes in risk scoring since July 2020 with the exception of workforce risk in the BAF. There is evidence that deep dives and discussions on scoring do take place by the Board and sub-committee throughout the year in relation to each risk and as such there is an effective mechanism in place for adjusting risks should that be required.	Yes	No
Governance - expand the remit of Strategic Risk 4 in the BAF regarding the SWL ICS to encompass financial restraints explicitly.	The risk now includes reference to system-wide financial pressures impacting on transformation opportunities	Yes	No
Governance - refresh business plan to encapsulate existing financial and non-financial strategic plans including where the priorities have changed in light of COVID-19.	As part of the 2022/23 business planning process the Trust have drafted activity, financial and workforce plans in line with 2022/23 planning guidance and in collaboration with the ICS. This was submitted to NHSEI by the deadline in April 22 and our work on financial sustainability confirmed appropriateness of the assumptions included.	Yes	No
Governance - for the clarity of its reporting to board the budget should be reviewed, stating where decisions are able to be made by you in isolation and which budgetary lines are decided more centrally by NHSEI. This would give the executive and the governance a better understanding of what you are able to impact and whether you need to impact this in an organisational or system wide basis.	By virtue of the NHSEI planning guidance the Trust is expected to develop its financial plan in liaison with the local health system and there is extensive evidenced to confirm this has taken place with the South West London Integrated Care System (SWL ICS). The Trust has developed its own financial, activity and workforce plans has liaised with the ICS via fortnightly Director of Finance meetings with other ICS members to align assumptions and include these within each iteration of Trust plans. In addition, each time the plan is presented internally there is inclusion of the SWL position split by Trust to ensure the Board have a full picture of the region and can understand the Trust position within it. This is effective reporting, and coupled with quarterly reporting of the SWL financial position and the narrative detail in the planning documents explaining local assumptions, the Trust have effectively responded to the prior year recommendation in relation to greater clarity between ICS and Trust assumptions within the lines of the budget.	Yes	No

Follow-up of previous recommendations

Recommendation	Progress to date	Addressed?	Further action and management response
Governance – declaration of interest disclosure online appears that only 50% of staff have followed the policy that they must make a declaration. It is not clear to a reader whether this means only 50% of decision makers have complied or whether 50% of decision makers have an interest. We recommend that nil responses should still be submitted so that it is clear that all staff have understood that they have to consider their interests.	We have noted several actions the trust has taken to improve overall declarations at the Trust. 51% of decision makers, specifically, have made a declaration for 2021/22. Review of returns made confirm that nil returns have been provided across the Trust, as such actions taken have improved these types of responses, however compliance at decision making level remains a challenge. The risk is partially mitigated by the fact that each Board and sub-committee meeting provides the opportunity to declare interests prior to decisions being made. Declarations are regularly made via this route and we have not noted any issues with unethical practices in the year.	Partially	We will follow up on progress in 2022/23 to ensure the improvement trajectory improves. Management update: The Trust introduced a new approach to managing declarations of interest in late 2019. Following positive initial engagement by staff, responses dropped significantly during the height of the pandemic. 2021/22 has seen a marked upturn in the level of engagement but we recognise that there is a need to ensure further improvement. We plan to continue with monthly reminders to all decision-making staff, introduce escalation routes to managers where there is persistent lack of engagement, introduce regular reporting to Divisions on compliance, and promote awareness of declarations of interest and gifts and hospitality through our communications channels during 2022/23.
Improving 3E's - Given the improvements in A&E performance the Trust should investigate what changes arising due to COVID-19 have improved performance that could continue when services return to business as usual.	To improve the Emergency Department performance the Trust have taken extensive actions which include a capital plan to expand Same Day Emergency Care (SDEC) and Medical Ambulatory capacity, working with London Ambulance Service to reduce out of borough arrivals and worked with Merton and Wandsworth and community providers to increase overall bed capacity. Challenging performance has been observed in year however this is reflective of the sector demand and not a lack of response by the Trust. The Trust have continually monitored and reacted to Emergency Department flow and pathway positively and as such we are satisfied that the actions taken are robust and respond to our recommendation from prior year.	Yes	No

Follow-up of previous recommendations

Recommendation	Progress to date	Addressed?	Further action and management response
Improving 3E's - The Trust forward plans for cancer treatment should also factor in how backlogs will be managed and what the operational and cost implications of this will be.	There has been a decline in cancer wait performance over the year, the Trust has been unable to respond to the backlog effectively as a result of the ongoing impact of the pandemic. However the Trust has taken steps to identify specific areas of challenge. The performance is specifically related Breast Cancer patients and investigation by the Trust has revealed the underling cause to be an increased number of referrals since pre-COVID-19 and the suspension of breast screening at various points during the pandemic which has increased the backlog. A comprehensive range of actions have been taken which are clearly reported including mutual aid from the Royal Marsden, increasing the number of triple assessment clinics and a further recovery plan to divert referrals to other ICS providers.	Partially	We will follow up on progress in 2022/23 to ensure the improvements implemented result in the backlog being cleared or significantly reduced. Management update For TWR (breast) the Trust has a robust recovery trajectory in place, with the trajectory to have fully recovered this by August 2022. We are on track to deliver this. To sustain this position given the ongoing increase in breast TWR referrals whilst pathway efficiencies are introduced, a business case is under review by SWL – this is a pan-SWL challenge. The Trust also has a cancer improvement plan underway to recover and sustain all the cancer standards across all tumour site groups, which includes the following key efficiency improvements: (programmes 1-6 in the attached slides) -faster diagnosis, best practice timed pathway, non-site specific cancer pathway, ASI into PTL (completed), and MDT improvement. The Cancer Programme Board has been re-convened post-COVID, and is now chaired by the COO. It reports by exception to OMG and TMG.

Follow-up of previous recommendations

Recommendation	Progress to date	Addressed?	Further action and management response
Improving 3E's – Consider where it is pertinent to factor in performance of the other Trusts when reporting against KPIs. Without this context it is difficult for stakeholders to understand the trade-offs made between Trusts.	Actions taken against existing metrics in the IQPR do reference collaborative activities with the ICS therefore Board members do have appropriate information to understand how working with the local health system impacts performance. However, the Trust does not present comparative performance of other Trust's performance when reporting its own KPIs. Without this context it is difficult for stakeholders to understand the relative performance of the Trust and the trade-offs made between Trusts in the ICS. The Trust has this information available as reporting to NHSE for the ICS comprises system and individual Trust performance.	Partially	The Trust should consider including benchmarking against other Trusts in the local health system to ensure that the Board can gauge relative performance and gain information on system performance simultaneously. The Trust is an outlier in that most comparable Trusts do report benchmarking information in their formal performance reports (be it similar sized Trusts or those local to them. Management update As part of the SWL Acute Provider Collaborative and the NHSEI London Regional elective recovery, benchmarking on elective recovery by speciality is reported on a weekly basis for SWL and pan-London. This forms part of the SWL elective recovery review and is overseen by the CEOs group. Overall oversight sits with the SWL Elective Recovery Board, which is chaired by CEO. The contents of the Trust IQPR is also being reviewing in the first half of 2022.
Financial Sustainability - We recommend an estimation to when further information will become available to aide decision making be included in the papers. This would provide a trigger point for decisions made based on currently uncertain data to be reviewed. For example providing a date at which funding or information on funding will become available to assist with decision making and scrutiny.	This recommendation was highlighted as a result of the 21/22 planning cycle being divided into two 6 month periods. For 22/23 the Trust has been provided with a full years planning guidance including assumptions on funding, as such there is unlikely to be need for such information to be included in the Trust reports	N/A – no longer required	N/A

Follow-up of previous recommendations

Recommendation	Progress to date	Addressed?	Further action and management response
Financial Sustainability - the Trust should bring back some of the rigour and established tracking programmes as were operated during financial special measures. This high-touch approach has a proven track record and will be effective at re-establishing good practice after this break in budget and savings monitoring.	As COVID-19 funding continued in 2021/22 the Trust did not need to implement some of its previous processes around saving plans. We understand these will be re-introduced now that 2022/23 planning confirms the need for saving plans similar to previously required.	N/a as not required	We will follow up on progress in 2022/23 as these processes were not required for 2021/22.
Financial Sustainability - The Trust should complete a review of 'unintended' cost reductions to identify efficiencies to carry forwards into a post COVID-19 operating environment. As part of this exercise the Trust will also need to ensure clinical outcomes are given equal focus alongside the consideration of potential financial savings.	The basis of the 22/23 financial plan is the 21/22 exit run rate and therefore incorporates all recurrent income and expenditure, whether intended or unintended. Overall the pre-pandemic underlying deficit, under delivery of savings and cost pressures as opposed cost reductions are driving the proposed deficit position for 22/23. The Trust did identify some non-recurrent benefits, including those due to vacancies, and therefore the Trust has undertaken detailed workforce planning to inform the budget, therefore reflecting any ongoing benefits. Activity planning has also been incorporated into the cycle and is the driver of the financial plan	Yes	No

Opinion on the financial statements

Audit opinion on the financial statements

We issud an unqualified opinion on the financial statements on 23 June 2022.

Preparation of the accounts

The Trust provided draft accounts in line with the national deadline and provided a good set of working papers to support it.

Grant Thornton provides an independent opinion on whether the accounts are:

- True and fair
- Prepared in accordance with relevant accounting standards
- Prepared in accordance with relevant UK legislation

Appendices

Appendix A - Responsibilities of the Foundation Trust

The accounting officer is responsible for:

- Preparation of the statement of accounts
- Ensuring that income and expenditure is in line with relevant laws and regulations
- Assessing the Trust's ability to continue to operate as a going concern

Public bodies spending taxpayers' money are accountable for their stewardship of the resources entrusted to them. They should account properly for their use of resources and manage themselves well so that the public can be confident.

Financial statements are the main way in which local public bodies account for how they use their resources. Local public bodies are required to prepare and publish financial statements setting out their financial performance for the year. To do this, bodies need to maintain proper accounting records and ensure they have effective systems of internal control.

All local public bodies are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. Local public bodies report on their arrangements, and the effectiveness with which the arrangements are operating, as part of their annual governance statement.

The accounting officer is responsible for the preparation of the financial statements and 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. The accounting officer is also responsible for ensuring the regularity of expenditure and income.

The accounting officer is required to comply with the NHS foundation trust annual reporting manual and the Department of Health & Social Care group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. An organisation prepares accounts as a 'going concern' when it can reasonably expect to continue to function for the foreseeable future, usually regarded as at least the next 12 months.

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

Appendix B - Risks of significant weaknesses - our procedures and findings

As part of our planning and assessment work in January 2022, we considered whether there were any risks of significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources that we needed to perform further procedures on. We updated our assessment based on the release of planning guidance and the submissions the Trust has made in relation to its 2022/23 plans later on in the year. The risks we identified are detailed in the table below, along with the further procedures we performed, our findings and the final outcome of our work:

Risk of significant weakness	Procedures undertaken	Findings	Outcome
Financial sustainability was identified as a potential significant weakness, see page 5 to 7 for more details.	We reviewed the Trust's financial plans for 2022/23 to assess the robustness of the plan for addressing the financial position in the current year and the medium term We have reviewed the Trust's processes in place for understanding, communicating and challenging actions in relation to the planned deficit position We have reviewed the Trust's processes in place for identifying and monitoring risks to the plan including cashflow and savings	We have concluded there is no significant weakness in arrangements in relation to financial sustainability. The Trust has produced a financial plan for 2022/23 in line with the NHS planning guidance however the £50.8m deficit plan is forecast to reduce the Trust's cash reserve position to £3m and as such any additional risk not already accounted for in the plan cannot be supported by reserves. At the time of reporting there is no evidence to confirm whether the risks are materialising and the impact on the Trust's cashflow. The most significant potential risk to the plan is in relation to under delivery of savings as the Trust has a substantial savings target of £58.2m with £12.7m of this unidentified. At the time of reporting we have limited evidence to conclude on the success of CIP identification to determine any weakness in arrangements as the process is very much in progress.	We have raised improvement recommendations related to CIPs and risk identification and will revisit arrangements in six months to determine how the cash position is progressing as a result of any additional risks to the plan. At this time, we do not have sufficient evidence to determine whether there is weakness in arrangements. An assessment of the delivery of the 2021/22 plan in six months time will allow greater clarity on whether risks are materialising which could impact the financial position adversely and be evidence of whether a weakness in arrangements exists.

Appendix C - An explanatory note on recommendations

The recommendations that can be raised by the Trust's auditors are as follows:

Type of recommendation	Background	Raised within this report	Page reference
Key	The NAO Code of Audit Practice requires that where auditors identify significant weaknesses as part of their arrangements to secure value for money they should make recommendations setting out the actions that should be taken by the Trust. We have defined these recommendations as 'key recommendations'.	No	N/A
Improvement	These recommendations, if implemented should improve the arrangements in place at the Trust, but are not a result of identifying significant weaknesses in the Trust's arrangements.	Yes	See relevant section

Appendix D - Use of formal auditor's powers

We bring the following matters to your attention:

Public Interest Report Under Schedule 10 of the National Health Service Act 2006, auditors of foundation trusts have a responsibility to make a report in the public interest if they consider a matter is sufficiently important to be brought to the attention of the audited body or the public as a matter of urgency, including matters which may already be known to the public, but where it is in the public interest for the auditor to publish their independent view.	Not applicable
Referral to NHS Regulator Under Schedule 10 of the National Health Service Act 2006 auditors of foundation trusts have the responsibility to report to the relevant NHS regulatory body if the auditor has reason to believe that the foundation trust (or director or officer of the foundation trust) is: • about to make, or has made a decision which involves or would involve unlawful expenditure; • About to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss of deficiency.	Not applicable

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