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 2022/23

St George's University Hospitals NHS Foundation Trust

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1. Chairman's introduction

Despite the challenges I am optimistic about the future and would like to express my appreciation to our engaged Trust Board, Governors, and Members for their dedication to their roles at St George's.

I am pleased to present the Trust's Annual Report and Accounts for 2022/23, which allow us to reflect on our achievements as well as the challenges from the past 12 months. Colleagues across St George's have worked tirelessly to deliver outstanding care to our patients, and we are extremely grateful for their extraordinary efforts. The Trust Board is fully appreciative of their continuous commitment to making a real difference to the lives of the communities we serve.

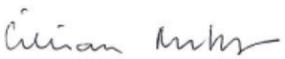
Although the impact felt from Covid has reduced, the past year has not been without its challenges. Our hospitals – like many across the country – have faced ongoing operational pressures and increased demand for services. However, by collaborating with our partners and introducing new approaches to improve flow, we have continued to provide safe and timely care for our patients. Our staff have once again been instrumental in how we have responded to periods of intense pressure.

Our Group collaboration with Epsom and St Helier University Hospitals NHS Trust has strengthened throughout the year. This closer working has enabled us to share resources, expertise, and knowledge to serve our communities better. Our new five-year strategy for the Group, published in May 2023, will crystallise our ambitions, and set out how we plan to achieve our vision of providing outstanding care, together.

There is no doubt that the coming year will be another difficult one financially. However, the Trust Board will remain vigilant in its focus on quality and safety while ensuring rigorous scrutiny of our use of public funds.

Despite the challenges I am optimistic about the future and would like to express my appreciation to our engaged Trust Board, Governors, and Members for their dedication to their roles at St George's.

Finally, I would like to extend my gratitude to our volunteers and the many charities that have supported us throughout the year, including the St George's Hospital Charity. Their contributions have significantly improved the lives of our patients and staff.



Gillian Norton OBE DL
Chairman

30 June 2023

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 over the world.

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

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

St George's is a major centre for neurosciences, and is 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, 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 Executives 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

Throughout the past year, the staff in our hospitals have been exceptional, as ever. Despite the difficulties, our teams have stayed dedicated to delivering outstanding care to our patients, and the achievements mentioned in this report are proof of their commitment and talent. We have made progress over the past year, but there is still much room for improvement, and the challenges we face are significant.

Operational pressures

As with many NHS Trusts across the country, a key area of challenge has been the pressure on our urgent and emergency care pathway, and the difficulty this presents in terms of flow through the hospital, to the wards, and home.innovation. This enables us to attract staff from all over the world.

As well as the exceptionally large volumes of patients coming to our doors during the period, we have continued to see a significant number of high acuity patients, and people presenting with complex needs which makes it even more challenging to find suitable follow-on care when they

Throughout the year we have introduced new approaches to help mitigate these challenges. These include the trial of a new regularised patient flow system to support expedited flow through the hospital in order to reduce risk and keep patients safe, along with the introduction of a team to assess elderly and frail patients attending the emergency department and discharge them home without admission – where this is right and safe to do so. In September we opened a new Urgent Treatment Centre – a purpose – designed area close to our emergency department, which has increased our capacity for treating urgent cases.

We are also working more closely with our community partners to ensure our patients can move safely to appropriate care facilities as needed once fit for discharge, and we are increasing the frequency of multi-agency discharge events to support and resolve some of the discharge issues as a system. You can read more about this in the Collaboration section of our performance analysis.

Despite the challenges, St George's has been the top ten performing Trust in the country in keeping those waiting in our emergency department under four hours, which is testament to the hard work and commitment of our teams at every level in the Trust.

Recovering from Covid-19

There is no doubt that the challenge presented by Covid has reduced, but it is still with us and needs to be managed. The vaccination programme continues, and we need to meet the needs of people who require hospital care for the virus and those with longer term symptoms following infection. We must also remain prepared for further peaks as the pandemic runs its course, as we saw in summer and again in January. This includes plans to manage and increase capacity to respond to demand that may be fuelled by further waves or severe outbreaks of respiratory and other illness, particularly over the winter months.

In August 2022, NHS England published its business plan aiming to support the NHS on its pathway to post-Covid recovery and to transform services to meet new challenges. The key commitments outlined in the plan include delivering more elective care to tackle the backlog, reducing long waits, improving cancer waiting times, and increasing urgent and emergency care capacity. St George's has used these clear objectives to guide our own plans and direction as we continue to live with Covid.

Despite the challenges, St George's has been the top ten performing Trust in the country in keeping those waiting in our emergency department under four hours, which is testament to the hard work and commitment of our teams at every level in the Trust.

Key performance indicators

The table below shows how we performed at year end against key performance indicators.

It shows that we have reduced the number of patients waiting over 52 weeks for treatment, however, the percentage of pathways completed within 18 weeks fell over the year due to a focus on treating the longest waiting patients.

Overall, our performance against the target of admitting, transferring, or discharging patients who arrive in ED within four hours has remained strong, and consistently in the top 12 nationally and top two in London.

Our performance in relation to the percentage of cancer patients being treated within 62 days of urgent GP referral or screening referral has fallen since last year. This is due to the trust treating 15% more GP referred cancers – with a particular increase in breast and skin. Achieving the backlog reduction target has also impacted on 62-day performance. Pathway changes in breast, and increasing one-stop support, and our focus will support improvement in this area.

Financial recovery

It has been a hugely challenging year financially for Trusts across the NHS, and St George's is no exception. We ended the year with a deficit of £30m, and while this is a significant amount, this position was forecasted early in the year. I'd like to thank our teams for their hard work in ensuring we stayed within forecast.

The drivers of this deficit include a growth in workforce since 2019/20, the withdrawal of Covid support funds, and considerable growth in costs due to inflation.

We have spent the year looking at stabilising our position through immediate and short-term actions including identifying cost improvement plans (CIPs), using data to improve outcomes for patients and identifying opportunities to be more efficient, as well as looking at how we will bring about longer term and significant change and transformation to deliver financial savings while ensuring quality of care is protected.

Despite this, we have continued to invest in our estate and equipment, with £41m helping to improve the experience and outcomes of our patients and improve the working environment for staff.

Next year will be equally as tough, and we do not underestimate the challenge of meeting the levels of cost improvement needed across the organisation. Working collaboratively and innovatively across the Group, and with regional colleagues and system leaders will be key as we navigate the need to make savings while also recovering elective activity, meeting workforce pressures, and ongoing industrial action.

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. 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.

KPI	Standard	Target	Annual performance 2019-20	Annual performance 2020-21	Annual performance 2022-23	Annual performance 2022-23
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	84.20%	69.30%	72.30%	67.9%
Referral to treatment times	Number of 52 week breaches	0	32	3644	846	517
ED access	95% of patient wait less than 4 hours	>=95%	83.20%	92.80%	81.60%	76.60%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	>=85%	85.20%	77.10%	72.60%	66.0%
Cancer access	% patients treated within 62 days from screening referral	>=90%	88.80%	80.80%	75.90%	71.0%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	99%	95.70%	89.80%	98.20%	98.20%

Throughout this year, we have continued to progress this collaboration across the group for the benefit of staff and patients, and continued to look at where we have variations in care, where we can learn from each other, and integrate services. This includes the move towards a shared system for electronic patient records across our Group, with clinicians being able to access the whole record irrespective of site.

In a significant step in working together we have developed a new five year strategy for the group, published in May 2023. It has given staff a common sense of direction, a clear set of priorities, and will define how we allocate our resources over the coming years to realise our vision of providing outstanding care, together.

You can read more detail about our group strategy in the performance analysis section of this report.

Working as a system

In addition to the focus on our internal operations, we are also remaining involved with key developments at a regional and national level. On 1 July 2022, the South West London Integrated Care System (ICS) took on health and care statutory responsibilities, South West London Integrated Care System (ICS) took on health and care statutory responsibilities, and we are continuing to support the body with its priorities. This includes feeding into the South West London Joint Forward Plan by sharing our insight and engagement reports in order to help respond to the needs and views of our people and communities in the region. The final plan will be published at the end of June 2023.

I would like to acknowledge our amazing staff, and also talk about the importance we place on their wellbeing and making sure they feel included and valued.

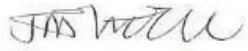
By working together, we can do more to support people to live healthier and happier lives and I am pleased to be able to play my part as lead for the Acute Provider Collaborative (APC) on the Integrated Care Board (ICB). Close collaboration with our system partners – as well as NHS England, also means we can ensure our strategies and activity aligns with the long-term strategic goals of the NHS as a whole.

Supporting our staff

Finally, I would like to acknowledge our amazing staff, and also talk about the importance we place on their wellbeing and making sure they feel included and valued.

It's been an unsettling year for staff across the NHS. The cost of living crisis, and several rounds of industrial action across the sector have taken their toll. We support the right of our staff to strike, but our priority throughout the prolonged period of action we have seen since January 2023 has been to provide safe patient care. Our staff have put in an exceptional amount of work to ensure this, whether rebooking appointments, reorganising rotas, or taking on additional duties. We have continued to make sure all staff feel supported, no matter what decision they make about taking industrial action – whether by signposting them to our staff support teams, or offering free food and wellbeing areas. However, I recognise the immense strain that the past few months have placed on so many, and I appreciate the effort required for everyone to come together once more and rise to the challenge.

The results of our 2022 Staff Survey show some positive changes in how staff feel about working here. For example, views about managing and being managed, the Trust respecting individual differences, and what staff think about learning opportunities and career progression. However, there were some areas where despite our efforts we didn't see the improvements we'd hoped for – particularly on our values and behaviours work, feeling secure in raising concerns, and how we recognise staff. We are committed to acting on what our staff have told us and making St George's a better place to work. You can read more detail on the actions we are taking in the Staff Report section of this document. Let me end by saying that I remain ever grateful for the extraordinary efforts of our staff to care for our patients, day in and day out. This report is full of examples of their innovations and achievements, and I am incredibly proud.



Jacqueline Totterdell
Group Chief Executive

30 June 2023

Highlights of 2022/23

April 2022	• Jacqueline Totterdell was named as one of HSJs 'Top CEOs of 2022. • Group Chief Nurse Arlene Wellman awarded MBE in recognition of her contribution to nursing. • Channel 4's Baby Surgeons, filmed at St George's, was nominated for a BAFTA.
May 2022	• Deputy Director of Estates and Facilities, Jenni Doman, shortlisted for HEFMA Leader of the Year Award. • St George's surgeon Zak Vinnicombe won prestigious national competition hosted by Royal College of Surgeons.
June 2022	• St George's nurse Ediscyll Lorusso carried the baton in Queen Elizabeth II's Platinum Jubilee baton relay. • We celebrated 10 years of Project Search at St George's, a programme which helps local young people with autism and learning disabilities into work. • Former Health Secretary, Sajid Javid, visited St George's with CEO of Moderna, to learn about the clinical research taking place at St George's.
July 2022	• Our Liver Unit was awarded national quality accreditation by the Royal College of Physicians. • The NHS was presented with the George Cross by Queen Elizabeth II. • We launched 'Our values based behaviours' – a guide developed by staff, for staff, describing how we should all live the Trust values. • St George's first in the UK to trial 'green gas and air' in our dental department.
August 2022	• A new dual-strain Covid vaccine was approved for use in the UK following clinical trials led by the St George's Vaccine Institute. • We opened our new Urgent Treatment Centre, purpose built to see patients presenting with minor illnesses injuries and relieve pressure on our Emergency Department.
September 2022	• Childhood Cancer Awareness Month celebration event, reuniting current and former patients with the clinicians who cared for them. • Macmillan Health and Wellbeing Co-ordinator Estelle Le Galliot won BBC Radio London's 'Make a Difference Key Worker' award.
October 2022	• We celebrated Black History Month with a vibrant community event, coinciding with the launch of 'See ME First' equality and diversity pledge. • Juliann Welch won the Royal College of Nursing's Black History Month Rising Star award. • We brought back Long Service Awards for the first time since the start of the Covid pandemic, celebrating colleagues who have worked at St George's for 25 years or more.
November 2022	• The Health Secretary Steve Barclay visited St George's vaccination clinic to receive his Covid booster and flu vaccine. • Our Homelessness Inclusion service celebrated its one year anniversary. • We launched our new patient flow model to reduce delays in ambulance handovers and patients reaching inpatient beds.
December 2022	• We officially opened our new MRI unit, replacing a 20 year old modular build with brand new state of the art facilities.
January 2023	• Fleur Anderson, MP for Putney, visited our Emergency Department to learn more about the pressures faced by our emergency care team.
February 2023	• One year anniversary of NHSE elective recovery plan, St George's surgical 'super-hub' led the celebration of successes.
March 2023	• Adult Critical Care Emergency Support Service launches.

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.
- Children, Women's, Diagnostics and Therapies Division.

Alongside these, the Corporate Division comprises key corporate services including estates and facilities, information communication and technology,

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finance, human resources, strategy and corporate affairs.

In total, the Trust employs more than 9,000 staff across our sites.

St George's is part of a Group with Epsom and St Helier University Hospitals NHS Foundation Trust, and 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.

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

Our vision, priorities and objectives

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

Each year, we set corporate objectives for the organisation. For 2022/23, 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 recover 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 our Covid-19 response.

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 recovers from Covid-19 and in how we respond to any future wave.

Planned care

We continue to make good progress on elective care recovery, and we are performing well at a national level. 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 built up in planned care as a result of the pandemic.

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. At the end of February 2023 this number had reduced to 481 and is below the plan of 800. While this is a significant improvement, our focus is to reduce this number to an absolute minimum.

We have made real progress, but know we have more to do. We are continuing to focus on optimising our theatre utilisation, and holding regular meetings with our south west London colleagues to discuss elective care recovery activity to distribute activity to where it can be managed more efficiently.

Our system network is crucial in ensuring elective activity remains on track despite disruptions. Our surgical hub at Queen Mary's Hospital has protected theatre space, which has been vital in supporting our vision of working through high volume, low complexity cases across south west London to aid recovery and allow other spaces – such as St George's – to focus on specialist and complex cases. The hub started treating patients in June 2021, and since opening we have undertaken more than 7,000 operations.

Improvements to our estate

We are continuing to deliver on our estates strategy agreed in July 2021. It 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 was developed alongside our green plan, taking into account the importance of sustainability for both staff and patients. You can read more about our green plan in the Environmental Analysis section of this report.

Despite our focus on operational pressures and challenging financial position, we have continued to invest in improving our estate and upgrading clinical areas. Two examples of this are below.

In August 2022 we opened a new Urgent Treatment Centre (UTC) at St George's. It has helped to ease pressure on our Emergency Department, and provides the best possible care for patients with minor injuries and illnesses, and its opening was especially timely as we headed into winter. The area was purpose built, and also provides a great opportunity for our ED team to enhance their clinical skills.

In August 2022 we opened a new Urgent Treatment Centre (UTC) at St George's. It has helped to ease pressure on our Emergency Department, and provides the best possible care for patients with minor injuries and illnesses, and its opening was especially timely as we headed into winter. The area was purpose built, and also provides a great opportunity for our ED team to enhance their clinical skills.

In October we celebrated completion of works on five cardiac catheter laboratories in our Atkinson Morley Wing. The laboratories contain specialist imaging equipment to allow for the diagnosis and treatment of cardiovascular diseases and conditions more rapidly and effectively. They also contain improved ventilation and enhanced temperature control to keep patients and staff more comfortable.

Tackling health inequalities

We have identified tackling health inequalities as part of one of our nine strategic initiatives in our new Group strategy. This will mean working with our partners to actively pursue a more strategic and systematic approach, making reasonable adjustments to the way care is provided to ensure we are not further embedding health inequalities. We will also embrace proactive outreach into communities most impacted and we plan to develop the Group as an 'anchor institution' ensuring that our workforce is reflective of the local population and that we can attract employees from all spectrums of society.

In 2023/24 we want to enhance our understanding of the population we serve by improved data collection and improved use of our patient portal and triangulation of patient feedback. This is to ensure we fully understand and use the feedback we receive. You can read more about this is our Quality Account.

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.

One of our quality priorities for 2022/23 was to provide an equitable experience for patients from vulnerable groups, with success in this area defined as improvement in our self-assessment against the National Learning Disability Standards.

There is more to do but progress throughout the year included the creation of a part time Healthcare additional psychosocial support for inpatients and outpatients with a learning disability and our learning disability team receiving approval from charity funds to purchase tablet computers to enhance the experience of inpatients with a learning disability. We also created a new pathway, in collaboration with the South West London ICB, that refers to STOMP (stopping over medication of people with a learning disability, autism, or both) and our learning disability patient partnership and engagement group was relaunched as a face-to-face meeting.

The self-assessment was completed against national standards for Learning Disability patients and at the time of writing we are awaiting the results.

Another example of progression in providing equality of service delivery to different groups is our Homelessness Inclusion Service in St George's Emergency 18 Department, run in collaboration with the charity Pathway. The team works with our local authorities to find service users more secure housing, registering them with a GP and connecting them with other means of social support. In November 2022, the service celebrated its one-year anniversary of being set up, and in the first nine months alone the team helped 246 patients, seeing a 66% fall in them returning to rough sleeping, and a 77% fall in those patients who were frequent attenders in our ED being seen again.

Public Sector Equality Duty Report (PSED)

Our PSED is in the process of being finalised and approved by our Board. It will be published after 30 July 2023 on our website: https://www.stgeorges.nhs.uk/about/living-our-values/equality-diversity-and-inclusion/human-rights-and-equality. Our duties relating to Workforce reporting can also be found on this page.

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.

Values based behaviours

We want our staff to feel supported, respected and motivated to do their best. As part of our ongoing culture improvement work, we launched our values based behaviours in July 2022. It was the result of six months' diagnostic work led by our culture champions on behalf of the Board that involved speaking to staff about what it's really like working for St George's.

Our values based behaviours is a guide describing how we should all live our values of Excellent, Kind, Responsible, and Respectful. It includes examples of behaviours staff told us they would expect to see, those they would love to see, and those they don't want to see. These examples help us to celebrate positive behaviours, as well as challenge negative ones.

As well as the guide, we created a short film where our staff shared their experiences of the impact living our values can make, and how it feels when behaviour falls short of what we would expect.

These values and behaviours will be at the heart of all we do, and we have been embedding them throughout the organisation. This includes through facilitated workshops and training for individuals and teams, and by reviewing and updating our values policy to reflect them. You can read more detail on other ways we are embedding them in the Staff Report section.

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. One of our main four aims set out in our new group strategy is 'empowered and engaged staff' and we recognise that our key quality and financial objectives can only be achieved through the contribution of a well-led and happy workforce.

We have launched a plan for addressing the key themes arising from last year's NHS Staff Survey

One of our main four aims set out in our new group strategy is 'empowered and engaged staff'

– these are our 'Big 5' priorities, and will give us focus and clarity for our staff about what can be improved to make St George's a great place to work. You can read more about our Big 5 in the staff survey section of this report.

We continued to make progress in strengthening our culture, and have developed a culture and leadership programme, driven forward by our culture, equity and inclusion (CEI) programme board, chaired by the Group Chief Executive. Our plan moving forward is for the board to cover both St George's and Epsom and St Helier, with local culture groups focusing on local people and culture issues.

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.

You can read more about our focus on culture, equality, diversity, and inclusion in the staff report section of this report.

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 our Covid-19 response.

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

As mentioned in the overview section of this report, we are continuing to progress with collaboration across the Group for the benefits of staff and patients.

Since summer 2022 we have been developing a five-year strategy for the Group. This was approved by the Boards of both Trusts in April 2023, and will be published in May.

In its development we spoke to hundreds of patients, staff, and partners about how we provide the best possible services, the role we should play in our local communities and across the wider NHS, and how we remain ready for the future as demand for our services increases and resources become more stretched.

The resulting strategy sets out our aims. Our vision is that we provide outstanding care, together. We want to provide local services for the people of Surrey Downs, Sutton, Merton and Wandsworth, and be a major tertiary centre for south west London – particularly known for our specialist major trauma, renal, neuroscience, paediatric and cancer services. As university hospitals, we'll focus on research and education, working closely with St George's, University of London.

While our Trusts will have distinct identities, we'll work as one family to maximise the benefits of being a group, and work with partners to join up care around patients' needs.

We will also act as anchor institutions, and have a positive impact on our local communities beyond healthcare.

In order to achieve our vision we have chosen four overall aims for 2028. We will collaborate and work in partnership to meet the needs of our patients; and make sure our services are affordable and fit for the future. We will offer the right care, in the right place, at the right time, all while ensuring our highly skilled, committed workforce is empowered and engaged.

While our Trusts will have distinct identities, we'll work as one family to maximise the benefits of being a group, and work with partners to join up care around patients' needs.

The strategy also sets out how we will need all 17,000 members of staff from across the Group to make our vision a reality. This will happen as individual teams, as corporate services, and as a whole organisation as we embark on nine major strategic initiatives that will help us deliver outstanding care, together.

Corporate Services Integration

2022/23 saw teams across gesh working more closely together following formation of the Group. Steps began in early 2023 to formalise some of that working to help achieve Group objectives, led by Corporate Services at both Trusts - Communications, Corporate Governance, Corporate Medical, Corporate Nursing, Estates, Finance and HR.

Levels of integration and co-working for each department will take different forms, begin at different times and proceed at paces best suited to success. Those details have yet to be decided, but it is hoped these moves can be completed in

Safe discharge of our patients

Collaborating with our partners is key in ensuring our patients are able to move to appropriate care once they are safely discharged from our hospitals.

Our Transfer of Care team works on a patient-by-patient basis with our community partners to get people home safely. They help to identify patients who require more support with onward care – including the very frail and elderly – then work with partners such as charities to expedite discharges where possible.

Early discharge is associated with better outcomes and experience for patients, but despite this, there are often delays in the process and patients could have left hospital sooner. We are working on a number of projects with Wandsworth Council, South West London ICS, and other partners to improve the discharge process.

For example, our Hospital at Home scheme includes an assessment for patients who arrive at our Emergency Department to investigate if they are suitable for the scheme, which involves monitoring patients at home with community nursing and virtual consultant care. Using digital technology, we are able to care for patients at home, often the best setting for them.

In the case of complex discharge processes, we are working with our wider south west London partners on early notification to allow planning earlier in the patient's journey, prior to them being medically ready for discharge.

We also host MADE events (multi agency discharge events) with our system partners to support and resolve some of the discharge challenges we face. We increase the frequency of these meetings when discharge is a particular issue to expedite progress.

We will also act as anchor institutions, and have a positive impact on our local communities beyond healthcare.

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 2022/23 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 2023. 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 2022/23 were:

St George's Board Assurance Framework 2022/23	
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. **SR 10:** 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 2022/23 the Board directly oversaw one strategic risk – working as part of 22 our Integrated Care System to transform care for patients across south west London. The Board received the full BAF at its public meetings on a quarterly basis throughout 2022/23.

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

130,000

children treated by us every year

Financial performance

The Trust had a deficit of £30.0m in 2022/23, following two years of financial balance after the Trust's exit from financial special measures in 2020/21. The Trust was showing a £0.1m surplus in 2021/22.

For 2022/23, the Trust developed a plan to breakeven, predicated on the delivery of £95.7m of CIPs. CIP delivery was £65.7m at year end, a shortfall against target of £30.0m, entirely explaining the adverse variance to the overall financial plan.

St George's did not formally deliver a CIP owing to the demands of the COVID-19 pandemic in 2021/22.

Covid block contracts and top-ups

The Trust instead received block contract funding from its main commissioners in the financial year, in line with 2021/22 and 2020/21. As the NHS moves out of the COVID-19 pandemic, these block contracts have reduced in value (after inflation adjustment), to reflect the need for the NHS to make further savings. No formal top-up payments existed in 2022/23, although additional funding for specific services has been made available to the Trust.

Performance against plan

The 2022/23 financial plan was challenged as divisions found difficulties in fully identifying and delivering CIP schemes against targets allocated to them. This was the first year since the start of the pandemic where a significant target was allocated, which explains the shortfall.been made available to the Trust.

Capital expenditure

The Trust spent £60.3 million of capital in 2022/23. This was funded from internally generated funds, and additional one-off public dividend capital (PDC) 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.

IFRS16 (Right of use assets - ROU)

As part of IFRS16's new lease standard, £10.3m of existing finance leases, £2.3m medical equipment, £33k transport and £12.4m of building operating leases have been classified as IFRS 16 ROU assets (Right of Use asset) in 22/23.

Cash flow

We began the financial year with £68.5 million of cash and cash equivalents. During the year, cash balances decreased slightly to £58.5m. The high 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 2023/24.

Financial performance against plan

	2022/23 Actual £ millions	2022/23 Plan £ millions	Variance £ millions
Total income excl capital & PSF	1,127.1	1,028.6	98.5
Expenditure excluding donated	- 1,157.1	1,028.6	- 128.6
Adjusted financial performance	- 30.0	-	- 30.0
Capital donations/depreciation/AME impairment	- 2.6	1.0	- 1.7
PSF/FRF/MRET/top-up	-	-	-
Surplus deficit incl PSF/FRF/MRET/top-up	- 32.6	- 1.0	- 31.7
Adjusted financial performance incl PSF/FRF/MRET/top-up	- 30.0	-	- 30.0

Financial performance comparison

	2022/23 Actual £ millions	2021/22 Actual £ millions	Change £ millions
Total income excl capital & PSF	1,127.1	1,067.1	60
Expenditure excluding donated	- 1,157.1	- 1,076.4	- 80.7
Adjusted financial performance	- 30.0	- 9.3	- 20.7
Capital donations/depreciation/AME impairment	- 2.6	7.3	- 9.9
PSF/FRF/MRET/top-up	-	9.4	- 9.4
Surplus deficit incl PSF/FRF/MRET/top-up	- 32.6	7.4	- 40

Cash flow

	2022/23 Actual £ millions	2021/22 £ millions
Operating surplus/deficit before finance and other costs	- 18.0	6.9
Add back non-cash and expense	51.4	40.2
Increase/decrease in operating activities	39.4	35.3
Net cash generated from operating activities	72.7	82.4
Net cash generated from investing activities	- 67.0	- 63.3
Net cash generated from financing activities	- 15.7	12.8
Net increase / decrease in cash	- 10.0	31.9
Total Cash and equivalents at 31 March	58.5	68.5

Charitable funding

We received £424k from charitable sources during the year, principally from St George's Hospital Charity. However, the Trust also received £78k 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 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 £2.4 million (£20.2 million 21/22) reduction in value of some buildings and £5.1m (£0 21/22) reduction in value of land.

However, there is a £19m (£2.6m 21/22) increase in building and £70k (£5m 21/22) increase in land to revaluation reserve. 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 £198,000 in audit fees in relation to the statutory audit of the Trust to 31 March 2023.

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 2023-24 reflects a further move away from the COVID arrangements of the previous three financial years. Guidance from NHS England is that Trusts will still be funded through block contracts although more elements will now be subject to cost and volume adjustments. The Trust will lose a significant portion of non-recurrent income 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 ensure we manage stock holdings to agreed levels.

Capital planning

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

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 continued transformation and development within the procurement service, in an incredibly challenging supply market environment – both in respect of inflation, but also product availability and supply chain resilience. The main focus and key achievements of procurement in 2022/23 have been split over the following main areas:

- **Procurement expertise:** We have continued to implement category and contract management approaches to procurement to deliver and enhance value and maximise savings opportunities. This has helped ensure the Trust was not adversely affected in the current challenging supply market with hyper-inflation and delivering over £6m in savings across the Trust and all member Trusts in the procurement partnership.
- **Systems:** We successfully completed the implementation of Scan4Safety across approximately 93 point of care areas (theatres and other settings) within St George's and 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. In addition, the procurement department has supported the roll out of two new purchase to pay and finance systems across St George's and Kingston.
- **Collaboration:** We have worked with other Trusts in south west London, and across the London regional as a whole with collaborative agreements for Cardiac Rhythm Management and High Cost devices. Within south west London we also completed the joint Electronic Patient Record (EPR) contract for the Group enabling a significant saving of over £13m shared across both Trusts.

Cost Improvement Programme 2022/23

CIPs are returning to pre-pandemic arrangements, returning to the governance of Quality Impact Assessments signed off by the Group Chief Medical and Group 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 2022/23.

Countering fraud and corruption

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

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. Most 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 adheres to the Government Function Standard 013: Counter Fraud, as well as 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. 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 £30m deficit financial position for the year ended 31 March 2023.

The final financial plan for 2023/24 has been finalised as a deficit of £15.7m, having taken account of the underlying financial position going into 2023/24 and the Block contract arrangements.

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 2022/23, 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

Our Green Plan and commitment to sustainability

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.

"Climate change is the greatest global health threat facing the world in the 21st century, but it is also the greatest opportunity to redefine the social and environmental determinants of health." - ***The Lancet 2021***

Our commitment to develop healthcare more sustainably is one of St George's core objectives for the year ahead and beyond. Since launching our Green Plan in July 2021, we have made some good progress on a range of projects and improvements to the way we operate to ensure that we can deliver outstanding healthcare for the future.

The St George's Green Plan outlines key workstreams that will contribute to the continuous improvement of sustainability across St George's, and will set us on our way to Net Zero – in line with the main Greener NHS objective to deliver a net zero health service by 2028-32.

For our Green Plan to be a success, it requires Trust-wide awareness and close working with our staff, our partners, and our communities. In light of this, our sustainability team and our communications team have worked closely to produce a strategy for keeping staff engaged and informed, as well as developing a Green Plan hub which acts as a forum for staff to suggest and discuss ideas for how we can be more sustainable.

St George's generated 32.4 million kWh of electricity, exporting 1.3 million kWh back to the national grid.

We have created a Green Champion programme to encourage staff to get involved and make improvements within the areas they work. We have also organised events, including our internal Green Plan Refresher in March, and in partnership with our south west London partners, the RCN, and NHS England.

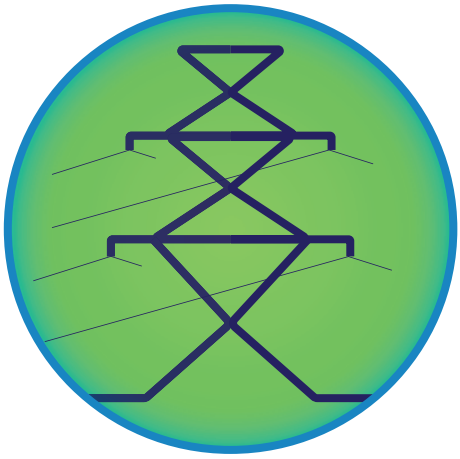
Our hope is that over time we will grow a network of engaged and passionate ambassadors who can support us along our journey towards Net Zero.

Our progress so far includes:

- Delivering 40% of all outpatient appointments in 2022 virtually, reducing the need for patient travel to and from our sites
- Making cycling more viable for staff, including partnering with DASH for discounted e-bike rental, our bike recycling scheme, improved cycle facilities and access to Dr Bike bicycle maintenance
- Large reduction in our use of the most polluting anaesthetic gases such as desflurane
- Trust imported electricity is generated from 100%
- We have developed the first low carbon patient menu in the UK renewable energy sources.

We are making some progress with delivering our Estates Strategy, published in 2021. It is an ambitious document that details how we will manage and invest in our estate over the next 10 to 20 years. It outlines the changes would hope to make in order to develop and maintain an efficient, high quality, sustainable and flexible estate which meets the demands of the Trust and the wider south west London healthcare system – and promotes long-term collaboration with our health and education partners.

A key part of this is our Heat Decarbonisation Strategy which will guide our investment to achieve a Zero Carbon Estate by 2032.



Energy usage analysis

During the 2022/23 financial year, the Trust's energy costs were £4.84m, an increase of 4.5% attributed to increasing energy prices and system downtime. Despite the challenges, the Trust maintained regular operations and achieved financial savings through the efficient operation of the boiler house and energy recharges.

St George's generated 32.4 million kWh of electricity, exporting 1.3 million kWh back to the national grid, resulting in energy cost savings of nearly £875,000 representing a 12% decrease

Our initiative of LED lighting installation covers approximately 55% of the hospital, an ongoing project expected to extend for several more years.

In line with our goal of reducing our 2017 levels of emissions by 80% by 2032 and achieving net zero by 2040, we have taken various steps.

Our estates strategy will have substantial input towards the reduction of our carbon emissions. The Energy Centre, which was opened in June 2018, houses two combined heat and power (CHP) units, and successfully delivers energy cost savings through local generation. However, due to the increasing renewable energy supply from the grid, the technology needs to be reviewed to align with decarbonisation targets. Our Green Plan supports the development of a roadmap towards increasing the efficiency performance from our boiler and chiller system, as well as energy-efficient lighting and controls.

Continuing our commitment to sustainable and efficient operations, we have upgraded and improved our infrastructure, which includes replacing old and inefficient heat exchangers and utilising low-temperature hot water from the CHP units. Moreover, our initiative of LED lighting installation covers approximately 55% of the hospital, an ongoing project expected to extend for several more years.

Despite the rising energy costs, we continue to adapt and pursue operational efficiency and sustainability. With strategies in place, including our Green Plan that embeds sustainability decisions in all new Trust projects, we are moving closer to our net zero target. The Trust remains dedicated to achieving its environmental targets while continuing to deliver high quality healthcare services.

Jacqueline Totterdell
Group Chief Executive

30 June 2023

3. Accountability report

Accountability report

Director's report: Leadership through strategic direction

Our five-year strategy was published in April 2019. While our priorities over the past two years have been on recovering from the Covid pandemic, these have remained the overarching priorities that have driven the focus of the Board, and which have informed the key decisions we have made.

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 2022/23, we have continued our focus on implementing these supporting strategies. 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 ageing 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.

With the formation and development of our hospital group with Epsom and St Helier University Hospitals NHS Trust, we have worked across our group to develop a new strategy for the group as a whole, and for its constituent trusts. Our new group strategy was launched in May 2023 and sets out our shared vision for 2028.

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 received an unannounced CQC inspection of its maternity services in March 2023 and, following this, received a Section 29A Warning Notice under the Health and Social Care Act 2008. The CQC report is pending. The Trust put in place a number of immediate actions to address the concerns set out by the CQC and submitted a detailed action plan to the CQC in June 2023.

Across our services, we continue to work closely with the CQC to ensure safe and effective care for our patients and to build upon the outcomes of the CQC's last full inspection report for St George's, published 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

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:

- Patients were asked to have their say on the development of our new Group strategy.
- In February 2023 a new General Intensive Care Unit (GICU) patient support group started. It held its first virtual session, welcoming old and new adult ICU survivors. The group has met virtually monthly, with an in-person social event planned in May.
- A new Patient Engagement Award is due to be launched at the Trust for the best project involving patients and improving patient experience
- We continue to have a patient story at each of our Board meetings, enabling our executives to hear about their
- Our Head of Patient Experience has been working with St George's, University of London, Queen Mary's Hosptial, Healthwatches, and Talk Wandsworth to widen networks and encourage involvement.

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

The past year has seen the continued evolution of quality improvement projects covering core priorities such as patient flow and elective recovery and into support services such as pharmacy. The application of improvement-thinking and techniques are increasingly being applied in support of the Trust's wider sustainability agenda.

The very worst of the Covid-19 pandemic may be behind us, but its legacy impacts have significantly increased the need for collaboration within and between teams as we respond to reduced staffing levels and a backlog of patient demand. In response, we launched the High Performing Teams approach, which is now part of the Trust's strategic priorities over the next five years. Examples of improvement activities are set out below.

Pre-operative Assessment (POA) – streaming non-complex patients (ASA1) into simple, fast telephone appointments	
The problem	The central POA team traditionally offered face-to-face appointments of either 30 or 45 minutes to all adult patients. Using a 17-page pro-forma to record appointment information, all patients received the same basic schedule of tests.
The solution	The team evolved a solution, which has worked well at other NHS trusts, to stream generally low risk and otherwise fit and healthy patients via a non-complex pathway. These patients have a 10-minute telephone pre-operative appointment using a simple 10-point pro-forma. Audit data shows that up to 35% of patients coming to St George's meet the criteria, so the impact of the change is significant.
The outcome	In the 5 months following its introduction in November '22 over 100 patients per month transferred to telephone assessments, saving them time off work, travel time and cost. In turn, the POA team redesigned its appointments schedule to see the more complex patients more quickly using the time freed up by the ASA1 appointments. There have been additional cost saving by only carrying out POA testing (bloods, urine, echo etc.) on patients who need these investigations. The service is now more able to focus on actual patient needs.

Introduction of a dedicated maternity service telephone support line	
The problem	During the worst of the Covid-19 pandemic, the maternity service successfully maintained contact with patients via telephone and virtual appointments when access to the hospital and face-to-face clinical support was widely restricted. As the Covid challenges eased, the team wanted help to translate this embryonic system into a sustainable service for timely advice & guidance for its patients.
The solution	Following a successful bid to The Health Foundation, the team secured £30,000 to develop a long-term solution. A team was formed to work in close collaboration with patients, specialist maternity staff and teams across the Trust to develop the support processes, staffing models and secure a physical space where calls could be taken outside the bustle of the busy clinical environment
The outcome	The introduction of the telephone support service offers timely advice, guidance and assurance to expectant mothers. It has also helped identify cases where urgent admissions are a priority and reduced unnecessary visits, saving time and money for patients and the hospital. The newly structured service means fewer disruptive calls into busy clinical areas allowing staff to prioritise planned and urgent cases.

Introduction of a dedicated maternity service telephone support line	
The problem	As part of an Appreciative Inquiry (AI) within pharmacy services, the dispensary department identified opportunities to increase overall levels of staff engagement and support a team-based implementation of improvement ideas generated by staff members.
The solution	Starting in April 22, the Trust's improvement team designed and led a series of engagement and learning workshops. Staff members across the dispensary and pharmacy services reviewed feedback from the AI and identified new opportunities to improve team understanding and collaboration. Next the team was introduced to quality improvement techniques and supported to co-design develop a format structure for their regular improvement huddles
The outcome	The huddles launched in June 22 with good levels of staff attendance, but the initial corridor setting proved disruptive and later moved to a discrete location. Attendance levels fluctuated because of rising work pressures and higher than normal levels of temporary staff, but despite the challenges, data still showed improvement in key operational performance. It remains a challenge to innovate and change in the face of current operational pressures and results are not always as stable at the team would want. Critically, even with the natural turnover of staff and team leaders, the process has enhanced confidence to implement improvement. It is an ongoing process and has provided important input into the Trust's High Performing Team programme.

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. 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, including work on tackling health inequalities; and the south west London-wide focus on elective care.

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.

For example, trusts within south west London are continuing to work together to reduce the number of patients that are waiting longest for elective care. During 2022/23 the number of patients waiting over 78 weeks has reduced from 85 to 17. The aim will be to continue this trend so that no patient is waiting over 65 weeks by the end of March 2024.

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, 34 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.

St George's Hospital Charity

In Spring 2022 St George's Hospital Charity launched a major new appeal called 'Time for a Change'. It aims to raise £5m for facilities in our children's services at St George's.

In October 2022, the appeal reached its £1.5m milestone, and as of May 2023, the total stands at £2.25m. Many staff and loyal supporters of St George's signed up for challenge events or to become Time for a Change Champions, which has all contributed to the children's appeal total.

Challenge events during the year raised more than £40,000. These continue, and include skydiving, London to Brighton Cycle, and the Royal Parks Half Marathon. A significant contributor was the abseil event in March, which raised more than £60,000 thanks to 136 fundraisers.

The Charity has also focused on expressing gratitude to our staff. In December, it ran 'Christmas on Us', providing staff working over the festive period with a free hot meal. The annual Arts Week in July 2022 was another success, treating staff and patients to live music, dance, and visual arts throughout the hospital.

In Spring 2022 St George's Hospital Charity launched a major new appeal called 'Time for a Change'. It aims to raise £5m for facilities in our children's services at St George's.

Health Overview and Scrutiny Committees

Executive team members from St George's regularly attend meetings of the Wandsworth Health Overview and Scrutiny Committee and have provided updates on several occasions in the last year. The Trust provided regular virtual updates to the committee throughout the pandemic on our response to Covid-19. More recently the focus has been on performance, pressures, resilience and recovery, infection control and service quality and safety. Such appearances are also beneficial in that they provide an opportunity to highlight our services that help groups of patients, such as the Homelessness Inclusion Service and our HIV opt-out testing scheme in our emergency departments.

Members of the Committee are kept informed of developments and challenges across the Trust and group through our monthly stakeholder bulletin. In addition to this, we proactively brief the Chair of the Committee in advance of major announcements or adverse media stories being published. Although no clinical service changes during this time have required input from members, they have been kept informed and are always welcome to ask questions or get involved. Trust and group representatives regularly attend other local Health Overview and Scrutiny Committees including in Merton and Sutton. We value the importance of keeping our local elected representatives and the wider community informed and engaged and are working to broaden our reach.

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 Chairman, the Board of Directors sets the strategy for the Trust, determines objectives and priorities, oversees quality, operational and financial performance and shapes the culture of the organisation. The Board is responsible for ensuring that there are effective systems of governance and internal control in place. The Board is supported in its work by a number of Board Committees.

Our Council of Governors

Our Council of Governors forms an integral part of our governance framework and is led by the Trust Chairman. Our Council of Governors represents our membership body, and during the reporting period its activities contributed to the Trust's work on providing high quality services and care to its patients.

In 2022/23, the Council appointed a new non-executive director to the Trust Board, who serves as the Chair of the Quality Committee. The Council also appointed a new associate non-executive director to the Trust Board. It continued to help to ensure that the Board of Directors had the right balance of skills and knowledge to lead the Trust. These appointments followed the succession planning for non-executive directors undertaken by the Council of Governors in March 2022, in which the Council 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. 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

Govenor	Constituency/Office	Term	Elected/ Re-elected/ Appointed	Period in Office
Gillian Norton	Trust Chairman	N/A	N/A	N/A
ELECTED PUBLIC GOVENORS				
Adil Akram	Wandsworth	First	1 February 2021	1 February 2021 - 1 January 2024
Afzal Ashraf	Wandsworth	Second	February 2023	1 February 2023 - 31 January 2026
John Hallmark	Wandsworth	Third	1 February 2021	1 February 2021 - 1 January 2024
Shalu Kanal	Wandsworth	First	1 February 2021	1 February 2021 - 1 January 2024
Lucy Mowatt	Wandsworth	First	February 2023	1 February 2023 - 31 January 2026
Ataul Qadir Tahir	Wandsworth	Second	February 2023	1 February 2023 - 31 January 2026
Nasir Akhtar	Merton	Second	February 2023	1 February 2023 - 31 January 2026
Patrick Burns	Merton	First	21 April 2021	1 February 2023 - 31 January 2026
Hilary Harland	Merton	Third	1 February 2021	1 February 2021 - 1 January 2024
Khaled Simmons	Merton	Third	1 February 2021	1 February 2021 - 1 January 2024
Richard Mycroft	South West Lambeth (Lead Governor)	Second	1 February 2021	1 February 2021 - 1 January 2024
Michael Amherst	Rest of England	First	1 February 2023	1 February 2023 - 31 January 2026
Padraig Belton	Rest of England	First	1 February 2021	1 February 2021 - 31 January 2024
Derek Cattrall	Rest of England	First	1 February 2023	1 February 2021 - 31 January 2024
Sandhya Drew	Rest of England	Second	1 February 2020	1 February 2023 - 31 January 2026
ELECTED STAFF GOVENORS				
Marlene Johnson	Nursing & Midwifery	Second	1 February 2021	1 February 2021 - 31 January 2024
Alexander Quay-le	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
Huon Snelgrove	Non-Clinical	First	1 February 2023	1 February 2023 - 31 January 2026
APPINTED STAKEHOLDER GOVERNORS				
Julian Ma	St. George's University of London	First	1 February 2023	1 February 2023 - 31 January 2026
Alfredo Benedic-to	Healthwatch Merton	Second	1 February 2021	1 February 2021 - 31 January 2024
Sarah Forrester	Healthwatch Wandsworth	First	1 February 2021	1 February 2021 - 31 January 2024
Sangeeta Patel	South West London CCG	Second	1 February 2021	1 February 2021 - 31 January 2024

On 31 January 2023, the following Governors stood down from the Council of Governors:

- Mia Bayles, Public Governor, Rest of England
- Jenni Doman, Staff Governor, Non-Clinical
- Basheer Khan, Public Governor, Wandsworth
- Stephen Sambrook, Public Governor, Rest of England

Elections to the Council of Governors were held in January 2023 and the following Governors were re-elected commencing three-year terms of office:

- Afzal Ashraf, Public Governor, Wandsworth
- Ataul Tahir, Public Governor, Wandsworth
- Nasir Akhtar, Public Governor, Merton
- Patrick Burns, Public Governor, Merton
- Sandhya Drew, Public Governor, Rest of England

In addition, the following were newly-elected to serve on the Council for three-year terms of office:

- Michael Amherst, Public Governor, Rest of England
- Lucy Mowatt, Public Governor, Wandsworth
- Huon Snelgrove, Staff Governor, Non-Clinical

Derek Cattrall was successfully elected for a term of office of one year, and will serve the remainder of the term of office originally held by Mia Bayles.

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 the Trust's Constitution and is reflected in the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

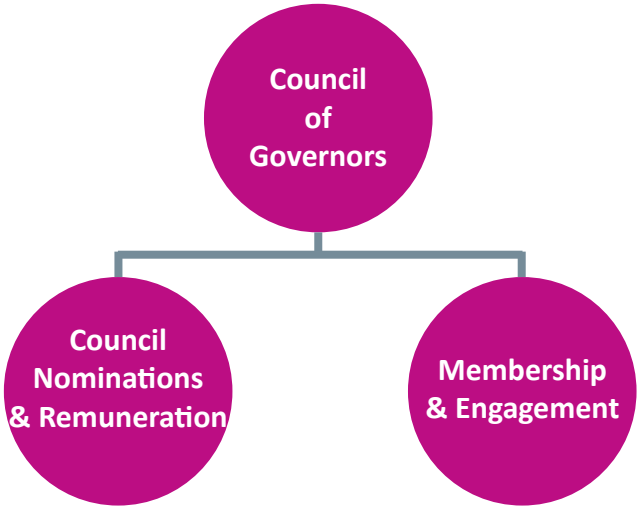
The Council of Governors has additional key decision-making responsibilities including:

- 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.

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. In 2022/23, the Council undertook a review of its training and development needs which included reviewing the knowledge-based and skills-based training required to support the Council to fulfil its role effectively.

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.

With the support of this Committee the Council was able to:

- receive the appraisal of the Chairman and other non-executive directors
- appoint one new non-executive director
- appoint one new associate non-executive director.

The Committee is led by the Trust Chairman and the other members are Governors. During 2022/23 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 four times during the year and considered:

- the development of a new Membership Engagement Strategy
- delivery of the objectives of the current Membership Strategy
- plans for undertaking a survey of members and the public
- plans for engagement events and activities including: Annual Members Meeting, constituency events, implementation of tiered membership.

During 2022/23 the following Governors were members of the Committee:

Members	Title
Afzal Ashraf	Public Governor, Wandsworth
Jenni Doman	Staff Governor – Non-Clinical
Patrick Burns	Public Governor, Merton
Basheer Khan	Public Governor, Wandsworth
Shalu Kanal	Public Governor for Wandsworth
Tunde Odutoye	Staff Governor, Medical and Dental
Padraig Belton	Public Governor, Rest of England
Sandyha Drew	Public Governor, Rest of England
Sarah Forester	Appointed Governor, Healthwatch Wandsworth
Alex Quayle	Public Governor, Allied Health Matters

The Council of Governors met in person during 2022/23, but introduced hybrid meetings in December 2022 both to help facilitate attendance by members of the Council of Governors with caring responsibilities and to facilitate attendance by Governors in the context of their wider commitments. 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

Govenor	Constituency/Office	Term
Gillian Norton	Trust Chairman	5/5
ELECTED PUBLIC GOVENORS		
Nasir Akhtar	Merton	5/5
Adil Akram	Wandsworth	5/5
Afzal Ashraf	Wandsworth	5/5
Mia Bayles	Rest of England	0/5
Padraig Belton	Rest of England	5/5
Patrick Burns	Merton	2/5
Sandhya Drew	Rest of England	4/5
John Hallmark	Wandsworth	5/5
Hilary Harland	Merton	5/5
Shalu Kanal	Wandsworth	4/5
Basheer Khan	Wandsworth	5/5
Richard Mycroft	South West Lambeth (Lead Governor)	5/5
Ataul Qadir Tahir	Wandsworth	4/5
Stephen Sambrook	Rest of England	3/5
Khaled Simmons	Merton	3/5
Michael Amherst	Rest of England	2/2
Derek Cattrall	Rest of England	2/2
Lucy Mowatt	Wandsworth	2/2
Ataul Qadir Tahir	Wandsworth	1/2
Stephen Worrall	Wandsworth (Appointed	1/2
ELECTED STAFF GOVENORS		
Jenni Doman	Non-Clinical	2/5
Marlene Johnson	Nursing & Midwifery	4/5
Tunde Odutoye	Medical & Dental	4/5
Alex Qualye	Allied Health Professionals	4/5
Huon Snelgrove	Non-Clinical	1/2
APPINTED STAKEHOLDER GOVERNORS		
Alfredo Benedicto	Healthwatch Merton	5/5
Kathy Curtis	Kingston University	4/5
Sarah Forrester	Healthwatch Wandsworth	5/5
Sangeeta Patel	Merton/Wandsworth Clinical Commissioning Group	3/5
Julian Ma	St. George's University of London	1/2

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
30 May 2022	Annual planning 2022/23 Group Governance arrangements – Update Developing a new Group Strategy Maternity Services Update following Ockenden Review
5 July 2022	Financial Update Estate strategy and green plan Culture programme update Integrated Quality & Performance Report (Outcomes, Performance and Productivity) Annual Members Meeting 2022 Plan Elections to the Council of Governors 2022
22 September 2022	Integrated Care System Update Integrated Quality & Performance Report (Patient Safety) Developing a new Group Strategy External Auditors Report 2021/22 New Patient Safety Framework Patient Engagement and Experience Report Finance Update Council of Governors Learning and Development Programme
8 December 2022	SWL Integrated Care System update Financial Performance Update Membership Engagement Committee Report
16 March 2023	Financial Performance and Planning Quality and Safety Performance (IQPR highlights) Patient Engagement and Experience Report

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.

Governors are able to question the non-executive directors at Council meetings, and also have the opportunity to attend Board meetings and ask questions. As the Trust emerged from the Covid-19 pandemic in 2021/22, opportunities for Governors' engagement with members have returned to pre-pandemic levels with the Council considering innovative ways of promoting membership engagement at its meeting in December 2022.

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 2022/23.

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. The Trust continues to provide a range of training and development opportunities for Governors to support them in their roles. In 2022/23 Governors were provided with opportunities to attend the Trust for a range of

visits to clinical and non-clinical areas across the Trust as well as observing meetings of the Trust Board. We are aiming to recommence Governors participating in PLACE inspections and ward accreditations in 2023/24. During 2022/23, as part of its development, the Council held a development session, led by the GovernWell Programme from NHS Providers.

Our membership

The Trust is committed to involving patients, families and carers, as well as members of the Trust, in the delivery and development of our services. Our Governors and members ensure that we are accountable to, and listen to the needs and views of, our patients and the communities we serve. We have a combined membership of around 22,000 members:

Membership constituency	2020/22	2022/23
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 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) is eligible to become a staff member.

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.

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, 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 CBE, 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 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 also a Trustee of ReSurge Africa, a Scottish medical charity working in Ghana and Sierra Leone. Stephen took up the role of Non-Executive Director in October 2016.

Professor Jenny Higham,

Non-Executive Director

Professor Jenny Higham is Vice Chancellor 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.

Chiew Yin Jones,

Associate Non-Executive Director

Chiew Yin Jones joined St George's as an Associate Non-Executive Director in January 2023. Chiew Yin is a barrister with over 25 years' experience in criminal justice and is an experienced advocate with a substantial casework and litigation background. She also sits as a Legally Qualified Chair for the Police Misconduct Panel in London and the South-East region. She has several health related roles including being a member of the Lay Committee at the Royal College of Anaesthetists and a former trustee of the Cleft Lip and Palate Association.

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, and performance. He is also a non-executive director of the Institute of Fiscal Studies and Education and Skills Funding Agency Board and 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 University Hospitals NHS Trust.

Dr Andrew Murray,

Non-Executive Director

Dr Andrew Murray joined St George's as a Non-Executive Director in January 2023. He is a GP Partner and acting CEO at the Nelson Medical Practice in Merton, a Population Health Associate at the King's Fund, and an Executive Coach. He also has an interest in developing world healthcare, and education and community development. He helped to set up a community health worker training programme in Myanmar which has trained nearly 1000 health workers. He served for a number of years as a trustee and chair of the charity supporting this work.

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. 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.

Professor 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.

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.

Non-voting Board members

Andrew Asbury,

Group Chief Infrastructure, Facilities and Environment Officer

Andrew joined St George's in 2020 as Director of Estates and was appointed as Acting Group Chief Facilities, Infrastructure and Environment Officer in January 2023. He has overseen the development of a new estate strategy for St George's, together with delivering several significant capital projects and overseeing the estates response to Covid. Prior to joining St George's and the NHS, Andrew worked in the higher education sector, including UCL and the Royal College of Art together with working client-side on several significant capital projects including BBC Broadcasting House, London 2012 and Terminal 5.

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.

Other Directors who served on the Board during 2022/23

During 2022/23, two other Non-Executive Directors served on the Trust Board who have since left the Trust:

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 a 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.

Trust Board Attendance Register 2022/23

Board of Directors	Appointed Role	Eligible Period	Actual/Eligible Attendance
Gillian Norton	Chairman	1 April 2022 – 31 March 2023	6/6
Ann Beasley	Non-Executive Director	1 April 2022 – 31 March 2023	5/6
Stephen Collier	Non-Executive Director	1 April 2022 – 31 March 2023	6/6
Prof. Jenny Higham	Non-Executive Director	1 April 2022 – 31 March 2023	6/6
Peter Kane	Non-Executive Director	1 April 2022 – 31 March 2023	5/6
Dame Parveen Kumar	Non-Executive Director	1 April 2022 – 12 January 2023	4/5
Dr Andrew Murray	Non-Executive Director	23 January 2023 - 31 March 2023	0/6
Tim Wright	Non-Executive Director	1 April 2022 – 31 March 2023	4/6
Voting Executive Directors			
Jacqueline Totterdell[1]	Nursing & Midwifery	1 April 2022 – 31 March 2023	6/6
Andrew Grimshaw[2]	Allied Health Professionals	1 April 2022 – 31 March 2023	6/6
Arlene Wellman	Clinical & Dental	1 April 2022 – 31 March 2023	
Dr Richard Jennings[2]	Non-Clinical	1 April 2022 – 31 March 2023	5/6
Non-Voting Non-Executive Directors			
Chiew Yin Jones	Associate Non-Executive Director	1 March 2023 – 31 March 2023	1/1
Pui-Ling Li	Associate Non-Executive Director	1 April 2022 – 12 January 2023	4/5
Non-Voting Executive Directors			
Andrew Asbury	St. George's University of London	16 January 2023 – 31 March 2023	1/1
Stephen Jones2	Healthwatch Merton	1 April 2022 – 31 March 2023	6/6
Paul Da Gama2	South West London CCG	1 April 2022 – 31 March 2023	5/6
James Marsh	Kingston University	1 April 2022 – 31 March 2023	4/6
Kate Slemeck	Wandsworth Council	1 April 2022 – 31 March 2023	6/6

[1] Appointed Group Chief Executive from 1 August
[2] 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 2022/23: Stephen Collier, Tim Wright, Andrew Murray (from 23 January 2023), Chiew Yin Jones (from 2 March 2023), and Parveen Kumar and Pui-Ling Li (until 12 January 2023). Gillian Norton, Ann Beasley and Peter Kane (from 1 October 2022) served on the Board of Epsom and St Helier University Hospitals NHS Trust during 2022/23. 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. The terms of office of our current non-executive directors are set out below:

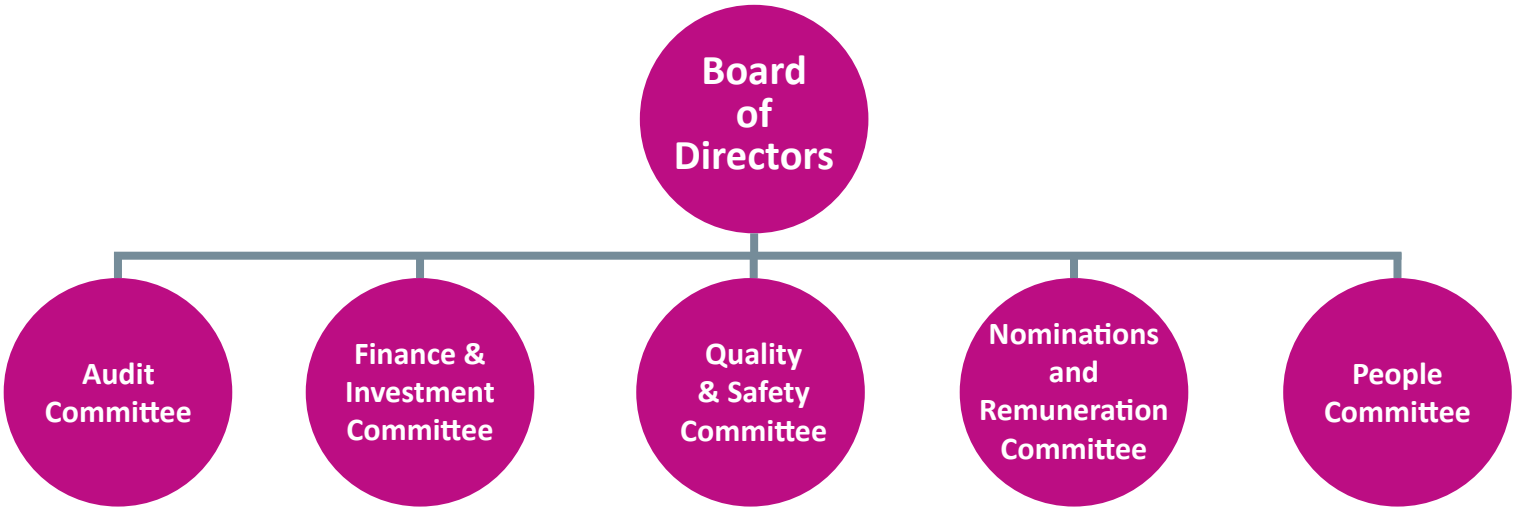
Name	Current term of office	Term length	Previous term of office (if relevant)
Gillian Norton	1 April 2023 – 31 March 2025**	2 years	1 April 2020 – 31 March 2023
Ann Beasley	13 Oct 2022 – 12 Oct 2025**	3 years	13 Oct 2019 – 12 Oct 2022
Stephen Collier	13 Oct 2022 – 12 Oct 2023**	1 year	13 Oct 2019 – 12 Oct 2022
Jenny Higham	1 January 2016 (open ended)*	3 years	N/A
Chiew Yin Jones	13 Jan 2022 – 12 Jan 2025	2 years	N/A
Peter Kane	1 Oct 2021 – 30 Sept 2024	3 years	N/A
Andrew Murray	13 Jan 2023 – 12 Jan 2026	3 years	N/A
Tim Wright	26 Sept 2023 – 25 Sept 2024**	1 year	26 Sept 2020 – 25 Sept 2023**

* 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 Finance, Quality and People Committees met on a monthly basis throughout 2022/23. The Audit Committee met five times and the Nominations and Remuneration Committee also met on five occasions during this period.

Following the agreement of the Trust Board in March 2022, from the start of 2022/23 the Finance, Quality, People and Nominations and Remuneration Committees met as Committees-in-Common with the equivalent committees of the Board of Epsom and St Helier University Hospital NHS Trust. These Committees-in-Common each developed and agreed a forward plan which ensured that the assurance needs of each Trust were appropriately met. Meetings operated with a single shared agenda, with a number of Group-wide agenda items as well as Trust-specific items where necessary. Under these arrangements, each of the Committee of the St George's Board retained its own Chair, its own separate terms of reference, and each needed to be quorate in its own right, reflecting the fact that the two Trusts within the Group remain separate legal entities. The advantage of these in-common arrangements were that it facilitated a Group-wide perspective on issues of shared focus, provided an opportunity to identify and share learning and good practice, support closer collaborative working within a robust governance framework.

The committees each produced reports for the Trust's Board meetings held in public following each meeting summarising the key areas of focus, assurance and risk considered. The committees also conducted annual effectiveness reviews 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 2022/23 the Committee held five meetings and attendance is recorded below:

Members/Attendees	Title	Meetings Attended/ Eligible to Attend
Peter Kane	**Non-Executive Director, Chair**	**5/5**
Ann Beasley	**Non-Executive Director**	**5/5**
Tim Wright	**Non-Executive Director**	**5/5**
Pui-Ling Li (until 12 January 2023)	**Non-Executive Director**	**1/4**

During the period, the Committee:

- reviewed the 2021/22 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 2022/23 Annual Report;
- monitored the programme of internal audit based on which the Trust received a reasonable assurance rating of its systems and internal controls;
- reviewed themes and trends arising from internal audit reviewed undertaken during 2021/22.
- agreed a process for the tendering of internal audit services across south west London, and approved the appointment of a new internal audit provider.
- received regular updates from the Trust's counter-fraud specialist.
- reviewed the Trust's cybersecurity arrangements.
- agreed a new policy on managing conflicts of interest and oversaw the Trust's actions to increase compliance of decision-making staff registering appropriate declarations.
- provided oversight of the management of losses and special payments.

Finance Committee

The Finance Committee operated as a committee-in-common with the Finance Committee of Epsom and St Helier University Hospitals NHS trust throughout 2022/23.

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

During 2022/23 the Committee held 12 meetings and attendance is recorded below:

Members/Attendees	Title	Meetings Attended/ Eligible to Attend
Ann Beasley	Non-Executive Director, Chair	10/12
Stephen Collier	Non-Executive Director	11/12
Tim Wright	Non-Executive Director	10/11
Peter Kane	Non-Executive Director	11/12
Andrew Grimshaw	Group Chief Finance Officer	11/12
Kate Slemeck	Managing Director, SGUH	9/12
Dr Richard Jennings	Group Chief Medical Officer	10/12
Arlene Wellman	Group Chief Nursing Officer	7/12
James Marsh	Group Deputy Chief Executive Officer	11/12

During the period, the Committee:

- reviewed the delivery of the Trust's financial plan in 2022/23 and the risks associated with delivery.
- reviewed the delivery of the Trust's Cost Improvement Programmes (CIPs).
- reviewed the development of the Trust's financial plans for 2023/24.
- closely monitored operational performance, including against emergency care operating standard, elective performance, productivity and activity levels.
- 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 Committee

The Quality Committee operated as a committee-in-common with the Quality Committee of Epsom and St Helier University Hospitals NHS trust throughout 2022/23.

The 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, Group Deputy Chief Executive Officer, and Group Chief Corporate Affairs Officer regularly attended the meetings of the Committee. During 2022/23 the Committee held 12 meetings and attendance is recorded below:

Members/Attendees	Title	Meetings Attended/ Eligible to Attend
Dame Parveen Kumar (until 12 January 2023)	Non-Executive Director, Chair	8/9
Andrew Murray (from 23 January 2023)	Non-Executive Director	2/2
Prof. Jenny Higham	Non-Executive Director	11/12
Peter Kane	Non-Executive Director	11/12
Pui-Ling Li (until 12 January 2023)	Associate Non-Executive Director	9/9
Chiew Yin Jones (from 2 March 2023)	Associate Non-Executive Director	1/1
Dr Richard Jennings	Group Chief Medical Officer	11/12
Arlene Wellman	Group Chief Nursing Officer	12/12
Kate Slemeck	Managing Director, SGUH	9/12

As part of its annual work programme, the Committee:

- held regular deep dives across a range of quality and safety issues within its remit where it considered further assurance was necessary. During 2022/23, the Committee conducted a total of nine 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 the Trust's arrangements for and performance in relation to infection prevention and control;
- reviewed the Trust's maternity services, particularly in the context of the Ockenden and Kirkup reviews and in relation to the safety actions in the Maternity Incentive Scheme;
- received reports on quality, safety and operational performance in cardiac surgery;
- focused on safeguarding, medicines management, mortality monitoring, learning disabilities services and improving the clinical governance infrastructure of the Trust.

People Committee

The People Committee operated as a committee-in-common with the People Committee of Epsom and St Helier University Hospitals NHS trust throughout 2022/23.

The 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 Committee membership comprises non-executive and executive directors. The Chairman, Group Chief Executive, Group Deputy Chief Executive and Group Chief Corporate Affairs Officer regularly attend the meetings of the Committee. During 2022/23 the Committee held 11 meetings and attendance is recorded below:

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Stephen Collier	Non-Executive Director, Chair	12/12
Dame Parveen Kumar (until 12 January 2023)	Non-Executive Director	12/12
Andrew Murray (from 23 January 2023)	Non-Executive Director	12/12
Tim Wright	Non-Executive Director	9/12
Pui-Ling Li (until 12 January 2023)	Associate Non-Executive Director (SGUH)	12/12
Chiew Yin Jones (from 10 March 2023)	Associate Non-Executive Director (SGUH)	6/12
Paul Da Gama	Group Chief People Officer	8/10
Arlene Wellman (from 1 Feb 2022	Group Chief Nursing Officer	
Kate Slemeck	Managing Director, SGUH	
Andrew Grimshaw	Group Chief Finance Officer	1/2

During the year the Committee:

- reviewed key workforce performance indicators, including turnover rates, stability, sickness absence, training;
- conducted deep dives into areas where the Committee felt that further assurance was required;
- considered, approved and monitored progress against the culture change programme, staff engagement plan, and diversity and inclusion plans;
- reviewed the Trust's plans for and results from the annual NHS Staff Survey;
- rreceived reports on results from the General Medical Council National Training survey;
- received reports on the Trust's Freedom to Speak Up Guardian and Guardian of Safe Working;
- reviewed the two strategic risks assigned to the Committee on the Board Assurance Framework;
- reviewed progress in implementing the Board approved workforce and education supporting strategies.

Declaration of interests

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

Performance evaluation of the Board

The Trust has in place established processes for undertaking performance evaluations of Board members, both executive and non-executive. The Trust has a policy, agreed by the Council of Governors, which governs the appraisal process for the Chairman and other non-executive directors. The Council of Governors reviewed and approved an updated policy in May 2022. 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. 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 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.

NHS System Oversight Framework

NHS England has set out an updated NHS system oversight framework 2022/23. 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. • A new Group-wide strategy was developed during 2022/23 and is scheduled for publication in May 2023.

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 Group Executive meeting and by relevant Board committees. • 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. • Through the Group-wide governance arrangements introduced in 2022/23 there are also processes to facilitate learning and sharing of good practice across the St George's, Epsom and St Helier University Hospitals and Health Group.

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	2022-23 NUMBER	2022-23 £000s	2020-21 NUMBER	2020-21 £000s
Total non-NHS trade invoices paid in the year	107,405	414,591	114,294	390,672
Total non-NHS trade invoices paid within target	76,456	313,834	66,172	299,852
PERCENTAGE OF NON-NHS TRADE INVOICES PAID WITHIN TARGET	71.18%	75.7%	57.90%	76.75%

NHS PAYABLES	2022-23 NUMBER	2022-23 £000s	2020-21 NUMBER	2020-21 £000s
Total NHS trade invoices paid in the year	3,779	57,740	5,905	104,284
Total NHS trade invoices paid within target	2,148	38,169	2,178	86,401
PERCENTAGE OF NHS TRADE INVOICES PAID WITHIN TARGET	56.84%	66.10%	36.88%	82.85%

Total				
Total bills paid in the year	111,184	472,331	120,199	494,956
Total bills paid within target	78,604	352,003	68,350	386,253
PERCENTAGE OF BILLS PAID WITHIN TARGET	70.70%	74.52%	56.86%	78.04%

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 England and the National Audit Office, and a review of the Quality Accounts (in 2022/23 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 £198,000 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 2022/23 included but were not limited to: Core Financial Systems, Risk Management, Data Quality, DSP Toolkit, ICT Programme and Project Management, Cybersecurity, Clinical Systems not supported by central IT, Procurement, Rostering of Junior Medical Staff, Temporary Staffing and Payroll. During the period the Trust paid internal audit fees of £122,000. The Committee approved the re-appointment of TIAA as the Trust's internal auditors in August 2019. In January 2023, the Committee reviewed the outcome of a tender process for the provision of internal audit services from April 2023 and approved the appointment of a new provider from this date.

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

30 June 2023

4. Remuneration report

Remuneration report

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 remuneration report comprises:

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

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).

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). In 2022/23, the Board's Nominations and Remuneration Committee has met as a Committee-in-Common with the equivalent Committee at Epsom and St Helier University Hospitals NHS Trust.

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

MEMBERS/ATTENDEES	TITLE	MEETINGS ATTENDED/ ELIGIBLE TO ATTEND
Gillian Norton	**Trust Chairman, Chair**	**5/5**
Ann Beasley)	**Non-Executive Director (Vice Chair)**	**5/5**
Stephen Collier	**Non-Executive Director**	**4/5**
Professor Jenny Higham	**Non-Executive Director**	**5/5**
Peter Kane	**Non-Executive Director**	**3/5**
Dame Parveen Kumar	**Non-Executive Director**	**4/4**
Pui-Ling Li	**Associate Non-Executive Director**	**2/4**
Tim Wright	**Non-Executive Director**	5/5
Andrew Murray	**Non-Executive Director**	0/0
Chiew Yin Jones	**Associate Non-Executive Director**	**0/0**

The Council of Governors' Nominations and Remuneration Committee determines the remuneration of non-executive directors, oversees the process for the appointment of new non-executive directors, and oversees the outcomes of annual appraisals of non-executives. During 2022/23 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 2022/23 disclosures

The banded remuneration of the highest paid director in the financial year 2022-23 was £212k (2021-22 £198k). The relationship to the remuneration of the organisation's workforce is disclosed in table 2 below.

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 6.0 times (2021-22, 4.5 times) the median remuneration of the workforce, which was £35.2k (2021-22 £44.1k).

50% salary of the Chief Executive was recharged to Epsom and St Helier Hospital NHS Trust (EPSH) for the FY 22-23.

Range of staff remuneration for 2022/23 (audited)

In 2022/23, the lowest annualised salary was £41.64 (2021-22 £79.80). 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 £20,270 (2021-22 £18,456 (Band1). The highest paid was £529,079 (2021-22 £390,153).

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	PERFORMANCE PAY AND BONUSES £000	SALARY AND ALLOWANCES £000	PERFORMANCE PAY AND BONUSES £000
FY 2022-23	154	0	40	4
FY 2021-22	198	0	48	3
% increase/decrease	-22%	0%	-16%	37%

Notes

1. In FY22-23 highest-paid board member was Chief Executive, and in FY21-22, it was the finance director. There is a 22% decrease in the highest paid in FY22-23 compared to FY21-22 due to the group board between St George's University Hospital NHS FT and Epsom and St Helier Hospital NHS Trust. The current year figures excludes on-costs included in recharges from Epsom and St Helier Hospital NHS Trust in 21/22. The drop in the highest paid Directors Remuneration resulted from the full year effect of a joint Board of Executive Director's serving both St Georges Healthcare NHS Foundation Trust and Epsom and St Heliers NHS Trust.

2. 50% salary of the Chief Executive was recharged to Epsom and St Helier Hospital NHS Trust (EPSH) for the FY 22-23

St Helier Hospital NHS Trust in 21/22. The drop in the highest paid Directors Remuneration resulted from the full year effect of a joint Board of Executive Director's serving both St Georges Healthcare NHS Foundation Trust and Epsom and St Heliers NHS Trust.

2. 50% salary of the Chief Executive was recharged to Epsom and St Helier Hospital NHS Trust (EPSH) for the FY 22-23

3. The highest-paid Chief Executive received no performance pay and bonuses in FY22-23.

4. 16% decrease in average pay for employees in FY22-23 compared to FY21-22. This excludes the highest-paid Chief Executive.

5. An increase in performance pay and bonuses (Local Clinical Excellence Awards) is due to increase in performance pay and bonus payment in FY 22/23 compared to FY 21/22

Table 2: Multiple table

MULTIPLE TABLE	2022/23	2020/21
Payroll costs (£000)	711,137	642,750
Whole time equivalent	10,180	9,983
25th percentile	25	30
Median (£000)	35	44
75th percentile	52	53
Highest paid director (£000)	154	198
25th percentile pay ratio	6..2	6.6
Median will fit into highest	4.4	4.5
75th percentile pay ratio	3.0	3.7

Table 3: Pay ratio disclosure

YEAR	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
FY 2022-23	6.2	4.4	3.0
FY 2021-22	6.6	4.5	3.7

Table 4: Pay ratio information table

FY 2022-23	25th percentile	Median	75th percentile
Total remuneration (£000)	25	35	52
Salary component of total remuneration (£000)	25	35	52
Pay ratio information	6.2	4.4	3.0

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

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 2023.

4. In 2022/23, the lowest annualised salary was £41.64 (2021-22 £79.80). The highest paid was £529,079 (2021-22 £390,153). This is as per the payroll report and is distorted by bank staff and several variables such as prior year arrears payment including clinical excellence award paid in FY22-23. The lowest paid salary of £41.64 FY22-23 is due to the bank staff who was not active in the respective financial year but got paid for previous year arrears. The lowest paid annualised band in the Trust for the FY22-23 is £20,270 (2021-22 £18,456 (Band1)

Remuneration report (audited)

NAME	JOB TITLE	PERIOD	2022/23							2021/22				
EXECUTIVE DIRECTORS			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	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
Ms Jacqueline Totterdell	Group Chief Executive	from 1st May 2017	150-155 *(Note 1)	0	0	0	0 *(Note 1)	150-155	180-185	0	0	0	0 *(Note 1)	180-185
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.	105-110 *(Note 1)	0	0	0	0 *(Note 1)	105-110	195-200	0	0	0	0 *(Note 1)	195-200
Mr Paul Da Gama	Chief People Officer	from 8th February 2021	75-80 *(Note 5)	1200	0	0	42.5-45	120-125	125-130	0	0	0	50-52.5	180-185
Mr Stephen Jones	Chief Corporate Affairs Officer	from 5th March 2018	65-70 *(Note 5)	0	0	0	32.5-35	95-100	105-110	0	0	0	27.5-30	130-135
Dr Richard Jennings	Chief Medical Officer	from 19th November 2018	100-105 *(Note 5)	0	0	5-10	52.5-55	165-170	175-180	0	0	15-20	20-22.5	215-220
Kate Slemeck	Managing Director – St George's	from 3rd February 2022	195-200 *(Note 6)	0	0	0	0-2.5	195-200	30-35	0	0	0	7.5-10	40-45
Arlene Wellman	Group Chief Nursing Officer	from 1st February 2022	75-80	0	0	0	0 *(Note 4)	75-80	15-20	0	0	0	0	15-20
James Marsh	Group Deputy Chief Executive Officer	from 1st February 2022	125-130	0	0	0	0 *(Note 4)	125-130	20-25	0	0	0	0	20-25
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	0	0	55-60	55-60	0	0	0	0	55-60
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	0	0	10-15	10-15	0	0	0	0	10-15
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	0	0	10-15	10-15	0	0	0	0	10-15
Mr Timothy Wright	Non-executive Director	from 25th September 2017	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Peter Kane	Non-Executive Director	from 1st October 2021	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Mr Andrew Murray	Non-executive Director (Chair of Quality Committee)	from 23rd January 2023* (Note 7)	0-5	0	0	0	0 *(Note2)	0	0	0	0	0	0	0
Chiew Yin Jones	Associate Non-executive Director	from 1 March 2023* (Note 7)	0-5	0	0	0	0 *(Note2)	0	0	0	0	0	0	0
Professor Jennifer Higham *(Note 3)	Non-executive Director	from 1st November 2015 (see note 1)	0	0	0	0	0	0	0	0	0	0	0	0
LEAVERS														
Dr Pui-Ling Li	Associate Non-executive Director	from 13th January 2020 – 12 January 2023 (see note 8)	5-10	0	0	0	0 *(Note 8)	5-10	5-10	0	0	0	0	5-10
Professor Dame Parveen Kumar	Non-executive Director (Chair of Quality & Safety Committee)	from 13th January 2020– 12 January 2023 (see note 8)	10-15	0	0	0	0 *(Note 8)	10-15	10-15	0	0	0	0	10-15

Notes

1. Ms Jacqueline Totterdell & Mr Andrew Grimshaw- For FY22-23 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). Salary includes a financial year 2021/22 pay award of £9,354 split equally between SGH and ESTH that was paid in 2022/23

2. No comparative information in 2022/2023 for Andrew Murray and Chiew Yin Jones as they joined the Trust this financial year.

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

4. Arlene Wellman and James Marsh have 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.

5. 50% of salary recharged to Epsom and St Helier for Jacqueline Totterdell, Andrew Grimshaw, Richard Jennings, Paul da Gama, Stephen Jones for FY 22/3. Kate Slemeck is St. George's managing director; therefore, there are no recharges for Kate

6. Kate Slemeck – For the FY 22/23, 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

7. Andrew Murray joined the Trust from 23 January 2023 as Chair of Quality & Safety Committee (NED) and Chiew Yin Jones joined the Trust from 1 March 2023 as an Associate Non-Executive director.

8. Dr Pui-Li and professor Dame Parveen Kumar left the Trust board on 12 January 2023

The reported pay in 21/22 for the Group Directors included on-cost recharges received from Epsom and St Helier Hospital NHS Trust. This has been removed in 22/23

Pensions report (audited)

NAME	JOB TITLE	PERIOD	2022/23							
EXECUTIVE DIRECTORS			Real increase in pension at pension age	Real increase in pension and related lump sum at pension age	Total accrued pension at Pension Age at 31 March 2023	Lump sum at pension age related to Accrued pension at 31 March 2023	Cash Equivalent Transfer Value at 01 April 2023	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 22	Employer's contribution to state holder pension
			(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Ms Jacqueline Totterdell	Group Chief Executive	from 1st May 2017	0	0	0	0	0	0	0	0
Mr Andrew Grimshaw	Chief Financial Officer and Deputy Chief Executive	(CFO) from 19th June 2017 and (Deputy CEO) from 25th April 2019	0	0	0	0	0	0	0	0
Mr Paul Da Gama	Chief People Officer	from 8th February 2021	2.5-5	0	25-30	0	348	29	289	0
Mr Stephen Jones	Chief Corporate Affairs Officer	from 5th March 2018	2.5-5	0	10-15	0	132	13	98	0
Dr Richard Jennings	Chief Medical Officer	from 19th November 2018	2.5-5	2.5-5	70-75	190-195	1746	77	1600	0
Kate Slemeck	Managing Director – St George's	from 3rd February 2022	0	0	50-55	90-95	1065	0	1110	0
NAME	JOB TITLE	PERIOD	2021/2022							
Ms Jacqueline Totterdell	Group Chief Executive	from 1st May 2017	0	0	0	0	0	0	0	0
Mr Andrew Grimshaw	Chief Financial Officer and Deputy Chief Executive	(CFO) from 19th June 2017 and (Deputy CEO) from 25th April 2019	0	0	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	238	0
Mr Stephen Jones	Chief Corporate Affairs Officer	from 5th March 2018	0-2.5	0	5-10	0	98	9	71	0
Dr Richard Jennings	Chief Medical Officer	from 19th November 2018	0-2.5	0	65-70	185-190	1,600	49	1,525	0
Kate Slemeck	Managing Director – St George's	from 3rd February 2022	0-2.5	0-2.5	55-60	105-110	1,110	9	1,019	0

Notes

9. McCloud judgement: The Court of Appeal ruling on 'protection', known 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

10. The method used to calculate CETVs changed, to remove the adjustment or Guaranteed Minimum Pension (GMP) Indexation on 8th 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

11. As non-executive directors do not receive pensionable remuneration, the are no entries in respect of non-executive directors.

12. The above disclosures are audited by Trust's external auditor

Pension scheme (audited)

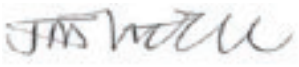
As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

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.

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

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

30 June 2023

Andrew Grimshaw
Group Chief Finance Officer

30 June 2023

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	10	9	52.63%	47.37%
Senior manager (AFC 8c+)	90	69	56.62%	43.38%
All staff	6,375	2,646	70.67%	29.33%

Average number of employees (audited)

TYPE	2022/23			2021/22
	PERMANENTLY EMPLOYED NUMBER	OTHER NUMBER	TOTAL NUMBER	TOTAL NUMBER
Medical and dental	1,543	143	1,686	1,588
Administration and estates	2,103	186	2,289	2,291
Healthcare assistants and other support staff	1,869	252	2,120	1,403
Nursing, midwifery and health visiting staff	2,665	467	3,132	3,074
Scientific, therapeutic and technical staff	841	112	953	1,626
Total average numbers	9,021	1,159	10,180	9,982
Number of employees (WTE) engaged on capital projects	31	14	45	52

Sickness absence data

Sickness absence data for the financial year 2022/23 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 2022/23 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

Total employee expenses (audited)

COST	2022/23			2021/22
	Permanently employed £000	Other £000	Total £000	Total £000
Salaries and wages	538,970	5,530	544,500	486,262
Social security costs	58,925	0	59,925	53,759
Apprenticeship Levy	2,736	0	2,736	2,178
Employer's contributions to NHS pensions	58,589	0	58,589	78,229
Pension Cost – employer contribution paid by NHSE on provider's behalf (6.3%)	25,618	0	25,618	23,793
Pension cost – other	95	0	95	49
Other post-employement benefits	0	0	0	0
Other employement benefits	0	0	0	0
Temination benefits	0	0	84	84
Temporary staff	0	20,974	20,674	22,189
Total gross staff costs	684,933	26,204	666,543	638,409

Expenditure on consultancy

EXPENDITURE ON CONSULTANCY	2022/23	2021/22
Consultancy costs (£k)	480	626

Staff exit packages (audited)

EXIT PACKAGE COST BAND	NUMBER OF COMPULSORY REDUNDANCIES	NUMBER OF OTHER DEPARTURES AGREED	TOTAL NUMBER OF EXIT PACKAGES BY COST BAND
<£10,000	0	7	7
£10,001 – £25,000	0	1	1
£25,001 – £50,000	0	0	0
£50,001 – £100,000	0	1	1
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	0	9	9
Total resource cost (£k)	£0	£107	£107

Exit packages: non-compulsory departure

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	8	87
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	1	0
Total	9	107

EARLY RETIREMENT DUE TO ILL HEALTH	2022/23		2021/22	
	NUMBER	£0	NUMBER	£0
No of early retirements on the grounds of ill-health	3	0	2	
Value of early retirements on the grounds of ill-health		76		210

Off-payroll engagements

Table 1: For all off-payroll engagements as of 31 March 2023 for more than £245 per day and that last longer than six months.

	2022/23 NUMBER OF ENGAGEMENTS	2021/22 NUMBER OF ENGAGEMENTS
Number of existing engagements as of 31 March 2023	8	16
Of which...		
No. that have existed for less than one year at time of reporting	7	15
No. that have existed for between one and two years at time of reporting	1	1
No. that have existed for between two and three years at time of reporting	0	0
No. that have existed for between three and four years at time of reporting	0	0
No. that have existed for more than four years at time of reporting	0	0

Table 2: For all new off-payment engagements, or those that reached six months duration, between 1 April 2022 and 31 March 2023, for more than £245 per day and that last longer than six months.

	2022/23 NUMBER OF ENGAGEMENTS	2021/22 NUMBER OF ENGAGEMENTS
Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2023	8	16
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 2022 and 31 March 2023. payments (audited)

	2022/23 NUMBER OF ENGAGEMENTS	2021/22 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 making 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 Culture and Leadership Programme – taking an in-depth look at the culture of our organisation
- Continued work to embed our values-based behaviours into everything that we do.

Staff engagement work continues to be monitored at executive level by our People Management Group and Culture, Equity, and Inclusion Programme Board, and at Board level by the People Committee in Common.

Staff recognition programmes

At St George's we have many ways in which we can recognise staff. Over the year, there has been an increased demand for recognition and recognition events. Furthermore, the most recent staff survey results show that staff recognition is one of the key drivers for staff engagement in our organisation.

One of our main achievements in this area has been the relaunch of our Long Service Awards in October to celebrate staff who had achieved 25 years continuous Trust service. We held three events in the Hyde Park Room, where recipients enjoyed an afternoon tea, entertainment provided from our charity, and were presented with awards from our Group CEO and Trust Managing Director. Recipients received a certificate and a £50 voucher.

Living our Values

At St George's we have many ways in which we can recognise staff. Over the year, there has been an increased demand for recognition and recognition events. Furthermore, the most recent staff survey results show

Living our Values

Since launching our values-based behaviours in July 2022, we have been working to embed the values widely across St George's including:

- Launching facilitated values workshops and training for individuals and teams
- Reviewing and updating our values policy to reflect our new values-based behaviours
- Delivering a regular session on values at the (face to face) corporate induction programme introducing all new starters to our values-based behaviours
- Embedding our values-based behaviours into the management fundamentals toolkit
- Launching a values-based behaviours assessment tool with the cohorts of our leadership programme
- Developing inspirational and educational video content with staff representative of our organisation, explaining why it's important that we all live the Trust values.
- Developing branding to ensure our communications consistently represent what we're trying to achieve.

This continues to be a collaborative process with staff in which we keep them informed and give opportunities to share their views.

Diversity and Inclusion

We will be working towards developing an engaged and diverse workforce in the months ahead. We have made some progress in achieving an inclusive culture at St George's, but we recognise there is more to do if we are to improve the experience of all our staff.

Through doing this, we know that we'll be able to improve recruitment, retention, and ultimately patient care. Through our staff survey we will be able to track our progress towards this goal.

As the largest healthcare provider in southwest London, the diversity of our workforce must reflect the communities we serve. We recognise the need to continue working towards this goal.

Diversity and Inclusion Action Plan

We have made progress in delivering our Diversity and Inclusion Action Plan, which consists of several key workstreams with clear objectives and milestones to monitor our progress. The plan comprises short, medium, and long-term actions aimed at addressing workplace inequalities, and making a real and sustainable difference. These workstreams align with both the NHS Equality Delivery System (EDS2) and our public sector equality duties (PSED).

We are revising our plans for EDS and PSED to reflect the progress we've made, and the next steps we need to take to address workforce, patient care, and health inequalities. The Culture, Equity, and Inclusion Programme Board oversees a series of projects and initiatives 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 continued to be led by an executive lead and supported by a professional lead and project manager. This has been 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 delivered against targets and success measures for the other protected characteristics.

Culture, Equity and Inclusion (CEI) Programme Board

We introduced a Culture, Equity and Inclusion Programme Board in 2021 to oversee our culture and leadership programme, and the diversity and 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. It 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 has divisional representation, to make sure we have a range of views and voices from across the organisation on these matters.

This group is going through some change in response to the development of a Group-wide Culture Development Programme that also applies Epsom and St Helier. Both Trusts have spent a significant amount of time understanding their cultures and where they need to be developed further. The programme will start to be implemented in May 2023.

Recruitment Inclusion Specialists (RIS) Scheme

Our Recruitment Inclusion Specialists project has continued throughout the year. The project was due to be expanded to band 6 roles, but this will follow once improvements in compliance at band 7 and above have been achieved.

The RIS project is also being rolled out across Epsom and St Helier thanks to the collaboration that has taken place between the two ED&I teams. We will continue to monitor progress carefully.

Leadership Development Training

We have made significant inroads with our Active Career Conversations and Coaching and Mentoring projects. The Active Career Conversations have run as a pilot in finance, theatres and anaesthetics departments, with significant positive feedback from staff involved. We will now proceed to roll out the project to the rest of the organisation. We have a trained cohort of eight coaches with a further 10 being trained in 2023. These colleagues are engaging with our Black, Asian, and Minority Ethnic (BAME) staff network to support colleagues from those communities with career development and progression.

Training for interviewees

We have developed a training programme for all staff to help them with being highly effective at interviews. The training involves career webinars, drop-in sessions, and a recently developed impostor syndrome module. We are now promoting this through our BAME network and seeking feedback on its effectiveness.

Staff networks

Our four networks launched in late 2019 continue to meet. Our diversity and inclusion workforce team have worked closely with each network, and supported several events and initiatives, including the development of action plans for three of the four networks. The current membership for each of the following networks remains strong:

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

The networks will be key stakeholders for the Culture Development Programme and will be providing invaluable feedback, challenge, and suggestions for improvement in relation to the programme. Empowering and equipping staff network leads and members to advocate for themselves and their respective communities in relation to the programme, as well as in areas like the culture, equity and inclusion board meetings will be essential.

We have also been involved in the development of the Disability Advice Line that is being implemented across south west London and look forward to that coming on line in 2023.

The Women's staff network has 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. Our diversity and inclusion team has 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, and the launch of a new breastfeeding room for staff returning from maternity leave. This breastfeeding facility was kindly supported by our charity.

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 BAME staff. Our full WRES report for 2022/23 is currently in development and will be published in late August 2023. The data below is a snapshot of data from 31st March 2022 and our 2022 NHS Staff Survey results.

WRES INDICATOR	2020	2021	2022
Relative likelihood of white applicants being appointed from short listing across all posts compared to BAME applicants	1.47	1.47	1.26
Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	2.54	1.82	1.65
Relative likelihood of white staff accessing non mandatory training and CPD compared to BAME staff	1.05	1.03	0.98
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27.3%	23.3%	23.3%
Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	30.1%	25.9%	25.9%
Percentage of BAME staff believing the Trust provides equal opportunities for career progression or promotion	41.1%	42.1%	42.1%
Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	18.0%	16.6%	16.6%
BAME Board membership	-25.9%	-33.1%	-34.1%

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 2022, reports on data from a snapshot date of 31 March 2021. 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 2022/23 is currently in development and in line with requirements will be published in late 2023.

In addition to the initiatives described above regarding Recruitment Inclusion Specialists and the Disability Advice Line, we have also made good progress in relation to increasing disability awareness for all staff. Since its launch in Sept 2022, over 5,500 staff members (60% of our workforce) have completed our Disability Awareness and Essential Workplace Adjustments modules. We are aiming to achieve 90% and above during 2023.

Improving staff health and wellbeing

We want everyone who works at St George's to feel appreciated and supported.

The cost of living crisis added to the pressures experienced by our colleagues in 2022. To address this, we offered a range of tools and resources:

- A financial wellbeing intranet page was updated with toolkits and resources covering different staff needs, from discounts and budget calculators to debt and benefits resources, including access to emergency funding.
- The Trust partnered with Earlsfield foodbank to enable access to food for the most vulnerable, with food collections on St George's Hospital site for those unable to leave their workplace to visit the foodbank.
- A number of financial wellbeing webinars and regular articles in staff communications were shared to help staff navigate the financial squeeze, understand their NHS pension, and make their money go further.
- A bicycle user group, with the support of St George's Charity, offered free recycled bicycles to staff on lower pay bands.

We continued to support staff's mental and physical wellbeing through a range of online resources and more targeted interventions.

- Health and wellbeing pages on the intranet were updated with resources on various topics and offered access to free wellbeing apps (Headspace, Unmind, The Body Coach).
- We put in place 54 Mental Health First Aiders who can offer support locally to their peers and signpost them to further professional help.
- A network of over 60 Health and Wellbeing Champions delivered wellbeing initiatives in their teams, including lunchtime walks with PAT dogs, book clubs and Tai Chi sessions.
- 730 colleagues won a Spa Day, and 120 received free onsite massages as a part of staff lottery funded by SW London ICP.
- Staff experiencing menopause symptoms received access to the menopause café, MenoPAUSE education programme, and free access to Peppy menopause app. Colleagues could enter a draw to win one of 32 goodie bags with items that help manage menopause symptoms.
- A fitness and nutrition course was delivered to support staff with forming healthy lifestyle habits.
- Wellness Action Plans for staff to fill out with line managers to identify what keeps us healthy at work.We continued to support staff's mental and physical wellbeing through a range of online resources and more targeted interventions.
- The outdoor staff gym opened in December 2022.
- In January, 291 colleagues participated in the Wellbeing Challenge and completed tasks that boosted their physical, mental and social wellbeing

Our Staff Support teams offer one-to-one and group interventions to support psychological wellbeing.

- Staff counselling service offering up to six free, confidential, one-to-one support sessions.
- Group debriefing and reflective sessions facilitated on the wards.
- Conflict mediation.

Staff also have access to:

- Free annual flu vaccination and Covid-19 vaccination
- Assessment and recommendation for reasonable adjustments
- Fast-tracked physiotherapy
- Schwartz Rounds, which promote open discussions and support staff wellbeing
- Ongoing wellbeing and mental health trainingFast-tracked physiotherapy
- Smoking cessation support
- Arts and choir classes from the Arts team at St George's Charity.

NHS Staff Survey 2022

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 2022, staff survey questionnaires were sent to 9,141 eligible members of Trust staff and of those, 4,401 were returned. This was a 48.0% response rate, which is 2% higher than the average response rate for Acute and Acute & Community Trusts nationally (46%). A high response rate ensures we can be more confident in understanding what our staff think is working well, and areas for improvement.

For the second time this year, results were grouped into the seven People Promises. Staff Engagement and Morale continue to be reported on as previously. In the table below, our average scores (out of 10) are compared to the national average for each indicator, and also against our scores from the previous year.

	2022/23		2021/22	
	Trust	Benchmarking group	Trust	Benchmarking group
Promise 1: We are compassionate and inclusive	7.0	7.2	7.1	7.2
Promise 2: We are recognised and rewarded	5.6	5.7	5.7	5.8
Promise 3: We each have a voice that counts	6.5	6.6	6.5	6.7
Promise 4: We are safe and healthy	5.8	5.9	5.8	5.9
Promise 5: We are always learning	5.3	5.4	5.2	5.2
Promise 6: We work flexibly	5.7	6.0	5.7	5.9
Promise 7: We are a team	6.5	6.6	6.5	6.6
Staff Engagement	6.8	6.8	6.8	6.8
Morale	5.5	5.7	5.5	5.7

Comparing our results to the benchmark average, we can see that we are slightly below the average in most indicators, with the exception of Staff Engagement, where we are in line. However, positive takeaways from our results are that:

- The majority of questions about the experience of our line managers has seen an improvement year on year:
  - Furthermore, the largest increase year on year has been the question 'My immediate manager asks for my opinion before making decisions that affect my work' which has seen a 3.4% increase
- Views on appraisals and learning opportunities have also seen an improvement
  - 52.4% said they have access to the right learning and development opportunities when needed to (improvement from 49.7% in 2021)
  - The majority of respondents had received an appraisal in the last 12 months and the views on the quality of appraisals have seen a slight improvement since 2021
- Finally, 58.5% of respondents recommend the organisation as a place to work and 67.6% of respondents would recommend us as a place for treatment or care.

However, the majority of the results have seen little movement year on year, meaning 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.

The table below shows previous years' survey results and benchmarking from before the change in reporting format in 2021.

	2019/20		2018/19		2017/18	
	TRUST	BENCHMARKING GROUP	TRUST	BENCHMARKING GROUP	TRUST	BENCHMARKING GROUP
Equality, diversity and inclusion	8.4	9.1	9.1	9.1	8.4	9.1
Health and wellbeing	5.9	6.1	5.9	5.9	5.7	6.0
Immediate managers	6.6	6.8	6.4	6.7	6.5	6.7
Morale	6.0	6.2	5.6	6.1	n/a	n/a
Quality of appraisals	7.6	7.5	5.6	5.4	5.5	5.3
Quality of care	7.8	8.1	7.4	7.4	7.4	7.5
Safe environment – bullying and harassment	9.3	9.5	7.9	7.9	7.6	8.0
Safe environment – violence	6.6	6.8	9.4	9.4	9.4	9.4
Safety culture	7.0	7.0	6.4	6.6	6.5	6.6
Staff engagement	7.0	6.5	6.8	7.0	6.9	7.0
Team working	6.4	6.5	n/a	n/a	n/a	n/a

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, Culture, Equity and Inclusion (CEI) programme board, and our divisions to agree a top five. This builds on our top five from the previous year, providing more focus in areas that require momentum and improvement. These five areas – known as our Big 5, are:

1. Civility and psychological safety

2. Bullying and harassment/keeping staff safe (violence and aggression)

3. Inclusive behaviour within teams

4. Compassionate and inclusive leadership

5. High performance teams

Each of our five areas has subthemes and measures that we will closely monitor in future staff surveys. Progress in these areas will also be monitored through our People Management Group, CEI Programme Board and People Committee for governance and assurance:

THEME	SUB THEMES	STAFF SURVEY MEASURES
Civility and psychological safety	• Civility and respect • Psychological safety and speaking up • Values based behaviours • Team openness to admit to and learn from mistakes and be curious about what leads to mistakes happening. • Speaking up about concerns regarding behaviour • Speaking up about patient safety	• There has been a 2% decline in respondents saying colleagues are understanding and kind to one another (68% in 2022 from 70% in 2021). Furthermore, there has been a 1% decline in respondents saying colleagues are polite and treat each other with respect (69% in 2022 from 70% in 2021). The average is 71%.
Bullying and harassment & keeping staff safe	• Tackling violence and aggression • Bullying & Harassment (and all forms of verbal abuse) as a serious safety issue impacting mental health and the quality of care that can be provided when staff feel unsafe. • Clarity on processes and support for staff • Sharing local action and best practice (e.g. ED)	• The survey shows little change in the amount of people saying they have experienced violence from patients/service user or the public (14% in 2021 and 2022) • We have seen a decline in the percentage of respondents reporting violence. In 2021 70% of respondents said that they reported the last incident of violence, whereas this was 66% in 2022. • We are beginning to see increase in respondents saying that they have experiencing bullying and harassment from other colleagues and managers.
Inclusive behaviour within teams	Spotlight on work in WRES/F, emphasis on local action to achieve change in: • antidiscrimination, • de-biasing recruitment, • increasing representation at senior levels, • Reasonable adjustments and career progression • A continual improvement approach to implementing change	• The question regarding reasonable adjustments saw the biggest negative deviance from the acute average (62% for the trust verse 72% for the acute average). • Implementing WRES core pillars requires change at local rather than only corporate levels. There is a focus on culture of inclusion in people strategy as pillar of the NHS People Promise.
Compassionate and inclusive leadership	• Values based appraisal processes • Taking the lead in creating an inclusive team culture and holding team members to account • Continued development and promotion of management and leadership development offer	• The majority of questions on line managers has seen an improvement year on year • Largest increase year on year has been the question Immediate manager asks for my opinion before making decisions that affect my work (58% in 2022 increased from 55% in 2020 in SGUH) • However, most questions on line managers perform lower than average
High performance teams	• Health and wellbeing is central to high performance and prioritised. • Causes of stress and burnout to be well understood and addressing these prioritised • Managers tools to support staff to work together effectively • Conflict management	• The survey shows 45% of respondents, have felt unwell due to work related stress. • Furthermore, 26% of respondents say they have Never/rarely feel burnt out because of work (as opposed to 25% in 2021) • There has been no change in question I have never/rarely worn out at the end of work with scores of 18% in both 2021 and 2022. • However, there has been a 1% decline in respondents saying the Organisation takes positive action on health and well-being, with scores of 50% in 2022 (down from 51% in 2021). • My immediate manager takes a positive interest in my health & well-being saw the largest negative difference (4%) from the average, with a score of 64% against an average of 68%

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 People Committee.

Freedom to Speak Up Guardian

At St George's, we are committed to encouraging and supporting colleagues to speak up when they have concerns relating to any aspects of their working life, including for example concerns about the safety or quality of patient care, staff experience, and poor behaviours from their colleagues. We are also committed to supporting an outstanding safety culture. We want out staff to feel psychologically safe and empowered to raise concerns and to have confidence that those concerns will be addressed.

The Trust has in place a well-established Freedom to Speak Up (FTSU) service, which includes a guardian and deputy guardian. The team is supported by FTSU champions across the Trust who help to advise staff on how to raise concerns. Having access to support and advice close to where staff work, we seek to become aware of issues at an early stage and provide support in a timely manner which supports faster resolution and staff feeling well supported.

The Trust has experienced challenges in relation to staff feeling safe to raise concerns and the latest NHS Staff Survey demonstrates that there is more that we need to do.

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 People Committee. As part of the "Big 5" programme of activities to respond to key themes from the NHS Staff Survey, the Trust held a month of activities focused on raising concerns, 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.

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 2022/23, we focused on the importance of education and training of our staff at all levels in Freedom to Speak Up. During 2022/23, we have focused on ensuring that staff undertake training in raising concerns and over 4,500 staff have now completed this.

The team continued to proactively raise awareness of the advice and support available to staff throughout the year, including during Speak Up month in October – an initiative organised annually by the National Guardian's Office, raising awareness of Freedom to Speak Up and the work which is being done to make speaking up business as usual

Trade union facility time

ACTIVITY	TIME OR COST
Number of trade union representatives	42
Total FTE of trade union representatives	35.45
Number who spend between 1 – 50% of their time on Trade Union activities	42
Number who spend 100% of their time on trade union activities	0
Total Trust pay bill	£711,220,011.00
Total cost of facility time	23414.1023
Percentage of total pay spent on facility time	0.003%
Hours spent on paid facility time	1647.53
Hours spent on paid trade union activities	1170
Percentage of total paid facility time hours spent on paid TU activities	71.02%

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 England.

NHS England, 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.

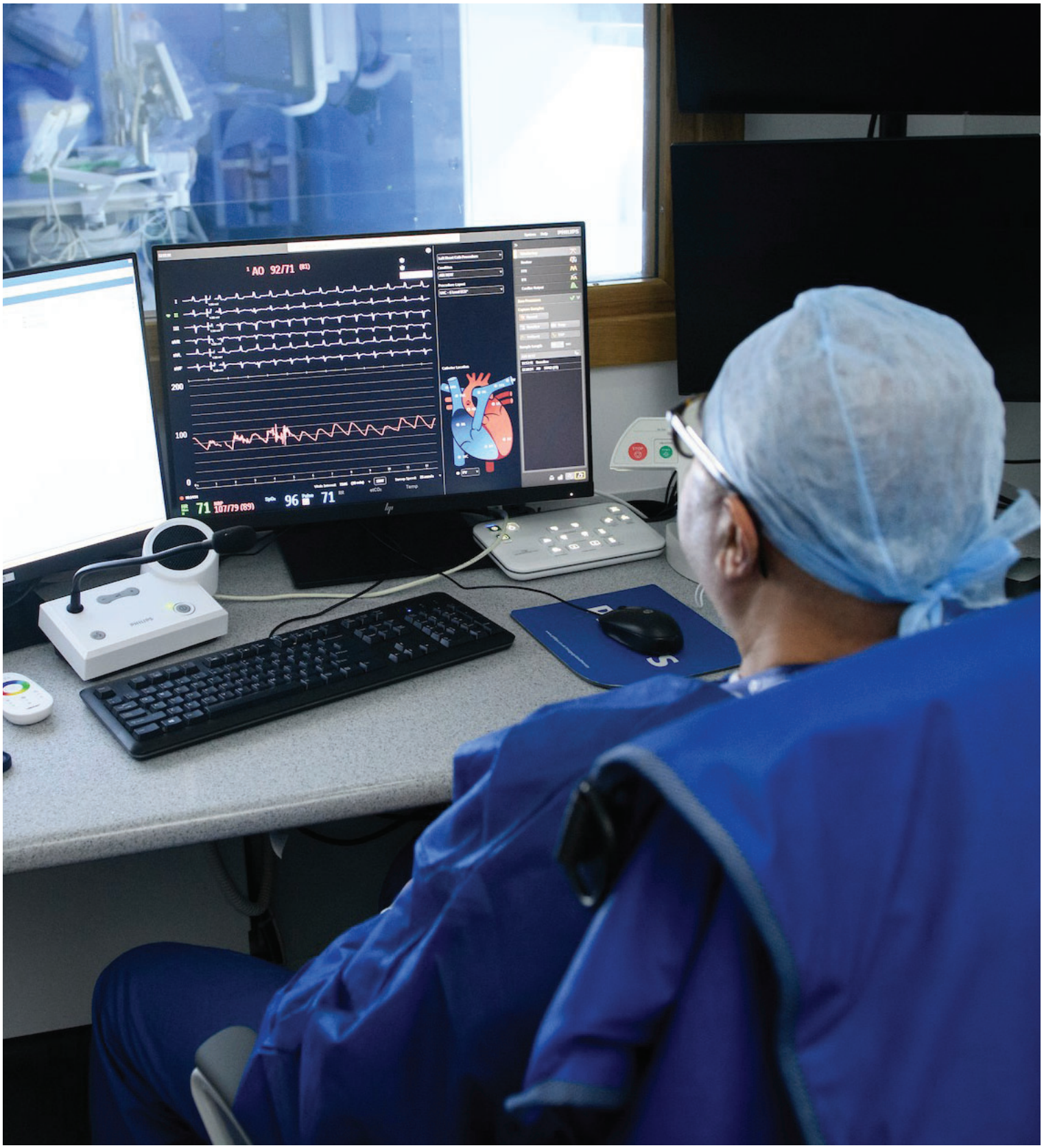
As accounting officer, I can confirm we keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable me to ensure that the accounts comply with requirements outlined in the above mentioned Act. I can confirm that we 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
30 June 2023

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 2023 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. The clinical divisions report into the St George's Site Leadership Team, which itself reports into the Executive, 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 is accountable to the Group Executive which, in turn, is accountable to the Board through the Chief Executive. The Group Executive comprises the Chief Executive and Group Executive Director, 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 three sub-groups of the Trust Management Group to provide leadership and oversight of key areas: Patient Safety and Quality Group; Operations Management Group; and People Management Group. Each of these groups reports into the Trust Management Group.

In addition, following the completion of a three-part clinical governance review, in May 2022, the Trust Board reviewed the implementation of a programme of work to strengthen clinical governance across the Trust. The Board considered that the implementation of this review was now sufficiently embedded such that separate progress reports were no longer needed to the Quality Committee. In light of the progress achieved, the Board agreed that the risk on the Board Assurance Framework relating to clinical governance could be reduced. Issues identified by the CQC in its inspection of maternity services in March 2023, however, highlight the need for the Board to seek further assurance in terms of the robustness of our clinical governance structures, systems and processes and the Trust has commissioned an independent external quality governance review to be undertaken in 2023/24.

During 2022/23, the Quality, Finance, People and Nominations and Remuneration Committee have operated as Committees-in-Common with the equivalent Committees at Epsom and St Helier. The Trust's Audit Committee has continued 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

Strategic Risks on the 2022/23 Board Assurance Framework

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.	In 2022/23, the impact of the Covid-19 pandemic was mitigated by the vaccination programme and the key drivers of Strategic Risk 1 evolved from those driven by the safety risks of the pandemic to those driven by the risks posed by the intense operational pressures, particularly in relation to emergency care, the challenges in respect of patient flow, the availability of intensive care beds, and the particular risks posed by industrial action.
	Strategic Risk 2: We are unable to provide outstanding care as a result of weaknesses in our clinical governance.	In relation to clinical governance, in May 2022, the Trust Board reviewed the implementation of the Trust's Clinical Governance Improvement Programme, which had been put in place following a three-part external clinical governance review which had been undertaken between 2019 and 2021. The progress achieved in implementing the Plan enabled the Board to reduce the strategic risk score and increase the assurance rating for this strategic risk. However, the issues identified by the CQC in relation to maternity services, have prompted the Board to take action to review the robustness of clinical governance both within maternity and more generally across the Trust, and the Group as a whole.
	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.	In terms of our operational performance, we have also taken steps to mitigate the risks of delays to treatment. Compliance with the four hour emergency department operating standard, has been challenging, albeit the Trust has been one of the stronger performers in London in this respect. Ambulance handovers have been challenging, and the Trust's performance in relation to the cancer standards is not where the Trust would wish it to be and action is being taken to address this. Likewise, industrial action has had a significant impact operationally across the Trust, and in particular on the elective backlog.
	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 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. An estates strategy and green plan are in place.

Risks to the Trust

Strategic Risks on the 2022/23 Board Assurance Framework

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.	Improving our culture has been continued to be one of our key areas of focus in 2022/23. The Trust has undertaken a focused piece of work on Values as part of this culture work, and has also focused on health and wellbeing support to our staff. One area highlighted in our NHS Staff Survey 2022 were particular concerns in relation to the experience of staff with disabilities and we are taking this forward as a priority in 2023/24. Likewise, while we continue to focus on diversity and inclusion, we want to make further and faster progress in relation to tackling racism, and this is also one of our key priorities in the year ahead. We are also focused on building the psychological safety of staff, so they feel able to raise concerns.
	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.	In 2022/23, we have regularly reviewed progress against our Workforce Improvement Plan, which sets out the organisation's priorities in respect of key workforce measures including recruitment, retention, sickness absence, training, and development. The People Committee has closely monitored this. We undertook a review of our Employee Relations function, and identified a number of actions that we need to take to ensure that we have an effective and resilient service and are focused on delivering this in 2023/24.
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.	On 1 July 2022, new legislation putting Integrated Care Boards onto a statutory basis came into effect. We have worked closely with our ICB over the past year, playing an active role with our partners to help improve the care provided to patients across South West London. The scale of the changes, the nature of the financial challenges, and delays to the devolution of specialised commissioning, contribute to the past year being one of considerable change, but also opportunity. We continue to focus on working collaboratively and in partnership with all of our partners in the system
	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to release wider efficiency opportunities.	In terms of our financial risks, 2022/23 was a particularly challenging year. We rated the financial sustainability risk as a risk score of 25, the highest possible score, which reflected the fact that we were unable to break even and deliver our plan in 2022/23.
	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.	Capital remained very challenged during the year but we continued to invest in our estate and IT.
	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.	and Clinical Research Institute. We continue to work to improve our research IT infrastructure and to seek investment to allow more clinical academic appointments. We recognise that the financial climate within which the Trust is seeking to deliver its objectives in relation to research is more challenges due to the financial pressures than ever before.

Information governance

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

The Digital Assurance Group (DAG) 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. Group Chief Financial Officer is our Senior Information Risk Officer (SIRO), and a senior consultant is the Caldicott Guardian. The Trust also has an information governance management team which includes our Chief Information Officer, the Data Protection Officer, and Information Governance Manager. We have 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 2022/23, 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 stakeholders to implement the Data Protection Accountability Framework.

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

Review of effectiveness

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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 practised 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 2022/23

The acronym EPRR stands for Emergency, Preparedness, Resilience, and Response. EPRR is defined by a series of statutory responsibilities under the Civil Contingencies Act (2004). This requires NHS-funded organisations to maintain a robust capability to plan for, and respond to, incidents or emergencies that could impact on patient, staff and services. All NHS funded organisations are subject to an annual EPRR assurance process carried out by NHS England to assess their compliance to EPRR core standards framework. 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.

The Trust's emergency preparedness team (EPT) is made up of one Emergency Planning Manager, and one EPRR Officer. The team is responsible for writing, updating and exercising all the Trust emergency plans and assisting teams with developing their own service business continuity plans.

In the event of a major incident the team will help to coordinate the Trust response and provide specialist advice to the Trust's command staff. The EPT work with a number health partners and external agencies as part of a whole system approach to manage emergencies effectively and minimise the disruption to services

The assurance process identified some areas for improvement in our current arrangements and judged that this year our overall level of compliance against the 2022-23 core standards for EPRR is Partially Compliant. This equates to an amber rating. St George's has not had a dedicated EPRR manager for two years and the majority of NHS Trusts have achieved partial compliance coming out of their Covid response. There is an action plan to improve this position against the 23/24 assurance process.

It should be noted that the review team reported they were confident that, if required, the Trust would be able to stand up an appropriate operational response to any disruptive challenge or major incident.

Team priorities for 2022/23 to support the annual accreditation process

We will prioritise the following tasks over the following assurance period.

- Developing a sector approach for risk assessment and risk management.
- Development of the Trust EPRR resource commensurate with the position as a Major Trauma Centre for London.
- Re-establishing the South West London EPRR Trauma Network.
- Major Incident Plan review and encapsulation of learning from exercises and incident response.
- Update all plans in line with current legislation and guidance.
- Further development of mandatory training for on-call staff.

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 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
30 June 2023

8. Quality Report (Account) 2022/23

Quality Report (Account) 2022/23

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Quality Report (Account) 2022/23

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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 whilst trying to recover from the impact of the Covid-19 pandemic are also detailed in this report together with some key achievements across the year.

It continues to be 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. Many staff have gone above and beyond to give patients the best experience of care and I am very grateful for their hard work and dedication.

As we now learn to live with Covid-19 we continue to respond to the effects of the pandemic and have worked hard on our recovery plans to deliver improved performance against the national access measures to ensure patients get the planned and emergency care they need.

The impact of Covid on our waiting lists has been significant and part of our recovery efforts, as in 2021-22, has involved collaborative working with our hospital Group colleagues in Epsom and St Helier, system colleagues in Croydon and Kingston hospitals, and partners in the region. The Surgical Treatment Centre at Queen Mary's Hospital which we opened in June 2022 providing four new operating theatres has continued to be pivotal in supporting our recovery efforts.

At the end of March 2023 98.2% of patients received their diagnostic test within 6 weeks, which was an improvement of 3.1% when compared with February 2023 (95.1%). The decrease is driven by reductions in Endoscopy. Performance is meeting the elective recovery target of 95%.

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. At the end of February 2023 this number had reduced to 481 and is below the plan of 800. While this is a significant improvement, our focus is to reduce this number to an absolute minimum.

allow other spaces – such as St George's – to focus on specialist and complex cases. Theatre utilisation increased to 82% and the average case per list continues to rise - we are currently at 1.65 compared to 1.4 which is our pre-Covid level. We continue to make positive progress on elective activity and continue to focus on tackling our cancer performances too.

This year we have also seen unprecedented demand for urgent and emergency care

93 with a significantly increased number of people visiting our emergency department from June 2022 onwards and into the winter months. This increased demand and severe operational pressures has meant that for some of our patients we were not able to ensure they were seen, treated, and either admitted or discharged within four hours.

Many staff have gone above and beyond to give patients the best experience of care and I am very grateful for their hard work and dedication.

Colleagues across the south west London healthcare system meet weekly to discuss elective care recovery activity and seek to distribute activity where it can be managed most efficiently. Our system network is crucial in managing pressures and ensuring elective activity remains on track despite the disruptions. As outlined above, we have set up surgical hubs with protected theatre space, which has been vital in supporting our vision of working through high volume, low complexity cases across south west London to aid recovery and

Although the Trust does compare well with others with reference to the four hour performance target, due to the increased pressures we have had patients waiting in our ED for admission to an inpatient bed for longer that twelve hours. We continue to work hard to improve flow throughout the hospital.

We also 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.

The Kirkup Report was published in October 2022 and set out the findings of the investigation of maternity services at East Kent Hospitals University NHS Foundation Trust and the outcomes for 202 mothers and families who received maternity care at the Trust between 2009-2020. It describes how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care and poor outcomes. This made for difficult reading. We conducted a gap analysis, which we discussed at Trust Board, on the broad areas for action and associated recommendations and developed an improvement plan.

We champion an open culture at St George's where everyone feels psychologically safe to raise concerns. We have been working on this for over two years as part of our culture improvement work, supported by the Board.

We are pleased to report on our compliance against the eight 'immediate and essential actions' as part of the assurance process for the Ockenden review, which was published in March 2023. 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.

However, in light of both reports we have commissioned an external review of the culture of Maternity and Midwifery Services at St George's and at Epsom and St Helier Hospitals with the report expected in August 2023.

This year we were unable to declare full compliance with the CNST (Clinical Negligence Scheme for Trusts) for maternity services. Trusts are required to self-assess and make a declaration of compliance against ten safety actions. We took our self-assessment to Trust Board in January 2023 and confirmed our compliance in six out of ten safety actions. We also reviewed a comprehensive improvement plan to address the areas where it was required. Although disappointing, this reflected our challenges in staffing and the impact on safety actions.

Following the Ockenden Review the Care Quality Commission (CQC) initiated a national inspection programme of maternity and midwifery services. Our services were inspected on 28 March 2023. The national inspection programme focussed on the Safe and Well-led key lines of enquiry. Following this inspection, the CQC issued the Trust with a section 29A Warning Notice in relation to:

- Effective and timely triage services
- Environment and equipment maintenance
- Staffing levels
- Oversight and governance

We immediately commenced a targeted improvement plan to address the issues and will formally respond to the CQC by 28 June 2023 to provide assurance – together with supporting evidence - on the completion of the improvement actions taken.

The full inspection report is expected by the end of June 2023.

Disappointingly, the Trust has breached the NHSE number of Clostridium Difficile infections for 2022/23 and recorded 60 cases against the national threshold set for the Trust of 43 cases. An action plan is in place and since quarter two of 2022/23 we have seen the monthly prevalence start to reduce. The improvement actions include increased surveillance and audits on areas where positive cases are identified to ensure we identify all IPC issues where we can do better.

We are seeing more people with respiratory conditions and viruses requiring hospital care including children, and these illnesses are also impacting our staff. We are continuing to promote our roll-out of the flu vaccine to support greater protection levels and reduce the risk of requiring hospital care for these conditions over the winter months. We also saw a rise in cases of Strep A, but overall, there are still fewer cases than this time two years ago. We saw a real decline in these type of infections in the pandemic as people were not mixing. This is why there are more reported cases in children under four, who have not previously been exposed to infection during the pandemic. We also worked closely with our clinical partners in the community to support families in managing Strep A infections and we worked closely across south west London to manage the new Monkeypox virus successfully treating patients in most cases on a virtual basis in their own homes.

We sustained our significant research portfolio and recruited 9,600 patients to more than 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 led 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, and VTE (venous thromboembolism) assessments have increased to 97%. We also delivered a clinical audit programme where the Trust performed above the national average on a number of important quality and safety indicators.

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 and upgrading our cardiac catheter labs. We have also completely refurbished one of our surgical wards in St James Wing to deliver a dedicated 22 bed Major Trauma Ward. We have doubled the number of single occupancy rooms within the accommodation, introduced motorised patient hoists and improved the overall facility for patients and staff. Our new MRI Annex delivers a dedicated MRI facility accommodating three scanners, multiple reporting rooms and dedicated training and seminar space. Our new ITU building will provide 20 additional ITU beds in a purpose-built unit. Patients as well as our staff have benefitted from these new environments.

The formation of the St George's, Epsom and St Helier University Hospitals Health Group last year continues to build on our 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 our local people and communities.

The partnership continues to bring benefits to patient care. For example this year we have action plans in place to drive improvement across the Group for pressure ulcer prevention, falls prevention and reduction of Covid-19 nosocomial deaths. In addition, our plans for the implementation of the new Patient Safety Incident Response Framework have been driven at a Group level for implementation at our sites in order to reduce any unwarranted variation in our processes. Going forward, this will enable reduction in avoidable harm to be effectively measured both at Trust-level and 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
30 June 2023

Part 2

2.0 Priorities for improvement and statements of assurance from the board

2.1 Our quality priorities for 2023/24

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 2022 the Trust Board agreed a refresh of our corporate objectives, setting out our priorities for rest of the year (September 2022 to March 2023). This did not change our vision or our five-year strategy.

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

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

Care	Culture	Collaboration
Patients and staff feel cared for when accessing and providing high quality timely care at St George's	Transform our culture to create an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in delivering high quality clinical care for our patients and service users	We will engender an ethos of collaborative working across our teams within St George's, Epsom and St Helier and with our ystem partners to achieve the best outcomes for patients, building on the spirit of collaboration developed internally and externally through the Covid-19 response.
1. Improve patient safety by reducing avoidable harm in relation to: ➢ Learning from all local SWL nosocomial Covid cases ➢ Treatment Escalation Plans agreed within 24 hours of admission ➢ Improving the practice of consent 2. Improve the clinical effectiveness and efficiency of all patient pathways 3. Embed a quality, safety and learning culture through monthly patient safety, mortality and morbidity meetings for every specialty	4. Deliver on our Health and Wellbeing promise to all staff by investing in physical and mental health staff services and flexible working 5. Develop an environment where staff feel psychologically safe to speak up and use their voices to improve our services to patients 6. Taking action on our culture to ensure we are more inclusive and diverse, where discrimination, violence and bullying is not tolerated – improving the experience of BAME staff in particular 7. Develop and implement an inclusive talent management approach to ensure that we improve our opportunities for our staff	8. Continue to work in partnership and collaboration with the SWL Integrated Care System (ICS) and Acute Provider Collaborative (APC) 9. Delivering a transformational step change in use of resources (to achieve the Cost Improvement Programme) at SGUH, across the Group and across South West London ICS, for the benefit of patients and the welfare of our staff 10. Explore and deliver opportunities for collaboration across the Group 11. Make best use of our resources at St George's and across South West London ICS, for the benefit of patients and the welfare of our staff

A new five-year strategy for St George's, Epsom St Helier (gesh) Group (2023-2028)

St George's and Epsom and St Helier hospital have been working together for some time and in 2021, became a Hospital Group. As a result, over the course of 2022/23, a new 5-year strategy for St George's, Epsom St Helier (gesh) Group has been developed, launched May 2023, which sets our ambitions for 2028 across the following domains:

- **Collaboration and Partnership**
- **Affordable healthcare, fit for the future**
- **Right care, right place, right time**
- **Empowered, engaged staff**

Our ambition for 2028 is that our corporate objectives provide a framework against which staff across the Group can pursue continuous improvement. This could apply at every level of the organisation, from a site team to service triumvirate to an individual ward.

Our corporate objectives, set out below (for example, improving productivity and collaborating across teams, departments, Group, and system to improve flow), sit alongside strategic initiatives which are large, complex, multi-year programmes of work that require significant executive leadership and board oversight (for example, the Outpatient Transformation Programme and the Group Collaboration Programme).

Corporate objectives

Collaboration and Partnership	Affordable healthcare, fit for the future	Right care, right place, right time	Empowered engaged staff
Work across teams, the Group & the wider system to improve flow & elective waits	**Return to pre- COVID productivity levels**	**Make improvements in safety / the fundamentals of care**	**Retain and develop our staff**
Measured by: • Average non-elective LOS back to 19/20 level • Reduction in 12 hour waits vs 22/23 • Delivery of elective recovery trajectories • Narrowing performance gap between ESTH and SGUH	Measured by: • 85% theatre utilisation • Reduction in DNA & 1st/FU ratio Elective LOS back to 19/20 level	Measured by: • Reduction in falls with harm vs 22/23 • 95% VTE • 0 pressure ulcers grade 3 & 4 HSMR <100, SHMI <1	Measured by: • Turnover rate ≤ 12% • 90% appraisal rate Improvement in staff survey feedback on quality of appraisals

Our new gesh Group Strategy (2023-2028), will help both organisations to shape a common sense of direction and identify a clear set of ambitions for our patients and public for the years ahead. Corporate objectives for 2024/25 will reflect the new strategy priorities.

Corporate objectives

Throughout 2022/23 and whilst the above strategies were developed the Trust continued to implement the quality priorities against the seven priority areas as set out below 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

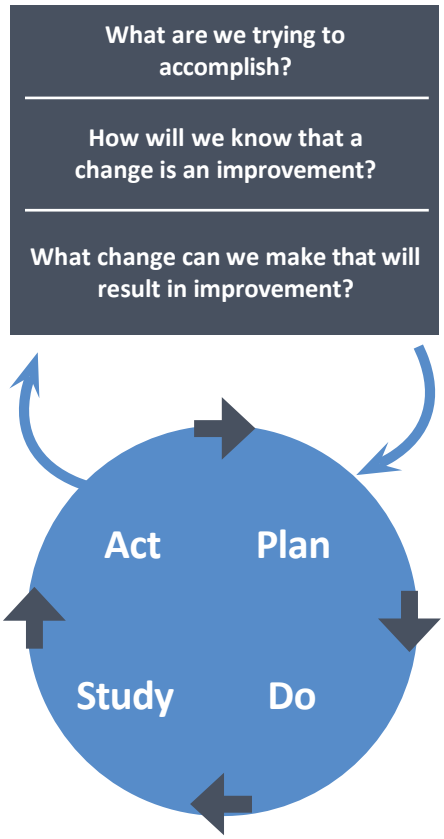
3. We will provide patients with an excellent experience through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients

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



Our Approach to Quality Improvement

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.

Together with the focus on the quality priorities the Trust's quality improvement (QI) programme amalgamates human factors concepts and tools with QI methodology (The Model for improvement), pushing QI beyond is traditional boundaries to offer a more diverse spectrum of methods to explore everyday work and help develop collaborative solutions. We have been incorporating human factor principles to optimise system and human performance, and enhance staff wellbeing across many strands of work, including simulation-based education and patient safety investigation.

We continue to use a simple yet effective approach to improvement 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 2022/23 we developed the implementation plan for that year 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 ongoing impact of the pandemic, progress was made across all areas. The progress we made was reported to our Quality Committee in Common, which is a sub-committee of the Trust Board and is outlined in part 3.

Our quality priorities for 2023/24, what they were informed by and why we chose them

- Our progress against the Quality Priorities for 2022/23 which was impacted by the ongoing effects of the Covid-19 pandemic
- Themes highlighted from our ward and departmental accreditation programme
- The findings of the 2019 CQC inspection and the resulting improvement action plan which we implemented during 2020-21
- Analysis of our complaints and PALs enquiries
- Analysis of our serious incidents and moderate and low harm incidents
- Previous feedback from Healthwatch 'Enter and View' visits
- Local and national audit
- National priorities for sepsis, safe staffing, falls, pressure ulcer prevention, and infection prevention and control

We have not held specific listening events in the last year. However in the previous 2 years and due to the Covid-19 pandemic we have rolled forward the quality priorities to provide a longer period of time to generate real improvement. This year we have taken a different approach to identifying our quality priorities for 2023/24 and held a half-day workshop where we discussed and re-set our quality priorities outlined below with key stakeholders. Our key stakeholders comprised colleagues from Epsom and St Helier Hospitals and the Integrated Care System and we identified our quality priorities under three quality themes:

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

Linking our quality priorities to our new 5-year strategy for St George's, Epsom St Helier (gesh) Group (202302028)

Our new 5-year strategy for St George's, Epsom St Helier (gesh) Group (2023-2028) as outlined on page 8 above, has identified the following domains:

- Collaboration and Partnership
- Affordable healthcare, fit for the future
- Right care, right place, right time
- Empowered, engaged staff

With reference to our new strategy our quality priorities for 2023/24 will help us to deliver against the domain of Right care, right place, right time.

Our quality priorities for 2023/24, what they were informed by and why we chose them

- Our progress against the Quality Priorities for 2022/23 which was impacted by the ongoing effects of the Covid-19 pandemic
- Themes highlighted from our ward and departmental accreditation programme
- The findings of the 2019 CQC inspection and the resulting improvement action plan which we implemented during 2020-21
- Analysis of our complaints and PALs enquiries
- Analysis of our serious incidents and moderate and low harm incidents
- Previous feedback from Healthwatch 'Enter and View' visits
- Local and national audit
- National priorities for sepsis, safe staffing, falls, pressure ulcer prevention, and infection prevention and control

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 2023/24 we want to focus on fundamentals of care and getting the basics right every time in terms of screening, risk assessments and review, we want to learn from all patient safety incidents to reduce avoidable harm and improve patient experience, and we want to respond appropriately to our patients needs if their condition deteriorates whilst under our care.

In order to address these patient safety priorities, we will continue to work collaboratively across the 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.

Priority 1 – Improve patient safety **Domain from 5-year strategy: Right care, right place, right time**							
Reduce waiting times		Improve patient safety	√	Improve patients outcome and experience with us	√	Tackle health inequalities	
What		**How**		**What will success look like**			
Delivering the fundamentals of care		We will get the basics right every time and consistently complete risk assessments in line with expected standards of performance		With reference to pressure ulcer prevention there will be: • no category 4 pressure ulcers • a 5% reduction in category 3 pressure ulcers With reference to VTE there will be: • a 5% reduction in the number of hospital acquired thrombosis when compared with the previous year With reference to falls we will see: • a 5% reduction in the number of falls with harm per 1000 bed days when compared with the previous year With reference to delirium, we will see: • a 10% improvement in the number of delirium risk assessments completed for our patients with a diagnosis of dementia when compared to baseline			
Learning from patient safety incidents		In line with the national patient safety strategy we will develop the Trust's learning response plan and implement the new patient safety incident response framework		Patient Safety Incident Reporting Framework in place including: • Governance structure • Patient Safety Incident Response Plan • A Group Policy for Patient Safety Incident reporting			
Responding to the deteriorating patient: 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 2024 Reduction in the number of cardiac arrests compared with 2022/23			

Priority 2 - Improve patient experience

We want to improve our communication with our patients. We will listen to our patients and their carers and use patient feedback to focus on continuous improvement.

In 2023/24 we want to enhance our understanding of the population we serve with improved data collection and IT systems that talk to each other, improved use of our patient portal and improved triangulation of patient feedback to ensure we fully understand and use the feedback we receive.

In order to address these patient experience priorities, we will work continue to work collaboratively across the 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.

Priority 2 - Improve patient experience							
Domain from 5-year strategy: Right care, right place, right time							
Reduce waiting times		Improve patient safety		Improve patients outcome and experience with us	√	Tackle health inequalities	√
What		**How**		**What will success look like**			
Ensuring enhanced data collection		We will improve how we capture patient ethnicity data		95% of patients our will have their ethnicity recorded (excluding those patients who choose not to confirm their ethnicity) by March 2024 Ethnicity profiles of our patients will be increasingly included in quality and safety reports from ward and directorate level up to and including Group Board and we will analyse the quality impact to determine areas where there may be inequalities to improve patient care to identified groups			
Using MyCare, our patient portal		Determine the patient demographic using MyCare and identify areas for improvement and increased use		Include details on the demographic using MyCare in our patient experience reports Increase the use of MyCare by 10% by March 2024			
Understanding what our patients tell us about their experience		In collaboration with our Integrated Care System colleagues, we will consistently review and triangulate all sources of patient feedback to improve our understanding of what good looks like for our patients and their families		We will utilise our QI approach and hold 3 Group wide learning events We will develop, implement and monitor a Group improvement plan with SMART improvement actions (specific, measurable, achievable, realistic and time bound) to reflect the learning from the above events and update this as required throughout the year			

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 2023/24 we want to focus on the quality, safety and learning culture and working with the Integrated Care System to improve the discharge pathway for our patients and the pathway for CAMHS (Children and Adolescent Mental Health Services) following an in-patient admission.

In order to improve effectiveness and outcomes for patients, we will continue to work collaboratively across the 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.

Priority 3 - Improve effectiveness and outcomes							
Domain from 5-year strategy: Right care, right place, right time							
Reduce waiting times	√	Improve patient safety	√	Improve patients outcome and experience with us	√	Tackle health inequalities	√
What		**How**		**What will success look like**			
Ensuring a quality, safety and learning culture Working in collaboration with our Integrated Care System colleagues to improve patient flow particularly with reference to improved discharge processes		We will integrate our Quality Improvement resources across the Group to maximise service improvement activity		We will see collaborative QI projects in place across the Group underpinned by the Group Quality and Safety Strategy (in development)			
Working in collaboration with our Integrated Care System colleagues to 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 compared with 2022/23 Improvements in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2022/23			
Working in collaboration with our Integrated Care System colleagues to improve the pathway for CAMHS (Children and Adolescent Mental Health Services) following an inpatient admission		Continue to escalate discharge delays for CAMHs patients awaiting a specialist inpatient admission for MDT and system discussion		We will see a reduction in the average number of days our CAMHS patients wait in our paediatric wards for specialist inpatient admission to CAMH inpatient services			

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 Committee in Common, a sub-committee of the Group Board.

2.1.5 Progress against priorities for 2022/23 [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 George's University Hospitals NHS Foundation Trust. These are common to all quality reports and can be used to compare our Trust with other organisations.

St George's 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.

As outlined in the Chief Executive's introduction, the NHS has remained pressured - with St George's no exception.

Our urgent and emergency care pathway has been very busy and flow is increasingly difficult through the hospital, to the wards and home.

We have had added pressures culminating from industrial action across the healthcare sector, often coinciding with bank holiday weekends. To mitigate these, our senior team developed detailed operational plans, and our communications team worked with our system partners to promote alternatives to ED to the public. We know that tens of thousands of people saw our messages and we hoped it helped to ensure some people were redirected to the right care for their needs.

St Georges, Epsom and St Helier Group

This year we have seen a number of exciting developments across the Group.

- We continue to make strides towards collaboration with Epsom and St Helier for the benefit of staff and patients. We are having good conversations on cancer 109 collaboration and how we work with our partners in the system. We continue to look at where we have variations in care, where we can learn from each other, integrate services across the group, and are asking our staff to talk to their partners at Epsom and St Helier.
- We continue to make progress with Cerner (sometimes referred to as iClip) development and implementation to provide a shared electronic patient records system to deliver streamlined patient care. Due to 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).
- We have seen increased joint working in Infection Prevention and Control (IPC) with the infection prevention and control teams from both sites working together on a weekly basis led by the Group Chief Nurse and Director of Infection Prevention and Control to discuss any IPC issues and agree required actions.
- We continued to respond to Covid-19 guidance throughout the year and we enter this year with reduced levels of lateral flow testing for our patients and staff, no requirement for the wearing of face masks in most clinical environments (unless the patient or staff member chooses to do so) and fully restored patient visiting practices.

St George's

Despite the ongoing demand for our services and capacity issues this year we have seen a number of exciting developments at St George's.

- St George's documentary 'Baby Surgeons: Delivering Miracles' was nominated for a BAFTA. The documentary was filmed inside our fetal medicine, neonatal and maternity units at St George's, and followed the extraordinary work of our staff as they treat women experiencing rare and complex pregnancies.
- We opened a new training suite for parents and carers of ill children offering training in life-saving interventions. Parents are supported by a new specialist nurse, in the WellChild Better at Home training suite, which was funded by WellChild, the national charity for seriously ill children. Previously, training for parents and carers would often take place at a child's hospital bedside prior to discharge. Bedside training can be limited and does not always prepare families for emergency situations which might arise at home. This training suite is a wonderful addition that is already helping parents and carers learn the skills they need to care for children after they leave hospital.
- 18,000 patients registered on MyCare - our new, secure online portal launched in March 2022 that allows patients to access their hospital record, view upcoming appointments, and receive test results and messages from clinicians. It is very important to us that our patients are better informed about their care, especially as evidence shows that people being more actively involved in their own care can improve outcomes and experience for patients
- We received accreditation from the Improving Quality in Liver Services (IQILS) programme run by the Royal College of Physicians. The aim of the programme is to improve the quality of medical liver services throughout the UK.
- A new Urgent Treatment Centre (UTC) was opened in a purpose-designed area, close to our Emergency Department, and will significantly support our capacity for treating urgent cases.
- Our cardiac catheter labs three, four and five are now operational. This will boost our capacity for diagnostics and support efficient and speedy patient care.
- We held our first ever Childhood Cancer Awareness event in September 2022. The event brought together former young cancer patients and their families, to raise awareness and celebrate their cancer journeys, and our staff who have treated them. It was especially heart-warming for our former and current patients to reunite with the staff who treated them, and for parents to connect and share experiences with other families to empathise and support each other.

Staff awards

Our staff and teams have been successful in a range of award programmes. Just a few of the successes include:

- Our Group Chief Nurse and Director of infection Prevention and Control was awarded her MBE at Windsor Castle by the then HRH Prince Charles. As a fantastic role model and visible leader who listens to staff and flies the flag for the thousands of nurses, midwives and health care support workers across our hospital Group.
- Our Group Chief Executive Jacqueline Totterdell was named as one HSJ's top 50 hospital CEOs. The 15 strong panel looked at a range of criteria including performance during the pandemic, overall performance and the Trust's contribution to the wider health and social care system.
- Professor Indranil Chakravorty – consultant in acute and respiratory medicine at St George's – was awarded an MBE for his contributions to healthcare as part of the Queen's platinum jubilee honours. Passionate about diversity and inclusion in healthcare, he has made an enormous contribution to medical education, and research into tackling health inequalities.
- Lt Col Jey Jeyanathan, one of our consultants in Anaesthetics and Intensive Care, received an OBE in King Charles' first New Year's honours in recognition of his hugely commendable service, and more recently his major role in developing transfer services for critically ill patients to manage bed shortages across the south est.
- Dr Sree Kondapally, Locum Consultant Cardiologist, was awarded the top prize for his service improvement project in cardiology. Dr Kondapally received the award at this year's centenary conference of the British Cardiovascular Society (BCS), under the society's flagship Emerging Leadership Programme (ELP). Dr Kondapally's project was on the implementation of iClip triage for cardiology outpatient referrals and was judged the top service improvement project for this year.
- Juliann Welch staff nurse on Gordon Smith ward received the RCN London Black History Month Rising Star Award. She was recognised as a Rising Star by the Royal College of Nursing, for her work supporting international colleagues.
- Estelle Le Galliot a Health and Wellbeing Co-ordinator in the Macmillan team received the BBC Radio London Make A Difference Key Worker Award. She was recognised for her work during lockdown when she went above and beyond for our cancer patients by helping shielding patients by setting up a YouTube channel and Chemotherapy Comfort Kits.

- A team of staff covering Medical Physics, Radiology and Trauma and Orthopaedics British Institute of Radiology received the Make it Better Award at the British Institute of Radiology (BIR) Annual Congress. The team was nominated for the creation of a new pathway which has improved the service for patients, which came about as a result of surgeon colleagues and our CT team in Radiology discussing how they could improve the imaging carried out on their post-surgical patients.
- Our Functional Neurologic Disorder team won Best designed virtual service award at the Healthcare Excellence Through Technology (HETT) Innovation awards ceremony. The service was set up to provide a digital first approach to treating functional neurological disorders. The outcomes have been excellent, reducing waiting times by 90% and is delivered at 10% of the cost of usual treatment.
- The St George's Musculoskeletal (MSK) Physiotherapy team was shortlisted for a Health Service Journal (HSJ) NHS Partnership of the Year Award for their involvement in the GetUBetter project. GetUBetter is a digital tool which helps musculoskeletal patients self-manage their symptoms - giving them more independence and freeing up time for clinicians.
- Seamus McMahon, was shortlisted for the National MyPorter Awards for Porter of the Year. These awards are organised by NHS England and are a great way to bring some national recognition to NHS facilities teams for the wonderful work they do.

For our commissioned services

2.2.1 During 2022/23 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 2022/23 represents 100% of the total income generated from the provision of relevant health services by St George's University Hospitals NHS Foundation Trust for 2022/23.

2.2.2 Participation in clinical audit and National Confidential Enquiries

During 2021/22, 60 national clinical audits and 4 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 were relevant to St George's University Hospitals NHS Foundation Trust and those Trust was eligible to participate in during 2022/23 (n=60) are as listed in Table 1 below

2.2.3 The national clinical audits and national confidential enquiries for which data collection was completed during 2022/23 are listed 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. For the remaining projects that the Trust participated in (Table 1) the 2022/23 data collection completes during 2023/24 and therefore submission rates are not available at the time of this report.

TITLE		RELEVANT	PARTICIPATING	% of cases submitted
Breast and Cosmetic Implant Registry	Breast and Cosmetic Implant Registry	✓	✓	Ongoing
Case Mix Programme	Neurology Intensive Care Unit	✓	✓	100%
	General Adult Intensive Care	✓	✓	Ongoing
	Cardiothoracic Intensive Care Unit	✓	✓	Ongoing
Child Health Clinical Outcome Review Programme	Transition from Child to Adult Health Services	✓	✓	100%
	Testicular Torsion Study	✓	✓	100%
Cleft Registry and Audit Network Database		X	X	
Elective Surgery (National PROMs Programme)		✓	X	0%
Emergency Medicine QIPs	Pain in Children (care in Emergency Departments)	✓	✓	100%
	Assessing for cognitive impairment in older people	✓	✓	100%
	Mental health self-harm	✓	✓	100%
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People [2]	✓	✓	100%
Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	✓	✓	100%
	National Audit of Inpatient Falls	✓	✓	100%
	National Hip Fracture Database	✓	✓	100%
Gastro-intestinal Cancer Audit Programme	National Bowel Cancer Audit	✓	✓	100%
	National Oesophago-gastric Cancer	✓	✓	100%
Inflammatory Bowel Disease Audit		✓	✓	100%
LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)		✓	✓	Ongoing

TITLE		RELEVANT	PARTICIPATING	% of cases submitted
Maternal and Newborn Infant Clinical Outcome Review Programme	Maternal and Newborn Infant Clinical Outcome Review Programme	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Crohn's Disease Study	✓	✓	100%
	Epilepsy Study	✓	✓	100%
Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	X	x	N/A
Muscle Invasive Bladder Cancer Audit	Muscle Invasive Bladder Cancer Audit	✓	X	0%
National Adult Diabetes Audit	National Diabetes Core Audit	✓	✓	100%
	National Diabetes Foot care Audit	✓	✓	100%
	National Diabetes Inpatient Safety Audit	✓	✓	100%
	National Pregnancy in Diabetes Audit	✓	✓	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Adult Asthma Secondary Care	✓	✓	100%
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	Ongoing
	Paediatric Asthma Secondary Care	✓	✓	100%
	Pulmonary Rehabilitation - Organisational and Clinical Audit	✓	✓	100%
National Audit of Breast Cancer in Older Patients	National Audit of Breast Cancer in Older Patients	✓	✓	100%
National Audit of Cardiac Rehabilitation	National Audit of Cardiac Rehabilitation	✓	✓	100%
National Audit of Cardiovascular Disease Prevention (Primary Care)	National Audit of Cardiovascular Disease Prevention (Primary Care)	X		N/A
National Audit of Care at the End of Life	National Audit of Care at the End of Life	✓	✓	100%
National Audit of Dementia	National Audit of Dementia	✓	✓	100%
National Audit of Pulmonary Hypertension	National Audit of Pulmonary Hypertension	X		N/A
National Bariatric Surgery Registry	National Bariatric Surgery Registry	✓	✓	Ongoing
National Cardiac Arrest Audit	National Cardiac Arrest Audit	✓	✓	Ongoing
National Cardiac Audit Programme	a. National Congenital Heart Disease	X	X	N/A
	Myocardial Ischaemia National Audit Project	✓	✓	100%
	National Adult Cardiac Surgery Audit	✓	✓	100%
	National Audit of Cardiac Rhythm Management	✓	✓	100%
	National Audit of Percutaneous Coronary Interventions	✓	✓	100%
	National Heart Failure Audit	✓	✓	100%
National Child Mortality Database	National Child Mortality Database	✓	✓	100%
National Clinical Audit of Psychosis	National Clinical Audit of Psychosis	X	X	N/A
National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit	✓	✓	Ongoing
National Emergency Laparotomy Audit	National Emergency Laparotomy Audit	✓	✓	Ongoing
National Joint Registry	National Joint Registry	✓	✓	Ongoing
National Lung Cancer Audit	National Lung Cancer Audit	✓	✓	Ongoing
National Maternity and Perinatal Audit	National Maternity and Perinatal Audit	✓	✓	100%
National Neonatal Audit Programme	National Neonatal Audit Programme	✓	✓	100%
National Ophthalmology Audit Database	National Ophthalmology Audit Database	X	X	N/A
National Paediatric Diabetes Audit	National Paediatric Diabetes Audit	✓	✓	Ongoing
National Perinatal Mortality Review Tool	National Perinatal Mortality Review Tool	✓	✓	100%
National Prostate Cancer Audit	National Prostate Cancer Audit	✓	✓	Ongoing
National Vascular Registry	National Vascular Registry	✓	✓	100%
Neurosurgical National Audit Programme	Neurosurgical National Audit Programme	✓	✓	Ongoing

TITLE		RELEVANT	PARTICIPATING	% of cases submitted
Paediatric Intensive Care Audit	Paediatric Intensive Care Audit	✓	✓	100%
Perioperative Quality Improvement Programme	Perioperative Quality Improvement Programme	✓	✓	100%
Prescribing Observatory for Mental Health	The use of melatonin	X	X	N/A
Renal Audits	National Acute Kidney Injury Audit	✓	✓	100%
	UK Renal Registry Chronic Kidney Disease Audit	✓	✓	100%
Respiratory Audits	Adult Respiratory Support Audit	✓	✓	100%
	Smoking Cessation Audit- Maternity and Mental Health Services	✓	✓	100%
Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme	✓	✓	82.6%
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Serious Hazards of Transfusion UK National Haemovigilance Scheme	✓	✓	100%
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine Benchmarking Audit	✓	✓	100%
Trauma Audit and Research Network	Trauma Audit and Research Network	✓	✓	Ongoing
UK Cystic Fibrosis Registry	UK Cystic Fibrosis Registry	X	X	N/A
UK Parkinson's Audit	UK Parkinson's Audit	✓	✓	Ongoing

2.2.2.5 National clinical audits - action taken

The reports of 36 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2022/23 and the Trust intends to take the following actions based on the information available at the time of publication.

National Clinical Audit	**Action:** Based on information available at the time of publication
Breast and Cosmetic Implant Registry	The clinical audit lead reports that whilst participation has historically been low, that the service has planned to increase engagement with this project. Action planning for the coming year: - Enlisting consultants and theatre staff to complete data collection in a timely manner - Use of both paper and electronic data collection methods to ensure data completeness
National Confidential Enquiry into Patient Outcome and Death: Epilepsy Care for Adults	This report was released in late 2022 in response to data collected in 2021/22. The recommendations were disseminated to relevant specialities and operational managers by the project lead. Action planning includes clinical audit projects to assess the organisations performance against the key findings.
National Confidential Enquiry into Patient Outcome and Death: Physical Healthcare in Mental Healthcare	This report was released in late 2022 in response to data collected in 2021/22. The recommendations were disseminated to relevant specialities and operational managers by the project lead. Action planning includes strengthening clinical pathways between St George's and our partner organisations.
Pain in children	The audit report breaks down performance into 3 key metrics. St George's performed inline or above the national average for both fundamental standards but fell below the recommended standard for patients with moderate or severe pain having documented evidence of re-evaluation and action within 60 minutes of receiving the first dose of analgesic. Action planning in response included: - Electronic documentation improvement, including automatic prompting to clinicians. - Simplifying triage pain documentation. - Implementing discharge leaflets and QR for patients.

Infection Control	Three key metrics were identified from the data collection. St Georges performed inline with one of these metrics, whilst performing below for potentially infectious patients being placed in a non-clinical area following triage, and the need for vulnerable patients to be isolated in a side-room as soon as possible. In response an action plan was drawn up by the clinical audit lead: - Implementing a new patient flow system throughout 22/23 based on the successful North Bristol NHS Trust model. Enabling a significant reduction in delays for ambulance offloads and patients reaching their inpatient beds - Mandatory screening questions added to electronic patient record system.
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People [2]	The clinical audit lead monitors and updates on performance regularly within the Trust. The overall ascertainment completeness for the organisation is 99.6%, compared to 85% nationally. The Trust performed well in a the majority of the 12 of the key performance metrics. With areas for improvement when reviewing performance for patients' diagnostic status, most notably having a higher percentage of children diagnosed as 'uncertain episodes'. The clinical audit project lead is continuing to drive high standards across the service, including implementing epilepsy training delivered to the general paediatricians.
Fracture Liaison Service Database	The service reports continued live data entry onto the audit portal. The latest report was released in January 2023 and show that the Trust submitted 385 cases in 2021 and achieved green status for 3 of the 10 key performance metrics and red for 6 and 1 was amber. The clinical audit lead has acknowledged the report and its findings. They believe that acute resource constraints have led to reduced coverage in the organisation and are reflected in the audit findings. Action planning for the coming year includes business planning for additional support, and automated prompts for referrals on the electronic healthcare systems.
National Audit of Inpatient Falls	The Trust is currently 100% compliant in the study, with continuous data collection. The latest findings from the October 2022 report were summarised by the clinical audit lead however, the results were only based on 3 cases. The Trust reported 33% for having checked signs of injury before movement from the floor, nationally this was reported at 74%, medical assessment completed within 30 minutes of a fall was recorded for 100% of cases (72% nationally), and 0% using a safe manual handling method to move patient from the floor (33% nationally). The Trust falls meeting have acknowledged and discussed these findings, and plan on ensuring that manual handling training is addressed at ward level across the organisation.
National Hip Fracture Database	The Trust performed within expected limits of 5 out of 6 performance metrics in the latest audit report. But were below the national average for crude overall hospital length of stay (21 days compared to 15 days nationally). The clinical lead has presented these findings and is working to improve this metric in the upcoming year.
National Oesophago-gastric Cancer	Annual report released in January 2023 for data from April 2019 to March 2021. The findings indicate that the Trust was within the expected threshold for case ascertainment, and that the percentage of urgent GP referrals who waited longer than 62 days from referral to first treatment was below the national average (58.3% compared to 62.1%). The Trust achieved 37.7% for patients with clinical stage 0-3 disease who have a treatment plan compared to 58.5% nationally. The clinical lead is investigating this further and is working to assemble an action plan for the coming year.
Inflammatory Bowel Disease Audit	The clinical audit lead reports that quarterly uploads of data are continuing but cautions that limited data completeness has been achieved data due to resource constraints in the service. These constraints are affecting medical, nursing, pharmacy, and corporate support staff. This has been raised through with corporate management with action planning for the coming year will be focussed on relieving these pressures in order for better support for quality improvement and audit initiatives.
Maternal and Newborn Infant Clinical Outcome Review Programme	The latest report was published in November 2022 and examined lessons learned in order to inform maternity care. The key findings based on national data show an increase in maternal deaths during or up to six weeks after the end of pregnancy. There remain disparities in maternal mortality rates amongst women from black, Asian and white ethnic backgrounds, along with women from deprived areas continuing to see an increase in mortality over their peers in affluent areas. The report has been shared with the service and actions for the following year will be based on the recommendations.

National Diabetes Foot Care Audit	The latest audit report was released in May 2022 and reviewed performance from 2021. The results showed the Trust was compliant with all the integrated specialist survey structures listed within the national report which also relate to specific NICE guidelines. A SMART action plan was completed by the clinical lead, with all key recommendations acknowledged and responded to: - Providing training to HCP locally and across the regional network - Maintaining regular contact with our community colleagues - continuing to provide rotational opportunities, advice and support - Maintaining daily specialist clinics and weekly MDTs in line with NICE, local and GIRFT guidance for patients with diabetes - Continuing to promote awareness and education surrounding foot ulcers
National Diabetes Inpatient Safety Audit	Audit methodology changed in last year, with data collection and reporting now a continuous process. Results indicate that the Trust have the correct structures and systems in place of care for people with diabetes. The clinical lead reports that action planning for the year ahead is to address the Getting it Right First Time (GIRFT) review findings.
National Pregnancy in Diabetes Audit	The clinical audit lead reports that data collection is continuing apace, and that all recommendations have been reviewed and planned for in the coming year. Key actions: - Implementing a real time continuous glucose monitoring system, so that this is available to all children and young people with diabetes who wish to use one - Supporting this implementation with an education programme to ensure optimal use.
Adult Asthma Secondary Care	The latest benchmarking data was released in January 2023 and broke down results into 5 key performance indicators. The Trust were above the national average for all 5 of the key metrics reported - however this is based on a limited data set. The clinical lead acknowledged the findings and is looking forward to continuing the positive performance in the coming year. The lead also reports full data collection is now taking place despite workforce pressures.
Chronic Obstructive Pulmonary Disease Secondary Care	The latest benchmarking data was released in January 2023 and broke down results into 6 key performance indicators. The Trust generally performed in line with equivalent organisations, however fell below the national average (60% compared to 44% locally) for patients having a respiratory review within 24 hours of admission to hospital. Action planning for the year is centred on an electronic referral system within the Trust, to flag up patient admissions.
Pulmonary Rehabilitation - Organisational and Clinical Audit	The clinical audit lead reports that 2021 data indicated good performance for the Trust with patients starting pulmonary rehab within 90 days of referral, and average wait times from referral is 34 days. Data from July 2022 showed the Trust compliant with 5 of 6 key performance indicators, with further work needed to ensure patients are offered six-minute walk tests (6MWT) to measure exercise capacity, use a 30-metre course to adhere to technical standards. SMART action planning included: - Assessing and providing PR options patients within 1 month of receipt of referral to ensure they have 2 months to start PR programme - Ensure use of 6MWT standardised outcome measure at every face to face initial assessment - Every patient is assessed using an outcome measure in mobility/strength (6MWT/60second STS), anxiety/depression (PHQ-4)and health status (CAT) - Each site face-to-face and virtual service to have a standard operating procedure (SOP) written - Complete discharge assessments with the non-completers despite the fact they have chosen not to continue with PR course
National Audit of Breast Cancer in Older Patients	The latest report was released in May 2022, with 18 key metrics for performance improvement. The Trust performed above expectation with 5 of these, 10 in line with expectations, 2 metrics did not provide data, and 1 metric was below expectation. This was proportion of patients (non-screen detected) receiving a triple diagnostic assessment in a single visit. Action planning for the following year was recommended to comprise: - Ensuring older patients have sufficient information about their care and treatment and are engaged in a shared decision- making process - Ensuring adoption of fitness assessments for patients attending the first diagnostic clinic - Examination of reoperation rates after breast conservation surgery to identify areas where reoperation rates can be reduced, whilst supporting safe breast conservation. - Review chemotherapy associated morbidity in their units, to reduce unplanned chemotherapy-related admission rates. - Ensure an identified clinician can take responsibility for reviewing data returns and feeding back to staff within their breast units. - Investigate consistency between (1) discussion of patients with recurrence at MDTs, (2) recording of recurrence (3) low percentages of recurrence found in national datasets, by reviewing data capture, and ensuring these data are uploaded to cancer registration. - Ensure information on the initiation of endocrine therapy treatment, and use of bisphosphonates for disease modification, in secondary care is recorded within routine data submissions.

National Audit of Cardiac Rehabilitation	The latest report showed that the Trust achieved above expectation performance in the 7 key performance metrics and are performing well in this audit. Action planning has centred around preparing for the possible increased workload of the national data opt process, however this has now been resolved due to the NACR receiving an exemption. The clinical lead is now focussing on continuing to keep standards high within the service.
National Audit of Care at the End of Life	Data submission for 2022/23 completed in October 2022 The latest national report was published in June 2022. St George's achieved a positive outcome when compared to the national average for most of the key measures and were inline or above for 11 of the 13 key metrics. The Audit Lead responded to all key recommendations and a SMART action plan has been completed: - End of life nursing care plan is currently being updated on the electronic record system. - Creating a mandatory EOLC training video for staff. - Trust wide training, analysing and highlighting what training each staff member should have. - Specific training days to be implemented including simulation training days, human rights training days, EOLC champions and individual wards, and medical students and post-grad individuals.
National Audit of Dementia	The clinical audit lead reports that data collection ongoing for Round 5 of the clinical audit. Actions throughout this year and into next year focus on a pilot project between the clinicians and estates team to investigate whether the introduction of coloured crockery increases intake of food and drink in patients with dementia. There is some evidence that this can increase oral intake by 20%. Patients, their carers and staff feedback will also be collected.
Myocardial Ischaemia National Audit Project	The latest report was published in 2022 and examines data from 2020/21, at the height of the COVID-19 pandemic. The clinical lead has received and acknowledged the findings. Action planning for the year ahead will centre on delays in primary percutaneous coronary intervention, place of care provided, and referrals for cardiac rehabilitation.
National Adult Cardiac Surgery Audit	The cardiac surgery audit report showed that the number of procedures completed in the Trust was far lower in 20/21, including emergency procedures. The total captured in the audit was 346, compared to 670 in 2019/20 and over 1000 in 2017/18. This fall in participation is mirrored nationally with 19333 cases audited across the UK in 2020/21 compared to 29112 in 2019/20. This figure is likely to be caused by the pandemic where national clinical audits were made non-mandatory for a large part of the financial year. The risk adjusted in-hospital survival rate remains just above 97% which is slightly below the national average but within the control limits. The clinical audit project lead is continuing to drive high standards across the service, with performance being closely monitored and reported on.
National Audit of Cardiac Rhythm Management	The most recent report published in June 2022. Previous reporting highlighted the Trust having a higher-than-expected re-intervention rate for complex devices, this trend continues in the current report. The clinical lead reports this was due to a system error duplicating entries not an issue with the care provided. Action planning for the coming year will focus on improvements on two key areas based on the most recent set of results: - ECG Indication in-particular shows over 40% of patients were not meeting the NICE related standard (TA314). - Improving completeness on GMC numbers, and new consultants and SPRs must be added correctly to the system.
National Heart Failure Audit	The most recent findings were published in June 2022 and the latest figures showed the Trust were above the national average for 10 of the 15 key metrics listed in the national report. The clinical audit lead is continuing to work on two key areas for improvement: - To increase the number of patients being referred to cardiac rehab. The national report showed that this figure had increased nearly 5% since the previous set of results. - To drive improvements to heart care in cardiology wards as this figure has decreased over the last two audit rounds
National Early Inflammatory Arthritis Audit	The service have recruited a new consultant to lead on a Early Inflammatory Arthritis service. Action planning for the year ahead centres around consolidating the new patient pathway and more consistent recruitment of patients for inclusion in the clinical audit.
National Emergency Laparotomy Audit	The clinical audit lead provided a validated action plan for the latest findings of the audit: - The service to establish a team of junior doctors allocated to upload data with consultant support from surgery, anaesthetics, and radiology - QI project being launched to ensure initial data upload is done prospectively at the time of surgery alongside the WHO checklist - Fostering good communication across MDT in emergency, surgical, perioperative, acute, and critical care to increase fruitful collaboration - Organising training days for discussion of interesting cases which highlight the merit of good communications amongst all specialties.

National Joint Registry	The Trust performed in line with the expected rate with regard to 90-day mortality rates on knee & hip procedures, with data quality at 100% on all measures, higher than the expected standard. The clinical audit lead is working towards the following actions in the coming year: - Due to the increasing medical complexity of the patients referred to the Trust and as the revision network matures we are developing our multidisciplinary team to include anaesthetic and care of the elderly support. - We are developing a one stop clinic for emergent regional referrals for periprosthetic joint infection and impending periprosthetic fractures performing surgical, diagnostic and high risk anaesthetic review. - Despite increases in surgical and medical complexity, the service is aiming to ensure patient morbidity and mortality is reduced.
National Neonatal Audit Programme	The latest report was released in November 2022 and reports on based on NNAP data relating to babies discharged from neonatal care in England and Wales between January and December 2021. St Georges performed well with most metrics in the audit. The clinical audit lead has acknowledged the report and is working towards compiling an action plan for the coming year.
National Perinatal Mortality Review Tool	The latest report indicated that the Trust performed above the national average in the following metrics: stabilised and risk- adjusted extended perinatal mortality rate, and stabilised and risk-adjusted extended perinatal mortality rate, excluding congenital anomalies. Both figures were still within the control limits. The report has been shared with the service and actions for the following year will be based on the recommendations.
National Prostate Cancer Audit	The latest report released in January 2023. There are limited but positive results available for the Trust. The organisation compares favourably to the national average in both available measures – 'Number of men who had an emergency readmission within 90 day of radical prostate cancer surgery' (1.8% of STG patients against 12.4% nationally), and 'Number of men who experienced at least one GU complication' (3.2% locally, compared to 7.2% nationwide). 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 latest audit report was released in November 2022 with benchmarking comparing site level and national performance for 5 key metrics. For 3 metrics the Trust continued to perform well compared to the national average. Of note is the median time from symptom to surgery for patients receiving a Carotid Endarterectomy (8 days compared to 13 days nationally) highlighting a quick response time. The clinical lead has responded to these findings and is working towards addressing them in in the coming year.
UK Renal Registry Chronic Kidney Disease Audit	The latest report was published in September 2022 and was shared with the service. The results of the patient reported experience measures (PREM) survey shows that the Trust is performing below national average for each of the three metrics. The clinical audit lead is compiling an action plan to respond to these patient concerns.
National Smoking Cessation Audit	This report released in July 2022 and covered data collection from 2021. The clinical lead acknowledged the report and the findings of the report, in response they provided a SMART action plan: - Working with Trust Estates to enshrine a vape friendly policy and to provide designated vaping areas. - Ensuring that a standardised clerking proforma has space for documenting smoking status of newly admitted patients. - Working with pharmacy colleagues to ensure that Bupropion pharmacotherapy is added to the formulary.
Sentinel Stroke National Audit Programme	The audit results indicate that the Trust is performing above or in line with national averages on all key indicators. The clinical lead has conducted horizon scanning and raised the issue of increased workforce pressures, impacting on the revised audit methodology into the next year. This has been raised through the divisional structures, and planning is being prepared to alleviate these pressures.

2.2.2.6 Local clinical audits – actions taken

The reports of more than 70 local clinical audits were reviewed by the Trust in 2022- 23 and at quality half day meetings and the appropriate divisional management team meetings. Table four details the actions in relation to a sample of local audits that the Trust intends to take to improve the quality of healthcare provided based on the information available at the time of publication.

Local Clinical Audit	**Action:** Based on information available at the time of Publication
Controlled Drugs Check & Stock 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, which ensures storage and security of controlled drugs, has been largely positive despite wider disruptions due to workforce and resource constraints. The focus of actions for the coming year will be expanding the training outreach to ensure learning points are embedded across the all areas of the Trust.
Audit of Local Safety Standards for Invasive Procedures (LocSSIPs) - Theatre areas	This audit project runs quarterly and examines the use of LocSSIPs for all invasive procedures across the in theatres areas across the organisation. The clinical audit lead provided actions for coming year based on the findings: - Establishing a LocSSIPs dashboard to more easily access timely information - Refining the data collection tool to accurately reflect all specialities - Piloting new variants of the audit tool with staff to ensure full data capture.
Audit of Patient Group Directions (PGD)	An annual audit and review of every PGD in practice must be undertaken as per Trust policy. The Patient Directions Authorisation Group (PAG) are responsible for providing assurances and compliance. The 2022/23 audit took place in July 2022 and 113 PGDs were audited across the Trust over a 2-week period. 95% compliance was achieved in all but one of the 12 measurable 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. Specific focus areas for the coming year is ensuring PGD and associated documents are stored correctly in designated folders in speciality areas.
Consent Audit	The Trust Consent Audit aims to measure the effectiveness of the consent process throughout the organisation. And focuses on both a quantitative measure of data completeness of consent forms, and a qualitative assessment of the consent process as recorded in the patient records. The audit has been piloted this year, and actions for the coming year are expanding this to be a quarterly audit with results reported to corporate patient safety and quality meetings.
Falls Prevention Audit	The Trust wide Falls Prevention Audit has been re-launched and piloted across several specialities in the Trust this year, and seeks to expand on the data collected in the Falls and Fragility Fracture Audit Programme (FFFAP). Actions for the coming year include roll out to all clinical areas, and to provide more timely and actionable data.
Protected Mealtimes Audit & Nutritional Screening Audit	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. Action for the coming year centre around targeted training in poorer performing areas, ensuring that patient feedback is gathered, and focussed work on all wards participating in the audit project in a timely manner.
Treatment Escalation Plan Audit	This audit examines the National Early Warning Score (NEWS) process, which provides a graded response strategy for patients identified as being at risk of clinical deterioration. All adult wards are included in this project. Action plans for the year ahead focus on understanding the barriers and enablers to complete a treatment escalation plan (TEP) within 24 hours of patient admission.
VTE - Risk assessment compliance	This audit is run by the Hospital Thrombosis Group (HTG) to assess Trust-wide performance based on standards set by NICE, GIRFT and VTE Exemplar Status revalidation criteria. The audit shares examples of both excellent practice, and areas for improvement. Action planning for specific areas in the coming year focus on: - Clinical teams focussing on completing the initial VTE risk assessment within the 14-hour target and to carry out reassessments in a timely manner. - Clinicians to ensure they are up to date with Trust policy and know where to access this information. - To ensure accurate documentation on the Trust's locally adapted risk assessment tool on electronic records system to provide an auditable trail of the decision-making process. - Use the VTE prevention plan on electronic records system to ensure correct weight-based dosing is prescribed

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 commenced 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, and during 2023 we will extend this across GESH

A key way to develop and offer new treatments is through participation in clinical research studies that are approved by the NIHR, which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS.

In 2022 we also appointed our first Research Director for Nursing, Midwifery and Allied Health Professions (NMAHPs) to develop and implement an innovative and forward-thinking strategy to support a research culture in these professions. The role has led to an increase in the development of clinical academic opportunities and pathways for NMAHPs, including Trust research internships and fellowships which provide salary and training costs for aspiring researchers. There has also been a growth in the number of NMAHPs leading research studies at St George's and a network for those undertaking doctoral and post-doctoral study.

The number of patients receiving relevant health services provided or subcontracted by St George's University Hospitals NHS Foundation Trust in 2022/23 that were recruited during that reporting period to participate in research approved by a research ethics committee was 9, 690 compared with 7,955 in the previous year.

2.2.4 Our Commissioning for Quality and Innovation (CQUIN) performance

The NHS Contracting Framework was suspended during the Covid pandemic. NHS England re-introduced the requirement for Commissioners and Providers to hold an NHS Contract from 2022-23. The contract requirements suspended during Covid have been re-introduced, including Commissioning for Quality and Innovation (CQUIN) schemes.

CQUIN schemes are developed nationally by NHS England and each Trust is required to report data on each scheme that applies to it. In addition, local Commissioners may choose 5 CQUIN schemes (per contract) to performance manage. CQUIN funding is 1.25% of the total contract value and Commissioners may withhold a proportion of this funding on underperformance of the schemes. The Trust's contract with South West London Integrated Care Board (SWLICB) states that Providers will not be financially penalised for CQUIN underperformance.

Following negotiations with Commissioners, the following 6 CQUINs (5 Acute and one Community) were included in the Trust's NHS Contract. The performance in each quarter is outlined in the table below.

The Trust manages the CQUINs through the CQUIN Programme Board, chaired by the site Chief Nurse with project management and administrative support provided by the Finance Department.

CQUIN Programme 2022/23

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.

No	CQUIN GOAL DESCRIPTION	Baseline %	Trajectory %	Q1 value	Q2 Value	Q3 value	Q4 value	Comments
CCG1	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact	72%	Q1: n/a Q2: n/a Q3: 70% Q4: 80%	n/a	n/a	n/a	47.8%	Challenges nationally due to 'vaccination fatigue' and concurrent COVID vaccination programme negatively impacting uptake versus previous financial years where Trust had achieved upwards of 85% performance. As this scheme is mandatory nationally, it is carried forward into 23/24
CCG2	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment	Joint agreement between CNO, CMO and ICB Director of Quality that this CQUIN was not achievable due significant resource requirement for reporting of data. Scheme had been amended from previous years scheme to include a much wider cohort of patients across the organisation. Agreement that one-off touch point audit to be undertaken over specified time-period to provide assurance on Quality aspect.						
CCG3	Achieving 60% of all unplanned critical care unit admissions from non- critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) Recorded	60%	Q1: 40% Q2: 50% Q3: 55% Q4: 60%	68%	70%	97%	72%	Performance met in all 4 quarters. Small cohort of patients for audit results in some quarter- to-quarter fluctuations.

CCG4	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	12.65%	Q1: 12.65% Q2: 32% Q3: 45% Q4: 55%	17.9%	14.9%	24.2%	34.2%	Remedial action plan has been in place throughout the year to improve performance. System issues around electronic triaging process being worked through with IT and Business Intelligence colleagues which has allowed steady improved performance to develop automation for each Tumour Group. Nationwide issues with performance against this indicator especially due to issues surrounding diagnostic capacity.
CCG8	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending	55%	Q1: 55% Q2: 60% Q3: 65% Q4: 70%	55%	73%	52%	Not available at time of writing	Action plan in place to address issues around documentation in notes in areas affecting CQUIN performance.
CCG13	Achieving 70% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks	52%	Q1: 52% Q2: 55% Q3: 60% Q4: 65%	52%	62%	58%	Not available at time of writing	Performance in line with trajectory.

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 2022/23.

However, on 28 March 2023 following the inspection of Maternity and Midwifery Services as part of the national inspection programme focusing on the key lines of enquiry Safe and Well-led, the CQC issued the Trust with a section 29A Warning Notice. The Trust immediately commenced a targeted improvement plan to address issues identified in:

- Effective and timely triage services
- Environment and equipment maintenance
- Staffing levels
- Oversight and governance

The Trust will formally respond to the CQC by 28 June 2023 to provide assurance together with supporting evidence on the completion of the improvement actions taken.

The last formal CQC inspection of CQC selected 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 last year the Trust has continued to meet with the CQC on a three monthly basis to discuss service and Trust wide issues of quality and safety.

Throughout 2022/23 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 mortality for patients undergoing Cardiac Surgery on a regular basis.

It has been recognised across the NHS that the Covid-19 pandemic has impacted on the quality of services. In October 2022 a St George's, Epsom and St Helier (GESH) Quality Recovery Plan was approved at Board level. The plan outlines a programme of supported self-assessment, action planning, implementation and re-assessment focusing on a return to quality, team engagement/ collaboration and sharing of success. The plan has helped services to identify areas for improvement against the CQC key lines of enquiry of Safe, Caring, Responsive, Effective and Well-led. Targeted improvement plans have been developed and are in place supported by an effective governance framework to ensure the oversight and monitoring of delivery.

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 2022/23 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)

98.4% for accident and emergency care (against a 98.8% 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)

99.5% for accident and emergency care (against a 99.2% 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 2022/23 and planned compliance for 2023/24 by 31 March 2023. The Trust aims to submit the Toolkit with all the mandatory requirements by "Satisfactory Standard Met Status" by 30 June 2023. 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 2022/23.

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 learned 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 have been designed to enable improved documentation of immediate major trauma care 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 2022/23 and plans for 2023/24

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.

T0 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

Reporting for standards for 7-day services has changed to reflect the framework published in February 2022 and is now undertaken biannually.

The updated framework no longer refers to compliance for standards 2 and 5 and now advises that for each acute specialty consultant job plans should be reviewed to ensure that there is sufficient timetabled consultant time to meet the anticipated demand from emergency admissions. The framework also advises that the precise level of consultant presence required to deliver these standards is for the provider to assess locally rather than being specified centrally, as each organisation has its own requirements.

The Trust has increased weekend consultant presence across 7 specialties to improve performance against standards 2 and 5 and a divisional review process has confirmed adequate mitigations for safety and hospital flow are in place. With reference to standard 8 and 7-day equitable access to MRI scanning, the service is currently limited to a number of conditions.

In addition, hospital SITREP data shows a similar length of stay for admissions over 7 days, with no significant weekend disparity. The percentage of discharges occurring at the weekend continues to be lower than weekday activity, and this pattern for discharge activity is similar to regional and national benchmark data. Any individual clinical areas showing variance are subject to deep dives and oversight by the hospital flow programme.

2.2.13 How our staff can speak up

Staff are encouraged and supported to speak up about any concerns they have about any aspect of their work and have various ways of doing so. The Trust has in place a clear policy that sets out how staff can raise concerns which reflects relevant national guidance from NHS England and the National Guardian's Office for Freedom to Speak Up.

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
- Any other Executive and non- executive
- Chairman

Staff can raise concerns in different ways such as:

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

Staff are also advised how they can raise concerns externally if they are unhappy with using any of the internal routes for raising concerns or if they indicate that after raising a concern they do not feel the concern was investigated in line with the Trust policy. These external routes include the Care Quality Commission, and recognised professional or union body. Staff with concerns about potential fraud are encouraged to raise concerns with NHS Counter Fraud.

Staff who speak up are advised to report incidents where they feel due to speaking up they have come to a detriment from speaking up. 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.

Themes and trends in the concerns raised by staff that come to the FTSU Service are reported to the Trust Board and to the Board's People Committee.

2.2.14 Guardian of safe working

The year 2022/2023 has not been dominated by the covid 19 pandemic in the same ways as previous years, but the impact of the pandemic is still felt. There has been no redeployment of juniors over this period and departments and specialties have resumed normal routine and acute work. There are additional pressures from back logs created during the pandemic and the ongoing care of patients suffering from covid 19 infection. The workload and intensity of work for junior doctors has remained very high throughout the year and across many specialities. January-December 2021 saw a total of 382 exception reports and January- December 2022 has seen a total of 500 reports. Although the increase in reports is in some ways disappointing- reflecting the additional work that juniors across the trust are putting in- it is clear that juniors are being encouraged, and feel able, to exception report.

As in previous years, approximately three quarters of all reports are from acute and general medicine. It is reassuring that medical consultants remain supportive of the juniors, encourage reporting and signing off exception reports for payment or TOIL in a timely manner. A long term work force strategy for medicine is being reviewed at senior level. There has been a pilot of physician assistants (PAs) working in acute medicine to help support junior doctors on the ward. This pilot will be reviewed during 2023.

Locally employed doctors (LED) have been able to exception report through the same system as trainees since beginning 2022. It was positive to see the first exception reports from this group received in January 2023. We plan to continue to work to increase reporting in this underrepresented group. The GOSW is also working with LED lead to look at study leave policies for LED across the trust in an attempt to standardise policy and support LED.

After a period of poor attendance over the covid 19 pandemic, interest and attendance at the Junior Doctors Forum (JDF) is improving. In October 2022, three new co-chairs for the JDF were appointed. The first JDF meeting in December 2022 was well attended, with over 25 junior doctors from across the trust present.

The redecoration and refurbishing works of junior doctor's mess commenced in February 2023 using well-being funds and will be completed before the summer.

We have started the new year with junior doctor industrial action. This is an unsettling time for juniors and the support of the consultants and wider team will be hugely important over the coming months.

Finally, the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 require the Trust's Guardian of Safe Working to provide quarterly reports on rota gaps to the Trust Board. We define rota gaps as the number of vacancies (which need to be filled to ensure that service provision requirements are met) which arise as a result of any shortfalls in the number of doctors in training recruited when compared with the number allocated by Health Education England. The gaps are derived from the HEE portal April trainee reports.

The rota gaps by Division for 2022-23 are summarised below.

Division	WTE
Medicine	13
Surgery	13.6
Children and women	9
Total gaps in the rota	**35.6**

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 (where available).

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	Jan22- Dec22
SHMI	**0.81**	**0.83**	**0.83**	**0.83**	**0.85**	**0.85**	**0.85**	**0.86**	**0.84**	**0.90**	**0.91**	**0.94**
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**	**As expected**
% Deaths with palliative care coding	**50**	**49**	**49**	**50**	**49**	**49**	**48**	**47**	**49**	**54**	**54**	**58**

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.involvement of palliative care services.

2.3.2 Patient reported outcome measures

For Trusts providing relevant acute services 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 paients reporing an increase in health following surgery		2020-21*	2021-22*	2022-23*
		SGH	SGH	SGH
Hip replacement	EQ-5D™	No data	No data	Not published at time of writing and will be included in the 2023-24 report
	EQ-VAS	No data	No data	
	Specific	No data	No data	
Knee replacement	EQ-5D™	No data	No data	
	EQ-VAS	No data	No data	
	Specific	No data	No data	

Source: NHS Digital 9https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome- measures-proms/hip-and-knee-replacement-procedures---april-2019-to-march-2020

*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 (SWELEOC).

This year given the level of activity at St George's we have explored the option of submitting data alongside Epsom and St Helier University Hospitals NHS Trust for SWELEOC cases but we made limited progress.

We also looked at St George's becoming accredited in order to submit data directly to the audit rather than submitting via an external data collector, however this process has been suspended by NHS Digital.

This year we will make the case for the Trust to withdraw from participation in this audit.

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	2019-20			2020-21			2021-22			2022-23		
	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	13022	47103	60125	8,522	34,886	43,408	9,945	35, 549	45, 494	9,365	32,041	41,406
28-day readmissions	932	4218	5150	524	3,638	4,162	672	3,233	3,905	576	2,781	3,357
28-day readmissions rate	7.16%	8.95%	8.57%	6.15%	10.43%	9.59%	6.76%	9.09%	8.58%	6.15%	8.68%	8.11%

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

Last year and in previous Quality Accounts the national inpatient survey asked five questions focussing on the responsiveness and personal care of patients. From the table below it can be seen that our scores were generally in line with the national average shown below. The data below also shows the average, highest and lowest performers and our previous performance.

Further to the merger of NHS Digital and NHS England the data in this format set out in the following table is no longer available via the https link below.

Patient Experience	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
St George's University Hospitals	**65**	**67.2**	**67.1**	65	Not available	
National average	68.6	67.2	64.2	67.1	Not available	
Highest (best)	85	85	84.2	84.4	Not available	
Lowest	60.5	58.9	59.5	54.4	Not available	

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

We have reviewed a related section in the national CQC inpatient survey (2021/22). This section is made up of several questions relating to personal care, food, and assistance with eating.

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

This data is validated through the external CQC national inpatient survey methodology

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

Paient Experience	2021-22	2022-23*
St George's University Hospitals	**7.3**	
National average		
Highest (best)		
Lowest		

St George's University Hospitals NHS Foundation Trust.pptx (live.com)

* The 2022/23 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2023/24

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 2022/23 shows a 3.6 % reduction in staff who would recommend St George's to their friends and families.

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

Staff recommendaion	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
St George's University Hospitals	73%	69%	72%	76%	71.2%	67.6%
Average for Acute	69%	70%	71%	74%	66.9%	61.9%
Highest Acute Trust	86%	87%	87%	92%	89.5%	86.4%
Lowest Acute Trust	47%	41%	40%	49%	43.6%	39.2%

http://www.nhsstaffsurveyresults.com/wpcontent/uploads/2021/02/NHS_staff_survey_2020_RJ7_full.pdfhttps://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 2022/23 with 98.42% 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 74.42% 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		2022-23	
St George's University Hospitals	A&E	Inpatient	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%	12.43%	29.17%
% would recommend	87.00%	97.00%	82.41%	96.5%	89.83%	97.5%	77.86%	97.70%	74.42%	98.42%
% would not recommend	8.50%	1.00%	12.36%	1.14%	6.52%	0.75%	12.82%	0.60%	17.24%	0.41%
National comparison positive response rate	12.3%	24.6%	12.1%	24.4%	N/A*	N/A*				
National comparison as at March 2020 % would recommend	86%	96%	85%	96%	N/A*	N/A*				
National comparison as at March 2020 % would not recommend	8%	2%	9%	2%	N/A*	N/A*				

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

Friends-and-Family-Test-inpatient-data-January-2022.xlsm (live.com)

* 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 TThe 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:

- 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 were an improvement on the previous year. The data is no longer benchmarked at a national level therefore data for the average, highest and lowest performers is no longer published.

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	2022-23
St George's University Hospitals	95.90%	96.0%	93.9%	96.18%	96.8%	97%
Naional Average	95.80%	95.6%	95.5%	95.33%	N/A	N/A
Best performing Trust*	100%	100%	100%	100%	N/A	N/A
Worst performing Trust*	72%	74.4%	71.7%	77.16%	N/A	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 further and so the quality of our services:

- Continue to working to achieve higher VTE risk assessment rates
- Optimisation of iClip and anticoagulation prescribing

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. The Trust has breached the NHSE number of Clostridium Difficile infections for 2022/23, an action plan is in place and on-going with monthly prevalence reduced since quarter 2, 2022/23.

Clostridium Difficile	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
St George's University Hospitals *Data is from April 21 to Mar 22						
Trust apporioned cases *Change in reporing: denotes those Cases confirmed due to lapses in care	16	31	8	34	33	60
Trust bed-days	296,981	282,339	285,321	225,244	278,832	290,474
Rate per 100,000 bed days	5.4	11.0	2.8	15.09	11.8	20.3
Naional average	31.2	33	3	21.52	25.81	27.51
Worst performing trust	113	177	15	98.61	91.6	98.8
Best performing trust	0	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: In 2020-21 Hospital capacity was 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

We are committed to improving safety by avoiding or reducing Clostridium Difficile which results in shorter length of stay and improved patient experience. The Trust has breached the NHSE number of Clostridium Difficile infections for 2022/23, an action plan is in place and on-going with monthly prevalence reduced since quarter 2, 2022/23.

Patient Safety Incidents	Apr 17-Sep 18	Oct 18-Mar 19	Apr 19-Sep 19	Oct 19-Mar 20	Apr 20-Mar 21	Apr 21-Mar 22	Apr 22-Mar 23
St George's University Hospitals							
Total reported incidents	5548	5934	6268	6697	12352	13092	13880
Rate per 1000 bed days	34.2	39.5	45.3	45.4	51.2	51.7	55.0
***Naional average (acute non-specialist)**	42.8	46.1					
***Highest reporing rate**	111.7	95.9					
***Lowest reporing rate**	23.5	16.9					

Paient Safety Incidents	Apr 17-Sep 18	Oct 18-Mar 19	Apr 19-Sep 19	Oct 19 – Mar 20	Apr 20-Mar 21	Apr 21-Mar 22	Apr 22-Mar 23
St George's University Hospitals							
Incidents causing severe harm or death	14	23	10	9	21	46	Not available at time Of writing
Rate per 1000 bed days	0.25%	0.38%	0.16%	0.13%	0.17%	0.35%	
***Naional average (acute non-specialist)**	0.35%	0.36%					
***Highest reporing rate**	1.23%	0.49					
***Lowest reporing rate**	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 is 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 It should be noted that 3 of the incidents in 2022-23 were never events. 2 were related to retained foreign object (retained guidewire and vaginal swab) and 1 was related to a misplaced nasogastric tube. Serious incident investigations were undertaken and improvement actions were identified and implemented.

2.3.9.3 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 2023/24. 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
- Commenced the implementation of the new Patient safety Incident reporting Framework (PSIRF) in line with the new National Patient Safety Strategy.

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.

		Target	Annual performance 2019-20	Annual performance 2020-21	Annual performance 2021-22	Annual performance 2022-23
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	84.20%	69.30%	72.30%	67.9%
	Number of 52 week breaches	0	32	2,644	846	517
ED access	95% of patient wait less than 4 hours	>=95%	83.20%	92.80%	81.60%	76.60%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	>=85%	85.20%	77.10%	72.60%	66.0%
	% patients treated within 62 days from screening referral	>=90%	88.80%	80.80%	75.90%	71.0%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	99%	95.70%	89.80%	98.20%	98.20%

3.2 Our performance against our Quality priorities in 2022-23

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.

1.0 Patient Safety			
Our quality priorities	**What will success look like?**	**How did we do in 2022/23?**	**How our performance compared with 2021/22**
Prevent Nosocomial Covid-19 infection for inpatients	Reduction in the level of Nosocomial Covid-19 infection when compared with the previous year	**We did not achieve this** Between April 2022 and March 2023 the Trust had reported 426 cases of HOHA (hospital onset, hospital acquired) nosocomial hospital onset healthcare associated >14 days after admission Between April 2022 and March 2023 the Trust had reported 247 cases of HOPA (hospital onset, probable acquired) nosocomial hospital onset healthcare associated 8-14 days after admission	In 2021/22 we reported 227 cases of HOHA nosocomial hospital onset healthcare associated >14 days after admission In 2021/22 we reported 137 cases of HOPA nosocomial hospital onset healthcare associated 8- 14 days after admission
Emergency patients will have a Treatment Escalation Plan (TEP)	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** All wards have a TEP Dashboard and daily tableau reports are generated for ward managers Compliance across all wards ranges between 36 - 51% against a trajectory of 40% and is monitored monthly by the Divisional teams Compliance on Senior Health wards was 90-95% In March 2023 45% of adults had a TEP in place confirmed by a snapshot audit The number of cardiac arrests in March 2023 was 1.92/1000 inpatient admissions NEWS2 audits showed an appropriate response performance of 92% in March 2023. The methodology for this audit is self-audit by a member of the ward team. Going forward enhanced assurance can be provided by the Bi-annual NEWS2 survey undertaken by the Critical Care Outreach Team supported by the audit team.	In 2021/22 we established an improvement project and built an electronic TEP in the test domain of iClip In March 2022 37.4% of adults had a TEP in place within 24 hours of admission. The number of cardiac arrests in 2021/22 was 7.7/1000 inpatient admissions NEWS2 audits showed an appropriate response performance of 90.8% in March 2022 which was an improvement in appropriate response performance from 89% in

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 Level 1 and 2 Mental Capacity Act (MCA) Training	**We did not achieve this** Internal audit (TIAA) report published in August 2022 – all but two recommended improvement actions arising have been completed. Consent Policy on two pages circulated to all care groups – inclusive of MCA flowchart. New consent audit live December to January and quarterly thereafter. Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 training performance was 90.70% in March 2023 Level 2 training performance was 61% in March 2023 **Important note:** In 2022/23 the Trust was still awaiting the release of the guidance for the implementation of the new framework for MCA/DoLS – the Liberty Protection Safeguards (LPS). The revision of the Level 2 training module was paused whilst the new framework was awaited which impacted on training performance. It has now been confirmed that LPS will not be implemented.	Since 2019 Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 training performance had achieved the target Level 2 training performance was 69.7% in March 2022
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 March 2023 45% of adults had a TEP in place confirmed by a snapshot audit At the time of writing this report consent audit data has not been published	In March 2022 35% of adults had a TEP in place within 24 hours of admission, performance in March 2021 was 33.8% No consent audit data was available in 2021/22
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
2.0 Patient experience			
Our quality priorities	**What will success look like?**	**How did we do in 2022/23?**	**How our performance compared with 2021/22**
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 The total number of complaints in 2022/23 was 650	The number of complaints received in previous years was as follows: • 2021/22: 1,044* • 2020/21: 708* • 2019/20: 956 • 2018/19: 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	**We partially achieved this** The action plan to address improvements identified in the 2021 national standards self-assessment did not progress as expected due to significant staffing shortages in the team. South West London ICB and Acute Hospitals worked together to create a pathway for referral to STOMP (stopping over medication of people with a learning disability, autism or both). This will cover each Acute Trust and will support patients to have psychotropic medication reviewed as part of ongoing care. A part time Healthcare Assistant post has been created to provide additional psychosocial engagement for inpatients, and support outpatients to navigate appointments. The Learning Disability (LD) team have approval from Charity Funds to purchase tablet computers to enhance patient experience whilst an inpatient. Radiology Administrative staff trained in LD, recognising a hospital passport LD PPEG was relaunched face to face. The self-assessment was completed against national standards for Learning Disability patients and at the time of writing we are awaiting the results.	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 to survey our patients on discharge and respond to what they tell us to ensure our patients are quipped 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 patientsmto leave our care with a follow upnappointment or investigation date if required	**We achieved this** The multi-agency Discharge Forum has continued Recruitment to full Transfer of Care (TOC) service undertaken with 7 day service running 08:00-18:00 Planning and mapping of involvement of voluntary services in expediting discharges and admission avoidance. New flow model implemented – 1 of 5 Trusts involved in national trial	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

3.0 Effectiveness and outcomes			
Our quality priorities	**What will success look like?**	**How did we do in 2022/23?**	**How our performance compared with 2021/22**
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 achieve this** Parity of Esteem (PoE) lead was recruited and commenced in post in December 2022. Mental Health Training Matrix in place The educational programme delivery with has been negotiated with SWLSTG and has commenced. The terms of reference have been reviewed to restart the inter-Trust operational meeting.	The integrated training and education framework was not developed due to the new post of Head of Nursing commencing in post December 2020
Embed a culture of quality, safety and learning	Implement the national patient safety training syllabus across the Trust Launch the new patient Safety training Incident Reporting Framework Establish Patient Safety Partners Share learning via the bi-monthly Patient Safety Bulletin	Carry forward to 2022/23 We were unable to deliver on this Quality Priority in 2022-23 as the new national Patient Safety Incident Response Framework was not launched until August 2022.	N/A
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 Treatment (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 of this report **RTT:** The Trust eliminated all 78 week waits by March, except for four patients that will be treated in April, due to patient choice. At the end of February 481 patients were waiting for treatment for more than 52 weeks, this is below the plan of 800. **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. We delivered 73.5% against the target of 95%	As reported in section 3.1, 2021-22 report **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

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

A1.1 Statement from South West London Integrated Care Board

Thank you for sharing the Trust's 2022/2023 Quality Account with South West London Integrated Care Board (SWL ICB). Having reviewed the Quality Account, we are pleased to see the progress made by the Trust in maintaining high quality care standards. It is evident that there is a significant amount of positive work the Trust has undertaken to improve outcomes for both patients and staff.

The ICB congratulates the Trust on achieving the priorities set for 2022/2023 and identifying areas where work will continue into 2023/2024. We are encouraged to see that you have a medical examiner service embedded and learning from deaths processes in place, this will complement the work you are undertaking implementing the Patient Safety Incident Response Framework (PSIRF).

We applaud the improvements to patient flow, for embracing a multi-agency discharge forum and using the new flow model as one of five Trusts involved in the national trials. We are assured that you are recruiting to the Transfer of Care (TOC) service, which provides a 7-day service running 08:00- 18:00, including innovative ways to involve voluntary services in expediting discharges and admission avoidance.

We congratulate you on training your radiology administrative staff in recognising Learning Disability (LD) patients and developing the hospital passport, and also for relaunching LD PPEG face-to-face.

We are committed to ongoing work with you in creating a pathway for referral to STOMP (stopping over medication of people with a learning disability, autism or both) as we ensure all Trusts will support patients to have psychotropic medication reviewed as part of ongoing care. This is in alignment with the Integrated Care System's priorities to tackle health inequalities for people living with a learning disability.

We commend the work you are undertaking for staff around the integrated education and training framework with SWL St Georges' Mental Health Trust to support the care and treatment of mental health patients in an acute setting.

In the spirit of collaboration and integration, we compliment that your 2023/24 priorities and the new 5 year strategy have been jointly developed as a Group with alignment to Epsom and St Helier, with an aim to work closer with SWL ICS and the Acute Provider Collaborative. For 2023/2024, we acknowledge the Trust has identified the following quality priorities:

- **Priority 1 – Improve patient safety:** having the right systems and staff in place to minimize the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes
- **Priority 2 – Improve patient experience:** meeting our patients' emotional as well as physical needs
- **Priority 3 – Improve effectiveness and outcomes:** providing the highest quality care, with world class outcomes whilst also being efficient and cost effective.

We commend the alignment of your quality priorities to the 5-year strategy for GESH Group and note other quality priorities include:

Well Led

- Deliver on our Health and Wellbeing promise to all staff by investing in physical and mental health staff services and flexible working.
- Develop and implement an inclusive talent management approach to ensure that we improve our opportunities for our staff.

Reduce Health Inequalities

- Taking action on our culture to ensure we are more inclusive and diverse, where discrimination, violence and bullying is not tolerated – improving the experience of BAME staff in particular.

Develop Sustainable Quality-led Services

- Develop an environment where staff feel psychologically safe to speak up and use their voices to improve our services to patients.

Quality Management System

- Continue to work in partnership and collaboration with the SWL Integrated Care System (ICS) and Acute Provider Collaborative (APC).
- Delivering a transformational step change in use of resources (to achieve the Cost Improvement Programme) at SGUH, across the Group and across South West London ICS, for the benefit of patients and the welfare of our staff.

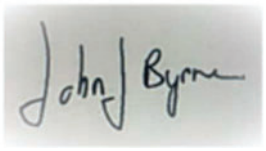
- Explore and deliver opportunities for collaboration across the Group.
- Make best use of our resources at St George's and across South West London ICS, for the benefit of patients and the welfare of our staff.

We are pleased to see all priorities align to the ICB's Joint Forward Plan and System Quality Strategy, and we are committed to working with the Trust and Group as a core a member of the Integrated Care System to improve outcomes and deliver our shared quality priorities.

We recommend that the Trust considers the following actions within its agreed priorities:

- Working in collaboration with system and local partners to tackle systemic health inequalities; a particular focus on quality in SWL is ensuring that all Trusts have effective and adequate pathways adhering to the NICE guidance to improve compliance of the 30-minute to analgesia target in Emergency Departments for sickle cell patients.
- Proactively work to improve and sustain quality of care in maternity services following the Care Quality Commission warning notice to the Trust.

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



John Byrne
Chief Medical 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. Please note that our comments are based on a draft copy of the Account which may not contain all the information that will appear in the final version.

The openness and honesty of the report, and the considerable detail is very welcome. There are examples of some good performance on tackling the back log of treatment and appointments, especially in those wating over 52 weeks. This year there have been a lot of factors adding to pressure and demand on hospital staff and resources, across services and particularly affecting the Emergency Department. In light of this, the achievements that have been made in these challenging circumstances are commendable. We hope that the next year that further progress can be made against some of the targets and indicators that were more difficult to achieve this year.

Hospital discharge is a particular area of interest for us and for local people. We heard from carers about the improvements that can be made to care when they are more informed and involved in the process and are very pleased that the carers toolkit will be used because it was informed by what people told us. Ambitions set out in the account for the next year aim to ensure people have the information to manage their health and know how to access support and that discharge summaries will be improved as well as making sure people have a planned follow-up appointment or investigation. We hope to see next year that these measures have had an impact on the indicators demonstrating re-admissions and in responses from patients to surveys about their experience.

We've also seen better collaboration with the Patient Involvement team over the past year and welcome the renewed focus on embedding this across all services. There is an encouraging statement in the account that there will be collaboration with Integrated Care System colleagues to review and triangulate all sources of patient feedback to improve our understanding of what good looks like for patients and their families. This will bring a welcome focus on ensuring that people are heard and an increased impact of the time they spend sharing their experiences. People often tell us they are asked to comment several times on aspects of their care, so avoiding duplicating collection of insight from people will be appreciated and will help build trust that there is a benefit to sharing their views.

The detail about insight from national inpatient surveys was very limited in the draft report we viewed, which means that we cannot make any meaningful comments. We hope there will be more reported on patient experience next year.

Another topic we often hear about that has an impact on experiences is communication, particularly around appointments. MyCare patient portal offers a solution that could help many people with information and with arranging and confirming appointments. Improving these things will ensure people can manage their own care and that they can access and navigate the system, as well as potentially breaking down some barriers in communication. We hope that the portal continues to develop to support people more, and that this is done by working with patients to understand how it works for them, what is working well or where there could be barriers to using it for others. We have particularly heard that communications and letters are an issue for people with sight loss and hope that there is further consideration of whether this portal or another means can improve the experience.

Other areas of welcome focus outlined in the report include:

- the focus on implementing the National Patient Safety Framework and the development of Patient Safety Partners which we hope will be achieved in a timely way.
- focus on inequalities starting with better data collection by ethnic and other protected characteristics to examine outcomes by different patient groups.
- meeting the emotional wellbeing of patients and their families.
- learning across the group and bench marking with similar institutions so best practice is implemented.

Areas for further development that we think will be important include:

- issues related to maternity services in particular the latest CQC inspection – we look forward to the action plan and improved outcomes.
- focus on improving efforts to reduce falls and pressure ulcers. These are areas which may have a direct impact on patients' length of stay, rehabilitation and plans for discharge.

- support for staff to feel safe raising concerns and to have an increased culture of openness.
- embedding the patient experience and feedback and making this real and meaningful within the new GESH strategy.
- that new measures to learn from deaths improve the Summary Hospital Level Mortality Indicator score.
- improvements to reverse the upward trend in the numbers reported in section 2.3.9 around patient safety incidents.Areas for further development that we think will be important include:

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

- Voluntary provision of comments – none received.

A1.4 Our response to our stakeholders

The Trust is grateful for the considered responses from all our stakeholders and their input in developing our Quality Account. These have been helpful and will be considered with the relevant stakeholders in 2023-24.

A1.5 Limited assurance report on the content of the Quality Reports and mandated performance indicators

[Not required and limited to a read through against the Annual Report and Accounts]

A1.6 Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

[Not required]

Annex 2:

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

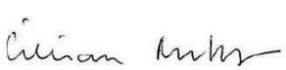
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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 2021/22 and supporting guidance Detailed requirements for quality reports 2021/22
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - i. board minutes and papers for the period April 2022 to June 2023
  - ii. papers relating to quality reported to the board over the period April 2022 to June 2023
  - iii. feedback from the Integrated Care Board
  - iv. feedback from Governors
  - v. feedback from local Healthwatch organisations (voluntary)
  - vi. the Trust's complaints report 2021-22 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - vii. the latest national patient survey for Adult Inpatients; Urgent and Emergency Care; Children and Young People; and Maternity Services
  - viii. the latest national staff survey
  - ix. the Head of Internal Audit's annual opinion of the Trust's control environment dated [Not required]
  - x. the CQC inspection reports dated 18 December 2019
- the quality report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporate the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board.



Gillian Norton
Chairman
30 June 2023

Jacqueline Totterdell
Chief Executive
30 June 2023

9. Annual accounts for the year ended 31 March 2023

Foreword to the accounts

St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2023, have been prepared by St George's University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name Jacqueline Totterdell

Job title Group Chief Executive

Date 29 June 2023

Statement of Comprehensive Income

	Note	2022/23 £000	2021/22 £000
Operating income from patient care activities	3	984,927	934,053
Other operating income	4	142,693	143,284
Operating expenses	6, 8	(1,145,666))	(1,070,481)
Operating surplus/(deficit) from continuing operations		(18,046)	6,856
Finance income	10	1,352	34
Finance expenses	11	(4,500)	(3,242)
PDC dividends payable		(10,951)	(10,866)
Net finance costs		(14,099)	(14,074)
Other gains/(losses)	12	(483)	-
Surplus/(deficit) for the year from continuing operations		(32,628)	(7,218)
Surplus/(deficit) for the year		(32,628)	(7,218)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(5,865)	(8,726)
Revaluations	16	19,199	
Total comprehensive income / (expense) for the period		(19,294)	(15,944)

Statement of Financial Position

	Note	31 March 2022/23 £000	31 March 2021/22 £000
Non-current assets			
Intangible assets	13	37,919	43,507
Property, plant and equipment	14	462,143	443,776
Right of use assets	17	15,223	
Receivables	20	-	8,592
Total non-current assets		679,150	495,875
Current assets			
Inventories	19	20,631	15,058
Receivables	20	79,008	75,306
Cash and cash equivalents	20	58,546	68,545
Total current assets		158,185	158,909
Current liabilities			
Trade and other payables	21	(199,382)	(170,694)
Borrowings	23	(19,238)	(5,783)
Provisions	24	(567)	(636)
Other liabilities	22	(14,807)	(11,965)
Total current liabilities		(233,994)	(189,078)
Total assets less current liabilities		603,341	465,706
Non-current liabilities			
Borrowings	23	(192,088)	(55,402)
Provisions	24	(2,227)	(2,128)
Total non-current liabilities		(194,315)	(57,530)
Total assets employed		409,026	408,176
Financed by			
Public dividend capital		585,984	565,840
Revaluation reserve		86,974	73,640
Other reserves		1,150	1,150
Income and expenditure reserve		(265,083)	(232,454)
Total taxpayers' equity		409,026	408,176

The notes on pages 1 to 32 form part of these accounts.

Signed 

Name Jacqueline Totterdell

Job title Group Chief Executive

Date 29 June 2023

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022 - brought forward	565,840	73,640	1,150	(232,454)	408,176
Implementation of IFRS 16 on 1 April 2023	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	(32,628)	(32,628)
Impairments	-	(5,865)	-	-	(5,865)
Revaluations	-	19,199	-	-	19,199
Public dividend capital received	20,144	-	-	-	20,144
Taxpayers' and others' equity at 31 March 2023	565,984	86,974	1,150	(265,083)	409,026

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)
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

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.

Revaluation reserve

reserveIncreases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve

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

Other reserves

This reserve of £1.15m was created in March 2003 to recognise the portion of land at St George's Grove that had been omitted from the land valuation used to establish the St George's opening PDC capital balance when it became a NHS Trust on 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	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(18,046)	13,923
Non-cash income and expense:			
Depreciation and amortisation	6.1	49,708	28,732
Net impairments	7	1,655	12
Income recognised in respect of capital donations	4	(502)	(5,451)
(Increase) / decrease in receivables and other assets		(9,567)	10,753
(Increase) / decrease in inventories		(5,573)	(1,344)
Increase / (decrease) in payables and other liabilities		42,529	16,785
Increase / (decrease) in provisions		43	1,402
Other movements in operating cash flows		(206)	(199)
Net cash flows from / (used in) operating activities		60,041	64,613
Cash flows from investing activities			
Interest received		1,352	34
Purchase of intangible assets		(421)	(5,404)
Purchase of PPE and investment property		(55,655)	(58,737)
Receipt of cash donations to purchase assets		424	795
Net cash flows from / (used in) investing activities		(54,300)	(63,312)
Cash flows from financing activities			
Public dividend capital received		20,144	33,934
Movement on loans from DHSC		(602)	(602)
Movement on other loans		(1,478)	(1,478)
Capital element of finance lease rental payments		(16,173)	(3,425)
Capital element of PFI, LIFT and other service concession payments		(1,392)	(1,301)
Interest on loans		(294)	(335)
Other interest		(4)	(17)
Interest paid on finance lease liabilities		(1,775)	(387)
Interest paid on PFI, LIFT and other service concession obligations		(2,449)	(2,540)
PDC dividend (paid) / refunded		(11,717)	(10,902)
Net cash flows from / (used in) financing activities		15,740	12,947
Increase / (decrease) in cash and cash equivalents		(9,999)	31,984
Cash and cash equivalents at 1 April - brought forward		68,545	36,561
Cash and cash equivalents at 31 March	20.4	58,546	68,545

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England 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 2022/23 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 £30m deficit for the year ended 31 March 2023 (after adjusting for excluded items against the control total). The final financial plan for 23/24 remains to be finalised, with the Trust aspiring to achieve a £24.9m deficit, having taken account of the underlying financial position going into 2023/24. Currently the Trust is exploring the funding streams confirmed for the new financial year, in order to decide if any risk or opportunities to this position exist. 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 2022/23, 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:

- Croydon University Hospitals NHS Trust -19.60%
- Kingston NHS Foundation Trust-20.50%
- Epsom & St Helier NHS Foundation Trust-32.40%
- St George's University Hospitals NHS Foundation Trust-27.50%

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 2022/23, 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 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 2022/23, 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. 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. Reimbursement is accounted for as variable consideration.

Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner.

In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria. Adjustments for actual performance are made through the variable element of the contract payments.

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

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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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.

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

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:

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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.

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.been met.

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.

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:

	Years	Years
Buildings, excluding dwellings	5	100
Dwellings	25	80
Plant & machinery	5	34
Information technology	3	34
Furniture & fittings	7	49

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 fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	**7**	**16**
Software licences	**3**	**10**

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.

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 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 with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

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).

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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 estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires

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

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

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 2023:

		Nominal rate	Prior year rate
Short-term	**Up to 5 years**	**3.27%**	**0.47%**
Medium-term	**After 5 years up to 10 years**	**3.20%**	**0.70%**
Long-term	**After 10 years up to 40 years**	**3.51%**	**0.95%**
Very long-term	**Exceeding 40 years**	**3.00%**	**0.66%**

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 2023:

	Inflation rate	Prior year rate
Year 1	**7.40%**	**4.00%**
Year 2	**0.60%**	**2.60%**
Into perpetuity	**2.00%**	**2.00%**

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (prior year: minus 1.30%).

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 24.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC fcrom, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

St George's University Hospitals NHS Foundation Trust has no corporation tax liability because under the relevant extant legislation Foundation Trusts are not subject to corporation tax.

Note 1.19 Climate change levy

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

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

From 1 April 2023, the measurement 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. Such remeasurements will be recognised as a financing cost. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred.

Initial application of these principles will be on 1 April 2023 using a modified retrospective approach with the cumulative impact taken to reserves. This is expected to result in an increased PFI liability on the statement of financial position. 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 2022/23 financial statements.

Note 1.27 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Buildings have the potential to deteriorate or last longer than predicted and therefore the useful lives estimated may not be appropriate. These are reviewed each year and therefore ensure that any changes to condition, use etc. which affect this, are picked up annually and at full valuation. Building asset lives range from 3 years to 100 years.

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.

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 CCG/ICBs account for 49% (2021/22 - 55%) of the Trust revenue with a further 38% (2021/22 -30%) 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)

	2022/23 £000	2021/22 £000
Income from commissioners under API contracts*	896,510	851,526
High cost drugs income from commissioners (excluding pass-through costs)	8,763	7,439
Other NHS clinical income	4,186	16,847
Private patient income	196	1,419
Elective recovery fund	26,133	26,573
Agenda for change pay offer central funding***	17,597	-
Additional pension contribution central funding**	25,618	23,793
Other clinical income	5,923	6,455
Total income from activities	984,927	934,053

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National Tariff payments system documents. https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

**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.

***** TEXT TO BE PROVIDED AFTER SUBMISSION**

Note 3.2 Income from patient care activities (by source)

	2022/23 £000	2021/22 £000
Income from patient care activities received from:		
NHS England	423,551	327,959
Clinical commissioning groups	131,232	597,644
Integrated care boards	422,587	
Department of Health and Social Care	-	-
Other NHS providers	1,097	1,097
NHS other	-	28
Local authorities	8	-
Non-NHS: private patients	196	1,419
Non-NHS: overseas patients (chargeable to patient)	3,550	1,803
Injury cost recovery scheme	2,258	3,991
Non NHS: other	448	112
Total income from activities	984,927	934,053
Of which:		
Related to continuing operations	984,927	934,053

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

	2022/23 £000	2021/22 £000
Income recognised this year	3,550	1,803
Cash payments received in-year	191	323
Amounts added to provision for impairment of receivables	1,899	97

Note 4 Other operating income

	2022/23			2021/22		
	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	8,059	-	8,059
Education and training	38,241	-	38,241	38,241	-	38,241
Non-patient care services to other bodies	70,859		70,859	70,859		70,859
Reimbursement and top up funding	9,420		9,420	9,420		9,420
Income in respect of employee benefits accounted on a gross basis	8,830		8,830	8,830		8,830
Receipt of capital grants and donations		795	795		795	795
Charitable and other contributions to expenditure		3,565	3,565		3,565	3,565
Other income	3,515	-	3,515	3,515	-	3,515
Total other operating income	138,924	4,360	143,284	138,924	4,360	143,284
Of which:						
Related to continuing operations			143,284			143,284
Related to discontinued operations						

Note 5.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider 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:

	2022/23 £000	2021/22 £000
Income from services designated as commissioner requested services	984,927	934,053
Income from services not designated as commissioner requested services	142,693	143,284
Total	1,127,620	1,077,337

Note 6.1 Operating expenses

	2022/23 £000	2021/22 £000
Purchase of healthcare from NHS and DHSC bodies	2,078	3,420
Purchase of healthcare from non-NHS and non-DHSC bodies	12,803	3,863
Staff and executive directors costs	711,137	642,750
Remuneration of non-executive directors	83	149
Supplies and services - clinical (excluding drugs costs)	109,911	125,793
Supplies and services – general	57,111	32,708
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	95,596	90,363
Inventories written down	-	32
Consultancy costs	480	728
Establishment	11,134	6,048
Premises	43,497	38,666
Transport (including patient travel)	1,233	17,970
Depreciation on property, plant and equipment	43,128	28,415
Amortisation on intangible assets	6,580	5,999
Net impairments	1,655	6,586
Movement in credit loss allowance: contract receivables / contract assets	155	(333)
Increase/(decrease) in other provisions	100	33
audit services- statutory audit	198	113
other auditor remuneration (external auditor only)	-	-
Internal audit costs	122	140
Clinical negligence	24,952	26,114
Legal fees	471	1,116
Insurance	77	66
Research and development	-	488
Education and training	2,310	2,991
Operating lease expenditure (comparative only)		17,560
Redundancy	-	49
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	8,436	7,751
Car parking & security	438	985
Losses, ex gratia & special payments	111	12
	423	
Other	11,487	9,904
Total	1,145,666	1,070,481
Of which:		
Related to continuing operations	1,145,666	1,070,481
Audit Fees		
The fees reconciles to the Financial statement as follows		
Statutory Audit Fee	165,000	93,750
VAT	33,000	18,750
Total Audit fee 2022,23	198,000	112,500

Note 6.2 Other auditor remuneration

	2022/23 £000	2021/22 £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 (2021/22: £2 million).

Note 7 Impairment of assets

	2022/23 £000	2021/22 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	1,655	6,586
Total net impairments charged to operating surplus/deficit	1,655	6,586
Impairments charged to the revaluation reserve	5,865	8,726
Total net impairments	7,520	15,312

Note 8 Employee benefits

	2022/23 Total £000	2021/22 Total £000
Salaries and wages	544,500	486,262
Social security costs	58,925	53,759
Apprenticeship levy	2,736	2,178
Employer's contributions to NHS pensions	84,207	78,229
Pension cost - other	95	49
Termination benefits	-	84
Temporary staff (including agency)	20,674	22,189
Total gross staff costs	711,137	642,750
Recoveries in respect of seconded staff	-	-
Total staff costs	711,137	642,750
Of which		
Costs capitalised as part of assets	-	-

Note 8.1 Retirements due to ill-health

During 2022/23 there were 3 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £76k (£210k in 2021/22).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 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.

IThe latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

C) 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 Finance income

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

	2022/23 £000	2021/22 £000
Interest on bank accounts	1,352	34
Total finance income	1,352	34

Note 11.1 Finance expenditure

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

	2022/23 £000	2021/22 £000
Interest expense:		
Loans from the Department of Health and Social Care	230	243
Other loans	54	80
lease obligations	1,776	387
Interest on late payment of commercial debt	4	2
Main finance costs on PFI and LIFT schemes obligations	2,449	2,540
Total interest expense	4,513	3,252
Unwinding of discount on provisions	(13)	(10)
Other finance costs	-	-
Total finance costs	4,500	3,242

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2022/23 £000	2021/22 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	4	2

Note 12 Other gains/(losses)

	2022/23 £000	2021/22 £000
Interest on bank accounts	(483)	-
Total other gains / (losses)	(483)	-

The Trust dispose £483k of old plant and equipment in 2022/23

There were expired leases of £4.3m in 22/23 (£5m in 21/22) with 0 net book value.

Note 13.1 Intangible assets - 2022/23

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2022 - brought forward	2,197	65,596	64,793
Additions	141	280	421
Reclassifications	136	435	571
Valuation / gross cost at 31 March 2023	2,474	63,311	65,785
Amortisation at 1 April 2022 - brought forward	1,036	20,250	21,286
Provided during the year	438	6,142	6,580
Impairments	-	-	-
Amortisation at 31 March 2023	1,474	26,392	27,866
Net book value at 31 March 2023	1,000	36,919	37,919
Net book value at 1 April 2022	1,161	42,346	43,507

Note 13.1 Intangible assets - 2021/22

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2021 – as previously stated	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 – as previously stated	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 14.1 Property, plant and equipment - 2022/23

	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 2022 - brought forward	55,148	260,007	113	54,222	91,840	30,186	7,391	492,931
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-			-	(19,227)	-	-	(19,227)
Additions	-	9,152	-	32,741	258	559	96	44,957
Impairments	(5,128)	(20,271)	-	-	-	-	-	(7,520)
Revaluations	70	(18,725)	-	6	-	-	-	9,696
Reclassifications	-	23,869	-	(25,630)	5,662	643	108	(569)
Disposals/derecognition	-	-	-	-	(4,781)	-	-	(4,781)
Valuation/gross cost at 31 March 2023	50,090	254,032	113	61,339	73,752	31,388	7,595	515,487
Accumulated depreciation at 1 April 2022 – brought forward	-	(0)	24	-	31,650	13,858	3,622	49,155
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	(8,920)	-	-	(8,920)
Provided during the year	-	9,503	4	-	9,877	6,915	609	26,908
Revaluations	-	(9,503)	-	-	-	-	-	(9,503)
Reclassifications	-	-	-		-	-	2	2
Disposals/derecognition	-	-	-	-	(4,298)	-	-	(4,298)
Accumulated depreciation at 31 March 2023	-	(0)	28	-	28,309	20,773	4,233	53,344
Net book value at 31 March 2023	50,090	291,211	85	61,339	45,442	10,615	3,362	462,143
Net book value at 1 April 2022	55,148	254,032	89	54,222	60,189	16,328	3,769	443,776

Note 14.2 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 – as previously stated	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 – As previously stated	-	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 14.3 Property, plant and equipment financing - 31 March 2023

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Owned – purchased	48,867	228,760	85	61,339	37,275	10,615	3,301	390,241
On-SoFP PFI contracts and other service concession arrangements	-	49,273	-	-	-	-	-	49,273
Owned – donated/ granted	1,223	13,178	-	-	8,167	-	61	22,629
NBV total at 31 March 2023	50,090	291,211	85	61,339	45,442	10,615	3,362	462,143

Note 14.4 Property, plant and equipment financing - 31 March 2022

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
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 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Subject to an operating lease	-	-	-	-	-	-	-	-
Not subject to an operating lease	50,090	291,211	85	61,339	45,442	10,615	3,362	462,143
NBV total at 31 March 2023	50,090	291,211	85	61,339	45,442	10,615	3,362	462,143

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 5 years to 100 years.

Dwelling asset lives range from 25 to 80

Plant and machinery asset lives range from 5 year to 34 years

Information technology assets range from 3 years to 34 years.

Furniture asset lives ranges from 7year to 49 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 22/23. 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 20223 is £341m (2022 £309m)

In 2022/23 the Trust had an impairment of £7,520m (2021/22 £15,312m). There was a decrease in value of land of £5,128m (2021/22 £4,959k increase) and a decrease in buildings of £2,392m (2021/22 £20.2m). In relation to the decrease in buildings, 0.805m (2021/22 £13,685m) was charged to the revaluation reserve and £1,587m (2021/22 £6,586m) was charged to operating expenses as there was insufficient balance in the revaluation reserve for the asset.

Note 17 Leases - St George's University Hospitals NHS Foundation Trust as a lessee

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.

This note details information about leases for which the Trust is a lessee.

The Trust has a number of finance leases for high value capital medical equipment including MRI scanners, CT scanners and ultrasound equipment and building.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Note 17.1 Right of use assets - 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	-	19,227	-	19,227	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	155,042	-	41	155,083	152,451
Additions	-	2,275	33	2,308	-
Remeasurements of the lease liability	12,387	-	-	12,387	12,219
Valuation/gross cost at 31 March 2023	167,429	21,502	74	189,005	164,670
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	-	8,920	-	8,920	-
Provided during the year	13,010	3,170	40	16,220	12,555
Accumulated depreciation at 31 March 2023	13,010	12,090	40	25,140	12,555
Net book value at 31 March 2023	154,419	9,412	34	163,865	152,115
Net book value of right of use assets leased from other NHS providers					2,361
Net book value of right of use assets leased from other DHSC group bodies					149,754

Note 17.2 Revaluations of right of use assets

The Trust RoU assets were not revalued as part of the revaluation of assets in 2023

Note 17.3 Reconciliation of the carrying value of lease liabilities

The Trust RoU assets were not revalued as part of the revaluation of assets in 2023

	2022/23 £000
Carrying value at 31 March 2022	7,612
IFRS 16 implementation - adjustments for existing operating leases	155,083
Transfers by absorption	-
Lease additions	2,308
Lease liability remeasurements	12,387
Interest charge arising in year	1,776
Early terminations	-
Lease payments (cash outflows)	(17,948)
Other changes	-
Carrying value at 31 March 2023	161,218

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets in £0k and is included within revenue from operating leases in note 4.

Note 17.4 Maturity analysis of future lease payments at 31 March 2023

	Total	Of which leased from DHSC group bodies:
Undiscounted future lease payments payable in:	31 March 2023 £000	31 March 2023 £000
not later than one year;	15,575	13,007
later than one year and not later than five years;	58,483	52,606
later than five years.	87,160	86,065
Total gross future lease payments	161,218	151,678
Finance charges allocated to future periods	-	-
Net lease liabilities at 31 March 2023	161,218	151,678
Of which leased from other NHS providers		2,350
Of which leased from other DHSC group bodies		149,328

Note 17.5 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the trust previously determined to be finance leases under IAS 17 at 31 March 2022.

Undiscounted future lease payments payable in:	31 March 2022 £000
not later than one year;	2,523
later than one year and not later than five years;	4,566
later than five years.	1,546
Total gross future lease payments	8,635
Finance charges allocated to future periods	(1,023)
Net finance lease liabilities at 31 March 2022	7,612
Of which payable not later than one year	2,224
Of which payable later than one year and not later than five years	4,025
Of which payable later than five years	1,363
Total	7,612

Total of future minimum sublease payments to be received at the reporting date -

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 17.6 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

Operating lease expense	2021/22 £000
Minimum lease payments	17,560
Contingent rents	-
Less sublease payments received	-
Total	17,560

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

Note 17.8 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 13.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	214,912
Impact of discounting at the incremental borrowing rate	-
IAS 17 operating lease commitment discounted at incremental borrowing rate	198,459
Less:	
Other adjustments:	
Differences in the assessment of the lease term	(37,266)
Finance lease liabilities under IAS 17 as at 31 March 2022	7,612
Other adjustments	(6,110)
Total lease liabilities under IFRS 16 as at 1 April 2022	162,695

Note 18 Disclosure of interests in other entities

The Trust does not have any subsidiaries and is not part of a joint venture

Note 19 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	5,304	4,506
Consumables	15,327	10,552
Total inventories	20,631	15,058
of which:		
Held at fair value less costs to sell	-	-

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 2022/23 the Trust received £2,168k of items purchased by DHSC (2021/22: £3,346k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 20.1 Receivables

	31 March 2023 £000	31 March 2022 £000
Current		
Contract receivables	77,658	63,234
Allowance for impaired contract receivables / assets	(11,996)	(11,881)
Prepayments (non-PFI)	3,589	6,816
PDC dividend receivable	1,164	398
VAT receivable	4,224	5,078
Other receivables	4,369	11,661
Total current receivables	79,008	75,306
Non-current		
Contract receivables	13,720	7,244
Other receivables	1,503	1,348
Total non-current receivables	15,223	8,592
Of which receivable from NHS and DHSC group bodies:		
Current	42,565	37,759
Non-current	1,503	1,348

Note 20.2 Allowances for credit losses

	2022/23 Contract receivables and contract assets £000	2021/22 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	11,881	14,700
New allowances arising	115	-
Changes in existing allowances	-	(329)
Reversals of allowances	-	(4)
Utilisation of allowances (write offs)	-	(2,486)
Allowances as at 31 Mar 2023	11,996	11,881

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 20.3 Exposure to credit risk

The Trust has carried out a review of 22/23 receivables and there is no material exposure to credit risks

Note 20.4 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	68,545	36,561
Net change in year	9,999	31,984
At 31 March	58,546	68,545
Broken down into:		
Cash at commercial banks and in hand	107	52
Cash with the Government Banking Service	58,439	68,493
Total cash and cash equivalents as in SoFP	58,546	68,545
Total cash and cash equivalents as in SoCF	58,546	68,545

Note 21.1 Trade and other payables

	31 March 2023 £000	31 March 2022 £000
Current		
Trade payables	50,830	35,095
Capital payables	21,569	32,552
Accruals	116,029	92,994
Social security costs	748	625
Other taxes payable	1,508	1,066
Pension contributions payable	8,624	8,189
Other payables	74	8,362
Total current trade and other payables	199,382	170,694

Of which payables from NHS and DHSC group bodies:		
Current	13,727	10,830
Non-current	-	-

Note 21.2 Early retirements in NHS payables above

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

	31 March 2023 £000	31 March 2023 Number	31 March 2022 £000	31 March 2022 Number
To buy out the liability for early retirements over 5 years	-	-	-	-
Number of cases involved	-	-	-	-

Note 22 Other liabilities

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

	31 March 2023 £000	31 March 2022 £000
Current		
Deferred income: contract liabilities	14,807	11,965
Total other current liabilities	14,807	11,965

Note 23.1 Borrowings

	31 March 2023 £000	31 March 2022 £000
Current		
Loans from DHSC	685	689
Other loans	1,488	1,478
Lease liabilities*	15,575	2,224
Obligations under PFI, LIFT or other service concession contracts	1,490	1,392
Total current borrowings	19,238	5,783

Non-current		
Loans from DHSC	9,636	10,238
Other loans	739	2,217
Lease liabilities*	145,643	5,388
Obligations under PFI, LIFT or other service concession contracts	36,070	37,559
Total non-current borrowings	192,088	57,045

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 17.

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 2022/23. As at 31/03/23 the balance owed by the Trust on this loan is £10.24m.

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 2022/23. As at 31/03/23 the balance owed by the Trust on this loan is £2.22m.

Note 23.2 Reconciliation of liabilities arising from financing activities - 2022/23

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2022	10,927	3,695	7,612	38,951	61,185
Cash movements:					
Financing cash flows - payments and receipts of principal	(602)	(1,478)	(16,173)	(1,392)	(19,645)
Financing cash flows - payments of interest	(234)	(60)	(1,775)	(2,449)	(4,618)
Non-cash movements:					
Impact of implementing IFRS 16 on 1 April 2022	-		155,083	-	155,083
Additions	-	-	2,308	-	2,308
Lease liability remeasurements	-		12,387	-	12,387
Application of effective interest rate	230	54	1,776	2,449	4,509
Other changes	-	(16)	-	-	16
Carrying value at 31 March 2023	10,321	2,227	161,218	37,559	211,325

Note 23.3 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 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2022	780	472	1,512	2,764
Arising during the year	73	-	183	256
Utilised during the year	(116)	(97)	-	(213)
Unwinding of discount	(13)	-	-	(13)
At 31 March 2023	724	375	1,695	2,794
Expected timing of cash flows:				
- not later than one year;	-	375	192	567
- later than one year and not later than five years;	724	-	58	782
- later than five years.	(0)	-	1,445	1,445
Total	724	375	1,695	2,794

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 24 Provisions for liabilities and charges analysis

At 31 March 2023, £395,494k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2022: £608,770k).

Note 25 Contingent assets and liabilities

	31 March 2023 £000	31 March 2022 £000
Value of contingent liabilities		
NHS Resolution legal claims	(33)	(45)
Gross value of contingent liabilities	(33)	(45)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(33)	(45)
Net value of contingent assets	-	-

Note 26 Contractual capital commitments

	31 March 2023 £000	31 March 2022 £000
Property, plant and equipment	14.034	4,123
Intangible assets	1.064	-
Total	15,098	4,123

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

Note 27.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

	31 March 2023 £000	31 March 2022 £000
Gross PFI, LIFT or other service concession liabilities	58,971	62,812
Of which liabilities are due		
- not later than one year;	3,941	3,841
- later than one year and not later than five years;	15,363	15,363
- later than five years.	39,767	43,608
Finance charges allocated to future periods	(21,412)	(23,861)
Net PFI, LIFT or other service concession arrangement obligation	37,559	38,951
- not later than one year;	1,490	1,392
- later than one year and not later than five years;	7,076	6,614
- later than five years.	28,993	30,946

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 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2023 £000	31 March 2022 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	223,395	223,395
Of which payments are due:		
- not later than one year;	11,163	11,163
- later than one year and not later than five years;	46,930	46,930
- later than five years.	165,302	165,302

Note 27.3 Analysis of amounts payable to service concession operator

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

	2022/23 £000	2021/22 £000
Unitary payment payable to service concession operator	12,277	11,592
Consisting of:		
- Interest charge	2,449	2,540
- Repayment of balance sheet obligation	1,392	1,301
- Service element and other charges to operating expenditure	8,436	7,751
Total amount paid to service concession operator	12,277	11,592

Note 28 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 2022/23 or 2021/22.

Note 29 Financial instruments

Note 29.1 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.

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 2023 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 21/22and 22/23

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2023	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	85,254	-	-	85,254
Cash and cash equivalents	58,546	-	-	58,546
Total at 31 March 2023	143,800	-	-	143,800

Financial assets as per Statement of Financial Position	£000
Trade and other receivables excluding non financial assets	94,231
RTA	(4,224)
Prepayments	(1,164)
PDC	(3,589)
Total at 31 March 2023	85,254

Statement of Financial Position	
Non Current Receivables	15,223
Current Receivables	79,008
Total at 31 March 2023	94,231

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
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

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2023	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	10,321	-	10,321
Obligations under finance leases	161,218	-	161,218
Obligations under PFI, LIFT and other service concession contracts	37,559	-	37,559
Other borrowings	2,227	-	2,227
Trade and other payables excluding non financial liabilities	178,241	-	178,241
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2022	389,566	-	389,566

Borrowing	£000
Loans from the Department of Health and Social Care	10,321
Obligations under finance leases	161,218
Obligations under PFI, LIFT and other service concession contracts	37,559
Other borrowings	2,227
Total at 31 March 2023	211,325

Statement of Financial Position	
Current Borrowings	19,238
Non Current Borrowings	192,087
Total at 31 March 2023	211,325

Trade and other payables	£000
Trade and other payables excluding non financial liabilities	199,382
Social Security cost	(748)
Other Taxes	(1,508)
Accruals	18,885
Total at 31 March 2023	178,241

Statement of Financial Position	
Current Trade and other payables	178,241
Total at 31 March 2023	178,241

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	-	11,534
Obligations under finance leases	7,612	-	5,651
Obligations under PFI, LIFT and other service concession contracts	38,951	-	40,253
Other borrowings	53,695	-	5,196
Trade and other payables excluding non financial liabilities	169,003	-	139,051
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2022	230,188	-	201,685

The Financial Liabilities as per Statement of Financial Position	
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

Note 29.4 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 2023 £000	31 March 2022 £000
In one year or less	200,009	177,731
In more than one year but not more than five years	77,732	25,373
In more than five years	135,093	54,086
Total	412,834	257,190

Note 29.5 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.

	2023 Book Value £000	2023 Fair Value £000	2022 Book Value £000	2022 Fair Value £000
Carrying values of financial assets as at 31 March 2023 under IFRS 9				
Trade and other receivables excluding non financial assets	85,254	71,606	70,299	70,299
Other investments / financial assets	-	-		-
Cash and cash equivalents at bank and in hand	58,546	58,546	68,545	36,561
Total at 31 March 2023	143,800	143,800	140,151	140,151

	2023 Book Value £000	2023 Fair Value £000	2022 Book Value £000	2022 Fair Value £000
Carrying values of financial liabilities as at 31 March 2023 under IFRS 9				
Loans from the Department of Health and Social Care	10,321	10,321	10,927	10,927
Obligations under finance leases	161,218	161,218	7,612	7,612
Obligations under PFI, LIFT and other service concession contracts	37,559	37,559	38,951	38,951
Other borrowings	2,227	2,227	3,695	3,695
Trade and other payables excluding non financial liabilities	13,625	13,625	10,684	10,684
Other financial liabilities	164,616	164,616	158,319	158,319
Total at 31 March 2023	230,188	230,188	230,188	230,188

Note 30 Losses and special payments

	2022/23		2021/22	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Stores losses and damage to property	5	37	-	-
Total losses	5	37	-	-
Special payments				
Extra-contractual payments	-	-	-	-
Ex-gratia payments	**55**	**49**	**39**	**24**
Special severance payments	1	20	-	-
Total special payments	**56**	**69**	**39**	**24**
Total losses and special payments	**61**	**106**	**39**	**24**

Note 31 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	
	2022/23 £000	2021/22 £000	2022/23 £000	2021/22 £000
Non - NHS Related party transactions				
St George's University of London	**4,050**	**4,027**	**5,543**	**4,718**
St George's Hospital Charity	**324**	**564**	**-**	**1**
Total	**4,374**	**4,591**	**5,543**	**4,719**

	Receipts from Related Party		Payments to Related party	
	2022/23 £000	2021/22 £000	2022/23 £000	2021/22 £000
Non - NHS Related party transactions				
St George's University of London	**2,087**	**1,945**	**500**	**10,434**
St George's Hospital Charity	**381**	**1,924**	**-**	**153**
Total	**2,468**	**3,839**	**500**	**10,587**

2022/23 Related parties

There are no related parties for Directors in 22/23 and 2021/22.

Note 32 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 2023, 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 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 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 2022-23; 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 2022-23 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 2022) 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.

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.

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.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report. 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.

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 themselves. 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 2022/23 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:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS foundation trust annual reporting manual 2022/23; and
- based on the work undertaken in the course of the audit of the financial statements 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. We have nothing to report in this regard.

Responsibilities of the Accounting Officer

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 2022/23, 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.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2022-23).
- We enquired of management and the Audit Committee, concerning the Trust's policies and procedures relating to:
  1. the identification, evaluation and compliance with laws and regulations;
  2. the detection and response to the risks of fraud; and
  3. 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:
  1. Journal entries which met a range of criteria defined as part of our risk assessment;
  2. Revenue recognition for material streams of patient care income and other operating revenues; and

3. Fraudulent expenditure recognition to meet externally set targets.

- Our audit procedures involved:

1. evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
2. journal entry testing, with a focus on journals meeting a range of criteria defined as part of our risk assessment;
3. challenging assumptions and judgements made by management in its significant accounting estimates;
4. challenging the Trust's estimates and the judgments in order to arrive at the total income from contract variations recorded in the financial statements and other manual accruals/ deferrals of healthcare income and other revenues;
5. challenging and evaluating assumptions and judgements made by management in its recognition of expenditure at year-end; and
6. 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 land and building valuations.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

1. understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
2. knowledge of the health sector and economy in which the Trust operates
3. 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:

1. 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.
2. 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.

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

Report on other legal and regulatory requirements – 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 2023.

We have nothing to report in respect of the above matter, except on 15 June 2023 we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This was in relation to the Trust's failure during 2022/23 to develop plans for required efficiency savings for 2023/24 which are intrinsic to addressing its underlying deficit and to maintain financial sustainability. We recommended that the Trust should:

- progress at speed the development of cost improvement plans for 2023/24, and
- continue to reassess the level of risk within these cost improvement plans, and if delivery is not on track, consider what remedial actions should be taken.

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 January 2023. 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 ing 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 cannot formally conclude the audit and issue an audit certificate for St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2023 in accordance with the requirements of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary to issue our Whole of Government Accounts Component Assurance statement for the Trust for the year ended 31 March 2023. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2023.

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

30 June 2023

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

In our auditor's report issued on 30 June 2023, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2023, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had completed the work necessary to issue our Whole of Government Accounts Component Assurance statement for the Trust for the year ended 31 March 2023. We have now completed this work.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2023 issued on 30 June 2023 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since 30 June 2023 that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2023 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

19 July 2023