St George's University Hospitals NHS
NHS Foundation Trust

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Annual Report and Accounts 2018/19

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I am pleased to write this introduction to the Trust's Annual Report and Accounts for 2018/19.

Twelve months ago I had just completed my first year as Chairman of St George's. Another year on, it remains a privilege to be part of an organisation which does so much good and to see the progress we are making.

The past year has been one of celebration for the health service, as the NHS marked its 70th anniversary on 5 July 2018. The Trust held a series of celebration events and activities in July to mark the occasion, including tea parties at both St George's and Queen Mary's Hospitals. In addition, 70 members of staff completed a fundraising walk from Hyde Park Corner, the home of the original St George's Hospital, to our current home in Tooting – which was a great experience for everyone involved.

Many of our volunteers took part in the NHS 70 celebration events – but it is their commitment throughout the year, day in, day out, that continues to make an enormous difference to our patients and the communities we serve. The Trust Board and I are extremely grateful.

The past year has seen closer working between the Trust and the St George's Hospital Charity which is a positive step forward. We benefited from charitable donations throughout the year – including research grants totalling hundreds of thousands of pounds – and the support we receive from the charity makes a significant difference to our teams and the care we provide. It also helps our staff feel valued and I am very much looking forward to our second charity-supported staff awards in May.

The Trust has made strides forward this year, as Jacqueline Totterdell our Chief Executive, sets out in detail in her introduction to the performance section of this document. I am delighted that we are now reporting our 18 week referral to treatment data again at the St George's Hospital Tooting site, after an absence of nearly two and a half years. This is highly significant, and means that we now have accurate waiting lists in which both our staff and, more importantly, our patients can trust and have confidence.

I am also pleased that we launched our new five year strategy in April 2019. This gives everyone connected with St George's clarity about what we want to achieve in the future – and what we need to do to get there. One of my ambitions for the organisation when I became Chairman in April 2017 was to make the Trust a more outward looking organisation, and closer collaboration with our partners is one of four key priorities in the new strategy we have agreed.

Of course, there are still a number of challenges to overcome. In particular, delivering operational performance more consistently across emergency care and planned operations, as well as reducing our financial deficit are key deliverables for the coming 12 months. Cancer and diagnostic performance have improved but we need to see improvements in waiting times across all disciplines – because it is the right thing for our patients.

Finally, I would like to thank my fellow Non-Executive Directors and the Trust Board for their considerable efforts over the past 12 months. This goes as well for our Governors who give up their time to make a difference and help the organisation improve. I am particularly grateful to Kathryn Harrison, whose term as lead governor ends shortly. Kathryn has worked extremely hard since taking on the role and been a real champion of the organisation and the staff who work within it.

Gillian Norton
Chairman
23 May 2019

Gillian Norton
Chairman
23 May 2019

Our hospitals

The hospitals and health centres that make up St George's University Hospitals NHS Foundation Trust have a rich history dating back to the opening of the original St George's Hospital on Hyde Park Corner in 1733. Since then, we have built an international reputation for quality of care, education, research and medical advances.

We share our main hospital site in Tooting, Wandsworth with St George's, University of London, and together we train future generations of NHS staff involved in the delivery of patient care.

As an NHS organisation, we are bound by the NHS constitution. Our business is to care for people. Our goal, irrespective of who uses our hospital and community services, is to improve the health and well-being of our patients. We support patients to keep mentally and physically fit and help them to get better when they are unwell.

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

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

Even further afield, we provide care for patients from across the south west of England in specialties such as complex pelvic trauma, for example. 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. We also provide a nationwide endoscopy training service.

St George's is one of the four major trauma centres for London, and home to hyper acute stroke and heart attack centres. We are home to 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, in partnership with the Royal Marsden, and the seventh largest centre for cancer surgery/chemotherapy in London.

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

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

St George's in numbers:

- We have 1,083 beds; 995 at St George's Hospital and 88 at Queen Mary's Hospital
- The beds at St George's Hospital comprise 871 general and acute, 67 maternity and 57 critical care

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

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

These networks include being the main surgical provider for Royal Marsden Hospital as part of the Royal Marsden Cancer Partners Vanguard; the South London Cardiac and Stroke Network; and the South West London and Surrey Trauma Network, of which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

A year in numbers *(Infographic in final document) (all rounded)*

- 121,000 GP referrals
- 40,000 patients transferred to us by ambulance
- 57,000 emergency admissions
- 170,000 emergency attendances
- 97% of our inpatients recommend us as a place for care
- 5,100 babies delivered
- 24,000 children inpatient admissions
- 70,000 children outpatients
- Total trust income of £844 million

Performance Report - Overview

Annual Performance Statement from the Chief Executive

I write this introduction as I start my third year as the Trust's Chief Executive. Overall, I am pleased with the progress we have made, while continuing to provide a vital service for the hundreds of thousands of patients we treat every year.

We have made positive steps forward during the last 12 months. We have improved leadership across the organisation, and the quality of care we provide – resulting in an improved rating from the Care Quality Commission (CQC) in July 2018 (from Inadequate to Requires Improvement).

We also delivered strong performance for cancer and diagnostic care, meaning patients are getting the care when they need it most. We tackled some of the pressing issues with our estate at St George's Hospital, as well as our IT infrastructure – with nearly all of our inpatient wards moving to electronic documentation during 2018.

We returned to reporting our referral to treatment/18 week performance data, meaning we now have robust systems and processes in place for managing our waiting lists at the St George's Hospital Tooting site - which is a significant and positive move.

We should be proud of the progress we have made, and the publication of our new five year strategy - *Delivering outstanding care, every time* - is also a big step forward for the organisation.

At the same time, there is still a huge amount to do. Like many other Trusts, we experienced challenges in managing the demands on our Emergency Department; and it is still the case that too many patients are waiting longer than they should for planned treatment.

Our financial deficit has not reduced as much as we hoped this year and, whilst there are reasons for this as set out later in this report, the importance of delivering savings during the next 12 months is now more important than ever.

Our staff are our most important asset and whilst we saw a significant reduction in our vacancy rates, our staff survey results remained broadly the same this year. Over the coming year, we will be working with our staff to identify ways of improving their experience of working at the Trust.

Our strategy and the 10 year NHS long-term plan

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

However, like many Trusts across the UK, healthcare delivery is proving more challenging year on year. As a result, it was positive to see that the Government's long-term plan for the NHS, published in January 2019, sets out ways of addressing this – including tackling challenges around funding, staffing, increasing inequalities, and pressures from a growing and ageing population.

Our new five year strategy draws on the central tenets of the Government's plan, setting out local solutions for delivering care closer to people's homes; reducing the need for long stays in hospital; and greater working with our local partners in healthcare delivery.

For many years, there has been a lack of clarity about St George's ambitions, and what our future priorities are. Our new strategy gives us a greater focus moving forward, which is crucial in ensuring that our services are fit for future generations; and that our patients are treated with state-of-the-art equipment that enables the latest research, and personalised diagnosis and treatment.

New technology and innovation

Over the past twelve months, we have invested over £16 million in our IT infrastructure, which has

previously suffered from years of under-investment. The most significant investment we made is in the extension of iClip (Cerner Millennium) to all inpatient wards at St George's Hospital.

This means that a patient's medical record is now stored electronically rather than on paper. This ensures all of our clinicians have the same access to patient records, making their lives easier, and creating a safer environment for our patients. We have also stabilised our IT network, which means there are far fewer network failures, which is a small but important step forward in terms of reliability.

As a specialist provider, we have a responsibility to engage in more innovative care, pioneer new treatments and ensure we are sharing best practice and research across the NHS. For example, during 2018, more than 10,000 patients took part in clinical research trials, making it our busiest year on record. One of our rolling organisational priorities is to develop tomorrow's treatments today, so it is positive to have made such huge strides when it comes to research here at the Trust, in partnership with St George's, University of London.

Our hospital estate

Our hospital estate at St George's continues to present challenges to the day-to-day running of the services we provide.

We have invested in our estate, however, which is important in order for our teams to continue delivering safe and high quality care. We also installed a new CT scanner, which plays a key supporting role for our status as one of London's four major trauma centres.

We also opened a new £15 million Energy Centre during the summer 2018/19. This is one of the most significant and advanced NHS energy projects in the country, and will bring us significant financial and environmental savings in the years to come.

Despite this, there is still a huge amount to do, particularly at St George's Hospital; and we will prioritise investment in our hospital estate during 2019/20, with capital spending plans for the year ahead highly developed. This will help ensure we can deliver safe care, and reduce the risks posed by our ageing hospital estate.

Patient access to our services

Patients attending our hospitals for cancer treatment and diagnostic tests were seen quickly during 2018/19, and our performance for diagnostics in particular is among the best in the country.

We returned to reporting our 18 week referral to treatment data in March 2019 at the St George's Hospital Tooting site, which is the end product of over two years of hard work involving many people across the organisation. This was a long-standing patient safety issue, so I am delighted that we are now in a position to say that we have accurate and reliable waiting lists at St George's Hospital, and robust processes for managing patients on their referral pathways.

Of course, it is as important that we see and treat patients quickly, and in line with national standards – this is not currently the case for both emergency care and planned operations, and we need to rectify this quickly. It is true that demand for our services during the past year has been greater than ever before, but we still need to look at ways of improving performance in this area.

We established a number of new ambulatory care units at St George's Hospital during 2018 – and I anticipate that, as we move into the new financial year, their effectiveness and ability to reduce pressure on our Emergency Department will continue to grow. This is better for patients, and our staff.

Championing our staff

I continue to be impressed and inspired by many of the 9,000 staff who work at the Trust - in a wide variety of roles. It is clear that staff engagement is improving – for example, more than 54% of staff completed the NHS staff survey in 2018, which is above the national average. In addition, our flu vaccination rates for staff are among the very best in the country.

When I first arrived at St George's in May 2017, only 36% of our staff said they would recommend the Trust as a place to work. The latest NHS Staff Friends and Family test at the end of the year put this at a more positive 65% of staff recommending St George's as a place to pursue their careers - but this is still below the level we would want.

In the same survey, staff also raised concerns about bullying and harassment, and other cultural issues that create a barrier for some staff groups. As a result, I am pleased that we embarked on a new approach to diversity and inclusion at the start of 2019 – but I have challenged the organisation, and my executive colleagues, to make sure this delivers meaningful change to the many people who work here who are from a wide variety of backgrounds. We are not a truly inclusive organisation at the moment, and this has to change.

The year ahead

The year ahead is an important one for the Trust, as we start the process of delivering our new strategy.

I am optimistic about the future. There have been challenges over the past 12 months, and the steps we've taken to deliver improvements within our cardiac surgery service has been particularly challenging. Cardiac surgery at St George's is safe, and Mr Steve Livesey, cardiac surgeon, has brought much needed clinical leadership to the service – but there is clearly more to do.

However, if we want to deliver improvements to the way we work, and the care we provide, difficult decisions must be taken, and challenges will arise – but as long as we are doing the right thing, I am confident we will continue making progress, as we have done over the past 12 months.

Finally, like many of our staff, I am enormously proud to be a part of St George's, and the wonderful work we do. We have much to be proud of as well as much to do – but I know the passion, dedication and professionalism of our staff will help us make the Trust a great place to work, and a great place to be treated.

Jacqueline Totterdell
Chief Executive
23 May 2019

Performance Report

In this section of the Annual Report, we detail our operational performance during the 2018/19 financial year. It is structured into five sections, which includes performance against our six core objectives, as set out in our Annual Plan for 2018/19.

Our performance is measured against a number of standards or targets, including those set by NHS Improvement, NHS England, NHS standard contract requirements and measures we agree locally with our commissioners.

Our Board of Directors regularly review our progress against a range of internal and external metrics. Each month, detailed scorecards with a core set of performance indicators are reviewed by the Trust Board at its public meeting.

The Trust Board will regularly review and assimilate evidence on new or improved ways of organising or providing care. They will also challenge data and information provided to them on areas such as performance or serious incidents.

Performance Report - Clinical performance analysis

Our clinical performance is monitored against key national standards. These include the four hour emergency care standard, referrals for cancer treatment, plus referral to treatment (RTT) data for elective procedures within 18 weeks. In addition, our Board of Directors reviews progress against a range of internal and external metrics through our Integrated Quality and Performance Report.

Returning to reporting our referral to treatment data

In March 2019, we returned to reporting our referral to treatment (RTT) data for St George's Hospital. This section briefly explains why we suspended national reporting of our RTT data in 2016, and the steps we have taken since to ensure our waiting lists at St George's Hospital are accurate and robust.

In January 2016, we became concerned about the integrity of our data reporting, particularly in relation to how we manage our referral to treatment times. An external review of our RTT data and patient tracking systems identified serious issues relating to our operational processes and technology.

These issues created significant risks to the quality and safety of the care we were able to provide. As a result, we suspended national reporting of our RTT data in June 2016 until we had full confidence that the information we were reporting was reliable.

Over the past eighteen months, we have undertaken a systematic and detailed audit of the processes and systems we use for managing patients on our waiting lists at St George's Hospital.

This has resulted in an increase in the number of patients reported to be waiting over 18 weeks for planned treatment from referral to treatment. We also identified a number of patients who had been waiting over 52 weeks for care.

We have since created new and robust systems for managing patients on their clinical pathways at St George's Hospital. We have trained over 3,500 staff on new patient tracking systems, and have validated over 30,000 patient care pathways. A clinical harm review of patients, led by the Trust's Medical Director with external representation, has also been completed.

In March 2019, we returned to reporting our RTT data for St George's Hospital which was a significant step forward for us. We now have robust and effective systems in place at St George's Hospital for prioritising and tracking those patients waiting for planned treatment.

We are not currently reporting RTT data for Queen's Mary's Hospital. We will begin this process once we have installed iClip (Cerner Millennium) across the services we provide at this site.

Emergency department

The overall number of attendances to the emergency department (ED) at St George's and minor injuries unit at Queen Mary's grew by three percent this year.

We also experienced a much larger increase in the percentage of patients requiring admission to hospital, which demonstrates that the patients we are seeing often have greater and more complex health needs than in previous years. Despite the efforts of our staff, we did not achieve the national standard requiring 95% of all patients visiting ED to be seen, treated and either admitted or discharged within four hours.

Like all hospitals, our teams experienced seasonal surges in demand during the winter months, which affected our overall yearly performance, resulting in an average of 88% patients being seen, treated and either admitted or discharged from ED within four hours this year.

We also failed to meet our NHS Friends and Family Test patient feedback target, with only 83% of patients recommending our ED as place to receive care, against a target of 90%. It is important that all of our teams continue to deliver safe, high quality and timely care and ensuring we meet our Emergency Department targets will be a priority for the coming year.

Right emergency care, in the right place

The 'NHS Five Year Forward View' recommended that all emergency departments should follow a national model for streaming patients.

We embedded the national model and our streaming improvement project continues to deliver excellent streaming rates. By March 2019, our rates for re-directing patients to other services were at their highest, with over 800 patients streamed back to primary care. Indeed, the percentage of patients directed away from ED for assessment and treatment elsewhere increased by 33% in March 2019 compared to the same month last year. Our non-elective length of stay for patients in hospital reduced towards the end of the year; however, the number of patients spending longer than seven days in hospital increased over the last quarter in 2018/19.

We have improved the cost effectiveness of operating our ED. In 2016/17 the financial cost to run our ED rated in the worst 25% of Trusts in the country. Despite an increase in ED attendances of nearly 2,000 patients this year, we are now in the top half of Trusts nationally for this measure.

We also made significant progress towards offering more patients same-day emergency care, rather than having to be admitted to hospital overnight. Our Adult Ambulatory Assessment units and Blue Sky Centre for children, alongside service specific initiatives in haematology and oncology, have helped patients to go home earlier, whilst reducing the pressure on our ED.

The hyper acute neurology service at St George's was also shortlisted for a prestigious Health Service Journal (HSJ) Value Award for their work to provide a new service for patients with acute neurological disorders, including stroke. The new service established at St George's involves patients receiving earlier specialist consultant input in ED or the Acute Medical Unit, and in new emergency 'hot' clinics.

This resulted in fewer admissions of patients into our stroke unit and medical beds, and shorter stays for those who do need to come into hospital. The team's efforts have also seen more patients being able to go straight home from ED, with appropriate follow-up care in rapid access 'hot' clinics if required. GPs are also now able to refer patients with urgent neurological problems to a specialist clinic at the Trust, where patients are seen within just a few days, instead of waiting weeks for a routine appointment or referring for admission.

Cancer Performance

Cancer accounts for 10% of all activity at St George's, touching most specialties across the hospital and accounting for almost one in six operations carried out at St George's.

It's vital that the emotional and psychological needs of patients are met throughout their cancer treatment and care, so we put significant effort in to ensuring patients are referred and treated on time.

Our work with the charity Macmillan over the past three years has played a key role in helping us to provide a range of cancer support services for adult and young patients, as well as their families.

We made significant performance improvements against the eight national cancer targets in 2017/18, and this has continued throughout the past 12 months. In November and December 2018, we achieved the national referral to treatment time across all eight cancer standards – including 14, 31 and 62 day cancer referrals.

Throughout last year, we never fell below the standard performance required nationally for cancer patients who required diagnosis and treatment within 31 days. 97% of patients received their care on time.

Our performance against the 14 day referral target for first and subsequent cancer treatments fell below the required standard only once this year (in June 2018). Like many other Trusts, we also found it challenging to begin treatment for all cancer patients within 62 days of referral from their GP. However, for the first time in many years, we met the 62 day target in 2018/19 with 86% of patients beginning their treatment within the national requirement.

Rising demand for healthcare will also impact on our ability to ensure that 99% of our patients receive a diagnostic test within six weeks. In line with our ambition for the year, our teams worked hard to ensure that this year 99% of patients received a diagnostic test within 31 days of referral. This puts us as one of the highest performing Trusts in the country for patients to receive their diagnostic tests, meaning patients will have a condition identified more quickly than at most other hospitals in the country.

Outpatients

There were nearly 700,000 outpatient appointments across our hospitals and community services this year. We also handle around 5,000 telephone calls to our appointments centre each week. Our outpatient activity for the period 2018/19 was above our plan by 0.5%, with particularly good performance by our children's and women's services, plus medical specialities, which exceeded the target for how quickly they arranged both first and follow up appointment for their patients.

To reduce waiting times for patients, we installed ten check-in-kiosks in outpatient areas across the Trust, the most recent in rheumatology in March 2019.

By the end of the year, we reduced the number of patients waiting over 18 weeks for an appointment from 974 in November 2018 to 141 by the middle of March 2019. On average, 96% of our patients recommended us as a place to receive their outpatient care in the NHS Friends and Family Test (FFT) during 2018/19. However, we did not achieve the improvement in the FFT response rate in outpatients to 20%. We also need to improve response rates to the FFT in other services. A number of changes have been made in the final quarter of 2018/19 to make this a reality. These include the FFT being made available on the Trust website, and the launch of FFT by text message.

Clinical Performance against National Standards

Performance	Target	2018/19	2017/18	2016/17
ED: maximum waiting time of four hours from arrival to admission , transfer or discharge	>=95%	88.38%	87.5%	91.6%
Consultant led referral to treatment waiting times incomplete pathways	>=92%	86.1%	n/a	83.3%
62 day wait for first treatment from urgent GP referral for suspected cancer	>=85%	86.9%	82.6%	84.9%
62 day wait for first treatment from NHS cancer screening service referral	>=90%	86%	90.3%	93.2%
62 day wait for second or subsequent treatment - surgery	>=94%	96.7%	94.2%	97.2%
31 day wait for second or subsequent treatment – anti cancer	>=98%	100%	100%	99.6%
All cancers: 31 day wait from diagnosis to first treatment	>=96%	98.2%	97.1%	97.2%

Cancers 2 week wait from referral date for patients (cancer not suspected)	>=93%	93.6%	88%	90.30%
Cancers 2 week wait from referral date first seen for symptomatic breast patients (cancer not initially suspected)	>=93%	85.9%	93.3%	93.70%
Clostridium difficile – meeting the Clostridium objective	30	31	16	36
MRSA bacteraemias (bloodstream inspections)	0	1	5	2

National and local clinical audits - actions taken

Each year, we also participate in up to 40 national clinical audits, and two national confidential enquiries, all of which provide external scrutiny and benchmarking for our clinical and quality performance. We also undertake a number of local clinical audits each year. The actions we are taking from the audits to improve the quality of care we provide is on page 78 in the Quality Report.

OUR VISION: OUTSTANDING CARE, EVERY TIME | 2017-19

St George's University Hospitals NHS
NHS Foundation Trust

At St George's, our aim is to provide Outstanding Care, Every Time for all of our patients, wherever they are treated.

As part of this, we have agreed a set of organisational objectives – all of which are designed to improve care for patients, and the working lives of our staff.

We are confident these will give staff, patients, and our local and national stakeholders much greater clarity about where we are focussing our energies, and where we want to improve.

1 TREAT THE PATIENT, TREAT THE PERSON

- We will deliver the fundamentals of patient care to ensure our patients are kept safe and free of avoidable harm
- We will continue to improve the experience for patients and their loved ones at the end of their life
- We will ensure there is no decision without the patient's or carer's involvement, and that the patient's wishes are at the centre of their care
- We will recognise and manage deteriorating patients, and provide staff support patients and their carers to make choices regarding their treatment
- We will ensure the safe and efficient storage and use of medicines, and continue to reduce the time patients wait for their medicines

2 RIGHT CARE, RIGHT PLACE, RIGHT TIME

- We will improve the timeliness of emergency care for patients, and consistently meet the four hour operating standard
- We will ensure we admit patients to the right ward or place of care first time, and ensure a positive experience for our patients
- We will align our people and clinical capacity to pathway demand, and ensure our patients are taken to the most appropriate environment for their assessment, treatment and care
- We will reduce cancellations of operations and make efficient use of our operating theatres
- We will offer patients greater choice about how they access our services, and ensure we match capacity to patient demand
- We will tackle our data quality and waiting list challenges, so ensuring patients are effectively tracked on our systems

3 BALANCE THE BOOKS, INVEST IN OUR FUTURE

- In 2017/18, we will achieve the target deficit agreed with NHS Improvement
- We will continue to reduce our deficit, and aim to break even in 2019
- We will deliver organisational efficiencies – from the way we buy drugs to how we use our clinical IT systems
- We will develop a financial model to help us identify and prioritise future investment requirements

4 BUILD A BETTER ST GEORGE'S

- We will develop an organisational and clinical strategy that asserts St George's position as a provider of local and world-leading specialist services
- We will work with our partners and stakeholders to new, bold visions, so we address the challenges we face together
- We will improve our governance arrangements, as well as our everyday management systems (such as Agresso and ESR)
- We will modernise theatres and wards so they are better for patients and staff. We will also improve capacity in our Emergency Department and Critical Care Unit.
- We will address our maintenance backlog to ensure fire, water, heating, electrical and ventilation safety
- We will continue to stabilise and improve our IT infrastructure
- We will work with St George's Hospital Charity to assess money raised by fundraisers and donors is invested to improve care for patients, and improve the working lives of our staff

5 CHAMPION TEAM ST GEORGE'S

- We will improve staff engagement
- We will tackle bullying and harassment
- We will improve equality and diversity
- We will develop our leadership capability, and up-skill our managers
- We will develop a behaviour charter based on our values of being Excellent, Kind, Responsible, Respectful

6 DEVELOP TOMORROW'S TREATMENTS TODAY

- We will work closely with St George's, University of London to train the healthcare professionals of the future
- We will embed research into clinical practice, to further foster a 'search to evaluate' culture within our organisation
- We will innovate, and ensure our patients have access to the latest treatments and surgical procedures
- We will use the latest technology to improve outcomes for patients, and make it easier for staff to provide care safely and effectively

OUR QUALITY IMPROVEMENT PLAN

In October 2017, we launched our Quality Improvement Plan, which will play a key part in helping us deliver Outstanding Care, Every Time for our patients.

Our Quality Improvement Plan is made up of three improvement programmes, which are supported by two enabling programmes. They are:

IMPROVEMENT PROGRAMMES

Safe and Effective Care | Flow and Clinical Transformation | Quality and Risk

ENABLING PROGRAMMES

Estates and IT | Leadership and Engagement

Our Quality Improvement Plan is a major priority for the organisation, and successful delivery **of the plan is closely linked with the strategic objectives set out in this** document.

To find out more about our Quality Improvement Plan, log onto our website at www.stgeorges.nhs.uk

excellent kind responsible respectful

Performance Report - Our objectives

At the end of 2018/19, the Trust Board approved a new five year strategy for the organisation.

The new strategy, published on 23 April 2019, sets out how we plan to achieve our vision of providing outstanding care, every time for patients, staff and the communities we serve.

You can read more about the strategy in the Director's Report on page 33.

Over the past year, we have been working towards achieving our six annual organisational objectives launched in December 2017. Assessing our progress against our organisational objectives is an important aspect of our performance analysis.

Many of the programmes of work and activity undertaken in 2018/19 support more than one of our objectives. However for ease of reporting, we have selected some examples and set them out in this report under the primary objective to which they relate.

Objective 1: Treat the patient, treat the person

Treat the patient, treat the person, focuses on our efforts to provide the fundamentals of good patient care across our hospital and community services. It is about getting the basics right – to ensure that risks to patients are minimised through good training, assessment and care planning; and that we continue our efforts to ensure that people with complex needs get consistently good care. This includes frail older people, people with dementia or reduced mental capacity, and people with mental health needs.

Our Quality Improvement Plan

Our Quality Improvement Plan was agreed in October 2017 and delivery of the plan has been a key priority over the past year – and it is central to our ambition of providing outstanding care, every time.

Measuring how well the plan is implemented at an operational and service level is overseen by the Trust Executive Committee and the Quality and Safety Committee. The key performance indicators of the plan are included in the Integrated Quality and Performance Report which is reviewed by the Quality and Safety Committee each month. Each month the Board reviews the Trust-wide quality performance indicators via the Integrated Quality Performance Report. Alongside the executive level monitoring, we measure how safe and effective our care is in a number of ways. These include audit programmes, ward safety huddles, back to the floor meetings, the Ward Accreditation Programme and Trust Board visits.

Safe and effective care for our patients

Many of the improvement indicators set out in our Quality Improvement Plan demonstrated sustained improvements this year, leading to better patient care, experience and outcomes. In parallel with the Quality Improvement Plan, we have been addressing the recommendations from our most recent CQC inspection in July 2018. These range from ensuring we have adequate systems in place to monitor the risk to fire safety on paediatric wards, to ensuring staff are following the Trust's policy in relation to swab and instrument count. By March 2019, we had addressed 72 of the 78 recommendations made by the CQC, which demonstrated our absolute commitment to resolve any areas that may affect our patients care or experience.

Towards the end of the year, we improved our performance for the identification and treatment of sepsis. Through the efforts of our staff, we achieved the 2018/19 national CQUIN (Commissioning for Quality and Innovation) goals for services to patients with mental health needs in the emergency department, and we reduced the number of patient falls resulting in significant harm by more than 30% from 2017/18. However, we did experience a number of avoidable patient falls this year against our target of zero. To mitigate this we have introduced a range of measures, led by our dedicated Falls Prevention Coordinator which includes a falls champions for each ward to be nominated who reviews incidents to highlight patterns, trends and themes.

A new falls working group with multidisciplinary team involvement will be set up in 2019/20 in order to review audit results and formulate action plans. Our Falls Prevention Coordinator is now part of a regional

network of falls leads, which meets quarterly in order to share best practice as well as provide the opportunity for networking. Although the process for reporting of pressure ulcers has been strengthened during 2018/19, we had 20 incidents of the most serious type of avoidable pressure ulcer and did not achieve our target of a 20% reduction in ulcers compared to 2017/18. In 2019/20, the prevention of pressure ulcers will be monitored through our governance framework as part of ensuring we achieve high quality standards for care.

To improve the carer or relative experience, we introduced a dementia carers' passport across all of our wards, following a successful pilot project the previous year. Dementia training rates for our staff have increased this year, with over 90% of staff completing mandatory dementia training.

Infection control remains a priority and we believe the vigilance of staff contributed to our ability to avoid bed closures and maintain capacity this winter. 87% of frontline staff, above our target of 75%, were vaccinated against flu, and our monthly audited hand hygiene compliance never fell below 96%.

Our pharmacy team worked hard to ensure that our patients received their medication and discharge medication as quickly as possible, with four out of five patients receiving their medication to take home within one hour. We also increased the number of pharmacists who are able to prescribe and transcribe medications to patients. This was particularly effective in our acute medical and surgical units and hepatology and haematology outpatient services, where pharmacy staff supported our doctors with prescribing medicines and provided guidance to improve medication usage – reducing the workload on our clinical staff so that they can spend more time caring for patients.

Providing the best care to our most unwell patients

As part of our Quality Improvement Plan, this year we improved the way we care for our most unwell patients and those who are coming towards the end of their life. Towards the end of 2018, we migrated to the national early warning scores (NEWS2) model, which is a system to standardise the assessment and response to acute illness.

In October 2018, the care we provided was further enhanced by the introduction of a new process called a Treatment Escalation Plan. The plan shapes discussions with patients about their care choices, and treatments available to them in the event of their health deteriorating. Our objective for next year is to ensure all adult emergency inpatients have a treatment escalation plan within 24 hours of admission to hospital.

One chance to get it right

End of Life Care (EoLC) at St George's is provided by all of our clinical staff, with approximately 1600 deaths per year for patients under our care in our hospitals and across our community services.

The improvements we made through our EoLC strategy *Achieving Priorities of Care in the Last Hours and Days of Life Nursing Care Plan* were reflected in the outcomes of our bereavement survey. We ask every family to participate in the survey and in 2018/19, with a 29% return rate, 94% of respondents rated the overall care their loved one received as good or excellent.

Living with and beyond cancer

In November 2018, patients and staff celebrated the achievements and completion of a three-year programme to provide an excellent experience of care for people affected by cancer at St George's.

Macmillan has invested £1.7 million since 2015 to help support patients at St George's during what can be an overwhelming and difficult experience. We introduced, through the programme, a 'surgery school' for patients to attend to prepare them for an operation. We also opened an Ambulatory Oncology Care Unit at St George's Hospital, which means our patients do not have to wait in ED for care, and can access rapid specialist care without the need to stay in hospital.

Caring for our most vulnerable patients

There was a Trust-wide effort this year to improve our application of the Mental Capacity Act (MCA), which is important for patients and their ability to consent to care and treatment.

In June and December 2018, we launched two new MCA eLearning modules. Developed by St George's staff, they aim to enhance the skills of staff who care for our most vulnerable patients. By March 2019, over 3,000 clinical staff had completed at least one of the modules.

A programme of monthly audits was implemented after revising our audit tool to better capture key performance elements of the MCA. Staff across a number of different disciplines were invited to participate in the local audits to ensure the process not only provides a barometer of practice, but also education to team members who can then lead in supporting others to deliver best practice in relation to the MCA. We also regularly assess MCA documentation and application of mental capacity through our Ward Accreditation Programme.

Measuring for improvement

During 2018, our Ward Accreditation Programme for inpatient wards was extended to include assessments of outpatient areas, daycare areas, the emergency department, maternity and theatres.

The programme, developed from our Quality Dashboard and the Care Quality Commission's (CQC) model for assessing care, measures how well an area is performing though a rigorous assessment. One outcome has been the development of an educational-based improvement project by GAPS (our inter-professional training facility and simulation centre) which has been creating a number of learning packages for staff. At the end of 2018/19, six wards had achieved gold standard, which is a measure of providing consistently outstanding care to patients.

However, there remain areas within our Quality Improvement Plan that require more focus in 2019/20. These include improving our response to complaints, completing duty of candour within ten working days of incidents occurring, improving the use of our day surgery pre-operative assessment appointments, ensuring we provide affective care to patients with dementia and better understanding the experience of patients with mental health needs. These will make up part of our wider quality improvement agenda as detailed in the Trust's Annual Plan 2019/20.

On page 92 in the Quality Report is more information about progress against quality priorities for 2018/19 and page 75 sets out the Trust's quality priorities for 2019/20.

Objective 2: Right care, right place, right time

Achieving the best outcomes for our patients means providing the right care, in the right place, at the right time. Many initiatives are in place across the Trust to ensure patients move through our planned, urgent and emergency pathways as quickly and as safely as possible. We engage many of our clinical teams in our Flow and Clinical Transformation programme as part of their day-to-day work. The programme is in place to ensure that patients coming into the Trust for emergency and planned care are able to access their assessment, treatment and care in a more appropriate way.

Over the past year we have been monitoring our improvement in three main areas:

- Unplanned and admitted care
- Planned care
- Maternity

Our unplanned and admitted care and outpatient performance is detailed in our clinical performance report.

A better experience for our theatre patients

We experienced another busy year with an increase of 3,500 elective and day case operations, totalling over 53,000 operations. Each year we set a target number of elective and day case patients we expect to treat per working day. Although we saw more patients, last year our performance against this target was inconsistent. To mitigate this, we have been working to ensure that our theatres are working as effectively as possible – including a prompt start to all theatre sessions. Towards the end of this year, we agreed a plan to improve the technology we use, which will support more accurate timings of theatre cases and theatre utilisation.

Through our theatres transformation programme, we are pleased to say that we reduced the number of times we rearranged operations for patients from 26% to 15% in 2018/19. We also reduced the number of patients eligible for, but not having, pre-operative assessments 30% to 3% from over the same period.

We also worked closely with our patients to ensure their views and experience of care underpins the changes we make. In July 2017 our theatre patient focus groups highlighted the need to improve patient communication, timeliness of care and patient dignity. This year, a survey of 150 surgical patients reported that overall staff-to-patient communication had improved throughout their care, with 100% of patients saying they had received a thorough explanation of the procedure they were undergoing, and 100% of patients said they received information about their anaesthetic.

In May 2018, we introduced a new 'On the Day Cancellations - Standard Operating Procedure' to meet the requirements set out within the NHS Patient Charter for patients cancelled on the day of their procedure for clinical or non-clinical reasons. The charter states that if a hospital cancels a patient's operation at the last minute for non-clinical reasons, we must offer the patient a new date for their procedure within 28-days of their original appointment. Our focus remained on this throughout the year, and on average 93% of our patients were re-booked within 28 days of their appointment being cancelled in 2018/19

Delayed transfers of care

NHS England and NHS Improvement stated in their 'Winter 2018/19 Planning Update' that they expect to see important progress delivered in several key areas, including reducing delayed transfers of care (DToC) - where patients are ready to go home or be transferred to another setting but are unable to do so. DToCs are widely recognised as one of the most significant pressures and risks in the NHS. Through effective discharge planning and working with our local health economy and social services, we are now in the top 25% in the country for reducing delayed transfers of care.

High performing teams

As part of a national focus on improving urgent and emergency care pathways, NHS Improvement issued guidance to help reduce delays for patients in adult inpatient wards. These measures include: ensuring patients have a senior review before midday by a clinician, and making sure there is a multi-disciplinary review of patients who have been in hospital more than seven days. These measures are called the 'SAFER' patient flow bundle. After piloting SAFER in 2017, in late 2018 we developed the model and renamed it the Minimum Standards Model. Although we are in the early stages of implementing this, we experienced an immediate improvement in patient discharge times from the pilot wards.

Virtual clinics

Over 20,000 patients benefited from our outpatient expertise this year without the need to travel in to hospital. We recognised that a number of consultations do not need to be delivered face-to-face and that consultants can communicate with patients and GPs via letter, telephone or video without compromising the quality of patient care.

Through virtual clinics in services such as ear, nose and throat (ENT) and fracture clinics, patients are being reviewed and receiving their management plan and results sooner without requiring a hospital attendance. Through these clinics we are providing more virtual follow-up appointments which reduces the length of time our patients wait to be seen.

Text messaging

Missed appointments cost the Trust money every year – and we have taken steps to reduce the chances of this occurring. In January 2019, we introduced a system to allow patients to confirm by text their dermatology, plastics, clinical haematology, ear, nose and throat (ENT) and audiology outpatient appointments. Over 300 messages have been sent per day since January 2019. Since the launch of the service, the response rate has continued to improve, with 41% of patients in March 2019 confirming their appointment, and 6% of patients requesting a rebooking or cancellation.

Objective 3: Balance the books, invest in our future

We want to ensure we balance the books and invest in our future – which is why good financial management is so important. This means working more efficiently as an organisation and generating savings, whilst also continuing to provide safe and high quality care for our patients. Our overriding objective is to return a financial surplus, so that we can invest in key services, and modernise the care we provide for patients.

Our financial position

At the start of the year, we agreed a control total with NHS Improvement which required us to deliver an underlying deficit of £29 million by the end of 2018/19. Taking into account capital donations and impairments, as well as planned levels of Sustainability and Transformation Funding (STF), this equated to a planned deficit of £17.1 million.

Against the underlying deficit control total of £29 million, the Trust is reporting a deficit of £52 million (45.4m including Provider Sustainability Funding), an adverse variance to plan of £23 million. The key drivers behind this adverse position were an overspend on medical pay, a delay in achieving the required elective activity through our theatres in the first half of the year, as well as a loss of income as a result of the reduction in activity within our cardiac surgery service.

Cost improvement programmes

The Trust delivered £50 million of efficiencies in 2018/19, without compromising on patient safety, or the quality of care we provide. This included a significant reduction in the Trust's contribution to the Clinical Negligence Schemes for Trusts (CNST) payment, as a result of our maternity services being able to evidence progress against safety metrics designed to improve the delivery of best practice in maternity and neonatal services.

Recurrent savings initiatives

The Trust set a challenging cost improvement plan target of £50 million for 2018/19, equivalent to 6% of turnover. This was delivered in full, with £40 million recurrent and £10 million non-recurrent savings.

We achieved this through a range of pay, non-pay and income savings plans, with a focus operationally on recurrent productivity improvements in outpatients and theatres, which supported improvements in waiting times for patients, as well as financial efficiency. This programme of initiatives delivered a financial improvement in theatre productivity of £5 million over the financial year and £3.6 million during the same period in outpatients.

The programme delivered a theatre session improvement plan which resulted in 254 more funded operations compared with 2017/18. This represents a year-on-year improvement of 4% in the number of patients being treated. Outpatient clinic utilisation improved by 5%, with undefined slots reducing by 50% and the number of patients waiting over 18 weeks for their first appointment reducing from 1,200 in October 2018 to 75 on 1 April 2019.

As described in the Directors Report, the Trust has also led and participated in the south west London pathology and procurement networks, which contributed to our and other Trusts' cost improvement programmes.

The deployment of the electronic prescribing electronic referrals and records management to all outpatient areas are also aimed at improving safety and delivering financial improvement in the year ahead.

Reducing expenditure

We achieved a £23 million reduction in bank and agency spend this year, whilst remaining compliant with NHS Improvement's agency 'cap' which sets maximum pay levels for agency staff. This was due to sustaining a record low staff vacancy rate of 9% for the last six months in 2018/19, from an 18% historical high. We achieved this by reducing the average time it takes to recruit a member of staff from 70 to 30 days. We also reduced the use of interim staff across many of our corporate services.

In May 2018, we launched a new Inventory Management System to ensure appropriate theatre costing and to maximise stock efficiency across our 32 operating theatres. The new system is in line with the Department of Health's GS1 procurement standards which aim to save every Trust an average of £3 million each year.

Objective 4: Build a better St George's

Building a better St George's is about modernising our estate, IT systems and processes; as well as listening to our stakeholders and partners to seek their views so that we address the challenges we face together. By delivering these improvements, staff can spend more time and energy doing what they do best – treating patients. Although we have made some improvements, we recognise our estate needs investment to ensure we can provide safe and effective care today. We also need to ensure it is fit for future generations and that our patients are treated with cutting-edge equipment that enables the latest research, and personalised diagnosis and treatment.

Our estate

We face significant challenges with our hospital estate at St George's, which we are taking urgent action to address; this includes water safety, and the risk of legionella bacteria growing in our water supply. We are taking action to maintain water safety, including regular testing and monitoring of the water supply. We've also installed special filters to taps in a number of areas. During 2019/20, we will be investing a further £3.5m to improve our water safety.

There are also historical issues with our electrical infrastructure, fire safety, and theatre ventilation at St George's, all of which have suffered from years of under-investment. Improvement programmes are in place to manage and address risks in these areas, and we will be targeting significant investment in these areas – but they continue to present a challenge for staff, and the day to day running of the hospital at St George's.

Our teams work hard to maintain surgical and medical equipment, but in some areas – such as our cardiac catheter laboratories at St George's – we need to invest in new equipment, despite the financial constraints, because doing so is the only way we will be in a position to deliver a safe and effective service for our patients.

Modernising for the future

In July 2018, Professor Gordon-Smith, a retired professor of haematology at St George's, opened our new Apheresis Day Unit. The service has experienced 41% activity growth since 2015. The unit has three beds, an air conditioned area and uses the latest technology for red cell exchange transfusions, plasma exchange and stem cell harvesting.

As one of London's biggest children's hospitals and one of only four paediatric trauma units in London, we care for many children and young people. It is naturally very important our young patients have a positive experience whilst in hospital. In August 2018, we opened a new paediatric playroom at St George's, with an adolescent 'chill out room' and a tailored sensory play area which houses specialist equipment that aids sensory play. The playroom gives the children and young people a relaxing space to come to during their time in hospital.

In December 2018, a £2 million refurbishment transformed one of our oldest wards at St George's to a modern environment. The 22 bed Dalby ward was remodelled to create extra space for beds and bathrooms with en-suite facilities. We designed it to meet the changing health needs of our patients. Specialist signs, clocks, toilets and name boards were installed to ensure the ward is fully dementia-friendly and is suitable for frail and older people.

In July 2018, we installed an automatic fire-fighting system to our helipad to replace the current fixed manual system. In December 2018, we completed the works on our pharmacy robot with the replacement of the automatic pharmacy medicines dispensary equipment to speed up the time it takes to get medicines to the wards. In addition, the St George's Advanced Patient Simulation & Skills Centre designed and opened a new dental simulation training suite.

Better systems, better care

One of our most significant projects over the past year was a £15 million investment to transfer 31 inpatient areas at St George's from paper to digital clinical systems. The deployment, which completed in November 2018, means information about patients previously recorded on paper is now stored electronically in 89% of inpatient areas at St George's. The deployment will continue in 2019/20 with neonatal and obstetrics wards at St George's and at Queen Mary's Hospital.

We also introduced electronic healthcare records within the Emergency Department (ED). This allows clinicians across St George's to access patient information more quickly, which improves the speed at which patients arriving in ED can be brought to the right place for diagnosis, treatment or discharge.

Meeting our patients' needs

In June 2018, NHS England reported that St George's led the country in a peer review of transplant centres across the UK. The report, published by NHS England's Quality Surveillance Team, highlighted a 96% level of compliance in regard to key quality indicators, including clinical effectiveness, patient safety and patient experience.

To further improve the experience for our renal patients, we relocated all renal services in October 2018, including peritoneal dialysis and renal transplant clinics, to one central location at St George's Hospital. As well as bringing the service together in one area, our renal team also performed an outstanding 150 transplants this year.

Listening to our patients

St George's is committed to working with our patients and the public, so that their views help to shape our services. In October 2018, we established a new Patient Partnership and Engagement Group (PPEG) to engage our patients in improvement work from the earliest stage.

Twelve patient partners now meet monthly, and their work includes acting as a hub to receive wider patient feedback and evaluating areas of the Trust as part of the Ward Accreditation Programme. We also established service level patient groups in dermatology and urology at Queen Mary's Hospital.

In June 2018, a team of local residents, Trust governors and Healthwatch representatives provided very positive feedback on the improvements they had seen since their previous yearly Patient-Led Assessments of the Care Environment (PLACE) inspection. The yearly assessment involves patient assessors visiting clinical areas to gauge how the environment supports the provision of clinical care, privacy and dignity, food and cleanliness and, more recently, the extent to which the environment supports the care of those with dementia and disability.

Learning from patient feedback

The Trust cared for over one million patients in 2018/19. We accept that among this number of patients, the experience for some will not meet their expectations, or the high standards we expect.

We take complaints very seriously and are committed to learning from them, so as to reduce the risk of the same type of incident from happening again. We recognise that over the next twelve months we must improve how quickly we respond to complaints, in accordance with the national requirements.

We adhere to the Parliamentary and Health Service Ombudsman's 'Principles for Remedy', which provides guidance on the way in which public bodies respond to complaints and concerns raised by patients and their representatives. We are absolutely prepared to change and improve in response to feedback from patients, visitors and other stakeholders. The lessons learned and trends identified from the information collected via our complaints process play an important part in improving the quality of care we provide.

In addition, our Patient Advice and Liaison Service (PALS) help to address any problems or concerns that patients may have regarding the Trust's services. They advise staff regarding access to interpreters, signers and other services patients may need to improve their experience. PALS staff also provide customer care training to colleagues and often assist staff when they are in need of support.

Complaint type received in 2018/19

Complaint type	2018/2019
Admission arrangements	6
Attitude	105
Cancellation	77
Cancellation of surgery	26
Care	173
Car Parking	5
Clinical treatment	210
Communication	274
Discrimination	4
Discharge arrangements	27
Hotel and site services	6
Request for Information	1
Other	58
Respect for privacy	3
Medical records	10
Transport arrangements	16
Transfer arrangements	2
Unhelpful	3
Waiting times	68
Total	1074

Objective 5: Champion Team St George's

We employ over 9,000 staff across our hospital and community services and they are the lifeblood of our organisation. Championing team St George's means involving our staff in defining what great patient care is, ensuring they are helping to shape the systems and processes that deliver great patient care and ensuring we live the Trust's values as we do so. It also includes creating the right culture and environment for staff to work in. The staff report on page 53 of this report provides more detail about how we are responding to the outcomes of this year's NHS National Staff Survey

In response to the growing challenge of staff shortages nationally, especially in nursing, this year we have also been taking a proactive approach to ensuring we have enough people with the right skills and the organisation is a great place to work.

Nursing Associates Programme

We are very proud of our programmes to create accessible pathways into nursing, midwifery and other professions, and our ground-breaking work with Nursing Associates is a good example of this. The Nursing Associate role is designed to bridge the gap between existing health care assistants, who have completed a care certificate, and registered nurses.

This year, our first eight Nursing Associates completed their two-year degree delivered jointly by Kingston University and St George's, University of London. They began their course back in January 2017, and are now one of the first cohorts of Nursing Associates in the country registered with the Nursing and Midwifery Council.

Developing our newly qualified nurses

To increase the learning opportunities for our newly qualified nurses, this year we introduced a new accredited course. Upon successful completion of preceptorship, we now invite our newly qualified nurses to apply for a place on a Level 7 course with Kingston University. The course, designed by nursing

faculties at both Kingston and St George's, has seen two cohorts so far, and further in-takes are being scheduled for the coming year.

Our preceptor training programme for newly qualified nurses was also the first in south London this year to gain the Capital Nurse Charter Mark.

Physician associates

We continued to train one of the largest cohorts of Physician Associates in the UK, in specialties including orthopaedics, urology, infectious diseases and cardiology. Physician associates are new healthcare professionals specifically trained in medicine to deliver medical care to patients, under the supervision of, and in partnership with, our doctors. We are ensuring that our physician associates become integral to multi-disciplinary teams, to help with the redistribution of the medical workload, which helps to ease the pressure on the medical team providing the care required for patients.

Developing our senior leaders

This year, we introduced 360º reviews for our middle and senior managers, enabling each manager to receive peer feedback. Between April and November 2018, 250 senior clinicians and managers attended a professional development course run by the King's Fund.

Our clinical divisions benefited from more focussed training with the development of bespoke quality improvement workshops for our paediatrics, surgery, cancer, neurology and divisional leadership teams.

This year many of our staff developed bespoke local training courses for the speciality they work in, including an innovative Neurosurgical Education Program education for multidisciplinary teams, using simulation, social media and peer assessment to develop our future senior nurses at St George's.

We added a number of new leadership development and management programmes to our portfolio of courses, which included:

- Ward Managers Programme
- New Consultant or New Manager Programme
- Ashridge Degree Apprenticeships: BA in Business & Management
- Ashridge Degree Apprenticeships: Masters in Leadership & Management
- Personal Impact and Presence Interviewing with Impact 2018
- Developing a strategy
- Mentoring/Coaching support from our Board and Executive team.

Quality Improvement Week

We celebrated our second Quality Improvement Week at St George's in December 2018 with four days of improvement-based market stalls, a series of short talks and quality improvement based interactive workshops. This year's event focussed on:

- educating our staff for continuous quality improvement and patient safety
- providing staff with opportunities to share best practice
- focussing on how we build the right leadership relationships and culture
- supporting frontline staff to understand and engage in quality improvement programmes.

In an organisation as large and diverse as St George's, shifting culture will take time and staff invariably need a variety of ways to connect with our future plans. The improvement week provides an opportunity for staff to hear about many of the innovative projects currently underway, and to learn more about quality improvement and its role in the Trust.

Objective 6: Develop tomorrow's treatment today

Our final objective is to develop tomorrow's treatments today. As a specialist provider, we have a responsibility to engage in more innovative practice, pioneer new treatments and ensure we are sharing best practice and research across the NHS. Research and development is central to our work and achieving excellence in research is one of our core objectives.

10,000 patients take part in research

This year, we recruited over 10,000 patients into clinical research trials which is the first time we passed this significant milestone during a 12 month period. Patients who take part in clinical trials may be one of the first people to benefit from a new clinical treatment. We were also placed seventh overall, with a total of 1,022 participants, in life science industry research studies across the UK. These not only improve treatments for patients, but continue to make the UK a global centre for healthcare research.

In October 2018, we became the leading Trust in south London for recruiting patients to cardiovascular research. Three years ago, we created our Cardiology Clinical Academic Group with one of its principal objectives to become the largest recruiting Trust in this area of research. Their achievement reflects the efforts by the Trust and the University's joint Cardiology Clinical Academic Group to carefully select their research trials, and a coordinated partnership effort across the south west London Clinical Research Network.

Clinical Research Facility has European first

In November 2018, our Clinical Research Facility achieved a European first. A patient with Crohn's disease was the first person in Europe to trial two experimental drugs simultaneously. Over the past few years, our gastroenterology team has increased their clinical trial portfolio from two to ten clinical trials per year. The team is now seen as one of the top five research hubs in the country and the outcome from this trial will inform future types of clinical research.

Urology department recognised as a European Robotic training centre

Our urology robotic service maintained a zero percent mortality rate this year and the urology department was recognised by the European Robotic Urology Society as a host training centre. This accolade places our robotic urology service on a par with other internationally acclaimed robotic units, and enables us to continue with high quality research and to attract high calibre international robotic trainees.

New outpatient bladder service launched at Queen Mary's Hospital

In June 2018, we began a new outpatient bladder botox service in the Endoscopy Unit at Queen Mary's Hospital. The procedure is performed under local anaesthetic via a small flexible cystoscopy and treats patients with overactive bladder symptoms, which can be the result of conditions including multiple sclerosis or a patient who has had a stroke. The procedure would previously have been carried out in the day surgery unit at St George's; however, patients now do not need to undergo surgery or have an anaesthetic for the procedure.

St George's develops UK first anti-reflux surgery service

Surgeons at St George's carried out a new endoscopic treatment for acid reflux, called Stretta, for the first time in October 2018. This means that St George's is now the only NHS hospital in the UK to offer a fully comprehensive endoscopic and surgical anti-reflux service. Acid reflux, otherwise known as heartburn, is a chronic condition where stomach acid passes into the oesophagus causing a variety of symptoms including pain and regurgitation. It affects approximately 20% of the population and although medication is usually successful in treating this condition, some patients with severe symptoms require surgery.

Major risks to the Trust's objectives

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

The BAF is reviewed by the relevant Board sub-committees on a monthly basis and the Trust Board reviews it on a quarterly basis, against the Trust's six strategic objectives. We have revised the BAF to reflect the risks associated with delivering our new strategy published in April 2019. Each Trust Board committee reviews the BAF and the strategic risks allocated to the committee. The key risks from the BAF as identified by our six organisational objectives are:

- Our ability to develop and maintain our estate, resulting in buildings which are not fit for purpose impacting delivery and risking patient safety. We have been taking urgent action to address any issues that affect patient safety.
- Our ability to exit special financial measures. We are working closely with NHS Improvement to ensure a robust financial control environment, which will enable the Trust to exit financial special measures. However, with the current financial systems and processes, there is a risk that the Trust will remain in financial special measures.
- Our ability to reduce our deficit. We have set ourselves a challenging target to reduce the deficit to £3 million in 2019/20. This requires cost savings of £45.8 million in 2019/20. Whilst there is a risk that this is not achieved, every effort is being made to ensure that the level of savings required is delivered.
- Our ability to provide stable IT systems which can impact on the care we provide and the data analysis required to manage the Trust effectively. In 2019/20 a new Information Communications and Technology (ICT) strategy will be presented to the Trust Board for approval

Risk of disengagement of staff and impact on staff living the trust values due to: perceived poor staff engagement from senior manager; perceived inadequate management of bullying and harassment episodes; perceived inconsistent application of equality and diversity standards.

Performance Report - Financial analysis

For the financial year 2018/19, we remained in Financial Special Measures at the request of NHS Improvement (NHSI). This followed the Trust reporting a deficit of £78.7 million in 2016/17 and £53.1 million in 2017/18. Financial Special Measures means NHSI undertakes regular oversight and review of our financial plans and performance.

For 2018/19, we developed a plan to reduce the deficit to £17.1 million, an improvement of £36.7 million on the previous year. Actual performance for the year was a deficit of £45.4 million (including Provider Sustainability Funding) representing an improvement on 2017/18 of £7.7 million, but an adverse variance from the plan of £29.0 million.

We achieved the cost savings and efficiencies target included in the 2018/19 plan of £50.0 million, but were £7.5 million short of plan in income, comprising £4.5 million lower than expected elective activity and £3.0 million other shortfalls. Our expenditure overspend relate to medical staffing pay costs and higher than expected pass-through non-pay costs.

Our financial performance

At the start of the 2018/19 financial year, we set a plan to reduce our deficit to £29.0 million. NHSI set us a target deficit of £6.1 million for 2018/19, which entitled the Trust to £25.2 million (PSF). NHSI agreed to increase this funding to £29.0 million, but only made half (£12.6 million) of the originally PSF available.

We ended 2018/19 with a £45.4 million deficit, and were able to earn quarter one's PSF income (£6.9 million). However, future quarters' PSF income was not earned as we missed the year to date financial plans at those dates.

Cost Improvement Programme

We set ourselves a cost improvement (CIP) target of £50 million for 2018/19. This represented 6% of our turnover. This was set as a challenging yet achievable level of efficiencies given the need to reduce the overall deficit.

This target was met through a range of efficiency measures and additional income. Local savings at a directorate level were complemented by Trust-wide savings, many of which were delivered through our Cost Improvement Programme (CIP) to improve quality, safety and efficiency. Together, these actions enabled us to deliver our planned Cost Improvement Programme of £50 million.

Provider Sustainability Funding

We received quarter one Provider Sustainability Funding (PSF) from NHSI following acceptance of the revised £29.0 million planning deficit. We were unable to receive future quarters; the funds potentially available to the Trust stood at £12.6 million, but we were eligible to receive an additional £5m from this fund at the end of the financial year.

Performance against plan

Delivering the 2018/19 financial plan represented a major challenge for us. It required us to make material improvements in our financial run rate. As indicated above, the plan was seen as challenging but achievable. Across 2018/19, we reported many positive actions, notably the delivery of cost improvement plans. However, the challenges in cardiac surgery (in particular lost activity), together with a reduction in elective activity and overspends in medical pay, caused the plan to be missed. We were able to identify a range of non-recurrent actions to help support the reported position.

Capital Expenditure

We spent £24.1 million of capital in 2018/19. This was funded from internally generated funds. The capital funds available to us were used to support ongoing investment in IT, the estate and medical equipment.

The level of funds meant we were unable to address the full investment programme we had hoped to complete. However a successful bid for further funding made to NHSI resulted in the Trust receiving £27 million and this will be used as part of our 2019/20 financial plan.

Finance Leases

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

During 2018/19 we took out new finance leases with various leasing companies for equipment with a capital value of approximately £200,000.

Cash flow

We began the financial year with £3.5 million of cash and cash equivalents. During the year, cash balances reduced by £0.3 million to £3.2 million, in line with the cash target in place. For details of our net cash balances, see note x the annual accounts.

Financial performance against plan

	2018/19 Actual	2018/19 Plan	Variance
	£ millions	£ millions	£ millions
Total income excluding capital & PSF	836.8	822.3	-14.4
Expenditure excluding donated	-888.7	-851.3	-37.4
Adjusted financial performance	**-52.0**	**-29.0**	**-23.0**
Capital donations/depreciation	-0.3	-0.7	0.4
PSF	6.9	12.6	-5.7
Surplus deficit including PSF	**-45.4**	**-17.1**	**-28.3**

Financial performance comparison

	2018/19 Actual	2017/18 Actual	Change
	£ millions	£ millions	£ millions
Total income excluding capital & PSF	836.7	819.9	-16.8
Expenditure excluding donated	-888.7	-873.0	-15.7
Adjusted financial performance	-52.0	**-53.1**	**+1.1**

Capital donations/depreciating/CQUIN 17-18	-0.3	0.0	-0.3
PSF	6.9	0.0	6.9
Surplus deficit including PSF	**-45.4**	**-53.1**	**7.7**

Cash flow

	2018/19	2017/18
	£ millions	£ millions
Operating surplus/deficit before finance and other costs	-34.9	-43.0
Add back non-cash items	35.4	12.1
Net cash generated from operating activities	0.5	-30.9
Investing activities	-34.1	-41.4
Financing	33.3	69.9
Net increase / decrease in cash	-0.3	-2.5
Total Cash and equivalents at 31 March	3.2	3.5

Charitable funding

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

Private Finance Initiative

We entered into a private finance initiative 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 million. All of these loans are included within borrowings in the statement of financial position within the accounts, included separately in this annual report.

Revaluation of land and buildings

As part of the preparation of the annual accounts, we are required to assess the value of our land and buildings. This exercise is carried out at the end of each financial year. The annual revaluation of our land and buildings led to a £12.9 million increase in value, which reflects changes in the basis of the valuation. This increase was not included in the plan and represents a technical accounting adjustment.

External audit services

Grant Thornton received £95,000 (£96,600 in 2017/18) in audit fees in relation to the statutory audit of the Trust to 31 March 2019.

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

We have agreed contracts with our principal commissioners and these, in the main, are via a block arrangement. This is a reflection of the direction of travel across the NHS to managing resources across health economies and a move towards more collaboration rather than competition. This protects us if activity is lower than expected with our main commissioners. However, should activity increase and require additional cost to deliver, we would not be able to mitigate this through higher income. Therefore mitigation would focus on cost control and reduction.

A range of mitigation actions are in place to ensure we meet our control total next year. These include:

- The Trust Board approving the financial plan prior to the start of financial year
- Budgets being agreed with all budget holders
- Ensuring Cost Improvement Plans are embedded in budgets and effective financial performance management process is in place.

Processes to manage cash and working capital

There is a risk that we do not have up to date processes to manage cash and working capital and risk having insufficient cash available to pay staff and creditors. The mitigation in place includes accurate and clear cash forecasting and collection processes, an achievable aged debt recovery plan, clear payments processes for creditors and ensuring we manage stock holdings to agreed levels.

Capital planning

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

- The urgent need for stabilising and up grading 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 Sustainability and Transformation Plan)
- Investment in digital transformation and analytical capacity

Cost Improvement Programme

Our refreshed *Cost Improvement Programme* builds on a strong platform and this Trust-wide programme has already supported directorates to deliver numerous quality, safety and efficiency improvements, including £50 million savings for 2018/19.

There are high levels of staff engagement with the programme and our collective focus aims to create a culture of continuous improvement where staff feel empowered to deliver change and transformation.

During 2019/20 we will take forward programmes in the following workstreams: Theatre Productivity, Outpatients, Ambulatory, Medical Workforce, Nursing Workforce, Workforce (other), Corporate, Coding, Medicines Optimisation, Digital, Estates & Facilities, Procurement and Commercial Income which aim to deliver significant cost and quality improvements.

Delivering the Carter recommendations

We continue to support NHS Improvement with the on-going development and implementation recommendations of the Carter Review. Building on this foundation, the Trust will be working with NHSI, to utilise benchmarking information from the model hospital to identify and realise opportunities in clinical services to improve resource utilisation. We will continue to improve clinical coding to ensure that the Trust received the correct income for the care delivered.

Recurring savings initiatives

This year we achieved recurring savings initiatives through a range of pay, non-pay and income savings plans. These focused on recurrent productivity improvements in outpatients and theatres which supported improvements in waiting times for patients and financial efficiency. This programme delivered a financial improvement in theatre productivity of £5 million by financial year end, and £3.6 million in outpatients during the same period. The programme delivered a theatre session improvement of 254 more funded sessions run compared with 2017/18 with a productivity improvement of 4 per cent more patients treated. Outpatient clinic utilisation improved by 5 per cent, with undefined slots reducing by 50 %, and the number of patients waiting over 18 weeks for their first appointment reducing from 1,200 in October 2018 to 75 by 1 April 2019.

We also led and participated in the south west London pathology and procurement networks, which contributed to our and other Trusts' cost improvement programmes.

Procurement

We are continuing to improve our performance against Model Hospital metrics.

statements give a true and fair view of the state of affairs of the NHS foundation Trust and of the income and expenditure of the NHS foundation Trust for that period. In preparing those financial statements, the directors are required to: apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury; make judgements and estimates which are reasonable and prudent; and state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.

The directors confirm to the best of their knowledge and belief that they have complied with the requirements in preparing the financial statements. The directors are required under the NHS Foundation Trust Code of Governance to consider whether or not it is appropriate to adopt the going concern basis in preparing the Trust's financial statements (annual accounts). As part of its normal business practice, the Trust prepares annual financial plans. After making enquiries, the Board has reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. Accordingly, the Board continues to adopt a going concern basis in preparing the annual report and financial statements.

Performance Report - Environmental analysis

In 2018/19 the Trust's electricity and gas costs were £5.27 million, which was a reduction of £129,000 in comparison to 2017/18. However, across our sites there was a 7% rise in consumption of gas and electricity utilities this year.

The Trust produced 3m kWh of electricity, some of which we exported back to the national grid, which contributed to the combined energy savings of £1 million for the year. As well as financial savings, this year we made an annual reduction in carbon dioxide emissions of 6,000 tonnes, which is the same amount produced by 3,000 cars over the same time period. We are also on track to reduce our emissions by 2050 as prescribed in the Climate Change Act.

The Trust has been carrying out energy reduction schemes for many years through our Sustainable Development Management Plan in order to meet our carbon reduction plan.

Since April 2015 we have procured all of our imported electricity from EDF Energy. In June 2018, we officially opened our new £15 million energy centre which houses two combined heat and power (CHP) units that will deliver almost all of the energy requirements to run St George's Hospital.

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

We continue to invest in our infrastructure, recently replacing existing 20% of the St George's Hospital site with new LED lighting, with a view to installing LED lighting throughout the hospital over the next five years.

Our Director of Estates and Facilities is the Board level lead for sustainability. This ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Jacqueline Totterdell
Chief Executive
23 May 2019

We have achieved the National Standards of Procurement Level 1. The focus of procurement in 2018/19 has been split over the following main areas:

- Contract Rationalisation – Making contract and sourcing efficiencies through the consolidation of supplier contracts including with partners across south west London
- Operational Savings – Reducing the operational cost of running the Trust divisions whilst maintaining quality of the service, through the reduction of costs in areas where service requirements can be safely reduced. We are performing well within the price benchmarking element of Model Hospital. Price performance is above peer and National Median targets.
- Improving data quality – new systems have been created and implemented that have enhanced the spend and contract data available to the Trust. This enables more efficient identification of cost improvement opportunities or for commercial advantage.
- We also continue to work collaboratively with other Trusts both within south west London and across the wider London region.

Political and charitable donations

We have not made any political or charitable donations during 2018/19.

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 on-going programme of work to raise the profile of counter fraud measures and carries out ad hoc audits and specific investigations of any reported alleged frauds. This includes the use of fraud awareness presentations and fraud awareness surveys.

The Audit Committee receives and approves the Counter Fraud Annual Report, monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

Income from the provision of goods and services

We have 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.

Transactions with related parties

Transactions with third parties are presented in the accounts. For the other Board Members, the Foundation Trust's Councillors, 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 on page 46 in the Remuneration Report in the report.

Anti-bribery and fraud policies and issues

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

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

Statement of going concern

The directors are required under the National Health Service Act 2006 to prepare financial statements for each financial year. The Secretary of State, with the approval of the Treasury, directs that these financial

Accountability Report

Directors Report

Our commitment

We have experienced a number of years of financial, operational, quality and leadership challenges. The Trust remains in Financial and Quality Special Measures (FSM and QSM), and we reported a deficit of £45.4 million in 2018/19. However, whilst challenges remain, the Trust has seen a number of areas of improvement during 2018/19 and we have an ambition to build on these, taking our workforce with us, to continue our improvement journey during 2019/20 and beyond.

As a Board of Directors, we must ensure we collectively and individually uphold the qualities that make the NHS what it is, whilst also helping to define the future for a healthcare system in the face of continuing social, demographic and technological change.

As set out in the NHS Long Term Plan, the way healthcare is delivered in the future needs to change, and this is already happening; with a greater focus on delivering care close to where people live, and using technology to deliver care and treatment in a more effective way.

Our new five year strategy – Delivering outstanding care, every time - takes this into account, with a greater focus on meeting the needs of patients, and giving them greater access to personalised care; whilst also delivering care in a way that maximises the resources at our disposal.

At the same time, we recognise the challenges of turning both the NHS plan and our own strategy into reality. There are the significant challenges – including funding and workforce - which are linked to our most immediate challenge, which is managing the increased demand on our healthcare system and the services we provide here at St George's.

The Trust Board

As a Board we are accountable, through the Chairman, to NHS Improvement and are collectively responsible for the strategic direction, performance and culture of the Trust. The Board has a general duty, both collectively and individually, to act in a way that promotes the success of the organisation.

The Trust Board, listed on page 41 of this report, has a wide range of skills and brings experience gained from NHS organisations, other public bodies (nationally and internationally) and the private sector. The Trust Board is confident that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability.

A Board selection process is in place to ensure that the Directors and Non-Executive Directors have the appropriate skills and level of understanding to undertake their roles, and that the Board has the capability and experience necessary to deliver the Trust's 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 to be Directors of the Trust.

The Trust's governance structure is in place to ensure the Trust operates effectively. In addition, we have established a Board development programme to help the Board reflect on and make improvements to its ways of working, to consider emerging issues and issues that require more in depth discussion than is possible during formal Board meetings. In 2018/19, we held a Board away day to consider the Board effectiveness. We also held a total of six Board seminars on a range of topics including the development of improvements to the Board Assurance Framework, the implementation of the Premises Assurance Model, Financial Planning, and ten seminars to develop the new Trust strategy.

This Board is fit to govern the Trust; is able to set and review performance standards in all areas of responsibility; operates as a unitary body; is aware of, and successfully manages competing priorities and

future challenges against the Trust's strategic objectives; and can assure itself on aspects of clinical quality.

The performance of all Directors is reviewed in an annual appraisal which forms the basis of their individual development plan: for Executive Directors, by the Chief Executive; for Non-Executive Directors and the Chief Executive, by the Chairman; and for the Chairman, by the senior independent non-executive. Details of the Trust Board member's declarations of interests can be found on page 44 of this report.

Leading through a clear vision and strategy

Our Board is responsible for all aspects of the leadership of Trust. They have a duty to conduct our affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing high quality, sustainable care. Throughout this report are many examples of how we ensure that arrangements in place to ensure the services we provide are well led, and we adhere to the well-led guidance from both NHSI and the Care Quality Commission.

In March 2019, the Trust Board agreed a new five year strategy for the organisation, and this was officially launched to patients, staff and key stakeholders on 23 April 2019.

To inform the development of the strategy we engaged our clinicians through 32 presentations by individual services, care group leads and medical staff to the Trust Board. As well as this, we held many meetings with staff from our many services and clinical leads. This is in addition to the 26 engagement events attended by 500 members of public, staff, governors and our stakeholders.

The end result of these conversations is a strategy that builds on our strengths, and the progress we have made in recent years, whilst setting out a roadmap for the next five years, and priority areas for development and investment.

The strategy is based on four key priorities. These are:

- **Strong foundations: We will be an organisation with strong foundations, providing outstanding care, every time.** We will ensure we have the fundamentals in place, including a culture of quality improvement. We will provide the right care in the right place at the right time; invest in our staff; balance our books financially; upgrade our buildings and hospital estate; and improve our digital infrastructure.

- **Excellent local services: We will be a provider of excellent local hospital services for the people of Wandsworth and Merton**. We will seize the opportunities identified by our patients, staff and partners to offer planned care (such as outpatient appointments) that is designed around the lives of our patients and delivered using the latest technology; and offer more 'same day' emergency care, so that more patients can be seen, treated and discharged without needing to be admitted to a hospital bed.

- **Closer collaboration: We will be a leading partner in delivering joined up, sustainable health services for people across south west London.** We will work more closely with our local GPs, community services and other hospitals in the area to ensure that patients get the right care in the right place at the right time. We will also work in partnership to respond to the changing needs of our ageing population, and help support the financial sustainability of the wider NHS – so patients can access outstanding care both now, and in the future.

- **Leading specialist healthcare**: **A provider of leading specialist healthcare for the people of South West London, Surrey, Sussex and beyond**. We will strengthen and develop our specialist services, working in partnership with other Trusts across south west London and beyond. Crucially, this will involve continuing to be the Major Trauma Centre for the region, and acting as a major centre for cancer, children's and neuroscience services. We will continue to develop our growing strength in research. We will also continue to play a key role in training the next generation of clinicians, in partnership with St George's, University of London.

Many of the long-standing issues we face, including our ageing hospital estate at St George's Hospital and fragile information technology infrastructure, will not be solved overnight; and delivery of our strategy will be dependent on our ability to target investment in these key, fundamental aspects of patient care.

Our focus, now the strategy has been agreed, is delivering on our ambitions, and the coming year will see detailed implementation plans put in place to make the strategy a reality for our staff and the people who use our services.

Our regulatory position

The Care Quality Commission's inspection report for St George's, published in November 2016 following their inspection in June 2016, raised concerns about the quality of care the Trust provides in certain areas.

On 1 November 2016 the Trust was placed in quality special measures and had further conditions imposed on its Licence.

A group of core services were inspected by the CQC in March 2018; the report by the CQC was published in July 2018 and our rating improved to 'requires improvement'. They reported that some of our services were rated as 'good' and in the caring domain we were pleased to receive a rating in some areas services as outstanding. Some of our core services did not rate as highly and our plan to address the outcome of the CQCs inspection in March 2018 is detailed in the Performance Report on page 17 of this report.

In the past year, we have responded to mortality rates that were identified as higher than expected when compared with the national average by the National Institute for Cardiovascular Outcomes Research (NICOR), the data related to 2013-2016 and 2014-2017. Following an internal review of the cases we took steps to deliver improvements within our cardiac surgery service and we commissioned Professor Mike Bewick, former deputy medical director of NHS England, to carry out an independent review of our cardiac surgery service.

In August 2018 the CQC carried out a focused inspection of our cardiac surgery services. The report published in December 2018 confirmed that our cardiac surgery service is safe. The report required some further improvements and the plan to deliver the improvements needed in the service is being overseen by an independent scrutiny panel established by NHS Improvement in September 2018.

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 are available on the CQC's website.

The Trust received a Financial Improvement Notice in April 2017 and was notified by NHS Improvement that it would be placed in to financial special measures on 24 March 2017. As detailed in the Performance Report – financial analysis on page 27 of this report, we are putting measures in to place to reduce our deficit.

Building a culture of continuous improvement

Our organisational priorities for 2019/20 are focussed on improving the quality of our services to patients, ensuring they are financially sustainable, and that the organisation is a place where staff want to work and can develop their skills. We are committed to being an employer of choice, offering an excellent working environment for staff who are dedicated to providing outstanding patient care.

Over the past year we have been working to build a positive culture that supports staff at all levels and makes providing outstanding care everyone's responsibility, not just those holding formal leadership positions.

We accelerated the delivery of the Quality Improvement Plan through our Quality Improvement Academy. This year the Quality Improvement Academy (QIA) has been a key enabler to driving and implementing sustainable change. The QIA, in partnership with the Institute of Healthcare Improvement (IHI) and with support from NHS Improvement, has held workshops for staff on how to create the right

culture for continuous improvement across the organisation, to improve both patient safety and outcomes. To drive improvements, this year we supported a growing number of improvement projects, initiated by our staff.

Developing our leaders

In 2017/18, the Board approved a new Leadership Development Strategy as part of our commitment to invest in our leadership and our teams. This is being implemented and our Leadership Academy's suite of development opportunities focuses on the following four critical capabilities:

- Compassionate, inclusive leadership skills
- Improvement skills
- Talent Management systems
- Systems leadership skills

Between March and May 2018, the top 250 leaders at St George's took part in a leadership development programme specifically designed to simulate the challenges facing the Trust. This year we also put more into the Leadership Development Strategy, with 2 cohorts of Ward Managers completing the Leadership Programme. The programme in 2019/20 will be extended to include band 7 nurses in leadership positions. We will also be developing more programmes for senior Junior Doctors looking for their first consultant post, therapists looking for a team leaders post and senior staff nurses looking for management posts.

Community Services

In December 2016, Wandsworth Local Authority put the integrated sexual health services (reproductive sexual health and genitourinary medicine) for Wandsworth, Merton and Richmond out to competitive tender. In February 2017, the Trust decided not to bid for the service, and in April 2017 the contract was awarded to Central London Community Healthcare NHS Trust (CLCH).

In 2017/18, we were unsuccessful in tendering for some of the community services we provide. In May 2018, based on the belief that some of our community services would benefit from being delivered by the same provider, and that we need to focus our energies on delivering the improvements required at our two main hospital sites, we decided not to tender for future community service based contracts and served notice on a number of existing community service contracts.

Commissioner	Service	Exit Date
London Borough of Wandsworth	School Nursing	08/18
London Borough of Wandsworth	School Nursing - Special Needs Team	11/18
Richmond CCG	Child Health Admin Team	08/18
Wandsworth CCG	Homeless and Refugee Service	03/19
Wandsworth CCG	Haemoglobinopathy	03/19
Wandsworth CCG	Child Safeguarding	03/19
Wandsworth CCG	People with Learning Difficulty	03/19

Our mortality rates

The Trust's nationally published risk adjusted mortality is significantly better than expected. The summary hospital-level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates for acute NHS Trusts. The SHMI gives the ratio between the actual numbers of patients who die compared to the expected number given the characteristics of the patients treated. SHMI covers the deaths of all admitted patients who either die in hospital or within 30 days of being discharged, and shows whether the number of deaths at an organisation is more or less than would be expected compared to average national mortality figures. It also shows whether that difference is statistically significant.

This year our mortality rates for both SHMI and another risk adjusted mortality statistic (Hospital Standardised Mortality Ratio, HSMR) are again amongst the best in the country. We are one of only 15

Trusts in the country to have statistically significant lower than expected mortality rates as measured by the SHMI and the HSMR for 2018/19.

St George's has been named in this elite group of Trusts every year since mortality data started to be published, demonstrating that St George's is one of the safest Trusts in the country and that the most complex and seriously ill patients are more likely to survive at St George's than at most other Trusts in the country. We place significant importance on learning from deaths and sharing this information back to our care groups and staff. Over the 18 months we have worked to substantially reduce our mortality rate for complex patients with hip fractures, who are usually our elderly patients with complex health needs, from 13% to 6%.

Cardiac surgery at St George's

Despite the Trust's longstanding high performance in relation to mortality, in April 2017, as reported in our previous Annual Report, the Trust received an alert from the National Institute for Cardiovascular Outcomes Research (NICOR) that mortality rates among patients undergoing cardiac surgery at St George's were higher than the national average. The Trust took a number of immediate steps to improve and strengthen the cardiac surgery service in 2017/18. During 2018/19, the Trust built on these actions and took further measures to deliver improvements within the service.

In May 2018, we commissioned Professor Mike Bewick, former deputy medical director of NHS England, to carry out an independent review of cardiac surgery at the Trust. We received Professor Bewick's report in July 2018 which made clear that cardiac surgery at St George's was safe and had improved since the NICOR alert of April 2017 but which also highlighted that there were a number of areas in which further improvements were needed, including in relation to team working and behaviours within the unit.

We accepted Professor Bewick's recommendations in full, and have introduced a series of improvements within the service as a result – including moving to a consultant of the week model (which is considered best practice). We also appointed two new consultants, and all new cardiac surgery cases are now reviewed by a multi-disciplinary team on a daily basis. In September 2018, we arranged for the most complex cardiac surgery operations to be temporarily transferred to other cardiac surgery centres, and trainees to be removed from the service in the medium-term, to enable us to deliver the required improvements. In addition, we also commissioned a review into team working within the unit in August 2018 as a result of the findings of the Bewick report. Unfortunately, this did not allow the Trust to address its concerns in this area and in December 2018 the Trust appointed Mr Steve Livesey, an experienced cardiac surgeon previously based in Southampton, to provide clinical leadership within the service and to improve team working.

The Trust continues to provide a safe cardiac surgery service, and this was confirmed by the Care Quality Commission (CQC) following an inspection of the service in August 2018. The CQC also confirmed that further improvements are needed, and our plan to deliver the required changes within the service is being overseen by an independent scrutiny panel set up by NHS Improvement in September 2018. Alongside this, we have also undertaken work to review and strengthen our governance at service, divisional and Trust levels.

A separate panel of independent experts is also reviewing all patient deaths following cardiac surgery that occurred between April 2013 and September 2018. The panel is examining the safety and quality of care that patients received during this period.

National inpatient survey

One of the indicators of our success is if patients recommend the organisation as a place to be treated. As part of a national requirement, we commissioned Picker to undertake the National Adult Inpatient Survey. The sample group consisted of patients who had an inpatient stay at St George's Hospital and were discharged in July 2018. The sample size for the audit was 1250 patients with a response rate of 38% of eligible patients (460 patients). The survey consists of 62 questions spread across 11 domains, with the report detailing scores for individual questions and an aggregated score for each domain.

We are pleased to report our 2018 results were as follows:

- 85% of patients rated their experience 7/10 or higher
- 98% of patients were treated with respect or dignity
- 99% of patients had trust and confidence in our Doctors
- 97% of patients had confidence and trust in Nurses

System Leadership

South West London Health and Care Partnership

We continued our work this year as a key partner within the South West London Health and Care Partnership. The Trust recognises that systems leadership and collaboration with our system partners will be increasingly important over the coming years, and this is reflected as one of four central themes in our strategy for 2019-24.

The Trust has been fully involved in local integrated care governance arrangements, which have continued to evolve over 2018/19. At the south west London level, the Trust is a key partner in the STP Programme Board, a leading player in the Acute Provider Collaborative (bringing together the acute providers across the region), and involved in cross-system governance arrangements for thematic agendas such as for urgent and emergency care, cancer, estates, workforce and digital. At borough level, the Trust is also collaborating with system partners through local integrated care governance arrangements, via the Merton and Wandsworth Local Transformation Boards.

Through these system-wide governance arrangements the Trust has pursued a range of initiatives with our system partners.

We've looked at how we can work together to tackle our workforce challenges, and achieve better value for taxpayers through joint procurement and payroll systems. We have made important progress against these opportunities, such as through the South West London Elective Orthopaedic Centre (the busiest joint replacement unit in the UK), South West London Pathology, and the Joint Referral Unit. We also established a formal 'improvement network' between St George's and Kingston Hospital with a focus on improving quality of care and to also take forward the objectives from our new strategy. We continue to strengthen the Acute Provider Collaborative (APC), whose purpose is to support the acute Trusts' collaborative delivery of clinical services, and clinical and corporate support functions where this yields benefits (clinical, operational and financial) over and above the benefits gained from individual Trusts acting on their own or with other partners. In 2018/19 the Trust's Chief Executive Jacqueline Totterdell assumed the role of chair of the APC.

We have also pursued a number of initiatives aimed at developing more community-based models of care, with a focus on prevention and avoiding unnecessary trips to hospital. For instance, the Trust has worked closely with partners in primary care to redesign care pathways in gastroenterology, dermatology, and musculoskeletal problems, ensuring that patients get the right support and assessment in the community. Through Local Transformation Boards, the Trust has been involved in the development of joint Local Health and Care Plans for Merton and Wandsworth over the course of 2018/19, which should enable us to go further in pursuing these goals.

The Trust recognises that successfully working in partnership with other organisations in the health and care system to develop more community-based, integrated models of care will require cultural change, and further evolution of cross-system governance arrangements – for instance, to ensure that priorities identified at south west London level are aligned with those identified at borough level and pursued in a coordinated manner.

Looking beyond south west London, we are also increasingly collaborating with partner hospitals - for instance through Operational Delivery Networks in renal, neurosciences, paediatric, cardiac and critical care service.

West London Cancer Alliance

St George's continues to be an active and engaged member of RM Partners, the West London Cancer Alliance hosted by The Royal Marsden. As a partner, St George's has access to the national cancer transformation funding to support the implementation of innovative transformation projects and the

consistent delivery of operational standards to improve the care outcomes and experiences of our patients. Five of the major projects St George's has been involved with are set out below.

As one of three initial pilot sites for the HSJ award-winning RAPID prostate cancer diagnostic pathway, St George's has assessed over 300 men using the new pathway at the Queen Mary's hospital site. The positive impact of the pathway is reflected in both performance and patient feedback.

The St George's urology team is working towards expanding the RAPID pathway so that all men who are referred for prostate cancer investigation go through the RAPID pathway.

As one of the first Trusts in England to pilot the National Optimal Lung Cancer Pathway (NOLCP), almost 300 patients in south west London were referred on to this new pathway at St George's thanks to collaborative working with primary care. The patient navigator role was successfully established to enhance patient care and experience and also to support the clinical team, who have been extremely positive about the pathway's benefits.

The St George's lead cancer nurse, Clinical Nurse Specialists and support workers have all played an important part in the promotion and implementation of the recovery package for people living with and beyond cancer. As a result, the Trust has been able to provide increased health and well-being information and support, including holistic needs assessments, treatment summaries and health and wellbeing events. All of this provides a sound basis for the Trust moving toward offering personalised cancer care and follow up in 2019/20.

St George's was a strong contributor in the development of an RM Partners model for breast stratified follow-up. This will ensure that all patients who have completed active treatment will receive the same offer of interventions and support to help them in the management of their on-going needs following their cancer treatment. Work will continue in 2019/20 to implement this model in the Trust and evaluate its acceptability and effectiveness from a clinical and patient perspective.

The Trust has also been an active participant the RM Partners NICE FIT study to improve diagnosis of symptomatic bowel cancer, recruiting over 300 patients. Thanks to this the FIT trial reached its target of recruiting 10,000 patients across England much earlier than expected.

Health Overview and Scrutiny Committees

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

South West London Pathology

South West London Pathology (SWLP) is a partnership created in 2014 between St George's, Kingston and Croydon Hospitals. Pathology services are provided from the main 'Hub' laboratory at St George's with Essential Service laboratories (ESL) at Croydon and Kingston Hospitals, with St George's acting as the host for the partnership. In 2017 SWLP also took over the provision of pathology services for Royal National Orthopaedic Hospital (RNOH) at Stanmore.

It has been a busy year for the partnership and SWLP. Several innovations represent significant service improvements which are first in the country;

- The introduction of the 'ALFRED' analytical platform for improved Sepsis Pathway management has reduced the incubation time for diagnosis from 72 to 24 hours.
- The introduction of the 'Virclia' Infectious disease testing platform allows repatriation of more esoteric tests such as Zika Virus, Dengue and other diseases

- The introduction of a novel capillary method for blood borne virus (BBV) screening is attracting work from several other NHS and private providers.

Further innovations demonstrate the ability SWLP has through its larger scale to deliver further improvements and efficiencies.

- Faecal Immunochemical Testing has been introduced for Croydon and roll out to the other 5 CCGs in the coming months.
- Development of the Point of Care testing (POCT) team and repertoire extended the repertoire of tests to over 750 devices and 10,000 users now trained.

In partnership with SWLP we also continued the rapid molecular flu testing in our emergency department, meaning that flu can be diagnosed 24 hours earlier, allowing for patients with flu to be isolated to reduce the risk of cross infection.

SWLP works with its partners to ensure the quality and financial performance is in line with the yearly business plan and agreed cost improvement initiatives. Income from third parties continues to grow as individual contracts are signed and SWLP expands the test repertoire, scope of service and customer base.

South London NHS Genomics Network Alliance

The south London Genomic Medicine Centre (GMC) was set up to help gain a better understanding of the genetic causes of cancer and rare diseases. It is one of 13 GMC's across England and was part of the UK Government's 100,000 Genomes Project, which started in 2015. The Project aimed to sequence and analyse 100,000 genomes from people with cancer or rare diseases. This is currently the largest national sequencing project of its kind in the world.

The south London GMC comprises four leading NHS hospitals who worked together. These are:

- Guy's and St Thomas' NHS Foundation Trust
- St George's University Hospitals NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust

Each GMC is responsible for a specific geography and has a lead NHS organisation (ours is Guy's and St Thomas' NHS Foundation Trust). The GMC also works with extra NHS organisations within their boundaries called local delivery partners (LDP's) to ensure that as many eligible patients as possible were able to take part in the 100,000 Genomes Project.

We are advised by an alliance of local healthcare organisations – including St George's University, King's College London, Macmillan Cancer Support, Genetic Alliance UK, Health Innovation Network and Kent Surrey Sussex Academic Health Science Network.

South London Cardiac and Stroke Network

The South London Cardiac and Stroke Network (SLCSN) works with patients, carers, clinicians and other healthcare professionals to create high quality cardiac and stroke services that focus on the patient and are available to all. They provide general information to empower patients towards improved health and the prevention of cardiovascular disease and stroke.

The South West London & Surrey Trauma Network

The South West London & Surrey Trauma Network has been operating since April 2010 and consists of a Major Trauma Centre at St George's Hospital and seven Trauma Units. These are based at: Croydon University Hospital, Kingston Hospital, St Helier Hospital, Royal Surrey County Hospital, Frimley Park Hospital and St Peter's Hospital and East Surrey Hospital.

South West London Elective Orthopaedic Centre (SWLEOC)

SWLEOC is managed and run in conjunction with neighbouring Trusts on a partnership basis from Epsom and St Helier NHS Trust. This NHS run centre provides orthopaedic services to patients of St George's,

of 65 beds (two 25-bed post-operative wards and a 15-bed recovery suite with high dependency and critical care facilities) and has five state-of-the-art orthopaedic operating theatres.

St George's confirmed as part of south London genomics laboratory hub

In November 2018, we confirmed our position as part of a consortium of south London Trusts to deliver genetic testing for this part of the country. The consortium, known as the London South Genomic Laboratory Hub, is one of seven newly commissioned genomic laboratory hubs across the country confirmed by NHS England.

As part of the hub, we will be one of the largest providers of genomic testing in the UK, delivering services to south London, Kent, Surrey and Sussex (a population of over seven million people) as well as providing a national centre for specialist testing for cardiology, gastro-hepatology, haematology, and neurology, respiratory and skin conditions.

St George's Hospital Charity

St George's Hospital Charity is the official charity supporting the Trust. Working closely with our staff and patients, the charity exists to provide additional support through fundraising and donations. New equipment, research funding, staff support, new facilities, and training are all made available thanks to the generosity of supporters. St George's Hospital Charity is an independent charity run by independent Trustees and ensures all grants and donations are applied to projects over and above that which the NHS can provide.

The Trust Board

Gillian Norton, Chairman

Gillian Norton was appointed Chairman in April 2017, having been a Non-Executive Director since June 2016. She spent her executive career in local government, serving as Chief Executive for a total of 23 years, the last 17 of which were in London Borough of Richmond. She is also Representative Deputy Lieutenant for Richmond and was awarded an OBE for services to local government.

Jacqueline Totterdell, Chief Executive

Jacqueline Totterdell joined St George's as Chief Executive in May 2017. Jacqueline is an experienced NHS leader, having previously been Chief Executive of West Middlesex University NHS Trust, where she helped steer the organisation through its merger with Chelsea and Westminster Hospital NHS Foundation Trust. She has also been Chief Executive of Southend University Hospital NHS Trust, where she spent five years. She has also been Chief Operating Officer at Barts Health and The Hillingdon Hospital NHS Trust.

Non-Executive Directors

Ann Beasley, Non-Executive Director (Deputy Chair)

Ann Beasley joined St George's as a Non-Executive Director in October 2016. She has a background in finance, her most recent role being Director General for the Finance, Assurance and Commercial Group at the Ministry of Justice. Ann has also been Chair of Trustees for the Alzheimer's Society. Ann was awarded a CBE in 2010 and in September 2018 was appointed as Chair of South West London and St George's NHS Mental Health Trust.

Stephen Collier, Non-Executive Director

Stephen has worked extensively in the private health sector, including a period as Chairman of the NHS Partners Network – the trade association for private providers to the NHS. He is now Chairman at NHS Professionals Ltd (a company wholly owned by the Department of Health and Social Care) and 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

Jenny Higham is Principal at St George's, University of London. She previously had senior roles at Imperial College and the Lee Kong Chian School of Medicine in Singapore. 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. She is also the first female Chair of the Medical Schools Council, the representative body for UK medical schools.

Professor Sir Norman Williams, Non-Executive Director (Senior Independent Director)

Norman Williams was Professor of Surgery at Queen Mary's School of Medicine and Dentistry, honorary consultant at Barts Health NHS Trust and Director of the National Centre for Bowel Research and Surgical Innovation up to 2016. From 2011-14 he was President of The Royal College of Surgeons of England. He was Senior Clinical Advisor to the Secretary of State for Health and Social Care from 2015-18. He is now Chairman of the National Clinical Improvement Programme (NCIP), a Board member of the Private Information Network (PHIN), President of Bowel and Cancer Research and recently chaired the Rapid Review of Gross Negligence Manslaughter in Healthcare.

Sarah Wilton, Non-Executive Director

Sarah qualified as a chartered accountant with Price Waterhouse Coopers. She held several senior executive positions at Lloyd's of London. Sarah now holds Non-Executive Director appointments at two Lloyd's agencies, Capita Managing Agency since 2004 and Hampden Agencies Limited since 2008, and serves both as chair of the audit and risk committee. She is a Magistrate at Wimbledon Magistrates Court and the Central London Family Court and is a Trustee of the Paul D'Auria Cancer Support Centre.

Tim Wright, Non-Executive Director

Tim joined the Department for Education as Chief Information Officer in 2007, a position he held for almost six years. Tim also worked across government, with local authorities, the Cabinet Office and the Government Digital Service. Prior to joining government, Tim worked for 20 years in the oil and gas industry in IT development, consulting and senior IT leadership roles. He is a Fellow of the British Computer Society and a Member of the Institution of Mechanical Engineers. Alongside his role as a Non-Executive director, Tim is also a Trustee of the St Georges' Hospital Charity.

Executive Directors (voting)

Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control

Avey joined St George's as our Chief Nurse in February 2017. Avey was previously Chief Nurse at Maidstone and Tunbridge Wells NHS Trust, before which she was Deputy Chief Nurse at South London Healthcare NHS Trust from 2010-2013. Avey is also our Director of Infection Prevention and Control. Prior to joining South London Healthcare, Avey held senior nursing and management positions at St George's.

Andrew Grimshaw, Chief Financial Officer

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

Dr Richard Jennings, Chief Medical Officer (December 2018 – Present)

Richard joined St George's as our Chief Medical Officer in December 2018. Richard was previously Executive Medical Director at Whittington Health NHS Trust in North London from 2014 to 2018. He was also previously clinical co-chair of the North Central London Sustainability and Transformation Plan (STP). Richard has been a consultant in infectious diseases and acute medicine, and has a research background in the molecular immunology of malaria, in which he completed a PhD while working with the Medical Research Council in London and West Africa.

Professor Andrew Rhodes, Medical Director (April to December 2018)

Andrew Rhodes was the Acting Medical Director (2016 - December 2018), and a Consultant and Professor in Intensive Care Medicine and Anaesthesia. He has research interests in the fields of surgery, sepsis, haemodynamics and outcomes related to Peri-operative and Intensive Care Medicine. Andrew has been a Council member of the Faculty of Intensive Care Medicine (FICM), a past president of the European Society of Intensive Care Medicine (ESICM) and is the current co-Chairman of the Surviving Sepsis Campaign.

Non-voting Board Members

Harbhajan Singh Brar, Director of Human Resources and Organisational Development

Harbhajan Singh Brar has been Director of Human Resources and Organisational Development at St George's since May 2017. He joined St George's from Sodexo UK, where he was Director of Human Resources from 2011. Harbhajan has also held HR Director roles at the Department of Health, Barnet and Chase Farm NHS Hospitals Trust, ICTaL (ICT across London), Kingston Hospital NHS Foundation Trust and Lewisham College. In 2016, Harbhajan was listed in the Top 100 Black Asian Minority Ethnic executives across the USA, Ireland and the UK, published in the Financial Times.

Ellis Pullinger, Chief Operating Officer

Ellis started as our Chief Operating Officer in June 2017. He joined St George's from Imperial College Healthcare NHS Trust where he was Assistant Chief Executive. Prior to this he was Divisional Director of Operations for the Trust's Division of Investigative Sciences and Clinical Support. Ellis runs day-to-day operations, manages capacity and demand, and ensures we continue to provide quality services for patients.

James Friend, Director of Delivery, Efficiency and Transformation

James Friend joined as our Director of Delivery, Efficiency and Transformation in April 2017. James joined St George's from the Department of Health, where he was an advisor to the Secretary of State for Health. James is an experienced commercial sector and NHS Director, having held leadership roles in providers including Epsom St Helier University Hospitals NHS Trust, West Middlesex University Hospital NHS Trust, Chelsea and Westminster NHS Foundation Trust and elsewhere, alongside commissioning and system improvement leadership roles in Buckinghamshire, Sussex and Hampshire. Prior to working in the NHS, James held a number of leadership roles in the UK and International financial services sector specialising in delivery risk management, strategy & transformation and corporate & retail relationship management. James has been a volunteer in the NHS for over 30 years and has an in depth understanding of the partnerships between Local Authorities and the health sector through having been a founder member of the Surrey Health and Wellbeing Board

Kevin Howell, Director of Estates and Facilities

Kevin started in post in January 2018. He joined St George's from West Hertfordshire Hospitals NHS Trust, where he was Director of Environment from 2014. Kevin has over 30 years' experience in the NHS, and has held a number of senior and executive estates and facilities roles in the London area – including at the Princess Royal University Hospital, Barnet and Chase Farm and North Middlesex University Hospital.

Stephen Jones, Director of Corporate Affairs

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

Suzanne Marsello, Director of Strategy

Suzanne joined at St George's as Director of Strategy in January 2018. Suzanne joined St George's from neighbouring South West London and St George's Mental Health NHS Trust, where she was Director of Strategy and Commercial Development from March 2015 to December 2017. Suzanne is no stranger to St George's, having previously held a number of senior operational and strategic roles within the organisation. Suzanne has a clinical background, and worked as a Speech and Language Therapist for the first 11 years of her career.

Trust Board Attendance Register 2018/19

Name	Description	Actual/ possible attendance
Gillian Norton	Chairman	12/12
Ann Beasley	Non-Executive Director & Vice Chair	12/12
Stephen Collier	Non-Executive Director	10/12
Prof. Jenny Higham	Non-Executive Director	10/12
Prof. Sir Norman Williams	Non-Executive Director	11/12
Sarah Wilton	Non-Executive Director	10/12
Tim`6 Wright	Non-Executive Director	10/12
Executive Directors		
Jacqueline Totterdell	Chief Executive	10/12
Avey Bhatia	Chief Nurse and Director of Infection & Prevention Control	11/12
Andrew Grimshaw	Chief Financial Officer	10/12
Dr Richard Jennings	Chief Medical Officer	4/4
Prof. Andrew Rhodes	Medical Director (left)	7/8
Executive Directors (non-voting)		
Harbhajan Brar	Director of Human Resources and organisational Development	12/12
James Friend	Director of Delivery, Efficiency & Transformation	12/12
Kevin Howell	Director of Estates & Facilities	10/12
Suzanne Marsello	Director of Strategy	11/12
Ellis Pullinger	Chief Operating Officer	11/12
Stephen Jones	Director of Corporate Affairs	12/12

Board of Directors – Declarations of Interests

St George's is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register of Interests which draws together Declarations of Interest made by members of the Board of Directors and those serving on the Executive Team. In addition, at the commencement of each Board, Committee and Trust Executive Committee meeting, all present are required to declare any interests. In March 2019 we began the process to ensure all decision makers declare their interests from April 2019, as per the revised NHS England requirement. The Declarations of Interests for Board members and governors is published on the Trust's website. www.stgeorges.nhs.uk/about/board. Towards the end of last year we began the process to ensure all decision makers declare their interests from April 2019, as per the revised NHS England requirement.

Better Payment Practice Code

The Trust adopts a Better Payment Practice Code where we aim to pay 95 per cent of invoices within the agreed terms, unless there is a dispute

Better payment practice code - measure of compliance				
Non NHS Payables	**2018/1**	**2018/19**	**2017-18**	**2017-18**
	£000s	**£000s**	**£000s**	**£000s**
Total non-NHS trade invoices paid in the year	116,627	334,253	143,126	363,940
NHS Payables	**2018/19**	**2018/19**	**2017-18**	**2017-18**
	£000s	**£000s**	**£000s**	**£000s**
Total NHS trade invoices paid in the year	4,445	84,657	4,420	69,888
Total NHS trade invoices paid within target	1,053	41,844	1,265	32,888

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.

Auditors

The Trust's appointed external auditors are Grant Thornton LLP. The auditors provide audit services comprising carrying out the statutory audit of the Trust's annual accounts and the use of resources work, as mandated by Monitor and the National Audit Office, and a review of the Quality Accounts.

Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirement set out in HM Treasury and Office of Public Sector Information guidance.

Accounting for pension and other retirement benefits

The accounting policies for pensions and other retirement benefits are set out on in the Remuneration Report on page 46 of this report.

Statement of Compliance with the NHS Foundation Trust Code of Governance

The Directors consider 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 the NHS Foundation Trust's performance, business model and strategy. Each Director has stated that as far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware and they have taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Remuneration Report

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

The remuneration report comprises:

- Annual statement on remuneration
- Very senior managers' pay principles
- Annual report on remuneration.

Remuneration and Nomination 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 and give consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them.

The Committees aim to evaluate annually the balance of skills, knowledge and experience on the Board of Directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both Executive and Non-Executive Directors, including the Chairman. The Remuneration Committee makes decisions regarding pay for Executive Directors. The Committee is also responsible for determining, on behalf of the Board, the broad policy for remuneration of the Trust's very senior managers.

Attendance Register 2018/19

Name	Description	Actual/possible attendance
Gillian Norton	Chairman	6/6
Ann Beasley	Non-Executive Director & Vice Chairman	5/6
Stephen Collier	Non-Executive Director	4/6
Prof. Jenny Higham	Non-Executive Director	3/6
Sir Norman Williams	Non-Executive Director	6/6
Sarah Wilton	Non-Executive Director	3/6
Tim Wright	Non-Executive Director	4/6

Senior managers' remuneration policy

In the financial year 2019/20, the Remuneration Committee decided to award a flat rate uplift of £2,075 pa for the financial year 2018/19 to all VSMs who were appointed (FTC or substantive on or before the 1st April 2018. This was in line with guidance from NHSI. The Committee also reviewed the remuneration arrangements of Leadership Team posts

Very senior managers' pay principles

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

As a Foundation Trust, the Remuneration Committee has the freedom to determine the appropriate remuneration level for very senior managers, however given that Trust is in special measures, it has sought NHSI approval for all Executive Director Salaries. In reaching its decisions the Committee considers the responsibilities and requirements of the role, time in the role, marketability of the individual, benchmarking data from within the NHS or relevant sector, the external economic environment, NHS guidance and the performance of the Trust.

Median Pay (audited)

Multiple table	2018/19	2017/18	2016/17
Payroll costs	534,983	522,536	530,479
Whole time equivalent	9,589	9,254	9,588
Median (£000)	38.6	35.8	27.3
Highest paid director (£000)	222.5	302	432
Median will fit in to highest	5.8	8.4	15.8

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

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

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The banded remuneration of the highest paid director in the financial year 2018/19 was £222,500 (in 2017-18 it was £302,000). This was 5.8 times (2017-18 was 8.4 times) the median remuneration of the workforce, which was £38.6k (2017-18 £35.8k). The highest paid Director's remuneration has reduced significantly as the Director this year was a permanent member of staff. In the previous year, the highest paid Director had been an interim member of staff.

Range of staff remuneration for 2018/19

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

Expenses

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

Executive Directors	Non-Executive Directors	Governors
£1,055	£505	£0

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

Remuneration Report (audited)

Name	Job Title	Period	2018/19						2017/18					
			Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
Executive directors			(bands of £5000) £000	Total to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	total to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Ms Jacqueline Totterdell	Chief Executive	From 1st May 2017	220-225	0	0	0	7.5-10	**230-235**	200-205	0	0	0	380-385	**580-585**
Mr Andrew Grimshaw	Chief Financial Officer	From 19th June 2017	155-160	0	0	0	0 (*Note 2)	**155-160**	120-125	0	0	0	202.5-205	**325-330**
Mr Ellis Pullinger	Chief Operating Officer	From 12th June 2017	150-155	0	0	0	150-152.5	**300-305**	120-125	0	0	0	45-47.5	**165-170**
Ms Avinderjit Bhatia	Chief Nurse and Director of Infection Prevention and Control	Secondment from Feb 17 to Nov 17, permanent from Dec 2017	130-135	0	0	0	0 (*Note 3)	**130-135**	130-135	0	0	0	110-112.5	**240-245**
Mr Harbhajan Brar	Director of Human Resources and Organisational Development	From 2nd May 2017	165-170	0	0	0	0 (*Note 4)	**165-170**	145-150	100	0	0	0	**195-200**
Mr James Friend	Director of Delivery, Efficiency and Transformation	From 28th April 2017	130-135	0	0	0	25-27.5	**155-160**	120-125	0	0	0	30-32.5	**150-155**
Mr Kevin Howell	Director of Estates, Facilities and Capital Projects	From 2nd January 2018	140-145	0	0	0	227.5-228	**365-370**	30-35	0	0	0	82.5-85	**115-120**
Ms Suzanne Marsello	Director of Strategy	From 2nd January 2018	120-125	0	0	0	12.5-15	**130-135**	25-30	0	0	0	117.5-120	**145-150**
Mr Stephen Jones	Director of Corporate Affairs	From 5th March 2018	110-115	0	0	0	25-27.5	**140-145**	5-10	0	0	0	0-2.5	**10-15**
Dr Richard Jennings	Chief Medical Officer	From 19th November 2018 (Note 5)	65-70	0	0	5-10	362.5-365	**435-440**						
Left the board														
Dr Andrew Rhodes	Medical Director	From May 2016 - left 31st December 18	130-135	0	0	35-40	102.5-105	**270-275**	220-225	0	0	0	0	**220-225**
Mr Mark Gordon	Chief Operating Officer	Interim (from Oct 16 to April 17)	0	0	0	0	0	**0**	155-160	0	0	0	0	**155-160**
Mr Richard Hancock	Director of Estates, Facilities and Capital projects	Interim (from March 16 to Dec 17)	0	0	0	0	0	**0**	300-305	0	0	0	0	**300-305**
Ms Ann Johnson	Chief Financial Officer	Interim (April 17 to June 17)	0	0	0	0	0	**0**	30-35	0	0	0	270-272.5	**300-305**
Dr Simon Mackenzie	Acting Chief Executive	Acting CEO from May 2016 to April 2017	0	0	0	0	0	**0**	20-25	0	0	0	0-2.5	**20-25**

Mr Iain Lynam	Chief Restructuring Officer	From 15th February 2016 to 16th May 2017)	0	0	0	0	0	**0**	25-30	0	0	0	0	**20-25**
Non-executive Directors														
Ms Gillian Norton	Chair (Chair Nominations and Remuneration Committee)	From July 2016	60-65	0	0	0	0	**60-65**	60-65	100	0	0	0	**60-65**
Ms Ann Beasley	Non-executive Director (Chair Finance and Investment Committee)	From October 2016	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)	From October 2016	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**	5-10	0	0	0	0	**5-10**
Ms Sarah Wilton	Non-executive Director (Chair Audit Committee)	From January 2011	10-15	0	0	0	0	**10-15**	10-15	0	0	0	0	**10-15**
Professor Sir Norman Williams	Non-executive Director (Chair Quality and Safety Committee)	From April 2016	10-15	0	0	0	0	**10-15**	10-15	0	0	0	0	**10-15**
Professor Jennifer Higham	Non-executive Director	From 1st November 2015 (see note 1)	0	0	0	0	0	**0**	0	0	0	0	0	**0**
Left the Trust														
Mr Thomas Saltiel	Associate	From Sept 2016 to June 2017	0	0	0	0	0	**0**	0-5	0	0	0	0	**0-5**

Note 1. Professor Jenny Higham is the St George's University of London Medical School representative on the Trust Board. She is not remunerated by the Trust for her role on the Board.
Note 2. Mr Andrew Grimshaw - The valuation from NHS Pensions Agency resulted in a net reduction during the year which under the guidelines is reported as a zero value pension related benefit.
Note 3. Ms Avinderjit Bhatia - An error in 2018/19 has resulted in her being taken out of the NHS pension scheme. This is now rectified in 19/20.
Note 4. Mr Harbhajan Brar is not in the NHS pension scheme. The salary includes an additional allowance as approved by the Remuneration Committee
Note 5. No comparative information in 2017/18 for Dr Richard Jennings as he joined the Trust on 19 November 2018

Pensions Report (audited)

Name and job title	Period	2018/19								2017/18							
		Real increase in pension at pension age	Real increase in pension and related lump sum at pension age	Total accrued pension at pension age at 31 March 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension	Real increase in pension at pension age	Real increase in pension and related lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder 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	(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, Chief Executive	From 1st May 2017	0-2.5	(5-7.5)	90-95	260-265	1,995	179	1,732	32	17.5-20	67.5-70	85-90	260-265	1,732	377	1,341	29
Mr Andrew Grimshaw, Chief Financial Officer	From 19th June 2017	0-2.5	(5-7.5)	50-55	115-120	961	71	842	23	7.5-10	30-32.5	45-50	120-125	842	206	630	17
Mr Ellis Pullinger, Chief Operating Officer	From 12th June 2017	7.5-10	15-17.5	30-35	65-70	513	158	323	22	2.5-5	2.5-5	20-25	45-50	323	35	285	17
Mr Harbhajan Brar, Director of Human Resources and Organisational Development	From 2nd May 2017	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mr James Friend, Director of Delivery, Efficiency and Transformation	From 28th April 2017	0-2.5	0-2.5	5-10	0-5	74	13	40	19	0-2.5	0-2.5	0-5	0	22	22	0	17
Mr Kevin Howell, Director of Estates, Facilities and Capital Projects	From 2nd January 2018	10-12.5	27.5-30	55-60	170-175	1,312	318	947	19	2.5-5	15-17.5	45-50	140-145	947	126	813	5
Ms Suzanne Marsello, Director of Strategy	From 2nd January 2018	0-2.5	(0-2.5)	45-50	105-110	822	89	690	17	5-7.5	15-17.5	40-45	105-110	690	99	585	4
Dr Stephen Jones, Director of Corporate Affairs	From 5th March 2018	0-2.5	0-2.5	0-5	0-5	23	5	1	16	0-2.5	0-2.5	0-5	0	1	1	0	1

Dr Richard Jennings Chief Medical Officer	From 19th November 2018	15-17.5	47.5-50	30-35	95-100	744	391	878	6	0	0	0	0	0	0	0	0
Left the Trust Board																	
Dr Andrew Rhodes, Medical Director	Acting from May 2016. Left December 2018	5-7.5	7.5-10	50-55	130-135	1,058	179	1,103	19	(22.5-25)	(102.5-105)	40-45	95-100	693	(442)	1,124	26

Pension scheme

The pension scheme operated by the Trust is the NHS Pension Scheme, managed by the NHS Pensions Agency (NHSPA). Employer and employee contributions to the scheme are collected and paid over to the NHSPA on a monthly basis. Therefore, the cost of membership of the scheme is included within operating expenses.

Pension information for senior managers is disclosed in accordance with the requirements of the Greenbury Report in the enclosed remuneration report, whilst further information on the accounting and valuation policy of the NHS Pension Scheme is given in note in the accounts.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a result of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional benefit accrued to the member as a result of purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Audited disclosures

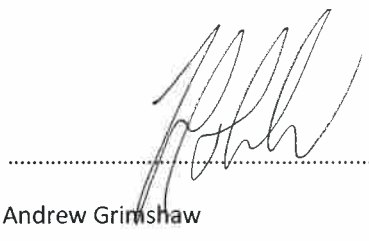
The following disclosures have been audited by the external auditor:

- Single total figure of remuneration for each director
- CETV disclosures for each director
- payments to past directors, if relevant
- "Fair pay" (pay multiples) disclosures
- Exit packages, if relevant, and
- Analysis of staff numbers and costs

Jacqueline Totterdell

Chief Executive

23 May 2019



Andrew Grimshaw

Chief Finance Officer

23 May 2019

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. Our staff work hard to improve efficiency and deliver the best possible care to our patients.

The majority of the Trust's staff are permanently employed clinical staff directly involved in delivering patient care. We also employ a significant number of scientific, technical and administrative staff who provide vital expertise and support. The table below provides a breakdown of our workforce.

Male and Female (Full time equivalent basis)

	Full time equivalent		%	
Staff group	Female	Male	Female	Male
Director	8	10	44.44%	55.56%
Senior manager	52	42	55.09%	44.91%
All other staff	5931	2318	71.90%	28.10%

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

Type	2018/19			2017/18
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,864	54	1,919	1,288
Administration and estates	1,932	200	2,132	2,099
Healthcare assistants and other support staff	1,137	153	1,290	850
Nursing, midwifery and health visiting staff	2,530	397	2,927	3,109
Scientific, therapeutic and technical staff	1,359	129	1,488	1,962
Total average numbers	8,822	933	9,756	9,308

Sickness by staff group

Sickness:	
Prof Scientific and Technical	3.23%
Additional Clinical Services	5.03%
Administrative and Clerical	4.46%
Allied Health Professionals	2.39%
Estates and Ancillary	5.20%
Healthcare Scientists	3.27%
Medical and Dental	1.27%
Nursing and Midwifery Registered	3.97%

Disclosures required by Health and Social Care Act

Total Employee Expenses

Cost	2018/19			2017/18
	Permanently employed	Other	Total	Total

	£000	£000	£000	£000
Salaries and wages	424,434	0	424,434	411,798
Social security costs	42,896	0	42,896	41,547
Apprenticeship levy	2,044	0	2,044	1,979
Employer's contributions to NHS pensions	48,416	0	48,416	47,071
Pension cost - other	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	122	0	122	163
Temporary staff	0	17,071	17,071	19,978
Total gross staff costs	**7,912**	**17,071**	**534,983**	**522,536**

Expenditure on consultancy

	2018/19	2017/18
Consultancy costs (£k)	**7,420**	**9,216**

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

Staff exit packages (audited)

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	2	2
£10,001 – £25,000	0	3	3
£25,001 – £50,000	0	2	2
£50,001 – £100,000	0	0	0
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	**0**	**7**	**7**
Total resource cost (£k)	**£0**	**£122**	**£122**

Exit packages: non-compulsory departure payments (audited)

	Agreements number	Total value of agreements
		£000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	1	27
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	6	95
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**7**	**£122**

Table 1: For all off-payroll engagements as of 31 March 2019 for more than £245 per day and that last for longer than six months.

	2018/19 Number of engagements	2017/18 Number of engagements
Number of existing engagements as of 31 March 2019	**13**	**14**
Of which...		
Number that have existed for less than one year at time of reporting	8	11
Number that have existed for between one and two years at time of reporting	3	3
Number that have existed for between two and three years at time of reporting	0	0
Number that have existed for between three and four years at time of reporting	0	0
Number that have existed for more than four years at time of reporting	0	0

Table 2: For all new off-payroll engagements, or those that reached six months duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months.

	2018/19 Number of engagements	2017/18 Number of engagements
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2018	26	24
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 significant financial responsibility, between 1 April 2017 and 31 March 2018.

	2018/19 Number of engagements	2017/18 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	11

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

Engaging for change

Our workforce is the most important asset we have. We understand the importance of engaging with our staff, because an engaged workforce delivers better patient outcomes.

In order to better understand what it is like to work at St George's, our Workforce and Education Committee monitors outcomes from the National Staff Survey, the quarterly NHS Staff Friends and Family Survey and Listening into Action events. The committee also monitors the delivery of our Staff Engagement Plan which was at the centre of our drive this year to develop a more inclusive culture at St George's. The programme focuses on staff engagement, equality, diversity and inclusion and one of its primary objectives is to ensure we exceed the Workforce Race Equality Standard (WRES) requirements.

Some of the achievements from the programme this year include a staff engagement pack for new starters, a 'Thank you' card system for managers and staff to give to colleagues, and we increased the communications and awareness of mediation and coaching opportunities for staff. We also launched a new our Diversity and Inclusion Strategy which you read more about in the next section of this report.

Towards the end of the year we aligned our Staff Engagement Group, Quality Improvement Academy and Leadership Academy to promote a single framework for continuous improvement. The framework focuses on four cultural change elements; psychological safety, teamwork, communication and continuous learning. Through this collaboration we delivered numerous quality, safety and efficiency engagement events, and developed bespoke improvement events for different staff groups. We also have an active partnership forum where we meet with our Staff Side colleagues (unions) to discuss issues of concern to staff. Our Staff Side representatives have been involved in the development of our Staff Engagement Plan and progress is discussed at the Partnership Forum each time they meet

Staff engagement will continue next year through our annual quality improvement week, a summer quality event, a successful Dragons' Den competition, and bespoke workshops and events, as well as through the number of channels we use to generate discussion on different issues that affect our staff.

Diversity and Inclusion

We serve a diverse range of communities in south west London and its surroundings. We understand the importance of making sure our services and culture supports fair, open structures, and champions the diversity of our workforce and patients. 43% of our staff are from BAME backgrounds, so we are a truly diverse organisation.

Our Trust Board and Executive Team oversee the strategic approach to equality, diversity and inclusion (ED&I), whilst the Workforce and Education Committee monitors policies, service developments and organisational change to identify any potential issues, and to propose ways to address them.

A refreshed approach to diversity and inclusion

In October 2018, we launched our Diversity and Inclusion Strategy. This document outlines our aims in relation to diversity and inclusion, and how we plan to create a more diverse organisation.

Our new strategy emerged from a review of existing diversity and inclusion practices and policies, together with intelligence gathered from staff data, surveys and consultations. Since the launch of the strategy, we have established executive director advocates for each of our four priority diversity strands, who will play an active role in championing their diversity.

The four areas are:

- Black, Asian and Minority Ethnic (BAME)
- Disability and wellbeing
- Lesbian, Gay, Bisexual and Transgender (LGBT)
- Women

Respecting and protecting the human rights of our patients, staff and members are at the heart of everything we do. We are committed to the principles of corporate social responsibility and therefore social, community and human rights issues are taken in to account when developing and or reviewing Trust policies. We also put a responsibility on ourselves to protect, and engage and develop our staff.

Although we are not yet mandated to report on our Ethnicity Pay Gap we have chosen to do so. This not only ensures greater transparency but also complements both the gender pay gap reporting and the Trust's Equality and Diversity Strategy. As with the Gender Pay Gap Report the data is based on a snapshot date of 31st March

2018 and is available via the Trust's website www.stgeorges.nhs.uk/about/living-our-values/equality-and-human-rights

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

We provide safeguarding training to all staff as part of the Trust's training programmes. We participate in our local, multi-agency Safeguarding Boards and aim to safeguard vulnerable people through a partnership approach.

Care and treatment is provided to all patients with their consent, and for patients who cannot consent to treatment, we aim to provide in their best interests in accordance with the Mental Capacity Act 2005.

The Trust provides a comprehensive patient information and language support service to meet the needs of our diverse population, and can provide interpreters for patients and their carers. We provide telephone interpreting services in most common languages and many of our core information leaflets are in an Easy Read format. A multi-faith spiritual care team is available to support patients, and reflects the diverse faiths and beliefs of our local population.

Workforce Race Equality Standard (WRES) 2018

Since 2017, all healthcare providers are required to publish their Workforce Race Equality Standard data which reports on the experience and treatment of BAME staff. The NHS WRES (2018 Data Analysis Report) published in February 2019 reports on data from the period April 2017 to March 2018, and uses data taken from our 2017 NHS Staff Survey Result.

In comparison to our data for 2017, there has been (marginal) progress on six of the eight indicators.

WRES Indicator	2017	2018
Relative likelihood of white applicants being appointed from short listing across all posts compared to BAME applicants	2.6	1.59
Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	2.05	2.04
Relative likelihood of BAME staff accessing non mandatory training and CPD compared to White staff	0.8	1.1
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27.5%	28.4%
Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	33%	31%
Percentage of BAME staff believing that Trust provides equal opportunities for career progression or promotion	63%	63%
Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	20%	18%
BAME Board membership	5.3%	12.5%

Improving the health and wellbeing of our staff

One of our workforce priorities this year has been to improve the health and wellbeing of our staff. The Health and Wellbeing Strategy is overseen by the Workforce and Education Committee.

As well as ensuring we deliver key initiatives such as Staff Health and Wellbeing Days, the Annual Air Quality Event and physical activity and wellbeing classes, we have made progress to improve specific areas of staff wellbeing.

We redeveloped our Staff Health and Wellbeing Portal, where staff can electronically log their health and wellbeing statistics and develop a tailored plan on how to improve them. At the end of March 2018/19, there were 3,869 active users of the site.

In addition to new mandatory mental health training launched this year, we trialled a new Mental Health Awareness programme designed to improve staff mental health and to reduce the associated stigma and

discrimination. Due to the positive feedback from participants, we will make the training available to staff throughout 2019/20.

We developed a booklet for all staff on managing common conditions that can cause emotional distress or a mental health condition. Over 9,000 copies of this booklet have been distributed to our staff. A study in 2018/19 reported that staff found the booklet helpful for providing information on mental health issues; however, further information was needed on providing support for particular health conditions. As a result, we will develop further self-help guides next year on specific topics.

We provide the following health and wellbeing opportunities to all staff working across the Trust:

- Free eye tests
- Health and safety at work week
- Nutrition and Hydration Week
- LiAiSe (Staff Support)
- Manual Handling training
- Occupational Health Service
- Staff Support Service (including staff counselling, trauma debriefing, mediation)
- Occupational Health Physiotherapy Service
- Smoking Cessation Support

Enabling staff to speak up and to raise their concerns about patient care, quality or safety in a supportive culture is integral to providing outstanding care, every time. Our Freedom to Speak Up service is in place for staff to raise any issues relating to patient care, quality or safety.

The Freedom to Speak up Guardian meets all new staff at Trust induction and there are other roles dedicated to supporting the rights and well-being of staff include the Guardian of Safe Working for Junior Doctors contracted working hours and the Champion of Supported Return to Work for Junior Doctors.

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

As part of our commitment to tackling unhelpful behaviours, we introduced values-based recruitment training across the Trust this year. In addition, we began to offer bespoke training across different departments on how behaviours can be perceived in the workplace.

In January 2019, we established a mediator's programme across the Trust. Individuals in the programme are trained to act as a neutral third party to assist in resolving conflict. They are trained and supervised every six weeks in the use of specialised communication and negotiation techniques.

Our staff support lead, as a member of a number of engagement groups, provides information and monthly updates on current caseload and activity. To mitigate bullying and harassment encountered by staff from patients, this year we introduced a debrief service for relatives or the public from our Staff Support Service.

Occupational Health

Our Occupational Health Service is committed to a strong focus on health, safety and wellbeing for staff, patients and visitors.

The service offers pre-commencement screening, work-related health checks, vaccination and immunisation programmes, and advice on reducing risks in the workplace.

The team also offers guidance to staff on maintaining wellness in the workplace and provides advice and information on dealing with sickness absence, and how to support staff to return to work.

Education and training

We are dedicated to providing opportunities for staff to engage, learn new skills, and to receive 1-2-1 support and guidance such as coaching, mentoring and employee assistant programmes.

The Trust invests in continuous professional and personal development for all staff by offering in-house and externally commissioned development programmes. The Trust will continue to work closely with Health Education England, and Higher and Further Education Institutions to explore new ways of supporting staff development. A number of initiatives are already in place and new ones are due to be rolled out in 2019/20 to support the development of a competent, capable and caring current and future workforce.

NHS Staff Survey 2018

The NHS Staff Survey is conducted annually. Staff Survey questionnaires were sent to 8,595 eligible members of staff with 4,482 staff returning the survey. This was a 54% response rate, which is higher than last year's response rate of 51% and higher than the average response rate of 44% for acute Trusts nationally. In this year's survey the results were grouped into ten indicators. The scores are out of 10 with the indicator score being the average of those.

	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	8.4	9.1	8.4	9.1	8.5	9.2
Health and wellbeing	5.6	5.9	5.7	6.0	5.7	6.1
Immediate managers	6.4	6.7	6.5	6.7	6.4	6.7
Morale	5.6	6.1	n/a	n/a	n/a	n/a
Quality of appraisals	5.6	5.4	5.5	5.3	5.5	5.3
Quality of care	7.4	7.4	7.4	7.5	7.5	7.6
Safe environment – bullying and	7.6	7.9	7.6	8.0	7.6	8.0
Safe environment - violence	9.4	9.4	9.4	9.4	9.4	9.4
Safety culture	6.4	6.6	6.5	6.6	6.3	6.6
Staff engagement	6.8	7.0	6.9	7.0	6.8	7.0

The ten indicators are compared against other Trusts. We are below the NHS average on seven indicators and equal or above the NHS average on three, but the target areas for improvement in the Trust's ways of working remain to:

- Improve overall staff engagement
- Address bullying and harassment
- Improve support for equality, diversity and inclusion

Future priorities and targets

The results from the NHS Staff Survey have been shared with the executive Team and with the Trust Board. Over the coming year our Staff Engagement Group, Leadership Academy and Quality Improvement Academy will focus on improving staff engagement, health and wellbeing of our staff and promoting a safety culture for our patients.

Friends and Family staff survey

We also have an internal staff feedback system called the NHS Staff Friends and Family test (FFT) and which helps us track our performance continuously throughout the year. The survey asks staff whether they would recommend St George's to friends and family as a good place to be treated as a patient, and whether it is a good place to work.

In 2018/2019 our scores are as follows:

Quarter 1 (April-June 2018)	Quarter 2 (July-Sept 2018)	Quarter 4 (January -February 2018)
85% would recommend for treatment	76% would recommend for treatment	78% would recommend for treatment
61% would recommend for work	56% would recommend for work	65% would recommend for work

* *the Trust did not undertake the staff FFT in quarter 3 due to the National Staff Survey being conducted.*

Right staff, with the right skills, in the right place

To provide high quality care, we must use our resources in the most efficient way. Ensuring we have the right staff, with the right skills, in the right place. This also includes ensuring we have the right leadership, culture, support and education to support our staff.

The Trust uses the methodology set out by the National Quality Board Guidance to set the right nursing levels on our wards. We reset this every six months using the evidenced based Acuity and Dependency Safer Nursing Care Tool which we coordinate with our quality indicators such as pressure ulcers, incidents, safe staffing red flags (NICE), and a comparison of the other Trusts methods via the Model Hospital.

Since May 2016, all hospital Trusts began reporting on the number of hours a member of staff spends with a patient each day. We use this data to review the staff numbers within a specialty against patient outcomes so that we can improve outcomes for patients and improve productivity.

The Trust uses an electronic rostering system to manage the allocation of all staff across the Trust, excluding medical staff. This ensures we can keep a very accurate track of our staffing levels, which provides evidence and assurance to the Board that our staffing processes are safe, sustainable and effective.

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 acts as the champion of safe working hours and 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. Gaps in the rota for medical staff are monitored and managed at service level. Information on unfilled shifts is not available at Trust level, but is monitored by individual services. A total of 369 exceptions were reported in 2018/19 which is a significant reduction from last year with 703 exception reports.

Trade union facility time

The following information is published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017. The relevant period is 1 April 2018 until 31 March 2019.

Activity	Time or cost
Number of trade union representatives	61
Total FTE of trade union representatives	57.72
Number who spend between 1 – 50% of their time on Trade Union activities	60
Number who spend 100% of their time on trade union activities	1
Total Trust pay bill	£46,950,000
Total cost of facility time	£13,388.73
Percentage of total pay spent on facility time	0.029%
Hours spent on paid facility time	1,477.6
Hours spent on paid trade union activities	977.68
Percentage of total paid facility time hours spent on paid TU activities	66.17%

Organisational Structure and Governance

Our Council of Governors

Our Council of Governors became a full council when the Trust was authorised as a Foundation Trust on 1 February 2015. During most of 2018/19 the Council was comprised of 15 elected public governors, four elected staff governors and seven governors appointed from stakeholder organisations. An elected member resigned

in June 2018 to take up an Non-Executive Director position in another NHS organisation and the runner-up from the previous election was appointed in his place. A second member resigned in October 2018 as he was moving out of his constituency. We made the decision to keep the position vacant until the next elections which will be held towards the end of 2019.

The Council of Governors is responsible for the appointment of the Chairman and Non-Executive Directors, agreeing their terms and conditions, as well as the appointment of the external auditor. Any disputes between the board and governors are resolved following the procedure set out on page 77 of The St George's University Hospitals NHS Foundation Trust Constitution. This details the procedure for resolving disputes when they arise between the board, governors and membership bodies.

Each financial year, the Council of Governors is consulted by the Board on the Trust's forward plan and receives the annual accounts, auditors' report, annual report and Quality Report. Governors are unpaid; however, they are entitled to receive reimbursement for their expenses.

Our Council of Governors is responsible for holding our Non-Executive Directors to account, individually and collectively, for the performance of the Board. Annual appraisals for the Non-Executive Directors performance were completed in May 2018 and the Council of Governors have certified that the Non-Executive Directors are performing effectively. The Council of Governors re-appointed two Non-Executive Directors in 2018/19 following positive annual appraisals.

The Trust held an election for a new staff Governor for a Nursing & Midwifery staff governor in February 2019, due to the retirement of the nursing and midwifery staff governor on 31 March 2019. A new governor was elected unopposed and will commence the term from 1 April 2019.

The Trust will hold further elections at the end of 2019 for eight Governor positions. The Council of Governors select one of their elected members to be the Lead Governor for the Council. The Lead Governor is responsible for co-ordinating communication between NHS Improvement and the other governors, and act as the main point of contact for the Chairman. Kathryn Harrison was our current Lead Governor throughout 2018/19. The Annual Members' Meeting was held in September 2018, and 85 people attended.

To support our governors to undertake their duties we provide them with training and development opportunities. This year, we provided workshops and governor induction sessions where Board members and governors meet to discuss various issues. A programme of internal and external training sessions took place during 2018/19 for governors in areas such as finance, strategy and quality inspections on the wards. The Council of Governors met five times in 2018/19. The Council of Governors engages with members through a variety of ways, including a monthly newsletter, bespoke Member Health Talks and public meetings.

Name	Description	Actual/ possible
Gillian Norton	Chairman	5/5
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	3/5
Anneke de Boer	Public Governor, Merton	5/5
Bassey Williams	Staff Governor, Allied Health Professionals	4/5
Damian Quinn	Public Governor, Rest of England	2/5
Derek McKee	Public Governor, Wandsworth	3/5
Donald Roy	Appointment Governor, Healthwatch Wandsworth	5/5
Doulla Manolas	Public Governor, Wandsworth	3/5
Dr Anup Sharma	Staff Governor, Medical & Dental	3/5
Dr Clive Studd	Public Governor, Merton	4/5
Emir Feisal	Public Governor, Wandsworth	0/1
Francis Gibson	Appointed Governor, St George's University	2/5
Helen McHugh	Staff Governor, Nursing & Midwifery	4/5
Hilary Harland	Public Governor, Merton	5/5
Jenni Doman	Staff Governor, non-clinical	4/5
John Hallmark	Appointed Governor, Healthwatch Wandsworth	5/5
Kathryn Harrison	Lead Governor, Rest of England	5/5
Khaled Simmons	Public Governor, Merton	4/5

Mia Bayles	Public Governor, Rest of England	5/5
Nick de Bellaigue	Public Governor, Wandsworth	2/3
Nigel Brindley	Public Governor, Wandsworth	2/3
Rebecca Lanning	Appointed Governor, Merton Council	2/3
Richard Mycroft	Public Governor, South West Lambeth	5/5
Sangeeta Patel	Appointed Governor for Merton & Wandsworth CCGs	3/3
Sarah McDermott	Appointed Governor, Wandsworth Council	5/5
Simon Price	Public Governor, Wandsworth	2/5
Stephen Sambrook	Public Governor, Rest of England	3/5
Val Collington	Appointed Governor, Kingston University	2/5

The following Directors attended the Council of Governors meetings.

Name	Title	Date
Harbhajan Brar	Director of Human Resources & Organisational Development	May 2018
Suzanne Marsello	Director of Strategy	May 2018
Stephen Jones	Director of Corporate Affairs	May 2018
Suzanne Marsello	Director of Strategy	July 2018
Stephen Jones	Director of Corporate Affairs	July 2018
Jacqueline Totterdell	Chief Executive Officer	October 2018
Avey Bhatia	Chief Nurse & Director of Infection Prevention and Control	October 2018
Stephen Jones	Director of Corporate Affairs	October 2018
Jacqueline Totterdell	Chief Executive Officer	December 2018
Stephen Jones	Director of Corporate Affairs	December 2018
Andrew Grimshaw	Chief Finance Officer	March 2019
Avey Bhatia	Chief Nurse & Director of Infection Prevention and Control	March 2019
Stephen Jones	Director of Corporate Affairs	March 2019
Suzanne Marsello	Director of Strategy	March 2019

Our Membership

We have a combined public and staff membership of around 22,000 members.

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

Our membership groups are split into two categories:

- **Public members:** the Trust's public members will include patients, volunteers and all other members of the public (non-staff). All public members are required to opt in to membership. Public members are divided into four geographical constituencies, Wandsworth, Merton, south west Lambeth and Regional (England and Wales).
- **Staff members:** Our 9,500 staff are also members of the Trust. Any member of staff employed by the Trust on permanent contracts or fixed term contracts of 12 months or longer can become a member. Staff employed through service partners, including transport, catering and cleaning staff, also provide valuable services and are also eligible to become members.

There are currently 12,417 public members and over 9,500 staff members. The public membership is broken down as:

Membership Constituency	Total
Public members	12,417
Out of Trust Area	25
Lambeth	555

Merton	3,167
Wandsworth	3,838
Rest of England	4,832

In March 2019, we approved a new membership engagement strategy. Our vision is to build on our engagement with our members in order to create an active and vibrant membership community, one that is representative of the diverse populations we serve and of the staff who work here, and one which has a real voice in shaping the future of the Trust and the services it provides. To achieve this vision, our strategy for 2019-2022 sets out three overarching aims:

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

The Council of Governors is ultimately responsible for the delivery of the strategy and it will be supported in this by the Governors' Membership Engagement Committee, which will undertake the detailed monitoring of implementation and will report regularly to the Council on this.

Members' views and opinions are heard through the Council of Governors, whose role is to represent the interests of members and hold the Board to account through the Non-Executive Directors. We also communicate with our members through a number of ways:

- The Trust's monthly magazine for all staff
- The Trust's twice-weekly e-bulletin for staff and regular e-bulletins for public members
- A programme of regular member events (including the Trust's Annual Members Meeting)
- Dedicated member and governor page on the Trust's website
- Social media, including Twitter and Facebook
- Governor constituency meetings with members.

Members can contact the Trust a dedicated email or by visiting the Membership Office at St George's Hospital.

Committee structure

The Trust is open and transparent with the community through the public Council of Governor meetings, public Board meetings, the various health events held during the year, the Trust's Freedom of Information service, and the large amount of information available on our website. Member of the Trust Board are listed in the Directors Report on page 41 of this report.

The Trust Board has a number of Non-Executive-Director (NED) chaired Board Sub-Committees:

- Audit Committee
- Finance and Investment Committee
- Quality and Safety Committee
- Nominations and Remuneration Committee
- Workforce and Education Committee

A description of the Remuneration and Nomination Committee and the attendance register for the Committee is detailed on page 46 of this report.

Audit Committee

The Audit Committee provides the Board of Directors with an independent review of financial and corporate governance and risk management. It provides assurance through independent external and internal audit; ensuring standards are set and monitors compliance in the non-financial, non-clinical areas of the Trust.

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek any information it requires from staff. During the period the Committee reviewed the 2017/18 draft Annual Report and Accounts, including the Quality Account, and recommended that the Board approve and adopt these reports as a true and fair record. The Committee also monitored the programme of internal audit based on which the Trust received a reasonable assurance rating of its systems and internal controls.

Other key matters of business for the Committee included consideration and approval the 2018/19 programme of work for internal auditors and counter fraud teams, monitoring whistleblowing and freedom to speak up activity and actions, monitoring the implementation of the new regulations around data protection review of compliance against key Trust documents for example the standing orders and scheme of delegation.

Each year the Committee conducts a review of the effectiveness of the internal and external audit functions. In 2017-18 the Committee with the Council of Governors undertook a competitive procurement process for the external audit function which resulted in Grant Thornton being appointed as the Trust External Auditors for a period of four years ending March 2022. During 2018/19 the Committee begun to consider and plan the process for tendering the internal audit function. The current internal auditor's (TIAA) contract is due to end in March 2020.

Attendance Register 2018/19

Name	Description	Actual/possible attendance
Sarah Wilton	Non-Executive Director, Committee Chair	5/5
Professor Sir Norman Williams	Non-Executive Director	4/5
Tim Wright	Non-Executive Director	5/5
Ann Beasley	Non-Executive Director & Vice Chair	5/5

Finance and Investment Committee

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

During the period the Committee considered and approved the annual plan and budgets for 2018/19, kept under close scrutiny key risks around estates, ICT and financial performance. The Committee also closely monitored performance against the emergency flow, activity levels and the transformation programme for outpatients.

Attendance Register 2018/19

Name	Description	Actual/possible attendance
Ann Beasley	Non-Executive Director & Vice Chair	11/12
Stephen Collier	Non-Executive Director	8/12
Sarah Wilton	Non-Executive Director	7/12
Andrew Grimshaw	Chief Financial Officer	10/12
Avey Bhatia	Chief Nurse and Director of Infection & Prevention Control	10/12
Professor Andrew Rhodes	Medical Director	7/8
Dr Richard Jennings	Chief Medical Officer	2/4

Quality and Safety Committee

The Quality 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 required by corporate strategy are being met.

The Committee also looks at the extent to which patient and user satisfaction matches that required by corporate strategy and whether the Trust can demonstrate learning and improvement and the level of compliance with Fundamental Standards of Care.

During the period notable areas of work for the Committee include scrutiny of the work around quality improvement plans and conducted deep dives in key improvement programmes such as theatres, unplanned/admitted patient care programme, end of life care and learning from incidents and outpatients performance. The Committee were also part of the process for establishing the Trust's Patient Experience and Partnership Group. The Committee, on behalf of the Board, also monitored progress against the Trust's CQC action plan following the inspection in 2018. The committee also oversaw the improvements to Trust's cardiac surgery unit and provided assurance to the Board on this.

Attendance Register 2018/19

Name	Description	Actual/possible attendance
Professor Sir Norman Williams	Non-Executive Director (Committee Chair)	12/12
Professor Jenny Higham	Non-Executive Director	12/12
Sarah Wilton	Non-Executive Director	5/12
Tim Wright	Non-Executive Director	5/6
Professor Andrew Rhodes	Medical Director	7/8
Avey Bhatia	Chief Nurse and Director of Infection & Prevention Control	12/12
Dr Richard Jennings	Chief Medical Officer	3/4

Workforce & Education Committee

The Workforce and Education Committee provides assurance to the Trust Board in relation to the development and delivery of the Trust's priories in relation to workforce training and staff development.

Much of the Committee's work in the period focused largely on leadership and progression, workforce planning, compliance with relevant workforce standards and requirements and engagement. The Committee approved the Trust's staff wellbeing strategy oversaw the development of the Diversity and Inclusion strategy and monitored progress against the staff engagement plan. The Committee also scrutinised workforce risks enshrined in the Board Assurance Framework.

Attendance Register 2018/19

Name	Description	Actual/ possible attendance
Stephen Collier	Non-Executive Director & Committee Chair	6/6
Ann Beasley	Non-Executive Director	3/4
Sarah Wilton	Non-Executive Director	1/2
Tim Wright	Non-Executive Director	3/4
Harbhajan Brar	Director of Human Resources and Organisational Development	6/6
Avey Bhatia	Chief Nurse & Director of Infection & Prevention Control	4/6
Dr Richard Jennings	Chief Medical Officer	0/2
Professor Andrew Rhodes	Acting Medical Director	2/4

Auditors

The Trust's appointed external auditors are Grant Thornton LLP. The auditors provide audit services comprising carrying out the statutory audit of the Trust's annual accounts and the use of resources work, as mandated by Monitor and the National Audit Office, and a review of the Quality Accounts. The Council of Governors is responsible for appointing External Auditor. During the period the Trust paid £95k for external auditor's fees.

The Trust has a rigorous internal audit function provided by TIAA. Each year the Audit Committee considers a programme of internal audit work to be carried out. 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 2018/19 included but were not limited to, GDPR compliance, Patient Engagement, Freedom to Speak Up. Theatre Productivity, Consultants job Planning, Data Security & Protection, Data Quality, Friends and Family Tests and Elective Care Recovery Programme and Cancer Management Pathway reviews. During the period the Trust paid internal audit fees of £140,000.

Auditors attend the meetings of the Audit Committee and as part of the systems of internal control meet periodically meeting privately 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.

Quality Governance Reporting Statement

The NHS defines quality care as that which is:

- Safe
- Effective and
- With positive patient experience.

It is important to focus on all three aspects in order to deliver a high quality of care to our patients and ensure required standards are met.

Within this Annual Report and Accounts, our Annual Quality Account, Annual Governance Statement and Board Assurance Framework explains in further detail the Trust's Quality Governance Framework, which helps us ensure our care meets the best possible standards. The Trust has a formal governance structure in place to monitor its quality governance framework, but, at the most senior level, the Board of Directors and Council of Governors receive the Trust Quality Accounts, which reports on Trust performance against national and local targets for that year under each of the three categories listed above.

Furthermore, the Board has a sub- committee, the Quality and Safety Committee, which is a fundamental part of our Quality Governance Framework. This committee focuses on the Trust's performance with regard to quality and safety issues and managing clinical risks. It reviews feedback, complaints, claims and incidents.

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. This includes responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts as set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

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

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

- We have observed the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- We have made judgements and estimates on a reasonable basis
- We have met the applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) and have followed, disclosed and explained any material departures in the financial statements
- Ensured that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepared the financial statements on a going concern basis.

As accounting officer I can confirm we keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and 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.

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

Jacqueline Totterdell
Chief Executive
23 May 2019

Annual Governance Statement

Statement of Compliance with the NHS Foundation Trust Code of Governance

The Board of Directors considers that it was compliant with the provisions of the revised NHS Foundation Trust Code of Governance. The Council of Governors retains the power to hold the Board of directors to account for its performance in achieving the Trust's objectives.

The directors consider 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 the NHS foundation Trust's performance, business model and strategy (Code of Governance C.1.1). Each director has stated that as far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware and they have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

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 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 Audit Committee, internal auditors, clinical audit and the executive managers and clinical leads within the 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, the Audit Committee, and the Quality and Safety Committee and a plan to continue to identify and address weaknesses and ensure improvement of the system continues.

I am confident as to the effectiveness of the system described above and that conclusion is informed in a number of ways:

- The overall opinion of the Head of Internal Audit is that reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.
- The internal audit plan for 2018/19 included reports of the main operational areas at the Trust. The Trust has produced a quality account for 2018/19 and the governance system described above has been used to validate its content and the data on which it is based. 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.

A key concern continues to be our ability to develop and maintain our estate, resulting in buildings which are not fit for purpose potentially impacting on delivery and patient safety. The Board also remains concerned that we achieved an outturn deficit of £45.4m which is greater than planned for at the start of the year, and that we remain in both quality and financial special measures.

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 for the year ended 31 March 2019 and up to the date of approval of the Annual Report and Accounts.

The 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 risks 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's 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.

Capacity to handle risk

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

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

The Board itself has standing orders, reservation and delegation of powers and standing financial instructions in place which is reviewed annually. As the Accountable Officer, I support the Chairman in ensuring the effective performance of the Board and its committees. I achieve this in a number of ways by:

- 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 Director of Corporate Affairs who also acts as the Trust Secretary. Governance is embedded across the Trust's Directorates and clinical divisions and is led by Directors or a Divisional Chairman, therefore ensuring clear responsibility and accountability across the Trust.

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

During 2018/19, the Trust took a number of steps to further strengthen its governance arrangements following the independent external review of governance considered by the Trust Board in February 2018 to ensure they continued to be fit for purpose and support the delivery of key activities. Where areas of weakness were identified, these have been prioritised for action. In 2018/19, the Trust restructured its clinical divisions,

strengthened the reporting of the divisions through the Trust Executive Committee, and launched a review of clinical governance which is expected to report the first quarter of 2019. We have reviewed the effectiveness of our Board sub-Committees and made improvements where appropriate.

Risks to the Trust

As with all NHS organisations, balancing the need to deliver high quality care in the context of increasing demand and acuity, while increasing productivity, represents an on-going challenge. The NHS is in a period of long-term financial constraint. This context is important in understanding both St George's risks, and some of the drivers for those risks, as well as the constraints on the mitigations that the Trust can necessarily call on.

The Board identified major risks for 2018/19 during strategic planning activities in late 2017/18 as well as in year and will continue to reconsider key risks which may impact on our clinical strategy in 2019/20. The BAF has been updated for 2019/20 to reflect risks to the delivery of the new strategy.

The following key risks to delivery of the Trust's objectives are recorded in detail in the Board Assurance Framework as at March 2019. These are monitored monthly by the Board sub-committees and by the Board on a quarterly basis, and are available in full via the Board papers on the Trust's website. In 2018/19 some of the key risks with potential impact on achieving our objectives are described in the table below.

Trust Objective	Risk Description	Mitigation
Treat the patient, treat the person	NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing). We are unable to develop new roles, changes in skill mix and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could impact upon the care we provide.	We are working to improve our vacancy rate and the time taken to recruit. This has been monitored through our Workforce and Education Committee (WEC). Our vacancy rate has reduced from 17% to 10% in 2018/19 and turnaround reduced from 19% to 16%. Our staffing rates kept under constant review to ensure staffing levels do not lead to a clinically unsafe environment.
	Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway need to be more robust and effective.	We have reduced the risk of harm to patients due to long waiting lists or poor management of pathways by returning to reporting on our waiting list data. The Unplanned Admitted Care Programme will improve control of this risk, and throughout 2019/20 we plan to improve performance against key performance indicators and national indicators through five programmes of work 1) Front door streaming 2) Emergency Department process efficiency 3) Ambulatory care efficiency 4) Inpatient processes 5) Discharge processes.
Right care, right place, right time	Our pathways are not well integrated with, or supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.	Work continues to develop relationships and pathways with our partners, including working closely with CCGs in order to re-set priorities We are working in an acute provider collaborative with other south west London hospitals to prioritise the collaborative delivery of clinical services, and clinical and corporate support functions where this yields benefits (clinical, operational and financial) over and above the benefits gained from individual Trusts acting on

		their own or with other partners.
Balance the books, invest in our future	Financial efficiency, forecasting and accountability are not seen as a priority for service managers or our wider workforce which results in overspending, and further regulatory action.	Our cost improvement programmes (CIPs) are closely monitored by the appropriate committees and the Board. We are putting additional effort into developing robust CIPS and moving them to a delivery position as soon as possible. We are devising a clear and standardised set of reports to go out with budget statements on a monthly basis and are putting extra resource in to training our clinical staff in financial decision making, where appropriate.
	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities.	We are reporting each month to Trust Executive Committee on progress, challenges, actions and mitigations Quarterly to Trust Board. We are making better use of our data through the of use of tableau reporting and consistency of messages and data across CommCell (weekly meeting of all operational leads), our Quality Improvement dashboard and Integrated Quality and Performance monthly Board report.
Champion team St George's	Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative or does not foster accountability amongst our workforce.	Over the coming year our Staff Engagement Group and Quality Improvement Academy will focus on improving staff engagement, health and wellbeing and promoting a safety culture.
	We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction, which can affect the care we provide to patients.	Key performance indicators for mandatory and statutory training and appraisal are provided to the Workforce and Education Committee so that they can be assured we are mitigating this risk. Over the coming year we will develop further online training packages and we are creating a skills development programme. We are also refining our appraisal process and revising the appraisal policy to ensure we identify development opportunity factors.
Build a better St George's	Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.	In 2019/20 a new Information Communications and Technology (ICT) strategy will be presented to the Trust Board for approval. This includes, as part of our Clinical Information Systems programme retiring many legacy IT systems which do not provide sufficient auditability. We will continue to the deployment of Cerner Electronic Patient Record (EPR) system to remaining St George's inpatient areas and at Queen Mary's Hospital

	Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting our delivery and patient safety.	Many of the long-standing issues we face, including our ageing hospital estate at St George's Hospital, will not be solved overnight; and delivery of our strategy will be dependent on our ability to target investment in these key areas. In 2019/20 we plan to put significant investment in to our utilities to improve our estates infrastructure.
Develop tomorrow's treatments today	We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clinical service priorities and consequently a lack of engagement in the future success of the Trust.	The Board agreed the Trust strategy at the March 2019 Trust Board. During 2018/19 the Board also held a number of workshops to develop the strategy.

Single Oversight Framework

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

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

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

St George's University Teaching Hospitals NHS Foundation Trust has been placed in segment 4 – Special Measures and this reflects the latest position as published on the NHS Improvement website - April 29th 2019.

Finance and use of resources

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

Area	Metric	2018/19 scores				2017/18 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	[4]	[4]	[4]	[4]	[4]	[4]
	Liquidity	[4]	[4]	[4]	[4]	[4]	[4]
Financial efficiency	I&E margin	[4]	[4]	[4]	[4]	[4]	[4]
Financial controls	Distance from financial plan	[2]	[4]	[4]	[4]	[2]	[3]
	Agency spend	[1]	[1]	[1]	[1]	[1]	[1]
Overall Scoring		**[4]**	**[4]**	**[4]**	**[4]**	**[4]**	**[4]**

Information Governance

The Board is aware of the importance of maintaining high standards of information governance, including protecting the confidentiality of patients and staff information. The Trust has its Chief Financial Officer as the Senior Information Risk Officer and an Associate Medical Director as Caldicott Guardian.

The Trust also has a Data Protection Officer, an Information Governance Manager and a range of policies, procedures and training to ensure that all staff are aware of information governance requirements. The Informatics Governance Group (IGG) oversees the completion of the Data Security and Protection Toolkit (DSPT) on an annual basis, as well as reviewing any information governance incidents. The IGG reports to the Trust Executive Committee.

During 2018/19 three incidents were reported to the Information Commissioner's Office (ICO). They related to incidents regarding failure to follow appropriate process and inappropriate access to data.

Following the Trust's own investigation and response to the ICO, the ICO determined there was no need for further action.

Review of Effectiveness

The review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.

On behalf of the Board, the Committees regularly review the Integrated Quality and Performance report from the perspective of their committee. The Board also reviews this monthly. The monthly report details national priority and regulatory indicators including safety, clinical effectiveness and patient experience. The Integrated Quality and Performance report is supplemented by more detailed briefings on any areas of adverse performance. The Report is backed up by more detailed reports reviewed by Board committees; in addition to this the divisional directorates holds monthly performance review meetings with the care groups and individual services and regular performance meetings with the executive team.

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

Internal audit reports are issued to and followed-up with the responsible Executive Directors and the results are reported to the Audit Committee. Internal audit reports are also made available to the 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 Board

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.

The head of internal audit has provided reasonable assurance that the internal controls are operating effectively within the Trust as a whole. The opinion is that overall reasonable assurance could be provided, and that the controls are generally sound and operating effectively. The Trust has produced a quality account for 2018/19 and the governance system described in the Annual Governance Statement has been used to validate

its content and the data on which it is based. Through review of these assurances, the Board has considered any issues that fall within the definition of 'significant issue' according to the requirements of this governance statement. The Board remain concerned with the deficit position and outturn deficit of £45.4m

Additional disclosures

Emergency Preparedness, Resilience & Response (EPRR) assurance process 2018/19

Every year, NHS England requires NHS organisations to provide assurance of their ability to plan for, respond to and recover from emergencies. To give this assurance, the Trust was assessed in the autumn 2018 against 64 core standards for EPRR. At the end of this assurance process, NHS England felt that 'overall, the Trust demonstrated its commitment to EPRR' and did not find any aspects of our arrangements to be non-compliant.

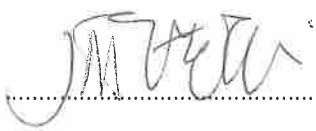
At the end of this assurance process, NHS England reported that overall, the Trust demonstrated its commitment to EPRR and did not find any aspects of our arrangements to be non-compliant. NHS England found the Trust to be partially compliant with eleven of the core standards and fully compliant with the rest.

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

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

Performance is monitored monthly, via the monthly quality and performance framework, by the Finance and Investment Committee and the Board. Our performance is reported through a number of key performance indicators (KPIs) through the appropriate regulatory framework. At the end of this reporting period, March 2019, the Trust was performing positively against a large number of key indicators. However there remain challenges including the ED four-hour standard. This is set out in more detail in the clinical and operational performance overview on page 12 of this report.

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



Jacqueline Totterdell
Chief Executive
23 May 2019

Auditors' Report

Quality Report

Statement on quality from the Chief Executive

Twelve months ago, I talked in my introduction to the quality report about our Quality Improvement Plan and the efforts across the Trust to improve both the quality and safety of the patient care we provide.

One year on, I am pleased at the progress we have made in a number of areas – and this is down to the efforts of staff across the organisation, in a wide variety of roles.

We want to see a cultural shift in how we look at improving quality and safety, and I believe we have made positive steps in this direction. Of course, there have also been challenges, some significant, which are rightly detailed in this report.

In March 2019, we took a big step forward as an organization when we recommenced reporting our 18 week referral to treatment figures, following a two year hiatus due to data quality concerns.

This means we are now reporting our referral to treatment data again, but – more importantly – it sends a clear message to our patients and the communities we serve that we can now monitor and track people on our waiting lists accurately.

Many of our patients would rightly assume this is something we have always been able to do, but sadly this has not been the case. However, we now have confidence that our waiting lists are robust and accurate, meaning patients are not at risk of suffering harm because of being inaccurately tracked on our systems.

During the past year, we also improved our Care Quality Commission (CQC) inspection rating from Inadequate to Requires Improvement. The Trust was rated Inadequate in November 2016, so moving to Requires Improvement is a significant milestone, but it is far from the end of our improvement journey if we want to provide outstanding care, every time for our patients.

I have said previously that there is a real will within the organisation to make our services safer and better for patients. This is fantastic, but it is clear that staff have not always had access to the tools and techniques they need to make this happen in a sustainable way. This is why I am pleased the work of our Quality Improvement Academy is making progress to embed a quality improvement culture within the Trust.

This will take time – we are a large organisation, and not everyone is open to change - but our work with the Institute for Healthcare Improvement (IHI) has been extremely valuable, and given us the impetus we need to drive this forward.

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

Finally, I would like to thank the 9,000 staff who work so hard to deliver outstanding care, every time for our patients – they are a credit to the organisation.

Jacqueline Totterdell

Chief Executive

23 May 2019

Our quality priorities for 2019-20

As described in the Trust's strategy, approved in March 2019, our vision is to provide outstanding care, every time for our patients, staff and the communities that we serve.

To achieve this, our aim is to embed quality improvement throughout the organisation. Two key tenants to make this ambition a reality are our Quality Improvement Plan (QIP) and our Quality Improvement Academy.

Towards the end of this year we refocused the QIP by reviewing the progress we have made against the Quality Improvement Plan 2018-2019 and external assessments (CQC inspections, national surveys and local and national audit) to ensure that we are both describing the change projects that will ensure we achieve our vision of outstanding care, every time – and that we are focusing on the areas we need to deliver upon to improve our rating of 'Requires Improvement' from the CQC.

To ensure that the QIP is not working in isolation the refocused QIP for 2019/20 has been integrated with the Trust Annual Plan 2019-2020 and aligned to the Trust's Corporate Objectives and Trust Strategy.

To deliver sustainable change we have established the Quality Improvement Academy (QIA) this is a key enabler for driving and implementing sustainable change. It is through the QIA that the Trust is building quality improvement capacity and capability throughout the organisation to create the right conditions for sustainable success.

Supporting programmes such as *Getting It Right First Time* (GIRFT) and *High Performing Teams* are led by the Quality Improvement Academy. GIRFT uses national data to identify variations and outcomes and is used by a service to reduce unwanted variations in practice.

Supporting programmes such as *Getting It Right First Time* (GIRFT) and *High Performing Teams* are led by the Quality Improvement Academy. GIRFT uses national data to identify variations and outcomes and is used by a service to reduce unwanted variations in practice.

Our quality priorities and why we chose them

The quality objectives for 2019-2020 were informed by reviewing themes highlighted from our ward and departmental accreditation scheme (as described on page 19 of this report) and progress against the Quality Improvement Plan 2018-2019.

We also reviewed information from external assessments and local and national audit and the national priorities for sepsis, safe staffing, falls, and infection control and actions remaining open from the CQC action plan 2018-2019. These include as part of the Trust's on-going improvement plans to improve our 4 hour performance in ED and time of arrival to receiving treatment in ED.

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

Each quality priority comes under one of three quality themes:

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

Improving patient safety

The patient safety priorities we will focus on in 2019/20 are inter- linked and with the establishment of a critical care outreach service will have a significant impact on supporting our staff to manage deteriorating patients promptly and effectively.

Treatment escalation plans

What success will look like: We will ensure that all non-elective inpatients have a treatment escalation plan (TEP) in place within 24 hours of admission as described on page 15 of this report.

Identification, protection and care of patients who lack mental capacity to make certain decisions

What success will look like: 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 MCA training.

Recognising the deteriorating patient

We will ensure that inpatients that deteriorate are recognised and treated promptly; consistently identifying the deteriorating patient so that we can intervene promptly and improve outcomes for patients

What success will look like: We will identify deteriorating patients early and so reduce the number of cardiac arrests compared with the 2018/19 baseline. We will improve the outcomes in our audits on appropriate response to the National Early Warning Score (NEWS2).

Improving patient experience

Provide a responsive, high quality complaints service.

This priority is being brought forward from 2018/19, our ambition is to provide a complaints service based on the principles in 'My expectations for raising concerns and complaints' (Parliamentary Health Service Ombudsman and others 2014) so that complainants are able to say: 'I felt confident to speak up and making my complaint was simple. I felt listened to and understood. I felt that my complaint made a difference.' In 2018/19 we made some of the changes to deliver against this priority and will deliver the improvement we want to see in 2019/20.

What success will look like: We will achieve our targets for responding to complaints by the end of September 2019.

Build a patient partnership structure to enable patients to be involved in improvement work from the earliest stage

This priority is being brought forward from 2018/19. We want to put working in partnership with our patients and the public at the centre of all that we do. We want to encourage the active participation of patients in their individual care and treatment and also give them a voice and enable their participation in the planning and development of services. During 2018/19 the Patient Experience and Partnership Group (PPEG) has been established; patient partners have been recruited and the first year of the Patient Experience and Partnership Strategy is being delivered.

What success will look like: We will deliver year one of the strategy and develop the strategy for the next three years. The PPEG strategy is published to the Trust's website www.stgeorges.nhs.uk/patients-and-visitors/patient-involvement/ppeg.

Improve immediate feedback from patients through the Friends and Family Test[1] (FFT) by increasing response rates for both inpatient and outpatient services

This priority is being brought forward from 2018/19. We want to hear from our patients about their experience so we can ensure that actions we take are directed at areas they are concerned about. We have not achieved the improvement in the response rate in outpatients to 20%. We also need to improve response rates to the FFT in other services. A number of changes have been made in the final quarter of 2018/19; these include the FFT being made available on the Trust website and the launch of FFT by text message. We are taking this priority forward into 2019/20 to ensure that action taken achieves the improvement we want to see and to ensure that learning is extended to other areas where response rates need to improve.

What success will look like: We will achieve a response rate of at least 20% by the end of 2019-20 for both inpatient and outpatient services and the emergency department.

[1] The Friends and Family Test (FFT) is a feedback tool that asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

Improving effectiveness and outcomes

Improve services for people with mental health needs who are in an acute healthcare setting.

People with known mental ill health are five times more likely to be admitted to acute hospitals. 80% of these emergency admissions are recorded as being primarily for physical health reasons. This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation, as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one.

What will success look like: We will demonstrate through audit of healthcare records that patients' mental health needs have been met when they are receiving care from our acute services.

Improve the effectiveness of our discharge process ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support.

We are carrying this priority forward from 2018/19 as we continue to receive feedback from our patients and the wider community through Healthwatch that we need to improve the way we discharge patients. Our patients tell us that they feel need to feel fully involved in their own care and treatment and are equipped with the information they need to feel safe at home.

What will success look like: We will see an improvement in the response to these questions on our local patient surveys and in the national patient survey 2019.

Improvement review of clinical governance

Changing our culture and a focus on leadership and engagement has been identified as an area for improvement. Cardiac surgery has highlighted the impact that the culture coupled with weak governance can have on a service.

What will success look like: We will carry out a review of our clinical governance processes throughout the trust to ensure they support the delivery of safe, high quality care.

Statements of assurance from the Board of Directors

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

A review of our **services** George's is the largest healthcare provider in south west London, and one of the largest in the country. St George's 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 St George's Hospital in Tooting, but we also provide services from Queen Mary's Hospital in Roehampton and health centres in Wandsworth. We also provide healthcare services for residents of HMP Wandsworth.

We 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 these include family HIV care and bone marrow transplantation for non-cancer diseases.

A number of our services are members of established clinical networks which bring together doctors, nurses and other clinicians from a range of healthcare providers working to improve clinical outcomes and patient experience. These networks include the South London Cardiac and Stroke Network and the South West London and Surrey Trauma Network, for which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

During 2018/19 we provided 54 NHS services. A detailed list is available in the Statement of Purpose on our website www.stgeorges.nhs.uk/about

We have reviewed data available on the quality of care in all of these services through our performance management framework and our assurance processes.

The income generated by the NHS services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of NHS services by St George's University Hospitals NHS Foundation Trust for 2018/19.

Participation in clinical audit and National Confidential Enquiries

During 2018/19, 63 national clinical audits and four national confidential enquiries covered NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period St George's University Hospitals NHS Foundation Trust participated in 98% 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.

The national clinical audits and national confidential enquiries that we are eligible to participate in during 2018/19 are listed below in Table 1.

Table 1

Title		Relevant	Participating
Adult Cardiac Surgery		✓	✓
Adult Community Acquired Pneumonia		✓	✓
BAUS Urology Audit - Cystectomy		✓	✓
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)		X	N/A
BAUS Urology Audit - Nephrectomy		✓	✓
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)		✓	✓
BAUS Urology Audit – Radical Prostatectomy		✓	✓
Cardiac Rhythm Management (CRM)		✓	✓
Case Mix Programme (CMP) (ICNARC)	Neurology Intensive Care Unit	✓	✓
	General Adult Intensive Care	✓	✓
	Cardiothroracic Intensive Care Unit	✓	✓
Child Health Clinical Outcome Review Programme	Cancer in Children, Teens, and Young Adults	✓	✓
	Long Term Ventilation	✓	✓
Elective Surgery (National PROMs Programme)		✓	✓
Falls and Fragility Fractures Audit Programme (FFFAP)*	Fracture Liaison Service Database	✓	✓
	Inpatient Falls	✓	✓
	National Hip Fracture Database	✓	✓
Feverish Children (care in emergency departments)		✓	✓
Inflammatory Bowel Disease programme / IBD Registry		✓	✓
Learning Disability Mortality Review Programme (LeDeR)		✓	✓
Major Trauma Audit		✓	✓
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection		✓	✓
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	✓	✓
	Perinatal Mortality and Morbidity confidential	✓	✓
	Maternal Mortality surveillance and mortality	✓	✓
	Maternal morbidity confidential enquiries	✓	✓
Medical and Surgical Clinical Outcome Review Programme	Perioperative Diabetes	✓	✓
	Acute Bowel Obstruction	✓	✓
	Pulmonary Embolism	✓	✓
Mental Health Clinical Outcome Review Programme		X	N/A
Myocardial Ischaemia National Audit Project (MINAP)		✓	✓
National Asthma and COPD Audit Programme	Pulmonary Rehabilitation	✓	✓
	COPD - Secondary Care Audit	✓	X
	Adult Asthma - Secondary Care Audit	✓	✓
National Audit of Anxiety and Depression		X	N/A
National Audit of Breast Cancer in Older People		✓	✓
National Audit of Cardiac Rehabilitation		✓	✓
National Audit of Care at the End of Life (NACEL)		✓	✓
National Audit of Dementia		✓	✓
National Audit of Intermediate Care		✓	N/A
National Audit of Percutaneous Coronary Interventions (PCI)		✓	✓
National Audit of Pulmonary Hypertension		X	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		✓	✓
National Bariatric Surgery Registry (NBSR)		✓	✓
National Bowel Cancer Audit (NBOCA)		✓	✓

National Cardiac Arrest Audit (NCAA)		✓	✓
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)		✓	✓
National Clinical Audit of Psychosis		X	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs		✓	✓
National Comparative Audit of Blood Transfusion programme*	Use of Fresh Frozen Plasma and Cryoprecipitate in	✓	✓
	Management of massive Haemorrhage	✓	✓
National Congenital Heart Disease (CHD)		X	N/A
National Diabetes Audit – Adults*	Core Audit	✓	✓
	Foot Care Audit	✓	✓
	Inpatient Audit (NaDia)	✓	✓
	Pregnancy in Diabetes	✓	✓
National Emergency Laparotomy Audit (NELA)		✓	✓
National Heart Failure Audit		✓	✓
National Joint Registry (NJR)		✓	✓
National Lung Cancer Audit (NLCA)		✓	✓
National Maternity and Perinatal Audit (NMPA)		✓	✓
National Mortality Case Record Review Programme		✓	✓
National Neonatal Audit Programme (NNAP)		✓	✓
National Oesophago-gastric Cancer (NAOGC)		✓	✓
National Ophthalmology Audit		X	N/A
National Paediatric Diabetes Audit (NPDA)		✓	✓
National Prostate Cancer Audit		✓	✓
National Vascular Registry		✓	✓
Neurosurgical National Audit Programme		✓	✓
Non-Invasive Ventilation - Adults		✓	✓
Paediatric Intensive Care (PICANet)		✓	✓
Prescribing Observatory for Mental Health (POMH-UK)		x	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Antibiotic Consumption	✓	✓
	Antimicrobial Stewardship	✓	✓
Sentinel Stroke National Audit programme (SSNAP) Royal College of Physicians		✓	✓
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance		✓	✓
Seven Day Hospital Services		✓	✓
Surgical Site Infection Surveillance Service		✓	✓
UK Cystic Fibrosis Registry		X	N/A
Vital Signs in Adults (care in emergency departments)		✓	✓
VTE risk in lower limb immobilisation (care in emergency departments)		✓	✓

The national clinical audits and national confidential enquiries for which data collection was completed during 2018/19 are listed in Table 2 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 2018/19 data collection completes during 2019/20 and therefore submission rates are not available at the time of this report.

Table 2

Title		Submission
Case Mix Programme (CMP) (ICNARC)	Neurology Intensive Care Unit	100%
	General Adult Intensive Care	100%
	Cardiothroracic Intensive Care Unit	100%
Child Health Clinical Outcome	Cancer in Children, Teens, and Young Adults	100%
Falls and Fragility Fractures Audit Programme (FFFAP)*	Inpatient Falls	100%
	National Hip Fracture Database	98%
Feverish Children (care in emergency departments)		100%
Learning Disability Mortality Review Programme (LeDeR)		100%
Major Trauma Audit		94%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection		100%
Maternal, New-born and Infant Clinical Outcome Review	Perinatal Mortality Surveillance	100%
	Perinatal Mortality and Morbidity confidential enquiries	100%

Programme	Maternal Mortality surveillance and mortality confidential enquiries	100%
Medical and Surgical Clinical Outcome Review Programme	Perioperative Diabetes	100%
	Pulmonary Embolism	100%
National Audit of Breast Cancer in Older People		100%
National Audit of Care at the End of Life (NACEL)		41%
National Audit of Dementia		100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)		100%
National Comparative Audit of Blood Transfusion programme*	Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	100%
	Management of massive Haemorrhage	100%
National Joint Registry (NJR)		94.2%
National Lung Cancer Audit (NLCA)		100%
National Maternity and Perinatal Audit (NMPA)		100%
National Mortality Case Record Review Programme		87%
National Neonatal Audit Programme (NNAP)		100%
National Oesophago-gastric Cancer (NAOGC)		100%
National Prostate Cancer Audit		100%
Neurosurgical National Audit Programme		100%
Paediatric Intensive Care (PICANet)		100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Antibiotic Consumption	100%
	Antimicrobial Stewardship	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance		100%
Seven Day Hospital Services		100%
Surgical Site Infection Surveillance Service		100%
Vital Signs in Adults (care in emergency departments)		100%
VTE risk in lower limb immobilisation (care in emergency departments)		100%

National clinical audits - action taken

The reports of 35 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2018/19 and we are taking the following actions to improve the quality of healthcare provided.

Chronic Obstructive Pulmonary Disease (COPD): National Report Pulmonary Rehabilitation 2018
We will continue to improve GP and primary care engagement to increase referral numbers for eligible patients We will work towards the Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS) National pulmonary rehabilitation audit data collection will be monthly from March 2019 Local audit projects to continue
COPD: Time to Integrate Care - Organisational Audit Report 2018
The service is working to reduce admissions and re-admissions More COPD patients to be cared for in respiratory wards Improved access to integrated, cross sector respiratory services Improved access to respiratory care at weekends An action plan was put in place to address these aims, the service reports piloting project to promote collaboration across primary and secondary care settings.
COPD: Working Together – National Clinical Audit Report 2018
The national report listed a number of recommendations: Ensure spirometry results are available for all admissions with acute exacerbation of COPD Ensure all current smokers are identified and offered smoking cessation pharmacotherapy
MBRRACE-UK Perinatal Mortality Surveillance Report – Jan to Dec 2016
Having reviewed the recommendations in the report the service confirmed that it is: Renewing efforts to focus on reducing stillbirths. Using the National Perinatal Mortality Review Tool to review all appropriate stillbirths and neonatal deaths. Ensuring data captured is of the highest quality, especially with complex and high-risk cases. Working to ensure all parents of babies who die are provided with unbiased counselling for post-mortem. Carrying out placental histology for all stillbirths and if possible all anticipated neonatal deaths
National Audit of Breast Cancer in Older People (NABCOP)
The report published in June 2018, the performance of the service at St George's was in line with national averages. The report

has been used to identify opportunities to improve further.
National Prostate Cancer Audit
Clinical Nurse Specialists are now in post and are can be contacted easily by patients helping to reduce anxiety that may be experienced after surgery. Patient reported urinary functional outcomes are in line with the national performance.
UK Parkinson's Clinical Audit - Transforming Care 2017
Improved provision of information at diagnosis by having information packs for newly-diagnosed patients available in outpatients clinic and ensure all neurologists are aware of them Development of a prompt sheet for patient completion prior to appointment in waiting area, to aid with patient decision making, these provide space for patients to identify three key areas to address in clinic. Improving documentation and assessment/management of fracture risk, through preparation of new pathway and protocol to assess bone health and fracture risk.
National Adult Bronchiectasis Audit 2017
The service is working to maintain and improve standards relevant to the management of bronchiectasis, these include: 85% of patients to have an up to date chest x-ray or CT scan 71% of trust patients were found in the audit to have been taught chest clearance techniques. The service exploring the possibility of a joint bronchiectasis and physiotherapy clinic to improve this performance.
National Paediatric Bronchiectasis Audit 2017
The service is developing closer working with Speech & Language Therapy for increased support.
National Audit of Dementia (NAD): Spotlight Audit 2017-2018
The emergency department have introduced 4AT (delirium screen) for all patients over the age of 65 and have a specific delirium pathway. We have introduced an automatic electronic delirium assessment for all inpatients over the age of 16. Training on applying the assessment is being provided for doctors. This electronic system will allow for easier auditing, so issues will be identified promptly. Piloting new nursing screening for development of delirium on selected medical wards to improve early recognition of delirium.
National Neonatal Audit Programme 2018
The service has focussed on neonatal hypothermia in the delivery suite and has purchased new monitoring equipment, re-arranged the team and is using heated mattresses to warm babies in the delivery suite. The service will be focusing on the rate of separation of mums and term and late preterm babies in the coming year.
National Paediatric Diabetes Audit (NPDA) Report 2018
St George's was declared an alarm level outlier for the metric 'case-mix adjusted mean HbA1C' by NPDA, this is an indicator of diabetic control. The service has put an action plan in place to improve: In August 2017, the service set up a weekly pre-clinic meeting held the day before the clinic where key issues of the patients attending the appointments the following day are highlighted. Patients due annual review have blood forms pre-printed and ready to be given at their appointments. Non-compliers with annual review checks are also identified and special attention given to complete their investigations.
National Emergency Laparotomy Audit (NELA)
The following improvement actions have been taken: Risk assessment is now part of trainee doctor induction programme and is highlighted on emergency theatre booking forms. Theatre delays are discussed at care group level and an emergency theatre protocol prioritising patients according to risk is being developed.
National Joint Registry (NJR) Annual Report 2018
St George's does not perform routine joint replacements; these are conducted by South West London Elective Orthopaedic Centre. St George's is not an outlier on any of the NJR measured criteria and compliance on reporting, consent rate, and linking (records with a valid NHS number) all exceeded the benchmark of 95%.
National Oesophago-Gastric Cancer Audit (NOGCA) 2018
The service is working on the following key areas in the coming year: Exploring the possibility of developing a direct access clinic for GPs to refer for Oesophago-Gastroduodenoscopy (OGD). A new clinic for investigations allows patients to have OGD earlier; this is being coupled with GP education sessions.
Royal College of Emergency Medicine (RCEM): Procedural Sedation in Adults Clinical Audit 2017/18
The service has increased training and education in the emergency department on procedural sedation and the use of the procedural sedation proforma to ensure the RCEM standards are met. The service is carrying out local audit to monitor the impact of the training.
Royal College of Emergency Medicine (RCEM) : Fractured Neck of Femur Clinical Audit 2017/18
To improve recording and acting on pain scores in the emergency department an education programme for staff has been put in place and new guidelines are being developed.

Royal College of Emergency Medicine (RCEM): Pain in Children Clinical Audit 2017/18
To improve documentation of the management of pain in children new documentation and electronic records are being introduced. Education in the emergency department is in place to raise awareness.
The National Audit of Cardiac Rehabilitation (NCAR) 2018
The service is participating in London wide cardiac rehabilitation review with a view to improving uptake of female patients.
Fracture Liaison Service Database (FLS-DB)
A new referral system is in place to make it easier for nurses and technicians to refer patients to the integrated falls service. The Fracture Liaison Service nurses are now telephone all patients after 3 months to check compliance, the national report had highlighted a decline in monitoring in 2017.
National Heart Failure Audit 2016/17 Summary Report
The service is exploring options for increasing the proportion of Heart Failure patients who receive specialist input - there is ongoing work with the CCG to improve access to cardiac rehabilitation.
Myocardial Ischaemia National Audit Report 2017
The service is exploring reasons why there is a difference in the call to balloon times for patients admitted directly to the Heart Attack Centre at St George's, and those transferred in. Areas to explore are possible delays in decision making (at either end), delays in the process of transferring patients from the referring hospital, or delays in door-to-balloon times.
National Audit of Percutaneous Coronary Interventions (PCI)
The service is investigating issues with data completion rates for non-ST-elevation myocardial infarction (NSTEMI) patients, specifically where they had been admitted from. Over the coming year, the audit team will be providing administrative support to improve data collection and so the information available to identify areas where the service could be improved.
National Vascular Registry audit 2018
70% of patients at St George's were discussed at MDT meetings compared to the national average of 83%. This is being investigated further and improvement in this area is being prioritised by the service. The national report also recommends that local services review their current pathways for vascular procedures. The times from diagnosis to treatment at St Georges are amongst national leading times for carotid endarterectomy and AAA patients.
British Association of Urological Surgeons (BAUS): Cystectomy
No recommendations from the report which showed that data quality was high and a 0% 90day mortality rate which is below the national average of 2.21%.
British Association of Urological Surgeons (BAUS): Nephrectomy
Report released in Aug 2018. While it made no recommendations on the basis of the results, data quality was reported to be high, with median length of stay in line with the national average, and mortality lower than average.
British Association of Urological Surgeons (BAUS): Radical Prostatectomy
Report released in September 2018. No recommendations were made on the basis of the results, but the audit showed that generally we operate on higher risk patients at St George's than the national average.
British Association of Urological Surgeons (BAUS): Percutaneous Nephrolithotomy (PCNL)
Report released in May 2018. It made no recommendations on the basis of the results. St George's was generally in line with national average on the key measures.
National Bowel Cancer Audit (NBOCA) 2018
Based on the report, the service confirmed that the trust is working on the below actions: Cancer data management team to continue with use of Infoflex (an information management software tool) which has been shown to maintain high data quality.
National Hip Fracture Database (NHFD) Annual Report 2018
The audit lead for the project reports that the service is responding to the national report with the following actions: Audit and look to putting together a business case to provide 7 day physiotherapy cover, which will improve rates of first day mobilisation. Review bed capacity modelling for patients admitted to orthopaedic wards to improve number of patients on ward within four hours of admission.
Surveillance of Surgical Site Infections (SSI) in NHS hospitals in England, 2017-2018
Report published in December 2018. St George's SSI rate is higher than the national average on all measures, although never by more than 0.2%.
Falls and Fragility Fractures Audit Programme (FFFAP): Inpatient Falls
The service is working to link up the National Audit Inpatient Falls and the National Hip Fracture Database to ensure that any gaps in care identified when patients suffer from inpatient falls and fractured neck of femur injuries are identified.
National Mortality Case Record Review Programme
See Learning from Deaths
Intensive Care National Audit and Research Centre (ICNARC) (Case mix)
This audit has three streams focussed on improving the quality of care in Intensive Care Units, Neurology, General Adult and Cardiothoracic in Intensive Care. The Trust has submitted 100% of the data for these streams; collection is underway for Q4 and closes in May 2019. The annual report is due to be published later this year.
Serious Hazards of Infection (SHOT)
Issues regarding the wrong blood put into tubes have been highlighted and in response a Trust wide campaign to raise awareness was conducted. The service is proposing a full end to end transfusion tracking system and the business case is being developed.

*Based on information available at the time of publication

Local clinical audits

The reports of 10 local clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided.

Controlled Drugs Audit
This audit relates to security, storage and record keeping of controlled drugs (CD). A new standard operating procedure (SOP) has been published to support staff when reviewing incidents involving CD discrepancies. All liquid CDs must now be fitted with an ENFit® compatible bottle adapter, to minimise discrepancies due to repeated small volumes lost when measuring out doses.
Venous Thromboembolism (VTE) Audit
This audit looks at four areas; whether a VTE Risk Assessment was completed and filled in correctly upon patient admission; whether VTE risk assessments were done every 24 hours; whether appropriate prophylaxis was provided. Improvement actions: The Thrombosis Group to continue to provide education and training to promote awareness of weight based dosing. The Trust has rolled out its electronic patient management system (iClip) throughout all wards; once established this will improve data collection.
Local Safety Standards for Invasive Procedures (LocSSIPs) Audit
This audit project looks at reviewing the Trusts use of LocSSIPs for all invasive procedures, and looks at how these are applied in both the theatre setting and outside of a theatre setting. Improvement actions: The audit tool is being reviewed to ensure it is suitable for the wide range of procedures being audited.
Early Warning Score (EWS)
This audit measures the response for patients identified as being at risk of clinical deterioration. This links to our quality priority 'recognising and responding to the deteriorating patient'. Improvement actions: Better performing wards providing mentorship to other wards. Quality improvement projects being undertaken with some teams, in order to analyse reasons why observations are poorly recorded or reported.
Patient-Led Assessments of the Care Environment (PLACE)
PLACE assessments are an annual appraisal of the non-clinical aspects of healthcare settings; they are carried out by teams made up of staff and members of the public. The main actions that were highlighted are: Following reports of potential gaps in accessibility for patients, funding has been provided by the St George's charity to audit the Trust on the disability access. This audit will be completed by the not for profit organization, AccessAble. Reviewing standards of cleaning, after an increased number of failures against cleaning in particular areas. Introduction of 24 hour access to catering services for visitors and carers. Looking at the possibility of providing a lockable storage solution for all patients.
Mental Capacity Act (MCA)
The annual report for MCA and Deprivation of Liberty Safeguards (DoLS) was reviewed in July 2018, improvement actions include: Staff across disciplines being invited to participate in the audits to provide education and information to team members who can then lead in supporting others to deliver best practice in relation to the MCA. Monthly Deep Dive Audits in different clinical areas Joint work with the Corporate Nursing Quality Team underway to analyse and interpret questions from the monthly observatory audit that relate to the use of restrictions and restraint. Further staff knowledge audits are planned on a rolling basis through the year.
Human Tissue Act (HTA)
This report was covered both the Human Application License Audit for Stem Cell Donor Consent & Work Up, along with the Human Application License Audit in Theatres. Knowledge based audits that are being conducted locally and reviewed throughout the year.
Cervical Screening
This annual report was reviewed in November 2018, and reported the following actions: Regular meetings are taking place with the sector Cervical Screening Provider Lead (CSPL's). The colposcopy unit is appointing a clinical nurse specialist to support the anticipated increase in colposcopy envisaged with the introduction of HPV Primary Screening. Working to improve the service provided for women attending their Cervical Screening, and onward referral to Colposcopy if required. Local Cervical Screening updates and training for sample takers is being provided by SWL Pathology
Falls Prevention
This work builds on the National Inpatient Falls Audit, and is overseen by a dedicated Falls Prevention Coordinator, based on this local project a number of actions have been highlighted: Falls champions for each ward are in place, they review incidents to highlight patterns, trends and themes and share results with other wards. Falls working group with multi-disciplinary team involvement has been established to review audit results and agree a quality improvement plan Joint partnership working with Tissue Viability Nurses, to share and develop similar approaches and learning as part of the wider patient safety perspective.
Safeguarding
The annual safeguarding report agreed that a service development plan would be produced and implemented: Reviewing the Trust's Safeguarding Children's training and capacity. Closer integration of Domestic Violence into both Children and Adults safeguarding work at the Trust. Reviewing internal governance, including a review of the Safeguarding Children Committee. Working closely with Clinical Commissioning Group colleagues and other partners to improve outcomes.

Our participation in clinical research

At St George's we are committed to innovating and improving the healthcare we offer. A key way to achieve this is by participating in clinical research. Our clinical staff are fully engaged with the latest treatment developments and through clinical trials patients can be offered access to new treatment interventions, leading to better clinical outcomes for patients.

St George's, in its partnership with St George's University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams are collaborating with scientists to investigate the causes of a range of diseases, to develop better ways of diagnosis and tailored treatments.

In the 2018 Research Excellence Framework, 100% of the research outputs submitted by St Georges and the University of London were judged to be of international standard in terms of originality, significance and rigour. The strongest aspects of clinical medical research were cardiovascular research and cell biology/functional genetics. The strong partnership between St George's and its partner University underpins this excellence. A key way to offer new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR), which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. In 2018/19 St George's recruited 13,082 patients onto the NIHR portfolio adopted studies.

Our Commissioning for Quality and Innovation (CQUIN) performance

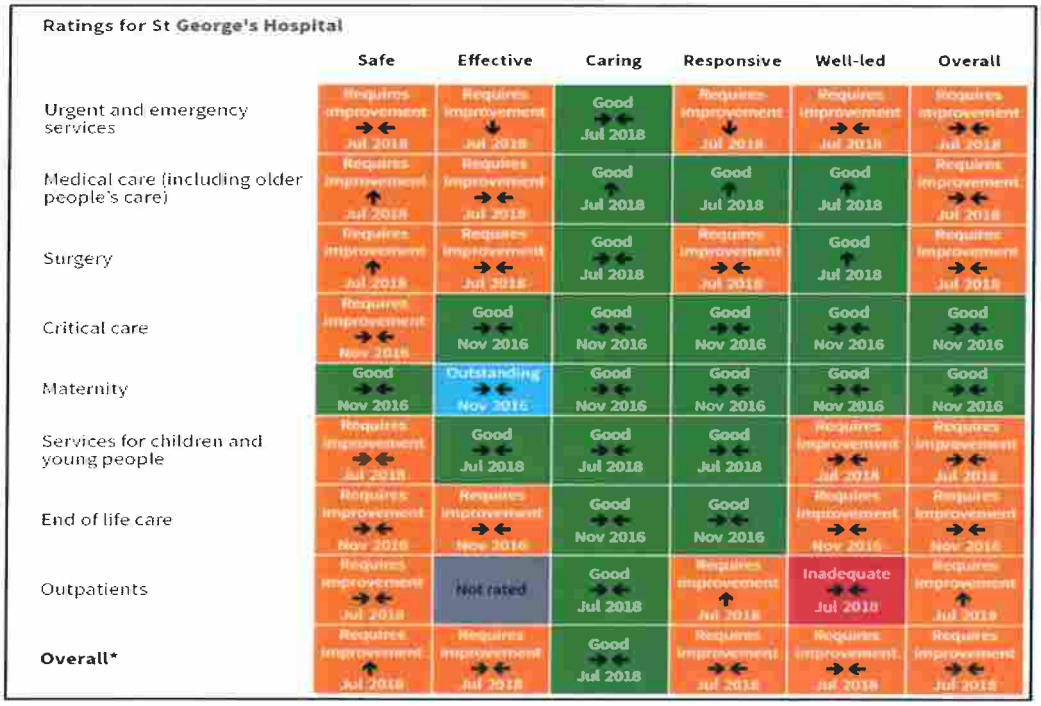
A proportion of St George's University Hospitals NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between St George's and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2018/19 £15.5 million of our income is conditional on achieving quality improvement and innovation goals. In 2017/18 the income achieved for achieving quality improvement and innovation goals was £13.5 million.

Our registration with the Care Quality Commission

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".

A group of core services were inspected by the CQC in March 2018; the report was published in July 2018 and our rating improved from Inadequate to Requires Improvement. There were services that were rated as 'good' and in the caring domain we were pleased to receive a rating of 'good', in some areas services were assessed as outstanding. The table below shows the core services detail behind our overall rating.



During 2018/19, the Trust took proactive steps to deliver improvements within our cardiac surgery service. At the start of the year, we commissioned Professor Mike Bewick, former deputy medical director of NHS England, to carry out an independent review of cardiac surgery at the Trust following concerns we had about team-working, and mortality rates that were higher than expected when compared with the national average.

We accepted Professor Bewick's recommendations in full, and have introduced a series of improvements within the service as a result – including moving to a consultant of the week model (which is considered best practice). We also appointed two new consultants, and all new cardiac surgery cases are now reviewed by a multi-disciplinary team on a daily basis.

In December 2018, we appointed Mr Steve Livesey, an experienced cardiac surgeon previously based in Southampton, to provide clinical leadership within the service. In addition, we arranged for the most complex cardiac surgery operations to be temporarily transferred to other cardiac surgery centres – and trainees to be removed from the service in the medium-term – to enable us to deliver the required improvements.

The Trust continues to provide a safe cardiac surgery service, and this was confirmed by the Care Quality Commission (CQC) following an inspection of the service in August 2018. They also confirmed that further improvements are needed, and our plan to deliver the required changes within the service are being overseen by an independent scrutiny panel set up by NHS Improvement in September 2018.

A separate panel of independent experts is also reviewing all patient deaths following cardiac surgery that occurred between April 2013 and September 2018. The panel is examining the safety and quality of care that patients received during this period.

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 are available on the CQC website www.cqc.org.uk.

Our data quality

St George's University Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service 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:

- 98.9% for admitted patient care
- 99.6% for outpatient care; and
- 94.5% for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care; and
- 99.9% for accident and emergency care

*Source – SUS Data quality reports as at 10/04/19

Data Security and Protection toolkit

The Information Governance Toolkit closed at the end of 2017/18 and has been replaced by the Data Security and Protection Toolkit which sets out the standards for management of information in the NHS. The Trust is compliant with all the mandatory requirements of the NHS DSPT.

Payment by Results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19.

Improving data quality

In January 2016, St George's University Hospitals NHS Foundation Trust became concerned about the quality and robustness of data being reported; particularly the management of referral to treatment (RTT) waiting lists. The Trust has taken, and will be taking, the following actions to improve data quality.

An external review of RTT data and patient tracking systems identified serious issues relating to Trust operational processes and technology. These issues created significant risks to the quality of care and patient safety as well as flaws with reporting at St George's Hospital. A subsequent review carried out in April 2017 identified similar problems at Queen Mary's Hospital in Roehampton. As a result the Trust suspended national reporting of RTT data in June 2016 and made a decision not to recommence reporting until confidence could be assured on the accuracy and quality of data available.

In September 2017 the appointed Chief Operating Officer took over the management of the dedicated waiting list improvement programme, the Elective Care Recovery Programme. Following the formation of the programme a systemic and detailed audit of the waiting lists for patients at the St George's site was undertaken. This resulted in an increase in the number of patients reported to be waiting over 18 weeks on an open pathway (yet to have received treatment). There was also an increase in the number of patients who had reportedly waited over 52 weeks. To ensure that no patients came to harm as a result of waiting longer on the waiting list a Clinical Harm Review panel was established to review any patients identified by the validation exercise that may have suffered some harm.

In early 2018 the Trust introduced a new Patient Tracking List (PTL) for patients waiting for elective care at St George's. The new single system improved the speed at which patients received treatment, effectively manage waiting times and ensure that the Trust was capturing information accurately and consistently.

Clinical teams have since focused on treating those patients who have waited the longest; they have also improved administrative processes, and increased capacity through additional evening and weekend clinics and operating lists.

In March 2018 the Trust introduced a new Patient Tracking List (PTL) for patients waiting for elective care at Queen Mary's Hospital. Plans are being created to migrate Queen Mary's Hospital data onto the same Patient Administration System (PAS) as used at St George's. This will ensure consistency of pathway management and create seamless management of patients across both hospital sites. Migration is currently planned for autumn 2019 subject to Trust Board approval.

In December 2018 the Trust underwent an external assessment of its data quality and operational processes. This assessment was jointly commissioned by the Trust and Merton and Wandsworth CCG. The aim of the

assessment was to provide assurance of the accuracy of Trust data and operational readiness to return to national reporting on RTT performance. There were three conditions outlined in the report which needed to be met, these were resolved and as a result the recommendation from the external assessment was for the Trust to return to national reporting from February 2019 using January 2019 performance data.

The full external report on our data quality was taken through our governance framework. In January 2019 the Trust Board had sufficient assurance on data quality to make the decision to return to national reporting of our referral to treatment times.

A separate assessment will be carried out before data from Queen Mary's Hospital is moved to the patient administration system used at St George's Hospital. This will ensure that data quality on the St George's Hospital system will not be adversely affected.

Learning from deaths

During 2018/19 1,550 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:

Table 1

Number of deaths 2018/19	Q1	Q2	Q3	Q4
	366	342	395	447

By 31 March 2019 1346 case record reviews have been carried out in relation to 87% of the deaths in table 1. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Table 2

Case record review or investigation	Q1	Q2	Q3	Q4
	300	284	343	419

Ten representing 0.7% 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:

Table 3

Problems in healthcare	Q1	Q2	Q3	Q4
Number	2	3	3	2
% of all deaths	0.67%	1.06%	0.87%	0.48%

These numbers have been estimated using our locally developed online screening tool and structured review, which is based on the Royal College of Physicians (RCP) tool. We have a dedicated independent team supporting the bereavement office, and we ensure that we review deaths in a timely way. All patients where a care issue may have contributed to death are escalated to the risk team on the same day and included in our serious incident decision meeting (SIDM) discussions. Any death where review suggests it may have been avoidable is escalated to the risk team to consider possible investigation and rapid response through our serious incident process and the duty of candour is carried out. Any significant problem of care, whether or not it affected outcome, is brought to the attention of the clinical team for discussion and learning at the local morbidity and mortality meeting.

There were no (0) case record reviews and no (0) investigations completed after 30 April 2018 which related to deaths which took place before the start of the reporting period. All case record reviews and investigations for deaths in 2017/18 are included in the report for the 2017/18 reporting period.

What we have learnt and action taken

Management of deterioration and establishing ceilings of care

Although a large number of patients have good and early discussions about resuscitation, reviews continue to identify patients where such discussions should have occurred, but did not, or could have occurred earlier. Issues that have been highlighted to care groups include the appropriateness of transfer between hospitals and

the need for consultant level discussion; frequency of consultant review; multi-disciplinary team (MDT) discussion and decision making between teams; ceilings of care and appropriateness of do not attempt cardiopulmonary resuscitation (DNACPR) decisions.

Cases have been referred to the deteriorating adults group for investigation when they have occurred following a cardiac arrest outside of an intensive care area. For the majority of these cases there was no clear end of life plan. This indicates that we need to improve our discussions with patients and families about establishing ceilings of care. In 2018/19 we launched the Treatment Escalation Plan; this documents these discussions and the agreed plan of care for an individual patient.

Medical Examiner

From April 2019, a national system of medical examiners will be introduced to provide much-needed support for bereaved families and to improve patient safety. The expectation of the National Medical Examiner (ME) is that from April 2019 NHS Trusts will be designing and implementing local systems and that by the end of March 2020 all deaths in secondary care will be subject to scrutiny by a local ME.

In January 2019 the Trust approved a business case to introduce an ME office and the implementation plan is progressing under the guidance of the Chief Medical Officer and Chief Nurse. The ME office will build on established good practice in bereavement and independent mortality review and we are confident that the Trust will meet the National Medical Examiner's requirements by the end of 2019/20.

Guardian of safe working

We have a Guardian of Safe Working who ensures our doctors are always working a safe number of hours. The Guardian acts as the champion of safe working hours and receives reports and monitor's 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. Gaps in the rota for medical staff are monitored and managed at service level. Information on unfilled shifts is not available at Trust level, but is monitored by individual services.

During 2018/19 a business case has been developed and approved to extend our health roster system to medical staff. The project team has been established and roll out began at the end of Q4 2018/19. Twenty services will go live before August 2019.

Standards for Seven day Services

The Trust is compliant with standards 5, 6 and 8 for seven day services and has improved compliance with standard 2 (all emergency admissions must be seen by a consultant within 14 hours of admission) from 70% to 82% in the past two years. To be fully compliant with standard 2 would require a significant increase in staffing resources in certain specialities and therefore opportunities for pathway redesign and alternative ways of delivering a consultant review within 14 hours are being explored.

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.

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 100, a score below 100 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.

Summarised hospital level mortality indicator (SHMI)	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sept 16	Jan 16 - Dec 16	Apr 16 - Mar 17	July 16 - June 17	Oct 16 - Sep 17	Oct 17 - Sep 18

SHMI	89.5	88.2	86.5	84.4	83.6	83.8	82.5	83.9
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
% Deaths with palliative care coding	39.1%	42.8%	48.9%	51.3%	51.1%	52.4%	50.9%	50.6%

Source: NHS Digital

St George's 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.

We have taken the following actions to improve our SHMI and so the quality of our services:

We have fully implemented the Learning from Deaths Framework and have been recognised as an exemplar Trust. We will continue to strengthen our mortality monitoring process and review of all deaths to ensure we identify every opportunity to learn, and in sharing learning to improve the care our patients receive.

Patient reported outcome measures

Patient reported outcome measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of two clinical procedures, which are hip replacement or knee replacement (the varicose vein and groin hernia PROMs programmes were discontinued in October 2017).

We believe our data is as shown for the following reasons:

Patients who have had these procedures are asked to complete a short questionnaire which measures a patient's health status or health related quality of life at a moment in time. The questionnaire is completed before, and then some months after surgery, and the difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient.

Percentage of patients reporting an increase in health following surgery		2013-14		2014-15		2015-16		2016-17		2017-18	
		SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average
Hip replacement	EQ-5D™	86	87.9	90	88.2	100	88.4	77	89.1	71	90
	EQ-VAS	65	64.2	80	65.1	58	65.6	75	67.2	43	68.3
	Specific	81	96	100	96.4	94	96.5	71	96.7	75	97.2
Knee replacement	EQ-5D™	60	80.3	60	80.5	69	80.7	100	81.1	0	82.6
	EQ-VAS	50	54.6	50	55.3	33	56.4	40	57.5	33	59.7
	Specific	80	93	82	93.2	85	93.6	100	93.8	33	94.6

For both procedures the EQ-5D™ and EQ-VAS scores give the patients view of their general health improvement, the specific score comes from questions about improvement related to the hip or the knee replacement, higher scores are better. It should be noted that at St George's we perform only a small number of complex cases of knee and hip replacements, with the majority of routine cases being referred to the South West London Elective Orthopaedic Centre for treatment and we consider it likely that this explains our variance from the national average score. For example where we have scored 0 in 2017/18 we know that this concerns two patients, one patient felt there had been no change and the other patient declined to participate.

Readmission within 28 days of discharge

The most recent information available from NHS Digital is for 2014-15. Using our own data we are able to access full year information for 2018-19.

Readmissions	2016-17			2017-18			2018-19		
	Under 16	16 and over	Total	Under 16	16 and over	Total	Under 16	16 and over	Total
Discharges	14102	46946	61048	14201	47572	61773	13975	48206	62181
28 day readmissions	659	4236	4895	651	4428	5079	751	4006	4757
28 day readmissions rate	4.67%	9.02%	8.02%	4.58%	9.31%	8.22%	5.37%	8.31%	7.65%

We consider our data is as shown for the following reasons: Monitoring emergency re-admission rates help the Trust to prevent or reduce unplanned re- admission into the hospital. An emergency re-admission occurs when a patient has an unplanned re-admission to hospital with 30 days of a previous discharge.

St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by committing to reducing re-admission for all patients irrespective of whether that care is planned or unplanned. We will work to improve our current overall re-admission rate 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.

Patient experience

Our score for the five questions in the national inpatient survey relating to responsiveness and personal care are consistent with the national average as shown below. The data compared to average, highest and lowest performers and our own previous performance is shown below.

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

We consider that the data is as shown as it is validated through the Trust's informatics and reporting processes. St George's University Hospitals NHS Foundation Trust intends to take the following actions to maintain and improve this percentage, and so the quality of its services, by continuous and on-going engagement with patients, family, friends and carers.

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 shows that we are in a band with the majority of Trusts for staff recommendation of the Trust as a place to receive care, we achieved an average score.

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

St George's University Hospitals NHS Foundation Trust intends to improve this percentage, and so the quality of its services, by focusing on staff engagement and quality improvement, listening to staff and addressing their concerns.

Patient recommendations to friends and family

Friends and Family Test	2016-17		2017-18		2018-19*	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	23.10%	30.76%	20.19%	25.50%	26.20%	26.40%
% would recommended	83.80%	95.81%	84.26%	96.24%	87.00%	97.00%
% would not recommend	10.51%	1.29%	10.39%	1.08%	8.50%	1.00%
* 2018-19 data to Feb 19						

Infection control

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

We consider that the data is as described for the following reasons, the Trust has a process in place for collating data on C.difficile cases. The data is collated internally and submitted to Public Health England.

Cdifficile	2014-15	2015-16	2016-17	2017-18	2018-19
St George's University Hospitals					
Trust apportioned cases	38	29	36	16	31
Trust bed-days	254,213	273,493	287,962	296,981	282,339
Rate per 100,000 bed days	14.9	10.6	12.5	5.4	11.0
National average*	33.7	33.7	30.2	31.2	
Worst performing trust*	121	139	116	113	
Best performing trust*	0	0	0	0	
trust apportioned cases					

St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services.

We are taking urgent action to address significant challenges with our estate which impact on infection control. This includes water safety, and the risk of legionella bacteria growing in our water supply. We are taking action to maintain water safety, including regular testing and monitoring of the water supply. We have installed special filters to taps in a number of areas. During 2019/20, we will be investing a further £3.5m, which will enable us to create additional water supplies to the site.

Patient safety incidents

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: this data is validated through the Trust's informatics and reporting processes.

Patient Safety Incidents	Oct 14 - Mar 15	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sept 17	Oct 16- Mar 17	Apr 17- Sep 18
St George's University Hospitals						
Total reported incidents	5,188	5,353	5,453	5,964	5,928	5,548
Rate per 1000 bed days	34.1	33.2	32.8	36.5	37.6	34.2
National average (acute non-specialist)	37.1	39.3	39.6	40.8	41.1	42.8
Highest reporting rate	82.2	74.7	75.9	71.8	69	111.7
Lowest reporting rate	3.6	18.1	14.8	21.1	23.1	23.5

Patient Safety Incidents	**Oct 14 - Mar 15**	**Apr 15 - Sep 15**	**Oct 15 - Mar 16**	**Apr 16 - Sept 17**	**Oct 16- Mar 17**	**Apr 17 - Sep 18**
St George's University Hospitals						

Incidents causing Severe Harm or death	16	23	20	15	13	14
% incidents causing Severe Harm or death	0.31%	0.43%	0.37%	0.25%	0.22%	0.25%
National average (acute non-specialist)	0.50%	0.43%	0.79	0.38%	0.37%	0.35%
Highest reporting rate	5.10%	1.96%	1.33%	1.38%	1.09%	1.23%
Lowest reporting rate	0.05%	0.09%	0%	0.02%	0.03%	0.02%

St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this number and rate, and so the quality of its services, by introducing a number of learning initiatives and continuing to work towards enhancing existing mechanisms throughout 2018/19. These include: risk management input into training programmes, increased frequency of root cause analysis (RCA) training, increased involvement from medical staff in following up incidents, a monthly governance newsletter and a quarterly analysis report and thematic learning.

Venous thromboembolism

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: this data is validated through the Trust's informatics and reporting processes.

VTE Assessments	2014-15	2015-16	2016-17	2017-18	2018-19
St George's University Hospitals	95.89%	96.77%	96.64%	95.90%	95.50%
National Average	96.10%	95.76%	95.61%	95.80%	
Best performing Trust*	100%	100%	100%	100%	
Worst performing Trust*	79%	78.1%	63%	72%	

St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by maintaining our high risk assessment rate (this is currently higher than the national average).

Progress against priorities for 2018-19

The progress we have made in delivering our quality priorities for last year is set out in the following tables. 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.

Patient Safety		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
We will reduce the impact of serious infections	Achievement of the 2018-19 CQUIN goals for the identification and treatment of sepsis	**We achieved this** We will continue to monitor our performance with the management of serious infections through the patient safety priorities for 2019/20 concerning identification of the deteriorating patient and the consistent use of treatment escalation plans.
We will reduce patient falls resulting in significant harm	Achieve a 30% reduction in falls that cause significant harm against the number of these falls in 2017/18	**We achieved this** Significant progress has been made in the training and education of staff. Falls champions are in place on wards and the falls prevention coordinator provides intensive support to wards based on their risk of falls. In 2019/20 performance in preventing falls will be monitored through our governance framework as part of ensuring we achieve high quality standards for getting the basics right.
We will reduce acquired	Achieve a 20% reduction in	**We have not achieved this reduction**

category 3 pressure ulcers	the total number of category 3 pressure ulcers against the number for 2017/18.	The process for reporting of pressure ulcers has been strengthened during 2018/19 improving our assurance that all category 2 and above pressure ulcers are reported and investigated, identifying root causes and improving practice. In 2019/20 the prevention of pressure ulcers will be monitored through our governance framework as part of ensuring we achieve high quality standards for getting the basics right.
Patient experience		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
We will provide a responsive, high quality complaints service	We will achieve a reduction in the number of complaints where local resolution is not achieved with the first response to 4 or fewer in a month. We will achieve compliance with the response target for each complaint.	**We did not achieve this** At the time of report this measure has been achieved in only one month to date with a year to date average of 7.5%. **We did not achieve this** Action being taken to improve responsiveness includes the restructure of the central complaints team which is underway. The post of Head of Patient Experience and Partnership is in the recruitment process. This priority is taken forward into 2019/20
We will build a patient partnership structure to enable patients to be involved in improvement work from the earliest stage.	We will establish a patient partnership forum and demonstrate involvement of patients in service development, improvement and change projects.	**We achieved this** Twelve patient partners have been recruited to the Patient Experience and Partnership Group which meets monthly and we have established service level patient user groups in dermatology, urology and at Queen Mary's Hospital.
We will improve immediate feedback from patients through the FFT by increasing response rates for both inpatient and outpatient services.	We will achieve a response rate of 20% to our outpatient family and friends test.	**We did not achieve this** Improvements that are expected to enable us to achieve this target have been put in place in Q4; these include the FFT being made available on our public website and in recent weeks the launch of FFT by text message. This priority is taken forward into 2019/20 to ensure that the action taken achieves this target and that the learning is extended to other areas where response rates to the FFT need to improve.
Clinical effectiveness		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
We will improve services for people with mental health needs who present to the Emergency Department.	We will achieve the 2018-19 national CQUIN goals for services to patients with mental health needs in the emergency department.	**We achieved this** We have met our CQUIN goal and achieved our objective for 2018/19. This has been achieved in part through a project together with SW London MH NHS Trust to improve physical and mental health care for those in crisis.
We will improve the effectiveness of our discharge process.	We will achieve an improvement against questions concerning discharge in the 2019 National Patient Survey.	**We will not know if we have achieved this at the time of this report.** Work with Healthwatch tells us that discharge continues to be an area where our patients and our local community want to see us improve. This priority is being carried forward into 2019/20.

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 we are required to report on most of them every three months.

Our performance against these indicators can be seen in the table below.

Key performance indicators

		Target	Annual performance
Referral to treatment times	Non reporting from April 18 – December 18		Not available
ED access	95% of patient wait less than 4 hours	>=95%	88.4%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	>=85%	86.9%
	% patients treated within 62 days from screening referral	>=90%	86%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	99%	99%

Statements

Statement of Directors' responsibilities in respect of 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 2018/19 and supporting guidance - Detailed requirements for quality reports 2018/19.

The content of the Quality Report is not inconsistent with internal and external sources of information including:

- board minutes and papers for the period April 2018 to 23 May 2019
- papers relating to quality reported to the board over the period April 2018 to 23 May 2019
- feedback from commissioners dated 16 May 2019
- feedback from local Healthwatch organisations dated 14 May 2019
- feedback from Wandsworth overview and scrutiny committee dated 14 May 2019
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2018
- the latest national patient survey (embargoed until July 2019)
- the latest national staff survey dated March 2019
- the Care Quality Commission inspection reports dated 19 July 2018 and 18 December 2018; and
- the Head of Internal Audit's annual opinion of the Trust's control environment dated April 2019
- The Quality Report presents a balanced picture of the Trust's performance over the period covered 2018/19.

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

23 May 2019

Jacqueline Totterdell

Chief Executive

23 May 2019

Statement from Wandsworth Clinical Commissioning Group

Wandsworth Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from St George's University Hospitals NHS Foundation Trust (SGUH) on behalf of the population of Wandsworth and surrounding boroughs.

Wandsworth CCG has worked in close partnership with SGUH during 2018/19 to ensure that we receive a high level of assurance in relation to these commissioned services, obtained mainly through the monthly Clinical Quality Review Group (CQRG) meetings. The CQRG meetings bring together stakeholders, including GPs, senior clinicians and managers from both SGUH and Wandsworth CCG, Commissioners from local CCGs, NHS England and NHS Improvement. Assurance is also gained through undertaking quality assurance visits in SGUH, which we have undertaken jointly with NHS Improvement colleagues.

SGUH has been proactive in addressing quality issues identified through the CCG's well-established GP Quality Alert system (Make a Difference). This is a system which allows General Practitioners and other healthcare professionals to raise quality issues relating to a provider to the CCG. The provider is then required to address the issues and respond to the alert. SGUH have successfully addressed a number of quality issues identified through this system, and the CCG is pleased to note that some of these issues, including improving the effectiveness of the discharge process, have been included in the priorities for 2019/20. It is important that SGUH investigates and responds to the alerts thoroughly and that responses should involve senior members of the relevant clinical team to ensure that a quality improvement approach is facilitated and learning leads to embedded changes.

The CCG also acknowledges the significant progress made by the Trust in delivering on the CQC action plan that has been in place since the CQC inspection report was published in July 2018. The CQRG has monitored the actions closely and reported progress to the CQC throughout 2018/19. We have received assurance on the actions delivered. We will continue to monitor the outstanding actions which have now been incorporated within the Trust Quality Improvement plan.

The CCG welcomes the opportunity to provide a statement for SGUH's Quality Account for 2018/19. We confirm that we have reviewed the information contained within the draft Quality Account and acknowledge the work that has been put into delivering most of the quality priorities for 2018/19.

The CCG agrees with the Trust's assessment of the delivery of the 2018/19 priorities. We are disappointed to note that the target for time taken to respond to complaints, was not met for 2018/19. However, we are pleased to note that this has been rolled over to 2019/20, and hope that the work already undertaken in this area will support the Trust in achieving compliance in 2019/20.

The CCG welcomes the continued focus on patient safety, clinical effectiveness and patient experience. We have taken particular account of the identified quality priorities for 2019/20, including the rationale for identifying those. We are pleased to note that these priorities are in line with those agreed at the CQRG and acknowledge that other areas of work have also been identified for action at CQRG and although these do not appear in the quality report, they are nevertheless, of significance and require attention. We are pleased to note the Trust aspiration to set up a critical care outreach team to support the management of the deteriorating patient. We would urge SGUH to consider broadening the priority in relation to the deteriorating patient to include recognising and reporting/escalation of the deteriorating patient. This will ensure that the appropriate response is provided in a timely manner in order to avoid complications, as this has been a theme that has been identified from the CCG review of serious incidents from the Trust.

In addition, we would like to have seen an emphasis on quality improvement systems and processes across the organisation. There must be learning from the external review of deaths within the Cardiac Surgery Service, which can be applied across other departments and disciplines and work on this should get underway in 2019/20

The CCG would also support a greater focus on staff health and wellbeing, including staff engagement, as part of the priorities for 2019/20. This will build on the work already started by the Trust, to improve staff engagement based on the publication of the NHS 2018 staff survey results.

Overall comments

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

The CCG acknowledges the improvements made in 2018/19 and commends the Trust on the production of a quality report that sets out the key priorities for 2019/20. We are in agreement with the priorities, as specified in the report and would like to see the following areas also reflected:

- Recognising and **responding to** the deteriorating patient
- Staff health and wellbeing and staff engagement

Finally, commissioners would welcome the opportunity to review the Trust Quality Account earlier in the development stages in future years, in order to allow time to consult more widely with commissioning colleagues and neighbouring CCGs.

We will continue to work closely with the Trust and look forward to supporting it to deliver the priorities identified in the quality report for 2019/20.

Dr Nicola Jones MBE

MBChB DRCOG MRCGP MBA

Chair, Wandsworth Clinical Commissioning Group

14/05/2018

Statement from Healthwatch Wandsworth

Thank you for the opportunity to view and provide comments on this year's quality account. We have appreciated the opportunity to have been kept informed and involved in the monitoring of quality improvement throughout the year at the monthly Quality and Safety Committee. This year we have also been able to attend and take part in the newly formed Patient Partnership Engagement Group and continue to take part in other areas of governance with a Healthwatch appointed Governor.

In December 2018 we took the opportunity to ask attendees at our regular public meeting what they thought the priorities for quality at St. George's Hospital should be. Elizabeth Palmer, Director of Quality Governance, presented an introduction and asked the attendees for feedback. The following themes were suggested:

- Administration and communication improvements are needed because these services are affecting improvements in other issues.

- Patient advice and information should be clear, timely and include information to help people manage their condition and prevent further health problems. Discharge was mentioned as especially important.

- The hospital could improve how it works with other parts of the system as well as with patients and carers.

- To continue work to reduce sepsis, falls, and pressure ulcers.

We have been able to discuss these comments further with Elizabeth Palmer and staff focused on improvements across the hospital. Our comments on the specific detail in this year's quality account follows below.

Mental Capacity Act

One of the key aims for the next year is to identify and record proper protection and care for patients with mental health needs. We would suggest consideration as to whether audit alone would be sufficient as a tool to ensure compliance or whether something similar to a peer review process, involving staff might help give them more confidence in decision making and embedding practices. It could also be considered whether patients or a representative could be involved in this process.

It is important that family and carers fully understand the process and decisions made about mental capacity as well as what it means for them. We think it is important that there is assurance that patient information and communication is as helpful to the process and future management of health and wellbeing as possible.

Improving patient experience

The aim stated is to provide a responsive, high quality complaints service, and the Quality Account outlines performance targets for responding to complaints. It is an important topic and it is disappointing to see slow progress against target. We welcome the steps that the Trust are taking to make progress by September, but information about the steps being taken could be made clearer to tell people how you will achieve improvements. We also think it would be useful to review the complaints process and communication from the patient's perspective in the process. Last year we spoke to people about how they would like to be communicated with during a complaints process (this was not a discussion about St. George's Hospital in particular). The full report is available on our website, but in summary people has told us that they would like clear information about raising a complaint and about what might happen, as well as reassurance that they will be listened to and that their feedback will be useful to prevent problems happening again.

Many people also wanted to know that they can share feedback without making a complaint or that they could de-escalate a complaint at any stage. The National Inpatient survey and the National Patient Cancer survey performance showed that patients at St. George's Hospital reported having insufficient opportunity to discuss their worries and concerns with staff. If this situation were improved, we suggest that it might reduce the number of concerns that escalate into formal complaints.

A patient partnership structure to enable patients to be involved in improvement work from the earliest stage

The aim stated is to deliver year one of the strategy and develop the strategy for the next three years. We think it is important part of this strategic process to undertake an evaluation with staff and patients about how the Patient Partnership Engagement Group (PPEG) has progressed, including demonstrating how patients have been involved and the outcomes. An important measure of success would be the impact that those on the PPEG felt they had on influencing patient involvement throughout the hospital. We would welcome the opportunity to contribute to the evaluation and the development of the new strategy. We would also like to see mention of how patient involvement can help improve quality in the areas identified in the Quality Account.

Improve the effectiveness of the discharge process ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support.

We are pleased to see that our feedback on behalf of the local people who have spoken to us has been taken into account. We would question whether testing success through patient surveys should be the only indicator of success. It might not capture the knock-on effects if discharge hadn't gone as well as it could have, for example if someone is re-admitted or doesn't get a follow-up appointment. Perhaps outpatient or GP surveys might be useful.

Finally, we had a few comments about areas of quality improvement we could not see mention of in the Quality Account:

- Working with partners to make quality improvements and also assurance and measuring of improvements. We think, for example, there could be some really useful information available from partners about patient experience and areas for improvement.

- Outpatients has not been specifically mentioned as a priority, yet this is something we receive a lot of feedback from patients about. The focus on improving outpatients' efficiency and experience should still be prioritised for improvement.

- Improving support to carers is an important part of improving the quality of patient experience and ongoing care. Previously, a target about carer passports was included in quality governance. It would be useful to continue to focus on carers and support for them. Local carers have, for example, told us that they need more information the health condition of the person they care for and how to manage it. The hospital may be the first point at which a person becomes a carer and is an ideal opportunity to make sure they have the support they need as early as possible.

As a last comment we wanted to congratulate the hospital in achieving the sizable and complex task to re-organise and return to reporting referral to treatment waiting times.

Healthwatch Wandsworth

14 May 2019

Statement from Wandsworth Adult Care and Health Overview Scrutiny Committee

Whilst this statement is submitted on behalf of the Wandsworth Adult Care and Health Overview and Scrutiny Committee, the tight timescale for its submission means that any outstanding year end information that was not included in the original report sent on 24th April, has not been covered here. Also due to the timings allowed for its submission means that it has not been possible to agree it at a Committee meeting and the below comments have been prepared in consultation with its leading members.

We are encouraged by participation in 98% of eligible clinical audits and 100% of eligible National Confidential Enquiries and would be interested in how this compared to previous years.

From the performance against 2018/19 priorities, it was noted that the reduction in category 3 pressure ulcers priority was not achieved. We would like the Trust to confirm with figures whether this was reduced at all and by what percentage.

Following the CQC inspection in March 2018, overall the Trust moved from inadequate to requires improvement and it was noted that all core services of the Trust scored 'good' for the 'caring' domain. It was noted that maternity services were rated good in all areas and outstanding for effectiveness. The result of this inspection increases our confidence that Wandsworth residents using the Trust are receiving quality care in maternity services and that staff attitudes and behaviours are found to be supportive. We would like to agree how we can work together to build on these strengths to maximise the potential for early intervention in line with the ambitions set out in our early help strategy THRIVE Wandsworth and the local Health and Care Plan in line with the wider Prevention Framework.

However we are concerned that the remainder of all core services apart from maternity, 'require improvement' in one or more domains and that the least well performing domain is 'safety' and about the implications of this on Wandsworth residents. We would like to see an expansion of the proposed actions to address the 'inadequate' rating for the 'well led' domain for Outpatient Services, and a detailed action plan for how safety will be improved across all services. As a priority we would like an action plan to respond to all issues relating to Children's Safeguarding to include the actions identified in the quality account as below:

- Reviewing the Trust's Safeguarding Children's training and capacity
- Closer integration of Domestic Violence into both Children and Adults safeguarding work at the Trust
- Reviewing internal governance, including a review of the Safeguarding Children Committee, to ensure that the Committee's work is as effective as possible.
- Approaching CCG colleagues to ensure that working relationships and reporting structures are as productive and strategic as they can be
- Focus partnership working activity, within the available capacity of the team, which has a clear focus on improving outcomes

The Team participate in a variety of London wide discussions with Safeguarding Children's colleagues in provider Trusts and seeking to capture best practice regionally will be a theme of the year ahead and for progress to be reported to the Children's Safeguarding Board.

Domestic violence is highlighted in the quality account and this is a very significant issue for families, along with neglect and abuse this is a primary reason for social care involvement. We ask that specific actions are included to ensure close working at both a strategic and operational level between services in relation to these areas.

There are some key areas of improvement that are not specifically identified and in this context we would like to see more explicit references to meeting the needs of vulnerable adolescents particularly in speedy delivery of the improvements necessary in SANDPIT to ensure that statutory duties in respect of Looked After Children (timely and robust Initial Health Assessments and Health Reviews etc) are full discharged and a clear commitment to responding to the CCG's performance management in relation to children coming into care.

We would like specific commitments from the Trust to support our preventative agenda in relation to knife crime, gangs, CSE, missing and the use of drugs and alcohol.

We would like more explicit actions in relation to delivering the requirements in relation to children and young people with SEND (special education needs and/or disabilities) and the contribution that the

Trust will make to improving outcomes for these children. We are very concerned about and wish to seek clarity on, the intended withdrawal of Paediatric delivery in the Community. We believe this will disrupt St George's relationship with Special Schools in Wandsworth which has been built up over many years and impact negatively on children and families.

We are interested in the developments that took place in 2018/19 around cardiac surgery, following the issues previously reported, in particular to the new clinical leadership appointment, additional consultant surgeons and move to multidisciplinary case reviews to improve the outcomes for cardiac patients. We look forward to seeing how these actions are implemented and the outcomes from them. We would welcome information on how patients and their carers and relatives have been involved in these developments.

The inclusion of 24-hour access to catering services for visitors and carers and the audit of accessibility for people with disabilities, following the Patient-Led Assessments of the Care Environment (PLACE), is welcomed. We would like the Trust to confirm that the catering will comply with the NHS Hospital Food Standards recommended by the Department of Health and Social Care.

We welcome the new developments following national audit of dementia 2017-18 for the Trust to become more dementia-friendly, with delirium screening offered for all patients over 65 and a delirium pathway. We are interested to know what other actions are being taken around the dementia-friendly environment such as cubicles in relevant out-patients departments, A&E and waiting areas and staff training provision, including non-clinical staff e.g. receptionists, customer services in all retail outlets and cleaners. We would also like to see full detailed plans for managing in-patients who have dementia. Further information on how dementia patients, their carers and relatives have or will be involved in these developments would be welcomed.

We are encouraged by planned developments for the fracture clinic, with improved staffing levels, re-establishing longitudinal follow-up of patients to check compliance and more timely data uploads. Information on how fracture patients, their carers and relatives have been or will be involved in these developments is welcomed.

We are encouraged by the improvements in data quality following investigations in 2016 and this provides assurance of the services being delivered to Wandsworth residents.

We are also encouraged by the improved compliance with Standards for Seven Day Services, in particular for Standard 2 (all emergency admissions must be seen by a consultant within 14 hours of admission) from 70% to 82%. We would like the Trust to confirm how the risks of not being fully compliant with Standard 2 will be met in more detail, including staffing increases.

We have noted that Patient Experience scores have remained more or less consistent since 2011/12, which has ranged from 66% in 2018/19 to 68.8% in 2013/14 and would like the Trust to confirm what actions are being taken to maintain and improve this percentage for 2019/20.

We would be interested to see more detail about the results and actions of the Staff Survey, including response rate and the views relating to areas in need of improvement, as well as reflections on current improvements, to better understand staff opinions. We are keen to know if the Trust has a Workforce Strategy, which includes the health of staff, as a major London employer and if this strategy involves signing-up to the Healthy Workplace Charter. We recommend the Trust gets involved in the work around the local Health and Care Plan which proposes actions to improve workplace health in line with the wider Prevention Framework.

Smoking cessation is a highly evidenced-based intervention, giving an estimated 10 years of life back to a person after quitting. We understand that the Trust was certified smoke-free in 2018/19, following support from public health and note that there is no mention of this development in the report and would like the Trust to consider including this achievement to reflect their work in this area.

It is noted that there is no mention of mandatory reporting of female genital mutilation (FGM), given the diverse local population of Wandsworth, particularly in the immediate surroundings of the Trust following the audit undertaken in 2016. We ask the Trust to confirm the numbers of patients identified through mandatory reporting is included in this quality account. In addition, we ask how and how often FGM is communicated to staff and the public, how many staff and from which departments have engaged in training. We would also like the Trust to confirm whether palliative care services are involved in identifying women who have undergone FGM and reversing the procedure.

We welcome the new priority identified in the quality account around improving care for people with mental health needs who are in an acute setting. We would suggest this is of particular note for South West London and St George's Mental Health NHS Trust, who provide the Psychiatric Liaison Service for St George's. However, officers from Adult Social Care receive regular referrals to assess people in acute care under the Mental Health Act 1983. The key concern encountered by our Approved Mental Health Act Professionals when carrying out assessments at St George's Hospital, is a lack of appropriate rooms in which to conduct the assessment interviews. We note that Kingston Hospital recently opened a Mental Health Assessment Unit (managed by the acute Trust) that is separate from the A&E department, which would be useful to have at St George's.

It is also noted that there is no mention of people with learning disabilities in this report and we would like the Trust to confirm how the needs of patients of all ages with learning disabilities are being met.

There are also areas that impact on service quality that are not included in the quality account report which would benefit patients. We would welcome an update on what progress is being made to improve and integrate IT systems to facilitate joined up record keeping, and enable patients to book and change appointments online. Another area we highlight as a concern is in respect of the current estates, and would welcome an update on what is the current estates strategy to bring redundant buildings back into use or disposed of, and to upgrade substandard buildings.

We have been receiving update briefings from the Trust on the progress made in respect of its quality improvement plan at our meetings over the past couple of years, as well as updates on any other significant areas of interest, and we would like to thank the Trust for attending the meetings and answering our questions.

Finally, we would like to take this opportunity to thank the Trust for the opportunity to comment on this quality account.

Wandsworth Adult Care and Health Overview and Scrutiny Committee

14 May 2019

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

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

Independent Practitioner's Limited Assurance Report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.
We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to 23 May 2019
- papers relating to quality reported to the Board over the period 1 April 2018 to 23 May 2019
- feedback from commissioners dated 16 May 2019
- feedback from local Healthwatch organisations dated 14 May 2019
- feedback from the Overview and Scrutiny Committee dated 14 May 2019
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 1 September 2018
- the national patient survey embargoed until July;

- the national staff survey dated March 2019
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2019
- the Care Quality Commission's inspection report dated 19 July 2018 and 18 December 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and St George's University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by St George's University Hospitals NHS Foundation Trust.

Our audit work on the financial statements of St George's University Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as St George's University Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to St George's University Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose.

Our audits of St George's University Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than St George's University Hospitals NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
London

23 May 2019

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

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of St George's University Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2019 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 Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Health Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates that the Trust incurred a deficit of £45.4 million during the year ended 31 March 2019 and borrowed £51.9 million from the NHS Independent Trust Financing Facility.

As stated in note 1.2, the Trust has identified that further working capital borrowing of £3 million, and financing to repay existing loans in March 2020 of £48.7 million and £15.1 million, will be required from the Department of Health and Social Care (DHSC) in 2019/20. At the date of our report these discussions have not yet concluded.

The Department has advised the Trust that is expected the Trust will be able to access borrowing to fully finance the repayment of this facility but that this will not be confirmed until later in the 2019/20 financial year.

These events or conditions, along with the other matters as set forth in note 1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Grant Thornton

Overview of our audit approach

Financial statements audit

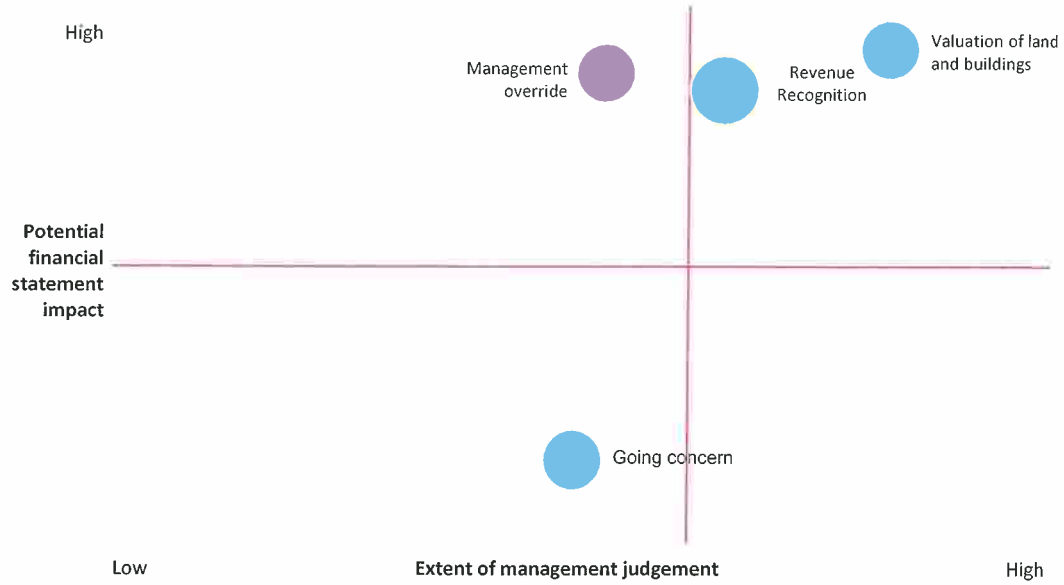
- Overall materiality: £12,950,000, which represents 1.5% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Revenue recognition
  - Valuation of land and buildings
  - Going concern material uncertainty
- We have tested the Trust's material income and expenditure streams and assets and liabilities, covering 100% of the Trust's income, 99% of the Trust's expenditure, 98% of the Trust's assets and 96.5% of the Trust's liabilities

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

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

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the Material Uncertainty Related to Going Concern section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 Revenue recognition Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. In this environment, we considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue. We rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We determined these to be income from: • Block contract income element of patient care revenues We did not deem it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue. We therefore identified the occurrence and accuracy of these income streams of the Trust and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2018/19 • updating our understanding of the Trust's system for accounting for income from patient care and other operating revenue, and evaluating the design of the associated controls • with regards to patient care income, obtaining the exception report from DHSC that details differences in reported income and expenditure; and receivables and payables between NHS bodies; agreeing figures in the exception report to the Trust's financial records; and for differences calculated by the DHSC as being in excess of £300,000, obtaining corroborating evidence to support the amount recorded in the financial statements by the Trust • agreeing, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners • evaluating the Trust's estimates and the judgments made by management on with regard to corroborating evidence in order to arrive at the total income from contract variations recorded in the financial statements. • agreeing, on a sample basis, income and year end receivables from other

Key Audit Matter	How the matter was addressed in the audit
	operating revenue to invoices and cash payment or other supporting evidence The Trust's accounting policy on recognition of income is shown in note 1.4 to the financial statements and related disclosures are included in notes 3 and 4. **Key observations** We obtained sufficient audit assurance to conclude that: • the Trust's accounting policy for recognition of income from patient care activities and other operating revenues complies with the DHSC Group Accounting Manual 2018/19 and has been properly applied; and • income from patient care activities and other operating revenues and the associated receivable balances are not materially misstated.
Risk 2 Valuation of land and buildings The Trust revalues its land and buildings on an annual basis to ensure that the carrying value is not materially different from current value in existing use at the financial statements date. This valuation represents a significant estimate by management in the financial statements. Management have engaged the services of a valuer to estimate the current value in existing use as at 31 March 2019. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. We therefore identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • evaluating management's processes and assumptions for the calculation of the estimate, including the instructions issued to the valuation experts and the scope of their work • evaluating the competence, capabilities and objectivity of the external valuer • evaluating the assumptions made by management for any assets not revalued during the year and how management satisfied themselves that these are not materially different to current value. • challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding • testing, on a sample basis, revaluations made during the year to ensure they had been recorded accurately in the Trust's asset register The Trust's accounting policy on

Key Audit Matter	How the matter was addressed in the audit
	property, plant and equipment, including land and buildings is shown in note 1.7 to the financial statements and related disclosures are included in note 15. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation was appropriate, and the assumptions and processes used by management in determining the estimate were reasonable; • the valuation of land and buildings disclosed in the financial statements is reasonable.

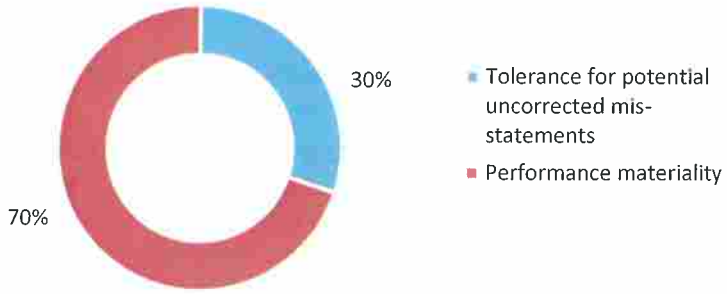
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.
Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£12,950,000 which is 1.5% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	70% of financial statement materiality
Communication of misstatements to the Audit Committee	£250,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

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

Overall materiality – Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and in particular included:

- gaining an understanding of and evaluating the Trust's internal controls environment including its IT systems and controls over key financial systems during an interim audit visit before the year end;
- obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams covering 100% of the Trust's revenues;
- obtaining supporting evidence, on a sample basis, for 99% the Trust's operating expenses and finance costs;
- obtaining supporting evidence, on a sample basis, for property plant and equipment and the Trust's other assets and liabilities

There were no changes in the scope of the current year audit from the prior year.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or

- Audit Committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, 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 2018/19, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.
In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer

has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.
The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.
Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.
A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects St George's University Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for adverse conclusion

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

- NHS Improvement placed the Trust into financial special measures on 22 March 2017 and the Trust remained in financial special measures throughout 2018/19. The Trust delivered a deficit of £45.4 million in 2018/19, which represents a significant overspend compared to its original budgeted deficit of £29 million. This was principally due to activity levels, and hence income, being lower than forecast, as planned savings delivery was on target. In 2017/18, The Trust reported a deficit of £53.1 million compared to its budgeted deficit of £28.5 million.
- The Trust has set a forecast deficit budget of £3 million for 2019/20, which includes planned delivery of £45.8 million of transformational savings and receipt of £34.7 million of Provider Sustainability Fund (PSF), Marginal Rate Emergency Tariff and Financial Recovery Fund (FRF) income. The Trust will only receive its full allocation of PSF and FRF income if it delivers its agreed deficit target. Achieving the budgeted deficit will be a challenge for the Trust and will require continued changes to the Trust's arrangements for delivery of transformational savings.
- The Care Quality Commission (CQC) inspected the Trust in March to April 2018 and reported in July 2018. The report rated the Trust as 'Requires Improvement'. The Care Quality Commission (CQC) had previously inspected the Trust in June 2016 and gave the Trust an overall rating of 'Inadequate'. The Trust was placed in quality special measures following an earlier CQC inspection in 2016, and these measures continued to apply to the Trust throughout 2018/19.

These matters identify weaknesses in the Trust's arrangements for:

- setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services;
- responding to service delivery issues raised by regulators.

They are evidence of weaknesses in proper arrangements for:

- planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions; and
- acting in the public interest through demonstrating and applying the principles and values of sound governance.

Significant risks

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

Significant risks forming part of our qualified conclusion	How the matter was addressed in the audit
Risk 1 Financial outturn and financial sustainability As a result of the Trust's poor financial performance, in March 2017 NHS Improvement placed the Trust into Financial Special Measures and this remains the case in 2018/19. The Trust's audited financial statements for the year ended 31 March 2018 reported a deficit of £53 million. The Trust agreed a budgeted deficit for 2018/19 of £29 million with NHS Improvement. The current scale of the Trust's deficit will not be sustainable in the longer term.	Our audit work included, but was not restricted to: • assessing the Trust's arrangements for putting together and agreeing its budget, including identification of savings plans; and its arrangements for monitoring and managing delivery of its budget and savings plans for 2019/20, including the impact on service delivery • meeting with key officers to discuss and review planned arrangements for returning the Trust to a position of financial stability. **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis for adverse conclusion section of the report.
Risk 2 Care Quality Commission (CQC) inspection An inspection by the Care Quality Commission in June 2016 rated the Trust as requiring significant improvement. Follow-up CQC inspections in May 2017 and March to April 2018 identified that progress had been made by the Trust in addressing the CQC's initial findings, but that areas for improvement remained.	Our audit work included, but was not restricted to: • assessing how the Trust is implementing and monitoring delivery of its agreed action plan which was designed to address the findings of the CQC inspection. • Evaluating CQC reports issuing following inspection visit during the

The CQC rating was changed from 'inadequate' to 'requires improvement' in July 2018, but the Trust remained in quality special measures. There is a risk that the Trust will not be able to adequately respond to areas identified by the CQC as requiring improvement.	2018/19. **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis for adverse conclusion section of the report.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

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

Use of our report

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

Paul Dossett
Paul Dossett, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London
24th May 2019

St George's University Hospitals NHS
NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

St George's University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by St George's University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed  .....

Name **Jacqueline Totterdell**
Job title **Chief Executive**
Date **23 May 2019**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	19,509	22,384
Property, plant and equipment	15	370,963	354,841
Receivables	20	11,901	9,935
Other assets	21	11	11
Total non-current assets		**402,384**	**387,171**
Current assets			
Inventories	19	7,763	6,444
Receivables	20	90,325	102,328
Cash and cash equivalents	23	3,232	3,541
Total current assets		**101,320**	**112,313**
Current liabilities			
Trade and other payables	24	(124,215)	(132,596)
Borrowings	26	(73,805)	(57,710)
Provisions	28	(545)	(197)
Other liabilities	25	(2,484)	(2,049)
Total current liabilities		**(201,049)**	**(192,552)**
Total assets less current liabilities		**302,655**	**306,932**
Non-current liabilities			
Borrowings	26	(269,589)	(241,665)
Provisions	28	(1,037)	(950)
Total non-current liabilities		**(270,626)**	**(242,615)**
Total assets employed		**32,029**	**64,317**
Financed by			
Public dividend capital		133,358	133,153
Revaluation reserve		110,890	97,945
Other reserves		1,150	1,150
Income and expenditure reserve		(213,369)	(167,931)
		32,029	**64,317**

The notes on pages 8 to 63 form part of these accounts.

Name Jacqueline Totterdell
Position Chief Executive
Date 23 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	686,114	672,625
Other operating income	4	158,019	147,610
Operating expenses	7, 8	(879,058)	(863,250)
Operating surplus/(deficit) from continuing operations		**(34,925)**	**(43,015)**
Finance income	11	88	61
Finance expenses	12	(10,776)	(8,465)
PDC dividends payable		-	(1,369)
Net finance costs		**(10,688)**	**(9,773)**
Other gains / (losses)	13	175	(302)
Corporation tax expense		-	-
Surplus / (deficit) for the year from continuing operations		**(45,438)**	**(53,090)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	13	-	-
Surplus / (deficit) for the year		**(45,438)**	**(53,090)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	17	12,945	8,842
Foreign exchange gains / (losses) recognised directly in OCI		-	-
Total comprehensive income / (expense) for the period		**(32,493)**	**(44,248)**

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

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

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**129,956**	**89,103**	**1,150**	**(114,841)**	**105,368**
Surplus/(deficit) for the year	-	-	-	(53,090)	**(53,090)**
Revaluations	-	8,842	-	-	**8,842**
Public dividend capital received	3,197	-	-	-	**3,197**
Taxpayers' equity at 31 March 2018	**133,153**	**97,945**	**1,150**	**(167,931)**	**64,317**

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 Trust. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend.

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

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

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(34,925)	(43,015)
Non-cash income and expense:			
Depreciation and amortisation	7.1	23,836	20,930
Income recognised in respect of capital donations	4	(524)	(286)
(Increase) / decrease in receivables and other assets		8,878	(9,358)
(Increase) / decrease in inventories		(1,319)	131
Increase / (decrease) in payables and other liabilities		3,968	1,009
Increase / (decrease) in provisions		435	(178)
Other movements in operating cash flows		(189)	(182)
Net cash generated from / (used in) operating activities		**160**	**(30,949)**
Cash flows from investing activities			
Interest received		88	61
Purchase of intangible assets		(1,533)	(3,365)
Purchase of property, plant, equipment and investment property		(33,355)	(38,371)
Sales of property, plant, equipment and investment property		175	-
Receipt of cash donations to purchase capital assets		524	286
Net cash generated from / (used in) investing activities		**(34,101)**	**(41,389)**
Cash flows from financing activities			
Public dividend capital received		205	3,197
Movement on loans from the Department of Health and Social Care		47,722	83,307
Movement on other loans		(1,478)	(1,478)
Capital element of finance lease rental payments		(2,523)	(2,936)
Capital element of PFI, LIFT and other service concession payments		(1,062)	(993)
Interest on loans		(7,379)	(4,867)
Other interest		(1)	(29)
Interest paid on finance lease liabilities		(204)	(198)
Interest paid on PFI, LIFT and other service concession obligations		(2,779)	(2,848)
PDC dividend (paid) / refunded		1,131	(3,299)
		33,632	**69,856**
Increase / (decrease) in cash and cash equivalents		**(309)**	**(2,482)**
Cash and cash equivalents at 1 April - brought forward		**3,541**	**6,023**
Cash and cash equivalents at 31 March	23.1	**3,232**	**3,541**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 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

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. IAS 1 has been adapted for the public sector in that accounts are prepared on going concern basis if services will continue. The Trust incurred a deficit of £45.4m for the year ended 31 March 2019. During the year the Trust borrowed £51.9m under interim revenue support facilities provided by the NHS Independent Trust Financing Facility.

The board has reviewed the proposed 2019/20 plan throughout its development from October 2018 to date. The 2019/20 plan is for a deficit of £3m having taken account of the underlying financial position going into 2019/20. The Trust has identified in its financial plan submitted to NHS Improvement that further borrowing of £3m is required in order to fund the planned deficit, as well as further working capital support to allow for the timing of some elements of the Provider Sustainability Fund, and Financial Recovery Fund payments occurring in 2020/21.

In addition to the access requested to borrowing facilities to finance the planned 2019/20 deficit, the Trust will be requesting that the Department of Health provides borrowing facilities of £48.7m and £15.1m to finance the repayment of an existing DH borrowing facility in March 2020. The Department of Health and Social Care has advised the Trust that it is expected the Trust will be able to access borrowing to fully finance the repayment of this facility but that this would not be confirmed until later in the 2019/20 financial year.

At the time these financial statements were prepared the Trust was engaged in discussions with the regulator regarding the financial plan for 2019/20 and the arrangements to access further borrowing facilities to finance the planned deficit and finance the repayment of the facility maturing in March 2019 however these discussions had not concluded at the time the financial statements were approved. Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the directors, having made appropriate enquiries, 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 2018/19, 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 and has not included the adjustments that would result if it were unable to continue as a going concern.

Note 1.3 Interests in other entities

Joint operations

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 28.23%
- Kingston NHS Foundation Trust 30.24%
- St George's University Hospitals NHS Foundation Trust 41.53%

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 1.4.1 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). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The majority of income received by the Trust is via NHS commissioning organisations and is paid in the month that the activity is undertaken as per the SLA. Variances to commissioner plan are dealt with through over and under performance invoices and credit notes which are finalised following agreement with commissioners on 'Freeze' performance. Typically this is 2-3 months after the end of the period that the contractual obligation is undertaken.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. Income recognised at year end is also consistent with the year end settlement agreement from the Trust's main commissioners- these cover approximately 85% of the NHS Commissioning income of the Trust.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

In reviewing income recognised in the annual accounts in accordance with IFRS15, the Trust has reviewed contractual challenges and penalties, CQUIN delivery and education and training income as all are material elements of the Trust's income performance.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract

The Trust receives income from Health Education England for Education and training of medical and non medical trainees. Revenue is in respect of training provided and is recognised when performance obligations are satisfied when training has been performed. All performance obligation are undertaken within the financial year and is as agreed and invoiced to HEE.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust's accounting treatment of the income is on an accruals basis, rather than a defrayals basis. The accrual is based on historic data, for which the Trust has received notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. This income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

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.

The value of the benefit received when accessing funds from the 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, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, 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.

Employer's pension cost 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 1.6 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 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Trust
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Measurement

Valuation:

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at current value. Land and buildings used for the Trust's services or for the administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust changed the basis of the valuation of the land to an alternative site basis in 2015/16.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at current value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the statement of comprehensive income.

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.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.
Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Property, plant and equipment is depreciated as follows:
- Medical equipment is in general depreciated over 5, 10 or 15 years.
- Buildings (excluding dwelling) asset lives range from 3 years to 100 years.
- Plant and machinery asset lives range from 1 year to 25 years
- Transport equipment asset lives range from 5 years to 7 years.
- Information technology assets range from 5 years to 10 years.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.
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 DH 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 income 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.

Note 1.7.3 De-recognition
Assets intended for disposals are reclassified as 'held for sale' once all of the following criteria are met:
- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.:
  - o management are committed to a plan to sell the asset
  - o an active programme has begun to find a buyer and complete the sale
  - o the asset is being actively marketed at a reasonable price
  - o the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - o the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated, government grant and other 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.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at current value in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to finance costs within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the statement of comprehensive income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value. The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's statement of financial position.

Other assets contributed by the NHS trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Note 1.7.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	3	100
Dwellings	-	-
Plant & machinery	1	25
Transport equipment	5	7
Information technology	5	10
Furniture & fittings	-	-

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 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 only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

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.

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating.

Where intangible assets, which are held for operational use, have short useful economic lives, or are of low value (or both), then these are held at depreciated historic cost, as this is not considered to be materially different from current value in existing use.

Revaluations, gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

Note 1.8.3 Useful economic life of intangible assets

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

	Min life Years	**Max life Years**
Information technology	10	12
Software licences	5	7
Goodwill	5	7

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 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 1.11 Financial assets and financial liabilities

Prior Year

Note 1.11.1Recognition

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.
Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.
Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade - date.
All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.
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.

Note 1.11.2 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.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".
Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.
The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".
Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.
Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health and Social Care are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.
Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices/independent appraisals/discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.11.3 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.

Note 1.11.4 Financial assets and financial liabilities

Current year incorporatings IFRS9

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.

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

in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables including contract receivables, other receivables loans receivable, cash and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument. The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12.2 The trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

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

Note 1.13 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 the discount rates published and mandated by HM Treasury.

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

Non-clinical risk pooling

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

Note 1.14 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 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, 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 1.15 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.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.16 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 1.17 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 1.18 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

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

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in note 23.2 to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 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, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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 1.21 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 1.22 Critical judgements in applying accounting policies

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Land valuation:

The Trust has updated the valuation of its land and buildings in these financial statements. The valuation report was prepared by an independent valuer, Gerald Eve LLP, a firm of professionally (RICS) qualified valuers. The valuation was effective from 31 March 2019.

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 Trust's buildings and still serve the same local population. Gerald Eve LLP has identified an alternative site in Merton and has formulated a valuation for the land using relevant valuation metrics. The Trust considers that the Merton site identified by the valuer as the alternative site for valuation purposes is reasonable and consistent with the provision of the services from the current location as it is near the St George's Hospital site in Tooting.

Gerald Eve LLP have valued the existing buildings as they stand using Gross Internal Floor areas provided by the Trust by reference to the cost of providing a modern equivalent asset capable of delivering the required service provision. In instances where buildings or parts of buildings would not form part of the MEA, then this has been reflected in the valuation.

The applicable valuation principles make clear that where specialised buildings e.g. hospital facilities are involved and re-provision of buildings on the existing site would represent a waste of economic resources then a feasible lower cost site may be valued as an alternative. The Trust is satisfied the assumptions underpinning the valuation of the St George's Hospital site on the alternative site basis in these financial statements is reasonable and consistent with the principles of the alternative site valuation method.

Note 1.22.1 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.

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

- Plant, property and equipment - note 1.7 and note 15.1
- Intangible assets - paragraph 1.8 and note 14.1
- Provision for impairment of receivables – note 20.2
- Provisions - note 1.13 and note 28.1.

Revenue figures have been adjusted for the impairment of receivables. The Trust has made an appropriate, prudent provision for impairment of debts past their due date according to their age and assessment of their collectability.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018-19. These standards are still subject to HM Treasury FReM adoption and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning 1 April 2020.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 2 Operating Segments

This note is not applicable to St George's University NHS Foundation Trust as the organisation does not consider itself to have more than one operating segment that accounts for at least 10% of total revenue.
Income from CCGs account for 44% (2017/18: 44%) of the Trust revenue with a further 34% (2017/18: 35%) 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 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	114,398	109,671
Non elective income	164,409	158,670
First outpatient income	44,741	44,782
Follow up outpatient income	50,287	48,511
A & E income	22,740	22,350
High cost drugs income from commissioners (excluding pass-through costs)	39,556	42,097
Other NHS clinical income	201,379	203,071
Community services		
Community services income from CCGs and NHS England	34,558	32,144
Income from other sources (e.g. local authorities)	738	5,778
All services		
Private patient income	3,120	3,533
Agenda for Change pay award central funding	6,617	-
Other clinical income	3,571	2,018
Total income from activities	**686,114**	**672,625**

Note 3.2 Income from patient care activities (by source)		
Income from patient care activities received from:	**2018/19 £000**	**2017/18 £000**
NHS England	292,584	285,559
Clinical commissioning groups	370,201	364,375
Department of Health and Social Care	6,621	-
Other NHS providers	1,032	1,364
NHS other	1,491	2,090
Local Authorities	741	8,770
Non-NHS: private patients	3,120	3,533
Non-NHS overseas patients (chargeable to patient)	3,571	1,740
Injury cost recovery scheme	6,569	5,026
Non NHS: other	184	168
Total income from activities	**686,114**	**672,625**
Of which:		
Related to continuing operations	686,114	672,625
Related to discontinued operations	-	-

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

	2018/19	2017/18
	£000	£000
Income recognised this year	3,571	1,740
Cash payments received in-year	460	398
Amounts added to provision for impairment of receivables	(541)	807
Amounts written off in-year	-	-

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	5,121	4,709
Education and training (excluding notional apprenticeship levy income)	35,264	35,584
Non-patient care services to other bodies	65,210	60,407
Provider sustainability / sustainability and transformation fund income (PSF / STF)	6,904	-
Income in respect of employee benefits accounted on a gross basis	40,618	40,066
Other contract income	4,004	5,870
Other non-contract operating income		
Research and development (non-contract)	-	-
Education and training - notional income from apprenticeship fund	-	-
Receipt of capital grants and donations	524	286
Charitable and other contributions to expenditure	374	688
Total other operating income	**158,019**	**147,610**
Of which:		
Related to continuing operations	158,019	147,610
Related to discontinued operations	-	-

*Other income includes property rental income, pharmacy production income, car parking income and estates services

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,049
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Income from activities arising from commissioner requested services

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

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	685,733	673,318
Income from services not designated as commissioner requested services	153,390	144,938
Total	**839,123**	**818,256**

Note 5.3 Profits and losses on disposal of property, plant and equipment
2018/19

In 2018/19 the Trust disposed of old plant and equipment with a net book value of £0k.

2017/18

In 2017/18 the Trust disposed of old plant and equipment with a net book value of £302k.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19	2017/18
	£000	£000
Income	-	-
	-	-
Surplus / (deficit)	-	-

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,105	2,627
Purchase of healthcare from non-NHS and non-DHSC bodies	1,931	3,510
Purchase of social care	-	-
Staff and executive directors costs	534,983	522,536
Remuneration of non-executive directors	137	129
Supplies and services - clinical (excluding drugs costs)	96,720	97,583
Supplies and services - general	20,831	18,482
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	82,925	82,910
Inventories written down	-	-
Consultancy costs	7,420	9,215
Establishment	5,026	4,960
Premises	30,038	33,453
Transport (including patient travel)	7,944	7,908
Depreciation on property, plant and equipment	19,428	17,157
Amortisation on intangible assets	4,408	3,773
Net impairments	-	-
Movement in credit loss allowance: contract receivables / contract assets	2,713	
Movement in credit loss allowance: all other receivables and investments	-	1,312
Increase/(decrease) in other provisions	598	29
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	84	96
other auditor remuneration (external auditor only)	10	18
Internal audit costs	140	140
Clinical negligence	24,795	23,306
Legal fees	1,050	426
Insurance	62	63
Research and development	49	118
Education and training	3,471	3,062
Rentals under operating leases	18,119	18,224
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	6,358	7,535
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	-	-
Car parking & security	12	15
Hospitality	-	-
Losses, ex gratia & special payments	18	38
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	3,684	4,625
Total	**879,058**	**863,250**
Related to continuing operations	879,058	863,250
Related to discontinuing operations	-	-

Note 7.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	10	14
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	4
Total	**10**	**18**

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	424,434	411,798
Social security costs	42,896	41,547
Apprenticeship levy	2,044	1,979
Employer's contributions to NHS pensions	48,416	47,071
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	122	163
Temporary staff (including agency)	17,071	19,978
Total gross staff costs	**534,983**	**522,536**
Recoveries in respect of seconded staff	-	-
Total staff costs	**534,983**	**522,536**
Of which		
Costs capitalised as part of assets	-	-

Note 8.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £182k (£227k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

d) National Employment Savings Scheme (NEST)

The Trust offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), for those members of staff who do not qualify for the NHS pension scheme.

Note 10 Operating leases

Note 10.1 St George's University Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where St George's University Hospitals NHS Foundation Trust is the lessor.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Total	-	-

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
Total	-	-

Note 10.2 St George's University Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where St George's University Hospitals NHS Foundation Trust is the lessee.

The Trust has operating leases for the use of accommodation to operate clinical facilities at a number of properties managed by NHS Property Services Company Ltd (NHSPS). The most significant operating lease with NHSPS is for the space occupied at Queen Mary's Roehampton for which the Trust pays NHSPS approximately £13.2m pa. The leases are subject to annual review and renewal.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	18,119	18,224
Contingent rents	-	-
Less sublease payments received	-	-
Total	**18,119**	**18,224**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	17,993	18,103
- later than one year and not later than five years;	71,973	71,974
- later than five years.	17,993	17,983
	107,959	**108,060**
Future minimum sublease payments to be received	-	-

	31 March 2019 £000	31 March 2018 £000
Category of Lease		
Land	-	-
Building	103,548	106,136
Other	4,411	1,924
Total	**107,959**	**108,060**

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	88	61
Total finance income	**88**	**61**

Note 12.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	7,629	5,201
Other loans	161	187
Overdrafts	-	-
Finance leases	203	198
Interest on late payment of commercial debt	1	29
Main finance costs on PFI and LIFT schemes obligations	2,779	2,848
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**10,773**	**8,463**
Unwinding of discount on provisions	3	2
Other finance costs	-	-
Total finance costs	**10,776**	**8,465**

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

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	1	29
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	175	-
Losses on disposal of assets	-	(302)
Total gains / (losses) on disposal of assets	**175**	**(302)**
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
	-	-
Total other gains / (losses)	**175**	**(302)**

2018/19

In 2018/19 the Trust disposed of old plant and equipment with a net book value of £0k.

2017/18

In 2017/18 the Trust disposed of old plant and equipment with a net book value of £302k.

Note 14.1 Intangible assets - 2018/19

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**2,164**	**34,974**	**37,138**
Transfers by absorption	-	-	-
Additions	679	854	**1,533**
Reclassifications	36	(36)	-
Valuation / gross cost at 31 March 2019	**2,879**	**35,792**	**38,671**
Amortisation at 1 April 2018 - brought forward	**1,553**	**13,201**	**14,754**
Transfers by absorption	-	-	-
Provided during the year	371	4,037	**4,408**
Amortisation at 31 March 2019	**1,924**	**17,238**	**19,162**
Net book value at 31 March 2019	**955**	**18,554**	**19,509**
Net book value at 1 April 2018	**611**	**21,773**	**22,384**

Note 14.2 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**1,300**	**28,596**	**29,896**
Prior period adjustments	-	-	-
Valuation / gross cost at 1 April 2017 - restated	**1,300**	**28,596**	**29,896**
Transfers by absorption	-	-	-
Additions	271	3,094	**3,365**
Reclassifications	1,274	4,995	**6,269**
Transfers to / from assets held for sale	-	-	-
Disposals / derecognition	(681)	(1,711)	**(2,392)**
Valuation / gross cost at 31 March 2018	**2,164**	**34,974**	**37,138**
Amortisation at 1 April 2017 - as previously stated	**981**	**12,422**	**13,403**
Prior period adjustments	-	-	-
Amortisation at 1 April 2017 - restated	**981**	**12,422**	**13,403**
Transfers by absorption	-	-	-
Provided during the year	331	3,442	**3,773**
Reclassifications	922	(952)	**(30)**
Transfers to / from assets held for sale	-	-	-
Disposals / derecognition	(681)	(1,711)	**(2,392)**
Amortisation at 31 March 2018	**1,553**	**13,201**	**14,754**
Net book value at 31 March 2018	**611**	**21,773**	**22,384**
Net book value at 1 April 2017	**319**	**16,174**	**16,493**

Note 15.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**46,144**	**221,784**	**113**	**35,327**	**77,874**	**-**	**20,361**	**10,073**	**411,676**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	6,501	-	4,898	6,767	-	4,012	427	**22,605**
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	9,785	(4,343)	-	-	-	-	-	-	**5,442**
Reclassifications	-	1,343	-	(1,585)	-	-	-	243	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(1,233)	-	-	-	**(1,233)**
Valuation/gross cost at 31 March 2019	**55,929**	**225,285**	**113**	**38,640**	**83,408**	**-**	**24,373**	**10,743**	**438,490**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**5**	**-**	**39,791**	**-**	**10,794**	**6,245**	**56,835**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	7,503	5	-	7,795	-	3,441	683	**19,428**
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(7,503)	-	-	-	-	-	-	**(7,503)**
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(1,233)	-	-	-	**(1,233)**
Accumulated depreciation at 31 March 2019	**-**	**(0)**	**10**	**-**	**46,353**	**-**	**14,235**	**6,928**	**67,527**
Net book value at 31 March 2019	**55,929**	**225,285**	**103**	**38,640**	**37,054**	**-**	**10,138**	**3,815**	**370,963**
Net book value at 1 April 2018	**46,144**	**221,784**	**108**	**35,327**	**38,083**	**-**	**9,567**	**3,828**	**354,841**

The depreciation charge for buildings of £7,503k for 2018/19 is transferred from accumulated depreciation to gross cost in accordance with the accounting requirements for the revaluation of buildings. This transfer has no impact on the Statement of Comprehensive Income or on the carrying value of buildings and is effected to comply with the DHSC Group Accounting Manual.

Note 15.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	45,922	202,053	113	33,136	90,439	144	31,713	33,997	437,517
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	45,922	202,053	113	33,136	90,439	144	31,713	33,997	437,517
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	11,099	-	25,397	11,987	-	1,783	151	50,417
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	222	1,360	-	-	-	-	-	-	1,582
Reclassifications	-	7,272	-	(23,059)	8,468	-	987	63	(6,269)
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(147)	(33,020)	(144)	(14,122)	(24,138)	(71,571)
Valuation/gross cost at 31 March 2018	46,144	221,784	113	35,327	77,874	-	20,361	10,073	411,676
Accumulated depreciation at 1 April 2017 - as previously stated	-	-	-	-	66,087	144	22,364	29,584	118,179
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2017 - restated	-	-	-	-	66,087	144	22,364	29,584	118,179
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	7,260	5	-	6,586	-	2,552	754	17,157
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(7,260)	-	-	-	-	-	-	(7,260)
Reclassifications	-	-	-	-	30	-	-	-	30
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(32,912)	(144)	(14,122)	(24,093)	(71,271)
Accumulated depreciation at 31 March 2018	-	-	5	-	39,791	-	10,794	6,245	56,835
Net book value at 31 March 2018	46,144	221,784	108	35,327	38,083	-	9,567	3,828	354,841
Net book value at 1 April 2017	45,922	202,053	113	33,136	24,352	-	9,349	4,413	319,338

The depreciation charge for buildings of £7,260k for 2017/18 is transferred from accumulated depreciation to gross cost in accordance with the accounting requirements for the revaluation of buildings. This transfer has no impact on the Statement of Comprehensive Income or on the carrying value of buildings and is effected to comply with the DHSC Group Accounting Manual.

Note 15.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	54,914	161,314	103	38,640	28,702	10,108	3,638	**297,418**
Finance leased	-	-	-	-	7,167	-	-	**7,167**
On-SoFP PFI contracts and other service concession arrangements	-	51,585	-	-	-	-	-	**51,585**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - government granted	-	2,181	-	-	5	-	13	**2,199**
Owned - donated	1,015	10,205	-	-	1,180	30	164	**12,594**
NBV total at 31 March 2019	**55,929**	**225,285**	**103**	**38,640**	**37,054**	**10,138**	**3,815**	**370,963**

Note 15.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	45,129	157,576	108	35,269	27,528	9,522	3,604	**278,736**
Finance leased	-	-	-	-	9,348	-	-	**9,348**
On-SoFP PFI contracts and other service concession arrangements	-	51,636	-	-	-	-	-	**51,636**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-
Owned - government granted	-	2,184	-	-	25	-	19	**2,228**
Owned - donated	1,015	10,388	-	58	1,182	45	205	**12,893**
NBV total at 31 March 2018	**46,144**	**221,784**	**108**	**35,327**	**38,083**	**9,567**	**3,828**	**354,841**

Note 16 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 17 Revaluations of property, plant and equipment

In 2018/19 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 2019 and the results of the valuation are included in these accounts. The valuations were prepared on the modern equivalent asset (MEA) basis applicable to NHS Trusts.

In 2015/16, the Trust changed the basis of the valuation of the land on the St George's Hospital site to an alternative site basis. 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 Trust's buildings and still serve the same local population. Gerald Eve LLP have identified an alternative site in Merton and have 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.

In 2016/17 the Trust changed the basis of valuation for Atkinson Morley wing to exclude VAT on the grounds that this building is financed by a PFI scheme for which the VAT on the unitary charges payable by the Trust is recoverable. This treatment is permitted under a change in the applicable valuation techniques effective from 2016/17 onwards.

Buildings are subject to composite depreciation rates according to their elemental breakdown eg substructure 80 years, internal wall 25 years etc.

Medical equipment is in general depreciated over 5, 10 or 15 years.

Buildings (excluding dwelling) asset lives range from 3 years to 100 years.

Plant and machinery asset lives range from 1 year to 25 years

Transport equipment asset lives range from 5 years to 7 years.

Information technology assets range from 5 years to 10 years.

There is no compensation from third parties for assets impaired, lost or given up that is included in the Trust's deficit for the year.

Note 18 Disclosure of interests in other entities

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

Note 19 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	2,678	1,963
Work In progress	-	-
Consumables	5,085	4,481
Energy	-	-
Other	-	-
Total inventories	**7,763**	**6,444**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £81,514k (2017/18: £82,128k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 20.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	82,168	-
Trade receivables*		54,567
Accrued income*		21,270
Allowance for impaired contract receivables / assets*	(8,642)	-
Allowance for other impaired receivables	-	(8,347)
Prepayments (non-PFI)	4,782	4,728
PDC dividend receivable	799	1,930
VAT receivable	4,362	6,806
Other receivables	6,856	21,374
Total current trade and other receivables	**90,325**	**102,328**
Non-current		
Contract receivables*	11,901	-
Other receivables	-	9,935
Total non-current trade and other receivables	**11,901**	**9,935**
Of which receivables from NHS and DHSC group bodies:		
Current	47,652	54,765
Non-current	-	-

Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 20.2 Allowances for credit losses - 2018/19	Contract receivables and contract assets	All other receivables	31 March 2019
	£000	£000	
Allowances as at 1 Apr 2018 - brought forward	-	8,347	
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	8,347	(8,347)	
New allowances arising	2,713	-	
Utilisation of allowances (write offs)	(2,418)	-	
Allowances as at 31 Mar 2019	**8,642**	**-**	

The Trust determines the provision for impairment of receivables on the bases of the age of the debt and the risk of non- collection.

Note 20.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**6,358**
Increase in provision	1,310
Amounts utilised	677
Unused amounts reversed	2
Allowances as at 31 Mar 2018	**8,347**

Note 20.4 Exposure to credit risk

The Trust has carried out a review of 18/19 receivables and there is no material exposure to credit risks

Note 21 Other assets

	31 March 2019	31 March 2018
Current	£000	£000
Total other current assets	-	-
Non-current		
Other assets	11	11
Total other non-current assets	**11**	**11**

Note 22 Non-current assets held for sale and assets in disposal groups

There were no non-current assets for sale in 2018/19 or 2017/18

Note 22.1 Liabilities in disposal groups

	31 March 2019 £000	31 March 2018 £000
Total	-	-

Note 23.1 Cash and cash equivalents movements

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

	2018/19 £000	2017/18 £000
At 1 April	**3,541**	**6,023**
Prior period adjustments	-	-
At 1 April (restated)	**3,541**	**6,023**
Transfers by absorption	-	-
Net change in year	(309)	(2,482)
At 31 March	**3,232**	**3,541**
Broken down into:		
Cash at commercial banks and in hand	56	68
Cash with the Government Banking Service	3,176	3,473
Total cash and cash equivalents as in SoFP	**3,232**	**3,541**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**3,232**	**3,541**

Note 23.2 Third party assets held by the trust

The trust held £5,827 in cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019 £000	31 March 2018 £000
Bank balances	-	-
	6	6
Total third party assets	**6**	**6**

Note 24.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	95,721	94,412
Capital payables	4,270	15,406
Accruals	4,043	5,262
Receipts in advance (including payments on account)	-	-
Social security costs	13,702	13,043
VAT payables	-	-
Other taxes payable	5,475	1,581
PDC dividend payable	-	-
Accrued interest on loans*		779
Other payables	1,003	2,112
Total current trade and other payables	**124,215**	**132,596**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables to NHS and DHSC group bodies:		
Current	17,107	17,177
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 33.3 . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 25 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	2,484	2,049
Other deferred income	-	
Total other current liabilities	**2,484**	**2,049**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 26 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	69,157	52,921
Other loans	1,478	1,478
Obligations under finance leases	2,034	2,249
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,136	1,062
Total current borrowings	**73,805**	**57,710**
Non-current		
Loans from the Department of Health and Social Care	217,932	185,283
Other loans	6,652	8,130
Obligations under finance leases	3,536	5,647
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	41,469	42,605
Total non-current borrowings	**269,589**	**241,665**

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 2018/19. As at 31/03/19 the balance owed by the Trust on this loan is £12.6m.

2. The Trust drew down a capital loan of £16.2m during 2016/17 and 2017/18. This capital loan is repayable over 10 years at a fixed interest rate of 0.56%. As at 31/03/18 the balance owed by the Trust on this loan is £14.6m.

3. The Trust drew down a capital loan of £10m in March 2018. This capital loan is repayable over 10 years at a fixed interest rate of 1.26%. As at 31/03/19 the balance owed by the Trust on this loan is £9m.

DH working capital loans and working capital facilities

4. The Trust has a working capital loan of £15m from the Department of Health of Social Care (received in 2014/15) which is repayable over 15 years in equal instalments at a fixed interest rate of 1.38%.The Trust repaid £1m of this loan in 2018/19. As at 31/03/19 the balance owed by the Trust on this loan is £11m.

5. The Trust borrowed a total of £48.7m during 2015/16 and 2016/17 under an interim revenue support facility agreed with the Department of Health and Social Care in February 2016. This facility was originally repayable in full in March 2019 however before the end of the 2018/19 financial year the Department of Health deferred the repayment of the facility to March 2020 and so the repayment of this facility is classified as a current liability for the third successive year in 2018/19. The interest rate is fixed at 1.5% and the full amount borrowed of £48.7m is repayable in March 2020. As at 31/03/19 the balance owed by the Trust on this facility is £48.7m.

6. The Trust borrowed £64.3m under an interim working capital facility in 2016/17. The interest rate is 3.5% for all borrowings under this facility. The facility is repayable in full in September 2020. As at 31/03/19 the balance owed by the Trust on this facility is £64.3m.

7. The Trust borrowed £15.1m under an interim working capital loan in 2016/17. The interest rate is 1.5% for all borrowings under this loan facility. The facility is repayable in full in March 2020. As at 31/03/19 the balance owed by the Trust on this facility is £15.1m.

8. The Trust borrowed £34.5m interim working capital facility loans in the period July - October 2017. The interest rate is 6% for all borrowings under these loan agreements. These loans are repayable in full in the period July 2020 to October 2020 inclusive. As at 31/03/19 the balance owed by the Trust on these loans is £34.5m.

9. The Trust borrowed £25.8m interim working capital facility loans in the period November 2018 to March 2018. The interest rate is 3.5% for all borrowings under these loan agreements. These loans are repayable in full in the period November 2020 to March 2021 inclusive. As at 31/03/19 the balance owed by the Trust on these loans is £25.8m.

10. The Trust borrowed £51.9m interim working capital facility loans in the period April 2018 to March 2019. The interest rate is 3.5% for all borrowings under these loan agreements. These loans are repayable in full in the period April 2021 to March 2022 inclusive. As at 31/03/19 the balance owed by the Trust on these loans is £51.9m.

Borrowings from other bodies

London Energy Efficiency Fund

11. The Trust received a loan from the London Energy Efficiency Fund (LEEF) for £13.3m in 2014/15 to finance an energy performance contract capital project with British Gas. The LEEF loan is repayable over 10 years at a fixed interest rate of 0.67% for the period July 2014 to March 2015 inclusive and a fixed interest rate of 1.81% thereafter. The Trust repaid £1.5m of this loan in 2018/19. As at 31/03/19 the balance owed by the Trust on this loan is £8.1m.

Finance leases

12. The Trust uses leasing to supplement capital investment in medical equipment where appropriate taking into account a number of factors including implicit rates of interest, the expected useful economic life of the equipment, the residual value of the equipment at the end of the lease term and the expected rate of technological change, to ensure value for money. During the course of 2018/19 the Trust took out new finance leases with a leasing company for equipment with a capital value of approx £0.2m in respect of various items of medical equipment. The Trust made repayments of principal under finance leases of £2.5m in 2018/19. As at 31/03/19 the capital balance owed by the Trust for finance leases is £5.6m.

Private Finance Initiative on-SoFP scheme

13. The Trust entered into a Private Finance Initiative contract in March 2000 for the exclusive use of Atkinson Morley wing on the St George's hospital site. The capital value of the buildings and equipment encompassed within the PFI contract was approx £50m. The Trust accounts for this PFI contract as an on-Statement of Financial Position scheme and includes the value of the buildings and equipment within Property Plant and Equipment and the associated finance lease creditor within Borrowings. The implicit rate of the finance lease is approx. 7.5%. The Trust repaid approx £1m of the PFI finance lease creditor in 2018/19. As at 31/03/19 the capital balance owed by the Trust for the PFI scheme lease creditor is £42.6m.

Note 26.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**238,204**	**9,608**	**7,896**	**43,667**	**299,375**
Cash movements:					
Financing cash flows - payments and receipts of principal	47,722	(1,478)	(2,523)	(1,062)	**42,659**
Financing cash flows - payments of interest	(7,379)	-	(204)	(2,779)	**(10,362)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	712	67	-	-	**779**
Application of effective interest rate	7,629	161	203	2,779	**10,772**
Change in effective interest rate	-	(228)	198	-	**(30)**
Other changes	201	-	-	-	**201**
Carrying value at 31 March 2019	**287,089**	**8,130**	**5,570**	**42,605**	**343,394**

Note 27 Finance leases

Note 27.1 St George's University Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where St George's University Hospitals NHS Foundation Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**6,120**	**8,671**
of which liabilities are due:		
- not later than one year;	2,233	2,466
- later than one year and not later than five years;	3,743	5,919
- later than five years.	144	286
Finance charges allocated to future periods	(550)	(775)
Net lease liabilities	**5,570**	**7,896**
of which payable:		
- not later than one year;	2,034	2,249
- later than one year and not later than five years;	3,406	5,389
- later than five years.	130	258
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as an expense in the period	-	-

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 28.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2018	**995**	**53**	**99**	**1,147**
Transfers by absorption	-	-	-	**-**
Change in the discount rate	-	-	-	**-**
Arising during the year	205	371	121	**697**
Utilised during the year	(166)	-	-	**(166)**
Reclassified to liabilities held in disposal groups	-	-	-	**-**
Reversed unused	-	-	(99)	**(99)**
Unwinding of discount	3	-	-	**3**
At 31 March 2019	**1,037**	**424**	**121**	**1,582**
Expected timing of cash flows:				
- not later than one year;	-	424	121	**545**
- later than one year and not later than five years;	1,037	-	-	**1,037**
- later than five years.	(0)	-	-	**(0)**
Total	**1,037**	**424**	**121**	**1,582**

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 28.2 Clinical negligence liabilities

At 31 March 2019, £354,931k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of St George's University Hospitals NHS Foundation Trust (31 March 2018: £312,264k).

Note 29 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(101)	(38)
Gross value of contingent liabilities	**(101)**	**(38)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(101)**	**(38)**
Net value of contingent assets	**-**	**-**

The contingent liability relates to member's costs of potential insurance claims under the Liability to Third Parties scheme managed on the Trust's behalf by NHS Resolution who assess the probability of claims.

Note 30 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	1,215	2,297
Intangible assets	-	-
Total	**1,215**	**2,297**

The capital commitments total of £1.215m as at 31/03/19 relates to the work for the Trust's standby generators.

Note 31 On-SoFP PFI, LIFT or other service concession arrangements

Note 31.1 Imputed finance lease obligations

St George's University Hospitals NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**74,335**	**78,175**
Of which liabilities are due		
- not later than one year;	3,841	3,841
- later than one year and not later than five years;	15,363	15,363
- later than five years.	55,131	58,971
Finance charges allocated to future periods	(31,730)	(34,508)
Net PFI, LIFT or other service concession arrangement obligation	**42,605**	**43,667**
- not later than one year;	1,136	1,062
- later than one year and not later than five years;	5,399	5,045
- later than five years.	36,070	37,559

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

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

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**246,021**	**238,896**
Of which liabilities are due:		
- not later than one year;	10,125	11,376
- later than one year and not later than five years;	42,568	45,504
- later than five years.	193,328	182,016

Note 31.3 Analysis of amounts payable to service concession operator

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

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**10,199**	**11,376**
Consisting of:		
- Interest charge	2,779	2,848
- Repayment of finance lease liability	1,062	993
- Service element and other charges to operating expenditure	6,358	7,535
Total amount paid to service concession operator	**10,199**	**11,376**

Note 33 Financial instruments

Note 33.1 Financial risk management

The applicable standards for financial instruments are IAS 32/IAS 39/IFRS 7 for 2017/18. In 2018/19 IAS 39 has been superseded by IFRS 9.

IAS 32 defines financial instrument as a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Examples of financial assets are cash or a contractual right to receive cash.

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The Trust is not exposed to the degree of financial risk faced by business entities because of the continuing service provider relationship that the Trust has with clinical commissioning groups and the way those bodies are financed. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's cash management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has minimal overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure subject to affordability as confirmed by the regulator. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust also borrows from government to finance working capital and to finance operating losses using working capital loans and working capital facilities respectively. These borrowings are at fixed rates of interest. The Trust has a loan with the London Energy Efficiency Fund to finance capital expenditure which is also at a fixed rate of interest. Therefore the Trust has low exposure to interest rate fluctuations.

Credit risk

The Trust has low exposure to credit risk because the majority of the Trust's revenue comes from contracts with other public sector bodies. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred primarily under contracts with clinical commissioning groups which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks in terms of the timing of payments for most of its receivables. The Trust has incurred operating deficits since 2014/15 and this has necessitated borrowing from government to maintain liquidity.

Note 33.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	89,717	-	-	**89,717**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents at bank and in hand	3,232	-	-	**3,232**
Total at 31 March 2019	**92,949**	**-**	**-**	**92,949**

The £89.7m Trade and other receivable excludes the following non Financial assets

Financial assets as per Statement of Financial Position

	£000
Trade and other receivables excluding non financial assets	89,717
RTA	2,566
Prepayments	4,782
PDC	799
VAT	4,362
Total at 31 March 2019	**102,226**

Statement of Financial Position	
Non Current Receivables	11,901
Current Receivables	90,325
Total at 31 March 2019	**102,226**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	86,411	-	-	-	**86,411**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	3,541	-	-	-	**3,541**
Total at 31 March 2018	**89,952**	**-**	**-**	**-**	**89,952**

Note 33.3 Carrying value of financial liabilities

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	287,089	-	**287,089**
Obligations under finance leases	5,570	-	**5,570**
Obligations under PFI, LIFT and other service concession contracts	42,605	-	**42,605**
Other borrowings	8,130	-	**8,130**
Trade and other payables excluding non financial liabilities	98,511	-	**98,511**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2019	**441,905**	**-**	**441,905**

The Financial Liabilities as per Statement of Financial Position

Borrowing	£000
Loans from the Department of Health and Social Care	287,089
Obligations under finance leases	5,570
Obligations under PFI, LIFT and other service concession contracts	42,605
Other borrowings	8,130
Total at 31 March 2019	**343,394**

Statement of Financial Position	
Current Borrowings	73,805
Non Current Borrowings	269,589
Total at 31 March 2019	**343,394**

Trade and other payables	£000
Trade and other payables excluding non financial liabilities	98,511
Social Security cost	13,702
Other Taxes	5,475
Accruals	6,527
Total at 31 March 2019	**124,215**

Statement of Financial Position	
Current Trade and other payables	124,215
Total at 31 March 2019	**124,215**

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	
Borrowing	343,394
Trade and other payables	98,511
	441,905

	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	238,204	-	**238,204**
Obligations under finance leases	7,896	-	**7,896**
Obligations under PFI, LIFT and other service concession contracts	43,667	-	**43,667**
Other borrowings	9,608	-	**9,608**
Trade and other payables excluding non financial liabilities	111,798	-	**111,798**
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	**411,173**	**-**	**411,173**

Note 33.4 Fair values of financial assets and liabilities

The Trust considers that the fair value of financial assets and financial liabilities are the same as book value.

	31 March 2019 Book Value £000	31 March 2019 Fair Value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	89,717	89,717
Other investments / financial assets	-	-
Cash and cash equivalents at bank and in hand	3,232	3,232
Total at 31 March 2019	**92,949**	**92,949**

	31 March 2019 Book Value £000	31 March 2019 Fair Value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	287,089	287,089
Obligations under finance leases	5,570	5,570
Obligations under PFI, LIFT and other service concession contracts	42,605	42,605
Other borrowings	8,130	8,130
Trade and other payables excluding non financial liabilities	98,511	98,511
Other financial liabilities	-	-
Provisions under contract	-	-
Total at 31 March 2019	**441,905**	**441,905**

Note 33.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	157,243	169,508
In more than one year but not more than two years	23,942	24,150
In more than two years but not more than five years	198,550	148,754
In more than five years	62,170	68,761
Total	**441,905**	**411,173**

Note 34 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Total losses	-	-	-	-
Special payments				
Ex-gratia payments	70	68	76	239
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**70**	**68**	**76**	**239**
Total losses and special payments	**70**	**68**	**76**	**239**
Compensation payments received		-		-

Note 35.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £712k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £12,387k.

Note 35.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 36 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	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Non - NHS Related party transactions				
St George's University of London	1,540	1,291	3,207	1,218
St George's Hospital Charity	455	328	-	-
Total	**1,995**	**1,619**	**3,207**	**1,218**

	Receipts from Related Party		Payments to Related party	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Non - NHS Related party transactions				
St George's University of London	4,087	4,945	3,154	6,032
St George's Hospital Charity	1,369	1,545	46	33
Total	**5,456**	**6,491**	**3,200**	**6,065**

Under the Requirements of IAS 24 (Related Party Disclosures), the Trust has disclosed as a related party where key management services have been provided by another entity such as personal service companies. The total transactions for these companies where key management services were provided are detailed below.

	Receipts from Related Party		Payments to Related party	
	2018/19	2017/18	2018/19	2017/18
Company	£000	£000	£000	£000
MR Strategic Ltd	-	-	-	150
IT Matters Ltd	-	-	-	37
	0	**0**	**0**	**187**

2018/19 Related parties

There are no related parties for Directors in 2018/2019

2017/18 Related parties

MR Strategic LTD provided Mark Gordon in the role of Chief operatiing officer from Oct 16 to April 17

IT Matters Ltd provided Richard Hancock in the role of Director of estates, facilities and capital projects from March 2016 to March 2017

Note 37 Transfers by adjustments

There were no transfers by adjustments in 2018/19 or 2017/18.

Note 38 Transfers by absorption

There were no transfers by absorption in 2018/19 or 2017/18.

Note 39 Prior period adjustments

There were no prior period adjustments in 2018/19 or 2017/18.

Note 40 Events after the reporting date

There were no events to report post 31 March 2019.

Note 41 Final period of operation as a provider of NHS healthcare

This note is not applicable for 2018/19 or 2017/18

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